Children with Special Health Care Needs (CSHCN) Services Program

PROVIDER MANUAL

April 2025

TMHP
Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

TEXAS
Health and Human Services

Introduction

CSHCN Services Program Provider Manual

April 2025

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INTRODUCTION

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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.
- 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, webinars).

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 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), International Classification of Disease (ICD) code descriptions, 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), World Health Organization (WHO), 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.

1.5 Copyright Acknowledgments

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TMHP AND HHSC CONTACT INFORMATION

CSHCN SERVICES PROGRAM PROVIDER MANUAL

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TMHP AND HHSC CONTACT INFORMATION

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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 Helpline	1-800-252-8023, Option 2
TMHP Electronic Data Interchange (EDI) Help Desk	1-888-863-3638, Option 4
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	1-512-776-7238

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 12365-A Riata Trace Parkway, Suite 100 Austin, TX 78727
Provider Complaints	CSHCN Services Program ATTN: Complaints MC-1938 PO Box 149030 Austin, TX 78714-9947
Prior Authorization and Authorization	Texas Medicaid & Healthcare Partnership Attn: TMHP-CSHCN Services Program Authorizations Department, MC-A11 12365-A 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
Electronic Claims and Rejected Reports (Past the 95-day filing deadline)	Texas Medicaid & Healthcare Partnership PO Box 200645 Austin, TX 78720-0645

Correspondence	Address
Other Correspondence (Must be directed to a specific department or individual)	Texas Medicaid & Healthcare Partnership Attn: CSHCN Services Program Appeals, MC-A11 12365-A 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.*

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.*

Refer to: https://www.ama-assn.org/practice-management/cpt/cpt-overview-and-code-approval

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/resources/provider-support-services.

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.
- A chatbot for frequently asked questions and a live chat to speak with an agent.

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.
- EDI reference and connectivity guides.
- Fee schedules.
- Provider manuals.

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 offices of the CSHCN Services Program are administratively located within the Office of Primary and Specialty Health, Health & Developmental Services section of the division for Health, Developmental & Independence Services, at the Health and Human Services Commission (HHSC).

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 at 1-512-776-7162 or the Austin local number at 1-512-776-7238
- Send email to cshcn@dshs.texas.gov

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 TMHP website at https://www.tmhp.com/topics/provider-enrollment/how-apply-enrollment.

Mail completed enrollment applications to the following address:

CSHCN Services Program—Provider Enrollment
MC-1938
PO Box 149030
Austin, TX 78714–9947
Fax: 1-512-776-7238

Deliveries and overnight mail to the following address:

CSHCN Services Program—Provider Enrollment
MC-1938
Health and Human Services Commission-Moreton Building
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.hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/children-special-health-care-needs-services-program.

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" for definitions of the abbreviated academic degrees listed in the following tables.

1.3.2.1 Region 1

DSHS Health Service Region (HSR) 1 3407 Pony Express Way, Amarillo, TX 79118 Telephone: 1-806-655-7151 Fax: 1-806-373-4757	
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	

1.3.2.2 Region 2

2A - Abilene Office Health Services Region 2 4601 South First Street, Suite L Abilene, TX 79605–1466 Telephone: 1-325-795-5847 Fax: 1-325-795-5894	

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: 1-817-264-4634 or 1-817-264-4619 Fax: 1-817-264-4911	
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 Fax: 1-940-591-6254	

1.3.2.4 Region 4

4/5N - Regional Office (Tyler) Health Service Region 4/5N 2521 West Front Street Tyler, TX 75702–7822 Telephone: 1-903-533-5269 Toll free: 1-877-340-8842 Fax: 1-903-535-7593	
Athens Office 708 East Corsicana Athens, TX 75751 Telephone: 1-903-675-9107 Fax: 1-903-675-3622	

Carthage Office 1430 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	
Linden Office 213 Hwy 8 N (physical address) 123 Kaufman (mailing address) PO Box 300 Linden, TX 75563 Telephone: 1-903-756-4807 Fax: 1-903-756-5146	
Longview Office 1750 North Eastman Road Longview, TX 75601–3347 Telephone: 1-903-232-3289 Toll Free: 1-866-327-1364 Fax: 1-903-232-3278	
Marshall Office 4105 Victory Drive Marshall, TX 75670 Telephone: 1-903-927-0218 Toll Free: 1-866-327-1364 Fax: 1-903-927-0290	
Mount Pleasant Office 1014 North Jefferson Mount Pleasant, TX 75455 Telephone: 1-903-577-1929 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	
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 3101 Summerhill Road Texarkana, TX 75703 Telephone: 1-903-791-3229 Fax: 1-903-791-3230	

1.3.2.5 Region 5 North

Center Office 912 Nacogdoches Center, TX 75935 Telephone: 1-936-598-1231 Fax: 1-936-591-0162	
Crockett Office 1034 South Fourth Street Crockett, TX 75835 Telephone: 1-936-545-0360 Fax: 1-936-544-0280	
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 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 Toll Free: 1-877-340-8840 Fax: 1-936-633-3667	
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	

1.3.2.6 Regions 5 South and 6

6/5S - Regional Office (Houston) 5425 Polk Avenue, Suite 460 Houston, TX 77023–1497 Telephone: 1-713-767-3111 Fax: 1-713-767-3125	
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: 1-254-771-6791 or 1-800-789-2865 Fax: 1-254-750-9372	

7A - Austin Office Health Services Region 7 1601 Rutherford Lane, Suite C-3 Austin, TX 78754–5119 Telephone: 1-512-873-6308 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	
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 421 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 or 1-254-750-9248 Fax: 1-254-753-0879	

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 1-210-949-2155 Fax: 1-210-949-2047	
Uvalde Office 112 Joe Carper Drive 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: 1-830-758-4252 Fax: 1-830-773-4688	
Victoria Office 2306 Leary Lane Victoria, TX 77901 Telephone: 1-361-574-7421 Fax: 1-361-574-7396	

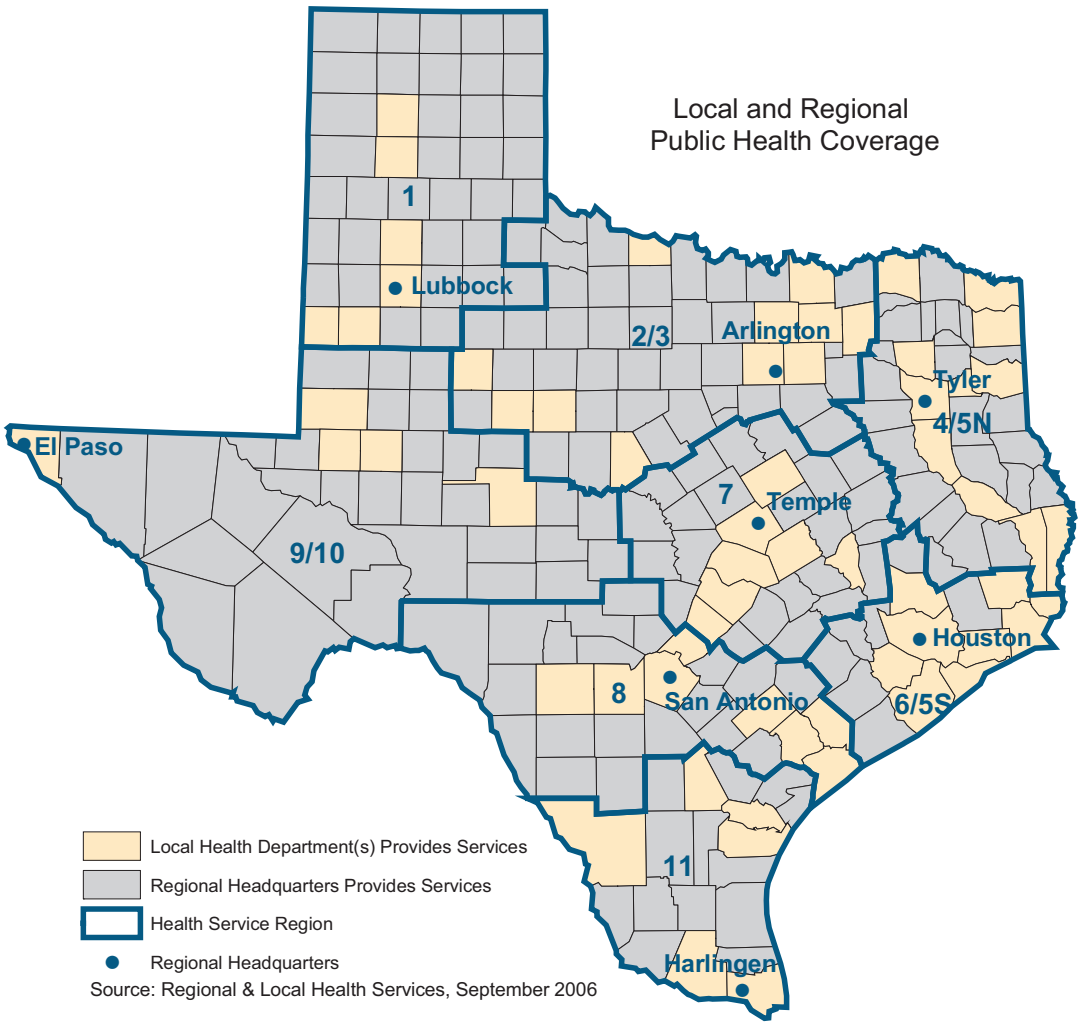
1.3.2.9 Regions 9 and 10

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	
Midland Office 2301 N Big Spring Street, Suite 300 Midland, TX 79705 Telephone: 1-432-683-9492 Fax: 1-432-684-3932	
San Angelo Office 622 South Oakes, Suite H San Angelo, TX 76903 Telephone: 1-325-659-7853 Fax: 1-915-655-6798	

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	
Alice Office 408 N. Flournoy, Suite C Alice, TX 78332 Telephone: 1-361-660-2263 Fax: 1-361-668-4000	
11C - Corpus Christi Office Health Services Region 11 5155 Flynn Pkwy., 4th floor Corpus Christi, TX 78401 Telephone: 1-361-878-3450 Fax: 1-361-883-9942	
11L - Laredo Office 1500 Arkansas Avenue, Suite 3 Laredo, TX 78043–3049 Telephone: 1-956-794-6385 Fax: 1-956-729-8600	
11M - McAllen Office Health Services Region 11 4501 West Business Hwy 83 McAllen, TX 78501–9907 Telephone: 1-956-971-1312 Fax: 1-956-971-1275	
Mercedes Office Health Services Region 11 202 West 2nd Street Mercedes, TX 78570 Telephone: 1-956-825-5300 Fax: 1-956-825-5320	
Brownsville Office 1000 W. Price Road Brownsville, TX 78520 Telephone: 1-956-554-5500 Fax: 1-956-554-5581	
Rio Grande City Office 608 N. Garza Rio Grande City, TX 78582 Telephone: 1-956-487-5556 Fax: 1-956-487-8865	

1.4 DSHS Health Service Regions Map



Provider Enrollment and Responsibilities

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PROVIDER ENROLLMENT AND RESPONSIBILITIES

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2.1 Provider Enrollment

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

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

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

Chapter 39, "Transportation of Deceased Clients."

To enroll in the CSHCN Services Program, a provider must enter into a written Provider Agreement with the CSHCN Services Program using TMHP's Provider Enrollment and Management System (PEMS). 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.

Providers can submit the following optional items if applicable using PEMS:

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

Providers enroll online by logging into PEMS.

Online enrollment has the following advantages:

- NPI-based enrollment
- Single application for all programs
- Single revalidation date and enrollment period
- Flexible application completion
- Alignment of effective and approval dates
- Paperless
- Consolidated provider agreement
- Email and online communication
- Online help features
- Enhanced data validation
- 45 business days to correct all deficiencies

Providers can update their demographic information online through PEMS by going to the TMHP home page and selecting "Log in to My Account."

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

A 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 the same day that the enrollment is completed in PEMS.

2.1.1 Affordable Care Act of 2010 (ACA) Enrollment Requirements

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

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

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

2.1.1.1 Medical Foods and Hospice Providers

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

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

2.1.1.2 Enrollment for Ordering and Referring-Only Providers

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

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

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

2.1.2 Changes in Enrollment

When a provider has one of the following changes, a new enrollment application must be completed using PEMS:

- 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.
  - 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 NPIs 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 within 90 days of the date of termination through PEMS. 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 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 PEMS.
- 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.

2.1.3 Claim Filing

New providers must follow all claims filing procedures while completing the enrollment process.

TMHP must receive all claims for services rendered to CSHCN Services Program-eligible clients within the required filing deadlines, regardless of enrollment status.

Claims for group providers must include the NPIs 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 has questions, the provider may call the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413.

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

2.1.3.1 NPIs Terminated After 24 Months of No Claim Activity

Payment denial codes are applied to an NPI that has had no claim activity for a period of 24 months. The NPI will be considered inactive and cannot be used to submit claims.

A courtesy letter will be sent to providers whenever an NPI goes 18 months without claims activity. Providers are encouraged to use electronic claims filing, such as TexMedConnect and Electronic Data Interchange (EDI), for timely claims processing, which will help prevent an NPI from being disenrolled. The letter will inform providers that if they want to keep their NPI active, they must submit a claim within 6 months of the date of the letter using the NPI referenced in the letter. TMHP will apply a payment denial code to any NPI that has had no claims activity within 6 months of the date of the courtesy letter and will notify the provider that the NPI has been terminated because the provider has not submitted claims using the NPI for a period of 24 months or more.

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

To have the status code removed from an NPI, 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

status code to be removed. If the provider has moved to a different address or joined a different group, the status code will not be removed from the old NPI. A new enrollment record for the new group will be created using the existing NPI.

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

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

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

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

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

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

2.1.5 Provider Enrollment Application

2.1.5.1 Types of Providers

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

- *Individual*. This type of enrollment applies to an individual health-care professional who is licensed or certified in Texas, and who is seeking enrollment under the name, and social security or tax identification number of the individual. An individual may also enroll as an employee, using the tax identification number of the employer. Certain provider types must enroll as individuals, including dieticians, licensed vocational nurses (LVNs), and speech therapists.
- *Group*. This type of enrollment applies to health-care items or services provided under the auspices of a legal entity, such as a partnership, corporation, limited liability company, or professional association, and the individuals providing health-care items or services are required to be certified or licensed in Texas. The enrollment is under the name and 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 Owner/Creditor/Principal Entry 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. An Owner/Creditor/Principal Entry in PEMS must be completed by each principal of the provider enrolling in the CSHCN Services Program. Principals of the provider include all of the following:

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

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

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

2.1.5.3 Provider Agreement

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

2.1.5.4 Request for Taxpayer Identification Number and Certification

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

2.1.5.5 Franchise Tax Account Status Page

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

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

2.1.5.6 Clinical Laboratory Improvement Amendments (CLIA) of 1988

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

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

2.1.5.7 Provider's License

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

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

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

- Texas Medical Board
- Texas State Board of Dental Examiners

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

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

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

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

TMHP directly obtains licensure information from the following licensing boards:

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

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

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

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

Copies of licenses or certifications should be uploaded using PEMS.

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

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

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

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

2.1.7 Transplant Specialty Centers

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

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

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

2.1.8 Pharmacy Enrollment

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

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

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

2.1.8.1 Immunizations

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

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

Refer to: Section 31.2.25, "Immunizations (Vaccines and Toxoids)" in Chapter 31, "Physician" for more information.

2.1.9 Out-of-State Providers

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

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

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

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

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

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

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

2.1.10 Substitute Physician

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

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

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

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

2.1.11 Providers of Family Support Services

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 in PEMS and can be submitted using PEMS.

2.2 Provider Complaints Process

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

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

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

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

Provide the following information when reporting the complaint:

- Point of contact name and phone number or email address
- Provider name
- Provider NPI
- Description of the complaint situation
- Client name
- Client PCN
- Date of service

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

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

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

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

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

CSHCN Services Program
ATTN: Administrative Review
MC-1938
PO Box 149030
Austin, TX 78714-9947
Fax: 1-512-776-7238 or 512-776-7162

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

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

2.3 Provider Responsibilities

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

By enrolling in the CSHCN Services Program, providers are responsible not only for knowledge of the adopted CSHCN Services Program agency rules published in 26 TAC, Part 1, Chapter 38, but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371. TAC rules can be found at www.sos.texas.gov/tac/index.shtml.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC, Part 1, §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to 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. Changes to provider information may be made online using PEMS. 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 PEMS.

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 by county.
- Doing business as (DBA) names appear for providers or provider groups.

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

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

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

Providers who have an e-mail address on file with TMHP will receive a confirmation e-mail from TMHP when a physical address has been updated. Providers can make other demographic changes online using a PEMS Maintenance request or Existing Enrollment request.

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

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

2.3.4 Retention of Records

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

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

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

2.3.5 Utilization Review: General Provisions

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

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

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

Depending on the intensity of the identified problem, the letter or visit may result in review of claims before payment. Medical staff develops parameters for prepayment review according to the identified problem. The purpose of the review is to provide additional information enabling the provider to under-

stand the scope of benefits by correlating billing practices and medical policy as billing occurs. As part of the prepayment review process, providers may be required to submit documentation. The documentation is used to ascertain the medical necessity of the services rendered. Prepayment review occurs for a minimum of 6 months. Services not consistent with medical policy are adjudicated in accordance with the established policies.

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

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

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

2.3.6 Release of Confidential Information

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

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

2.3.7 Fraud, Waste, and Abuse

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

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

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

- Current Procedural Terminology (CPT) as set forth in the American Medical Association's (AMA) most recently published CPT books, *CPT Assistant* monthly newsletters, and other publications resulting from the collaborative efforts of the AMA with medical societies.
- Healthcare Common Procedure Coding System (HCPCS) as developed and maintained by the federal government.

- National Correct Coding Initiative (NCCI), as set forth by CMS, and as explained in the NCCI Policy and Medicare Claims Processing Manuals. NCCI consists of procedure code combinations (pairs of procedure codes) that a provider must not bill together. One of the codes in the pair is considered a part of the primary procedure and not reimbursable to the same provider on the same date of service.

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

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

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

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

2.3.8 Provider Certification/Assignment

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

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

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

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

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

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

- The provider understands that endorsing or depositing a CSHCN Services Program check is accepting money from state or federal funds and that any falsification or concealment of material fact related to payment may be grounds for prosecution under state or federal laws.

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

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

2.3.9 Billing Clients

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

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

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

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

A provider may bill the client for:

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

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

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

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

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

Chapter 7, "Appeals and Administrative Review."

2.3.10 Credit Balance and Recovery Vendor

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

2.3.11 Texas Family Code Compliance

2.3.11.1 Child Support

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

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

2.3.11.2 Abuse and Neglect Reporting Requirements

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

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

2.3.12 2.3.12 Texas Medicaid and CHIP Hospital Data Collection and Reporting Requirements

In accordance with Executive Order GA-46 issued by Governor Greg Abbott on August 8, 2024, hospital providers must ask each patient during the hospital intake process whether the patient is (1) a citizen or an alien lawfully present in the United States, or (2) an alien not lawfully present in the United States. Hospital providers must report to HHSC quarterly the number of inpatient discharges of and emergency visits by all patients and patients who are (1) a citizen or an alien lawfully present in the United States, and (2) an alien not lawfully present in the United States. Hospital providers must also report to HHSC quarterly the costs of care for patients who are not lawfully present in the United States.

Hospitals are expected to begin collecting the information by November 1, 2024, and begin reporting to HHSC on March 1, 2025.

When collecting information about a patient's immigration status, hospital providers must provide notification that, as required by federal law, the response will not affect patient care.

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.

Client Benefits and Eligibility

CSHCN Services Program Provider Manual

April 2025

TEXAS
Health and Human
Services

CLIENT BENEFITS AND ELIGIBILITY

Table of Contents

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

Prior Authorization requests for prescription drug claims are submitted to the CSHCN Services Program and approved internally by CSHCN.

Providers do not need prior authorization for the following drugs and products:

- Insulin/insulin syringes
- Medications for home use

For the CSHCN Services Program, providers must obtain prior authorization for the following drugs and products by submitting the specified form:

- Aerosolized tobramycin (TOBI) (HHS Form 1143)
- Cayston (HHS Form 1143)
- Kalydeco (HHS Form 1143)
- Pulmozyme (HHS Form 1143)
- Growth hormone products (HHS Form 1312)
- Synagis (HHS Form 1055)

Prior authorization request forms are available on the CSHCN Services Program Prior Authorization Forms page of the Texas Vendor Drug Program website at www.txvendordrug.com/about/manuals/pharmacy-provider-procedure-manual/p-18-forms/prior-authorization-requests-cshcn-services-program. The forms must be faxed to 1-512-776-7238.

An approved prescribing physician must submit a completed and signed CSHCN Authorization Request Form to certify that the client continues to require these medications. The CSHCN Services Program generally grants authorizations for one year. Regardless of how long the authorization lasts, the client must be eligible for and enrolled in the CSHCN Services Program.

Pulmozyme and Kalydeco may not require an annual review if initial prior authorization criteria is established. Kalydeco will be approved for clients with cystic fibrosis who meet current CF Foundation and FDA indications and prescribing guidelines.

Coordination with primary payer insurance must be used when applicable.

Providers must obtain approval from the CSHCN Services Program for HIV products, family planning, and pulmonary hypertension drugs.

To obtain approval, the prescribing physician must compose a letter of medical necessity on office stationery and fax it to the CSHCN Services Program at 1-512-776-7238. The CSHCN Services Program generally grants approval for one year. Regardless of how long the approval lasts, the client must be eligible for and enrolled in the CSHCN Services Program.

HIV/AIDS drugs are a benefit of the CSHCN Services Program for 60 days. The CSHCN Services Program can extend the benefit beyond 60 days if the provider submits a denial from the Texas HIV Medicaid program or any other third-party payer.

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

3.1.2 Respiratory Syncytial 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 1055 must be faxed to the CSHCN Services Program at 1-512-776-7238.

Providers may refer to the Texas Health and Human Services Commission Texas Medicaid/CHIP Vendor Drug Program website at https://www.txvendordrug.com/formulary/respiratory-syncytial-virus-treatment 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 31.2.25.13, "Respiratory Syncytial Virus (RSV) Prophylaxis" in Chapter 31, "Physician."

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 2.1.9, "Out-of-State Providers" in Chapter 2, "Provider Enrollment and Responsibilities."

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, the CSHCN Services Program Physician/Dentist Assessment Form, or other documentation
- Fertility services
- Fetal medical and surgical services
- Implantation of anti-esophageal 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 24.3.1.6, "Transplants - Nonsolid Organ" in Chapter 24, "Hospital").*
- 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 use 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 26 Part I TAC §351.16 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.

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.
- *Spend down*. The effective date of eligibility for applicants with spend down is the day after the earliest DOS on which the cumulative bills are sufficient to meet the spend-down 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 spend-down 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 spend-down documentation must be received within 60 days of receipt of the application denial. Medical bills that are used to meet spend down 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 spend down. Eligibility then begins according to the spend-down 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 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.texas.gov. CSHCN Services Program inquires may also be mailed to:

CSHCN Services Program
MC 1938
PO Box 149030
Austin, TX 78714-9947

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. 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 Services 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 intellectual disability, 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*, Tenth Revision, Clinical Modification (ICD-10-CM) code, or its successor, 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 meet CSHCN Services Program 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 diagnosis code, including any suffixes (e.g., "D51.2" rather than "D51").
- 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 Texas Health and Human Services website.
- The CSHCN Services Program Physician/Dentist Assessment Form instructions

Important: *Providers can photocopy this form but should retain the original for future use.*

3.3 CSHCN Services Program Notice of Eligibility

The CSHCN Services Program Notice of Eligibility gives clients, parents, and providers a quick way to verify CSHCN Services Program eligibility. The Notice is designed to convey all of the information necessary to document identification information.

Refer to: Section 3.3.2, "CSHCN Services Program Notice of Eligibility Sample" in this chapter.

CSHCN Services Program Notices of Eligibility 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 notice is one way to verify client eligibility.

The client's notice of eligibility 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 gender.
- The 12 months of the client's eligibility.

Providers should ask for the notice when scheduling a client for an appointment. Under certain circumstances, the notice 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 Notice of Eligibility 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 (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 in Section 1.3.2, "Regional Offices" in Chapter 1, "TMHP and HHSC Contact Information" 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.texas.gov/cshcn/clapplforms.shtm.

3.3.1 Eligibility Restrictions

Under certain circumstances, the client eligibility notice 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 notice. 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 Notice of Eligibility Sample

TEXAS
Health and Human Services

Charles Smith
Executive Commissioner

Children with Special Health Care Needs (CSHCN) Services Program
Notice of Eligibility

John Client
123 Texas Street
City, TX 12345-0001

Client: John Client
Client ID: 123456789

This is your CSHCN Services Program Notice of Eligibility. Your Notice cannot be used for anyone else and can only be used for services between the current approval periods: **12/11/2017 - 12/10/2018**. Please bring this Notice with you when you visit your program providers. You are eligible for benefits as shown below.

Benefit Category	Approved	Start Date	End Date
Drugs	Yes	12/11/2017	12/10/2018
Medical/Dental	Yes	12/11/2017	12/10/2018
Medical Transportation	Yes	12/11/2017	12/10/2018
Insurance Premium Payment Assistance (IPPA)	No		
Family Support Services (FSS)	Yes*	12/11/2017	12/10/2018

***FSS requires prior authorization.** *This means that the program must make sure that you are eligible for each service before approving it. To learn more, please refer to your Client Handbook or call your case manager at your local health services regional office.*

To apply to continue receiving services after the Benefit End Date, the program must receive your new application no later than **12/10/2018**, but not sooner than **10/11/2018**.

To request a new copy of this Notice, get a new application, contact Eligibility Services, or for any other questions, please call **1-800-252-8023** or visit **dshs.texas.gov/cshcn**.

CSHCN Services Program • MC 1938 • PO Box 149347 • Austin, Texas 78714-9347
1-800-252-8023 • dshs.texas.gov/cshcn

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.

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 CHSCN Services Program Refund Information Form to the following address:

Texas Medicaid & Healthcare Partnership
Attn: Financial Unit
12365-A 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
- National Provider Identifier (NPI)

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.insurekidsnow.gov.

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 spend-down 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 spend-down documentation must be received within 60 days of receipt of the application denial Medical bills used to meet spend down 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 Notice of 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 Notice of 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 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.

Prior Authorizations and Authorizations

CSHCN Services Program Provider Manual

April 2025

TEXAS
Health and Human
Services

PRIOR AUTHORIZATIONS AND AUTHORIZATIONS

Table of Contents

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.
- Fax transmittal confirmations and postal registered mail receipts are not accepted as proof of timely authorization or prior authorization submission.

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: 2024 Authorization and Filing Deadline Calendar

Filing Deadline Calendar for 2025

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

4.2 Extension of Filing Deadlines for Holidays

For holidays that extend the filing deadline, please refer to Section 5.1.8, "Claims Filing Deadlines" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement."

4.2.1 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" 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.

4.2.2 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.

4.2.2.1 Electronic Signatures

4.2.2.1.1 Authority and Definitions

Texas Government Code §531.0055(m) requires the Health and Human Services Commission (HHSC) to establish standards for the use of electronic signatures in accordance with the Uniform Electronic Transactions Act (Chapter 322, Business and Commerce Code), with respect to any transaction, as defined by Section 322.003, Business and Commerce Code, in connection with the administration of health and human services programs.

The following definitions apply for the policy information outlined in this section:

Term	Definition
Asymmetric cryptosystem	A computer-based system that employs two different but mathematically related keys with the following characteristics: • One key encrypts a given message; • One key decrypts a given message; and • The keys have the property that, knowing one key, it is computationally infeasible to discover the other key.
Certificate	A message, as defined in 1 TAC §203.1(2), which: • Identifies the certification authority issuing it; • Names or identifies its subscriber; • Contains the subscriber's public key; • Identifies its operational period; • Is digitally signed by the certification authority issuing it; and • Conforms to ISO X.509 Version 3 standards.
Certification authority	A person who issues a certificate.
Digital signature	An electronic identifier intended by the person using it to have the same force and effect as the use of a manual signature, and that complies with the requirements of 1 TAC §203.23.
Digitized signature	An image of pen-to-paper.
Electronic record	A record created, generated, sent, communicated, received, or stored by electronic means.
Electronic signature	An electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record.
Prior authorization	A request submitted to the program, or its designated contractor, to provide a service the program ultimately considers for reimbursement. (Prior authorization must be obtained before the delivery or date of service.)
Program	The Children with Special Health Care Needs Services Program.
Public key	The public part of an asymmetric key pair that is used to verify signatures or encrypt data.
Texas Administrative Code (TAC)	A compilation of all state agency rules in Texas.

4.2.2.1.2 Electronic Signature Requirements

The CSHCN Services Program complies with 1 TAC, Chapter 203, Guidelines for the Management of Electronic Transactions and Signed Records, which details the requirements for state agencies that send and accept electronic records and electronic signatures or otherwise create, generate, communicate, store, process, use, or rely upon electronic records and electronic signatures.

The program, or its designated contractor, may accept electronic signatures on authorization or prior authorization requests and supporting documentation transmitted by mail, fax, or through the online prior authorization portal, if the electronic signature technology meets all applicable federal and state statutes and administrative rules.

Electronic signatures, also known as digital signatures, that comply with the Texas Department of Information Resources (DIR) rules at 1 TAC §203.24 will be considered to have the same legal effect as a handwritten signature.

Electronic signatures that are generated through an electronic medical record (EMR) or electronic health record (EHR) system that complies with applicable federal and state statutes and rules are acceptable.

Electronically-signed documents must have an electronic date on the same page as the signature.

Providers that utilize electronic signatures must provide a certification that the electronic signature technology that they use complies with all applicable federal and state statutes and administrative rules.

Electronically-signed transactions and electronically-signed documents must be kept in the client's medical record, and a paper copy must be available upon request.

All fax transmissions must reflect the date, time, and fax number of origination, and the original document must be maintained by the provider.

All documentation submitted with a handwritten provider's signature must have a handwritten date next to the signature and must be kept in the client's medical record.

Any signature (electronic or handwritten) on a submitted document certifies, to the best of the provider's knowledge, that the information in the document is true, accurate, and complete.

The provider understands and agrees that both the provider and the provider's representative whose signature is on an electronic signature method have the responsibility for the authenticity of the information being certified for which the authentication is provided.

The provider must exercise reasonable care to retain control of their electronic signature and prevent its disclosure to any person not authorized to create the electronic signature, as described in 1 TAC §203.24(c)(3).

The provider and the provider's representative understand and agree that systems and software products must include protections against modification and bear responsibility for ensuring administrative safeguards are in place.

Stamped signatures and signatures that have been typed in a document without using an electronic identifier will not be accepted.

Digitized signatures will not be accepted. (Examples include scanned images of handwritten signatures or signatures on a signature pad. Handwritten signatures on faxed documents are not digitized signatures.)

4.2.3 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.

Refer to: Section 5.6.2.3, "Determining Reimbursement Rates for New HCPCS Procedure Codes" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for more information.

4.2.4 Requests for Procedures That Are Manually Priced

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.

Claims for authorized procedure codes that are manually priced must list the claims detail information in the same order as itemized on the authorization letter.

4.2.5 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 the 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 the provider submits an explanation of benefits (EOB) from the TPR with a valid claim.

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 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
12365-A Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax: 1-512-514-4222

4.3.1 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 indicated 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, “Blood Pressure Monitoring and Devices”
Use:	The CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME)

Botulinum Toxin (Type A and B)	
Refer to:	Section 31.2.26.9, "Botulinum Toxin (Type A and Type B)" in Chapter 31, "Physician"
Use:	The CSHCN Services Program Prior Authorization Request for Outpatient Surgery—For Outpatient Facilities and Surgeons Form and Instructions

Clinician-Directed Care Coordination Services	
Refer to:	Section 31.2.12, "Clinician-Directed Care Coordination Services" in Chapter 31, "Physician"
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)"
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, "Bone Growth Stimulators" in Chapter 31, "Physician"
Use:	The CSHCN Services Program Authorization and Prior Authorization Request for Hemophilia Blood Factor Products

Home Health (Skilled Nursing Only) Up to 200 Hours Per Calendar Year	
Refer to:	Chapter 22, "Home Health (Skilled Nursing) Care"
Use:	The CSHCN Services Program Home Health Skilled Nursing Request and Plan of Care Form

Nebulizers, In Specific Instances	
Refer to:	Section 36.2.5, "Nebulizers" in Chapter 36, "Respiratory Equipment and Supplies"
Use:	The CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME)

Outpatient Dental Surgical Procedures	
Refer to:	Section 14.2.7, "Dental Treatment in Hospitals and ASCs" in Chapter 14, "Dental"
Use:	The CSHCN Services Program Prior Authorization Request for Outpatient Surgery—For Outpatient Facilities and Surgeons Form and Instructions
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 38.2.4, "Telemonitoring Services" in Chapter 38, "Telecommunication Services"
Use:	The Home Telemonitoring Services Prior Authorization Request Form

4.3.2 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
12365-A Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax: 1-512-514-4222

4.4 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 then the prior authorization request may be submitted on the next business day.

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

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.

Note: *Partial approvals for a hospital stay will not be granted.*

Requests for emergency hospital admissions must be received 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 the initial prior authorization request meets the deadline requirements and is denied for incomplete or inaccurate information, the provider may correct and resubmit the prior authorization request. The corrected request is a one-time resubmission only and must be received by the next business day following the denial of the initial request. If the corrected request is received by the next business day but still contains incomplete or inaccurate information, then the request will not be eligible for a second resubmission and will be denied for the entire hospital stay. Corrected requests received after the next business day following the initial denial will be denied for the entire hospital stay.

Refer to: Section 24.3.1.2, "Emergency Inpatient Hospital Admissions" in Chapter 24, "Hospital" for detailed information on prior authorization requirements.

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

4.4.1 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 indicated for procedures as outlined in specific sections of the CSHCN Services Program Provider Manual.

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

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)"
Use:	The CSHCN Services Program Prior Authorization Request for Augmentative Communication Devices (ACDs)

Stem Cell Transplants (initial and one subsequent transplant)	
Refer to:	Section 31.2.42.2, "Transplants - Nonsolid Organ" in Chapter 31, "Physician"
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)"
Use:	The CSHCN Services Program Prior Authorization Request for Respiratory Care—Certified Respiratory Care Practitioner (CRCP)

Cleft/Craniofacial Surgical Procedures	
Refer to:	Section 31.2.39.11, "Cleft/Craniofacial Procedures" in Chapter 31, "Physician"
Use:	The CSHCN Services Program Prior Authorization Request for Inpatient Surgery—For Surgeons Only
Use:	The CSHCN Services Program Prior Authorization Request for Outpatient Surgery—For Outpatient Facilities and Surgeons Form and Instructions

Cranial Molding Devices (Dynamic Orthotic Cranioplasty [DOC™] only)	
Refer to:	Section 28.2.2, "Orthoses and Prostheses (Not All-Inclusive)" in Chapter 28, "Orthotic and Prosthetic Devices"
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"
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"
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"
Use:	The CSHCN Services Program Home Health Skilled Nursing Request and Plan of Care Form

Home Health Services	
Refer to:	Chapter 21, "Home Health Services"
Use:	The CSHCN Services Program Authorization and Prior Authorization Request

Hospice Services	
Refer to:	Chapter 23, "Hospice"
Use:	The CSHCN Services Program Prior Authorization Request for Hospice Services

Inpatient Admissions	
Refer to:	Section 24.3, "Inpatient Services" in Chapter 24, "Hospital"
Use:	The CSHCN Services Program Prior Authorization Request for Inpatient Hospital Admission—For Use by Facilities Only

Inpatient Rehabilitation Admissions	
Refer to:	Section 24.3.1.4, "Inpatient Rehabilitation Services" in Chapter 24, "Hospital"
Use:	The CSHCN Services Program Prior Authorization Request for Inpatient Rehabilitation Admission

Medical Foods, In Specific Instances	
Refer to:	Section 26.3, "Medical Foods" in Chapter 26, "Medical Nutrition Services"
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" in Chapter 26, "Medical Nutrition Services"
Use:	The CSHCN Services Program Prior Authorization Request for Medical Nutritional Products

Non-Emergency Ambulance Transports	
Refer to:	Section 9.4, "Nonemergency Ambulance Transports" in Chapter 9, "Ambulance"
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 14.2.4, "Orthodontia Services" in Chapter 14, "Dental"
Use:	The CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services

Orthotics and Prosthetics	
Refer to:	Chapter 28, "Orthotic and Prosthetic Devices"
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)" in Chapter 30, "Physical Medicine and Rehabilitation"
Use:	The CSHCN Services Program Prior Authorization Request for Initial Outpatient Therapy (TP1)
Use:	The CSHCN Services Program Prior Authorization Request for Extension of Outpatient Therapy (TP2)

Outpatient Speech-Language Pathology Services (all services except initial evaluations)	
Refer to:	Chapter 37, "Speech-Language Pathology (SLP) Services"
Use:	The CSHCN Services Program Prior Authorization Request for Initial Outpatient Therapy (TP1)
Use:	The CSHCN Services Program Prior Authorization Request for Extension of Outpatient Therapy (TP2)

Pediatric Hospital Cribs and Tops	
Refer to:	Section 17.3.9, "Hospital Beds (Manual and Electric)" in Chapter 17, "Durable Medical Equipment (DME)"
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" in Chapter 28, "Orthotic and Prosthetic Devices"
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 34, "Radiation Therapy Services"
Use:	The CSHCN Services Program Prior Authorization Request for Outpatient Surgery—For Outpatient Facilities and Surgeons Form and Instructions

Reduction Mammoplasties	
Refer to:	Section 31.2.40, "Diagnostic and Surgical/Reconstructive Breast Therapies " in Chapter 31, "Physician".
Use:	The CSHCN Services Program Prior Authorization Request for Inpatient Surgery—For Surgeons Only

Renal Dialysis	
Refer to:	Chapter 35, "Renal Dialysis"
Use:	The CSHCN Services Program Prior Authorization Request for Renal Dialysis Treatment

Renal Transplants	
Refer to:	Section 31.2.42, "Transplants" in Chapter 31, "Physician"
Use:	The CSHCN Services Program Prior Authorization Request for Stem Cell or Renal Transplant

Rhizotomies	
Refer to:	Section 31.2.40.8, "Rhizotomy" in Chapter 31, "Physician"
Use:	The CSHCN Services Program Prior Authorization Request for Inpatient Surgery—For Surgeons Only

Total Parental Nutrition (TPN)	
Refer to:	Section 26.6, "Total Parenteral Nutrition (TPN)" in Chapter 26, "Medical Nutrition Services"
Use:	The CSHCN Services Program Authorization and Prior Authorization Request

Ultrasonic Nebulizers, In Specific Instances	
Refer to:	Section 36.2.5, "Nebulizers" in Chapter 36, "Respiratory Equipment and Supplies"

Ultrasonic Nebulizers, In Specific Instances	
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" in Chapter 17, "Durable Medical Equipment (DME)"
Use:	The CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME)
Use:	The CSHCN Services Program Wheelchair Seating Evaluation Form

4.4.2 Prior Authorization for Inpatient Admission After Business Hours

Important: *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: Section 24.3.1.1, "Initial Inpatient Prior Authorization Requests" in Chapter 24, "Hospital" for additional information.

4.4.3 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" in Chapter 2, "Provider Enrollment and Responsibilities" for more information about transplant specialty centers enrollment.

4.4.4 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.

4.4.5 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.

Providers that need to update information on a prior authorization request form must strike through the incorrect information with a single line. The original content must remain legible, and the change must be initialed and dated by the original signatory or ordering physician when applicable. Changes that have been made using correction fluid (e.g., Wite-Out) will not be accepted.

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
- 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

4.4.6 Prior Authorization Electronic Submissions through the TMHP Prior Authorization (PA) on the Portal

The TMHP Prior Authorization on the Portal (PA on the Portal) is available for CSHCN Services Program providers to submit CSHCN Services Program prior authorization requests to TMHP for consideration. The benefits of using the TMHP PA on the Portal are as follows:

- Real-time submissions.
- Robust status information available throughout the processing of the request, including the ability to quickly view and respond to pending action from providers.
- Electronic attachment capability. Providers can upload ALL information related to a request and submit online. Providers will receive immediate confirmation of receipt of information.
- The ability to save requests as a draft and update and submit at a later date.
- The ability to create templates which saves time when requesting similar prior authorizations frequently.
- Greater search capability including additional information provided in the search results and the ability to update existing requests with corrections, revisions or extensions.
- Portal availability using a variety of modern browsers.
- Pre-populated forms using information entered at the start of the request.
- Correct deficiencies or make revisions through the portal. No more mailing or faxing.

Providers can access the TMHP PA on the Portal from the TMHP Prior Authorization web page at www.tmhp.com/topics/prior-authorization, which can also be accessed from a topics page on the TMHP Provider Home Page. Providers will click on PA on the Portal and log on to the TMHP secure portal using their UserID and password obtained when the provider's account was activated.

Refer to: The TMHP Portal Security Training Manual available on the TMHP website for information about creating an account, obtaining a UserID and password, and granting permissions.

Important: *To submit CSHCN Services Program prior authorization requests to TMHP, the requesting provider must be enrolled as a CSHCN Services Program provider, and must have registered his or her CSHCN Services Program NPI in an active TMHP portal account. The client ID submitted in the request must be the client's CSHCN Services Program client ID and the client must be currently enrolled in the CSHCN Services Program.*

The following Authorization Areas and Submission Types are available for CSHCN Services Program prior authorizations submitted through the TMHP PA on the Portal:

Authorization Area	Submission Type
All CSHCN Services Program	Ambulance Prior Authorization
	Dental or Orthodontia Services
	Durable Medical Equipment and Supplies
	Home Health, Hospice, and/or Telemonitoring
	Hospital, Surgery, and/or Medical Services
	Outpatient Therapy (PT, OT, ST)

The provider will enter his or her provider, client, and authorization information including service details in the required fields of the Client Eligibility Pre-check screen and the Authorization Request – Service Details screen. All necessary documents, including, but not limited to, the TMHP fillable PDF of the authorization or prior authorization form, can then be electronically attached to the online authorization or prior authorization request.

The required authorization and prior authorization forms are available on the Authorization Request–Attachments screen in PA on the Portal along with a list of additional required documentation that the provider must upload as attachments. For prior authorization forms downloaded from the Authorization Request–Attachments screen in PA on the Portal, certain fields including, but not limited to, client name and client ID, will be automatically populated based on the information entered in the Client Eligibility Pre-Check and Service Details screens.

Note: *Authorization and prior authorization forms are also available on the TMHP Prior Authorization CSHCN PA Forms web page as fillable forms into which providers can type the required information and e-sign the forms using available software. Certain fields will only be pre-populated if the prior authorization form is downloaded from the Authorization Request–Attachments screen in PA on the Portal. Forms that are downloaded from the TMHP Prior Authorization CSHCN PA Forms web page are fillable, but fields will not be pre-populated. Providers can choose to use the pre-populated forms generated from PA on the Portal or the fillable forms available on the new TMHP Prior Authorization web page.*

Providers must submit to TMHP all pages of the prior authorization form, including the Prior Authorization Request Submitter Certification Statement page with "We Agree" checked, and the authorization pages completed and signed as applicable. The only pages that are not required to be submitted to TMHP are the instruction pages. Requests will be pended if the Prior Authorization Request Submitter Certification Statement page with the "We Agree" checked is not included with the submitted documents. Providers will be required to submit the Prior Authorization Request Submitter Certification Statement page, with "We Agree" checked, to TMHP before the request can be processed.

Once a prior authorization request has been submitted through PA on the Portal, providers will be able to submit corrections, revisions, and extensions to applicable prior authorization requests through PA on the Portal.

Providers can also save drafts and create templates to be used regularly as follows:

- Drafts can be saved with all uploaded attachments. Drafts created in PA on the Portal, but not submitted, will be deleted after 90 calendar days if the draft has not been submitted to TMHP. Up to 200 drafts can be saved per provider NPI and taxonomy combination.
- Attachments will not be saved as part of templates on PA on the Portal. Templates will be retained for up to 365 calendar days from the time the template was last used or modified. Up to 200 templates can be created and saved per provider NPI and taxonomy combination.

Providers can refer to the TMHP Prior Authorization (PA) on the Portal Submission Guide which is available on the TMHP Prior Authorization web page for detailed instructions about using the TMHP PA on the Portal.

4.4.7 Browser Compatibility and System Requirements

TMHP's PA on the Portal is compatible with Internet Explorer® (IE) 11.0, Chrome®, and Mozilla Firefox®.

Providers must use Adobe Reader® Version 11.0 or higher to download and complete the authorization and prior authorization forms from PA on the Portal or from the new TMHP Prior Authorization web page.

Reminder: *Providers can continue to download the forms and complete them by hand if the applicable version of Adobe Reader® is not available. (Adobe Reader® is free software that can be downloaded onto the provider's computer.)*

4.4.8 Electronic Attachments

TMHP's PA on the Portal will accept electronic attachments. Providers can submit the authorization or prior authorization forms as well as any other required forms or documentation as electronic attachments.

Up to ten files can be uploaded per authorization or prior authorization request, and each file cannot exceed 50 megabytes. PA on the Portal will accept electronic attachments in the following formats:

- Portable Document Format (PDF)
- Images with the following file extensions: JPG, TIF, PNG, GIF
- Microsoft (MS) Word
- MS Excel
- Rich Text Format (RTF)

Electronic attachments must be completed and electronically signed before they are uploaded to the PA on the Portal. Providers must use their own software to electronically sign forms, and those signatures must be added to the forms before they are uploaded to the PA on the Portal request. Submitters will not be able to electronically sign required forms once they are uploaded to the PA on the Portal request. Providers will be required to:

1) Download the authorization or prior authorization form, and save the downloaded form to their desktop or other folder.
2) Complete the form by typing into the fillable fields, and adding the appropriate signatures (providers can electronically sign the forms using the software of their choice).

3) Upload the form to the PA on the Portal request.

Important: *The PA on the Portal will always display the most current form that is available on the TMHP Prior Authorization web page to be used for the authorization or prior authorization request. Forms previously downloaded and saved to the providers desktop or folder may not reflect changes made to the form since the last submission. Provider should ensure the submitted form is the most recent.*

4.4.9 Maintaining Complete Documentation

To best maintain accurate client and provider documentation, all forms and documentation completed electronically and e-signed must be kept in the client's medical record, including:

- Prior authorizations submitted to TMHP.
- Documents completed but not submitted to TMHP as a prior authorization request.
- A hard copy of electronic transactions and signed documents must be available upon request.

4.4.10 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, resubmissions, and additional information needed to complete a request.*

Reminder: *Prior authorization cover sheets must not contain any protected health information (PHI) per Health Insurance Portability and Accountability Act (HIPAA). The faxed cover sheet is not meant to replace the appropriate prior authorization form. Providers cannot include information on a cover sheet that is needed to complete the review of a request.*

If a provider is faxing prior authorization requests for more than one client, each client request must be faxed individually with a separate cover sheet. Requests received with multiple clients will be returned to the provider for resubmission to ensure HIPAA compliance.

The fax number listed on the prior authorization form is the fax number used to send faxed responses or correspondences from TMHP.

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
12365-A Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax: 1-512-514-4222

4.5 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. Any alterations to the original denied request form must be made by using a single line strike-through so the original content is still legible, and the author of the alteration must initial and date the revision. 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" in Chapter 7, "Appeals and Administrative Review" for information about the administrative review process.

4.5.1 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.

To correct a denied request, the provider must strike through the error with a single line. The original content and the corrected information must be legible. The provider must initial and date the alteration.

Resubmitted requests must meet submission deadlines to be considered for approval. 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.

4.5.2 Closing a Prior Authorization

When a client decides to change providers or elects to discontinue prior-authorized services before the authorization ends, that prior authorization is updated to reflect the early closure date and the reason for closure.

If a client with an active prior authorization changes providers, TMHP must receive a change of provider letter with the request for a new prior authorization in accordance with submission guidelines for the service. The client must sign and date the letter, which must include the name of the previous provider, the current provider, and the effective date for the change.

The client is responsible for notifying the previous provider that the client is discontinuing services and the effective date of the change. TMHP also notifies the previous provider by mail when a prior authorization has been closed early. The letter includes the beginning date of service, the revised ending date of the authorization, and the reason for the early closure.

If a provider submits a Change of Provider letter in the middle of an existing authorization period, the current authorization will be end-dated and the original provider will be notified. TMHP will send the new provider an authorization that begins on the next business day after the end date and lasts through the remainder of the authorization period.

4.5.3 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 from 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 26 Part 1 TAC §351.16.

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
MC-1938
PO Box 149030
Austin, TX 78714-9947
Fax: 1-512-776-7238

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.

4.5.4 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
MC-1938
PO Box 149030
Austin, TX 78714-9947
Fax: 1-512-776-7238

Refer to: Section 7.2.2, "Fair Hearing Requests for Authorizations or Prior Authorizations" in Chapter 7, "Appeals and Administrative Review."

4.6 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.

CLAIMS FILING, THIRD-PARTY RESOURCES, AND REIMBURSEMENT

CSHCN SERVICES PROGRAM PROVIDER MANUAL

APRIL 2025

TEXAS
Health and Human
Services

CLAIMS FILING, THIRD-PARTY RESOURCES, AND REIMBURSEMENT

Table of Contents

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 TexMed-Connect 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 41, "TMHP Electronic Data Interchange (EDI)."

A listing of the providers and services that are paid by TMHP can be found in Chapter 3, "Client Benefits and Eligibility" 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
12365-A 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)*
12365-A 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 HHSC Contact Information."

5.1.3 CPT and HCPCS Claims Auditing Guidelines

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 necessity is 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 NCCI web page.

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 applicable 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."

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 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 locations; 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 NPI and taxonomy codes for both programs will be examined to determine whether any claims activity has occurred.

TMHP will send a courtesy letter to providers when 18 months have passed with no claims activity for the provider's NPI. The letter will inform providers that if they want to keep NPIs active, they must submit a claim within 6 months of the date of the letter using one of the NPIs referenced in the letter. TMHP will apply a payment denial code to any NPI that has had no claims activity following 6 months of the date of the courtesy letter and will notify the provider that the NPI has been inactivated because the provider has not submitted claims using the NPI for a period of 24 months or more.

To have the payment denial code removed from an NPI, 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 NPI. Instead, a new NPI will be issued for the new address or group.

Refer to: Section 2.1, "Provider Enrollment" in Chapter 2, "Provider Enrollment and Responsibilities" 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 2025 are:

Date	Holiday
January 1, 2025	New Year's Day
January 20, 2025	Martin Luther King, Jr. Day
February 17, 2025	Presidents' Day
May 26, 2025	Memorial Day
June 19, 2025	Emancipation Day
July 4, 2025	Independence Day
September 1, 2025	Labor Day
October 13, 2025*	Columbus Day
November 11, 2025	Veterans Day
November 27, 2025	Thanksgiving Day
November 28, 2025	Day after Thanksgiving
December 24, 2025	Christmas Eve Day
December 25, 2025	Christmas Day
December 26, 2025	Day after Christmas
***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: 2024 Authorization Filing Deadline Calendar

Filing Deadline Calendar for 2025

After filing a claim to TMHP, providers should review the weekly R&S Report. If within 30 days the claim does not appear in the Claims In Process section, or if it does not appear as a paid, denied, or incomplete claim, the provider should resubmit it to TMHP within 95 days of the DOS.

Electronic billers should notify TMHP about missing claims when:

- An accepted claim does not appear on the R&S Report within ten workdays of the file submittal.
- A claim or file does not appear on a TMHP Electronic Claims Submission Report within ten days of the file submission.

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
MC-1938
PO Box 149030
Austin, TX 78714-9947
Fax: 1-512-776-7238

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 Notice of Eligibility

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.

Important: *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" in Chapter 7, "Appeals and Administrative Review" 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 NPI
- 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
12365-A 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.

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

5.3.1 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.

5.3.2 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.*

5.3.3 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.

5.3.4 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: 2022 Authorization Filing Deadline Calendar

2023 Authorization 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 I = 0, J = 1, K = 2, and L = 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 J43.
- 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" in Chapter 7, "Appeals and Administrative Review" for 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,* Tenth Revision, Clinical Modification (ICD-10-CM). The CSHCN Services Program requires providers to provide 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- to seven-digit code, do not add additional zeroes. 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, and is divided into two principal subsystems, referred to as level I and level II:

- **Level I:** Level I procedure codes are created by the American Medical Associations (AMA), and are published in the Current Procedural Terminology (CPT®) manual. CPT procedure codes are numeric codes consisting of 5-digits. Maintenance of CPT is the responsibility of the AMA (AMA updates on a yearly basis) and coordinated with CMS before distribution of modifications to third-party payers.

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

- **Level II:** Level II procedure codes are created by CMS, and are published in the HCPCS manual. HCPCS procedure codes are alpha-numeric codes consisting of a single alpha character (A–V) followed by four numeric digits; the codes are for 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.

Level I CPT and Level II HCPCS procedure 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.*

To ensure an up-to-date coding structure, HCPCS is updated annually using the latest edition of the CPT manual (i.e., Level I coding) and nationally established CMS codes (i.e., Level II coding). The coding systems comply with *Health Insurance Portability and Accountability Act* (HIPAA) requirements.

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 5.6.2.3, "Determining Reimbursement Rates for New HCPCS Procedure Codes" in this chapter 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.

Refer to: The Centers for Medicare & Medicaid Services HCPCS web page.

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 NCCI web page 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. Providers must follow the current standard appeals process when appealing claims to TMHP.

Refer to: Section 7.3, "Claim Appeals" in Chapter 7, "Appeals and Administrative Review" for additional information about appealing claims.

5.6.2.3 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.

5.6.2.4 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.*

5.6.2.4.1 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:

UB-04 CMS-1450

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

Block No.	Description	Guidelines
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 a www.txvendordrug.com/formulary/clinician-administered-drugs. 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.

5.6.2.5 Drug Rebate Program

The CSHCN Services Program will reimburse providers only for clinician-administered drugs and biologicals whose manufacturers participate in the 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.*

5.6.2.6 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.*

5.6.2.7 Modifier U8 and the Federal 340B Drug Pricing Program

All eligible organizations and covered entities that are enrolled in the federal 340B Drug Pricing Program to purchase 340B discounted drugs must use modifier U8 when submitting claims for 340B clinician-administered drugs.

Non-compliance with this new requirement to use modifier U8 on all claims submitted for 340B clinician-administered drugs may jeopardize a covered entity's 340B status with the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA).

Note: *Providers can refer to the HRSA website at www.hrsa.gov/opa/index.html for more information about the 340B Drug Pricing Program.*

5.6.2.8 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)
6	Radiation Therapy (total component)
7	Anesthesia
8	Assistant surgery
9	Other medical items or services
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

TOS	Description
L	DME rental
R	Hearing aid
T	Technical component for radiology, laboratory, or radiation therapy
W	Dental

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	One-Digit Numeric Codes
Office	02, 10, 11, 15, 17, 20, 49, 50, 60, 65, 71, 72	1
Home	12, 27	2
Inpatient hospital	21, 51, 52, 56, 61	3
Outpatient hospital	19, 22, 23, 24, 55, 56, 57, 62	5
Other location	01, 03, 04, 05, 06, 07, 08, 16, 18, 26, 34, 41, 42, 53, 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 41, "TMHP Electronic Data Interchange (EDI)"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.

Claim forms must contain:

- The billing provider's:
  - Complete name.
  - Physical address.

  - ZIP + 4 code.
  - NPI.
  - Taxonomy code.
  - Benefit code (if applicable).
- The signature of the provider or an authorized representative or a "signature on file" statement.

Claim forms 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.

Claim forms must contain the following or the claim cannot be processed:

- The billing provider's:
  - Complete name.
  - Physical address.
  - ZIP + 4 code.
  - NPI.
  - Taxonomy code.
  - Benefit code (if applicable).
- The signature of the provider or an authorized representative or a "signature on file" statement.

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/topics/edi.

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 41, "TMHP Electronic Data Interchange (EDI)" 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" in 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.

Block No.	Description	Guidelines
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).
8	Benefit code	Enter the benefit code (if applicable) for the billing provider.
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.
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.

Block No.	Description	Guidelines
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.
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.*

Block No.	Description	Guidelines
21	Diagnosis or nature of illness or injury	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. 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.
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:*** Section 5.6.2.4, "National Drug Codes (NDC)" in this chapter.
24b	Place of service	Select the appropriate POS code for each service from the table under Section , "Place of Service (POS) Coding" in this chapter.

Block No.	Description	Guidelines
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:*** Section 5.6.2.4, "National Drug Codes (NDC)" in this chapter.
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:*** Section 5.6.2.4, "National Drug Codes (NDC)" in this chapter. Enter the number of blood factor units provided.
24j	Rendering provider taxonomy code (performing)	Enter the taxonomy code 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 taxonomy code 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.

Block No.	Description	Guidelines
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:*** Section 5.7, "Claims Filing Instructions" in this chapter
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, physical address, city, state, ZIP+4 Code, and telephone number.
33A	NPI	Enter the NPI of the billing provider.
33B	Other ID #	Enter the taxonomy code 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 41, "TMHP Electronic Data Interchange (EDI)" 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 benefit code (if applicable).
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)" in this chapter.
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)" in this chapter.

Block No.	Description	Guidelines
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.
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 5.6.2.4, "National Drug Codes (NDC)" in this chapter.

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.*

Block No.	Description	Guidelines
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.
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	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.
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: 0 = ICD-10-CM
67	Principal diagnosis (DX) code and present on admission (POA) indicator	Enter the 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)" in this chapter.

Block No.	Description	Guidelines
67A-67Q	Other DX codes and POA indicator	Enter the 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:*** *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)" in this chapter.
69	Admit DX code	Enter the 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 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)" in this chapter.
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	Other identification (ID) number	Enter the CSHCN Services Program taxonomy code (non-NPI number) of the billing provider.

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	Diagnosis was present at the time of admission.
N	No	Diagnosis was not present at the time of 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.
Blank	Unreported/Not used	Exempt from POA reporting.

5.7.2.11 Dental Claim Filing

Dental and orthodontia services must be billed using the 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 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 41, "TMHP Electronic Data Interchange (EDI)" 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 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/Preautho-rization 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 applicable box If both Dental and Medical are marked, complete blocks 5-11 for dental only
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.
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 provider.

Block No.	ADA Description	Instructions
17	Employer Name	Not applicable for the CSHCN Services Program.
18	Relationship to Policy-holder/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") Include the appropriate modifier.
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).
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.

Block No.	ADA Description	Instructions
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.*
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.
34	Diagnosis Code List Qualifier	Enter the appropriate code to identify the diagnosis code source: Enter "AB= ICD-10" to identify the diagnosis code source.
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.
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 ***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.

Block No.	ADA Description	Instructions
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 physical 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).
52A	Additional Provider ID	Enter the taxonomy code 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 taxonomy code for the performing dentist (provider who treated the client).

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 41, "TMHP Electronic Data Interchange (EDI)" 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, 2019, is entered as 08062019.*

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, 2019, to August 16, 2019. When submitting the paper claim, enter the from date of service as 08062019 and the to date of service as 08162019. 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	08062019	08092019	4
2	08102019	08132019	4
3	08142019	08162019	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 NPI and taxonomy code of the individual rendering the services on their claims as well as the group provider NPI. 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 NPI. The provider will receive one NPI 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/resources/rate-and-code-updates/rate-changes.

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

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) Maintenance Request through the TMHP Provider Enrollment and Management System (PEMS).

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: Section 24.3.7, "Payment Window Reimbursement Guidelines" in Chapter 24, "Hospital" 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.*

Claims for authorized procedure codes that are manually priced must list the claims detail information in the same order as itemized on the authorization letter.

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: Section 24.3.2, "Hospital Reimbursement" in Chapter 24, "Hospital" for more information about hospital reimbursement.

5.8.6.1 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 **Resources**
3) Click **Online Fee Lookup**
4) Click **Fee 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.

REMITTANCE AND STATUS (R&S) REPORTS

CSHCN SERVICES PROGRAM PROVIDER MANUAL

APRIL 2025

TEXAS
Health and Human
Services

REMITTANCE AND STATUS (R&S) REPORTS

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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 National Provider Identifier (NPI) 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: Chapter 41, "TMHP Electronic Data Interchange (EDI)" 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
- NPIs
- 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.

Row Heading/Section	Explanation
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.
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/Accommo-dation 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.

Row Heading/Section	Explanation
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."

Chapter 7, "Appeals and Administrative Review."

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.

6.1.4.3.1 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 (as described in Section 6.1.4.2, "Adjustments to Claims" in this chapter), 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.

6.1.4.3.2 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).

6.1.4.3.3 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).

6.1.4.3.4 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.

6.1.4.3.5 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.

6.1.4.3.6 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.

Row Heading/Section	Explanation
CSHCN number	The client's CSHCN Services Program number.
Date of service	The format MMDDYYYY (month, day, year) in *From* date of service.
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 either IRS levies or outstanding accounts receivable. Once a check has been voided, the associated claims may not be payable, and the transaction will be finalized after 24 months. Providers may submit a voided check appeal to TMHP Cash Financial at the following address:

Texas Medicaid & Healthcare Partnership
Attn: Cash Financial
12365-A Riata Trace Parkway
Austin, TX 78727

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 41, "TMHP Electronic Data Interchange (EDI)."

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.

Heading	Explanation
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.
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,* Tenth Revision, Clinical Modification (ICD-10-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 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

********** CLAIMS - PAID OR DENIED **********

DOE, JANE 40002001020070440000000 CSN 999999900 01147 E119
000123456789
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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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 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--- FROM / TO	TOS	PROC	-----BILLED----- QTY / CHARGE	-----ALLOWED----- QTY / CHARGE	POS	PAID AMT	EOB	EOB	EOB	EOB	EOB	MOD	MOD

********** ADJUSTMENTS - PAID OR DENIED **********

DOE, JANE 0000000000	40002303020110600000000			111111111	2222222				01147							M00071
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 0000000000	40002303020110620000000			111111111	2222222				01147							Q825
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	40002303120110770000000	CSN	111111111	2222222		01147							N310
0000000000													
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 40002303020110061231234 5													
ORIGINAL CLAIM:													
DOE, JOHN	40002301020110690000000	CSN	111111111	2222222		01147							N310
0000000000													
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	40002303120110740000000	CSN	111111111	2222222		01147							K029
0000000000													
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 / 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 **********

00123 THE CLAIM REPORTED ABOVE IS AN ADJUSTMENT TO PREVIOUS CLAIM 400023030201100612312345

ORIGINAL CLAIM:

DOE, JANNET 0000000000	400023031201104600000000	CSN	111111111	2222222				01147						K029	
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 400023030201100612312345

ADJUSTMENT CLAIM:

DOE, JOHNNY 0000000000	400023010201107600000000	CSN	111111111	2222222				01147						K029	
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 400023030201100612312345

ORIGINAL CLAIM:

DOE, JAMMIE 0000000000	400023031201105500000000	CSN	111111111	2222222				01147						K029	
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 0000000000 CSN 111111111

	$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

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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									J353
0000000000													
03/07/2011 03/07/2011	F	42820	1.0 6,878.36 $6,878.36			00I03							
DOE, JOE	40002303020110730000000		111111111	2222222									M899
0000000000													
02/11/2011 02/11/2011	F	29891	1.0 10,421.30 $10,421.30			00I03					RT		
DOE, DAVE	40002303020110760000000		111111111	2222222									R51
0000000000													
03/11/2011 03/11/2011	F	62270	1.0 7,690.00 $7,690.00			00I03							

********** 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 / PATIENT ACCT #	CLAIM NUMBER	BENEFIT	CSHCN #	MEDICAL RECORD #	MEDICARE #	EOPS	EOPS	EOPS	EOPS	DIAGNOSIS
---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.

Appeals and Administrative Review

CSHCN Services Program Provider Manual

April 2025

TEXAS
Health and Human
Services

APPEALS AND ADMINISTRATIVE REVIEW

Table of Contents

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" for additional information regarding the appeals process for authorization and prior authorization denials.

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

Section 2.1.4, "Provider Enrollment Determinations" in Chapter 2, "Provider Enrollment and Responsibilities" 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 4.5, "Authorization and Prior Authorization Denials" in Chapter 4, "Prior Authorizations and Authorizations" 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
MC-1938
PO Box 149030
Austin, TX 78714-9947
Fax: 1-512-776-7238

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
MC-1938
PO Box 149030
Austin, TX 78714-9947
Fax: 1-512-776-7238

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: 2024 Authorization Filing Deadline Calendar

Filing Deadline Calendar for 2025

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 41, "TMHP Electronic Data Interchange (EDI)" 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 liability (TPL) 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 can call 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
12365-A 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 enrollment 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" in Chapter 1, "TMHP and HHSC Contact Information" 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
MC-1938
PO Box 149030
Austin, TX 78714-9947
Fax: 1-512-776-7238

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 4.5.3, "Administrative Review for Authorization and Prior Authorization Denials" in Chapter 4, "Prior Authorizations and Authorizations."

7.3.5.1 Administrative Review Requirements

An administrative review is a request for a review as defined in 26 TAC §351.10 and §351.13.

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 CSHCN Services Program client 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 26 TAC §351.10 and §351.13 and in this manual.

Refer to: Section 5.1.8, "Claims Filing Deadlines" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" 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
MC-1938
PO Box 149030
Austin, TX 78714-9947
Fax: 1-512-776-7238

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/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals. 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 26 TAC §351.6(b)(1) through (2) at www.sos.texas.gov/tac/index.shtml.

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
MC-1938
PO Box 149030
Austin, TX 78714-9947
Fax: 1-512-776-7238

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
MC-1938
PO Box 149030
Austin, TX 78714-99347
Fax: 1-512-776-7238

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: 2024 Authorization Filing Deadline Calendar

Filing Deadline Calendar for 2025

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

CSHCN Services Program Provider Manual

April 2025

TEXAS
Health and Human
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ADVANCED PRACTICE REGISTERED NURSE (APRN [NP/CNS])

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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 Provider Enrollment and Management System (PEMS). 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 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

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

Certified registered nurse anesthetists (CRNAs) should refer to Chapter 12, "Certified Registered Nurse Anesthetist (CRNA)" 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 National Provider Identifier (NPI) 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" for detailed information about authorization and prior authorization requirements.

Section 31.2.12, "Clinician-Directed Care Coordination Services" in Chapter 31, "Physician" 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 41, "TMHP Electronic Data Interchange (EDI)" for information about electronic claims submissions.

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

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper 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/resources/rate-and-code-updates/rate-changes.

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

8.5 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.

AMBULANCE

CSHCN SERVICES PROGRAM PROVIDER MANUAL

APRIL 2025

TEXAS
Health and Human
Services

AMBULANCE

Table of Contents

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 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

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

9.2 General Information

The CSHCN Services Program may reimburse emergency and nonemergency 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 nonemergency 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	Q3014		

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.

Ground and air mileage (procedure codes A0425, A0435, and A0436) is reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

The inpatient hospital stay benefit includes medically necessary emergency and nonemergency 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)

The following are emergency Triage, Treat, and Transport (ET3) alternative destination and treatment in place (TIP) destination codes:

Destination	Description
C	Community mental health center (including substance use disorder center)
F	Federally qualified health center
O	Physician's office
U	Urgent care facility
W	Treatment in place (in person or via telehealth)

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, 27	2
Inpatient hospital	21, 51, 52, 56, 61	3
Outpatient hospital	22, 23, 24, 55, 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, Tenth Revision, Clinical Modification (ICD-10-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-10-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-10-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 Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program Non-Emergency 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 Triage, Treat, and Transport (ET3)

Emergency Triage Treat and Transport (ET3) services are designed to allow greater flexibility for enrolled ambulance providers to address clients' health care needs following a 9-1-1, fire, police, or other locally established system for emergency calls. ET3 permits emergency transportation (ground ambulance) providers to:

- Transport a client to an alternative destination, other than an emergency department; or
- Initiate and facilitate appropriate treatment in place (TIP) at the scene; or
- Initiate and facilitate appropriate TIP via telemedicine or telehealth.

9.3.1.1 Transport to an Alternative Destination

An ambulance provider may transport a client to an alternative destination (such as an urgent care clinic, mental health center, FQHC, etc.) when upon evaluation:

- The client's condition is determined to be non-emergent but requires medical attention.

- An alternative destination will meet the client's level of care more appropriately than an emergency department.
- There is no other appropriate transportation available.

The alternative destination must be within or near the responding emergency transportation provider's service area. Prior to initiating ET3 transport to an alternative destination, the provider must have pre-established arrangements with alternative destination partners within their region, and have knowledge of the alternative destination's:

- Hours of operation.
- Clinical staff available.
- Services provided.

HHSC expects ambulance providers to use best practices and exercise their normal standard of care to determine the nearest most appropriate alternative destination for a client.

9.3.1.2 Treatment in Place

Upon the emergency response team's arrival on the scene and their evaluation of the client, if the services required at that time are determined to be medically necessary, but not emergent, the emergency transportation provider may provide treatment to the client in accordance with the provider's scope of practice, their emergency transport service's medical direction and established protocols.

Treatment on scene may also be performed, when medically necessary, via a telemedicine or telehealth visit performed in accordance with telemedicine and telehealth services requirements outlined in the *Telecommunications Handbook*.

Refer to: *The Telecommunications Handbook (Vol. 2 Handbooks)* for telemedicine and telehealth requirements.

9.3.2 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 nonemergency 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.

9.3.3 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.

9.3.4 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							
B9689	B999	D75A	D8130	D8131	D8132	D8139	E869
F068	F10929	F19939	F29	G4489	G8929	H579	H814
I2693	I2694	I469	I4811	I4819	I4820	I4821	I499
I80241	I80242	I80243	I80249	I80251	I80252	I80253	I80259
I82451	I82452	I82453	I82459	I82461	I82462	I82463	I82469
J9600	J984	M549	O2690	Q7960	Q7961	Q7962	Q7963
Q7969	R002	R0602	R0603	R0689	R079	R092	R0989
R100	R109	R238	R4182	R4189	R4589	R509	R52
R55	R569	R58	R6889	R7309	S02121A	S02121B	S02121S
S02122A	S02122B	S02122S	S02129A	S02129B	S02129S	S02831A	S02831B
S02831S	S02832A	S02832B	S02832S	S02839A	S02839B	S02839S	S02841A
S02841B	S02841S	S02842A	S02842B	S02842S	S02849A	S02849B	S02849S
S0285XA	S0285XB	S0285XS	S0590XA	T07XXXA	T148XXA	T1490XA	T1491XA
T17300A	T300	T50904A	T50911A	T50911S	T50912A	T50912S	T50913A
T50913S	T50914A	T50914S	T50915A	T50915S	T50916A	T50916S	T59891A
T5994XA	T6701XA	T6701XS	T6702XA	T6702XS	T6709XA	T6709XS	T672XXA
T675XXA	T68XXXA	T699XXA	T7500XA	T751XXA	T754XXA	T782XXA	T7840XA
T8189XA	T82519A	T887XXA	Y35009A	Y35009S	Y35019A	Y35019S	Y35029A
Y35029S	Y35039A	Y35039S	Y35049A	Y35049S	Y35099A	Y35099S	Y35109A
Y35109S	Y35119A	Y35119S	Y35129A	Y35129S	Y35199A	Y35199S	Y35209A
Y35209S	Y35219A	Y35219S	Y35299A	Y35299S	Y35309A	Y35309S	Y35319A
Y35319S	Y35399A	Y35399S	Y35409A	Y35409S	Y35419A	Y35419S	Y35499A
Y35499S	Y35819A	Y35819S	Y35831A	Y35831S	Y35832A	Y35832S	Y35833A
Y35833S	Y35839A	Y35839S	Y3599XA	Y3599XS	Y710	Y828	Z209

Emergency Medical Condition Codes				
Z7401	Z779	Z9181	Z9981	Z9989

9.4 Nonemergency 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.

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 may appeal denied prior authorization requests by submitting a request for an administrative review to the CSHCN Services Program.

Providers may appeal denied payment for services when prior authorization was not obtained before the service was provided by submitting a request for an administrative review to the CSHCN Services Program.

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.

Clients and/or providers may contact the Medical Transportation Program (MTP) for assistance when non-emergent transports are not approved. 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 Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program Non-Emergency Ambulance Prior Authorization Request form must be submitted. The Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program Non-Emergency Ambulance Prior Authorization Request form 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.

For nonemergency ambulance transportation services rendered to a client, ambulance providers may coordinate the nonemergency ambulance prior authorization request with the requesting provider, which may include a physician, nursing facility, health-care provider, or other responsible party. Ambulance providers may assist in providing necessary information, such as their National Provider Identifier (NPI) number, fax number, and business address, to the requesting provider. However, the Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program Non-Emergency Ambulance Prior Authorization Request form form must be signed, dated, and submitted by the CSHCN Services Program-enrolled requesting provider, not the ambulance provider.

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
PO Box 200735
Austin, TX 78727-0735
Fax: 1-512-514-4205

The requesting provider must select from the following prior authorization periods on the Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program Non-Emergency Ambulance Prior Authorization Request form:

- **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 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 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 Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program Non-Emergency 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 Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program Non-Emergency Ambulance Prior Authorization Request form.

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 Non-emergency Ambulance Exception form that is signed and dated by a physician.

  Note: *Stamped signatures and dates are not accepted. Without a physician's signature and date, the form is considered incomplete.*

- A completed Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program Non-Emergency Ambulance Prior Authorization Request form
- 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 Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program Non-Emergency Ambulance Prior Authorization Request form and, if applicable, the Non-emergency Ambulance Exception form.

The requesting provider (i.e., physician, nursing facility, health-care provider, or other responsible party) must contact the transporting ambulance provider with the prior authorization number (PAN) and the dates of service that were approved. The transporting ambulance provider will submit claims for the nonemergency ambulance transportation services, using the approved PAN provided by the requesting provider.

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 nonemergency 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 nonemergency 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.

9.5.5 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.

Oxygen (procedure code A0422) is reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

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.

Procedure codes for ground ambulance transports (A0426, A0428, A0433, A0434, and A0999) must be submitted with mileage procedure code A0425. Emergency ground ambulance transports (procedure codes A0427 and A0429) may be billed without mileage code A0425 for ET3 TIP services. Providers must include TIP destination code W in the destination position of the origin/destination modifier combination.

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.

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. Waiting time 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:

- 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.

The CSHCN Services Program reimburses providers for ground emergency transports (procedure codes A0427 and A0429) that do not result in a transport to a facility, only as part of ET3 services when the destination modifier W indicating TIP is included on the claim. For all other transports, if a client contacts an ambulance provider, but the call does not result in a transport, the CSHCN Services Program will not reimburse the provider and the provider should have the client sign an acknowledgment statement and bill the client for services rendered.

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

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

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

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-10-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.

9.8.1.1.1 Emergency Triage Services Billing

To bill for ET3 services, a provider must:

- Be enrolled in the CSHCN Services Program as an ambulance provider.
- Be responding to a call initiated by an emergency response system (9-1-1 call, fire, police, or other locally established system for medical emergency calls).
- Upon arrival at the scene, the emergency team's field evaluation determines the client's needs are non-emergent but requires medical attention.
- Follow all requirements as outlined in section 9.1 Enrollment.

9.8.1.1.2 Transport to an Alternative Destination Billing

When billing for transport to an alternative destination, providers shall bill using the most clinically appropriate emergency transport code (A0427 or A0429), the ET modifier, and the appropriate destination modifier to indicate ET3 services. Providers should also include the mileage code (A0425) in the claim as appropriate.

> ***Note:*** *If an emergency transportation provider transports a client to an alternative destination and determines at the time that the site is either closed, or unable to provide the needed level of care, then the emergency transportation provider shall transport the client to the nearest emergency department. In these cases, the provider may not bill for two transports.*

9.8.1.1.3 Treatment in Place (TIP) Billing

Treatment in place (TIP) is classified as an emergency transportation service and must be billed using the most clinically appropriate emergency transport code (A0427 or A0429), the ET modifier, and the W destination modifier to indicate TIP.

Claims must indicate TIP destination modifier W in the destination position of the origin/destination modifier combination. TIP claims without modifier W in the emergency indicator field will be denied.

Supplies (procedure codes A0382 and A0398) and oxygen (procedure code A04220) are payable, but mileage (procedure code A0425) and other ambulance transportation services (A0426 and A0428) are not payable for TIP services. Claims billed with non-payable ambulance TIP services will be denied.

The following are TIP ambulance claim modifiers:

Modifier	Origination Site	Destination
DW	Diagnostic or therapeutic site, or freestanding facility (e.g., radiation therapy center) other than H or P	TIP
EW	Residential, domiciliary, or custodial facility (unskilled facility)	TIP
JW	Non-hospital-based dialysis facility	TIP
PW	Physician's office	TIP
RW	Residence (client's home or any residence)	TIP
SW	Scene of accident or acute event	TIP

If a client being treated in place has a real-time deterioration in their clinical condition necessitating immediate transport to an emergency department, the ambulance provider cannot bill for both treatment in place ambulance service and the transport to the emergency room. In this case, the ambulance provider shall bill only the emergency department transport.

For informational purposes, ambulance providers may include G2022 on ambulance transportation claims to an emergency department that met ET3 requirements, but the client refused TIP or transportation to an alternative destination.

When billing for TIP via telemedicine or telehealth, providers must bill using the most clinically appropriate emergency transport code (A0427 or A0429), the ET modifier, the W destination modifier to indicate TIP, and in addition, procedure code Q3014. The Q3014 code will be informational only used to identify TIP via telemedicine or telehealth services.

Ambulance TIP with telemedicine or telehealth encounters without a corresponding telemedicine or telehealth encounter will be denied. Claims for multiple TIP and transport claims rendered on the same date of service for the same recipient will be denied.

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

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

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: Section 24.3.7, "Payment Window Reimbursement Guidelines" in Chapter 24, "Hospital" 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.

AUGMENTATIVE COMMUNICATION DEVICES (ACDS)

CSHCN SERVICES PROGRAM PROVIDER MANUAL

APRIL 2025

TEXAS
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AUGMENTATIVE COMMUNICATION DEVICES (ACDS)

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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 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

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

Section 3.1.4, "Services Provided Outside of Texas" in Chapter 3, "Client Benefits and Eligibility" 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 submit claims for the purchase or rental of ACDs. Only one of the procedure codes for rental of ACDs will be reimbursed per calendar month, by any provider.

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
- 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 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

Refer to: 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 37, "Speech-Language Pathology (SLP) Services" 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

Requests for prior authorization must be submitted by the ordering provider using the CSHCN Services Program Prior Authorization Request for Augmentative Communication Devices (ACDs) form.

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 re-evaluation 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 41, "TMHP Electronic Data Interchange (EDI)" for information on electronic claims submissions.

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

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

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

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

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.

Blood Pressure Monitoring and Devices

CSHCN Services Program Provider Manual

April 2025

TEXAS
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BLOOD PRESSURE MONITORING AND DEVICES

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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 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

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

Section 3.1.4, "Services Provided Outside of Texas" in Chapter 3, "Client Benefits and Eligibility" for more detailed information.

11.2 Benefits, Limitations, and Authorization Requirements

11.2.1 Blood Pressure Devices

Blood pressure monitoring by either Self-Measured blood pressure monitoring (SMBPM) or 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 Self-Measured Blood Pressure Monitoring and Ambulatory Blood Pressure Monitoring

SMBPM and ABPM are 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

SMBPM and ABPM are indicated for initial diagnosis of hypertension and should not be used for maintenance monitoring. SMBPM may also be indicated for re-evaluation of clients previously diagnosed with hypertension.

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 Codes							
I10	I110	I119	I120	I129	I130	I1310	I1311
I132	I150	I151	I152	I158	I159	I160	I161
I169	I1A0	I219	I21A1	I21A9	I21B	I2541	I2582
I2585	I2601	I2602	I2603	I2604	I2609	I2690	I2692
I2693	I2694	I2695	I2696	I2699	I270	I271	I2720
I2721	I2722	I2723	I2724	I2729	I2781	I2782	I2783
I2789	I279	I340	I341	I342	I3481	I3489	I349
I350	I351	I352	I358	I359	I360	I361	I362
I368	I369	I370	I371	I372	I378	I379	I38
I39	I421	I422	I423	I424	I425	I428	I440
I441	I442	I4430	I4439	I444	I445	I4460	I4469
I447	I450	I4510	I4519	I452	I454	I455	I456
I4589	I459	I4710	I4711	I4719	I4720	I4729	I479
I480	14811	14819	14820	14821	I483	I484	I4891
I4892	I495	I501	I5020	I5021	I5022	I5023	I5030
I5031	I5032	I5033	I5040	I5041	I5042	I5043	I50810
I50811	I50812	I50813	I50814	I5082	I5083	I5084	I5089
I509	I5A	I950	I951	I952	I953	I9581	I9589
I959	N000	N001	N002	N003	N004	N005	N006
N007	N008	N009	N00A	N010	N011	N012	N013

Diagnosis Codes							
N014	N015	N016	N017	N018	N019	N01A	N02A
N02B1	N02B2	N02B3	N02B4	N02B5	N02B6	N02B9	N030
N031	N032	N033	N034	N035	N036	N037	N038
N039	N03A	N040	N041	N0420	N0421	N0422	N0429
N043	N044	N045	N046	N047	N048	N049	N04A
N050	N051	N052	N053	N054	N055	N056	N057
N058	N059	N05A	N08	N170	N171	N172	N178
N179	N181	N182	N1830	N1831	N1832	N184	N185
N186	N189	N19	N250	N251	N2589	N259	N269
N270	N271	Q208	Q2110	Q2111	Q2112	Q2113	Q2114
Q2115	Q2116	Q2119	Q2120	Q2121	Q2122	Q2123	R001
T800XXA	T81718A	T8172XA					

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
- Myocardial infarction
- Pulmonary embolism
- Acute pulmonary heart disease
- Chronic pulmonary heart disease
- Valve disorders
- 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
- Embolism
- Stenosis of either coronary artery stent or peripheral vascular stent

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

SMBPM and ABPM do not require authorization or prior authorization.

Providers must document that the SMBPM orABPM 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" in this chapter. 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.

11.2.2.3.1 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.

Only one method of blood pressure monitoring (SMBPM or ABPM) may be reimbursed within a rolling 12-month period. SMBPM submitted within the same rolling 12-month period as AMPM will be denied.

Procedure code 99473 is limited to one service per year, any provider. Procedure code 99473 may be considered for reimbursement more than once per year when the following documentation of medical necessity is submitted with the claim:

- Documentation of erroneous blood pressure readings – excessively high or low blood pressure, blood pressure readings excessively inconsistent with those measured professionally
- Documentation of erroneous blood pressure logs – day of the week, time of day, setting or location, or timing of medication administration inconsistent with prior professional instruction
- Documentation of poor health literacy, developmental, or intellectual challenges that may require repeated client education
- Client purchase or receipt of new blood pressure device

Procedure code 99474 is limited to four services per year, any provider, and may be reimbursed only if a claim for procedure code 99473 has been submitted within 12 rolling months.

11.2.2.3.2 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" for more information about authorizations and prior authorizations.

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

Providers must use the following procedure codes for ABPM:

Procedure Codes			
93784	93786	93788	93790

Providers must use the following procedure codes for SMPM:

Procedure Codes	
99473	99474

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 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" for general information about claims filing.

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

Chapter 41, "TMHP Electronic Data Interchange (EDI)" 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/resources/rate-and-code-updates/rate-changes.

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

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.

Certified Registered Nurse Anesthetist (CRNA)

CSHCN Services Program Provider Manual

April 2025

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CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA)

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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 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

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

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" in Chapter 31, "Physician" 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 physician. (Must be submitted when a CRNA has personally performed the anesthesia services, is not medically directed by the anesthesiologist, and is directed by the physician.)
- 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 41, "TMHP Electronic Data Interchange (EDI)" for information on electronic claims submissions.

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

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

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.

A CRNAs reimbursement for performing an anesthesia service when supervised by a physician other than an anesthesiologist is 92 percent of the maximum allowable fee.

A CRNA under the supervision of an anesthesiologist may be reimbursed the lesser of the billed charges or 50 percent of the calculated payment for a supervised anesthesia 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/resources/rate-and-code-updates/rate-changes.

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

Refer to: Section 31.2.5, "Anesthesia Services" in Chapter 31, "Physician" 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.

CERTIFIED RESPIRATORY CARE PRACTITIONER (CRCP)

CSHCN SERVICES PROGRAM PROVIDER MANUAL

APRIL 2025

TEXAS
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CERTIFIED RESPIRATORY CARE PRACTITIONER (CRCP)

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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 National Provider Identifier (NPI) by the National Plan and Provider Enumeration System (NPPES), 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 online through the Provider Enrollment and Management System (PEMS). 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 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

Refer to: Section 2.1, "Provider Enrollment" in Chapter 2, "Provider Enrollment and Responsibilities" for more detailed information about CSHCN Services Program 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 30 per calendar year, by any provider.

Expendable supplies are not a benefit for CRCPs.

Refer to: Chapter 36, "Respiratory Equipment and Supplies" 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) form. Services may be prior authorized for a maximum of 2 months at a time.

Refer to: Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" 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 for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

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

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

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper 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/resources/rate-and-code-updates/rate-changes.

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

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.

DENTAL

CSHCN SERVICES PROGRAM PROVIDER MANUAL

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DENTAL

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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) (see Title 22 *Texas Administrative Code* (TAC), §§110.1–110.18), 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)
- Proof of an anesthesiology residency recognized by the American Dental Board of Anesthesiology (required to be reimbursed at the enhanced rate for procedure codes D9222 and D9223), 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 26 TAC, but also with knowledge of the adopted Medicaid agency rules published in 1 TAC §§351.1–351.883 and specifically including the fraud and abuse provisions contained in 1 TAC §§371.1–371.1719.

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

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

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 authori-

zation 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 current. 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 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

Important: *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 Substitute Dentist

The following are conditions for reimbursement of services rendered by a substitute dentist:

- Dentists who take a leave of absence for no more than 90 days may bill for the services of a substitute dentist who renders services on an occasional basis when the primary dentist is unavailable to provide services. Services must be rendered at the practice location of the dentist who has taken the leave of absence. A locum tenens arrangement is not allowed for dentists.
- This arrangement will be limited to no more than 90 consecutive days. Under this temporary basis, the primary dentist (who is the billing agent dentist) may not submit a claim for services furnished by a substitute dentist to address long-term vacancies in a dental practice. The billing agent dentist may submit claims for the services of a substitute dentist for longer than 90 consecutive days if the dentist has been called or ordered to active duty as a member of a reserve component of the Armed Forces. CSHCN accept claims from the billing agent dentist for services provided by the substitute dentist for the duration of the billing agent dentist's active duty as a member of a reserve component of the Armed Forces.
- Providers billing for services provided by a substitute dentist must bill with modifier U5 in Block 19 of the American Dental Association (ADA) claim form.
- The billing agent dentist may recover no more than the actual administrative cost of submitting the claim on behalf of the substitute dentist. This cost is not reimbursable by CSHCN.
- The billing agent dentist must bill substitute dentist services on a different claim form from his or her own services. The billing agent dentist services cannot be billed on the same claim form as substitute dentist services.
- The substitute dentist must be licensed to practice in the state of Texas, must be enrolled in Texas Medicaid before enrolling in the CSHCN Services Program and must not be on the Texas Medicaid provider exclusion list.
- The dentist who is temporarily absent from the practice must be indicated on the claim as the billing agent dentist, and his or her name, address, and National Provider Identifier (NPI) must appear in Blocks 53, 54, and 56 of the ADA claim form.

- The substitute dentist's NPI number must be documented in Block 35 of the ADA claim form. Electronic submissions do not require a provider signature.

Dentists must familiarize themselves with these requirements and document accordingly. Those services not supported by the required documentation, as detailed above, will be subject to recoupment.

Note: *Dental services must be filed on the ADA claim form.*

14.2.3 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.

14.2.3.1 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 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

Section 14.2.3.3, "Cone-Beam Imaging" in this chapter.

14.2.3.2 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 • Limited to one service per day and ten services per client lifetime, with at least 60 days between visits by any provider

Procedure Code	Comments and Limitations
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
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

A caries risk assessment procedure code (D0601, D0602, or D0603) will be required on the same claim, for the same date of service, by the same provider when dental examination procedure code D0120, D0145, or D0150 is submitted for reimbursement. The client's dental condition(s) that justifies the risk assessment classification submitted with the claim must be clearly documented and maintained by the provider in the client's medical record.

Professionally developed caries risk assessment tools are available at:

- American Dental Association (ADA)
- American Academy of Pediatric Dentistry (AAPD)
- Department of State Health Services (DSHS), Oral Health Program

14.2.3.3 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.

14.2.3.4 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 hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/texas-health-steps/dental-providers/first-dental-home.

14.2.3.5 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 comprehensive 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	• Limited to one service every three years by the same provider • Denied when submitted on an emergency claim • 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
D0270	• Limited to one per day by the same provider • Age limitation = 1 year of age or older
D0272	• Denied when billed with procedure code D0210 same day, by the same provider • Limited to one per day by the same provider • Age limitation = 1 year of age or older
D0273	• Denied when billed with procedure code D0210 same day, by the same provider • Limited to one per day by the same provider • Age limitation = 1 year of age or older

Procedure Code	Limitations
D0274	• Denied when billed with procedure code D0210 same day, by the same provider • Limited to one per day by the same provider • Age limitation = 2 years of age or older
D0277	• Denied when billed with procedure code D0210 same day, by the same provider • Denied when billed with procedure code D0330 same day, by the same provider • Limited to one per day by the same provider • Age limitation = 2 years 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 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 • Prior authorization is required • Limited to a combined maximum of three services per calendar year • Additional services may be considered with documentation of medical necessity

14.2.3.6 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 14.2.6, "Therapeutic Services" in this chapter for additional information about endodontic procedures.

When billing for diagnostic procedures not adequately described by other procedure codes, providers should use procedure code D0999.

Procedure code D0470 is limited to once per lifetime, any provider.

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.

14.2.4 Orthodontia Services

Orthodontia services are benefits of the CSHCN Services Program for clients with prior authorization and an appropriate diagnosis code that indicates cleft lip, cleft palate, congenital anomalies of skull and face bones, dentofacial functional abnormalaties, or major anomalies of jaw size.

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.

14.2.4.1 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, and all active orthodontic treatments must be completed within 36 months. 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.

Extensions on allowed time frames may be considered no sooner than 60 days before the authorization expires. Extra monthly adjustments (procedure code D8670) will not be prior authorized, but the time frame may be considered for extension not to exceed 36 months of actual treatment.

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

14.2.4.2 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 procedures 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 orthodontia services must include one of the following indications:

- Cleft lip
- Cleft palate
- Congenital anomalies of skull and face bones
- Dentofacial functional abnormalities
- Major anomalies of jaw size

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

14.2.4.3 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 Current Dental Terminology (CDT) (national) procedure codes.

The following procedures are not included in comprehensive treatment:

CDT Procedure Code	Remarks Code	Description
D8660	Z2009	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.**		

Monthly adjustments (procedure code D8670) for comprehensive orthodontics are limited to one service per calendar month.

Only one retainer per arch per lifetime (procedure code D8680) is allowed. The delivery of a retainer includes any visits for retainer adjustments. Retainer adjustments are not reimbursed separately.

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	Z2009 *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		

Diagnostic model (procedure code D0470) are included in procedure codes (D8010 or D8020).

The orthodontic diagnostic work-up procedures are considered inclusive to procedure codes D8010 or D8020 and are not reimbursed separately. Panoramic radiographic images (procedure code D0330), cephalometric radiographic images (procedure code D0340), oral/facial photographic images obtained intraorally or extraorally (procedure code D0350) and diagnostic models (procedure code D0470) will be denied when billed with any one of the following procedure codes: D8010 or D8020.

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 D8010 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 D8020 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

Remarks Code	Fixed Appliances Description
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
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

Remarks Code	Removable Appliances Description
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
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

ADA Procedure Codes								
D8010	D8020	D8080	D8210	D8220	D8660	D8670	D8680	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 NPI when billing claims.

14.2.5 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

14.2.5.1 Authorization Requirements

Authorization or prior authorization is not required for preventive dental services.

14.2.5.2 Oral Hygiene Instruction

OHI (procedure code D1330) may be considered for reimbursement for clients who are 1 year of age or older in an office setting 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 rolling year by any provider and is denied when billed on the same day as procedure codes D1110, D1120, D1206, or D1208 by any 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 NPI when billing claims.

14.2.5.3 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.

Topical application of fluoride (procedure code D1206 or D1208) is limited to once every six months, by any provider.

Procedure codes D1110 and D1120 include oral health instructions, and are limited to one prophylaxis per 6 calendar months, by any provider. Procedure codes D1110 and D1120 will be denied when submitted on an emergency claim.

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 NPI when billing claims.

14.2.5.4 Dental Sealants

Dental sealants (procedure codes D1351 and D1352) are a benefit for clients who are 1 through 20 years of age when applied to primary teeth (Tooth Identification [TID] A, B, I, J, K, L, S, and T) or permanent teeth (TID 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, and 32).

Dental sealants may be applied by a dentist or dental hygienist.

Procedure codes D1351 and D1352 are limited to once per lifetime, per TID, by any provider. Exceptions may be considered when pretreatment documentation clearly supports medical necessity.

Sealants may be applied to the occlusal, buccal, and lingual pits and fissures of teeth. 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 NPI when billing claims.

Procedure code D1351 will be denied if it is billed on the same date of service for the same permanent TID as procedure code D1352.

Procedure code D1352 may be reimbursed for posterior permanent teeth only (TID 2-5, 12-15, 18-21, or 28-31) to clients who are 5 years of age or older.

Procedure code D1352 will be denied if a moderate or high caries risk assessment (procedure code D0602 or D0603) has not been submitted, by any provider, within 180 days prior to procedure code D1352.

Procedure codes D1351 and D1352 will be denied if billed as an emergency claim.

14.2.5.5 Caries Arresting Medicament

Application of caries arresting medicament (procedure code D1354) is a benefit for clients who are birth through 6 years of age.

Procedure code D1354 is limited to once per lifetime per TID (A-T and 3, 14, 19, and 30), any provider.

Procedure code D1354 will be denied if billed on the same date of service for the same TID as procedure code D1351 or D1352, any provider.

Procedure code D1354 will be denied when billed within six months of procedure code D9222 or 00170 with modifier U3 by any provider.

Note: *Silver diamine fluoride is the only material providers may use for procedure code D1354.*

14.2.5.6 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, D1516, D1517, D1520, D1526, D1527, and D1575.

Procedure codes D1510 and D1520 are limited to once per lifetime, per quadrant, by any provider.

Procedure codes D1516, D1517, D1526, and D1527 are limited to once per lifetime, per tooth ID, any provider.

Procedure codes D1551, D1552, and D1553 may be reimbursed for clients who are 1 through 12 years of age. Procedure codes D1551 and D1552 are limited to once per lifetime, same provider.

Procedure codes D1553 and D1556 are limited to once per quadrant, per lifetime, any provider.

Procedure code D1551 will be denied if D1516 has been reimbursed within the previous rolling year, same provider.

Procedure code D1552 will be denied if billed within one rolling year of procedure code D1517, same provider.

Procedure codes D1556, D1557, and D1558 may be reimbursed for clients who are 1 through 20 years of age. Removal of a space maintainer (procedure code D1556, D1557, or D1558) is not payable to the provider or dental group practice that originally placed the device. The provider may be reimbursed if the space maintainer was placed by a different provider.

Procedure codes D1510, D1516, D1517, D1520, D1526, and D1527 may be reimbursed for clients who are 1 through 12 years of age. 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 NPI when billing claims.

Space maintainers are designed to prevent tooth movement and are a benefit in the following situations:

- After premature loss of a deciduous (primary) tooth, first or second molars (tooth identification) (TID): A, B, I, and J for clients who are 1 through 12 years of age.
- After premature loss of deciduous (primary) tooth, first or second molars (tooth identification) (TID): K, L, S, and T for clients who are 1 through 12 years of age.
- After loss of a permanent first molar (TID: 3 and 14) for clients who are 3 through 12 years of age.
- After loss of a permanent first molar (TID: 19 and 30) for clients who are 3 through 12 years of age.
- After premature loss of a deciduous (primary) second molar (TID: A, J, K, and T) for clients who are 3 through 7 years of age billed with (procedure code D1575).

  Note: *Premature loss is defined as loss of the tooth prior to the expected or normal life of the tooth. For a deciduous/primary molar, this is before eruption of the comparable bicuspid permanent tooth.*

Space maintainers submitted with procedure code D1575 are limited to one per tooth ID, per client. Procedure code D1575 is limited to once per lifetime, per quadrant, any provider.

14.2.5.7 Noncovered Counseling Services

14.2.5.7.1 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, orthodontic, 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.

14.2.5.7.2 Tobacco Counseling

Procedure code D1320 is not a benefit of the CSHCN Services Program as a separate procedure. Tobacco counseling is considered part of any preventive, therapeutic, orthodontic, and diagnostic dental procedures.

14.2.6 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

14.2.6.1 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

Each distinct dental procedure code to be performed that requires prior authorization must be listed on the CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services Form. Repetitive dental procedure codes must be listed to indicate the total quantity to be performed.

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

14.2.6.2 Anesthesia Requirements for Clients who are Six Years of Age or Younger

For clients who are six years of age or younger, the following will apply:

- All Level 4 sedation/general anesthesia services provided by a dentist (procedure codes D9222 and D9223), and any anesthesia services provided by an anesthesiologist (M.D./D.O.) or certified registered nurse anesthetist (CRNA) (procedure code 00170 with modifier U3) provided in conjunction with dental therapeutic services must be prior authorized.
- The dentist performing the therapeutic dental procedure is responsible for obtaining prior authorization and is also responsible for providing the anesthesia prior authorization information to the anesthesiology provider.

- The current process of scoring 22 points on the Criteria for Dental Therapy Under General Anesthesia form does not guarantee authorization or reimbursement for clients who are six years of age and younger.

Procedure code 00170 with modifier U3, and procedure codes D9222 and D9223 is limited to once per six calendar months by any provider.

Requests for prior authorization must include, but is not limited to, the following client-specific documents and information:

- A completed CSHCN Services Program Criteria for Dental Therapy Under General Anesthesia form
- A completed CSHCN Services Program Prior Authorization Request for Dental of Orthodontia Services form
- The location of where the procedure(s) will be performed (office, inpatient hospital, or outpatient hospital)
- Name of the group providing the Level 4 anesthesia services
- A narrative unique to the client, detailing the reasons for the proposed level of sedation (indicate procedure code D9222, D9223, or 00170 with modifier U3). The narrative must include a history of prior treatment, information about failed attempts at other levels of sedation, behavior in the dental chair, proposed restorative treatment (tooth ID and surfaces), urgent need to provide comprehensive dental treatment based on extent of diagnosed dental caries, and any relevant medical condition(s).
- Diagnostic quality radiographs or photographs
  - When appropriate radiographs or photographs cannot be taken prior to general anesthesia. The narrative must support the reasons for an inability to perform diagnostic services. For special cases that receive authorization, diagnostic quality radiographs or photographs will be required for payment and will be reviewed by the TMHP dental director.

Note: *In cases of an emergency medical condition, accident, or trauma, prior authorization is not necessary. However, a narrative and appropriate pre- and post-treatment radiographs or photographs must be submitted with the claim, which will be reviewed by the TMHP dental director.*

14.2.6.3 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.

14.2.6.4 Restorations

Restorations do not require prior authorization except for onlays and crowns. Procedure code D2999 requires prior authorization.

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.

Reimbursement for crowns and onlay restorations are payable once per client, per tooth every ten years. Additional crowns and onlays may be considered with prior authorization and documentation of medical necessity.

Reimbursement for crowns and onlay restorations require submission of post-operative bitewing radiograph(s) (for posterior teeth) or post-operative periapical radiograph(s) (for anterior teeth) with the claim to verify that the restoration meets the standard of care.

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
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
A = Age limitation	

Procedure Codes	Limitations
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; will be denied if billed with the following procedure codes within one rolling year, same TID, same provider: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663 or D2664.
D2915	A = 6 years of age or older
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, limited to TID C-H, M-R, and all permanent teeth.
D2933	A = NA, limited to TID C-H and M-R primary teeth.
D2934	A = NA
D2940	A = NA
D2950	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
A = Age limitation	

Procedure Codes	Limitations
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
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
Other Restorative Services	
D2951	Limited to two times per lifetime for permanent teeth, same TID, any provider. Additional services will be considered with documentation of medical necessity. A = 6 years of age or older
A = Age limitation	

The following dental restoration procedure codes will be limited to once per rolling year, for the same TID, by the same provider:

Procedure Codes									
D2140	D2150	D2160	D2161	D2330	D2331	D2332	D2391	D2392	D2393
D2394									

Procedure codes D2335 and D2390 when provided to primary teeth will be limited to once per lifetime, same TID, any provider, and will be denied if any of the following anterior restorations have been paid within a rolling year, for the same TID, by the same provider as the following procedure codes:

Procedure Codes									
D2140	D2150	D2160	D2161	D2330	D2331	D2332	D2335	D2390	D2932
D2933	D2934								

Total reimbursement for direct restorations on primary teeth cannot exceed the total dollar amount allowed for a stainless steel crown, per TID, per date of service. This limitation does not apply to procedure code D2335.

14.2.6.4.1 Direct Restorations and Other Restorative Services

Direct restoration of a primary tooth with the use of a prefabricated crown will be considered as a once in a lifetime restoration, same TID, any provider. Exceptions may be considered when pre-treatment X-ray images, intra-oral photos, and narrative documentation clearly support the medical necessity for the replacement of the prefabricated crown procedure codes D2930, D2932, D2933, and D2934 during pre-payment review.

Procedure code D2930 will be denied if the following procedure codes have been billed within a rolling year, for the same TID, by the same provider:

Procedure Codes									
D2140	D2150	D2160	D2161	D2330	D2331	D2332	D2335	D2390	D2391
D2392	D2393	D2394							

Procedure codes D2933 and D2934 will be denied if the following procedure codes have been billed within a rolling year, for the same TID, by the same provider:

Procedure Codes								
D2140	D2150	D2160	D2161	D2330	D2331	D2332	D2335	D2390

Procedure codes D2931 and D2932 will be denied if the following procedure codes have been billed within a rolling year, for the same TID, by the same provider:

Procedure Codes									
D2140	D2150	D2160	D2161	D2330	D2331	D2332	D2335	D2390	D2391
D2392	D2393	D2394	D2931	D2932					

14.2.6.5 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.

14.2.6.5.1 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 dental 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 dental record

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 14.2.6.1, "Prior Authorization Requirements" in this chapter for more information about prior authorization requirements.

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

14.2.6.5.2 Pulp Caps and Pulpotomy

Procedure Code	Limitations
D3110	A = 1 year and older
D3120	A = 1 year and older
D3220	• A = NA. • Limited to once per lifetime, per primary tooth (TID A through T) • 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) and indirect pulp caps (procedure code D3120) are a benefit for permanent teeth only (TID 1-32).

Direct pulp caps (procedure code D3110) may be reimbursed when billed with the following procedure codes for the same tooth ID, on the same date of service, by the same provider:

Procedure Codes									
D2140	D2150	D2160	D2161	D2330	D2331	D2332	D2335	D2390	D2391
D2392	D2393	D2394	D2510	D2520	D2530	D2542	D2543	D2544	D2650
D2651	D2652	D2662	D2663	D2664	D2710	D2720	D2721	D2722	D2740
D2750	D2751	D2752	D2780	D2781	D2782	D2783	D2790	D2791	D2792
D2794	D2931	D2932							

Indirect pulp caps (procedure code D3120) may be reimbursed when billed with procedure code D2940 for the same tooth ID, on the same date of service by the same provider.

Procedure code D3221 is considered part of all endodontic procedures and will not be reimbursed separately.

14.2.6.5.3 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

Re-treatment claims for an incomplete pulpotomy performed by a dentist not associated with the original treating dentist or dental group will be considered for reimbursement upon appeal.

Documentation of medical necessity and the incomplete initial pulpotomy must be submitted with the appeal. The appeal must also include a written narrative and pre- and post-treatment X-rays, which will be reviewed by a Texas licensed dentist.

> ***Note:*** *The identified, original treating dentist or dental group will not be considered for reimbursement.*

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 14.2.6.4, "Restorations" in this chapter for additional limitations
D3120	A = 1 year of age or older
D3220	A = NA; see additional restrictions in Section 14.2.6.5.2, "Pulp Caps and Pulpotomy" in this chapter
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
A = Age limitation	

Procedure Codes	Limitations
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	

14.2.6.6 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, D1351, and D1352 will be denied when billed on the same date of service as any D4000 series periodontal procedure code.

Periodontal scaling and root planing (procedure codes D4341 and D4342) will be denied when submitted for the same date of service as other D4000 series codes, except D4341 and D4342, any provider.

Full mouth debridement (procedure code D4355) will be denied when submitted for the same date of service as the following procedure codes by any provider:

Procedure Codes									
D4210	D4211	D4230	D4231	D4240	D4241	D4245	D4249	D4260	D4261
D4266	D4267	D4270	D4273	D4274	D4275	D4276	D4277	D4278	D4283
D4285	D4381	D4910	D4920	D4999					

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, same TID, per rolling 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, limited to once per quadrant, per day, same provider
D4261	A = 13 years of age or older, limited to once per quadrant, per day, same provider

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
D4266	A = 13 years of age or older, prior authorization, DOC, PP2
D4267	A = 13 years of age or older, prior authorization, DOC, PP2
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, limited to one service per day, same provider
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
D4283	A = 13 years of age or older, limited to three teeth per site, DOC, PP1; procedure code D4283 must be billed with primary procedure code D4273 on the same claim, for the same date of service, by the same provider
D4285	A = 13 years of age or older, limited to three teeth per site, DOC, PP1; procedure code D4285 must be billed with primary procedure code D4275 on the same claim, for the same date of service, by the same provider
D4341	A = 13 years of age or older, prior authorization, denied when submitted on the same date of service as D4355; Current periodontal charting, a current full mouth radiograph, and a narrative describing the periodontal diagnosis must be submitted with the prior authorization request to determine medical necessity.
D4342	A = 13 years of age or older, prior authorization; Current periodontal charting, a current full mouth radiograph, and a narrative describing the periodontal diagnosis must be submitted with the prior authorization request to determine medical necessity.
D4355	A = 13 years of age or older, DOC, PP1, not payable within 90 days of procedure code D4910
D4381	A = 13 years of age or older, limited to one service per client, same TID, per rolling year
D4910	A = 13 years of age or older, 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 14.2.6.1, "Prior Authorization Requirements" in this chapter.

14.2.6.7 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 and rebase procedures are denied if billed within 1 rolling 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, and D5640.

Repairs to partial mandibular dentures (procedure code D5671) are denied as part of mandibular procedure codes D5212, D5214, 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
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
D5511	A = 1 year of age or older, prior authorization
D5512	A = 1 year of age or older, prior authorization
D5520	A = 3 years of age or older, prior authorization
D5611	A = 3 years of age or older
D5612	A = 3 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
A = Age limitation and NA = Not applicable	

Procedure Codes	Limitations
D5710	• A = 1 year of age or older, prior authorization. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5720, D5730, D5740, D5750, and D5760, same provider.
D5711	• A = 1 year of age or older, prior authorization. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5721, D5731, D5741, D5751, and D5761, same provider.
D5720	• A = 6 years of age or older, prior authorization. Limited to once every three rolling years, same provider. Will be denied within three rolling years of procedure codes D5710, D5730, D5740, D5750, and D5760, same provider.
D5721	• A = 6 years of age or older, prior authorization. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5711, D5731, D5741, D5751, and D5761, same provider.
D5730	• A = 1 year of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5710, D5720, D5740, D5750, and D5760, same provider.
D5731	• A = 1 year of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5711, D5721, D5741, D5751, and D5761, same provider.
D5740	• A = 6 years of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5710, D5720, D5730, D5750, and D5760, same provider.
D5741	• A = 6 years of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5711, D5721, D5731, D5751, and D5761, same provider.
D5750	• A = 1 year of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5710, D5720, D5730, D5740, and D5760, same provider.
D5751	• A = 1 year of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5711, D5721, D5731, D5741, and D5761, same provider.
D5760	• A = 6 years of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5710, D5720, D5730, D5740, and D5750, same provider.
D5761	• A = 6 years of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5711, D5721, D5731, D5741, and D5751, same provider.
D5810	A = 1 year of age or older, prior authorization
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
A = Age limitation and NA = Not applicable	

Procedure Codes	Limitations
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 14.2.6.1, "Prior Authorization Requirements" in this chapter.

14.2.6.7.1 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
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
A = Age limitation and NA = Not applicable	

Procedure Codes	Limitations
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 14.2.6.1, "Prior Authorization Requirements" in this chapter.

14.2.6.7.2 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
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 14.2.6.1, "Prior Authorization Requirements" in this chapter for more information about prior authorization requirements.

14.2.6.7.3 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 14.2.6.1, "Prior Authorization Requirements" in this chapter.

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									
Fixed Partial Denture Pontics									
D6210	D6211	D6212	D6240	D6241	D6242	D6245	D6250	D6251	D6252
Fixed Partial Denture Retainers—Inlays or Onlays									
D6545	D6548	D6549							
Fixed Partial Denture Retainers—Crowns									
D6720	D6721	D6722	D6740	D6750	D6751	D6752	D6780	D6781	D6782
D6783	D6790	D6791	D6792						
Other Fixed Partial Denture Services									

Procedure Codes					
D6920	D6930	D6940	D6950	D6980	D6999

14.2.6.8 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. Procedure code D7280 will be denied unless billed with an authorized procedure code D7283 for the same tooth, on the same day, by the same provider.
D7282	A = 1 year of age or older
D7283	A = 1 year of age or older, prior authorization, permanent dentition only (tooth identification [TID] 2-15 and 18-31). To obtain prior authorization, a copy of the orthodontic treatment plan must be submitted along with a current panoramic radiograph to determine medical necessity and a CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services Form.
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
D7961	A = 12 through 20 years of age, prior authorization
D7962	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 14.2.6.1, "Prior Authorization Requirements" in this chapter.

14.2.6.9 Adjunctive General Services

Refer to individual procedure codes in the following table for prior authorization requirements:

Procedure Code	Limitations
D9110	A = NA, see additional benefit information listed below table
D9120	A = 13 years of age or older, prior authorization
D9210	A = NA, denied when billed on the same day as procedure code D9248, any provider
D9211	A = NA, denied when billed on the same day as procedure code D9248, any provider
D9212	A = NA, denied when billed on the same day as procedure code D9248, any provider
D9222	A = NA, prior authorization, DOC, limited to 15 minutes (1 unit) per day
D9223	A = NA, prior authorization, DOC, limited to 2 hours and 45 minutes (11 units) per day must be billed with primary procedure code D9222, same provider
D9230	A = NA, denied when billed on the same day as procedure code D9248, any provider
D9239	A = NA, limited to 15 minutes (1 unit) per day, denied when billed on the same day as procedure code D9222, any provider
D9243	A = NA, limited to 1 hour and 15 minutes per day (5 units), must be billed with primary procedure code D9239, same provider
D9248	A = NA, DOC, limited to one service per day and two services per 12 months, refer to Section 14.2.6.10, "Dental Anesthesia" in this chapter. Denied when billed on the same day as procedure codes D9222, D9239, D9420, and D9920, any provider. Additional services may be considered with prior authorization and documentation of medical necessity.
D9310	A = NA, prior authorization
D9420	A = NA, prior authorization, DOC, refer to Section 14.2.7.1, "Dental Hospital Calls" in this chapter. Limited to two times per rolling year, any provider. Additional services may be considered with prior authorization and documentation of medical necessity.
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. Limited to two times per rolling year, any provider. Additional services may be considered with prior authorization and documentation of medical necessity.
D9630	A = NA, prior authorization, DOC
D9910	A = NA, limited to once per six months, any provider, 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 D9222, D9230, or D9239 or with an evaluation, prophylactic treatment, or radiographic procedure, DOC; claim must include diagnosis of intellectual disability, refer to Section 14.2.6.11, "Dental Behavior Management" in this chapter.
D9930	A = NA
D9944	A = NA
A = Age limitation, NA = Not applicable, and DOC = Documentation required	

Procedure Code	Limitations
D9950	A = 13 years of age or older, prior authorization
D9951	A = 13 years of age or older, prior authorization, may be reimbursed once every three rolling years per client, any provider, 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
D9974	A = 13 years of age or older, DOC, refer to Section 14.2.6.12, "Internal Bleaching of Discolored Tooth" in this chapter
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 14.2.6.1, "Prior Authorization Requirements" in this chapter for more information about prior authorization requirements.

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

14.2.6.9.1 Emergency Dental Treatment Services

Procedure code D9110 is an emergency service only. The type of treatment rendered and tooth identification must be indicated. It must be for a service other than a prescription or topical medication. The reason for the emergency and a narrative of the procedure actually performed must be documented and the appropriate block for emergency must be checked on the claim form.

Procedure code D9110 is a benefit for the following:

- Sedative or periodontal dressing
- Starting root canal procedure; (i.e.:, open and drain tooth or re-medication of previously opened tooth)
- Smoothing fractured tooth that is cutting lips or cheek
- Debridement or curettage of wound
- Excision of operculum over an erupting tooth
- Limited gingivectomy
- Suture removal by dentist other than the dentist who placed suture(s)
- Placement of a temporary crown by other than the patient's regular dentist and one who is not in the process, has not previously, or does not in the future intend to perform an acrylic, polycarbonate, stainless steel or cast crown on this same tooth
- Tissue conditioning of a full or partial denture
- Removal of spontaneously or post-surgically sequested bone spicule
- Spot or limited scaling and root planing
- Procedures necessary to treat a dry socket
- Procedures necessary to control bleeding
- Non-surgical reduction of TMJ dislocation

- Procedures necessary to relieve pain associated with pericoronitis, particularly third molars

Procedure code D9110 is not a benefit for the following:

- Prescription written
- Medication given or administered
- Application of topical medication to teeth or gums
- Occlusal adjustments
- Oral hygiene instructions

14.2.6.10 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 level 4 permit and an anesthesiology residency recognized by the American Dental Board of Anesthesiology to receive an enhanced rate for procedure codes D9222 and D9223.

All levels of sedation must have clinical documentation and a narrative in the client's dental record to support medical necessity of the service. The client's dental record must be available for review by representatives of HHSC or it's designee.

14.2.6.10.1 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
D9222	Level 4
D9223	Level 4
D9230	Level 1
D9239	Level 3
D9243	Level 3

Procedure Codes	Level of Sedation
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 codes D9239 is limited to 15 minutes (1 unit) per day. Procedure code D9243 is limited to 1 hour and 15 minutes per day (5 units).

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.

If more than two nonintravenous (IV) conscious sedation services are required by any provider in a 12 month period, prior authorization is required.

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 on the same day as procedure code D9248:

Procedure Codes			
D9210	D9211	D9212	D9230

Refer to: Section 14.2.7.3, "Dental General Anesthesia Provided in the Inpatient or Outpatient Setting (Medically Necessary Dental Rehabilitation or Restoration Services)" in this chapter.

14.2.6.10.2 Method for Counting Minutes for Timed Procedure Codes

All claims for reimbursement of procedure codes paid in 15-minute increments 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.

Time intervals for 1 through 12 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

Units	Number of 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
9 units	128 minutes through 142 minutes
10 units	143 minutes through 157 minutes
11 units	158 minutes through 172 minutes
12 units	173 minutes through 187 minutes

All levels of sedation must have clinical documentation and a narrative in the client's dental record to support the necessity of the service. Documentation must include the sedation record that indicates sedation start and end times in accordance with the American Academy of Pediatric Dentistry (AAPD) guidelines. The client's dental record must be available for review by representatives of HHSC or its designee.

14.2.6.11 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 a diagnosis of an intellectual disability described as mild, moderate, severe, profound, or unspecified.

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 disability, signed and dated within 1 year before the dental behavior management
- The client's diagnosis of intellectual disability
- 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" in Chapter 24, "Hospital" for more information about prior authorization in an ASC.

14.2.6.12 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.

14.2.6.13 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									

14.2.7 Dental Treatment in Hospitals and ASCs

Dental rehabilitation and restoration services requiring general anesthesia may be performed in the inpatient or outpatient setting.

14.2.7.1 Dental Hospital Calls

Dental hospital calls may be reimbursed for clients of any age that require medically necessary general 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 dental record and is subject to retrospective review. Procedure code D9420 is limited to twice per rolling year, per client, any provider. Additional services may be considered with prior authorization and documentation of medical necessity.

Refer to: Chapter 24, "Hospital" for more information about requirements for inpatient and outpatient services.

14.2.7.2 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 must be submitted to the TMHP-CSHCN Services Program with supporting documentation of medical necessity.

Refer to: Chapter 4, "Prior Authorizations and Authorizations" for additional information.

Chapter 24, "Hospital."

Refer to: CSHCN Services Program Prior Authorization Request for Inpatient Hospital Admission—For Use by Facilities Only form

Refer to: CSHCN Services Program Prior Authorization Request for Inpatient Surgery—For Surgeons Only form.

14.2.7.3 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 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

Supporting documentation must be retained in the client's chart and must reflect compliance with the CSHCN Services Program Criteria for Dental Therapy Under General Anesthesia and the CSHCN Services Program Policy About the Criteria for Dental Therapy Under General Anesthesia, Attachment 1. Dental general anesthesia may be reimbursed once every 6 months per client any 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 client's dental record as a separate form

Hospital and outpatient facility admissions are subject to medical necessity review.

14.2.8 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 (acpacares.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 31.2.39.11, "Cleft/Craniofacial Procedures" in Chapter 31, "Physician" 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.

14.2.8.1 Authorization Requirements

The following procedure codes require prior 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	15630	15781	15788	15789

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.

14.2.8.2 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	11000	11010	11011	11012	11042
11043	11044	11102	11103	11104	11105	11106	11107	11200	11201
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 procedures 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									
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**
15730	15733	15740	15750	15756	15757	15758	15760	15769	15770
15781**	15786	15787	15788**	15789**	15820*	15821*	15851	15852	17250
20100	20525	20551	20552	20600	20604	20605	20606	20615	20660
20670	20680	20690	20692	20693	20694	20696	20697	20900	20902*
20910	20912	20920	20922	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	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*	21255*
21256*	21260*	21261*	21263*	21267*	21268*	21270*	21275*	21280*	21282*
21295*	21296*	21299*	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	21452	21453	21454	21461	21462
21465	21470	21480	21485	21490	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

***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 procedures 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									
30802	30901	30903	30905	30906	30930	30999*	31020	31080	31081
31084	31085	31086	31087	31090	31200*	31201	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	40899*	41000	41005	41006
41007	41008	41009	41010	41015	41016	41017	41018	41100	41105
41108	41110	41112	41113	41114	41115	41116	41120	41130	41250
41251	41252	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
42425	42426	42440	42450	42500	42505	42507	42509	42510	42550
42600	42650	42660	42665	42699*	42700	42720	42725	42800	42804
42806	42808	42809	42810	42815	42890	42892	42894	42900	42950
42960	42961	42962	42970	42999*	61501	61559*	62147	64400	64640
64681	64722	64736	64738	64740	64742	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 procedures 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.**

14.2.8.3 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.

14.2.8.4 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.

14.2.8.5 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.

14.2.8.6 Other Procedures Payable to a Dentist Physician

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	J0121	J0290	J0295	J0330
J0558	J0561	J0690	J0692	J0694	J0696	J0697	J0698	J0702	J0720
J0744	J1010	J1100	J1165	J1170	J1200	J1364	J1580	J1631	J1720
J1790	J1810	J1885	J1940	J2010	J2060	J2401	J2402	J2540	J2560
J2700	J2770	J2919	J3000	J3260	J3300	J3301	J3303	J3370	J3430
J3480	J3490	T1013							

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; procedure code T1013 billed with modifier UA is limited to a quantity of 28 per day.

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.**									

14.2.8.7 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. 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 NPI. 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.cms.gov/medicare/coding/ncci-coding-edits or correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

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

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

Section 5.7.2.13, "Instructions for Completing the Paper ADA Dental Claim Form" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper claims. Blocks that are not referenced are not required for processing 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.

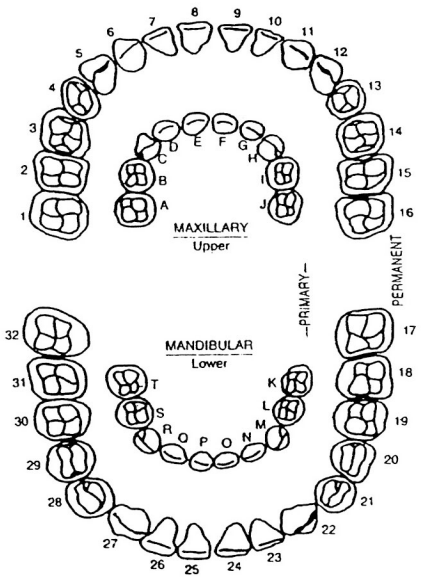
Additionally, the Comments field should be used to document the specific nature of the emergency. The Comments field in the HIPAA-approved 837D electronic transaction is 80 bytes long.

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

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

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.

Diabetic Equipment and Supplies

CSHCN Services Program Provider Manual

April 2025

TEXAS
Health and Human
Services

DIABETIC EQUIPMENT AND SUPPLIES

Table of Contents

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 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

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

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

Blood testing supplies may be reimbursed without prior authorization when submitted with one of the following diagnoses:

Diagnosis Codes							
E0800	E0801	E0810	E0811	E0821	E0822	E0829	E08311
E08319	E083211	E083212	E083213	E083219	E083291	E083292	E083293
E083299	E083311	E083312	E083313	E083319	E083391	E083392	E083393
E083399	E083411	E083412	E083413	E083419	E083491	E083492	E083493
E083499	E083511	E083512	E083513	E083519	E083521	E083522	E083523
E083529	E083531	E083532	E083533	E083539	E083541	E083542	E083543
E083549	E083551	E083552	E083553	E083559	E083591	E083592	E083593
E083599	E0836	E0837X1	E0837X2	E0837X3	E0837X9	E0839	E0840
E0841	E0842	E0843	E0844	E0849	E0851	E0852	E0859

Diagnosis Codes							
E08610	E08618	E08620	E08621	E08622	E08628	E08630	E08638
E08641	E08649	E0865	E0869	E088	E089	E0900	E0901
E0910	E0911	E0921	E0922	E0929	E09311	E09319	E093211
E093212	E093213	E093219	E093291	E093292	E093293	E093299	E093311
E093312	E093313	E093319	E093391	E093392	E093393	E093399	E093411
E093412	E093413	E093419	E093491	E093492	E093493	E093499	E093511
E093512	E093513	E093519	E093521	E093522	E093523	E093529	E093531
E093532	E093533	E093539	E093541	E093542	E093543	E093549	E093551
E093552	E093553	E093559	E093591	E093592	E093593	E093599	E0936
E0937X1	E0937X2	E0937X3	E0937X9	E0939	E0940	E0941	E0942
E0943	E0944	E0949	E0951	E0952	E0959	E09610	E09618
E09620	E09621	E09622	E09628	E09630	E09638	E09641	E09649
E0965	E0969	E098	E099	E1010	E1011	E1021	E1022
E1029	E10311	E10319	E103211	E103212	E103213	E103219	E103291
E103292	E103293	E103299	E103311	E103312	E103313	E103319	E103391
E103392	E103393	E103399	E103411	E103412	E103413	E103419	E103491
E103492	E103493	E103499	E103511	E103512	E103513	E103519	E103521
E103522	E103523	E103529	E103531	E103532	E103533	E103539	E103541
E103542	E103543	E103549	E103551	E103552	E103553	E103559	E103591
E103592	E103593	E103599	E1036	E1037X1	E1037X2	E1037X3	E1037X9
E1039	E1040	E1041	E1042	E1043	E1044	E1049	E1051
E1052	E1059	E10610	E10618	E10620	E10621	E10622	E10628
E10630	E10638	E10641	E10649	E1065	E1069	E108	E109
E10A0	E10A1	E10A2	E1100	E1101	E1110	E1121	E1122
E1129	E11311	E11319	E113211	E113212	E113213	E113219	E113291
E113292	E113293	E113299	E113311	E113312	E113313	E113319	E113391
E113392	E113393	E113399	E113411	E113412	E113413	E113419	E113491
E113492	E113493	E113499	E113511	E113512	E113513	E113519	E113521
E113522	E113523	E113529	E113531	E113532	E113533	E113539	E113541
E113542	E113543	E113549	E113551	E113552	E113553	E113559	E113591
E113592	E113593	E113599	E1136	E1137X1	E1137X2	E1137X3	E1137X9
E1139	E1140	E1141	E1142	E1143	E1144	E1149	E1151
E1152	E1159	E11610	E11618	E11620	E11621	E11622	E11628
E11630	E11638	E11641	E11649	E1165	E1169	E118	E119
E1300	E1301	E1310	E1311	E1321	E1322	E1329	E13311
E13319	E133211	E133212	E133213	E133219	E133291	E133292	E133293
E133299	E133311	E133312	E133313	E133319	E133391	E133392	E133393
E133399	E133411	E133412	E133413	E133419	E133491	E133492	E133493
E133499	E133511	E133512	E133513	E133519	E133521	E133522	E133523
E133529	E133531	E133532	E133533	E133539	E133541	E133542	E133543

Diagnosis Codes							
E133549	E133551	E133552	E133553	E133559	E133591	E133592	E133593
E133599	E1336	E1337X1	E1337X2	E1337X3	E1337X9	E1339	E1341
E1342	E1343	E1344	E1349	E1351	E1352	E1359	E13610
E13620	E13621	E13622	E13628	E13630	E13638	E13641	E13649
E1365	E1369	E138	E139	P702	Z7984		

15.2.1.1 Non Diabetic Diagnosis Codes

Diagnosis Codes							
E161	E162	E16A1	E16A2	E16A3	E71111	E71310	E71311
E71312	E71313	E71314	E71318	E7132	E7420	E7421	E7429
E88810	E88811	E88818	E88819	E88A	K911	R7303	R7309
R81							

Diagnoses not listed may be considered for prior authorization with supporting documentation of medical necessity.

15.2.1.2 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.

15.2.1.3 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 Section 15.2.1, "Glucose Monitor and Supplies" in 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

15.2.1.3.1 * 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 with modifier U9 for these procedure codes:

Procedure Code	[Revised] Limitation
A4253*	4 boxes per month
A4259	2 boxes per month
A9275*	4 units per month
[Revised] * A client may receive a combined total of 4 per calendar month of procedure codes A4253 and A9275.	

15.2.1.3.2 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 Section 15.2.1, "Glucose Monitor and Supplies" in 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).

15.2.1.4 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 Section 15.2.1, "Glucose Monitor and Supplies" in 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.

15.2.1.5 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 * Continuous Glucose Monitors (CGM)

The following procedure codes and related supplies are benefits in the home setting when the services are provided by home health durable medical equipment (DME), medical supplier (DME), and custom DME providers:

Procedure Codes	Limitations
A4238	One per month
A4239	One unit per month
E2102	One per three years
E2103	One per three years

A therapeutic or non-adjunctive CGM can be used to make treatment decisions without the need for a stand-alone BGM to confirm testing results. A non-therapeutic or adjunctive CGM requires the user to verify their glucose levels or the trends displayed on a CGM with a BGM before making treatment decisions.

The CGM system includes the following:

- A disposable sensor (attaches to the skin and inserts a tiny wire into the subcutaneous tissue to measure glucose levels)
- A transmitter (attaches to the sensor and sends the data to a wireless receiver/monitor)
- A receiver/monitor (records and stores the data and alerts the client when glucose levels are too high or too low)

Only CGM consisting of all three parts including the sensor, transmitter, and receiver/monitor are covered. Coverage requires a dedicated receiver/monitor. A CGM that uses a smart device (e.g., smart phone, tablet, watch, personal computer) as a receiver is not classified as durable medical equipment and therefore not covered by the CSHCN Services Program.

The non-adjunctive CGM system includes the device (procedure code E2103) and associated supplies (procedure code A4239).

The adjunctive CGM system includes a receiver/monitor (procedure code E2102) and associated supplies (procedure code A4238).

A CGM device (procedure code A9278) and associated supplies (procedure codes A9276 and A9277) for use with non-durable medical equipment are informational only.

Procedure codes E2102 and E2103 are limited to once per three rolling years, any provider.

Other home glucose monitors (procedure codes E2100 and E2101) will be denied when submitted within three calendar years of procedure codes E2102 or E2103.

The supply allowance (procedure code A4238 or A4239) used with a CGM system encompasses all items necessary for the use of the device. The DME provider is responsible for delivering all appropriate items and quantities to the client for continuous usage of the CGM.

[Revised] SBGM is used as a supplement to CGM devices. Allowance for SBGM supplies billed in addition to an approved CGM system will be reduced to four boxes for test strips (procedure code A4253) and two boxes for lancets (procedure code A4259) during the same calendar year by any provider.

The provider is responsible for submitting appropriate claims using procedure codes E2103 and A4239 for therapeutic devices and supplies. Claims must be submitted with modifier KF for a class III device (designated by FDA) and associated supplies. No modifier is required for a class II device (designated by FDA).

Modifier	Description
KF	Item designated by FDA as class III device

Procedure code A4239 will be denied when submitted during the same calendar month by any provider as procedure codes A4250, A4256, A9275, E2100, or E2101.

15.2.2.1 * Prior Authorization Requirements

Prior authorization is required for a CGM device (procedure codes E2102 and E2103) and its associated supplies (procedure codes A4238 and A4239) that exceed the limit of once per calendar month. All prior authorization requests must be submitted on the CSHCN Services Program Prior Authorization Request for Diabetic Equipment and Supplies Form.

CGM must be prescribed by the health-care provider who manages the client's diabetes. The order must include the make and model of the requested CGM device. A long-term personal CGM system for clients with diabetes to use at home may be considered for prior authorization for clients who have a documented diagnosis of insulin dependent diabetes mellitus and with clinical documentation of the following criteria:

- The client uses BGM and performs frequent testing (at least four times per day).
- The client has an insulin treatment regimen that requires frequent adjustments based on self blood glucose monitoring (SBGM) or CGM testing results.
- There is documentation that the client demonstrates compliance with his or her insulin regimen by monitoring his or her blood sugar with finger sticks.
- If the client already owns a monitor, the client must also meet at least two of the following criteria for the initial order of the monitor and supplies:
    - Elevated glycosylated hemoglobin level (HbA1c) > 7.0 percent
    - [Revised] History of dawn phenomenon with fasting blood sugars that frequently exceed 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
    - History of diabetic ketoacidosis

The provider must submit the CSHCN Services Program Prior Authorization Request for Diabetic Equipment and Supplies Form indicating the following:

- The client or caregiver possesses the following competencies:
    - The cognitive and physical abilities to use the CGM

  - An understanding of cause and effect
  - The ability to learn to use the device
  - The ability to hear and view CGM alerts and respond appropriately
  - The willingness to support the use of the CGM
- The prescribing provider attests the following:
  - A training or education plan will be completed prior to initiation of CGM therapy.
  - The client or caregiver will be given face-to-face education and instruction.
  - The client or caregiver will be able to demonstrate proficiency in integrating CGM therapy with the current treatment regimen for glucose control.

Prior to prescribing a CGM device, the ordering provider should verify that the client meets the CGM manufacturers' recommendations for:

- Medical Conditions.
- Appropriate age range.
- Testing and calibration requirements.

The initial prior authorization will be valid for six months. If the client complies with the use of the CGM and treatment plan, the physician may write an order and submit an updated PA request for an additional six months. After the first year, an order for replacement sensors, transmitter, and receiver may be submitted for a 12-month period.

15.2.2.2 Associated Supplies

When a CGM device (procedure code E2102 or E2103) is approved, the related supplies (procedure code A4238 or A4239) are also covered once per calendar month. Prior authorization for the related supplies is required only when the extra supplies provided exceed the allowance of once per calendar month.

Prior authorization to approve the initial once per calendar month allowance for the related supplies (procedure code A4238 or A4239) is also required when the client already owns a CGM device and the provider is not requesting a new CGM device. Clinical documentation of the following must be submitted with the prior authorization request:

- The client-owned device meets the CMS definition of a non-adjunctive CGM.
- A physician's statement verifying the client's current condition meets the non-adjunctive CGM coverage criteria.

SBGM-related supplies (procedure codes A4233, A4234, A4235, A4236, A4253, and A4259) provided within the same calendar month as an approved CGM device (procedure code E2103) and related supplies (procedure code A4239) will require prior authorization and documentation of medical necessity. Providers must use modifier U9 for insulin-dependent clients.

15.2.2.3 Noncovered Services

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

- Diagnostic glucose devices
- CGM without a dedicated receiver
- Smart devices (smart phones, tablets, personal computers, etc.) used as CGM monitors
- Non-medical items, even if the items may be used to serve a medical purpose

15.2.3 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
A4224	4 per month
A4225	15 per month
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	30 per month
A6259	15 per month
A9274	15 per month
A9900	As needed with prior authorization
K0604	1 per 6 months
K0605	1 per 6 months
E0784	1 per 3 years with prior authorization (purchase) 1 per month with prior authorization (rental)

Procedure codes A4230 and A4231 cannot be billed during the same calendar month.

Providers must bill the pump (procedure code E0784) used in the CGM integrated system with modifier UD. Providers also must bill procedure codes E2102 or E2103 with modifier U4 for the integrated system.

Additional quantities may be considered with documentation of medical necessity and prior authorization.

A tubeless external insulin pump (Omnipod) may be considered for prior authorization and must be submitted using procedure code E0784 with modifier U1 and supply procedure code A9274 for the disposable pods, supplies, and accessories.

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.

15.2.3.1 * Prior Authorization Requirements

[Revised] 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 Diabetic Equipment and Supplies form. Supporting medical necessity documentation must include past and current blood glucose levels and the most recent glycosylated hemoglobin level (HbA1c).

The rental of an external insulin pump may be considered for prior authorization with submission of clinical documentation that indicates one of the following:

- The client has a diagnosis of diabetes mellitus and meets at least 2 of the following criteria while on multiple daily injections of insulin:
  - Elevated glycosylated hemoglobin level (HbA1c) greater than 7.0 percent
  - [Revised] 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 Diabetic Equipment and Supplies 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.

15.2.3.2 CGM Integrated External Insulin Pump

A CGM integrated pump system, also called a closed-loop glucose management system, connects a CGM and an insulin pump. The system uses an algorithm to calculate insulin doses from the CGM readings based on thresholds of measured glucose levels and tells the pump to deliver or suspend the insulin into the client's body.

Clients currently utilizing an external insulin pump or who meet the criteria for an external insulin pump may be reimbursed for a CGM specific pump and CGM device to form an integrated system through prior authorization.

Prior authorization for an integrated system should be requested utilizing pump procedure code E0784 with modifier UD combined with one of the following CGM procedure codes:

- E2102
- E2103 with modifier U4

Tubeless external insulin pump (Omnipod) may be considered as an alternative to the CGM integrated pump system through prior authorization using pump procedure code E0784 with modifier U1 combined with disposable supply procedure code A9274.

Some CGM integrated pump systems might use smart devices to monitor the system instead of a CGM receiver/monitor. CSHCN Services Program excludes coverage for non-medical items, even when the items may be used to serve a medical purpose. The device provider is responsible for supplying the software applications to make the system work appropriately.

Once the client is on a CGM integrated insulin pump, either with therapeutic CGM capability or with adjunctive CGM capability, the claims for a stand-alone CGM will be denied.

The following modifiers should be used to bill for CGM integrated external insulin pump systems:

Modifier	Description
UD	Used for pump with CGM for integrated pump system
U1	Used for pump with Omnipod system
U4	Used for CGM devices with pump for integrated pump system

15.2.4 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" in Chapter 3, "Client Benefits and Eligibility" 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 for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

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

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

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

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

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

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.

Diagnostic Radiology Services

CSHCN Services Program Provider Manual

April 2025

TEXAS
Health and Human
Services

DIAGNOSTIC RADIOLOGY SERVICES

Table of Contents

16.1 Enrollment

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

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

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

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

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

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

16.2 Benefits, Limitations, and Authorization Requirements

16.2.1 Diagnostic Radiology Services Provided by Hospitals

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

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

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

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

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

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

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

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

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

16.2.3 Cardiac Blood Pool Imaging

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

16.2.4 Computed Tomography (CT) Scan

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

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

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

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

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

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

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

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

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

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

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

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

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

16.2.5 Contrast Material

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

16.2.6 Magnetic Resonance Angiography (MRA)

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

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

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

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

16.2.6.1 MRA Authorization Requirements

Authorization is not required for MRA services.

16.2.7 Magnetic Resonance Imaging (MRI)

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

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

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

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

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

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

16.2.7.1 MRI Authorization Requirements

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

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

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

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

16.2.7.2 MRI Benefits and Limitations

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

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

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

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

16.2.8 Mammography Certification

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

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

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

16.2.9 Positron Emission Tomography (PET)

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

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

Diagnosis Codes					
G249	G40201	G40209	G40211	G40219	R569

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

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

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

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

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

16.2.10 X-ray and Ultrasound Procedures

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

16.2.10.1 Diagnostic Imaging

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

Procedure Codes					
70030	76831	76881	76882	76883	93980

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

Procedure Codes
Q9950

Procedure code Q9950 must be billed in conjunction with procedure code 93306.

16.2.10.2 Interventional Radiological Procedures

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

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

Procedure Codes					
74235	75956	75957	75958	75959	76937

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

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

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

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

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

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

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

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

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

Procedure Codes		
74000	74010	74020

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

16.2.10.4 Reimbursement Information

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

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

Separate charges for injectable radioactive materials may be reimbursed.

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

Column A (Denied)	Column B
75958	75956, 75957

16.2.10.5 X-ray and Ultrasound Prior Authorization Requirements

Procedure code 93980 requires prior authorization.

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

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

16.2.11 Noncovered Services

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

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

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

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

16.3 Claims Information

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

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

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

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

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

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

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

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

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

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

16.4 Reimbursement

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16.4.1 One-day Payment Window Reimbursement Guidelines

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

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

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

16.5 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

DURABLE MEDICAL EQUIPMENT (DME)

CSHCN SERVICES PROGRAM PROVIDER MANUAL

APRIL 2025

TEXAS
Health and Human
Services

DURABLE MEDICAL EQUIPMENT (DME)

Table of Contents

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 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his/her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

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

Section 3.1.4, "Services Provided Outside of Texas" in Chapter 3, "Client Benefits and Eligibility" 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 2.1, "Provider Enrollment" in Chapter 2, "Provider Enrollment and Responsibilities." 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
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.

Prior authorization is required for quantities exceeding the limitations defined in the sections below.

Equipment that has been purchased may be considered for replacement when loss or irreparable damage has occurred outside the warranty terms, conditions, and limitations. A copy of the police or fire report when appropriate and the measures to be taken to prevent reoccurrence must be submitted with the prior authorization request.

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" 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
L8001	4 per rolling year, per modifier Modifier LT or RT required.
L8002	4 per rolling year
L8010	8 per rolling year
L8015	2 per rolling year
L8020	1 per 6 rolling months
L8030	1 per 2 rolling years
L8031	1 per 2 rolling years
L8032	8 per rolling year, same procedure, any provider
L8033	8 per rolling year
L8035	Requires prior authorization
L8039	Requires prior authorization

Refer to: Section 31.2.40, "Diagnostic and Surgical/Reconstructive Breast Therapies " in Chapter 31, "Physician" 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.

17.3.3.1.1 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, L8032, and L8033:

- 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.

17.3.3.1.2 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 codes L8035 and L8039 must include the following information:

- The client's diagnosis
- Prior treatment for the diagnosis
- Medical necessity of the requested prosthesis
- A clear, concise description of the prosthesis requested

The prior authorization request for procedure code L8039 must also include the following information:

- Reason for recommending this particular prosthesis
- A procedure code that is comparable to the prosthesis requested
- Documentation that indicates this prosthesis is not investigational or experimental
- The setting in which the service is to be rendered
- The physician's intended fee for this prosthesis

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" 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.

17.3.9.4.1 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.

17.3.10.1.1 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, osteo-arthritis, 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

17.3.10.4.1 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.

17.3.10.4.2 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.

17.3.10.4.3 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.

17.3.10.4.4 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.

17.3.10.4.5 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.

17.3.10.4.6 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 E0627 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.

17.3.14.1.1 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:

- Documentation that the child weighs more than 40 pounds or is more than 40 inches in height (actual height and weight must be provided).
- Providers must include a description of the child's postural condition, specifically including head and trunk control, including why a booster chair or seatbelt will not meet the client's needs.
- 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. Procedure code E0638 with modifier UA should be used to identify an upright or prone system stander, and modifier UB should be used to identify a supine stander. 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."

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 individuals with intellectual disabilities (ICF/IID). Providing wheelchairs for these children is the responsibility of the facility licensed to care for them.

17.3.19.1 Seating Evaluation Requirements

A seating evaluation performed by a physical therapist (PT), an occupational therapist (OT), or physician does not require prior authorization. A seating assessment performed by a physician is considered part of the physician evaluation and management service and will not be reimbursed separately.

Procedure code 97542 may be reimbursed for a seating assessment performed by the OT or PT when billed with the modifiers as follows:

Practitioner	Procedure Code	Modifiers
Occupational therapist	97542	GO and UC
Physical therapist	97542	GP and UC

The seating assessment must:

- Explain how the client or family will be trained in the use of the equipment.
- Anticipate changes in the client's needs and include anticipated modifications or accessory needs, as well as the growth potential of the wheelchair.
- Include significant medical information pertinent to the client's mobility and how the requested equipment will accommodate these needs, including intellectual, postural, physical, sensory (visual and auditory), and physical status.
- Address trunk and head control, balance, arm and hand function, existence and severity of orthopedic deformities, as well as any recent changes in the client's physical and/or functional status, and any expected or potential surgeries that will improve or further limit mobility.
- Include information on the client's current mobility/seating equipment, how long the client has been in the current equipment and why it no longer meets the client's needs.
- Include the client's height, weight, and a description of where the equipment is to be used.
- Include seating measurements.
- Include the accessibility of client's residence.
- Include manufacturer's information, including the description of the specific base, any attached seating system components, and any attached accessories, as well as the manufacturer's retail pricing information and itemized pricing for manually priced components.
- Include documentation supporting medical necessity for all accessories.
- Be documented on the Wheelchair Seating Evaluation Form, which must be signed and dated by the qualified practitioner completing the assessment (PT, OT, or physician). All signatures and dates must be current, unaltered, and original. Electronic signatures may be accepted when the national and state standards set by Health and Human Services, Department of Commerce, and the Texas Uniform Electronic Transactions Act are met. Stamped signatures and dates will not be accepted.
- Be submitted with the prior authorization request for the wheeled mobility system. The form must be completed, signed, and dated as outlined above.

Seating assessments are reimbursed in 15-minute increments (units) and are limited to four units (one hour).

17.3.19.2 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.

17.3.19.3 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.

17.3.19.4 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.

17.3.19.5 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.

17.3.19.6 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.*

17.3.19.6.1 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.

17.3.19.6.2 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

17.3.19.6.3 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.

17.3.19.6.4 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.

17.3.19.7 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.

17.3.19.8 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.

17.3.19.9 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 power elevating leg lifts 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.

17.3.19.10 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 wheelchair 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.

Repairs and modifications must be cost-effective. The cost of a new piece of equipment must be considered when the total cost of repairs and modifications will be greater than $1,000.00. The age of the current equipment and the amount of time that remains until the original equipment may be replaced (e.g., every three years for a manual wheelchair and every five years for a power wheelchair), must be considered when reviewing a request for repairs or modifications. 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 41, "TMHP Electronic Data Interchange (EDI)" for information on electronic claims submissions.

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

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

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

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

17.8 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 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.

Expendable Medical Supplies

CSHCN Services Program Provider Manual

April 2025

TEXAS
Health and Human
Services

EXPENDABLE MEDICAL SUPPLIES

Table of Contents

18.1 Enrollment

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

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

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

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

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

18.2 Benefits, Limitations, and Authorization Requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18.2.1 Incontinence Supplies

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

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

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

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

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

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

18.2.2 * Wound Care Supplies

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

Procedure Code	Maximum Limitation	Procedure Code	Maximum Limitation	[Revised] Procedure Code	[Revised] Maximum Limitation
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	As needed (Prior Authorization required)

18.2.3 Examples of Covered Supplies

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

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

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

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

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

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

18.2.4 Diapers, Briefs, Pull-ups, and Liners

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

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

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

18.2.4.1 Gastrostomy Devices

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

18.2.4.1.1 Authorization Requirements

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

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

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

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

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

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

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

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

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

18.3 Claims Information

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

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

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

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

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

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

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

18.4 Reimbursement

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

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

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

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

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

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

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

18.5 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

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

CSHCN Services Program Provider Manual

April 2025

TEXAS
Health and Human
Services

FEDERALLY QUALIFIED HEALTH CENTERS (FQHC) AND RURAL HEALTH CLINICS (RHC)

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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 through the Provider Enrollment and Management System (PEMS), 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 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1).

Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

Refer to: Section 2.1, "Provider Enrollment" in Chapter 2, "Provider Enrollment and Responsibilities" for more detailed information about CSHCN Services Program 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	96160	96161	99381	99382	99383	99384	99385	99386	99387
99391	99392	99393	99394	99395	99396	99397			
General medical services must be billed with one of the appropriate modifiers: AH, AJ, AM, SA, TD, TE, or U7.									

Note: *Procedure codes 96160 and 96161 are benefits of the CSHCN Services Program for clients who are 12 through 18 years of age and are limited to once per calendar year, any provider.*

Refer to: Section 31.2.18.10, "Preventive Care Medical Checkup Components" in Chapter 31, "Physician" in the Physician chapter for more specific information about guidelines and requirements for procedure codes 96160 and 96161.

The general medical services modifiers are defined as follows:

Modifier	Services Performed
AH	Services Performed By Psychologist
AJ	Services Performed By Social Worker
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 one of the general services modifiers above:

Preventive Care Medical Checkups									
96160	96161	99381	99382	99383	99384	99385	99386	99387	99391
99395	99396	99397							

Note: *Procedure codes 96160 and 96161 are benefits of the CSHCN Services Program for clients who are 12 through 18 years of age and are limited to once per calendar year, any provider.*

Refer to: Section 31.2.18.10, "Preventive Care Medical Checkup Components" in Chapter 31, "Physician" in the Physician chapter for more specific information about guidelines and requirements for procedure codes 96160 and 96161.

Adult preventive care must be billed with diagnosis code Z0000 or Z0001. Pediatric preventive care must be billed with diagnosis code Z00121 or Z00129. The provider cannot submit modifier EP for pediatric services.

19.2.3 Telecommunication Services

The procedure codes in the following table are a benefit of the CSHCN Services Program when they are provided by FQHC providers for telemedicine services at a distant site location:

Procedure Codes								
99202	99203	99204	99205	99211	99212	99213	99214	99215

Refer to: Section 38.2.2, "Telemedicine Services" in Chapter 38, "Telecommunication Services" for more detailed information about telemedicine services.

19.2.4 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	96130	96132	96136

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

19.2.5 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	D1208	D1351	D1352	D1510	D1516	D1517
D1520	D1526	D1527	D1551	D1552	D1553	D1575	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	D5611
D5612	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	D8010	D8020
D8080	D8210	D8220	D8660	D8670	D8680	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

Procedure Codes								
1073D	1074D	1075D	1076D	1077D	1078D	Z2009	Z2011	Z2012

19.2.6 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	92201	92202	92230	92235	92240	92242	92250
92260	92265	92270	92273	92274	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.

Hearing Services

CSHCN Services Program Provider Manual

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HEARING SERVICES

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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 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

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

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.

Hearing aid fitters and dispensers may enroll with the CSHCN Services Program as individuals or as facilities.

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 Texas Workforce Commission (TWC). The CSHCN Services Program may request that clients who meet these requirements apply to TWC, 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. The client's responsible adult may refuse to permit the referral or decline ECI services at any time. The provider must document the client's responsible adult's decision in the client's medical record.

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	92565	92567	92568	92570	92571	92572	92575	92576
92577	92579	92582	92583	92584	92587	92588	92650	92651	92652
92653									

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" in Chapter 31, "Physician" for more information 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	92537	92538	92540	92541	92542	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 billable on the same day by the same provider for the same client. If both procedure codes are billed for the same date of service by the same provider for the same client, they will be denied with instructions to bill with the more appropriate, comprehensive audiometry procedure code 92557.

Procedure codes 92551, 92552, and 92553 for pure tone audiometry are limited to one of any of these procedure codes per day, same provider, same client.

Procedure code 92547 is an add-on code, and must be billed with the primary procedure code (92540, 92541, 92542, 92544, 92545, or 92546) with the same date of service by the same provider to be considered for reimbursement.

Procedure codes 92558, 92587, 92588, 92650, 92651, 92652, and 92653 assume that testing is performed in both ears. If testing is only performed in one ear, use modifier 52 with 92558, 92587, 92588, 92650, 92651, 92652, and 92653 to indicate that a test has only been applied to one ear.

Procedure codes 92558, 92587, and 92588 will only be reimbursed once per day for the same provider and the same client.

Procedure codes 92650, 92651, 92652, and 92653 will only be reimbursed once per day by any provider.

Procedure codes 92620, 92621, and 92625 may be reimbursed for evaluative and therapeutic services and are limited to four services per rolling year. Providers must submit prior authorization requests with documentation of medical necessity.

Procedure code 92621 is an add-on code, and must be billed with the primary procedure code 92620, on the same day by the same provider in order to be considered for reimbursement.

Procedure codes 99211 and 99212 will be denied when billed for the same date of service by the same provider as procedure code 92592 or 92593.

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.

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.

Additional hearing aid checks may be reimbursed within a period of six months after a second revisit. Providers must submit a prior authorization request and documentation of medical necessity for the additional hearing aid checks.

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:** One per ear every five rolling 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 five years from the dispensing date of the initial services. • If within the same five-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 five-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 five years from the dispensing date of the initial services without prior authorization. For binaural procedure codes, bill a quantity of one. Replacement hearing aid devices that are required within the same five-year period must be prior authorized. Repairs or modifications may be reimbursed once per rolling year after the one-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. **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.
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.

Service	Limitation
Ear impression	**Limitation:** One each per hearing aid device as follows: • For monaural procedure codes, bill a quantity of one. • For binaural procedure codes, bill a quantity of two. 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 30 days, 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 is dispensed to the client.
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 five 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	V5171	V5172	V5181	V5244	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	V5211	V5212	V5213	V5214	V5215	V5221	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 five-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. See Chapter 4, "Prior Authorizations and Authorizations" 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 one-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 one-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 five-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.

Service	Limitation
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:** One 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 five weeks of the initial fitting, and is included in the reimbursement for the dispensing procedure. No separate reimbursement will be made. **Limitation:** One 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:** Two per calendar year when billed by any provider. Additional hearing aid checks may be reimbursed with prior authorization. **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 Acknowledgment 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 three 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.

A trial period of up to 30 days is authorized by Texas Occupations Code §402.401. The 30-day trial period, and any charged rental fee, must meet the Texas Department of Licensing and Regulation (TDLR) rule requirements in 16 TAC §112.140.

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 five 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 device (BAHD), are benefits of the CSHCN Services Program for clients of all ages.

20.3.1 Bone-Anchored Hearing Device (BAHD)

A bone-anchored hearing device (BAHD) 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 BAHD and related components:

Procedure Codes									
L8690	L8691	L8692	L8693	L8694	69711	69714	69716	69717	69719
69726	69727	69728	69729	69730	V5266				

20.3.1.1 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.

20.3.1.2 Prior Authorization Requirements

Prior authorization is required. Requests for prior authorization must be submitted by the ordering provider using the CSHCN Services Program Authorization and Prior Authorization Request form 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 indication that may be causing hearing impairment. Indications include, but are not limited to, one of the following:
  - Acquired deformities of auricle or pinna
  - Congenital anomalies of the external ear canal, middle ear or skull and face bones
  - Malignant neoplasm, benign neoplasm or carcinoma of the external ear canal and/or tympanic cavity
  - Otosclerosis in clients who cannot undergo stapedectomy
  - Severe chronic conductive or sensorineural hearing loss (i.e., otitis media, malformations of the inner ear)

20.3.1.3 Limitations

Replacement batteries for the BAHD may be reimbursed without prior authorization as follows:

- Using procedure code V5266
- Limited to clients with a previously-paid BAHD

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 BAHD 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.

BAHD 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, and L8694	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:

Procedure Codes									
L7368	L8499	L8614	L8615	L8616	L8617	L8618	L8619	L8623	L8624
L8625	L8627	L8628	L8629						

Procedure codes 92601, 92602, 92603, 92604, 92622, and 92623 may be reimbursed for diagnostic analysis and subsequent programming of the implant. Procedure code 92623 is an add-on procedure code and must be billed with primary procedure code 92622 on the same day, by the same provider in order to be considered for reimbursement.

The following procedure codes may be reimbursed for batteries:

Procedure Codes			
L8621	L8622	L8623	L8624

Replacement batteries for the cochlear device (procedure codes L8621, L8622, L8623, and L8624) are limited to clients with a previously billed cochlear implant procedure, device, or supply.

Note: *Replacement batteries beyond the limit of two batteries per calendar year require prior authorization and may be considered with documentation that supports the need for additional batteries.*

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, on the same day, by the same provider in order to be considered for reimbursement.

The benefit for auditory rehabilitation is one evaluation and 12 visits per 180-day period, without prior authorization. Additional therapy services may be available through the speech therapy benefit.

Refer to: Chapter 37, "Speech-Language Pathology (SLP) Services" 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. Requests for prior authorization must be submitted on the CSHCN Services Program Authorization and Prior Authorization Request form. 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 battery charger unit for the lithium-ion battery procedure code L7368 is limited to one replacement per five rolling years with prior authorization.

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.

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 per180-day 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 and older.

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.

Non-rechargeable batteries are limited to a maximum of 15 zinc air or a maximum of 31 alkaline batteries may be reimbursed per month without prior authorization. Rechargeable lithium-ion batteries (procedure codes L8623 and L8624) are limited to 2 batteries per calendar year.

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 NPI 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 for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

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

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

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper 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/resources/rate-and-code-updates/rate-changes.

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

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.

BAHD 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 maximum fee established by the Texas Health and Human Services Commission.
- 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.

Home Health Services

CSHCN Services Program Provider Manual

April 2025

TEXAS
Health and Human
Services

HOME HEALTH SERVICES

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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 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

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

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 or part-time basis.

Home health services are considered medically necessary for a client who:

- Requires skillful observations and judgment to improve health status, skilled assessment, or skilled treatments and procedures.
- Requires individualized, intermittent, or part-time acute skilled care.
- Requires skilled interventions 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.

A parent or guardian, primary caregiver, or alternate caregiver may not be reimbursed for skilled nursing (SN) services even if he or she is employed by an enrolled provider.

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.

21.2.1.1 Authorization Requirements

Prior authorization of home health services is required. Medical necessity documentation must be submitted along with the prior authorization request. Requests may be submitted by any approved method to the claims administrator.

Verbal orders will not be accepted. All prior authorization requests must be signed and dated by the ordering practitioner.

> ***Note:*** *An advanced practice registered nurse (APRN) or a physician assistant (PA) may sign and date all documentation related to the provision of SN, HHA, or extended skilled nursing services on behalf of the client's physician when the physician delegates this authority to the APRN or PA.*

Prior authorization must be obtained before the start of care however, if the service is medically necessary, 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 Home Health Skilled Nursing Request and Plan of Care Form and all other required documentation must be received within these deadlines for prior authorization to be considered. Dates of service requested before the submission date or the practitioner signature date will be denied as late submissions. Extensions to these deadlines are not given by the CSHCN Services Program for providers to correct incomplete prior authorization requests.

SN services or HHA services (procedure codes G0156, G0299, and G0300) will not be authorized during the same day as extended SN services (procedure codes S9123 and S9124).

SN and HHA services may not be provided during overlapping time periods (procedure codes G0156, G0299, and G0300), but can be requested for the same day.

SN services or HHA services (procedure codes G0156, G0299, and G0300) will not be authorized when the client is receiving PPECC services (procedure code T1026).

The initial nursing assessment is used to establish the POC and must support the medical necessity for the client to receive SN services, HHA services, extended SN services, PT services, OT services, speech-language pathology services, or medical nutritional counseling services. The provider must have an RN perform an initial client assessment or reassessment in the client's home. For initial prior authorization, providers must obtain prior authorization before the start of care (SOC). Initial prior authorization period may not exceed 60 calendar days.

> ***Note:*** *The initial RN assessment is an administrative cost and will not be reimbursed.*

The initial nursing assessment/reassessments must include, but are not limited to the following:

- Complexity and intensity of the client's care
- Stability and predictability of the client's condition
- Frequency of the client's need for SN care
- Identified medical needs and goals
- Description of wounds, if present
- Comprehension level of the client or parent, guardian or caregiver
- Receptivity to training and ability level of the client or parent, guardian or caregiver

The initial assessment and any reassessments are performed by an RN. The initial assessment must be completed no earlier than five business days before the client's SOC. Reassessments are required when changes in the client's condition occur during the course of the prior authorization period and revision of the plan of care is needed. Revisions to the POC must be submitted as soon as the need is identified but no later than 3 business days from the date of the revision.

If there is no change in the client's condition, the reassessment must document medical necessity, as defined in the Statement of Benefits, to support continued and ongoing acute, intermittent, part-time SN or HHA visits services beyond the initial 60 calendar day prior authorization period. Requests received after the five business days allowed will be denied for dates of service that occurred before the revision is approved.

For extension of acute intermittent, part-time SN or HHA services, providers must obtain prior authorization on the CSHCN Services Program Home Health Skilled Nursing Request and Plan of Care Form before the end of the current prior authorization period. A new client assessment and a current POC must also be submitted. Extension requests that are received after the current prior authorization expires will be denied for dates of service that occur before the extension request is approved.

21.2.1.2 Plan of Care (POC)

A copy of the home health provider's POC must be submitted for documentation of the required information. The POC must be signed by the practitioner who is ordering home health services and who will provide ongoing supervision of the POC. The POC must be signed and dated no earlier than 30 days prior to the start of care, reviewed and signed every 60 days at a minimum by the ordering practitioner or sooner if the client's condition changes and a reassessment and revision of the plan of care is needed. Dates of service requested before the submission date or practitioner signature date will be denied.

Providers must obtain prior authorization no earlier than three business days before the start of care (SOC) for an initial authorization. The initial prior authorization period may not exceed 60 calendar days. For extensions, providers must obtain prior authorization within seven business days before the end of the authorization period.

Providers are required to deliver the requested services from the SOC date, which is the date agreed to by the ordering practitioner, registered nurse (RN), home health agency, client, parent or guardian. The SOC must be documented on the POC.

A provider requesting prior authorization for SN and HHA services must submit all of the following documentation:

- A completed CSHCN Services Program Home Health Skilled Nursing Request and Plan of Care Form
- A completed client nursing assessment
- The completed POC must be signed and dated by the assessing RN and the ordering practitioner.

Note: *Home health providers may submit a client nursing assessment and a POC on forms developed by the home health agency along with the prior authorization request. Home health agency forms must contain all criteria specified.*

The POC must be initiated and written in a clear and legible format by the assessing RN and include the following:

- The client's CSHCN number
- The ordering practitioner's license number
- The provider's NPI number
- Date the client was last seen by the ordering practitioner
- The start of care (SOC) date for home health services

- All pertinent diagnoses
- The client's mental status
- The prognosis
- The types of service requested, including the number of visits and amount, duration, and frequency with measurable goals and objectives for each service provided
- The equipment and/or supplies required
- Rehabilitation potential
- Prior and current functional limitations
- Activities permitted
- Nutritional requirements
- Medications, including the dose, route and frequency
- Treatments, including amount and frequency
- Wound care orders and measurements
- Safety measures to protect against injury
- Instructions for timely discharge or referral

Requests must be based on the medical needs of the client. Documentation must support the quantity and frequency of intermittent or part-time SN or HHA visits or extended SN visits that will safely meet the client's needs. The amount and duration of SN, extended SN, or HHA visits requested will be evaluated by the claims administrator.

HHA services will not be prior authorized when the client is receiving extended SN services simultaneously but can be requested on the same day.

The home health agency must ensure the requested services are supported by the client assessment, POC, and signed and dated orders.

Physician orders must be submitted on the CSHCN Services Program Home Health Skilled Nursing Request and Plan of Care Form and include but are not limited to the following:

- Client name, date of birth, gender, and CSHCN Services Program Identification number
- Ordering practitioner name, contact information and NPI number
- Date last seen by the ordering practitioner
- Diagnoses and description of current medical condition
- Prognosis
- Mental status
- Documentation of medical necessity that the client requires part-time intermittent skilled nursing or ongoing extended skilled nursing services
- Nursing services required, i.e., RN, LVN, HHA
- Medication administration (dose/route/frequency), if applicable
- Treatments ordered
- Wound care, if applicable
- Other therapies if required
- Dietary and nutritional needs

- Activity level
- Other services as needed
- Functional status
- Safety measures
- Equipment/supplies needed
- Rehab potential

If a provider or client discontinues SN or HHA visits, or extended services, 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 CSHCN Services Program Home Health Skilled Nursing Request and Plan of Care Form. A physician, APRN, or PA signature is required on the form.

- A new client assessment and a current POC,
- A change of provider letter signed and dated by the client, parent, guardian or caregiver documenting:
  - The date the client ended SN or HHA visits, or extended SN services, (effective date of change) with the previous provider,
  - The names of previous and new providers,
  - An explanation of why providers were changed.

Providers who terminate services must give reasonable notice to the client and must maintain documentation of the reason in the client's medical record.

Concurrent services for telemonitoring are allowed for distinctly different medical reasons. Duplication of services by any provider will not be prior authorized.

Refer to: Chapter 4, "Prior Authorizations and Authorizations" for additional information about authorization and prior authorization requirements.

21.3 Home Health Aide (HHA) Services

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.

HHA services may 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
- Hygiene and grooming 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 exercises
- Safe transfer
- Positioning
- Assisting with nutrition and fluid intake
- Household services essential to the client's health care at home
- Assisting client with his or her self-administered medication
- Reporting changes in the client's condition and needs
- Completing appropriate documentation

21.3.1 Supervision of Home Health Aides

When HHA services have been ordered, an RN or therapist (PT or OT) must provide the HHA written instructions and supervision for the tasks delegated to the HHA.

The requirements for HHA supervision are as follows:

- When HHA services are provided in addition to an SN service, 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 present and providing care to the client.
- When HHA services are provided in addition to PT or OT services, the appropriate therapist may make the supervisory visit at least every two weeks in place of an RN. The supervisory visit must occur when the HHA is present and providing care to the client.
- Documentation of HHA supervision must be maintained in the client's medical record.

21.3.2 Skilled Nursing and Home Health Aide Services

The following definitions apply to CSHCN Services Program home health skilled nursing (SN) and home health aide (HHA) services:

- **Acute** is defined as a condition or exacerbation that is anticipated to improve and reach resolution within 60 days.
- **Part-time** is defined as SN or HHA visits less than eight hours per day for any number of days per week. Part-time visits may be delivered in interval visits up to 2.5 hours (10 units) per visit, not to exceed a combined total of three visits per day (7.5 hours [30 units]).
- **Intermittent** is defined as SN or HHA visits provided for less than eight hours per visit and less frequently than daily. Daily visits may be considered for a short-term period (7 to 10 days) when medically necessary. Examples might include a new diabetic who is blind or may have cognitive difficulties. Intermittent visits are not to exceed a combined total of three visits per day (7.5 hours total [30 units]).

SN visits are nursing services ordered by a physician, included in the CSHCN Services Program Home Health Skilled Nursing Request and Plan of Care Form, and provided by a registered nurse (RN) or licensed vocational nurse (LVN) under the supervision of a licensed RN. SN visits may be considered when a client requires nursing services for an acute condition or an acute exacerbation of a chronic condition that can be met on an intermittent or part-time basis and typically is expected to resolve in less than 60 calendar days.

> ***Note:*** *Providers must bill procedure codes G0156, G0299, or G0300 for conditions which are expected to resolve in 60 calendar days or less.*

HHA visits are services ordered by the physician, included on the CSHCN Services Program Home Health Skilled Nursing Request and Plan of Care Form, and are services the HHA is permitted to perform under State law. HHA visits may be considered when a client requires assistance with activities

of daily living for an acute condition or an acute exacerbation of a chronic condition that can be met on an intermittent or part-time basis and typically is expected to resolve in less than 60 calendar days. HHA visits will not be considered unless the client also requires SN or therapy services. HHA visits may be provided on consecutive days.

Note: *An advanced practice registered nurse (APRN) or a physician assistant (PA) may sign and date all documentation related to the provision of SN and HHA services on behalf of the client's physician when the physician delegates this authority to the APRN or PA.*

21.3.2.1 Medical Necessity

SN and HHA Services are considered medically necessary for a client who:

- Requires the skills of a nurse to perform observations and judgments to improve health status, skilled nursing assessments, or skilled treatment or procedures;
- Requires individualized, intermittent, or part-time acute skilled care;
- Requires skilled interventions to improve health status, and if skilled intervention is delayed, it is expected to result in:
  - Deterioration of a chronic condition
  - Loss of function, or
  - Imminent risk to health status due to medically fragility, or risk of death

Home health extended SN services are medically necessary when a client is medically fragile and has a disability, or chronic condition that requires ongoing skilled nursing beyond the level of intermittent part-time acute care. Medical necessity is defined by the following criteria:

- The client must require ongoing skilled nursing services provided by a RN or LVN
- The client must have a serious, chronic condition or disability that requires ongoing and complex SN interventions and monitoring beyond the level of intermittent part-time acute skilled care
- The client's care requires the routine use of a medical device or assistive technology to compensate for the loss of a body function needed to participate in activities of daily living
- The client lives with an ongoing threat to his or her continued well-being, deterioration of his or her condition and risk of death.

21.3.3 Skilled Nursing Services

Home health SN services are a benefit of the CSHCN Services Program when a client requires nursing services for an acute condition or an acute exacerbation of a chronic condition that can be met on an intermittent or part-time basis. SN services are intended to provide SN care to promote independence and support the client living at home.

SN services are limited to SN procedures performed by a registered nurse (RN) or licensed vocational nurse (LVN) licensed to perform these services under the *Texas Nursing Practice Ac*t and include the following:

- Direct SN care and parent, guardian, or caregiver training and education
- SN observation, assessment, and evaluation by an RN, provided that the ordering practitioner specifically requests that the nurse visit the client for this purpose and the signed and dated orders reflect the medical necessity for the visit.
- Supervision of delegated services provided by an HHA or others over whom the RN is administratively or professionally responsible.

Skilled nursing visits (procedure codes G0299 and G0300) 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 non-clinician 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 non-clinician 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, SN and HHA visits are limited to a maximum of 30 units (7.5 hours) per day. SN or HHA visits may be provided on consecutive days.

SN Services will not be prior authorized when the client is receiving extended SN services.

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)" in Chapter 26, "Medical Nutrition Services" for more detailed information.

21.3.3.2 Extended Skilled Nursing Services

Extended SN services may be a benefit of the CSHCN Services Program for medically fragile clients who meet the medical necessity criteria. Clients must require ongoing skilled nursing services provided by an RN or LVN.

Medically fragile clients are those who have a serious, chronic condition that requires extended and complex skilled nursing interventions and monitoring. Their care requires the routine use of a medical device or assistive technology to compensate for the loss of a body function needed to participate in activities of daily living. These individuals live with an ongoing threat to their continued well-being, deterioration of their condition, and risk of death.

Providers must bill procedure codes S9123 and S9124 for medically fragile clients requiring extended and complex skilled nursing care.

Medically fragile conditions include, but are not limited to:

- Cerebral palsy
- Cystic fibrosis
- Muscular dystrophy
- Other diagnoses which may be considered on a case by case basis with documentation of medical necessity

Services may include, but are not limited to:

- Skilled nursing assessment;
- Administration of medications, including IV medications and chemotherapy;
- Sterile catheter insertion;
- Medical treatments that require the skill of a licensed nurse; and
- Education of the client or parent, guardian, or caregiver.

Services must be delivered according to the following criteria:

- Services must be medically necessary and appropriate;
- Services must be prescribed by a physician, APRN, or PA;
- Services must be provided according to an established Plan of Care (POC) which is reviewed, signed, at minimum by the ordering practitioner every 60 days.

Up to 400 hours of extended SN services may be approved per client per calendar year with documented justification of need and cost effectiveness.

Note: *Extended SN services may not exceed 400 hours per client per calendar year.*

21.3.4 Occupational Therapy (OT), Physical Therapy (PT), and Speech-Language Pathology (SLP) Services

OT (procedure code G0152), PT (procedure code G0151), and SLP (procedure code G0153) services are benefits of the CSHCN Services Program for clients with acute or chronic medical conditions when documentation from the prescribing physician and the treating therapist indicates there is or will be progress made toward goals.

21.3.4.1 Prior Authorization for Occupational Therapy (OT), Physical Therapy (PT), and Speech-Language Pathology (SLP) Services

Evaluations or re-evaluations do not require prior authorization. Therapy treatment services require prior authorization.

Prior authorization for therapy services will be considered when all of the following criteria 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, home, 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.

Documentation supporting the medical need for therapy services includes:

- A completed CSHCN Services Program Prior Authorization Request form:
  - Initial Outpatient Therapy (TP1) Form for initial therapy treatment services, or
  - Extension of Outpatient Therapy (TP2) Form for extension of on-going therapy treatment services.

  Note: *The request form must be signed and dated by the ordering physician, APRN, or PA and therapy provider(s). A request form that is missing required information is considered incomplete.*
- A current evaluation or re-evaluation for each therapy service requested and comprehensive treatment plan with the following:
  - Date of the evaluation
  - Diagnosis(es)
  - Client's medical history and background
  - Client's current and prior functional level, to include current standardized assessment scores or criterion-referenced scores as appropriate for the client's condition
  - Date of onset of the illness, injury, or exacerbation requiring the therapy services
  - Short- and long-term treatment goals, including prior treatment goals, for the therapy discipline and associated disciplines requested, related to the client's individual needs
  - A description of the specific treatment modalities being prescribed and the recommended amount, frequency and duration of services
  - Prognosis for improvement

- Requested dates of service
- Date and signature of the licensed therapist

21.3.4.2 Limitations for Occupational Therapy (OT) and Physical Therapy (PT)

The following outpatient OT or PT treatment procedure codes will be denied if billed on the same date of service as procedure codes G0152 or G0151 respectively, by any provider:

Procedure Codes									
97012	97016	97018	97022	97024	97026	97028	97032	97033	97034
97035	97036	97110	97112	97113	97116	97124	97140	97150	97530
97535	97537	97542	97750	97755	97760	97761	97763	97999	

Therapy evaluations or re-evaluations are limited to four per 180 days, any provider for procedure codes G0151 and G0152.

21.3.4.3 Limitations for Speech-Language Pathology (SLP)

Outpatient speech therapy treatments (procedure codes 92507, 92521, 92522, 92523, 92524, 92526, 92610, and S9152) will deny if billed on the same date of service as procedure code G0153 by any provider.

Therapy evaluations or re-evaluations are limited to four per 180 days, any provider for procedure code G0153.

21.3.5 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. 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 reimbursed, and procedure code S9470 is denied.

Medical nutritional therapy procedure codes 97802, 97803, and nutritional counseling procedure code S9470 will not be reimbursed when the client is receiving PPECC services.

Refer to: Section 26.4.2, "Benefits, Limitations, and Authorization Requirements" in Chapter 26, "Medical Nutrition Services" for additional information about medical nutritional counseling services.

21.3.5.1 Prior Authorization for Medical Nutritional Counseling Services

Prior authorization is required for medical nutritional counseling services. Prior authorization must be submitted using the CSHCN Services Program Prior Authorization Request for Medical Nutritional Products Form and Instructions.

Providers are responsible for maintaining documentation to support medical necessity of nutritional counseling services in the clinical record.

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 for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

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

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

Section 5.7.2.7, "Instructions for Completing the UB-04 CMS-1450 Paper Claim Form" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper 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.

All claims for reimbursement of procedure codes G0156 (HHA services), G0299 (RN services), and G0300 (LVN services) are based on the actual amount of billable time associated with the service. For those services in 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, the minutes are converted to one unit of service if they are greater than seven, and converted to 0 units of service if they are seven or fewer minutes.

For example: 68 total billable minutes/15 = 4 units + 8 minutes. Since the 8 minutes are more than 7 minutes, those 8 minutes are converted to one unit. Therefore, 68 total billable minutes = 5 units of service.

Time intervals for 1 through 8 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

Units	Number of Minutes
6 units	83 minutes through 97 minutes
7 units	98 minutes through 112 minutes
8 units	113 minutes through 127 minutes

Procedure codes G0156, G0299, and G0300 will be limited to 30 units per day, for any procedure, any provider. All services are reimbursed hourly.

Procedure codes S9123 and S9124 must be used when billing for extended SN services. The unit of service is hour increments.

> ***Note:*** *These codes cannot be billed in conjunction with procedure codes G0156 (Home Health Aide), G0299 (RN services), and G0300 (LVN Services) on the same day unless approved by the CSHCN Medical Director. If approved, procedure codes G0156, G0299, and G0300 will not be reimbursed on the same day.*

All claims for reimbursement of these procedure codes are based on the actual amount of billable time associated with the service. For those services in which the unit of service is 1 hour (1 unit = 1 hour), partial units should be rounded up or down to the nearest tenth of an hour.

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

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

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.

Home Health (Skilled Nursing) Care

CSHCN Services Program Provider Manual

April 2025

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HOME HEALTH (SKILLED NURSING) CARE

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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 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

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

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" 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 HHSC Contact Information" 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)" in Chapter 26, "Medical Nutrition Services" 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 Request and Plan of Care Form.

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" 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 for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

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

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

Section 5.7.2.7, "Instructions for Completing the UB-04 CMS-1450 Paper Claim Form" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper 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/resources/rate-and-code-updates/rate-changes.

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

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.

Hospice

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HOSPICE

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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 Texas Health and Human Commission (HHSC), 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 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

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

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" in Chapter 26, "Medical Nutrition Services" 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:

23.2.1.1 The client's demographic information

- First and last name
- CSHCN Services Program number/client identifier
- Date of birth
- Hospice diagnosis codes
- Address

23.2.1.2 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

23.2.1.3 Required provider information and signature

- Provider name
- CSHCN Services Program National Provider Identifier (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 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" 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 for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

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

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

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

23.4 Reimbursement

Hospice services are limited to one of any hospice procedure per day, by any provider. 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/resources/rate-and-code-updates/rate-changes.

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

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.

HOSPITAL

CSHCN SERVICES PROGRAM PROVIDER MANUAL

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HOSPITAL

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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" in Chapter 25, "Laboratory Services" 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 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

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

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. The provider must be enrolled with Texas Medicaid before applying for 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" in Chapter 2, "Provider Enrollment and Responsibilities" 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" in this chapter. Additional information specific to outpatient services can be found in Section 24.4, "Outpatient Services" in this chapter and information on ASCs can be found in Section 24.5, "Ambulatory Surgical Centers" in this chapter.

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
12365-A Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax: 1-512-514-4222

Refer to: Chapter 4, "Prior Authorizations and Authorizations" 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 31.2.11, "Chemotherapy" in Chapter 31, "Physician" 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" in Chapter 20, "Hearing Services" 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" in Chapter 31, "Physician."

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 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 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" 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 National Provider Identifier (NPI) 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: Section 25.1, "Enrollment" in Chapter 25, "Laboratory Services."

24.2.6 Magnetoencephalography (MEG) Services

Inpatient and outpatient hospitals must use revenue code 860 or 861 for reimbursement of magnetoencephalography (MEG) services. The appropriate MEG procedure code must be listed on the claim.

Note: *Reimbursement to an outpatient hospital will be based on the submitted procedure code.*

Refer to: Section 31.2.29, "Magnetoencephalography (MEG)" in Chapter 31, "Physician" for additional information.

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.*

24.3.1.1 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 NPI 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.

24.3.1.2 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 received within 48 hours of an admission or by the next business day for weekend admissions. Late submitted requests for emergency admissions will be denied for the entire hospital stay.

Note: *Partial approvals for a hospital stay will not be granted.*

If the initial prior authorization request meets the deadline requirements and is denied for incomplete or inaccurate information, the provider may correct and resubmit the prior authorization request. The corrected request is a one-time resubmission only and must be received within 5 business days following the denial of the initial request. If the corrected request still contains incomplete or inaccurate information, then the request will not be eligible for a second resubmission and will be denied for the entire hospital stay. Corrected requests received after 5 business days following the initial denial will be denied for the entire hospital stay.

All applicable information must accompany the request documenting the emergent conditions that necessitated the inpatient admission.

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

24.3.1.3 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.

Revenue code 124 may be a benefit of the CSHCN Services Program for inpatient behavioral health services.

24.3.1.3.1 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 Psychiatric 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 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information on prior authorization requirements.

Chapter 29, "Outpatient Behavioral Health" for more information about behavioral health services.

Inpatient psychiatric hospitals may be reimbursed at 80 percent of the TEFRA rate for CSHCN services.

24.3.1.4 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

24.3.1.4.1 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 hospital 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 form 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.

24.3.1.4.2 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 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information on prior authorization requirements.

24.3.1.5 Renal (Kidney) Transplants

Renal transplants will only be approved for reimbursement when performed in a Medicaid-approved, CSHCN Services Program-enrolled transplant facility that is certified by the United Network of Organ Sharing (UNOS) 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 UNOS.

Renal transplants and post-transplant care will only be covered if the organ procurement is in alignment with the National Organ Transplant Act (NOTA). Only kidneys harvested voluntarily from within the United States under the oversight of the Health Resources and Services Administration (HRSA) and UNOS will be covered. Kidneys harvested for a fee or sponsorship and kidneys obtained from any country outside of the United States will not be covered for transplant or post-transplant care.

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 31.2.39.6, "Global Fees" in Chapter 31, "Physician."

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.

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

Renal transplant recipients are eligible for follow-up care (outside the $200,000 limit) immediately following hospital discharge for the renal transplant.

24.3.1.5.2 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.

24.3.1.6 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.

24.3.1.6.1 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 31.2.42.2, "Transplants - Nonsolid Organ" in Chapter 31, "Physician" for additional benefit information.

24.3.1.7 Neonatal Level of Care Designation for Inpatient Services

Hospitals enrolled in Texas Medicaid and the CSHCN Services Program may be reimbursed for inpatient neonatal services only if the hospitals have received a neonatal level of care designation from DSHS in accordance with Title 25 Texas Administrative Code §§133.181-133.190.

A neonatal service is any inpatient hospital service rendered to a client who is 28 days of age and younger.

Refer to: The DSHS website for more information on Neonatal Level of Care Designation.

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

A hospital that does not meet the minimum requirements for any level of care designation for neonatal services will not be reimbursed for inpatient neonatal services rendered to Texas Medicaid and CSHCN Services Program clients. Hospitals without a neonatal level of care designation may be reimbursed for emergency services to stabilize an infant prior to transport to a facility capable of providing the appropriate level of care.

Claims for inpatient neonatal services submitted by hospitals that do not have a neonatal level of care designation on file will be denied. Providers can appeal claims by providing documentation that emergency services were required.

If neonatal inpatient services are rendered by a facility that has applied for (but not yet received) a neonatal designation, the facility must still adhere to existing claim filing deadlines (95 days from the date of discharge). While awaiting neonatal level of care designation the facility is responsible for maintaining active claims appeals to adhere to the 120-day claim appeal deadline.

Requirements to obtain a neonatal level of care designation only apply to facilities located in Texas. Those entities that are physically located outside of Texas and enrolled in Texas Medicaid (i.e., out-of-state or border state facilities) are exempt from requiring a neonatal level of care designation for inpatient services rendered to neonatal clients.

Note: *When submitting paper claims for inpatient neonatal services rendered at a facility with an address that is different from the provider's physical address, providers must enter the address of the facility where services were rendered in the remarks field.*

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

24.3.1.7.2 Other Requirements

The submitted facility address on the claim must match the physical address of the location that has been issued a neonatal level of care designation. If the facility address is not included on the claim, the submitted billing address must match the physical address of the location that was issued a neonatal level of care designation by DSHS.

Important: *The hospital address on the health facilities license must match the address billed on the claim. Claims will be denied if the address submitted on the claim does not match the address on file. Providers should refer to the DSHS approval letter to verify the correct address.*

Refer to: The DSHS website for more information on address updates.

24.3.1.7.3 Transfers

When Texas Medicaid or CSHCN Services Program clients are 28 days of age or younger on the date of admission and are subsequently transferred to another facility, neonatal level of care designation requirements will apply to all facilities involved in that client's continuous inpatient stay.

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 §351.10 (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 NPI. 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 Day Outliers

All of the following criteria must be met to qualify for a day outlier payment:

- Inpatient days must exceed the mean length of stay (MLOS) by more than two days; and
- Inpatient days must exceed the DRG day threshold for the specific DRG.

Once the outlier payment criteria are met:

- 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 of 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.*

24.3.7.1 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							

Procedure code Q4081 is limited to three injections per calendar week (Sunday through Saturday).

24.3.7.2 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.*

24.3.7.3 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- to seven-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- to seven-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 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 codes 96130, 96131*, 96136, and 96137*) and neuropsychological testing (procedure codes 96132, 96133*, 96136, and 96137*) in the outpatient setting. Psychological and neuropsychological testing are limited to a total of 4 hours per day and 8 hours per calendar year, per client, by any provider. Time for interpretation and documentation, including time to document test results in the client's medical record, is included in procedure codes 96121*, 96130, 96131*, 96136, and 96137*and not reimbursed separately. Procedure codes 96130, 96131*, 96136, and 96137* will be denied if performed on the same day as procedure codes 96132, 96133*, 96136, and 96137*.

Note: *Add-on procedure codes indicated with asterisk must be billed with the appropriate primary procedure code*

Authorization is not required.

Refer to: Chapter 29, "Outpatient Behavioral Health."

24.4.1.2 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.

24.4.1.2.1 Hospital-Based Emergency Services Authorization

Authorization is not required for emergency medical services. Emergency department services are subject to retroactive review.

24.4.1.3 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.

24.4.1.3.1 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.

24.4.1.3.2 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

24.4.1.3.3 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.

24.4.1.3.4 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.

24.4.1.3.5 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 pread-mission 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.

24.4.1.3.6 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.

24.4.1.3.7 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.

24.4.1.3.8 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.
- A completed CSHCN Services Program Authorization Request for Inpatient Hospital Admission - For Use by Facilities Only form must be completed and submitted to the CSHCN claims contractor.
- Documentation supporting the medical necessity of the outpatient observation services must be submitted with the request for the inpatient hospital admission and must include the beginning and end times of the outpatient observation services.
- For the practitioner's professional services related to a diagnostic, therapeutic, or surgical procedure performed during the time the client is in observation status.

24.4.1.3.9 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.

24.4.1.3.10 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.*

24.4.1.4 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 https://aasm.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 31.2.38, "Sleep Studies" in Chapter 31, "Physician."

24.4.1.5 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 31.2.24, "Hyperbaric Oxygen Therapy (HBOT)" in Chapter 31, "Physician" 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. Rural hospitals are eligible for a different rate for outpatient imaging. The CSHCN Services Program Online Fee Lookup (OFL) will display imaging rates for rural outpatient hospitals with a note code of "RH."

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

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" in this chapter for additional information about the one-day payment window reimbursement guidelines.

24.5 Ambulatory Surgical Centers

24.5.1 Benefits, Limitations, and Authorization Requirements

The ASC or HASC payment represents a global payment and includes room charges and supplies. Benefit services provided are billed as one inclusive charge. All facility services provided in conjunction with the surgery (e.g., laboratory, radiology, anesthesia supplies, and medical supplies) are considered part of the global payment and cannot be itemized or billed separately. All nonroutine laboratory and X-ray services should be billed separately using the hospital's full care NPI and taxonomy code.

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

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, only the procedure with the highest reimbursement rate on the fee schedule will be reimbursed.

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 71 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 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" for additional information about claims filing.

Chapter 41, "TMHP Electronic Data Interchange (EDI)" 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 NPI 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 NPI 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.

24.6.2.1.1 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	413	419	420	421	422	423	424	429
430	431	432	433	434	439	440	441	442	443
444	449	450*	452*	456*	459*	460	469	470	471
472	479	480	481	482	483	489	540	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	780	789	860	861	880
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" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" 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.

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	729	750	759	760
761	762	769	881						

24.6.2.1.2 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 NPI 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 NPI and taxonomy code and not under the ASC NPI.

Claims for emergency, unscheduled outpatient surgical procedures should be filed with separate charges for all services using TOB 131 and the hospital's outpatient NPI and taxonomy code. 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 NPI and taxonomy code. 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" in this chapter 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 NPI and taxonomy code. 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 NPI and taxonomy code. 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 NPI and taxonomy code. If a complication occurs, the same guidelines presented in Section 24.6.4, "Inpatient Stays Following Scheduled Day Surgeries" in this chapter 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.

Laboratory Services

CSHCN Services Program Provider Manual

April 2025

TEXAS
Health and Human
Services

LABORATORY SERVICES

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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 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

Refer to: 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" in Chapter 2, "Provider Enrollment and Responsibilities" 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:

- Pay the applicable fee to Centers for Medicare & Medicaid Services (CMS).
- Contact HHSC at 1-512-834-6650 to receive a CLIA registration or certification number.

Submit CLIA applications to the following address:

Health Facility and Licensing Certification Division HHSC
1100 West 49th Street
Austin, TX 78756

CLIA updates can be submitted through a PEMS Maintenance - Licenses Transaction.

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.

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 NPI 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 NPI 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 NPI 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 NPI 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 80503, 80504, 80505, and 80506 using their National Provider Identifier (NPI).

Independent laboratories may submit claims for procedure codes 80503, 80504, 80505, and 80506 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 of the physician requesting the consultation, must be included on the claim. The NPI of the physician requesting the consultation should also be included.
- 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 lifetime			
S3840	S3841	S3842	S3846

25.2.5.1 Drug Testing and Therapeutic Drug Assays

The following procedure codes for drug testing and therapeutic drug assays are benefits of the CSHCN Services Program:

Procedure Codes									
Drug Testing									
80305^	80306	80307	80320	80321	80322	80323	80324	80325	80326
80327	80328	80329	80330	80331	80332	80333	80334	80335	80336
80337	80338	80339	80340	80341	80342	80343	80344	80345	80346
80347	80348	80349	80350	80351	80352	80353	80354	80355	80356
80357	80358	80359	80360	80361	80362	80363	80364	80365	80366
80367	80368	80369	80370	80371	80372	80373	80374	80375	80376
80377	G0480	G0481	G0482	G0483	G0659				
Therapeutic Drug Assays									
80143	80150	80151	80155	80156	80157	80158	80159	80161	80162
80163	80164	80165	80167	80168	80169	80170	80171	80173	80175
80176	80177	80178^	80179	80180	80181	80183	80184	80185	80186
80188	80189	80190	80192	80193	80194	80195	80197	80198	80199
80200	80201	80202	80203	80204	80210	80299			
^ QW Modifier									

Note: *The procedure codes above do not require prior authorization.*

Procedure codes G0480, G0481, G0482, G0483, and G0659 are limited to once per day by any provider.

Procedure codes 82540, 82550, 82552, 82553, 82554, 83986, and 84311 used for specimen validity testing will be denied when billed on the same date of service, by the same provide, as procedure codes G0480, G0481, G0482, G0483 and G0659.

The following CPT drug assay procedure codes will deny when billed on the same date of service, by the same provider with the corresponding HCPCS drug assay procedure codes identified by an "X" in the following table:

CPT Drug Assay Procedure Codes to HCPCS Procedure Codes limitations					
	G0480	G0481	G0482	G0483	G0659
80320	X		X	X	X
80321	X	X	X	X	
80323	X	X	X	X	X
80324	X	X	X	X	
80325	X				
80326	X	X	X	X	X
80327	X				
80328	X				
80329	X		X	X	X
80330	X			X	
80332	X		X	X	X
80333	X			X	
80335	X				
80336	X				
80337	X		X	X	X
80338	X				X
80339	X				X
80342	X				X
80345	X				X
80358	X				X
80363	X				X
80365	X				X
80368	X				X
80369	X				X
80370	X				X
80375	X				X
80377	X				X
X - The "8000" CPT procedure code will be denied if billed with the HCPCS "G" procedure code indicated with an "X". **^QW Modifier**					

25.2.5.2 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

Procedure Code	Quantity Allowed
88233	1 per day, any provider
88237	1 per day, any provider
88239	1 per day, any provider
88240	1 per day, any provider
88241	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	1 per day, any provider
88283	1 per day, any provider
88285	1 per day, any provider
88289	1 per day, any provider
Molecular Cytogenetics	
88271	16 per provider, per day
88272	10 per provider, per day
88273	3 per provider, per day
88274	5 per provider, per day
88275	10 per provider, per day

Providers must bill procedure code 88291 for the interpretation and report of cytogenetics testing.

Reimbursement for cytogenetics testing is limited to the following diagnosis codes:

Diagnosis Codes							
C810A	C811A	C812A	C813A	C814A	C817A	C819A	C820A
C821A	C822A	C823A	C824A	C825A	C826A	C8280	C8281
C8282	C8283	C8284	C8285	C8286	C8287	C8288	C8289
C828A	C8291	C8292	C8293	C8294	C8295	C8296	C8297
C8298	C8299	C829A	C830A	C8310	C8311	C8312	C8313
C8314	C8315	C8316	C8317	C8318	C8319	C831A	C83390
C83398	C833A	C835A	C837A	C8380	C8381	C8382	C8383
C8384	C8385	C8386	C8387	C8388	C8389	C838A	C839A
C840A	C841A	C8440	C8441	C8442	C8443	C8444	C8445
C8446	C8447	C8448	C8449	C844A	C8461	C8462	C8463
C8464	C8465	C8466	C8467	C8468	C8469	C846A	C8471
C8472	C8473	C8474	C8475	C8476	C8477	C8478	C8479
C847A	C847B	C849A	C84AA	C84ZA	C851A	C852A	C8581

Diagnosis Codes							
C8582	C8584	C8585	C8586	C8587	C8588	C8589	C858A
C859A	C8600	C8601	C8610	C8611	C8620	C8621	C8630
C8631	C8640	C8641	C8650	C8651	C8660	C8661	C8830
C8831	C8840	C8841	C8880	C8881	C8890	C8891	C9012
C9100	C9101	C9102	C9110	C9111	C9112	C9190	C9191
C9192	C91Z0	C91Z1	C91Z2	C9200	C9201	C9202	C9210
C9211	C9212	C9220	C9221	C9222	C9230	C9231	C9232
C9240	C9241	C9242	C9250	C9251	C9252	C9260	C9261
C9262	C9290	C9291	C9292	C92A0	C92A1	C92A2	C92Z0
C92Z1	C92Z2	C9300	C9301	C9302	C9310	C9311	C9312
C9330	C9331	C9390	C9391	C9392	C93Z0	C93Z1	C93Z2
C9400	C9401	C9402	C9420	C9421	C9422	C9430	C9431
C9432	C9480	C9481	C9482	C9500	C9501	C9502	C9510
C9511	C9512	C9590	C9591	C9592	D45	D821	E230
E291	E300	E3430	E3431	E34328	E34329	E3439	E83110
E8359	F50814	F5083	F70	F71	F72	F73	F78A1
F78A9	F800	F801	F802	F804	F8089	F810	F812
F8181	F8189	F819	F82	F840	F88	F900	F901
F902	F908	H0589	H9325	I77810	I77811	I77812	I77819
L6610	M2600	M2601	M2602	M2603	M2604	M2605	M2606
M2607	M2609	M6590	M65919	M65921	M65922	M65929	M65939
M65949	M65959	M65969	M65979	M6598	M6599	N6482	P2930
P2938	Q000	Q001	Q002	Q010	Q011	Q012	Q018
Q02	Q030	Q031	Q038	Q040	Q041	Q042	Q045
Q046	Q048	Q050	Q051	Q052	Q054	Q055	Q056
Q057	Q058	Q062	Q064	Q068	Q0701	Q0702	Q0703
Q078	Q079	Q100	Q101	Q102	Q103	Q104	Q106
Q107	Q110	Q111	Q112	Q113	Q120	Q121	Q123
Q124	Q128	Q129	Q130	Q131	Q132	Q133	Q134
Q135	Q1381	Q1389	Q140	Q141	Q142	Q143	Q148
Q150	Q158	Q159	Q160	Q161	Q162	Q163	Q164
Q165	Q169	Q170	Q171	Q172	Q173	Q174	Q175
Q178	Q179	Q180	Q181	Q182	Q183	Q184	Q185
Q186	Q187	Q188	Q189	Q200	Q201	Q202	Q203
Q204	Q205	Q206	Q208	Q209	Q210	Q2110	Q2111
Q2112	Q2113	Q2114	Q2115	Q2116	Q2119	Q2120	Q2121
Q2122	Q2123	Q213	Q214	Q218	Q219	Q220	Q221
Q222	Q223	Q224	Q225	Q228	Q230	Q231	Q232
Q233	Q234	Q2381	Q2382	Q2388	Q240	Q241	Q242
Q243	Q244	Q245	Q246	Q248	Q249	Q250	Q251

Diagnosis Codes							
Q2521	Q2529	Q253	Q2540	Q2541	Q2542	Q2543	Q2544
Q2545	Q2546	Q2547	Q2548	Q2549	Q2572	Q259	Q260
Q261	Q262	Q263	Q265	Q266	Q268	Q269	Q270
Q271	Q272	Q2730	Q2731	Q2732	Q2733	Q2734	Q274
Q278	Q279	Q280	Q281	Q282	Q283	Q288	Q289
Q300	Q301	Q302	Q303	Q308	Q309	Q310	Q311
Q312	Q313	Q315	Q318	Q320	Q321	Q322	Q323
Q324	Q330	Q331	Q332	Q333	Q334	Q335	Q336
Q338	Q339	Q348	Q349	Q351	Q353	Q359	Q360
Q369	Q370	Q371	Q372	Q373	Q374	Q375	Q380
Q381	Q382	Q383	Q384	Q385	Q386	Q387	Q388
Q391	Q392	Q393	Q394	Q395	Q396	Q398	Q400
Q401	Q402	Q408	Q409	Q410	Q411	Q412	Q419
Q420	Q421	Q422	Q423	Q428	Q430	Q431	Q432
Q433	Q434	Q435	Q437	Q438	Q440	Q441	Q442
Q443	Q444	Q445	Q446	Q4470	Q4471	Q4479	Q450
Q451	Q452	Q453	Q458	Q459	Q5001	Q5002	Q501
Q502	Q5031	Q5032	Q5039	Q504	Q505	Q506	Q510
Q5110	Q5111	Q5121	Q5122	Q5128	Q515	Q516	Q517
Q51811	Q51821	Q51828	Q520	Q5210	Q522	Q523	Q524
Q525	Q526	Q5270	Q5271	Q5279	Q528	Q529	Q5300
Q5301	Q5302	Q5310	Q53111	Q53112	Q5312	Q5313	Q5320
Q53211	Q53212	Q5322	Q5323	Q539	Q540	Q541	Q542
Q543	Q544	Q548	Q550	Q551	Q5521	Q5522	Q5523
Q5529	Q553	Q554	Q555	Q5561	Q5562	Q5563	Q5564
Q5569	Q558	Q559	Q560	Q561	Q562	Q563	Q564
Q600	Q601	Q603	Q604	Q606	Q6101	Q6119	Q612
Q613	Q614	Q615	Q618	Q619	Q6211	Q6212	Q622
Q6231	Q6239	Q624	Q625	Q6261	Q6262	Q6263	Q628
Q630	Q631	Q632	Q633	Q638	Q640	Q6410	Q6411
Q6412	Q6419	Q642	Q6431	Q6432	Q6433	Q6439	Q644
Q645	Q646	Q6471	Q6472	Q6473	Q6474	Q6475	Q649
Q6501	Q6502	Q651	Q6531	Q6532	Q654	Q6581	Q6582
Q6589	Q6600	Q6601	Q6602	Q6610	Q6611	Q6612	Q66211
Q66212	Q66219	Q66221	Q66222	Q66229	Q6630	Q6631	Q6632
Q6640	Q6641	Q6642	Q6651	Q6652	Q666	Q6670	Q6671
Q6672	Q6681	Q6682	Q6689	Q6690	Q6691	Q6692	Q670
Q671	Q672	Q673	Q674	Q675	Q676	Q677	Q678
Q680	Q681	Q682	Q683	Q684	Q688	Q690	Q691
Q692	Q699	Q7001	Q7002	Q7003	Q7011	Q7012	Q7013

Diagnosis Codes							
Q7021	Q7022	Q7023	Q7031	Q7032	Q7033	Q709	Q7101
Q7102	Q7103	Q7111	Q7112	Q7113	Q7131	Q7132	Q7133
Q7141	Q7142	Q7143	Q7151	Q7152	Q7153	Q7161	Q7162
Q7163	Q71811	Q71812	Q71813	Q71891	Q71892	Q71893	Q7191
Q7192	Q7193	Q7201	Q7202	Q7203	Q7211	Q7212	Q7213
Q7231	Q7232	Q7233	Q7241	Q7242	Q7243	Q7251	Q7252
Q7253	Q7261	Q7262	Q7263	Q7271	Q7272	Q7273	Q72811
Q72812	Q72813	Q72891	Q72892	Q72893	Q7291	Q7292	Q7293
Q730	Q731	Q738	Q740	Q742	Q743	Q748	Q749
Q75001	Q75002	Q75009	Q7501	Q75021	Q75022	Q75029	Q7503
Q75041	Q75042	Q75049	Q75051	Q75052	Q75058	Q7508	Q751
Q752	Q753	Q754	Q755	Q758	Q759	Q760	Q761
Q762	Q763	Q76411	Q76412	Q76413	Q76414	Q76415	Q76425
Q76426	Q76427	Q76428	Q7649	Q765	Q766	Q767	Q768
Q770	Q771	Q772	Q774	Q775	Q776	Q777	Q780
Q781	Q782	Q783	Q784	Q788	Q789	Q790	Q791
Q792	Q793	Q794	Q7959	Q7960	Q7961	Q7962	Q7963
Q7969	Q798	Q799	Q800	Q801	Q802	Q803	Q804
Q808	Q820	Q821	Q822	Q823	Q824	Q825	Q826
Q828	Q830	Q831	Q832	Q833	Q838	Q840	Q841
Q842	Q843	Q844	Q845	Q846	Q848	Q849	Q8503
Q851	Q8581	Q8582	Q8583	Q8589	Q859	Q870	Q8711
Q8719	Q87410	Q87418	Q8742	Q8743	Q8782	Q8783	Q8784
Q8785	Q8786	Q8901	Q8909	Q891	Q892	Q893	Q894
Q897	Q898	Q899	Q900	Q901	Q902	Q914	Q915
Q916	Q917	Q920	Q921	Q922	Q925	Q9261	Q9262
Q927	Q928	Q930	Q931	Q932	Q933	Q934	Q9351
Q9352	Q9359	Q937	Q9381	Q9382	Q9388	Q9389	Q950
Q952	Q958	Q960	Q961	Q962	Q963	Q964	Q968
Q969	Q970	Q971	Q972	Q973	Q978	Q980	Q981
Q984	Q985	Q986	Q987	Q988	Q990	Q991	Q992
Q998	Q999	Z31430	Z31438	Z315	Z810	Z8279	Z8482
Z8489							

25.2.5.3 Genetic Testing for Colorectal Cancer

Genetic testing for colorectal cancer is provided to clients that have a known preisposition (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	81233	81275	81288	81292	81293	81294
81295	81296	81297	81298	81299	81300	81301	81317	81318	81319
81327									

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.

25.2.5.3.1 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 provider's signature must have a date next to the signature and must be kept in the client's medical record.
- Stamped 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.

25.2.5.3.2 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.

25.2.5.3.3 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.

25.2.5.4 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									
81162	81163	81164	81165	81166	81167	81212	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.

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.

25.2.5.4.1 Authorization Requirements

Prior authorization is required for all BRCA1/BRCA2 genetic testing for susceptibility to breast and ovarian cancer.

A completed CSHCN Services Program Genetic Testing for Hereditary Breast and/or Ovarian Cancer Prior Authorization 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 physician's signature with a date next to the signature and must be kept in the client's medical record.
- No stamped 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/or Ovarian Cancer Prior Authorization 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	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	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	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	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 with QW Modifier
- Breath testing, procedure codes 78267, 78268, 83013, and 83014
- Amplified probe technique, procedure code 87513

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.

The amplified probe technique (procedure code 87513) is limited to 2 times per 28 days when submitted for the same procedure by any provider.

Procedure codes 83009 and 86677 are allowed once per lifetime when submitted by any provider. A second test may be considered on appeal with documentation that indicates 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	43229	43231	43232	43235	43236
43237	43238	43239	43241	43242	43250	43251	43259	43270	

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 Hematology and Coagulation

The following hematology and coagulation procedure codes are benefits of the CSHCN Services Program:

Procedure Codes									
85002	85004	85007	85008	85009	85013*	85014^	85018^	85025^	85027
85032	85041	85044	85045	85046	85048	85049	85055	85060	85097
85130	85170	85175	85210	85220	85230	85240	85244	85245	85246
85247	85250	85260	85270	85280	85290	85291	85292	85293	85300
85301	85302	85303	85305	85306	85307	85335	85337	85345	85347
85348	85360	85362	85366	85370	85378	85379	85380	85384	85385
85390	85396	85397	85400	85410	85415	85420	85421	85441	85445
85475	85520	85525	85530	85536	85540	85547	85549	85555	85557
85576^	85597	85598	85610^	85611	85612	85613	85635	85651*	85652
85660	85670	85675	85705	85730	85732	85810	85999	G0306	G0307
*** CLIA Waived test** **^QW Modifier**									

The following procedure codes may be reimbursed once per day by the same provider:

Procedure Codes						
85027	85347	85397	85520	85576^	85610^	85730
^QW Modifier						

Procedure code 85027 will deny if billed on the same date of service by the same provider as procedure codes 85007 and 85009.

Procedure code 85660 may be reimbursed once per lifetime by any provider. An additional test may be considered on appeal with documentation indicating the provider was unaware the client was tested previously or was unable to obtain the client's medical records.

25.2.11 Microbiology

The following microbiology procedure codes are benefits of the CSHCN Services Program:

Procedure Codes									
86790	86794	87003	87015	87040	87045	87046	87070	87071	87073
87075	87076	87077^	87081	87084	87086	87088	87101	87102	87103
87106	87107	87109	87110	87116	87118	87140	87143	87147	87149
87150	87152	87153	87158	87164	87166	87168	87169	87172	87176
87177	87181	87184	87185	87186	87187+	87188	87190	87197	87205
87206	87207	87209	87210^	87220	87230	87250	87252	87253	87254
87255	87260	87265	87267	87269	87270	87271	87272	87273	87274
87275	87276	87278	87279	87280	87281	87283	87285	87290	87299
87300	87301	87305	87320	87324	87327	87328	87329	87332	87335
87336	87337	87338^	87339	87340	87341	87350	87380	87385	87389^
87390	87391	87400^	87420^	87425	87427	87430	87449^	87451	87467
87468	87469	87471	87472	87475	87476	87478	87480	87481	87482
87484	87485	87486	87487	87490	87491	87492	87493	87495	87496
87497	87498	87500	87501	87502^	87503+	87505	87506	87507	87510
87511	87512	87513	87516	87517	87520	87521^	87522	87523	87525
87526	87527	87528	87529	87530	87531	87532	87533	87534	87535
87536	87537	87538	87539	87540	87541	87542	87550	87551	87552
87555	87556	87557	87560	87561	87562	87563	87564	87580	87581
87582	87590	87591	87592	87593	87594	87623	87624	87625	87626
87631^	87632	87633^	87634^	87640	87641	87650	87651^	87652	87653
87660	87661	87662	87797	87798	87799	87800	87801^	87802	87803
87804^	87806^	87807^	87808^	87809^	87810	87850	87880^	87899^	87900
87901	87902	87903	87904+	87905*	87906	87910	87912	87999	G0499

*** CLIA Waived test**
+ Add-on code
^QW Modifier

Note: *The procedure codes above do not require prior authorization.*

The following procedure codes may be reimbursed once per day by the same provider:

Procedure Codes									
86790	86794	87015	87046	87071	87075	87076	87077^	87081	87088
87101	87102	87106	87107	87140	87147	87149	87150	87152	87153
87154	87181	87184	87185	87186	87188	87190	87206	87209	87210^

^QW Modifier

Procedure Codes							
87252	87254	87634^	87300	87801^	87809^	87899^	87904
^QW Modifier							

25.2.11.1 Zika Virus Testing

Procedure codes 86794 and 87662 may be used to bill for Zika virus testing.

Procedure code 87662 may be reimbursed up to two times on the same day by the same provider.

25.2.12 Human Immunodeficiency Virus (HIV) Drug Resistance Testing

Standard treatment regimens for HIV therapy require a combination of three or more drugs. Standard therapy continues if a reduction in viral load is achieved. Incomplete virus suppression favors the development of a drug resistance and jeopardizes the success of future therapy. Testing for drug resistance as a prerequisite to further therapy is indicated under such circumstances.

To ensure accurate testing results, the client must be on appropriate antiretroviral therapy at the same time of testing or have discontinued the drug regimen within the past four weeks.

Testing for antiretroviral drug resistance is indicated in certain clinical situations. These indications include any of the following:

- Individuals who have an initial (new onset) acute HIV infection, to determine if a drug-resistant viral strain was transmitted, and to plan a drug regimen accordingly; or
- Individuals who have virological failure during antiretroviral therapy, laboratory results showing HIV RNA levels greater than 500, and less than 1000 copies/ml.

Documentation must be maintained in the client's medical record to support medical necessity for drug-resistance testing. Specific documentation requirements are dependent upon testing rationale. Documentation must include, but is not limited to, the date the drug regimen was initiated, the dosage and frequency of the prescribed medication, and laboratory tests which support all of the following:

- Acute HIV infection, with identification of the specific viral strain; and
- Virological failure during antiretroviral therapy with HIV RNA levels greater than 500 and less than 1000 copies/ml.

Drug resistance testing is not recommended if one of the following criteria is met:

- The drug regimen has been discontinued for more that four weeks; or
- The viral load is less than 500 copies/ml.

25.2.13 Organ or Disease-Oriented Panels

The following organ or disease-oriented panel procedure codes are benefits of the CSHCN Services Program:

Procedure Codes								
80047^	80048^	80050	80051^	80053^	80061^	80069^	80074	80076
^QW Modifier								

For all procedure codes listed in the organ or disease-oriented panels table above, refer to the Current Procedural Terminology (CPT) manual for information regarding laboratory panels and appropriate modifiers.

Reimbursement for the complete panel procedure code represents the total payment for all automated laboratory tests that are covered under that panel combined with any other automated tests that are billed for the client for the same date of service. Reimbursement for the individual components of the complete laboratory panel will not exceed the automated test panel (ATP) fee for the total number of automated tests that are billed for the client for the same date of service.

When all of the components of the panel are performed, the complete panel procedure code must be billed. When only two or more components of the panel are performed, the individual procedure codes for each laboratory test performed may be billed.

25.2.14 Urinalysis and Chemistry

The following urinalysis and chemistry procedure codes are benefits of the CSHCN Services Program:

Procedure Codes									
Urinalysis									
81000	81001	81002*	81003^	81005	81015	81020	81050	81099	
Chemistry									
82009	82010^	82013	82016	82017	82024	82030	82040^	82042*	82043^
82044^	82045	82075	82077	82085	82088	82103	82104	82105	82107
82108	82120^	82127	82128	82131	82135	82136	82139	82140	82150^
82154	82157	82160	82163	82164	82166	82172	82175	82180	82190
82232	82239	82240	82247^	82248	82252	82261	82270*	82271^	82272*
82274^	82286	82300	82306	82308	82310^	82330^	82331	82340	82355
82360	82365	82370	82373	82374^	82375	82376	82378	82379	82380
82382	82383	82384	82387	82390	82397	82415	82435^	82436	82438
82441	82465^	82480	82482	82485	82495	82507	82523^	82525	82528
82530	82533	82540	82542	82550^	82552	82553	82554	82565^	82570^
82575	82585	82595	82600	82607	82608	82610	82615	82626	82627
82633	82634	82638	82642	82652	82653	82656	82657	82658	82664
82668	82670	82671	82672	82677	82679^	82681	82693	82696	82705
82710	82715	82725	82726	82728	82735	82746	82747	82757	82759
82760	82775	82776	82784	82785	82787	82800	82803	82805	82810
82820	82930	82938	82941	82943	82945	82946	82947^	82948	82950^
82951^	82952+^	82955	82960	82963	82965	82977^	82978	82979	82985^
83001^	83002^	83003	83009	83010	83012	83013	83014	83015	83018
83020	83021	83026*	83030	83033	83036^	83037^	83045	83050	83051
83060	83065	83068	83069	83070	83080	83088	83090	83150	83491
83497	83498	83500	83505	83516^	83518	83519	83520*	83525	83527
83528	83540	83550	83570	83582	83586	83593	83605^	83615	83625
83630	83631	83632	83633	83655^	83670	83690	83695	83698	83700
83701	83704	83718^	83719	83721^	83722	83727	83735	83775	83785
83825	83835	83857	83864	83872	83873	83874	83880^	83883	83885
***CLIA Waived test** **+Add-on code** **^QW Modifier**									

Procedure Codes									
83915	83916	83918	83919	83921	83930	83935	83937	83945	83950
83951	83970	83986^	83992	83993	84035	84060	84066	84075^	84078
84080	84081	84085	84087	84100	84105	84106	84110	84119	84120
84126	84132^	84133	84134	84135	84138	84140	84143	84144	84145
84146	84150	84152	84153	84154	84155^	84156	84157*	84160	84165
84166	84181	84182	84202	84203	84206	84207	84210	84220	84228
84233	84234	84235	84238	84244	84252	84255	84260	84270	84275
84285	84295^	84300	84302	84305	84307	84311	84315	84375	84376
84377	84378	84379	84392	84402	84403	84425	84430	84431	84432
84436	84437	84439	84442	84443^	84445	84446	84449	84450^	84460^
84466	84478^	84479	84480	84481	84482	84484	84485	84488	84490
84510	84512	84520^	84525	84540	84545	84550^	84560	84577	84578
84580	84583	84585	84586	84588	84590	84591	84597	84600	84620
84630	84681	84702	84703^	84999					
Molecular Testing									
83006									
Opthalmology and Optometry									
83861^									
***CLIA Waived test** **+Add-on code** **^QW Modifier**									

Procedure codes 81099, 82105, 82107, 82803, 82805, 82948, 84703, and 84999 are limited to one per day when billed by any provider.

Procedure code 84583 will be denied if billed on the same day by the same provider as procedure codes 81000, 81001, 81002, 81003, 81005, or 81020.

Procedure code 82270 is limited to one per rolling year when billed by any provider.

Procedure code 83698 is limited to two per rolling year when billed by any provider. Claims submitted for procedure code 83698 that are in excess of two per year may be considered on appeal with documentation of any of the following:

- Medical necessity for the additional test.
- The provider was unable to obtain the previous records from a different provider.
- The provider was new to treating the client and was not aware the client had received the test.

Refer to: Section 25.2.9, "Helicobacter pylori (H. pylori)" in this chapter for information about limitations on procedure codes 83009, 83013, and 83014.

25.2.15 Other Laboratory Services

The following procedure codes are denied for pathologists as noncovered for specialty type

Procedure Codes		
Surgery		
36430	36440	36455

Procedure Codes			
Consultation			
99252	99253	99254	99255

Payment may be considered on appeal if the pathologist can document the medical necessity of performing the procedures.

25.2.16 Repeated Procedures

25.2.16.1 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."

25.2.17 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, NPI, address, and ZIP code of the outside receiving laboratory where the specimen was forwarded must be entered in Block 32, and the taxonomy code of the receiving laboratory must be indicated in Block 24j next to each procedure to be performed by the receiving laboratory. Enter the taxonomy code 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 NPI 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 for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

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

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

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper 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/resources/rate-and-code-updates/rate-changes.

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

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" in Chapter 24, "Hospital" 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.

Medical Nutrition Services

CSHCN Services Program Provider Manual

April 2025

TEXAS
Health and Human
Services

MEDICAL NUTRITION SERVICES

Table of Contents

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" in this chapter.

Detailed information about CSHCN Services Program provider enrollment procedures for providers of medical nutritional counseling services are in Section 26.4.1, "Enrollment" in this chapter.

Detailed information about CSHCN Services Program provider enrollment procedures for providers of medical nutrition products are in Section 26.5.1, "Enrollment" in this chapter.

Detailed information about CSHCN Services Program provider enrollment procedures for providers of total parenteral nutrition are in Section 26.6.1, "Enrollment" in this chapter.

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

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

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

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

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" in Chapter 17, "Durable Medical Equipment (DME)" for more detailed information about CSHCN Services Program provider enrollment procedures for DME and Custom DME providers and Section 21.1, "Enrollment" in Chapter 21, "Home Health Services" 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 are manually priced, and are benefits 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: *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 or Mineral	Condition
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 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 or Mineral	Condition
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 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

Requested Procedure or Service Information	
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. 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.

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

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.

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.

A maximum of $200.00 per month may be reimbursed for all medical foods. Clients may order up to a three-month supply of food at one time.

Claims for medical foods must be submitted with procedure code S9434 or S9435.

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 (i.e., foods with nutritional value):

Diagnosis Codes							
E700	E701	E7020	E7021	E7029	E7030	E70329	E70330
E70331	E70338	E70339	E7039	E705	E709	E710	E7119
E7201	E7202	E7203	E7204	E7211	E7212	E7219	E7221
E7222	E7223	E724	E7229	E723	E7289	H3120	

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 chapter 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 Form for medical foods prior authorization requests.

Refer to: Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" 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 for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

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

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

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

The Texas Vendor Drug Program website at www.txvendordrug.com for information about the VDP.

26.3.4 Reimbursement

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

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

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" in Chapter 2, "Provider Enrollment and Responsibilities" 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 Request for Authorization and Prior Authorization Request Form with documentation to support medical necessity or appropriateness.

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 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" 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 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 41, "TMHP Electronic Data Interchange (EDI)" for information about electronic claims submissions.

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

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper 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 procedure codes when requesting prior authorization or submitting claims:

Procedure Codes		
97802	97803	S9470

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

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

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" in Chapter 2, "Provider Enrollment and Responsibilities" 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 the following:

- Nutritional products that are traditionally used for infant feeding
- Pudding products
- Nutritional bars
- Nutritional products for individuals who can be sustained on an age-appropriate diet.

Oral electrolyte solutions are reimbursed through VDP and will not be approved as a nutritional product.

Claims for medical nutritional products must be submitted with one of the procedure codes listed in the following table:

Procedure Codes									
B4100	B4149	B4150	B4152	B4100	B4153	B4154	B4155	B4157	B4158
B4159	B4160	B4161	B4162	B9002	B9998	T1999			

Note: *Appropriate limitations for miscellaneous procedure code B9998 and T1999 are determined on a case-by-case basis through prior authorization and must be based on medical necessity.*

The following limitations apply for the rental or purchase of an enteral nutrition infusion pump, any type (procedure code B9002):

- Rental may be reimbursed once per calendar month, same procedure, any provider.
- Purchase may be reimbursed once every five rolling years, same procedure, any provider.

The feeding pump is considered purchased after 10 months of lease within the same year with the same provider.

26.5.2.1 Prior Authorization Requirements

Prior authorization is required every six months for nutritional products. Documentation must be submitted indicating that the client has a medical condition that is expected to be permanent or of indefinite duration that prevents the individual from being sustained on an age-appropriate diet and has manifested in nutritional deficiencies.

Prior authorization is not required for nutritional formulas administered via an enteral feeding tube.

Prior authorization requests must be submitted on the CSHCN Services Program Prior Authorization Request for Medical Nutritional Products Form. The form must be signed by the physician within 90 days prior to the requested start of service. All claims with dates of service prior to the prescribing provider's signature will be denied.

The following information must be provided on the CSHCN Services Program Prior Authorization Request for Medical Nutritional Products Form:

- The full name of the product
- The appropriate procedure code(s)
- The recommended total caloric intake from all sources ordered for nutritional products, except food thickeners
    - The percentage of the total caloric intake from formula or the total number of calories from formula each day
- Identification or explanation of the medical condition resulting in the requirement for a special nutritional product. Additional documentation may be submitted to supplement the information provided on the CSHCN Services Program Prior Authorization Request for Medical Nutritional Products Form. Documentation should be current (within the past 12 months.) Documentation must include:
    - The client's height and weight
    - The client's growth history, growth charts, or both (for clients who are 18 years of age or older, only a weight history is required)
    - Documentation to support why the client cannot be maintained on an age-appropriate diet

Food thickener may be considered for clients with a diagnosis of dysphagia. Documentation of the findings of a swallow study indicating a recommended thickness must be submitted.

Enteral feeding pumps may be considered for prior authorization for lease or purchase with documentation that gravity or syringe feedings are not medically indicated. Requests must be submitted on the CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form.

Procedure code B4105 may be considered for prior authorization for clients who are 5 years of age or older with documentation of the following:

- The client's diagnoses of both exocrine pancreatic insufficiency and cystic fibrosis
- The client's body mass index (BMI) below 18.5 for initial requests and a BMI below 25 for renewal requests
- The client's use of an enteral feeding pump for overnight feedings
- The amount of formula (mL) the client receives during overnight feedings
- An attestation that the client uses a compatible formula

Note: *One cartridge can be used with up to 500mL of formula with a maximum of two cartridges per day.*

Refer to: Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" 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 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 41, "TMHP Electronic Data Interchange (EDI)" for information about electronic claims submissions.

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

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper 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.

Reimbursement 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 code B9998 will be determined by prior authorization, based upon the average wholesale price (AWP) less 10.5%, the manufacturer's suggested retail price (MSRP) less 18%, or the documented invoice cost which must be submitted with the appropriate code to be considered for reimbursement.

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

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

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" in Chapter 2, "Provider Enrollment and Responsibilities" 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,with the exception of lipids (procedure codes B4185 and B4187).

- 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 codes B4185 and B4187) 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) with a valid prior authorization.

Procedure code B4187 is a benefit for clients who are birth through 18 years of age.

Providers can use the following procedure codes to request prior authorization and submit claims:

Procedure Codes								
B4185	B4187	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 B9006 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.*

The procedure codes in the above table 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.

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 and B4187.

Prior authorization will be considered for clients with one of the following conditions.

- Anatomical, physiological, or motility disorder of the gastrointestinal tract.
- Prolonged bowel rest
- Gastrointestinal fistula
- Malignancies
- Inborn errors of amino acid metabolism
- Cystic Fibrosis
- Major trauma and burns
- Severe malnutrition, significant weight loss and/or hypoproteinaemia when enteral therapy is not possible
- Other disease states or conditions in which oral or enteral feeding are not an option

TPN may be approved up to a six-month duration.

Note: *Prior authorization requests for clients with conditions other than those listed will be forwarded to the CSHCN Services Program Medical Director or designee for consideration.*

Refer to: Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior 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 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 41, "TMHP Electronic Data Interchange (EDI)" for information about electronic claims submissions.

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

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper 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/resources/rate-and-code-updates/rate-changes.

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

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.

Neurostimulators and Neuromuscular Stimulators

CSHCN Services Program Provider Manual

April 2025

TEXAS
Health and Human
Services

NEUROSTIMULATORS AND NEUROMUSCULAR STIMULATORS

Table of Contents

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 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

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

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

27.2.1 Dorsal Column Neurostimulation (DCN)

DCN (procedure codes 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 diagnosis codes listed in the table below:

Diagnosis Codes							
G1223	G1224	G1225	G129	G20A1	G20A2	G20B1	G20B2
G20C	G250	G251	G252	G500	G501	G5771	G5772
G5773	G5783	G5793	G8921	G8928	G8929	G893	M4321
M4322	M4323	M4324	M4325	M4326	M4327	M4328	M438X9
M4800	M4801	M4802	M4803	M4804	M4805	M48061	M48062
M4807	M4808	M50020	M50021	M50022	M50023	M50120	M50121
M50122	M50123	M5020	M5021	M50220	M50221	M50222	M50223
M5023	M5410	M792	S48011S	S48012S	S48021S	S48022S	S48111S
S48112S	S48121S	S48122S	S48911S	S48912S	S48921S	S48922S	S58011S
S58012S	S58021S	S58022S	S58111S	S58112S	S58121S	S58122S	S58911S
S58912S	S58921S	S58922S	S68011S	S68012S	S68021S	S68022S	S68110S
S68111S	S68112S	S68113S	S68114S	S68115S	S68116S	S68117S	S68120S
S68121S	S68122S	S68123S	S68124S	S68125S	S68126S	S68127S	S68128S
S68411S	S68412S	S68421S	S68511S	S68512S	S68521S	S68522S	S68610S
S68611S	S68612S	S68613S	S68614S	S68615S	S68616S	S68617S	S68621S
S68622S	S68623S	S68624S	S68625S	S68626S	S68627S	S68712S	S68721S
S68722S	S78011S	S78012S	S78021S	S78022S	S78111S	S78112S	S78121S
S78122S	S78911S	S78912S	S78921S	S78922S	S78929S	S88011S	S88012S
S88021S	S88022S	S88111S	S88112S	S88121S	S88122S	S88911S	S88912S
S88921S	S88922S	S98011S	S98012S	S98021S	S98022S	S98111S	S98112S
S98121S	S98122S	S98131S	S98132S	S98141S	S98211S	S98221S	S98222S
S98311S	S98312S	S98321S	S98322S	S98911S	S98912S	S98921S	T879

Prior authorization for the implantation and purchase of DCN or ICN devices may be considered with a condition indicating chronic pain that is refractory to conventional therapy. Covered diagnosis codes are listed in the above table.

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 who do not meet the criteria 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 for the implantation and purchase of DCN or ICN devices may be considered with one of the diagnosis codes listed in the table below:

Diagnosis Codes							
G1223	G1224	G1225	G129	G20A1	G20A2	G20B1	G20B2
G20C	G250	G251	G252	G500	G501	G5771	G5772
G5773	G5783	G5793	G8921	G8928	G8929	G893	M4321
M4322	M4323	M4324	M4325	M4326	M4327	M4328	M438X9
M4800	M4801	M4802	M4803	M4804	M4805	M48061	M48062
M4807	M4808	M50020	M50021	M50022	M50023	M50120	M50121
M50122	M50123	M5020	M5021	M50220	M50221	M50222	M50223
M5023	M5410	M792	S48011S	S48012S	S48021S	S48022S	S48111S

Diagnosis Codes							
S48112S	S48121S	S48122S	S48911S	S48912S	S48921S	S48922S	S58011S
S58012S	S58021S	S58022S	S58111S	S58112S	S58121S	S58122S	S58911S
S58912S	S58921S	S58922S	S68011S	S68012S	S68021S	S68022S	S68110S
S68111S	S68112S	S68113S	S68114S	S68115S	S68116S	S68117S	S68120S
S68121S	S68122S	S68123S	S68124S	S68125S	S68126S	S68127S	S68128S
S68411S	S68412S	S68421S	S68511S	S68512S	S68521S	S68522S	S68610S
S68611S	S68612S	S68613S	S68614S	S68615S	S68616S	S68617S	S68621S
S68622S	S68623S	S68624S	S68625S	S68626S	S68627S	S68712S	S68721S
S68722S	S78011S	S78012S	S78021S	S78022S	S78111S	S78112S	S78121S
S78122S	S78911S	S78912S	S78921S	S78922S	S78929S	S88011S	S88012S
S88021S	S88022S	S88111S	S88112S	S88121S	S88122S	S88911S	S88912S
S88921S	S88922S	S98011S	S98012S	S98021S	S98022S	S98111S	S98112S
S98121S	S98122S	S98131S	S98132S	S98141S	S98211S	S98221S	S98222S
S98311S	S98312S	S98321S	S98322S	S98911S	S98912S	S98921S	T879

ICN procedures may be reimbursed using the following procedure codes:

Procedure Codes								
61781	61850	61860	61863	61864	61867	61868	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 code 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, "NMES for Muscle Atrophy" in this chapter and Section 27.2.3.2, "NMES for Walking in Clients with Spinal Cord Injury" in this chapter.

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, 64590, 64596, 64597, and 64598) 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 who do not meet the criteria 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.

- Treatment with TENS must have failed or have been contraindicated for the client.
- The client must have a diagnosis indicating chronic pain that is refractory to conventional therapy. The covered diagnosis codes include the following:

Diagnosis Codes							
G1223	G1224	G1225	G129	G20A1	G20A2	G20B1	G20B2
G20C	G250	G251	G252	G500	G501	G5771	G5772
G5773	G5783	G5793	G8921	G8928	G8929	G893	M4321
M4322	M4323	M4324	M4325	M4326	M4327	M4328	M438X9
M4800	M4801	M4802	M4803	M4804	M4805	M4807	M4808
M50020	M50021	M50022	M50023	M50120	M50121	M50122	M50123
M5020	M5021	M50220	M50221	M50222	M50223	M5023	M5410
M792	S48011S	S48012S	S48021S	S48022S	S48111S	S48112S	S48121S
S48122S	S48911S	S48912S	S48921S	S48922S	S58011S	S58012S	S58021S
S58022S	S58111S	S58112S	S58121S	S58122S	S58911S	S58912S	S58921S
S58922S	S68011S	S68012S	S68021S	S68022S	S68110S	S68111S	S68112S
S68113S	S68114S	S68115S	S68116S	S68117S	S68120S	S68121S	S68122S
S68123S	S68124S	S68125S	S68126S	S68127S	S68128S	S68411S	S68412S
S68421S	S68511S	S68512S	S68521S	S68522S	S68610S	S68611S	S68612S
S68613S	S68614S	S68615S	S68616S	S68617S	S68621S	S68622S	S68623S
S68624S	S68625S	S68626S	S68627S	S68712S	S68721S	S68722S	S78011S
S78012S	S78021S	S78022S	S78111S	S78112S	S78121S	S78122S	S78911S
S78912S	S78921S	S78922S	S78929S	S88011S	S88012S	S88021S	S88022S
S88111S	S88112S	S88121S	S88122S	S88911S	S88912S	S88921S	S88922S
S98011S	S98012S	S98021S	S98022S	S98111S	S98112S	S98121S	S98122S
S98131S	S98132S	S98141S	S98211S	S98221S	S98222S	S98311S	S98312S
S98321S	S98322S	S98911S	S98912S	S98921S	T879		

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. Prior authorization for the implantation and purchase of SNS devices may be considered with one of the following medical conditions:

- Urinary incontinence secondary to urethral instability and/or detrusor muscle instability
- Chronic voiding dysfunction
- Non-obstructive urinary retention
- Fecal Incontinence

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 who do not meet the criteria 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)

Transcutaneous electrical nerve stimulation (TENS) involves the attachment of a transcutaneous nerve stimulator to the surface of the skin over the peripheral nerve to be stimulated.

TENS rental or purchase of devices and conductive garments is a benefit of the CSHCN Services Program when medically necessary and prior authorized.

TENS for the treatment of overactive bladder (OAB) is limited to clients who have had the following:

- An evaluation that was performed by an appropriate specialist, usually a urologist or urogynecologist, who determined that the client is a candidate for posterior tibial nerve stimulation (PTNS)
- A medical record that includes the following documentation:
  - The client has been compliant with and has failed a trial of symptom-appropriate behavioral therapy of sufficient length to evaluate potential efficacy.
  - The client has been compliant with and has failed or been unable to tolerate a trial of at least two appropriate medications administered for four to eight weeks.
  - The client's voiding diary shows continued findings of OAB.
  - The client has documented a willingness to attend in-office treatment sessions, to comply with behavioral therapies, and to continue to keep voiding diaries that include documentation of behavioral therapy compliance.

TENS (procedure code 64580) is a benefit of the CSHCN Services Program.

The following procedure codes may be reimbursed for the rental or purchase of a TENS device:

Procedure Codes									
E0720	E0730	E0731	E0733	E0736	E0745	E0762	E0764		

Procedure code E0733 is restricted to diagnosis code G500.

27.2.6.1 TENS Rental

The rental of a TENS device, accessories, and supplies may be a benefit and will 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.

Once it has been determined that electrical nerve stimulation should be continued for chronic pain and the client has been trained to use the stimulator, the CSHCN Services Program will no longer reimburse this therapy as an outpatient or office service.

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.
- 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. Prior authorization for the implantation and purchase of VNS devices may be considered for clients with partial onset intractable seizures when there is failure, contraindication or intolerance to all suitable medical and pharmacological management.

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 who do not meet the criteria 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 Hypoglossal Nerve Stimulators (HNS)

HNS (procedure code 64582) is a benefit of the CSHCN Services Program when medically necessary and prior authorized, for the treatment of obstructive sleep apnea (OSA) and seizures.

The revision or removal of an HNS may be reimbursed using procedure codes 64583 and 64584. Procedure codes 64583 and 64584 do not require prior authorization.

The surgical implantation of HNS and purchase of a device may be considered for prior authorization with documentation of the following:

- Client has a documented diagnosis of obstructive OSA or seizures by a qualified health-care provider.
- For OSA diagnosis, requests must include documentation that the client's compliant use of continuous positive airway pressure (CPAP) for a minimum of 1 month (5 nights per week for at least 4 hours per night) has not been successful or is unable to be tolerated.
- For OSA diagnosis, absence of complete concentric collapse at the soft palate level as seen on a drug-induced sleep endoscopy (DISE) procedure.

27.2.10 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	95976	95977	95983	95984

27.2.11 Electrocorticogram

Electrocorticogram (procedure code 95836) is a benefit of the CSHCN Services Program and may be reported only once for each 30 day period.

27.2.12 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	63661, 63662, 63663, 63664, or 63688
ICN	61781, 61880 or 61888*
SNS	64585 or 64595
***Not a benefit for assistant surgery.**	

Device	Procedure Codes
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 code 61781. 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.

27.2.13 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	L8683	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.

27.2.13.1 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.

27.2.13.2 NMES and TENS Supplies

NMES and TENS supplies may be reimbursed with procedure code A4541, 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 codes A4541 and A4595 are limited to one per month.
- Procedure code A4541 is restricted to diagnosis code G500.

The purchase of supplies for NMES/TENS may only be considered for reimbursement for clients with a purchased device and a claims history of a NMES/TENS procedure within the last 5 years.

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 National Provider Identifier (NPI) 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 for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

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

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

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

27.4 Reimbursement

Neuromuscular devices and the implantation codes must be billed on the same day by any provider.

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

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

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.

Orthotic and Prosthetic Devices

CSHCN Services Program Provider Manual

April 2025

TEXAS
Health and Human
Services

ORTHOTIC AND PROSTHETIC DEVICES

Table of Contents

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 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

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

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

Orthoses	Applicable Condition
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
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	E1803	E1804	E1805	E1806	E1807	E1808	E1810
E1811	E1812	E1813	E1814	E1815	E1816	E1818	E1820 (purchase only)	E1821 (purchase only)	E1822
E1823	E1825	E1826	E1827	E1828	E1829	E1830	E1840	E1841	
Cervical Orthoses									
L0112	L0113	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

Orthoses Procedure Codes									
L1085	L1090	L1100	L1110	L1120					
Thoracic–Lumbar–Sacral Orthoses–Initial and Additions									
L1200	L1210	L1220	L1230	L1240	L1250	L1260	L1270	L1280	L1290
Other Spinal Orthoses									
L1300	L1310	L1320	L1499						
Hip Orthoses									
L1600	L1610	L1620	L1630	L1640	L1650	L1652	L1653	L1660	L1680
L1685	L1686	L1690	L1700						
Legg Perthes Orthoses									
L1710	L1720	L1730	L1755						
Knee Orthoses									
L1810	L1812	L1820	L1821	L1830	L1831	L1832	L1833	L1834	L1836
L1840	L1843	L1844	L1845	L1846	L1847	L1848	L1850	L1851	L1852
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	L2006	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 *** May also be reimbursed in the outpatient hospital setting to hospital providers**									
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	L2760	L2768	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									

Orthoses Procedure Codes									
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	L3761	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	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" in this chapter.

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" in this chapter.

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, 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 4.3, "Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" 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" in this chapter.

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.

28.3.9.2.1 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.

28.3.9.2.2 Authorization Requirements

Prior authorization is required for cranial molding orthosis which will be reviewed by the CSHCN medical director or designee. Prior authorization requests must be submitted on the CSHCN Services Program Authorization and Prior Authorization Request Form.

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 sub-specialist, 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 4.3, "Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" 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									
L3161	L5615								
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	L5810*	L5811*	L5812*	L5814*	L5816
L5818*	L5822*	L5824*	L5826*	L5828*	L5830*	L5840*	L5841*	L5845	L5848*
L5850	L5855	L5856*	L5857*	L5858	L5859*	L5910	L5920	L5925	L5926
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									
*** Must be billed with the functional modifiers in Section 28.4.5, "Lower-Limb Prostheses" in this chapter.**									

Prostheses Procedure Codes									
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
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									
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	L7700								
*** Must be billed with the functional modifiers in Section 28.4.5, "Lower-Limb Prostheses" in this chapter.**									

Prostheses Procedure Codes									
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" in this chapter.**									

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 undergoing 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 Section 28.4.1, "Prior Authorization and Documentation Requirements" in this chapter. 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.

Functional Modifier	Functional Level	Description
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 40.2.1.9, "Eye Prostheses" in Chapter 40, "Vision Services" for information about eye prostheses.

Section 31.2.40, "Diagnostic and Surgical/Reconstructive Breast Therapies " in Chapter 31, "Physician" and Chapter 17, "Durable Medical Equipment (DME)" for information about breast prostheses.

Chapter 14, "Dental" 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 CMS NCCI web page for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

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

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

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper 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/resources/rate-and-code-updates/rate-changes.

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

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.

Outpatient Behavioral Health

CSHCN Services Program Provider Manual

April 2025

TEXAS
Health and Human
Services

OUTPATIENT BEHAVIORAL HEALTH

Table of Contents

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 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

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

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 direct 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 National Provider Identifier (NPI).

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 testing, neuropsychological testing, psychotherapy, and counseling.

Laboratory and radiology services do not count toward the 30 outpatient encounters per client, per calendar year limitation. Pharmacological management does not count toward the 30 encounters per client, per calendar year limitation.

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 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 psychiatric 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 with anticipated outcomes
- Desired therapeutic drug levels, if applicable
- Current laboratory values, if applicable
- Treatment goals

29.2.4 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:

- Psychologist
- Advanced practice registered nurse (APRN)
- Physician Assistant (PA)
- 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 NPI 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.

29.2.5 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 evaluation and management service. (List separately in addition to the code for primary procedure.)	30 minutes
90834	45 minutes	45 minutes
90836	45 minutes with an evaluation and management service. (List separately in addition to the code for primary procedure.)	45 minutes
90837	60 minutes	60 minutes
90838	60 minutes with an evaluation and management service. (List separately in addition to the code for primary procedure.)	60 minutes
90846	N/A	50 minutes
90847	N/A	50 minutes
96116	60 minutes	60 minutes
96121*	60 minutes	60 minutes
96130	60 minutes	60 minutes
96131*	60 minutes	60 minutes
96132	60 minutes	60 minutes
96133*	60 minutes	60 minutes
96136	60 minutes	30 minutes
96137*	60 minutes	30 minutes
N/A = Not Applicable ***Add-on procedure codes must be billed with their corresponding primary procedure code.**		

Note: *Procedure code 90853 is not included in the 12-hour system limitation, so it is not shown in the table.*

LCSWs, LMFTs, or LPCs may use only the following procedure codes when filing claims:

Procedure Codes					
90832	90834	90837	90846	90847	90853

LMFT services require the U8 modifier.

Only physicians, APRNs, and PAs may use the following procedure codes when filing claims:

Procedure Codes				
90791	90792	90833	90836	90838

Procedure codes 90833, 90836, and 90838 are add on codes and must be billed with a primary E/M code in order to be considered for reimbursement.

Physicians and psychologists may use the following procedure codes when filing claims:

Procedure Codes									
90791	90832	90834	90837	90846	90847	90853	96116	96121*	96130
96131*	96132	96133*	96136	96137					
***Add-on procedure codes must be billed with their corresponding primary procedure code.**									

Clinical psychologist services must be submitted with the AH modifier.

PLP services may be reimbursed using procedure code 90791 with modifier U9.

29.2.6 Psychological Testing, Neuropsychological Testing, and Neurobehavioral Status Exams

Psychological testing (procedure codes 96130, 96131*, 96136, and 96137*), neurobehavioral status exams (procedure codes 96116 and 96121*), and neuropsychological testing (procedure codes 96132, 96133*, 96136, and 96137*) are 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.

Note: **Add-on procedure codes must be billed with their corresponding primary procedure code.*

Reimbursement of psychological testing, neurobehavioral status exams, and neuropsychological testing includes testing, scoring, and interpretation of results.

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 or neurobehavioral status exam 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.

Psychological testing, neurobehavioral status exams, and neuropsychological testing 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 codes 96130, 96131*, 96136, and 96137*) and neuropsychological testing (procedure codes 96132, 96133*, 96136, 96137*) may be reimbursed on the same date of service as a psychiatric diagnostic evaluation (procedure code 90791 or 90792).

Testing procedure codes 96116, 96121*, 96130, 96131, 96132, 96133*, 96136, and 96137* count toward the 30 per calendar year limitation.

Psychological testing (procedure codes 96130, 96131*, 96136, and 96137*), neurobehavioral testing (procedure codes 96116 and 96121*), and neuropsychological testing (procedure codes 96132, 96133*, 96136, and 96137*) will not be reimbursed on the same date of service when performed by the same provider.

Note: *Add-on procedure codes indicated with asterisk must be billed with the appropriate primary procedure code.*

29.2.7 Psychotherapy and Counseling

Reimbursement for outpatient psychotherapy or counseling is limited to no more than 4 hours per client, per day.

Providers must bill the units of each half hour of psychotherapy and indicate that number of units on the claim form.

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.

Only the LMFT, LCSW, LPC, APRN, or PA 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.

A psychologist may also bill for services performed by a PLP under their direct supervision.

Interpretation and documentation time is not reimbursed separately for psychotherapy or counseling procedures.

Psychotherapy and counseling services count toward the 30 per calendar year limitation.

Psychotherapy services must not be continued if no longer beneficial to the client.

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.

29.2.7.1 Treatment for Alzheimer's and Dementia

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.

Psychotherapy for clients with Alzheimer's disease or dementia is limited to the diagnoses listed below and must be submitted on the CSHCN Services Program Authorization and Prior Authorization Request Form.

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	90846	90847	90853

Diagnosis Codes							
F0390	F03911	F03918	F0392	F0393	F0394	F03A0	F03A11
F03A18	F03A2	F03A3	F03A4	F03B0	F03B11	F03B18	F03B2
F03B3	F03B4	F03C0	F03C11	F03C18	F03C2	F03C3	F03C4
G3184	R41841						

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.

Supporting documentation (certification of need) must be documented in the individual client's record. This documentation must be maintained by each facility, as applicable to state and federal guidelines, and be available upon request.

29.2.8 Psychiatric Diagnostic Evaluations

Psychiatric diagnostic evaluations (procedure codes 90791 or 90792) are limited to once per day per client, any provider, regardless of the number of professionals involved in the interview.

Psychiatric diagnostic evaluations count toward the 30 per calendar year limitation.

29.2.9 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
- 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
- Multiple family group psychotherapy
- Narcosynthesis
- Psychoanalysis
- Unlisted psychiatric services or procedures
- "Adult activity" or "individual activity" (These services are payable only if guidelines for group therapy are met and termed "group therapy.")

The CSHCN Services Program does not reimburse procedure code 90849.

29.2.10 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 41, "TMHP Electronic Data Interchange (EDI)" for information about electronic claims submissions.

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

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper 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/resources/rate-and-code-updates/rate-changes.

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

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.

PHYSICAL MEDICINE AND REHABILITATION

CSHCN SERVICES PROGRAM PROVIDER MANUAL

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PHYSICAL MEDICINE AND REHABILITATION

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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 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

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

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 licensed physical or occupational therapists, physicians, home health agencies, hospitals, 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 the limits outlined in this chapter for each type of therapy.

Therapy evaluations and re-evaluations are limited to 180 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.

An evaluation or re-evaluation performed on the same day as therapy treatment from a different therapy type must be performed at distinctly separate times to be considered for reimbursement.

If an initial evaluation and a re-evaluation from the same therapy discipline are billed for the same date of service by any provider, the re-evaluation will be denied.

Outpatient OT or PT treatment services will deny if billed on the same date of service as procedure codes G0152 or G0151, respectively.

PT and OT services must be rendered in accordance with the Executive Council of Physical Therapy and Occupational Therapy Examiners or performed by a physician within their scope of practice.

> ***Note:*** *Therapy services provided by a licensed therapist assistant must be submitted by the licensed supervising 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. Each therapy discipline provided must be of the level of complexity that requires the judgment, knowledge, and skill of a licensed physical or occupational therapist, or physician. 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.

Providers must use the following procedure codes for claim submission when billing for physical and occupational therapy services:

Procedure Codes									
97012	97016	97018	97022	97024	97026	97028	97032	97033	97034
97035	97036	97110	97112	97113	97116	97124	97140	97150	97161
97162	97163	97164	97165	97166	97167	97168	97530	97535	97537
97542	97750	97755	97760	97761	97763	97799			

Physical therapists must use procedure code 97161, 97162, or 97163 for evaluations and procedure code 97164 for re-evaluations. Occupational therapists must use procedure code 97165, 97166, or 97167 for evaluations and procedure code 97168 for re-evaluations. These codes are untimed and do not require modifiers.

The following modifiers must be used to indicate when treatment services have been rendered by a licensed therapist or physician, or by a licensed therapy assistant under supervision of a licensed therapist:

Modifier	Description
U5	Services delivered by a licensed therapist or physician
UB	Services delivered by a therapy assistant under supervision of a licensed therapist

Note: *These modifiers are not required for evaluation and re-evaluation procedure codes because those services may not be rendered by licensed therapy assistants.*

30.2.3 Time-based PT and OT Treatment Procedure Codes

PT and OT time-based treatment procedure codes are payable as 15-minute units for all provider types.

Time-based treatment procedure codes are cumulatively limited to one hour per date of service, per discipline, up to four units per day. Four units are equal to one hour.

All time-based PT and OT treatment procedure codes listed in the table below will be cumulatively limited to four units (one hour) per date of service, per discipline:

Procedure Codes									
Limited to a combined total of 4 units (one hour) per date of service per discipline									
97032	97033	97110	97112	97113	97116	97124	97140	97530	97535
97537	97542	97750	97755	97760	97761	97763			
Limited to a total of 3 units (45 minutes) per date of service per discipline; may be combined with other time-based codes; not payable in the home setting									
97036									
Limited to a combined total of 2 units (30 minutes) per date of service per discipline; may be combined with other time-based codes									
97034	97035								

30.2.4 Untimed PT and OT Treatment Procedure Codes

The following PT and OT treatment procedure codes are limited to one each, one time per day, per discipline.

Procedure Codes								
97012	97016	97018	97022	97024	97026	97028	97150	97799

The following untimed procedure codes may only be reimbursed when billed on the same date of service with one or more time-based procedure codes listed in the Time-Based PT and OT Treatment Procedure Codes table above.

Procedure Codes						
97012	97016	97018	97022	97024	97026	97028

30.2.5 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

Units	Number of 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

30.2.6 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.

30.2.6.1 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 standards regarding group therapy.*

30.2.6.2 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.

30.2.7 Noncovered Services

The following services are not a benefit of the CSHCN Services Program:

- Therapy services provided by the following:
  - Unlicensed physical therapy aides, orderlies, students, or technicians
  - Unlicensed occupational therapy aides, interns, orderlies, students, or technicians
- Unattended electrical stimulation, as unattended services are not covered
- 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)
- 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

30.2.8 Authorization Requirements

PT and OT evaluations and re-evaluations 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. Requests for extensions of ongoing treatment services may be granted up to an additional 180 days for chronic conditions with documentation of medical necessity.

Time-based PT and OT treatment procedure codes are cumulatively limited to one hour per date of service, per discipline, up to four units per day. Four units are equal to one hour.

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. Untimed PT and OT treatment procedure codes are limited to one each, one time per date of service, per discipline.

Each supervised modality code must be requested on the prior authorization form and may only be reimbursed when billed with one or more time-based PT/OT procedure codes.

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.

30.2.8.1 Initial Prior Authorization Requests

The initial request for prior authorization must be approved 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 approved.

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 medical necessity documentation is required when submitting a request for PT or OT therapy services:

- A completed CSHCN Services Program Prior Authorization Request for Initial Outpatient Therapy (TP1) Form. The request form must be signed and dated by the ordering physician, APRN, or PA, and the therapy provider. A request form that is missing required information is considered incomplete.

  Note: *The ordering practitioner must sign and date the treatment plan and request form on or after the date the evaluation was performed.*

- A current evaluation and comprehensive treatment plan with all of the following:
  - Date of evaluation
  - Diagnoses
  - Client's medical history and background
  - Client's current and prior functional level, to include current standardized assessment scores or criterion-referenced scores as appropriate for the client's condition
  - Date of onset of the illness, injury, or exacerbation requiring the therapy services
  - Short-and long-term treatment goals for the therapy discipline, and associated disciplines, requested related to the client's individual needs
  - A description of the specific treatment modalities being prescribed and the recommended amount, frequency and duration of services
  - Prognosis for improvement
  - Requested dates of service
  - Date and signature of the licensed therapist

  Note: *A therapy evaluation is current when performed within 60 days before the initiation of therapy treatment services.*

30.2.8.2 Extension of Services Requests

A prior authorization request for extension of ongoing treatment services must be received and approved no earlier than 30 days prior to the expiration of the current prior authorization period. Requests received after the current prior authorization expires will be denied for dates of service occurring before the request's approval date.

Prior authorization requests for extension of ongoing treatment services may be considered for increments up to 180 days for chronic conditions with documentation of medical necessity and includes all of the following:

- A completed CSHCN Services Program Prior Authorization Request for Extension of Outpatient Therapy (TP2) Form signed and dated by the ordering physician, APRN, or PA, and the therapy provider. A request form that is missing required information is considered incomplete.

  Note: *The ordering practitioner must sign and date the updated treatment plan and request form on or after the date the evaluation or re-evaluation was performed.*

- A current therapy evaluation or re-evaluation, and updated treatment plan with all of the following:
  - Date of evaluation or re-evaluation
  - Diagnoses
  - Client's medical history and background
  - Client's current and prior functional level, to include current standardized assessment scores or criterion-referenced scores as appropriate for the client's condition
  - Date of onset of the illness, injury, or exacerbation that requires the therapy services
  - Prior and new short- and long-term treatment goals documenting the client's progress towards prior treatment goals
  - A description of the specific treatment modalities that are being prescribed and the recommended amount, frequency and duration of services
  - Prognosis for improvement
  - Requested date of service
  - Dated signature of licensed therapist

  Note: *A therapy evaluation or re-evaluation is current when performed within 60 days before the request for extension of ongoing services.*

30.2.8.3 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 evidence of the following, including all documentation required for an initial request for therapy services:

- 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 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

CSHCN Services Program Prior Authorization Request for Initial Outpatient Therapy (TP1) Form

CSHCN Services Program Prior Authorization Request for Extension of Outpatient Therapy (TP2) Form

Note: *Fax transmittal confirmations are not accepted as proof of timely authorization submission.*

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 treatment services must include modifier GP, and claims for OT treatment services must include modifier GO. Evaluation and re-evaluation 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 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 41, "TMHP Electronic Data Interchange (EDI)" for information about electronic claims submissions.

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

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

30.5 Reimbursement

PT or OT providers 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/resources/rate-and-code-updates/rate-changes.

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

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.

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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 Provider Enrollment and Management System (PEMS). Providers may also enroll or reenroll in the CSHCN Services Program online through PEMS. 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" in Chapter 2, "Provider Enrollment and Responsibilities."

Refer to: Section 2.1.9, "Out-of-State Providers" in Chapter 2, "Provider Enrollment and Responsibilities" 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 26 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 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

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

Section 2.1.5.1, "Types of Providers" in Chapter 2, "Provider Enrollment and Responsibilities" for additional information.

Section 3.1.4, "Services Provided Outside of Texas" in Chapter 3, "Client Benefits and Eligibility" 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 through PEMS.

Refer to: Section 2.1.2, "Changes in Enrollment" in Chapter 2, "Provider Enrollment and Responsibilities" 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" for additional information.

Section 4.3.1, "Services that Require Authorization" in Chapter 4, "Prior Authorizations and Authorizations" for a list of some of the services requiring authorization.

Section 4.4.1, "Services that Require Prior Authorization" in Chapter 4, "Prior Authorizations and Authorizations" 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. 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 codes B20, D8481, D84821, D84822, and D8489 for the treatment of pneumocystis carinii.

Procedure code J7605 may be reimbursed when billed with the following diagnosis codes:

Diagnosis Codes							
A150	E840	J09X1	J09X2	J09X9	J1000	J1001	J1008
J101	J1100	J1108	J111	J121	J15212	J188	J189
J210	J211	J218	J398	J410	J411	J418	J42
J430	J431	J432	J438	J439	J440	J441	J449
J4520	J4521	J4522	J4530	J4531	J4532	J4540	J4541
J4542	J4550	J4551	J4552	J45901	J45902	J45909	J45990
J45991	J45998	J470	J471	J479	J60	J61	J620
J628	J630	J631	J632	J633	J634	J635	J64
J660	J661	J662	J668	J670	J671	J672	J673
J674	J675	J676	J677	J678	J679	J680	J681
J682	J683	J684	J689	J690	J691	J698	J700
J701	J705	J708	J709	J9801	J9809	Q334	R051
R052	R053	R054	R058	R059	Z7182		

Procedure code J7608 may be reimbursed when billed with the following diagnosis codes:

Diagnosis Codes							
A150	E840	J09X1	J09X2	J09X9	J1000	J1001	J1008
J101	J1100	J1108	J111	J121	J15212	J188	J189
J210	J211	J218	J398	J410	J411	J418	J42
J430	J431	J432	J438	J439	J440	J441	J449
J4520	J4521	J4522	J4530	J4531	J4532	J4540	J4541
J4542	J4550	J4551	J4552	J45901	J45902	J45909	J45990
J45991	J45998	J470	J471	J479	J60	J61	J620
J628	J630	J631	J632	J633	J634	J635	J64
J660	J661	J662	J668	J670	J671	J672	J673
J674	J675	J676	J677	J678	J679	J680	J681
J682	J683	J684	J689	J690	J691	J698	J700
J701	J708	J709	J8281	J8282	J9801	J9809	Q334
R051	R052	R053	R058	R059	Z7182		

Procedure codes J7622, J7631, J7639, J7644, and J7682 may be reimbursed when billed with the following diagnosis codes:

Diagnosis Codes							
A150	E840	J09X1	J09X2	J09X9	J1000	J1001	J1008
J101	J1100	J1108	J111	J121	J15212	J188	J189
J210	J211	J218	J398	J410	J411	J418	J42
J430	J431	J432	J438	J439	J440	J441	J449
J4520	J4521	J4522	J4530	J4531	J4532	J4540	J4541
J4542	J4550	J4551	J4552	J45901	J45902	J45909	J45990
J45991	J45998	J470	J471	J479	J60	J61	J620
J628	J630	J631	J632	J633	J634	J635	J64
J660	J661	J662	J668	J670	J671	J672	J673
J674	J675	J676	J677	J678	J679	J680	J681
J682	J683	J684	J689	J690	J691	J698	J700
J701	J708	J709	J9801	J9809	Q334	R051	R052
R053	R054	R058	R059	Z7182			

Procedure code J7626 may be reimbursed when billed with the following diagnosis codes:

Diagnosis Codes							
A150	E840	J09X1	J09X2	J09X9	J1000	J1001	J1008
J101	J1100	J1108	J111	J121	J15212	J188	J189
J210	J211	J218	J398	J410	J411	J418	J42
J430	J431	J432	J438	J439	J440	J441	J449
J4520	J4521	J4522	J4530	J4531	J4532	J4540	J4541
J4542	J4550	J4551	J4552	J45901	J45902	J45909	J45990
J45991	J45998	J470	J471	J479	J60	J61	J620
J628	J630	J631	J632	J633	J634	J635	J64
J660	J661	J662	J668	J670	J671	J672	J673
J674	J675	J676	J677	J678	J679	J680	J681
J682	J683	J684	J689	J690	J691	J698	J700
J701	J708	J709	J9801	J9809	Q334	R051	R052
R053	R054	R058	R059	Z7182			

Procedure code J7633 may be reimbursed when billed with the following diagnosis codes:

Diagnosis Codes							
A150	E840	J09X1	J09X2	J09X9	J1000	J1001	J1008
J101	J1100	J1108	J111	J121	J15212	J188	J189
J210	J211	J218	J398	J410	J411	J418	J42
J430	J431	J432	J438	J439	J440	J441	J449
J4520	J4521	J4522	J4530	J4531	J4532	J4540	J4541
J4542	J4550	J4551	J4552	J45901	J45902	J45909	J45990

Diagnosis Codes							
J45991	J45998	J470	J471	J479	J60	J61	J620
J628	J630	J631	J632	J633	J634	J635	J64
J660	J661	J662	J668	J670	J671	J672	J673
J674	J675	J676	J677	J678	J679	J680	J681
J682	J683	J684	J689	J690	J691	J698	J700
J701	J708	J709	J9801	J9809	Q334	Z7182	

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	86008	86486	95004	95017	95018	95024	95027
95028	95076	95180	95199						

Allergy blood testing (procedure codes 86001, 86003, 86005, and 86008) 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 codes 86003 and 86008 are 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, 86005, and 86008.

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, 86005, and 86008 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

Blood pressure monitoring by either self-measured blood pressure monitoring or ambulatory blood pressure monitoring are benefits 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.

Self-measured blood pressure monitoring and ambulatory blood pressure monitoring are a benefit for the initial diagnosis of hypertension and should not be used for maintenance monitoring. Self-measured blood pressure monitoring and ambulatory blood pressure monitoring are 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 self-measured blood pressure monitoring and ambulatory blood pressure monitoring was performed for at least 24 hours.

Providers must use procedure codes 93784, 93786, 93788, and 93790 when billing for ambulatory blood pressure monitoring.

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.

Self-measured blood pressure monitoring procedure code 99473 is limited to one service per year, any provider. Procedure code 99473 may be considered for reimbursement more than once per year when the following documentation of medical necessity is submitted with the claim:

- Documentation of erroneous blood pressure readings - excessively high or low blood pressure, blood pressure readings excessively inconsistent with those measured professionally
- Documentation of erroneous blood pressure logs - day of the week, time of day, setting or location, or timing of medication administration inconsistent with prior professional instruction
- Documentation of poor health literacy, developmental, or intellectual challenges that may require repeated client education
- Client purchase or receipt of new blood pressure device

Self-measured blood pressure monitoring procedure code 99474 is limited to four services per year, any provider, and may be reimbursed only if a claim for procedure code 99473 has been submitted within 12 rolling months.

Only one method of blood pressure monitoring (self-measured or ambulatory) may be reimbursed within a rolling 12-month period. Self-measured blood pressure monitoring submitted within the same rolling 12-month period as ambulatory blood pressure monitoring will be denied.

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 or medically directs a CRNA, AA, or other qualified professional
- A CRNA who is 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 procedure 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.

31.2.5.3.1 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, AA, or other qualified professional.

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 modifier U1 or U2 in combination with an appropriate pricing modifier when billing for any payable anesthesia procedure codes.

31.2.5.3.2 Anesthesiologist Services and Modifier Combinations

When a single claim per client is billed by the anesthesiologist for personally performing the anesthesia service, the AA and U1 modifier combination must be billed together.

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 a single claim per client is billed by the anesthesiologist for medically directing anesthesia services of an anesthesia procedure provided by one CRNA, AA, or other qualified professional, the QY + U1 modifier combination must be billed together if the CRNA, AA, or qualified professional are a part of a clinic/group.	Only the anesthesiologist
QK and U1	When a single claim per client is billed by the anesthesiologist for medically directing anesthesia services of two, three, or four concurrent anesthesia procedures provided by CRNAs, AAs, or other qualified professionals.	Only the anesthesiologist

Modifier Combination Submitted by Anesthesiologist	When is it used?	Who will submit claims?
AA, U1, and GC	When a single claim per client is billed by the anesthesiologist for medically directing anesthesia services of an anesthesia procedure provided by one resident physician.	Only the anesthesiologist
AD and U1 (emergency circumstances only)	When a single claim per client is billed by the anesthesiologist for medically supervising anesthesia services provided by more than four concurrent procedures that are provided by a CRNA, AA, or other qualified professional. 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 two claims per client are billed, one by the medically directing anesthesiologist and one by the CRNA, AA, or other qualified professional.	Both the anesthesiologist and CRNA, AA, or other qualified professional
QK and U2	When two claims per client are billed for medically directing anesthesia services of two, three, or four concurrent anesthesia procedures provided by CRNA(s), AA(s), or other qualified professionals.	Both the anesthesiologist and CRNA(s), AA(s), or other qualified professional
AD and U2 (emergency circumstances only)	When two claims per client are billed for medically supervising more than four concurrent anesthesia procedures provided by CRNA(s), AA(s), or 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 requireing supervision of five or more concurrent procedures.	Both the anesthesiologist and CRNA(s), AA(s), or other qualified professional

31.2.5.3.3 CRNA, AA, or Other Qualified Professional Services

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 physician.

Modifiers QX and U2 must be submitted by a CRNA, AA, or other qualified professional who provided services under the medical direction of an anesthesiologist.

31.2.5.3.4 Monitored Anesthesia Care

Anesthesiologists, CRNAs, AAs, or other qualified professionals 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" for more information about dental services.

31.2.5.5 Epidural and Subarachnoid Infusion (Not including Labor and Delivery)

Epidural and subarachnoid infusion for pain management may be reimbursed for acute, chronic, and postoperative pain management.

Procedure code 01996 is limited to once per day and is denied when billed on the same day as a surgical/anesthesia procedure. If procedure code 01996 is billed longer than 30 days medical necessity documentation is required. Cancer diagnoses are excluded from the 30-day limitation.

31.2.5.6 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 50 percent of the maximum allowable fee.

The CRNA's or AA's reimbursement for performing an anesthesia service when supervised by a physician other than an anesthesiologist is 92 percent of the maximum allowable fee.

A CRNA or AA under the supervision of an anesthesiologist may be reimbursed the lesser of the billed charges or 50 percent of the calculated payment for a supervised anesthesia service.

Refer to: Chapter 12, "Certified Registered Nurse Anesthetist (CRNA)" 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.

31.2.5.7 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.

31.2.5.8 Time-Based Fees

Reimbursement of time-based anesthesia services is defined as [(Minutes/15) + Relative Value Units (RVUs)] x Conversion Factor = 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.

   Add the RVUs for the procedure performed (use the procedure with the highest RVUs when multiple procedures are performed at the same time).

   Multiply this sum by the appropriate conversion factor.

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" 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 Health and Human Services Commission (HHSC). The CSHCN Services Program is the payer of last resort and may request that clients meeting these requirements apply to HHSC.

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)."

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, 90912 and 90913 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, 90912 and 90913 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. Requests for prior authorization must be submitted by the ordering provider using the CSHCN Services Program Authorization and Prior Authorization Request Form.

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, 90912 and 90913, 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 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 31.2.9.1, "Prior Authorization Requirements for Bone Growth Stimulators" in this chapter 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.

31.2.9.1 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, 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.

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 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" 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.

31.2.9.1.1 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)

31.2.9.1.2 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

31.2.9.1.3 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.).

31.2.9.2 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 31.2.9.1, "Prior Authorization Requirements for Bone Growth Stimulators" in this chapter.

Authorization requests for bone growth stimulation must be submitted on the CSHCN Services Program Authorization and Prior Authorization Request Form.

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

31.2.10 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. Casting, splinting and strapping are subject to global surgery fee guidelines.

Supplies used for casting, splinting, and strapping are not reimbursed separately.

Procedure codes 29450 and 29750 are benefits for the following diagnosis codes:

Diagnosis Codes							
M21541	M21542	M21549	Q662	Q6651	Q6652	Q666	Q6681

Diagnosis Codes	
Q6682	Q6689

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	29240	29260	29280	29799					
Lower extremity casts									
29305	29325	29345	29355	29358	29365	29405	29425	29435	29440
29445	29580								
Lower extremity splints									
29505	29515								
Lower extremity strapping									
29520	29530	29540	29550						
Cast removal or repair									
29700	29705	29710	29720	29730	29740				

31.2.11 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	96440	96446	96450	96521	96522
96523	96542	96549	G0498						

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 96401, 96402, 96409, 96413, or 96416.

Procedure code 96415 must be used for each additional hour beyond the initial hour and must be used in conjunction with procedure code 96409, 96413, or 96416.

Procedure code 96416 will be denied if billed with procedure code G0498 on the same date of service, any provider.

Procedure code 96417 must be used for each subsequent infusion up to 1 hour and must be used in conjunction with procedure code 96409, 96413, or 96416 on the same day, by the same provider. 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.

31.2.12 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.

31.2.12.1 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 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.

31.2.12.2 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 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.

31.2.12.2.1 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			
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 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 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).

31.2.12.2.2 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.

31.2.12.2.3 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 Authorization Request for Non-Face-to-Face Clinician-Directed Care Coordination Services Form 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 National Provider Identifier (NPI) information

31.2.12.2.4 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. Prolonged services of less than 30 minutes duration are considered part of the physician E/M service being provided.

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.

Procedure codes 99358 and 99359 will be denied if billed on the same date of service as any of the following procedure codes:

Procedure Codes									
99202	99203	99204	99205	99212	99213	99214	99215	99221	99222
99223	99231	99232	99233	99234	99235	99236	99242	99243	99244
99245	99252	99253	99254	99255	99281	99282	99283	99284	99285
99304	99305	99306	99307	99308	99309	99310	99341	99342	99344
99345	99347	99348	99349	99350	99417	99418			

31.2.12.2.5 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 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.

31.2.13 Cochlear Implants

Cochlear implants and auditory rehabilitation are benefits for CSHCN Services Program clients.

Refer to: Section 20.3.2, "Cochlear Implants" in Chapter 20, "Hearing Services" for more information about cochlear implants.

31.2.14 Colon Capsule Endoscopy

Colon capsule endoscopy (procedure code 91113) is a benefit of the CSHCN Services Program and limited to the following diagnosis codes:

Diagnosis Codes					
K635	K921	K922	R195	Z5309	Z538

31.2.15 Colorectal Cancer Screening

Procedure codes 74263, 81528, 82270 (CLIA waived test), G0104, G0105, G0121, and G0328 (with modifier QW) are benefits of the CSHCN Services Program. 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.

Procedure code 81528 may be reimbursed once every 3 years for clients who are 45 years of age or older. Procedure code G0104 may be reimbursed once every 5 years, or as recognized by the ACS or the U.S. Preventive Services Task Force (USPSTF). Procedure code G0121 may be reimbursed once every 10 rolling years.

Refer to: Chapter 25, "Enrollment" for additional information about laboratory cancer screening or pathology procedures.

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
- Personal history of inflammatory bowel disease, including Crohn's disease and ulcerative colitis

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.

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.

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.

31.2.16.1 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.

31.2.16.2 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.

31.2.16.3 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.

31.2.16.4 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.

31.2.16.5 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.

31.2.16.6 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

Procedure code 76506 is a benefit of the CSHCN Services Program with the following diagnosis codes:

Diagnosis Codes							
A066	A170	A171	A1781	A1782	A1789	C410	C6961

Diagnosis Codes							
C6962	C700	C710	C711	C712	C713	C714	C715
C716	C717	C718	C719	C7221	C7222	C7231	C7232
C7241	C7242	C7259	C729	C751	C752	C768	C7931
C7932	C7940	C7949	C7951	C7952	C7989	D075	D098
D164	D3161	D3162	D320	D329	D330	D331	D332
D333	D3500	D3501	D3502	D420	D421	D429	D432
D433	D434	D438	D439	D47Z1	D47Z2	D480	D487
D492	D496	D497	F0390	F03911	F03918	F0392	F0393
F0394	G060	G062	G07	G08	G132	G138	G232
G233	G300	G301	G308	G309	G3101	G3109	G311
G312	G3180	G3183	G3184	G3185	G3186	G3189	G319
G910	G911	G912	G930	G932	G9340	G9341	G9342
G9343	G9344	G9345	G9349	G935	G936	G937	G9381
G9389	G939	G94	G988	G998	H35361	H4600	H4601
H4602	H4603	H4610	H4611	H4612	H4613	H462	H463
H468	H469	H47011	H47012	H47013	H47019	H47021	H47022
H47023	H47029	H47031	H47032	H47033	H47039	H47091	H47092
H47093	H47099	H4710	H4711	H4712	H4713	H47141	H47142
H47143	H47149	H4720	H47211	H47212	H47213	H47219	H4722
H47231	H47232	H47233	H47239	H47291	H47292	H47293	H47299
H47311	H47312	H47313	H47319	H47321	H47322	H47323	H47329
H47331	H47332	H47333	H47339	H47391	H47392	H47393	H47399
H4741	H4742	H4743	H4749	H47511	H47512	H47519	H47521
H47522	H47529	H47531	H47532	H47539	H47611	H47612	H47619
H47621	H47622	H47629	H47631	H47632	H47639	H47641	H47642
H47649	I6000	I6001	I6002	I6010	I6011	I6012	I602
I6030	I6031	I6032	I604	I6050	I6051	I6052	I606
I607	I608	I609	I610	I611	I612	I613	I614
I615	I616	I618	I619	I6200	I6201	I6202	I6203
I621	I629	I6330	I63311	I63312	I63319	I63321	I63322
I63323	I63329	I63331	I63332	I63333	I63339	I6339	I6340
I63411	I63412	I63419	I63421	I63422	I63429	I63431	I63432
I63439	I6349	I6350	I63511	I63512	I63513	I63519	I63521
I63522	I63523	I63529	I63531	I63532	I63533	I63539	I63543
I6381	I6389	I6601	I6602	I6603	I6609	I6611	I6612
I6613	I6619	I6621	I6622	I6623	I6629	I668	I669
I671	I6781	I6782	I6783	I67850	I67858	I6789	I680
I69098	I6921	I69210	I69211	I69212	I69213	I69214	I69215
I69218	I69219	I69220	I69221	I69222	I69223	I69269	I69290
I69291	I69292	I69293	I69298	O99411	O99412	O99413	O99419

Diagnosis Codes							
O9942	O9943	P0082	P0700	P0701	P0702	P0703	P0710
P0714	P0715	P0716	P0717	P100	P101	P102	P103
P104	P108	P109	P112	P119	P120	P121	P122
P123	P124	P1281	P1289	P129	P150	P151	P152
P153	P154	P155	P156	P158	P352	P370	P371
P372	P373	P374	P378	P520	P521	P5221	P5222
P523	P524	P525	P526	P528	P529	P90	P912
P91811	P91819	P91821	P91822	P91823	P91829	P9188	Q010
Q011	Q012	Q018	Q02	Q030	Q031	Q038	Q040
Q041	Q042	Q045	Q046	Q048	Q050	Q051	Q052
Q054	Q0701	Q0702	Q0703	Q282	Q283	R220	R221
R5600	R569	S0190XA	S0190XD	S0190XS	S060X0A	S060X0D	S060X0S
S060X1A	S060X1D	S060X1S	S060X9A	S060X9D	S060X9S	S060XAA	S060XAD
S060XAS	S061X0A	S061X0D	S061X0S	S061X1A	S061X1D	S061X1S	S061X2A
S061X2D	S061X2S	S061X3A	S061X3D	S061X3S	S061X4A	S061X4D	S061X4S
S061X5A	S061X5D	S061X5S	S061X6A	S061X6D	S061X6S	S061X7A	S061X8A
S061X9A	S061X9D	S061X9S	S061XAA	S061XAD	S061XAS	S06305A	S06305D
S06305S	S06306A	S06306D	S06306S	S06307A	S06308A	S0630AA	S0630AD
S0630AS	S06310A	S06310D	S06310S	S06311A	S06311D	S06311S	S06312A
S06312D	S06312S	S06313A	S06313D	S06313S	S06314A	S06314D	S06314S
S06315A	S06315D	S06315S	S06316A	S06316D	S06316S	S06317A	S06318A
S06319A	S06319D	S06319S	S0631AA	S0631AD	S0631AS	S06320A	S06320D
S06320S	S06321A	S06321D	S06321S	S06322A	S06322D	S06322S	S06323A
S06323D	S06323S	S06324A	S06324D	S06324S	S06325A	S06325D	S06325S
S06326A	S06326D	S06326S	S06327A	S06328A	S06329A	S06329D	S06329S
S0632AA	S0632AD	S0632AS	S06330A	S06330D	S06330S	S06331A	S06331D
S06331S	S06332A	S06332D	S06332S	S06333A	S06333D	S06333S	S06334A
S06334D	S06334S	S06335A	S06335D	S06335S	S06336A	S06336D	S06336S
S06337A	S06338A	S06339A	S06339D	S06339S	S0633AA	S0633AD	S0633AS
S06340A	S06340D	S06340S	S06341A	S06341D	S06341S	S06342A	S06342D
S06342S	S06343A	S06343D	S06343S	S06344A	S06344D	S06344S	S06349A
S06349D	S06349S	S06350A	S06346D	S06346S	S06347A	S06348A	S06349A
S06349D	S06349S	S0634AA	S0634AD	S0634AS	S06350A	S06350D	S06350S
S06351A	S06351D	S06351S	S06352A	S06352D	S06352S	S06353A	S06353D
S06353S	S06354A	S06354D	S06354S	S06355A	S06355D	S06355S	S06356A
S06356D	S06356S	S06357A	S06358A	S06359A	S06359D	S06359S	S0635AA
S0635AD	S0635AS	S06360A	S06360D	S06360S	S06361A	S06361D	S06361S
S06362A	S06362D	S06362S	S06363A	S06363D	S06363S	S06364A	S06364D
S06364S	S06365A	S06365D	S06365S	S06366A	S06366D	S06366S	S06367A
S06368A	S06369A	S06369D	S06369S	S06370A	S06370D	S06370S	S06371A

Diagnosis Codes							
S06371D	S06371S	S06372A	S06372D	S06372S	S06373A	S06373D	S06373S
S06374A	S06374D	S06374S	S06375A	S06375D	S06375S	S06376A	S06376D
S06376S	S06377A	S06378A	S06379A	S06379D	S06379S	S0637AA	S0637AD
S0637AS	S06380A	S06380D	S06380S	S06381A	S06381D	S06381S	S06382A
S06382D	S06382S	S06383A	S06383D	S06383S	S06384A	S06384D	S06384S
S06385A	S06385D	S06385S	S06386A	S06386D	S06386S	S06387A	S06388A
S06389A	S06389D	S06389S	S0638AA	S0638AD	S0638AS	S064X0A	S064X0D
S064X0S	S064X1A	S064X1D	S064X1S	S064X2A	S064X2D	S064X2S	S064X3A
S064X3D	S064X3S	S064X4A	S064X4D	S064X4S	S064X5A	S064X5D	S064X5S
S064X6A	S064X6D	S064X6S	S064X7A	S064X8A	S064X9A	S064X9D	S064X9S
S064XAA	S064XAD	S064XAS	S065X0A	S065X0D	S065X0S	S065X1A	S065X1D
S065X1S	S065X2A	S065X2D	S065X2S	S065X3A	S065X3D	S065X3S	S065X4A
S065X4D	S065X4S	S065X5A	S065X5D	S065X5S	S065X6A	S065X6D	S065X6S
S065X7A	S065X8A	S065X9A	S065X9D	S065X9S	S065XAA	S065XAD	S065XAS
S066X0A	S066X0D	S066X0S	S066X1A	S066X1D	S066X1S	S066X2A	S066X2D
S066X2S	S066X3A	S066X3D	S066X3S	S066X4A	S066X4D	S066X4S	S066X5A
S066X5D	S066X5S	S066X6A	S066X6D	S066X6S	S066X7A	S066X8A	S066X9A
S066X9D	S066X9S	S066XAA	S066XAD	S066XAS	S06890A	S06890D	S06890S
S06891A	S06891D	S06891S	S06892A	S06892D	S06892S	S06893A	S06893D
S06893S	S06894A	S06894D	S06894S	S06895A	S06895D	S06895S	S06896A
S06896D	S06896S	S06897A	S06898A	S06899A	S06899D	S06899S	S0689AA
S0689AD	S0689AS	S069X0A	S069X0D	S069X0S	S069X1A	S069X1D	S069X1S
S069X2A	S069X2D	S069X2S	S069X3A	S069X3D	S069X3S	S069X4A	S069X4D
S069X4S	S069X5A	S069X5D	S069X5S	S069X6A	S069X6D	S069X6S	S069X7A
S069X8A	S069X9A	S069X9D	S069X9S	S069XAA	S069XAD	S069XAS	S06A0XA
S06A0XD	S06A0XS	S06A1XA	S06A1XD	S06A1XS	S0990xA	S0990xD	S0990xS

31.2.17.1 Ambulatory Electroencephalogram

Ambulatory electroencephalographic monitoring is a benefit of the CSHCN Services Program with the following diagnosis codes:

Diagnosis Codes							
F05	F060	F0670	F0671	F068	G253	G40001	G40009
G40011	G40019	G40101	G40109	G40111	G40119	G40201	G40209
G40211	G40219	G40301	G40309	G40311	G40319	G40401	G40409
G40411	G40419	G40501	G40509	G40801	G40802	G40803	G40804
G40811	G40812	G40813	G40814	G40841	G40842	G40843	G40844
G4089	G40901	G40909	G40911	G40919	G40A11	G40A19	G40B01
G40B09	G40B11	G40B19	G40C01	G40C09	G40C11	G40C19	G912
G9381	G9389	P912	R561	R569	Z85020	Z85030	Z85040
Z85060	Z85110	Z85230	Z85520	Z85821	Z85841	Z85848	Z86011

Diagnosis Codes							
Z8669	Z87728	Z87798					

Procedure codes must be used when billing for ambulatory electroencephalograms:

Procedure Codes									
95700	95705	95706	95707	95708	95709	95710	95711	95712	95713
95714	95715	95716	95717	95718	95719	95720	95721	95722	95723
95724	95725	95726	95957						

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. When selecting the level of service provided, providers must follow either the 1995 or 1997 Documentation Guidelines for Evaluation and Management Services published by CMS.

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

Home/residence services are those services that are provided in a private residence, temporary lodging, or short-term accommodation (e.g., hotel, campground, hostel, or cruise ship), assisted living facility, group home (that is not licensed as an intermediate care facility for individuals with intellectual disabilities), custodial care facility, or residential substance abuse treatment facility.

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 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, 99344, and 99345 when billing for new patient services provided in the home/residence setting.

Providers may use procedure codes 99347, 99348, 99349, and 99350 when billing for established patient services provided in the home/residence setting.

A subsequent home/residence visit (procedure codes 99347, 99348, 99349, and 99350) billed on the same day as a new patient home/residence visit (procedure codes 99344 and 99345) by the same provider will be denied as part of another procedure billed on the same day, regardless of the diagnosis.

Subsequent home/residence evaluation and management procedure codes are limited to one per day regardless of diagnosis.

Office visits (procedure codes 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

31.2.18.2.1 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 inpatient/observation hospital visit (procedure codes 99231, 99232, and 99233) following admission is billed on the same day by the same provider as an emergency department visit (procedure codes 99281, 99282, 99283, 99284, and 99285), an office visit (procedure codes 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215), or an outpatient consultation (procedure codes 99242, 99243, 99244, and 99245), the subsequent hospital visit will be paid and the other visits will be denied.

One initial inpatient/observation consultation (procedure code 99252, 99253, 99254, or 99255) is allowed for each hospitalization within a 30-day period. Any subsequent consultation that is billed as an initial consultation during this time period will be denied.

A subsequent inpatient/observation 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.

31.2.18.2.2 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/observation or subsequent hospital visit (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.

31.2.18.2.3 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 up to six digits of the primary diagnosis codes match. 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.

31.2.18.3.1 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 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 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215), or outpatient consultation (procedure codes 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 inpatient/observation service (procedure codes 99238 and 99239) by the same provider.

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							
99242	99243	99244	99245	99252	99253	99254	99255

Office or outpatient consultations will be limited to one consultation every six-month period by the same provider for the same diagnosis. Subsequent office or outpatient consultation visits during this time period will be denied.

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.
- After-hours procedure codes are limited to one per day, same provider.

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 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								
99205	99215	99223	99233	99236	99245	99255	99345	99350

Prolonged services of less than 30 minutes duration should not be reported separately.

Procedure code 99417 should only be used when an outpatient evaluation and management service has been selected using time alone as the basis, and only after the minimum time required to report the addition to the code of the outpatient evaluation and management service has been exceeded by 15 minutes.

Procedure codes 99417 and 99418 are limited to 4 units (1 hour) per day and should not be used to report an additional time increment of less than 15 minutes.

Procedure code 99418 is only used when inpatient or observation evaluation and management service has been selected using time alone as the basis and only after the minimum time required to report the addition to the code of the inpatient and observation evaluation and management service has been exceeded by 15 minutes.

Physician standby service without face-to-face contact (procedure code 99360) is not a benefit of the CSHCN Services Program.

31.2.18.7 Observation Room Services

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" in Chapter 24, "Hospital."

Inpatient/observation care discharge day management (procedure codes 99238 and 99239) may be used to report services provided to a client upon discharge from "observation status" if the discharge date differs from the initial date of admission.

The following limitations apply to these procedure codes:

- Procedure codes 99211, 99212, 99213, 99214, 99215, 99221, 99222, and 99223 are denied if billed on the same day as procedure codes 99238 and 99239 by the same provider.
- If a physician inpatient/observation visit (procedure codes 99221, 99222, 99234, 99235, 99238, and 99239) is billed on the same day as prolonged services (procedure codes 99417 and 99418) by the same provider, the prolonged services are denied as part of another procedure on the same day.
- 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 Z00121 or Z00129 should be used for children's preventive care medical checkups. Diagnosis code Z0000 or Z0001 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 must 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 must be appended to the evaluation procedure code when the services rendered are distinct, provided for different diagnosis, or are performed for different reasons.

When the client visit is only for immunization, a preventive care visit will not be reimbursed. The administration fee and any vaccine or toxoid not obtained through Texas Vaccines for Children (TVFC) may be reimbursed when diagnosis code Z23 and the appropriate procedure code referencing an immunization is submitted with the claim.

Vaccinations, vaccine administration procedure codes, and laboratory services may be billed in addition to the preventive care E/M procedure code. Providers must 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.

Preventive care medical checkups are not a benefit of a telemedicine or telehealth service.

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.

31.2.18.9.1 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

31.2.18.9.2 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.

31.2.18.9.3 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.*

31.2.18.9.4 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.

31.2.18.9.5 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 required 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:

- The Ages and Stages Questionnaire (ASQ), Ages and Stages Questionnaire: Social - Emotional (ASQ:SE)
- Parents' Evaluation of Developmental Status (PEDS)
- The Modified Checklist for Autism in Toddlers (M-CHAT)
- The Modified Checklist for Autism in Toddlers, Revised with Follow-up (M-CHAT - R/F)
- The Survey of Well-being of Young Children (SWYC)

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.

Developmental screening procedure code 96110 and autism screening procedure code 96110 with modifier U6 may be reported separately when provided as part of a medical checkup or follow up visit. Developmental screening and testing may also be billed with other office visits when medically necessary.

Procedure codes 96110 and 96110 with modifier U6 are each limited to once per day, same provider and will be denied unless a checkup, follow up visit or office visit is paid for the same date of service by the same 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.

31.2.18.9.6 Developmental Testing

Procedure codes 96112 and 96113, which consists of an extended evaluation, require the use of a standardized tool and are limited to clients who are birth through 20 years of age. Procedure codes 96112 and 96113 are 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 codes 96112 and 96113:

Procedure Codes								
99202	99203	99204	99205	99211	99212	99213	99214	99215

Developmental testing procedure codes 96112 and 96113 are included in the system limitation of 12 hours of behavioral health services per day, per provider. Each additional 30 minutes may be reimbursed using add-on procedure code 96113. 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.

31.2.18.10.1 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 code Z00121 or Z00129.

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.*

31.2.18.10.2 Mental Health Screening

Mental health screening is a benefit at each preventive care medical checkup when it is provided in accordance with accepted guidelines or when a parent expresses concern about the client's mental health.

Mental health screening using one of the following validated, standardized mental health screening tools recognized by the CSHCN Services Program is required once per calendar year, any provider for clients who are 12 through 18 years of age:

- Pediatric Symptom Checklist (PSC-35)
- Pediatric Symptom Checklist for Youth (Y-PSC)
- Patient Health Questionnaire (PHQ-9)
- Patient Health Questionnaire (PHQ-9) Modified for Adolescents (PHQ-A [depression screen])
- Pediatric Symptom Checklist-17 (PSC-17)
- Car, Relax, Alone, Forget, Family, and Trouble Checklist (CRAFFT)
- Patient Health Questionnaire (PHQ-A [anxiety, eating problems, mood problems and substance use])
- Rapid Assessment for Adolescent Preventive Services (RAAPS)

Providers may be reimbursed separately when using one of the required screening tools during a preventive care medical checkup.

Procedure code 96160 or 96161 must be submitted for the required mental health screening. Procedure codes 96160 and 96161 are a benefit for clients who are 12 through 18 years of age.

Mental health screening at other medical checkups does not require the use of a validated, standardized mental health screening tool.

Procedure code 96160 or 96161 must be submitted on the same date of service and by the same provider as procedure code 99384, 99385, 99394, or 99395. Procedure codes 96160 and 96161 are limited to once per calendar year, any provider.

Procedure codes 96160 and 96161 will not be reimbursed for the same client for any date of service.

The client's medical record must include documentation identifying the tool that was used, the screening results, and any referrals.

31.2.18.10.3 Postpartum Depression Screening

Postpartum depression screening is a benefit of the CSHCN Services Program. Procedure codes G8431 and G8540 may be reimbursed when billing for postpartum depression screening.

Postpartum depression screening must be submitted under the infant's Medicaid client number.

Procedure codes G8431 and G8510 must be submitted on the same claim, for the same date of service, by the same provider as the checkup or follow-up visit procedure codes below:

Procedure Codes				
99211	99381	99382	99391	99392

Providers may receive separate reimbursement for postpartum depression screening in addition to the infant's preventive care medical checkup or follow-up visit. The reimbursement amount for procedure codes G8431 and G8510 covers all postpartum depression screenings provided during the checkup or follow-up visit.

Only one procedure code, either G8431 or G8510, may be reimbursed per provider in the 12 months following the infant's birth.

Postpartum Depression Screening and Referral Services

The American Academy of Pediatrics (AAP) recommends the infant's provider screen mothers for postpartum depression. Postpartum depression is the most common form of postpartum mood disturbance. Screening mothers for postpartum depression is appropriate for the general postpartum population.

> ***Note:*** *Screening for postpartum depression during the infant's preventive care medical checkup is recommended, not required.*

Postpartum depression meets the same clinical criteria as major depressive disorder, with the main difference being onset during pregnancy or after delivery.

While postpartum depression is the most common form of postpartum mood disturbance, providers should be aware that other mood disorders that may arise during the postpartum period include anxiety and panic disorders, obsessive-compulsive disorder, and postpartum psychosis.

Postpartum psychosis is a much more severe form of postpartum depression accompanied by psychotic features. Postpartum psychosis is rare, typically develops in the first few days to weeks after delivery, and is a psychiatric emergency requiring immediate medical attention.

In addition to postpartum psychosis, immediate or emergent medical attention may be necessary when the risk of imminent harm or danger is present.

Screening Guidelines

Screening using a validated tool is required. At a minimum, screening should occur at least once during the postpartum period. Validated tools may include the following:

- Edinburgh Postnatal Depression Scale
- Postpartum Depression Screening Scale
- Patient Health Questionnaire 9

Screening alone is inadequate for improving clinical outcomes. A positive screening for postpartum depression requires the THSteps provider to develop a referral plan with the mother.

Positive Screenings: Referrals and Follow-Up

Providers must discuss the screening results with the mother, discuss the possibility of depression, and the impact depression may have on the mother, family, and health of the infant.

The provider and mother should discuss the mother's options so the provider can refer her to an appropriate provider. Screening and referral is not contingent upon the mother's Medicaid eligibility. When needed, referrals should be made regardless of the funding source, including referral to local mental health authorities and local behavioral health authorities.

Providers should refer the mother to a provider who can perform further evaluation and determine an appropriate course of treatment. Appropriate providers include, but are not limited to:

- Mental health clinicians
- The mother's primary care provider
- Obstetricians and gynecologists
- Family physicians

Community resources such as Local Mental Health Authorities (LMHAs)

Resources should be provided for support in the interim until the mother is able to access care.

Scheduling a return visit for the infant sooner than the next scheduled visit may be appropriate in some cases.

Prior Authorization Requirements

Screening for postpartum mood disorders at the checkup or follow up visit does not require prior authorization.

While recommended, screening for postpartum depression is not a compulsory requirement of the infant visit.

Documentation Requirements

Documentation in the infant's record must include the name of the screening tool used and date the screening was completed.

If the mother screens positive for depression, at a minimum, the provider must note that a referral plan was discussed with the mother and a referral to a provider was made. Providers may give the mother a copy of the completed screening tool to take with her to referral appointments.

Documentation should also include any health education or anticipatory guidance provided, along with the time period recommended for the infant's next appointment.

31.2.18.10.4 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 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 (MAS) 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)

AFTs are a benefit of the CSHCN Services Program when submitted with procedure codes 95921, 95922, 95923, and 95924. Prior authorization is not required for AFTs.

Procedure codes 95921, 95922, 95923, and 95924 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	95875						

NCS Procedure Codes									
95885	95886	95887	95905	95907	95908	95909	95910	95911	95912
95913	95933	95937							

Prior authorization is not required for EMGs.

EMG and NCS are restricted to the following diagnosis codes:

Diagnosis Codes							
C701	C720	C721	D510	D511	D513	D518	D519

Diagnosis Codes							
D538	E0842	E0942	E1041	E1042	E10610	E1141	E1142
E1144	E11610	E1342	E5111	E5112	E512	E518	E519
E52	E530	E531	E538	E550	E559	E560	E568
E610	E7281	E7289	E7841	E7849	E786	E851	E852
E853	E8581	E8582	E8589	E859	G120	G121	G1221
G1222	G1223	G1224	G1225	G1229	G128	G129	G130
G243	G2589	G260	G320	G360	G370	G375	G501
G510	G511	G512	G5131	G5132	G5133	G5139	G514
G518	G519	G522	G523	G527	G528	G540	G541
G542	G543	G544	G545	G548	G549	G5601	G5602
G5603	G5611	G5612	G5613	G5621	G5622	G5623	G5631
G5632	G5633	G5641	G5642	G5643	G5681	G5682	G5683
G5691	G5692	G5693	G5701	G5702	G5703	G5711	G5712
G5713	G5721	G5722	G5723	G5731	G5732	G5733	G5741
G5742	G5743	G5751	G5752	G5753	G5761	G5762	G5763
G5771	G5772	G5773	G5781	G5782	G5783	G5791	G5792
G5793	G587	G588	G589	G590	G600	G601	G602
G603	G608	G609	G610	G6181	G6182	G6189	G619
G620	G621	G622	G6281	G6282	G629	G630	G650
G651	G652	G7000	G7001	G701	G702	G7081	G7089
G709	G7100	G7101	G7102	G7109	G7111	G7112	G7113
G7114	G7119	G7120	G7121	G71220	G71228	G7129	G713
G718	G719	G721	G722	G723	G7241	G7249	G7281
G7289	G729	G731	G733	G737	G800	G801	G802
G803	G804	G808	G809	G8311	G8312	G8313	G8314
G8321	G8322	G8323	G8324	G834	G8381	G8382	G8383
G8384	G8389	G839	G9009	G902	G904	G9050	G90511
G90512	G90513	G90519	G90521	G90522	G90523	G90529	G9059
G909	G950	G9511	G9519	G9520	G9529	G9581	G9589
G959	G990	G992	I776	I951	J3800	J3801	J3802
K5902	K5903	K5904	K5909	K592	K594	K624	K6289
M05411	M05412	M05421	M05422	M05431	M05432	M05441	M05442
M05451	M05452	M05461	M05462	M05471	M05472	M0549	M05511
M05512	M05521	M05522	M05531	M05532	M05541	M05542	M05551
M05552	M05561	M05562	M05571	M05572	M0559	M05711	M05712
M05721	M05722	M05731	M05732	M05741	M05742	M05751	M05752
M05761	M05762	M05769	M05771	M05772	M05779	M0579	M057A
M05811	M05812	M05821	M05822	M05831	M05832	M05841	M05842
M05851	M05852	M05861	M05862	M05871	M05872	M0589	M058A
M06011	M06012	M06021	M06022	M06031	M06032	M06041	M06042

Diagnosis Codes							
M06051	M06052	M06061	M06062	M06071	M06072	M0608	M0609
M060A	M06811	M06812	M06821	M06822	M06831	M06832	M06841
M06842	M06852	M06861	M06862	M06871	M06872	M0688	M0689
M068A	M069	M21271	M21272	M21331	M21332	M21511	M21512
M216X1	M216X2	M21831	M21832	M21931	M21932	M320	M3210
M3211	M3212	M3213	M3214	M3215	M3219	M328	M329
M3300	M3301	M3302	M3309	M3310	M3311	M3312	M3319
M3320	M3321	M3322	M3329	M3390	M3391	M3392	M3399
M340	M341	M342	M3481	M3482	M3483	M3489	M3500
M3501	M3502	M3503	M3504	M3505	M3506	M3507	M3508
M3509	M350A	M350B	M350C	M3581	M3589	M360	M4321
M4322	M4323	M4324	M4325	M4326	M4327	M4328	M436
M438X9	M4644	M4645	M4646	M4647	M4711	M4712	M4713
M4714	M4715	M4716	M4721	M4722	M4723	M4724	M4725
M4726	M4727	M4728	M47811	M47812	M47813	M47814	M47815
M47816	M47817	M47818	M47891	M47892	M47893	M47894	M47895
M47896	M47897	M47898	M4801	M4802	M4803	M4804	M4805
M48062	M4807	M4808	M5000	M5001	M50020	M50021	M50022
M50023	M5003	M5011	M50120	M50121	M50122	M50123	M5013
M5020	M5021	M50220	M50221	M50222	M50223	M5023	M5030
M5031	M50320	M50321	M50322	M50323	M5033	M5080	M5081
M50820	M50821	M50822	M50823	M5083	M5091	M50920	M50921
M50922	M50923	M5093	M5104	M5105	M5106	M5124	M5125
M5126	M5127	M5134	M5135	M51360	M51361	M51362	M51369
M51370	M51371	M51372	M51379	M5184	M5185	M5186	M5187
M5410	M5411	M5412	M5413	M5414	M5415	M5416	M5417
M5431	M5432	M5450	M5451	M5459	M546	M5489	M60011
M60012	M60021	M60022	M60031	M60032	M60041	M60042	M60044
M60045	M60046	M60051	M60052	M60061	M60062	M60070	M60071
M60073	M60074	M60076	M60077	M6008	M6009	M60111	M60112
M60121	M60122	M60131	M60132	M60141	M60142	M60151	M60152
M60161	M60162	M60171	M60172	M6018	M6019	M6090	M6250
M62511	M62512	M62519	M62521	M62522	M62529	M62531	M62532
M62539	M62541	M62542	M62549	M62551	M62552	M62559	M62561
M62562	M62569	M62571	M62572	M62579	M6258	M6259	M625A0
M625A1	M625A2	M625A9	M6281	M6284	M6285	M629	M7910
M7911	M7912	M7918	M792	M79601	M79602	M79604	M79605
M79621	M79622	M79631	M79632	M79641	M79642	M79651	M79652
M79661	M79662	M79671	M79672	M797	M961	N393	N3941
N3942	N3943	N3944	N3945	N3946	N39490	N39491	N39492

Diagnosis Codes							
N39498	N94819	R150	R151	R152	R159	R200	R201
R202	R203	R208	R209	R260	R261	R2681	R2689
R269	R290	R295	R29701	R29702	R29703	R29704	R29705
R29706	R29707	R29708	R29709	R29710	R29711	R29712	R29713
R29714	R29715	R29716	R29717	R29718	R29719	R29720	R29721
R29722	R29723	R29724	R29725	R29726	R29727	R29728	R29729
R29730	R29731	R29732	R29733	R29734	R29735	R29736	R29737
R29738	R29739	R29740	R29741	R29742	R320	R3914	R39191
R39192	R39198	R4702	R471	R4781	R4789	R498	R6884
S14101A	S14101D	S14101S	S14102A	S14102D	S14102S	S14103A	S14103D
S14103S	S14104A	S14104D	S14104S	S14105A	S14105D	S14105S	S14106A
S14106D	S14106S	S14107A	S14107D	S14107S	S14108A	S14108D	S14108S
S14109A	S14109D	S14109S	S14111A	S14111D	S14111S	S14112A	S14112D
S14112S	S14113A	S14113D	S14113S	S14114A	S14114D	S14114S	S14115A
S14115D	S14115S	S14116A	S14116D	S14116S	S14117A	S14117D	S14117S
S14118A	S14118D	S14118S	S14121A	S14121D	S14121S	S14122A	S14122D
S14122S	S14123A	S14123D	S14123S	S14124A	S14124D	S14124S	S14125A
S14125D	S14125S	S14126A	S14126D	S14126S	S14127A	S14127D	S14127S
S14128A	S14128D	S14128S	S14131A	S14131D	S14131S	S14132A	S14132D
S14132S	S14133A	S14133D	S14133S	S14134A	S14134D	S14134S	S14135A
S14135D	S14135S	S14136A	S14136D	S14136S	S14137A	S14137D	S14137S
S14138A	S14138D	S14138S	S14141A	S14141D	S14141S	S14142A	S14142D
S14142S	S14143A	S14143D	S14143S	S14144A	S14144D	S14144S	S14145A
S14145D	S14145S	S14146A	S14146D	S14146S	S14147A	S14147D	S14147S
S14148A	S14148D	S14148S	S14151A	S14151D	S14151S	S14152A	S14152D
S14152S	S14153A	S14153D	S14153S	S14154A	S14154D	S14154S	S14155A
S14155D	S14155S	S14156A	S14156D	S14156S	S14157A	S14157D	S14157S
S14158A	S14158D	S14158S	S142XXA	S142XXD	S142XXS	S143XXA	S143XXD
S143XXS	S144XXA	S144XXD	S144XXS	S145XXA	S145XXD	S145XXS	S148XXA
S148XXD	S148XXS	S149XXA	S149XXD	S149XXS	S24101A	S24101D	S24101S
S24102A	S24102D	S24102S	S24103A	S24103D	S24103S	S24104A	S24104D
S24104S	S24109A	S24109D	S24109S	S24111A	S24111D	S24111S	S24112A
S24112D	S24112S	S24113A	S24113D	S24113S	S24114A	S24114D	S24114S
S24131A	S24131D	S24131S	S24132A	S24132D	S24132S	S24133A	S24133D
S24133S	S24134A	S24134D	S24134S	S24141A	S24141D	S24141S	S24142A
S24142D	S24142S	S24143A	S24143D	S24143S	S24144A	S24144D	S24144S
S24151A	S24151D	S24151S	S24152A	S24152D	S24152S	S24153A	S24153D
S24153S	S24154A	S24154D	S24154S	S242XXA	S242XXD	S242XXS	S243XXA
S243XXD	S243XXS	S244XXA	S244XXD	S244XXS	S248XXA	S248XXD	S248XXS
S249XXA	S249XXD	S249XXS	S34109A	S34109D	S34109S	S34111A	S34111D

Diagnosis Codes							
S34111S	S34112A	S34112D	S34112S	S34113A	S34113D	S34113S	S34114A
S34114D	S34114S	S34115A	S34115D	S34115S	S34121A	S34121D	S34121S
S34122A	S34122D	S34122S	S34123A	S34123D	S34123S	S34124A	S34124D
S34124S	S34125A	S34125D	S34125S	S34131A	S34131D	S34131S	S34132A
S34132D	S34132S	S34139A	S34139D	S34139S	S3421XA	S3421XD	S3421XS
S3422XA	S3422XD	S3422XS	S343XXA	S343XXD	S343XXS	S344XXA	S344XXD
S344XXS	S345XXA	S345XXD	S345XXS	S4400XA	S4400XD	S4400XS	S4400XX
S4401XA	S4401XD	S4401XS	S4402XA	S4402XD	S4402XS	S4410XA	S4410XD
S4410XS	S4411XA	S4411XD	S4411XS	S4412XA	S4412XD	S4412XS	S4420XA
S4420XD	S4420XS	S4421XA	S4421XD	S4421XS	S4422XA	S4422XD	S4422XS
S4430XA	S4430XD	S4430XS	S4431XA	S4431XD	S4431XS	S4432XA	S4432XD
S4432XS	S4440XA	S4440XD	S4440XS	S4441XA	S4441XD	S4441XS	S4442XA
S4442XD	S4442XS	S4450XA	S4450XD	S4450XS	S4451XA	S4451XD	S4451XS
S4452XA	S4452XD	S4452XS	S448X1A	S448X1D	S448X1S	S448X2A	S448X2D
S448X2S	S448X9A	S448X9D	S448X9S	S4490XA	S4490XD	S4490XS	S4491XA
S4491XD	S4491XS	S4492XA	S4492XD	S4492XS	S5400XA	S5400XD	S5400XS
S5401XA	S5401XD	S5401XS	S5402XA	S5402XD	S5402XS	S5410XA	S5410XD
S5410XS	S5411XA	S5411XD	S5411XS	S5412XA	S5412XD	S5412XS	S5420XA
S5420XD	S5420XS	S5421XA	S5421XD	S5421XS	S5422XA	S5422XD	S5422XS
S5430XA	S5430XD	S5430XS	S5431XA	S5431XD	S5431XS	S5432XA	S5432XD
S5432XS	S5490XA	S5490XD	S5490XS	S5491XA	S5491XD	S5491XS	S5492XA
S5492XD	S5492XS	S6400XA	S6400XD	S6400XS	S6401XA	S6401XD	S6401XS
S6402XA	S6402XD	S6402XS	S6410XA	S6410XD	S6410XS	S6411XA	S6411XD
S6411XS	S6412XA	S6412XD	S6412XS	S6420XA	S6420XD	S6420XS	S6421XA
S6421XD	S6421XS	S6422XA	S6422XD	S6422XS	S6430XA	S6430XD	S6430XS
S6431XA	S6431XD	S6431XS	S6432XA	S6432XD	S6432XS	S64490A	S64490D
S64490S	S64491A	S64491D	S64491S	S64492A	S64492D	S64492S	S64493A
S64493D	S64493S	S64494A	S64494D	S64494S	S64495A	S64495D	S64495S
S64496A	S64496D	S64496S	S64497A	S64497D	S64497S	S64498A	S64498D
S64498S	S648X1A	S648X1D	S648X1S	S648X2A	S648X2D	S648X2S	S648X9A
S648X9D	S648X9S	S6490XA	S6490XD	S6490XS	S6491XA	S6491XD	S6491XS
S6492XA	S6492XD	S6492XS	S7401XA	S7401XD	S7401XS	S7402XA	S7402XD
S7402XS	S7411XA	S7411XD	S7411XS	S7412XA	S7412XD	S7412XS	S7421XA
S7421XD	S7421XS	S7422XA	S7422XD	S7422XS	S748X1A	S748X1D	S748X1S
S748X2A	S748X2D	S748X2S	S7491XA	S7491XD	S7491XS	S7492XA	S7492XD
S7492XS	S8401XA	S8401XD	S8401XS	S8402XA	S8402XD	S8402XS	S8410XS
S8411XA	S8411XD	S8411XS	S8412XA	S8412XD	S8412XS	S8421XA	S8421XD
S8421XS	S8422XA	S8422XD	S8422XS	S84801A	S84801D	S84801S	S84802A
S84802D	S84802S	S8491XA	S8491XD	S8491XS	S8492XA	S8492XD	S8492XS
S9421XA	S9421XD	S9421XS	S9422XA	S9422XD	S9422XS	S9431XA	S9431XD

Diagnosis Codes							
S9431XS	S9432XA	S9432XD	S9432XS	S948X1A	S948X1D	S948X1S	S948X2A
S948X2D	S948X2S	S948X9A	S948X9D	S948X9S	S9490XA	S9490XD	S9490XS
S9491XA	S9491XD	S9491XS	S9492XA	S9492XD	S9492XS	T85840A	T85840D
T85840S							

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.

31.2.19.2.1 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 one service 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.

Procedure codes 95872 and 95875 may be reimbursed up to two services per day, same provider.

31.2.19.2.2 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 2 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 on the same day, by the same provider.

Prior authorization is required for NCS for any diagnosis other than those listed above or when the anticipated number of studies planned for an evaluation exceeds the maximum number of studies, per date of service, by the same provider:

NCS Procedure Code	Studies Allowed per Date of Service
95937	3

Claims for nerve conduction studies that are denied for exceeding the maximum number of studies allowed per day may be appealed with documentation of medical necessity.

Prior authorization is required for more than three studies per day. Documentation must be submitted to establish medical necessity for the additional studies, including one or more of the following:

- Additional diagnoses to be considered
- Clinical signs, symptoms, or electrodiagnostic findings that necessitate the consideration of the additional diagnosis

Requests must include documentation supporting medical necessity for the number of studies requested, and they must be received on or before the requested DOS.

Medical record documentation must establish medical necessity for any additional studies, including one or more of the following:

- Other diagnoses in the differential requires consideration. The provider must identify both of 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).

NCS prior authorization requests must be submitted by the ordering provider on the CSHCN Services Program Authorization and Prior Authorization Request Form. The form must be signed and dated by the ordering provider.

Note: *An APRN or a physician assistant (PA) may sign all documentation related to the provision of evoked response tests and neuromuscular procedures 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 blocks are required.*

Refer to: Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" 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)

Prior authorization is not required for EP procedures.

Each EP test (procedure codes 92650, 92651, 92652, 92653, 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.

31.2.19.3.1 Vestibular Evoked Myogenic Potentials (VEMP)

VEMP testing procedure codes 92517, 92518, and 92519 are benefits of the CSHCN Services Program.

Some conditions under which VEMP testing (procedure codes 92517, 92518, and 92519) may be appropriate include:

- Evaluation of chronic symptoms of pressure, tinnitus, disorientation, or chronic vertigo after all other recommended vestibular tests are completed and is lacking a definitive diagnosis.
- Evaluation after a positive CT scan for Superior Semicircular Canal Dehiscence Syndrome (SCDS).

Documentation must include the following:

- The other differential diagnoses under consideration
- The additional diagnoses considered
- The clinical signs, symptoms or electrodiagnostic findings that necessitated the inclusion

VEMP testing must be medically indicated, and reimbursement requires one of the diagnosis codes listed:

Diagnosis Codes							
H81311	H81312	H81313	H81319	H81391	H81392	H81393	H81399
H814	H818X1	H818X2	H818X3	H818X9	H8190	H8191	H8192
H8193	H821	H822	H823	H829	H8301	H8302	H8303
H8309	H8311	H8312	H8313	H8319	H832X1	H832X2	H832X3
H832X9	H833X1	H833X2	H833X3	H833X9	H838X1	H838X2	H838X3
H838X9	H8390	H8391	H8392	H8393	H9311	H9312	H9313
H9319	R110	R111	R112	R42			

VEMP testing is not medically necessary for any other indications and will not be covered.

All of the following criteria are documentation requirements for VEMP testing:

- For each VEMP test performed, the referral reason must include a clear diagnostic impression documented in the client's medical record.
- Medical necessity for the VEMP test must be clearly documented in the client's medical record and reflect the actual results of specific tests (which could include latency and amplitude).
- Medical necessity for client reevaluation after the initial consultation and testing must be clearly documented in the client's medical record. Supporting documentation must include the following:
    - New symptoms unrelated to previously evaluated symptoms that may result in a new diagnosis

- Rapidly changing client condition documentation supported by the following:
  - Diagnosis
  - Current clinical signs and symptoms
  - Prior clinical condition
  - Expected clinical disease course
  - Clinical benefit of additional studies

The client's medical records are subject to retrospective review.

31.2.19.3.2 Intraoperative Neurophysiology Monitoring (IONM)

Intraoperative neurophysiology monitoring (procedure codes 95940 and 95941) are a benefit when performed in addition to each evoked potential test on the same day. Prior authorization is not required for intraoperative neurophysiology monitoring.

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, per same procedure, by any provider.

Procedure code 95940 and 95941 must be billed in conjunction with one of the following procedure codes on the same day, by the same provider, or the service will be denied:

Procedure Codes									
95822	95860	95861	95863	95864	95865	95866	95867	95868	95869
95870	95907	95908	95909	95910	95911	95912	95913	95925	95926
95927	95928	95929	95930	95933	95937	95938	95939		

Procedure codes 95940 and 95941 cannot be reported by the surgeon or anesthesiologist.

31.2.19.4 Motion Analysis Studies (MAS)

MA studies (procedure codes 96000, 96001, and 96002) will be considered for reimbursement through the CSHCN Services Program for clients who are 3 through 20 years of age and have a diagnosis of, but not limited to, cerebral palsy, traumatic brain injury, myelomeningocele, or stroke. Motion analysis is most often used as a diagnostic tool for clients with neuromuscular conditions, primarily as part of the surgical decision-making process when all conservative measures have been exhausted and surgical intervention is being considered.

Procedure codes 96000, 96001, and 96002 are limited to one per date of service by the same provider and two per year, any provider.

Procedure code 96000 will be denied if billed with 96001 by the same provider for the same date of service.

Procedure codes 95860, 95861, 95863, 95864, 95865, 95866, 95869, 95870, and 95872 will be denied if billed with 96002 by the same provider for the same date of service.

Prior authorization requests for a diagnosis other than cerebral palsy, traumatic brain injury, myelomeningocele, or stroke, or for more than two services per year, will be considered with medical necessity on a case-by-case basis upon review by the CSHCN Services Program medical director or designee.

Prior authorization requests for MA studies must include documentation with the following information that indicates the client meets all the requirements for MA studies:

- 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

Providers must complete the CSHCN Services Program Authorization and Prior Authorization Request Form for MA studies prior authorization requests.

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

31.2.20 Extracapsular Cataract Removal

Extracapsular cataract removal (procedure codes 66989 and 66991) is a benefit of the CSHCN Services Program for clients who are 21 years of age or older.

Procedure codes 66989 and 66991 are limited to the following diagnosis codes:

Diagnosis Codes					
H401111	H401112	H401121	H401122	H401131	H401132

Procedure codes 66989 and 66991 are limited to two services per lifetime, and must be billed with modifier LT or RT to identify the eye on which the service was performed.

Procedure code 66989 is denied if billed on the same date of service by the same provider as procedure code 67015, 67025, 67027, 67030, or 67031.

31.2.21 Extracorporeal Shock Wave Lithotripsy (ESWL)

Procedure code 50590 is a benefit for the following diagnosis codes:

Diagnosis Codes							
N130	N131	N132	N1330	N1339	N200	N201	N202
N209	N219	N22					

All claims received for ESWL must include one of these diagnoses.

31.2.22 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 18.2.4.1, "Gastrostomy Devices" in Chapter 18, "Expendable Medical Supplies" for more information about documentation requirements, limitations, and additional devices.

Chapter 18, "Expendable Medical Supplies" for more information about related supplies and equipment.

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

31.2.23 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									
96041	99213	99214	99215	99244	99245	99254	99255	99402	99404

Office or other outpatient consultations (procedure codes 99244, 99245, or 99404) are limited to once every 3 years. One office or other outpatient 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 or observation consultations (procedure code 99254 or 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.

31.2.23.1 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."

31.2.23.2 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.

31.2.23.3 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.

31.2.23.4 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 25.2.5.2, "Cytogenetics Testing" in Chapter 25, "Laboratory Services" for more information on cytogenetic testing.

31.2.24 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.

31.2.24.1 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 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" 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
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
***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
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
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 osteo-myelitis - initial authorization	40	10	Evidence of unsatisfactory clinical response to conventional multidisci-plinary treatment
Refractory osteo-myelitis - one subsequent authorization	15	5	Evidence of 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
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
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.

31.2.25 Immunizations (Vaccines and Toxoids)

Vaccines and vaccine administration, as recommended by the Advisory Committee on Immunization Practices (ACIP), is a benefit of the Children with Special Health Care Needs (CSHCN) Services Program.

A vaccine stimulates a person's immune system to produce immunity to a disease, thereby providing protection from that disease.

Vaccines may be administered orally, nasally, or by subcutaneous or intramuscular injection.

Providers must follow current ACIP recommendations; however, in the event of conflict, providers are required to more closely follow the Texas Vaccines for Children (TVFC) guidelines.

31.2.25.1 Texas Vaccines for Children (TVFC) Program

The CSHCN Services Program encourages providers administering vaccines to enroll in TVFC. Providers interested in enrollment information for TVFC may call the Department of State Health Services (DSHS), Immunizations Branch at 1-800-252-9152 or access the TVFC website at www.dshs.texas.gov/immunize/tvfc/.

If the provider is enrolled in TVFC, the provider must screen the client and, if indicated, immunize the client using TVFC-obtained vaccine.

Providers must provide the appropriate vaccine information statements (VISs) produced by the Centers for Disease Control and Prevention (CDC) to each client. VISs explain the benefits and risks of the vaccine.

31.2.25.2 Documentation Recommendations

Providers must document the following information in the client's medical record for each vaccine administered:

- The vaccine given
- The date of the vaccine administration (day, month, year)
- The name of the vaccine manufacturer
- The vaccine lot number
- The signature and title of the person who administered the vaccine
- The location of where the vaccine was administered
- The publication date of the VIS issued to the client, parent, or guardian

If a vaccine was administered outside of ACIP's recommended routine immunization schedules, the reason must be included in the client's medical record. Reasons for administering a vaccine outside the routine schedule may include but are not limited to:

- An impaired immune system.
- Suspected exposure to a disease.

The client's medical records are subject to retrospective review to determine whether the utilization and reimbursement of this service was appropriate.

Procedure codes 90460 and 90461 include counseling by a qualified healthcare professional. Documentation of the counseling must be noted in the client's medical record.

31.2.25.3 Vaccine Reporting to the DSHS

All administered vaccines and toxoids must be reported to DSHS. DSHS submits all reported vaccinations with consent to a centralized repository of immunization histories. This repository is known in Texas as ImmTrac2.

Note: *Documentation of the injection site is recommended, but not required.*

31.2.25.3.1 Vaccine Adverse Event Reporting System (VAERS)

VAERS encourages providers to report any adverse event that occurs after a vaccine has been administered. Even if the provider is unclear whether the adverse event was caused by the vaccine, it should still be reported. The National Childhood Vaccine Injury Act (NCVIA) requires health care providers to report:

- "Any adverse event listed by the vaccine manufacturer as a contraindication to subsequent doses of the vaccine.
- "Any reaction that is listed in the VAERS Reportable Events Table that occurs within the specified time period post vaccination.

A copy of the Reportable Events Table can be obtained by calling VAERS at 1-800-822-7967 or by downloading it from https://vaers.hhs.gov/resources/materials.html.

31.2.25.4 Authorization Requirements

Authorization is not required for any vaccine or its associated administration fee. Providers enrolled in TVFC are responsible for determining the eligibility of clients to receive TVFC reimbursement.

31.2.25.5 Vaccine Reimbursement

The diagnosis code Z23 should be reported regardless of the type of encounter when a vaccine was given. It must be reported and linked to both the vaccine product and the vaccine administration code.

When the client visit is only for vaccine administration, diagnosis code Z23 should be used as the appropriate vaccine diagnosis code.

When vaccines are given during a preventive health visit (e.g., well child exam), diagnosis code Z23 will follow the age appropriate diagnosis code for the preventive health visit.

When the client visit is only for vaccine administration, the office visit will not be reimbursed.

If a vaccine is administered as part of a preventive health visit (e.g., well child exam), or a visit due to a medical condition, the office visit will be reimbursed in addition to the vaccine given.

Reimbursement may be considered for any vaccine if it is not obtained through TVFC but has been recommended by ACIP and approved by the Health and Human Services Commission (HHSC).

Each vaccine and its administration must be submitted on the same claim in the following sequence: the vaccine procedure code immediately followed by the applicable vaccine administration procedure code(s). All of the vaccine administration procedure codes that correspond to a single vaccine procedure code must be submitted on the same claim as the vaccine procedure code.

Vaccines that are purchased by a provider may be reimbursed if the state-defined modifier U4 is billed with the vaccine 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.

Providers purchasing the vaccine are reimbursed the lower of the billed amount for the vaccine or the amount allowed by Texas Medicaid or the maximum fee established by the CSHCN Services Program. The maximum fee will be determined from the least average wholesale price (AWP) per vaccine dose according to the current information reflected in the Texas Vendor Drug Program system.

Providers must submit claims for procedure codes 90460 (administration of first/only component of vaccine, with counseling) and 90461 (administration of each additional vaccine component, with counseling) based on the number of components per vaccine.

31.2.25.6 Vaccine Administration

Procedure code 90460 must be submitted for the administration of the first component.

Procedure code 90461 must be 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.

Procedure codes 90471, 90472, 90473, and 90474 do not require counseling and can be reimbursed at any age.

RSV monoclonal antibodies (nirsevimab, procedure codes 90380 and 90381) may be administered to clients who are birth through 19 months of age.

Administration of nirsevimab (procedure codes 96380 and 96381) are limited to two per lifetime.

The age ranges for vaccine administration are listed in the following table:

Procedure Codes	Age Range
90460	Birth through 18 years of age
90461	Birth through 18 years of age
90471	All ages
90472	All ages
90473	All ages
90474	All ages
90653	65 years of age or older
96372	All ages
96372	All ages
96374	All ages
96380	Birth through 19 months of age
96381	Birth through 19 months of age

31.2.25.6.1 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 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.*

31.2.25.6.2 Administration Without Counseling

Procedure codes 90471, 90472, 90473, and 90474 may be reimbursed per vaccine based on the route 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

31.2.25.7 Vaccine and Toxoid Procedure Codes

The vaccine procedure codes listed in the following table are benefits of the CSHCN Services Program.

Note: *A component refers to all antigens in a vaccine that prevent disease(s) caused by one organism. Combination vaccines are those vaccines that contain multiple components. All procedure codes with an asterisk (*) can be distributed through TVFC.*

Procedure Code	Age Range	Number of Recognized Components
90287	All ages	1
90585	All ages	1
90611	18 years of age and older	1
90619	19 years of age and older	1
90620*	All ages	1
90621*	All ages	1
90623	10 years of age through 23 years of age	1
90632*	Birth through 20 years of age	1
90633*	Birth through 20 years of age	2
90636*	All ages	2
90647*	All ages	1
90648*	All ages	1
90651*	All ages	1
90670*	All ages	1
90678	10 years of age and older	1
90680*	Birth through 11 months of age	1
90681*	All ages	1
90684	19 years of age or older	1
90696*	4 years of age through 6 years of age	4
90698*	All ages	5
90700*	Birth through 6 years of age	3
90702*	Birth through 6 years of age	2
90707*	All ages	3
90710*	All ages	4
90713*	All ages	1
90714*	7 years of age and older	2
90715*	7 years of age and older	3
90716*	All ages	1
90723*	All ages	5
90732*	2 years of age and older	1
90733*	All ages	1
90734*	All ages	1
90736	60 years of age and older	1

90739	18 years of age and older	1
90740	All ages	1
90743*	All ages	1
90744*	All ages	1
90746*	All ages	1
90747	All ages	1
90748	All ages	2
90749	All ages	1
90750	50 years of age and older	1

Procedure code 90670 is limited to one per day for clients who are birth through five years of age, same procedure, any provider, and to one per lifetime for clients who are age six and older.

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)

31.2.25.8 Influenza Vaccines

The Advisory Committee on Immunization Practices (ACIP) reviews the composition of influenza vaccines annually and frequently makes updates to their recommendations. Providers should refer to the Centers for Disease Control and Prevention (CDC) website for current recommendations.

Providers should refer to the TVFC website for the most up-to-date list of the influenza vaccines that TVFC is distributing for clients and their age group for the current flu season.

Reimbursement for influenza vaccines is limited to three occurrences per one rolling year. Claims submitted for any influenza vaccine beyond three occurrences in a rolling year will be denied.

The age ranges for influenza vaccines are listed in the following table:

Procedure Code	Age Range
90655	6 months of age through 35 months of age
90656	3 years of age and older
90657	6 months of age through 35 months of age
90658	3 years of age and older
90660	All ages
90661	All ages
90662	All ages
90672	All ages
90673	All ages
90674	All ages
90682	18 years of age and older
90685	6 months of age through 35 months of age
90686	All ages
90687	6 months of age through 35 months of age

90688	All ages
90756	4 years of age and older

31.2.25.9 Bacille Calmette-Guerin (BCG) Vaccine

BCG vaccine (procedure code 90585) is a benefit of the CSHCN Services Program for diagnosis code Z23.

31.2.25.10 Botulinum Antitoxin

Procedure code 90287 is a benefit of the CSHCN Services Program for diagnosis code A051, A4851, A4852, or one of the following diagnosis codes for botulinum overdose or misinjection:

Diagnosis Codes							
T50901A	T50901D	T50901S	T50902A	T50902D	T50902S	T50903A	T50903D
T50903S	T50904A	T50904D	T50904S	T50991A	T50991D	T50991S	T50992A
T50992D	T50992S	T50993A	T50993D	T50993S	T50994A	T50994D	T50994S
T50Z91A	T50Z91D	T50Z91S	T50Z92A	T50Z92D	T50Z92S	T50Z93A	T50Z93D
T50Z93S	T50Z94A	T50Z94D	T50Z94S				

31.2.25.11 Hepatitis B Vaccine

Procedure codes 90740 and 90747 are not considered routine vaccines and must be billed using administration procedure code 96372 or 96374.

31.2.25.12 Rabies Postexposure Prophylaxis

Postexposure prophylaxis for rabies (procedure codes 90375, 90376, 90377, 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 wh

21o 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 Z203.

Injection administration is a benefit for administration of postexposure rabies vaccine.

31.2.25.13 Respiratory Syncytial 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 Services Program Synagis Prior Authorization form.

Providers may refer to the Texas Vendor Drug Program website at www.txvendordrug.com/formulary/respiratory-syncytial-virus-treatment for more information about obtaining palivizumab for CSHCN Services Program clients.

Prior authorization request forms are reviewed annually. Providers must use the most current version of the CSHCN Synagis Prior Authorization Request (HHS Form 1055) to submit prior authorization requests. Forms received outside the RSV season schedule will not be processed.

31.2.26 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.

Providers dispensing physician-administered drugs in an outpatient setting may utilize an optional delivery method referred to as "white bagging," in which the treating provider submits prescriptions to pharmacies and the prescription is shipped or mailed to the provider's office. Providers must use the following steps for this delivery method:

1) The treating provider identifies a CSHCN Services Program-enrolled client.

2) The treating provider or treating provider's agent sends a single prescription with no additional refills to a CSHCN Services Program-enrolled pharmacy and obtains any necessary prior authorizations. (The provider must write a new prescription for any additional refills.)

3) Once approved, the dispensing pharmacy fills the prescription and overnight ships an individual dose of the medication, in the name of the CSHCN Services Program client, directly to the treating provider. These medications must not be used on any other patient and cannot be returned to the pharmacy for credit.

4) The treating provider administers the medication to the CSHCN Services Program client in the office setting. The treating provider bills for an administration fee and any medically necessary service provided at time of administration. The treating provider must not bill the CSHCN Services Program for the drug.

Note: *Providers may perform other services in addition to any evaluation and management during the client's white bagging medication administration visit, such as: administering other medications or immunizations maintained in the office, administering treatments, X-rays, or labs.*

31.2.26.1 Reimbursement for the Unused Portion of the Single-Dose Vial

Providers may bill and receive reimbursement for the unused portion of weight-based or variable dosing clinician-administered drugs (CADs) manufactured only in single-dose vials.

Providers must also include modifier JW on their claims for consideration of reimbursement. The JW modifier on the claim will identify the unused portion and discarded portion of the vial contents.

This only applies to medical claims for weight-based or variable dosing CADs billed with HCPCS procedure codes, manufactured only in single-dose vials, and provided in a professional or outpatient setting.

31.2.26.2 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 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.

31.2.26.3 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 5.6.2.4, "National Drug Codes (NDC)" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for more information.

Section 5.6.2.5, "Drug Rebate Program" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" 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.

31.2.26.4 JW Modifier Claims Filing Instructions

Providers must not use the JW modifier for medications manufactured in a multi-dose vial format.

Providers must choose the most appropriate vial size(s) required to prepare a dose to minimize the discarded portion of the vial payable.

Claims considered for reimbursement must not exceed the package size of the vial used for preparation of the dose. Providers must not bill for vial contents overfill.

Providers must not use the JW modifier when the actual dose of the drug or biological administered is less than the billing unit.

Example: One billing unit for a drug is equal to 10mg of the drug in a single use vial. A 7mg dose is administered to a client while 3mg of the remaining drug is discarded. The 7mg dose is billed using one billing unit that represents 10mg on a single line item. The single line item of 1 unit would process for payment of the total 10mg of drug administered and discarded. Billing another unit on a separate line item with the JW modifier for the discarded 3mg of drug is not permitted because it would result in overpayment. Therefore, when the billing unit is equal to or greater than the total actual dose and the amount discarded, the use of the JW modifier is not permitted.

Reimbursement for JW modifier claims is only available for drugs covered in an outpatient setting.

Inpatient and diagnostic radiopharmaceuticals claims are not eligible for reimbursement, and may not include the JW modifier.

Coverage is for "buy and bill" providers only. Specialty pharmacies billing through the medical benefit must not submit claims with a JW modifier because they are unaware of how much the provider administered or discarded.

Federally Qualified Health Center (FQHC) and Rural Healthcare Clinic RHC) are not eligible to bill with the JW modifier because these providers do not bill for the coverage of drugs or biologicals separately.

Critical Access Hospitals (CAH) are eligible to bill with the JW modifier because these providers bill for the coverage of drugs or biologicals separately.

The JW modifier is not allowed for medications prepared in an institutional setting via "batch processing or bulk productions" methods. An example of a batch processing method is when a hospital or repackaging facility produces multiple non-patient specific doses of medications in advance of anticipated use. These preparations are labeled and distributed with client specific information only when orders are received. Because these doses may be recycled for other client use, they are not eligible.

Providers may utilize automatic systems to calculate dose and discard amounts. However, providers must continue to document the exact usage/discard accurately.

Providers must enter the dose administered (used portion) line item detail of the CAD and also enter the dose discarded (unused portion) line item detail of the CAD on the same claim. The dose discarded (unused portion) line item detail must include the JW modifier to be considered for reimbursement. When billing for reimbursement of wastage on an outpatient claim, the HCPCS and Current Procedural Terminology (CPT) code should always be provided along with the revenue code.

31.2.26.5 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)
Alglucosidase alfa	J0220	Diagnosis limitations: E7400, E7401, E7402, E7403, E7404, E7409
Andexxa	J7169	Restricted to clients who are 18 years of age or older
Anifrolumab-fnia	J0491	Restricted to clients who are 18 years of age or older
Antithrombin	J7197	Diagnosis limitations: D6800, D6801, D68020, D68021, D68022, D68023, D68029, D6803, D6804, D6809, D6851, D6852, D6859, D6861, D6862, D6869, D75821, D75822, D75828, D75829, D75838, D7584
Avalglucosidase Alfa-ngpt	J0219	Restricted to clients who are 1 year of age or older
Azacitidine (Vidaza)	J9025	Benefit for clients 13 years of age or older Diagnosis limitations: C9200, C9202, C9210, C9212, C9220, C9222, C9232, C9242, C9252, C9262, C9290, C9292, C92A2, C92Z0, C92Z2, C9310, C9312, C9330, C9332, C9502, C9510, C9512, C9592, D460, D461, D4621, D4622, D469, D46A, D46B, D46C, D640, D641, D642, D643 Must be submitted with an 11-digit NDC
Bevacizumab-maly (Alymsys)	Q5126	Restricted to clients who are 18 years of age or older
Blood Factor Product VIII (Jivi)	J7208	N/A
Bupivacaine	J0665	Restricted to clients who are 18 years of age or older
Cabotegravir (Apretude)	J0739	Restricted to clients who are 10 years of age or older
Cantharidin	J7354	Restricted to clients who are 2 years of age or older Diagnosis limitation: B081
Cidofovir	J0740	N/A
Ciltacabtagene autoleucel	Q2056	Restricted to clients who are 18 years of age or older
(Diagnosis limitations) The procedure code must be billed with one of the codes listed.		

Name of Injection	Procedure Code(s)	Limitation(s)
Clofarabine (Clorar)	J9027	Prior authorization is required. Requests for prior authorization must be submitted by the ordering provider using the CSHCN Services Program Authorization and Prior Authorization Request Form. Documentation of the following must be submitted with the prior authorization request form: • Diagnosis code C9100 or C9102 • At least 2 prior failed regimens
Coagulation Factor IX (Ixinity)	J7213	Restricted to clients who are 12 years of age or older
C1 Esterase Inhibitor (Human) (Cinryze)	J0598	Restricted to clients who are 6 years of age or older
C1 Esterase Inhibitor (Human) (Haegarda)	J0599	Restricted to clients who are 6 years of age or older Diagnosis limitation: D841
C1 Esterase Inhibitor (Recombinant) (Ruconest)	J0596	Restricted to clients who are 13 years of age or older Diagnosis limitation: D841
Dalteparin sodium	J1645	N/A
Eculizumab	J1300	Diagnosis limitations: D588, D5910, D5911, D5912, D5913, D5919, D5930, D5932, D5939, D594, D595, D596, D598
Efgartigimod Alfa-fcab (Vyvgart)	J9332	Restricted to clients who are 18 years of age or older Diagnosis limitations: G700, G7001
Eflapegrastim-xnst	J1449	Restricted to clients who are 18 years of age or older
Emapalumab-lzsg (Gamifant)	J9210	N/A
Enoxaparin sodium	J1650	N/A
Epcoritamab-bysp (Epkinly)	C9155	Restricted to clients who are 18 years of age or older
Epoprostenol	J1325	Diagnosis limitations: I270, I2720, I2721, I2722, I2723, I2724, I2729, I2783, P2930
Esmolol hydrochloride	J1805	Restricted to clients who are 18 years of age or older
Faricimab-svoa	J2777	Restricted to clients who are 18 years of age or older
Fecal microbiota	J1440	Restricted to clients who are 18 years of age or older Diagnosis limitations: A0471, A0472
Fondaparinux sodium	J1652	N/A
Furosemide (Furoscix)	J1941	Restricted to clients who are 18 years of age or older
(Diagnosis limitations) The procedure code must be billed with one of the codes listed.		

Name of Injection	Procedure Code(s)	Limitation(s)
Galsulfase	J1458	Diagnosis limitations: E7601, E7602, E7603, E761, E76210, E76211, E76219, E7622, E7629, E763, E768, E769
Granisetron hydrochloride	J1626	Diagnosis limitations: Z510, Z5111, Z5112 The quantity used must appear on the claim.
Idursulfase	J1743	Diagnosis limitations: E7601, E7602, E7603, E761, E76210, E76211, E76219, E7622, E7629, E763, E768, E769
Inclisiran	J1306	Restricted to clients who are 18 years of age or older
Invega hafyera	J2427	Restricted to clients who are 18 years of age or older
Ixabepilone	J9207	Diagnosis limitations: C50011, C50012, C50019, C50111, C50112, C50119, C50211, C50212, C50219, C50311, C50312, C50319, C50411, C50412, C50419, C50511, C50512, C50519, C50611, C50612, C50619, C50811, C50812, C50819, C50911, C50912, C50919, C563, C7963, C847A, D0500, D0501, D0502, D0510, D0511, D0512, D0580, D0581, D0582, D0590, D0591, D0592
Lanoxin (Digoxin)	J1920	Restricted to clients who are 1 year of age or older
Lanreotide (Cipla)	J1932	Restricted to clients who are 18 years of age or older
Lefamulin	J0691	Restricted to clients who are 18 years of age and older
Linezolid	J2020	N/A
Lioresal	J0475 J0476	Separate payment for the device is not a benefit for the physician or the hospital.
Loncastuximab Tesirine-lpyl	J9359	Restricted to clients who are 18 years of age or older Diagnosis limitations: C8330, C8331, C8332, C8333, C8334, C8335, C8336, C8337, C8338, C8339
Melphalan	J9245	Diagnosis limitations: C9000, C9001, C9002
Melphalan (Evomela)	J9246	Diagnosis limitations: C9000, C9001, C9002
Methotrexate (Jylamvo)	J8611	Restricted to clients who are 18 years of age or older
Midazolam hydrochloride	J2250	N/A
Moxetumomab Pasudotox-tdfk (Lumoxiti)	J9313	Restricted to clients who are 18 years of age and older
(Diagnosis limitations) The procedure code must be billed with one of the codes listed.		

Name of Injection	Procedure Code(s)	Limitation(s)
Natalizumab injection	J2323	Diagnosis limitations: G35, K5000, K50011, K50012, K50013, K50014, K50018, K5010, K50111, K50112, K50113, K50114, K50118, K5080, K50811, K50812, K50813, K50814, K50818, K5090, K50911, K50912, K50913, K50914, K50918, K50919, K5650, K5651, K5652, K56600, K56601, K56609, K56690, K56691, K56699, K9130, K9131, K9132
Naxitamab-gqgk (Danyelza)	J9348	Restricted to clients who are 1 year of age or older.
Nivolumab and Relatlimab-rmbw	J9298	Restricted to clients who are 12 years of age or older
Nitroglycerin	J2305	Restricted to clients who are 18 years of age or older
Nogapendekin Alfa Inbakicept-pmln (Anktiva)	J9028	Restricted to clients who are 18 years of age or older
Oliceridine	C9101	Restricted to clients who are 18 years of age or older
Omadacycline	J0121	Restricted to clients who are 8 years of age and older
Pegcetacoplan	J2781	Restricted to clients who are 18 years of age or older
Phenylephrine hydrochloride (Immphentiv)	J2373	Restricted to clients who are 18 years of age or older
Plazomicin	J0291	Restricted to clients who are 18 years of age and older
Porfimer sodium	J9600	Diagnosis limitations: C153, C154, C155, C158, C159, C787, C7880, C7889
Ranibizumab-eqrn (Cimerli)	Q5128	Restricted to clients who are 18 years of age or older
Ravulizumab-cwvz (Ultomiris)	J1303	Diagnosis limitations: D5930, D5931, D5932, D5939, G360
Releuko	Q5125	N/A
Remimazolam	J2249	Restricted to clients who are 18 years of age or older
Retifanlimab-dlwr (Zynyz)	J9345	Restricted to clients who are 18 years of age or older
Rituximab	J9310	N/A
Sirolimus Protein-bound Particles (Fyarro)	J9331	Restricted to clients who are 18 years of age or older
(Diagnosis limitations) The procedure code must be billed with one of the codes listed.		

Name of Injection	Procedure Code(s)	Limitation(s)
Sumatriptan succinate	J3030	Limited to treatment of classical migraines Diagnosis limitations: G43001, G43011, G43101, G43109, G43111, G43119, G43401, G43409, G43411, G43419, G43501, G43509, G43511, G43519, G43601, G43609, G43611, G43619, G43701, G43709, G43711, G43719, G43801, G43809, G43811, G43819, G43821, G43829, G43831, G43839, G43901, G43909, G43911, G43919, G43A0, G43A1, G43B0, G43B1, G43C0, G43C1, G43D0, G43D1
Sutimlimab-jome (Enjaymo)	J1302	Restricted to clients who are 18 years of age or older
Tebentafusp-tebn	J9274	Restricted to clients who are 18 years of age or older
Tezepelumab-ekko (Tezspire)	J2356	Restricted to clients who are 12 years of age or older
Tildrakizumab (Ilumya)	J3245	Restricted to clients who are 18 years of age and older
Tisotumab Vedotin-tftv	J9273	Restricted to female clients who are 18 years of age or older
Triamcinolone Acetonide (Xipere)	J3299	Restricted to clients who are 18 years of age or older
Ublituximab-xiiy (Briumvi)	J2329	Restricted to clients who are 18 years of age or older
Valrubicin	J9357	Diagnosis limitation: D090
Vasopressin	J2598 J2599 J2601	Restricted to clients who are 18 years of age or older
Verteporfin	J3396	Diagnosis limitations: H35021, H35022, H35023, H353110, H353111, H353112, H353113, H353114, H353120, H353121, H353122, H353123, H353124, H353130, H353131, H353132, H353133, H353134, H353190, H353191, H353192, H353193, H353194, H353210, H353211, H353212, H353213, H353220, H353221, H353222, H353223, H353230, H353231, H353232, H353233, H353290, H353291, H353292, H353293
(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.

31.2.26.6 Adalimumab

Adalimumab (procedure codes J0139 and Q5140) is a benefit of the CSHCN Services Program with the following diagnosis limitations:

Diagnosis Codes							
K5000	K50011	K50012	K50013	K50014	K50018	K5010	K50111
K50112	K50113	K50114	K50118	K5080	K50811	K50812	K50813
K50814	K50818	K5090	K50911	K50912	K50913	K50914	K50918
K50919	K5100	K51011	K51012	K51013	K51014	K51018	K51019
K5120	K51211	K51212	K51213	K51214	K51218	K5130	K51311
K51312	K51313	K51314	K51318	K5140	K51411	K51412	K51413
K51414	K51418	K51419	K5150	K51511	K51512	K51513	K51514
K51518	K51519	K5180	K51811	K51812	K51813	K51814	K51818
K51819	K5190	K51911	K51912	K51913	K51914	K51918	K5650
K5651	K5652	K56600	K56601	K56609	K56690	K56691	K56699
K9130	K9131	K9132	L400	L401	L402	L403	L404
L4050	L4051	L4052	L4053	L4054	L4059	L408	M00039
M00071	M00072	M00079	M00171	M00172	M00179	M00271	M00272
M00279	M00871	M00872	M00879	M0500	M05011	M05012	M05019
M05021	M05022	M05029	M05031	M05032	M05039	M05041	M05042
M05049	M05051	M05052	M05059	M05061	M05062	M05069	M05071
M05072	M05079	M0509	M05271	M0530	M0540	M05411	M05412
M05419	M05421	M05422	M05429	M05431	M05432	M05439	M05441
M05442	M05449	M05451	M05452	M05459	M05461	M05462	M05469
M05471	M05472	M05479	M0549	M0550	M05511	M05512	M05519
M05521	M05522	M05529	M05531	M05532	M05539	M05541	M05542
M05549	M05551	M05552	M05559	M05561	M05562	M05569	M05571
M05572	M05579	M0559	M0560	M05611	M05612	M05619	M05621
M05622	M05629	M05631	M05632	M05639	M05641	M05642	M05649
M05651	M05652	M05659	M05661	M05662	M05669	M05671	M05672
M05679	M0569	M0570	M05711	M05712	M05719	M05721	M05722
M05729	M05731	M05732	M05739	M05741	M05742	M05749	M05751
M05752	M05759	M05761	M05762	M05769	M05771	M05772	M05779
M0579	M057A	M0580	M05811	M05812	M05819	M05821	M05822
M05829	M05831	M05832	M05839	M05841	M05842	M05849	M05851
M05852	M05859	M05861	M05862	M05869	M05871	M05872	M05879
M0589	M058A	M059	M0600	M06011	M06012	M06019	M06021
M06022	M06029	M06031	M06032	M06039	M06041	M06042	M06049
M06051	M06052	M06059	M06061	M06062	M06069	M06071	M06072
M06079	M0608	M0609	M060A	M061	M0620	M06211	M06212
M06219	M06221	M06222	M06229	M06231	M06232	M06239	M06241
M06242	M06249	M06251	M06252	M06259	M06261	M06262	M06269

Diagnosis Codes							
M06271	M06272	M06279	M0628	M0629	M0630	M06311	M06312
M06319	M06321	M06322	M06329	M06331	M06332	M06339	M06341
M06342	M06349	M06351	M06352	M06359	M06361	M06362	M06369
M06371	M06372	M06379	M0638	M0639	M0680	M06811	M06812
M06819	M06821	M06822	M06829	M06831	M06832	M06839	M06841
M06842	M06849	M06851	M06852	M06859	M06861	M06862	M06869
M06871	M06872	M06879	M0688	M0689	M068A	M069	M0800
M08011	M08012	M08019	M08021	M08022	M08029	M08031	M08032
M08039	M08041	M08042	M08049	M08051	M08052	M08059	M08061
M08062	M08069	M08071	M08072	M08079	M0808	M0809	M081
M08811	M08812	M08821	M08822	M08831	M08832	M08839	M08841
M08842	M08849	M08851	M08852	M08859	M08861	M08862	M08871
M08872	M0888	M0889	M08911	M08912	M08919	M08921	M08922
M08929	M08931	M08932	M08939	M08941	M08942	M08949	M08951
M08952	M08959	M08961	M08962	M08969	M08971	M08972	M0898
M13871	M13872	M13879	M450	M451	M452	M453	M454
M455	M456	M457	M458	M459	M45A0	M45A1	M45A2
M45A3	M45A4	M45A5	M45A6	M45A7	M45A8	M45AB	M48061
M48062	M488X1	M488X2	M488X3	M488X4	M488X5	M488X6	M488X7
M488X8	M488X9						

31.2.26.7 Ado-Trastuzumab Emtansine

Ado-trastuzumab emtansine (procedure code J9354) is a benefit of the CSHCN Services Program with the following diagnosis limitations:

Diagnosis Codes							
C50011	C50012	C50019	C50021	C50022	C50029	C50111	C50112
C50119	C50121	C50122	C50129	C50211	C50212	C50219	C50221
C50222	C50229	C50311	C50312	C50319	C50321	C50322	C50329
C50411	C50412	C50419	C50421	C50422	C50429	C50511	C50512
C50519	C50521	C50522	C50529	C50611	C50612	C50619	C50621
C50622	C50629	C50811	C50812	C50819	C50821	C50822	C50829
C50911	C50912	C50919	C50921	C50922	C50929		

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.

31.2.26.8 Bevacizumab

Bevacizumab (procedure code J9035) is a benefit of the CSHCN Services Program with the following diagnosis limitations:

Diagnosis Codes							
C180	C181	C182	C183	C184	C185	C186	C187
C188	C189	C19	C20	C210	C211	C218	C3400
C3401	C3402	C3410	C3411	C3412	C342	C3430	C3431
C3432	C3480	C3481	C3482	C3490	C3491	C3492	C538
C539	C563	C641	C642	C649	C711	C712	C713
C714	C715	C716	C717	C718	C719	C7800	C7801
C7802	C7931	C7963	Z85038	Z85048	Z85118	Z853	

31.2.26.9 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 code J0585 is payable when billed with the following diagnosis codes:

Diagnosis Codes							
G114	G2401	G2402	G241	G243	G244	G245	G248
G250	G251	G252	G253	G35	G360	G370	G371
G372	G373	G374	G375	G3781	G3789	G379	G43701
G43709	G43711	G43719	G5131	G5132	G5133	G5139	G800
G801	G802	G803	G804	G808	G809	G8110	G8111
G8112	G8113	G8114	G8191	G8192	G8193	G8194	G8220
G8221	G8222	G8250	G8251	G8252	G8253	G8254	G830
G8310	G8311	G8312	G8313	G8314	G8320	G8321	G8322
G8323	G8324	G8330	G8331	G8332	G8333	G8334	G834
G8921	H4901	H4902	H4903	H4911	H4912	H4913	H4921
H4922	H4923	H4931	H4932	H4933	H4941	H4942	H4943
H499	H5000	H50011	H50012	H50021	H50022	H50031	H50032
H50041	H50042	H5005	H5006	H5007	H5008	H5010	H50111
H50112	H50121	H50122	H50131	H50132	H50141	H50142	H5015
H5016	H5017	H5018	H5021	H5022	H5030	H50311	H50312
H5032	H50331	H50332	H5034	H5040	H50411	H50412	H5042
H5043	H5050	H5051	H5052	H5053	H5054	H5055	H5060
H50611	H50612	H50621	H50622	H50629	H50631	H50632	H50639
H50641	H50642	H50649	H50651	H50652	H50659	H50661	H50662
H50669	H50671	H50672	H50679	H50681	H50682	H50689	H5069

Diagnosis Codes							
H50811	H50812	H5089	H510	H5111	H5112	H5121	H5122
H5123	H518	H519	I69031	I69032	I69033	I69034	I69041
I69042	I69043	I69044	I69051	I69052	I69053	I69054	I69061
I69062	I69063	I69064	I69065	I69098	I69131	I69132	I69133
I69134	I69141	I69142	I69143	I69144	I69151	I69152	I69153
I69154	I69161	I69162	I69163	I69164	I69165	I69198	I69231
I69232	I69233	I69234	I69241	I69242	I69243	I69244	I69251
I69252	I69253	I69254	I69261	I69262	I69263	I69264	I69265
I69298	I69331	I69332	I69333	I69334	I69341	I69342	I69343
I69344	I69351	I69352	I69353	I69354	I69361	I69362	I69363
I69364	I69365	I69398	I69831	I69832	I69833	I69834	I69841
I69842	I69843	I69844	I69851	I69852	I69853	I69854	I69861
I69862	I69863	I69864	I69865	I69898	J385	K117	K220
K594	K600	K601	K602	M436	M62838	M722	N310
N311	N312	N318	N319	N3281	N3644	R490	R498
R532							

Procedure code J0586 is payable when billed with the following diagnosis codes:

Diagnosis Codes							
G114	G2401	G2402	G241	G243	G244	G245	G248
G35	G360	G370	G371	G372	G373	G374	G375
G3781	G3789	G379	G800	G801	G802	G803	G804
G808	G809	G8110	G8111	G8112	G8113	G8114	G8191
G8192	G8193	G8194	G8253	G8254	G830	G8320	G8321
G8322	G8323	G8324	I69031	I69032	I69033	I69034	I69039
I69051	I69052	I69053	I69054	I69059	I69131	I69132	I69133
I69134	I69139	I69151	I69152	I69153	I69154	I69231	I69232
I69233	I69234	I69239	I69251	I69252	I69253	I69254	I69259
I69331	I69332	I69333	I69334	I69339	I69351	I69352	I69353
I69354	I69359	I69831	I69832	I69833	I69834	I69839	I69851
I69852	I69853	I69854	I69859	I69931	I69932	I69933	I69934
I69939	I69951	I69952	I69953	I69954	I69959	J385	M436
M62838	M722	R532					

The chemodenervation procedure codes in the following table are a benefit in addition to botulinum toxin type A:

Procedure Codes							
64600	64605	64610	64611	64612	64615	64616	64617
64620	64624	64625	64630	64632	64633	64634	64635
64636	64640	64642	64643	64644	64645	64646	64647

Procedure Codes		
64680	64681	67345

Procedure code 64612 requires prior authorization. All other chemodenervation and nerve destruction by neurolytic agent procedure codes do not require prior authorization. Add-on procedure codes 95873 and 95874 will be reimbursed only when billed with the appropriate primary procedure code on the same day, by the same provider.

Procedure code J0588 is a benefit and is limited to the following diagnosis codes:

Diagnosis Codes							
G243	G245	G800	G801	G802	G8110	G8111	G8112
G8113	G8114	G8253	G8254	G830	G8320	G8321	G8322
G8323	G8324	I69031	I69032	I69033	I69034	I69039	I69051
I69052	I69053	I69054	I69059	I69131	I69132	I69133	I69134
I69139	I69151	I69152	I69153	I69154	I69231	I69232	I69233
I69234	I69239	I69251	I69252	I69253	I69254	I69259	I69331
I69332	I69333	I69334	I69339	I69351	I69352	I69353	I69354
I69359	I69831	I69832	I69833	I69834	I69839	I69851	I69852
I69853	I69854	I69859	I69931	I69932	I69933	I69934	I69939
I69951	I69952	I69953	I69954	I69959			

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 Codes		
G243	G8921	K117

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 three months. Supplies used to administer the toxins will not be reimbursed separately.

Medications other than botulinum toxins may be used for chemodenervation procedures.

Claims for Botulinum Toxin Type A and B must indicate the number of units used. Providers should bill the amount of injections per units used for Botulinum Toxin. If the units are not specified, the claim may be reimbursed as a quantity of one.

Procedure Codes	Quantity Limitations of Medication	Billing Units
J0585	400 units	One billing unit is equal to 1 unit of medication. ***Example:*** *A provider that administers 400 units of medication would submit a claim for a quantity of 400.*

Procedure Codes	Quantity Limitations of Medication	Billing Units
J0586	1,500 units	One billing unit is equal to 5 units of medication. ***Example:*** *A provider that administers 1,500 units of medication would submit a claim for a quantity of 300.*
J0587	10,000 units	One billing unit is equal to 100 units of medication. ***Example:*** *A provider that administers 10,000 units of medication would submit a claim for a quantity of 100.*
J0588	400 units	One billing unit is equal to 1 unit of medication. ***Example:*** *A provider that administers 400 units of medication would submit a claim for a quantity of 400.*

Procedure codes J0586, J0587, and J0588 will be denied when billed on the same date of service, by any provider with procedure code J0585.

Procedure codes J0587 and J0588 will be denied when billed on the same date of service, by any provider with procedure code J0586.

Procedure code J0587 will be denied when billed on the same date of service, by any provider with procedure code J0588.

Providers may not bill for an office visit if botulinum injections are the only reason for the visit.

31.2.26.9.1 Prior Authorization Requirements

Prior authorization is required for quantities of medication greater than the defined limitations for botulinum toxins. Documentation of medical need for exceeding the limit must be submitted with the request for prior authorization.

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" 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.

31.2.26.9.2 Reimbursement

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

31.2.26.10 Epirubicin Hydrochloride

Epirubicin hydrochloride (procedure code J9178) is a benefit of the CSHCN Services Program with the following diagnosis limitations:

Diagnosis Codes							
C50011	C50012	C50019	C50021	C50022	C50029	C50111	C50112
C50119	C50121	C50122	C50129	C50211	C50212	C50219	C50221
C50222	C50229	C50311	C50312	C50319	C50321	C50322	C50329
C50411	C50412	C50419	C50421	C50422	C50429	C50511	C50512
C50519	C50521	C50522	C50529	C50611	C50612	C50619	C50621
C50622	C50629	C50811	C50812	C50819	C50821	C50822	C50829
C50911	C50912	C50919	C50921	C50922	C50929	C847A	

31.2.26.11 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 Codes							
B20	C880	C9000	C9001	C9002	D500	D501	D508
D509	D510	D511	D512	D513	D518	D519	D520
D521	D528	D529	D530	D531	D532	D538	D539
D550	D551	D553	D558	D560	D561	D562	D563
D564	D565	D568	D569	D5701	D5702	D571	D5720
D57211	D57212	D573	D5740	D57411	D57412	D5780	D57811
D57812	D580	D581	D582	D588	D590	D592	D594
D595	D596	D598	D600	D601	D608	D6101	D6109
D611	D612	D613	D61810	D61811	D61818	D6182	D6189
D619	D62	D630	D631	D638	D640	D641	D642
D643	D644	D6481	D6489	D649	D7801	D7802	D7821
D7822	E3601	E3602	G9731	G9732	G9751	G9752	H59111
H59112	H59113	H59119	H59121	H59122	H59123	H59129	H59311
H59312	H59313	H59319	H59321	H59322	H59323	H59329	H9521
H9522	H9541	H9542	I120	I129	I130	I1310	I1311
I132	I97410	I97411	I97418	I9742	I97610	I97611	I97618
I9762	J9561	J9562	J95830	J95831	K9161	K9162	K91840
K91841	L7601	L7602	L7621	L7622	M0540	M05411	M05412
M05419	M05421	M05422	M05429	M05431	M05432	M05439	M05441
M05442	M05449	M05451	M05452	M05459	M05461	M05462	M05469
M05471	M05472	M05479	M0549	M0550	M05511	M05512	M05519
M05521	M05522	M05529	M05531	M05532	M05539	M05541	M05542
M05549	M05551	M05552	M05559	M05561	M05562	M05569	M05571
M05572	M05579	M0559	M0570	M05711	M05712	M05719	M05721
M05722	M05729	M05731	M05732	M05739	M05741	M05742	M05749

Diagnosis Codes							
M05751	M05752	M05759	M05761	M05762	M05769	M05771	M05772
M05779	M0579	M0580	M05811	M05812	M05819	M05821	M05822
M05829	M05831	M05832	M05839	M05841	M05842	M05849	M05851
M05852	M05859	M05861	M05862	M05869	M05871	M05872	M05879
M0589	M059	M0600	M06011	M06012	M06019	M06021	M06022
M06029	M06031	M06032	M06039	M06041	M06042	M06049	M06051
M06052	M06059	M06061	M06062	M06069	M06071	M06072	M06079
M0608	M0609	M0620	M06211	M06212	M06219	M06221	M06222
M06229	M06231	M06232	M06239	M06241	M06242	M06249	M06251
M06252	M06259	M06261	M06262	M06269	M06271	M06272	M06279
M0628	M0629	M0630	M06311	M06312	M06319	M06321	M06322
M06329	M06331	M06332	M06339	M06341	M06342	M06349	M06351
M06352	M06359	M06361	M06362	M06369	M06371	M06372	M06379
M0638	M0639	M0680	M06811	M06812	M06819	M06821	M06822
M06829	M06831	M06832	M06839	M06841	M06842	M06849	M06851
M06852	M06859	M06861	M06862	M06869	M06871	M06872	M06879
M0688	M0689	M069	M96810	M96811	M96830	M96831	N19
N2589	N9961	N9962	N99820	N99821	Z48298	Z5111	Z5112
Z7682							

In addition to the diagnosis codes listed above, procedure code J0885 may also be considered for reimbursement with the following diagnosis codes:

Diagnosis Codes					
N181	N182	N184	N185	N186	N189

Procedure code J0882 is a benefit of the CSHCN Services Program for the following diagnosis codes:

Diagnosis Codes							
B20	C880	C9000	C9001	C9002	D500	D501	D508
D509	D510	D511	D512	D513	D518	D519	D520
D521	D528	D529	D530	D531	D532	D538	D539
D550	D551	D553	D558	D560	D561	D562	D563
D564	D565	D568	D569	D5701	D5702	D571	D5720
D57211	D57212	D573	D5740	D57411	D57412	D5780	D57811
D57812	D580	D581	D582	D588	D590	D592	D594
D595	D596	D598	D600	D601	D608	D6101	D6109
D611	D612	D613	D61810	D61811	D61818	D6182	D6189
D619	D62	D630	D631	D638	D640	D641	D642
D643	D644	D6481	D6489	D649	D7801	D7802	D7821
D7822	E3601	E3602	G9731	G9732	G9751	G9752	H59111
H59112	H59113	H59119	H59121	H59122	H59123	H59129	H59311

Diagnosis Codes							
H59312	H59313	H59319	H59321	H59322	H59323	H59329	H9521
H9522	H9541	H9542	I120	I129	I130	I1310	I1311
I132	I97410	I97411	I97418	I9742	I97610	I97611	I97618
I9762	J9561	J9562	J95830	J95831	K9161	K9162	K91840
K91841	L7601	L7602	L7621	L7622	M0540	M05411	M05412
M05419	M05421	M05422	M05429	M05431	M05432	M05439	M05441
M05442	M05449	M05451	M05452	M05459	M05461	M05462	M05469
M05471	M05472	M05479	M0549	M0550	M05511	M05512	M05519
M05521	M05522	M05529	M05531	M05532	M05539	M05541	M05542
M05549	M05551	M05552	M05559	M05561	M05562	M05569	M05571
M05572	M05579	M0559	M0570	M05711	M05712	M05719	M05721
M05722	M05729	M05731	M05732	M05739	M05741	M05742	M05749
M05751	M05752	M05759	M05761	M05762	M05769	M05771	M05772
M05779	M0579	M0580	M05811	M05812	M05819	M05821	M05822
M05829	M05831	M05832	M05839	M05841	M05842	M05849	M05851
M05852	M05859	M05861	M05862	M05869	M05871	M05872	M05879
M0589	M059	M0600	M06011	M06012	M06019	M06021	M06022
M06029	M06031	M06032	M06039	M06041	M06042	M06049	M06051
M06052	M06059	M06061	M06062	M06069	M06071	M06072	M06079
M0608	M0609	M0620	M06211	M06212	M06219	M06221	M06222
M06229	M06231	M06232	M06239	M06241	M06242	M06249	M06251
M06252	M06259	M06261	M06262	M06269	M06271	M06272	M06279
M0628	M0629	M0630	M06311	M06312	M06319	M06321	M06322
M06329	M06331	M06332	M06339	M06341	M06342	M06349	M06351
M06352	M06359	M06361	M06362	M06369	M06371	M06372	M06379
M0638	M0639	M0680	M06811	M06812	M06819	M06821	M06822
M06829	M06831	M06832	M06839	M06841	M06842	M06849	M06851
M06852	M06859	M06861	M06862	M06869	M06871	M06872	M06879
M0688	M0689	M069	M96810	M96811	M96830	M96831	N19
N2589	N9961	N9962	N99820	N99821	Z48298	Z5111	Z5112
Z7682							

EPO is limited to three injections per calendar week (Sunday through Saturday). Procedure code J0885 must be submitted with an 11-digit NDC.

31.2.26.12 Growth Hormone

The Vendor Drug Program (VDP) reimburses growth hormone (hGH) injections for CSHCN Services Program clients for any of the following conditions:

- Chronic kidney disease
- Pituitary gland insufficiency
- Prader-Willi syndrome

- Turner syndrome
- Noonan syndrome
- SHOX deficiency
- Other specified disorders resulting from impaired renal function

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 Form 1327 - Children with Special Health Care Needs (CSHCN) Services Program Biosynthetic Growth Hormone Agents Prior Authorization Request.

31.2.26.12.1 Prior Authorization Requirements

Requests for prior approval of the medical criteria for growth hormone therapy must be submitted on the CSHCN Biosynthetic Growth Hormone Agents Prior Authorization Request (Form 1327) by a program-approved endocrinologist. In addition to the conditions listed in the section above, the following criteria must also be met for an initial request:

- 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.

Clients with Turner's syndrome or Prader-Willi syndrome, Noonan Syndrome, or SHOX deficiency may be approved without evidence of deficient growth hormone production on provocative testing if other criteria are met.

Clients with a diagnosis of panhypopituitarism whose epiphyses have closed will be considered for approval with documentation of deficient growth hormone levels.

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" in Chapter 3, "Client Benefits and Eligibility" for more information about the VDP.

31.2.26.13 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	J1551	J1555	J1556	J1557	J1559	J1561	J1566	J1568	J1569
J1571	J1572	J1573	J1575	J1576	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 is an add-on code and must be billed with the appropriate primary procedure code on the same date of service, by the same provider, or the service will be denied.

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

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.

31.2.26.13.1 Authorization Requirements

Unlisted procedure code 90399 may be considered for reimbursement with prior authorization. Requests for prior authorization must be submitted using the CSHCN Services Program Authorization and Prior Authorization Request Form. 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

31.2.26.14 Infliximab, Inflectra, Renflexis, and Zymfentra

Infliximab (procedure code J1745), inflectra (procedure code Q5103), and renflexis (procedure code Q5104) are benefits of the CSHCN Services Program with the following diagnosis limitations:

Diagnosis Codes							
H2013	K5000	K50011	K50012	K50013	K50014	K50018	K50019
K5010	K50111	K50112	K50113	K50114	K50118	K50119	K5080
K50811	K50812	K50813	K50814	K50818	K50819	K5090	K50911
K50912	K50913	K50914	K50918	K50919	K5100	K51011	K51012
K51013	K51014	K51018	K51019	K5120	K51211	K51212	K51213
K51214	K51218	K51219	K5130	K51311	K51312	K51313	K51314
K51318	K51319	K5140	K51411	K51412	K51413	K51414	K51418
K51419	K5150	K51511	K51512	K51513	K51514	K51518	K51519
K5180	K51811	K51812	K51813	K51814	K51818	K51819	K5190
K51911	K51912	K51913	K51914	K51918	K51919	K603	K632
L400	L401	L402	L403	L4050	L4051	L4052	L4053
L4054	L4059	L408	L409	M0500	M05011	M05012	M05019
M05021	M05022	M05029	M05031	M05032	M05039	M05041	M05042
M05049	M05051	M05052	M05059	M05061	M05062	M05069	M05071
M05072	M05079	M0509	M0510	M05111	M05112	M05119	M05121
M05122	M05129	M05131	M05132	M05139	M05141	M05142	M05149
M05151	M05152	M05159	M05161	M05162	M05169	M05171	M05172
M05179	M0519	M0520	M05211	M05212	M05219	M05221	M05222
M05229	M05231	M05232	M05239	M05241	M05242	M05249	M05251
M05252	M05259	M05261	M05262	M05269	M05271	M05272	M05279
M0529	M0530	M05311	M05312	M05319	M05321	M05322	M05329
M05331	M05332	M05339	M05341	M05342	M05349	M05351	M05352
M05359	M05361	M05362	M05369	M05371	M05372	M05379	M0539
M0540	M05411	M05412	M05419	M05421	M05422	M05429	M05431

Diagnosis Codes							
M05432	M05439	M05441	M05442	M05449	M05451	M05452	M05459
M05461	M05462	M05469	M05471	M05472	M05479	M0549	M0550
M05511	M05512	M05519	M05521	M05522	M05529	M05531	M05532
M05539	M05541	M05542	M05549	M05551	M05552	M05559	M05561
M05562	M05569	M05571	M05572	M05579	M0559	M0560	M05611
M05612	M05619	M05621	M05622	M05629	M05631	M05632	M05639
M05641	M05642	M05649	M05651	M05652	M05659	M05661	M05662
M05669	M05671	M05672	M05679	M0569	M0570	M05711	M05712
M05719	M05721	M05722	M05729	M05731	M05732	M05739	M05741
M05742	M05749	M05751	M05752	M05759	M05761	M05762	M05769
M05771	M05772	M05779	M0579	M0580	M05811	M05812	M05819
M05821	M05822	M05829	M05831	M05832	M05839	M05841	M05842
M05849	M05851	M05852	M05859	M05861	M05862	M05869	M05871
M05872	M05879	M0589	M059	M060A	M068A	M069	M08011
M08012	M08021	M08022	M08031	M08032	M08041	M08042	M08051
M08052	M08061	M08062	M08071	M08072	M0809	M08832	M08841
M08842	M08851	M08852	M08861	M08931	M08932	M08941	M08942
M08951	M08952	M08961	M08962	M1389	M450	M451	M452
M453	M454	M455	M456	M457	M458	M459	M45A0
M45A1	M45A2	M45A3	M45A4	M45A5	M45A6	M45A7	M45A8
M45AB							

Procedure codes J1745, Q5103, and Q5104 will not be reimbursed for the same date of service by any provider.

Procedure code J1748 is a benefit for clients who are 18 years of age or older with the following diagnosis limitations:

Diagnosis Codes							
K5000	K50011	K50012	K50013	K50014	K50018	K50019	K5010
K50111	K50112	K50113	K50114	K50118	K5080	K50811	K50812
K50813	K50814	K50818	K50819	K5090	K50911	K50912	K50913
K50914	K50918	K5100	K51011	K51012	K51013	K51014	K51018
K51019	K5120	K51211	K51212	K51213	K51214	K51218	K5130
K51311	K51312	K51313	K51314	K51318	K5180	K51811	K51812
K51813	K51814	K51818	K5190	K51911	K51912	K51913	K51914
K51918	K51919						

31.2.26.15 Inotuzumab ozogamicin (Besponsa)

Inotuzumab ozogamicin (Besponsa) (procedure code J9229) is a benefit of the CSHCN Services Program for pediatric and adult clients who are 1 year of age or older.

Inotuzumab ozogamicin is indicated for the treatment of relapsed or refractory precursor B-cell acute lymphoblastic leukemia (ALL) and must be prescribed by an oncologist or in consultation with an oncologist.

Procedure code J9229 requires prior authorization and may be approved when all of the following criteria is met:

- The client has a confirmed diagnosis of precursor B-cell ALL.
- The client must have relapsed or refractory disease.
- The client is 1 year of age or older.

The provider must agree to monitor the client for signs and symptoms of hepatic veno-occlusive disease (VOD) during the duration of Besponsa therapy.

Requests for prior authorization of procedure code J9229 must be submitted using the CSHCN Services Program Authorization and Prior Authorization Request form.

31.2.26.16 Leuprolide Acetate Injection

Procedure code J1950 is limited to reimbursement once every 28 days. 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 28 days
3-month	22.5 mg	3	Once every 84 days
4-month	30 mg	4	Once every 112 days
6-month	45 mg	6	Once every 168 days

31.2.26.17 Monoclonal Antibodies - Asthma and Chronic Idiopathic Urticaria

31.2.26.17.1 Omalizumab

Omalizumab (procedure code J2357) is a benefit of the CSHCN Services Program when medically necessary and must be prior authorized.

Omalizumab is FDA approved for the treatment of clients who are 6 years of age and older with moderate to severe asthma. Omalizumab is also approved for the treatment of clients who are 12 years of age and older with chronic idiopathic urticaria, who remain symptomatic despite H1 antihistamine treatment. Clients who are younger than the FDA-approved age will be considered on a case-by-case basis by the CSHCN Services Program Medical Director or designee.

31.2.26.17.2 Benralizumab

Benralizumab (procedure code J0517) is a benefit of the CSHCN Services Program with prior authorization.

Benralizumab is an injectable drug that is FDA-approved and indicated for the treatment of clients who are 12 years of age and older that have severe asthma with an eosinophilic phenotype. Clients who are younger than the FDA-approved age will be considered on a case-by-case basis by the CSHCN Services Program medical director or designee.

31.2.26.17.3 Mepolizumab

Mepolizumab (procedure code J2182) is a benefit of the CSHCN Services Program when prior authorized.

Mepolizumab is an injectable drug that is approved by the U.S. Food and Drug Administration (FDA) for the treatment of clients who are 12 years of age and older and have severe asthma with an eosinophilic phenotype. Clients who are younger than the FDA-approved age will be considered on a case-by-case basis by the CSHCN Services Program medical director or designee.

Providers may not bill for an office visit if the only reason for the visit is an omalizumab, benralizumab, mepolizumab, or reslizumab injection.

31.2.26.17.4 Reslizumab

Reslizumab (procedure code J2786) is a benefit of the CSHCN Services Program when prior authorized.

Reslizumab is an injectable drug that is FDA-approved and indicated for the treatment of clients who are 18 years of age and older and have severe asthma with an eosinophilic phenotype. Clients who are younger than the FDA-approved age will be considered on a case-by-case basis by the CSHCN Services Program medical director or designee.

Procedure codes J0517, J2182, J2786, and J2357 may not be billed in any combination for the same date of services by any provider.

31.2.26.17.5 Prior Authorization Requirements

Omalizumab (procedure code J2357), benralizumab (procedure code J0517), mepolizumab (procedure code J2182), or reslizumab (procedure code J2786) must be used to request prior authorization and the exact dosage must be indicated on the CSHCN Services Program Authorization and Prior Authorization Request Form.

Prior authorization of omalizumab may be approved for clients who are 6 years of age or older with moderate to severe asthma (as defined by the National Heart, Lung, and Blood Institute's Guidelines for the Diagnosis and Management of Asthma).

Prior authorization of benralizumab and mepolizumab may be approved for clients who are 12 years of age or older that have severe asthma with an eosinophilic phenotype (as defined by the National Heart, Lung, and Blood Institute's Guidelines for the Diagnosis and Management of Asthma).

Prior authorization of reslizumab may be approved for clients who are 18 years of age or older with severe asthma (as defined by the National Heart, Lung, and Blood Institute's Guidelines for the Diagnosis and Management of Asthma).

Prior authorizations for omalizumab, benralizumab, mepolizumab, or reslizumab are for intervals of six months at a time. Clients must be compliant with their omalizumab, benralizumab, mepolizumab, or reslizumab regimen in order to qualify for additional authorizations. The provider must submit a statement documenting compliance with the requests for each renewal.

Benralizumab, mepolizumab or reslizumab may only be initiated after a six-month trial of omalizumab therapy that has resulted in inadequate response. Criteria is detailed below in the benralizumab, mepolizumab, and reslizumab sections.

Treatment of benralizumab, mepolizumab or reslizumab may not be used concurrently with omalizumab or any other interleukin-5 antagonist.

31.2.26.17.6 Chronic Idiopathic Urticaria

Prior authorization for omalizumab will be considered for clients who are 12 years of age or older with chronic idiopathic urticaria (CIU).

Documentation supporting medical necessity for treatment of CIU with omalizumab must be submitted with the request and include all of the following:

- Documented failure of, or contraindication to, antihistamine and leukotriene inhibitor therapies.
- Evidence of an evaluation that excludes other medical diagnoses associated with chronic urticaria.

31.2.26.17.7 Asthma Moderate to Severe (Omalizumab) and Severe (Benralizumab, Mepolizumab, and Reslizumab)

Documentation supporting medical necessity for treatment of asthma with omalizumab, benralizumab, mepolizumab, or reslizumab must be submitted with the request and must indicate the following:

- Symptoms are inadequately controlled with use of one of the following combination therapies:
  - 12 months of high-dose inhaled corticosteroid (ICS) given in combination with a minimum of 3 months of controller medication (either a long-acting beta2-agonist [LABA], leukotriene receptor antagonist [LTRA], or theophylline), unless the individual is intolerant of, or has a medical contraindication to these agents
  - 6 months of ICS with daily oral glucocorticoids given in combination with a minimum of 3 months of controller medication (a LABA, LTRA, or theophylline), unless the individual is intolerant of, or has a medical contraindication to these agents

  Note: *Exceptions to the criteria above will be considered on a case-by-case basis, which will require a letter from the prescribing provider stating the medical necessity for omalizumab, benralizumab, mepolizumab, or reslizumab, the client's asthma severity level, and the duration of current and past therapies and lack of asthma control. Consideration for these exceptions will be reviewed by the CSHCN Services Program Medical Director or designee.*
- Pulmonary function tests must have been performed within a three-month period and be documented for all clients.

  Note: *Exceptions may be considered with documentation of medical reasons explaining why pulmonary function tests cannot be performed.*
- Client is not currently smoking.
- When requesting prior authorization, the exact dosage must be included with the request.

31.2.26.17.8 Omalizumab

Additional documentation of the following must also be submitted for treatment with omalizumab:

- 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 1300 IU/ml within the past 12 months

31.2.26.17.9 Benralizumab

The following additional documentation for treatment with benralizumab must be submitted with the initial prior authorization request:

- Documented diagnosis of severe eosinophilic asthma
- Blood eosinophil count greater than or equal to 150 cells/microliter before the initiation of therapy, in the absence of other potential causes of eosinophilia, including hypereosinophilic syndromes, neoplastic disease, and known or suspected parasitic infection

  Note: *1microliter (ul) is equal to 1 cubic millimeter (mm3).*

- Prior authorization for an initial request for benralizumab will be considered when the client meets the criteria for benralizumab and has had an inadequate response after being compliant with 6 months of omalizumab treatment. Failure to respond to omalizumab must be documented in a letter that is signed and dated by the prescribing provider and submitted with the prior authorization request.

  Note: *Exceptions may be considered for clients who meet the requirements for treatment with benralizumab but who do not meet the criteria for omalizumab. Supporting documentation (IgE level falls outside of required range, negative skin test, or RAST to a perennial aeroallergen) must be submitted along with the other required documentation for treatment with benralizumab.*

31.2.26.17.10 Mepolizumab

Additional documentation of the following must also be submitted for treatment with mepolizumab:

- One of the following blood eosinophil counts in the absence of other potential causes of eosinophilia, including hypereosinophilic syndromes, neoplastic disease, and known or suspected parasitic infection:
  - Greater than or equal to 150 cells/microliter at initiation of therapy
  - Greater than or equal to 300 cells/microliter within 12 months prior to initiation of therapy

  Note: *1 microliter (ul) is equal to 1 cubic millimeter (mm3)*

Prior authorization for an initial request for mepolizumab will be considered when the client has had an inadequate response after being compliant for 6 months of treatment with omalizumab. Failure to respond to omalizumab must be documented in a letter, signed and dated by the prescribing provider and submitted with the request.

Note: *Exceptions may be considered for clients who meet the criteria for treatment with mepolizumab but do not meet the criteria for omalizumab. Supporting documentation, such as an IgE level fall outside of the required range or a negative skin test/RAST to a perennial aeroallergen, must be submitted along with the documentation for treatment with mepolizumab, as described above.*

31.2.26.17.11 Reslizumab

Additional documentation of the following must also be submitted for treatment with reslizumab:

- Has an eosinophilic phenotype as determined by blood eosinophils of 400 cells/microliter or higher to initiation of therapy (within 3-4 weeks of dosing).

  Note: *1 microliter (9ul) is equal to 1 cubic millimeter (mm3).*

- Prior authorization for an initial request for reslizumab will be considered when the client has had an inadequate response after being compliant for 6 months of treatment with omalizumab and meets the criteria for reslizumab. Failure to respond to omalizumab must be documented in a letter, signed and dated by the prescribing provider and submitted with the request.

  Note: *Exceptions may be considered for clients who meet the requirements for treatment with reslizumab, but who do not meet the criteria for omalizumab. Supporting documentation (IgE level falls outside of required range and/or negative skin test/RAST to a perennial aeroallergen) must be submitted along with the documentation for treatment with reslizumab as described above.*

When requesting prior authorization, the exact dosage must be included with the request.

31.2.26.17.12 Requirements for Continuation of Therapy

For continuation of therapy with omalizumab, benralizumab, mepolizumab, or reslizumab after 6 continuous months, the requesting provider must submit the following documentation of the client's compliance and satisfactory clinical response to omalizumab, benralizumab, mepolizumab, or reslizumab:

- Documentation of clinical improvement must include one or more of the following:
  - Decreased utilization of rescue medications
  - Increase in predicted FEV1 (forced expiratory volume) from pretreatment baseline
  - Reduction in reported asthma-related symptoms, as evidenced by decreases in frequency or magnitude of one or more of the following symptoms:
    - Asthma attacks
    - Chest tightness or heaviness
    - Coughing or clearing throat
    - Difficulty taking deep breath or difficulty breathing out
    - Shortness of breath
    - Sleep disturbance, night wakening, or symptoms upon awakening
    - Tiredness
    - Wheezing/heavy breathing/fighting for air
- Client has not exhibited symptoms of hypersensitivity or anaphylaxis (bronchospasm, hypotension, syncope, urticaria, and/or angioedema) after administration of omalizumab, benralizumab, mepolizumab, or reslizumab.

After lapses in treatment of 3 months or greater, prior authorization requests submitted with documentation will be reviewed by the CSHCN Services Program Medical Director or designee.

Requests for clients who do not meet the above criteria will be reviewed for medical necessity by the CSHCN Services Program Medical Director or designee.

31.2.26.18 Secukinumab

Procedure code J3247 is a benefit for clients who are 18 years of age or older and limited to the following diagnosis codes:

Diagnosis Codes							
L400	L401	L402	L403	L404	L4050	L4051	L4052
L4053	L4054	L4059	L408	L409	M0880	M450	M451
M452	M453	M454	M455	M456	M457	M458	M459
M4680	M4681	M4682	M4683	M4684	M4685	M4686	M4687
M4688	M4689						

31.2.26.19 Tocilizumab-aazg (Tyenne)

Tocilizumab-aazg (Tyenne) (procedure code Q5135) is a benefit of the CSHCN Services Program for clients who are 2 years of age or older and is limited to the following diagnosis codes:

Diagnosis Codes							
M0500	M05011	M05012	M05019	M05021	M05022	M05029	M05031

Diagnosis Codes							
M05032	M05039	M05041	M05042	M05049	M05050	M05052	M05059
M05061	M05062	M05069	M05071	M05072	M05079	M0509	M0510
M05111	M05112	M05119	M05121	M05122	M05129	M05131	M05132
M05139	M05141	M05142	M05149	M05151	M05152	M05159	M05161
M05162	M05169	M05171	M05172	M05179	M0519	M0520	M05211
M05212	M05219	M05221	M05222	M05229	M05231	M05232	M05239
M05241	M05242	M05249	M05251	M05252	M05259	M05261	M05262
M05269	M05271	M05272	M05279	M0259	M0530	M05311	M05312
M05319	M05321	M05322	M05329	M05331	M05332	M05339	M05341
M05342	M05349	M05351	M05352	M05359	M05361	M05362	M05369
M05371	M05372	M05379	M0539	M0540	M05411	M05412	M05419
M05421	M05422	M05429	M05431	M05432	M05439	M05441	M05442
M05449	M05451	M05452	M05459	M05461	M05462	M05469	M05471
M05472	M05479	M0549	M0550	M05511	M05512	M05519	M05521
M05522	M05529	M05531	M05532	M05539	M05541	M05542	M05549
M05551	M05552	M05559	M05561	M05562	M05569	M05571	M05572
M05579	M0559	M0560	M05611	M05612	M05619	M05621	M05622
M05629	M05631	M05632	M05639	M05641	M05642	M05649	M05651
M05652	M05659	M05661	M05662	M05669	M05671	M05672	M05679
M0569	M0570	M05711	M05712	M05719	M05721	M05722	M05729
M05731	M05732	M05739	M05741	M05742	M05749	M05751	M05752
M05759	M05761	M05762	M05769	M05771	M05772	M05779	M0579
M057A	M0580	M05811	M05812	M05819	M05821	M05822	M05829
M05831	M05832	M05839	M05841	M05842	M05849	M05851	M05852
M05859	M05861	M05862	M05869	M05871	M05872	M05879	M0589
M058A	M059	M0600	M06011	M06012	M06019	M06021	M06022
M06029	M06031	M06032	M06039	M06041	M06042	M06049	M06051
M06052	M06059	M06061	M06062	M06069	M06071	M06072	M06079
M0609	M060A	M0680	M06811	M06812	M06819	M06821	M06822
M06829	M06831	M06832	M06839	M06841	M06842	M06849	M06851
M06852	M06859	M06861	M06862	M06869	M06871	M06872	M06879
M0689	M068A	M069	M0820	M08211	M08212	M08219	M08221
M08222	M08229	M08231	M08232	M08239	M08241	M08242	M08249
M08251	M08252	M08259	M08261	M08262	M08269	M08271	M08272
M08279	M0829	M082A	M083	M315	M316		

31.2.26.20 Trastuzumab

Trastuzumab (procedure code J9355) is 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. Procedure code J9355 is payable when billed with the following diagnosis codes:

Diagnosis Codes							
C50011	C50012	C50019	C50021	C50022	C50029	C50111	C50112
C50119	C50121	C50122	C50129	C50211	C50212	C50219	C50221
C50222	C50229	C50311	C50312	C50319	C50321	C50322	C50329
C50411	C50412	C50419	C50421	C50422	C50429	C50511	C50512
C50519	C50521	C50522	C50529	C50611	C50612	C50619	C50621
C50622	C50629	C50811	C50812	C50819	C50821	C50822	C50829
C50911	C50912	C50919	C50921	C50922	C50929	C563	C7963
C847A							

31.2.26.21 Triamcinolone Acetonide

Triamcinolone acetonide (procedure code J3304) is a benefit of the CSHCN Services Program and is restricted to the following diagnosis codes:

Diagnosis Codes							
M170	M1711	M1712	M172	M1731	M1732	M174	M175
M1909	M1919	M1929					

Procedure code J3304 is limited to one per 12 weeks, any provider.

31.2.27 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.

31.2.28 Laboratory Services

31.2.28.1 Clinical Pathology Services and Pathology Consultations

Clinical pathology consultations (procedure codes 80503, 80504, 80505, or 80506) are a benefit when they are performed by a clinical pathologist or geneticist. A geneticist may submit claims for procedure codes 80503, 80504, 80505, or 80506 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.

31.2.28.2 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.

31.2.28.3 Reimbursement

Clinical laboratory services performed in a physician's office may be reimbursed 60 percent of the prevailing charge levels.

Refer to: Chapter 25, "Enrollment" for additional information concerning coding and reimbursement for laboratory procedures.

31.2.28.4 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 25.2.5.3, "Genetic Testing for Colorectal Cancer" in Chapter 25, "Laboratory Services" for additional information concerning coding and reimbursement for gynecological cytopathology studies.

31.2.28.5 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 25.2.5.2, "Cytogenetics Testing" in Chapter 25, "Laboratory Services" for additional information about reimbursement for cytogenetics testing.

31.2.28.6 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^	87513		
^ QW modifier required									

Refer to: Section 25.2.9, "Helicobacter pylori (H. pylori)" in Chapter 25, "Laboratory Services" for additional information about reimbursement for H. pylori testing.

31.2.28.7 CLIA Requirement

Refer to: Section 2.1.5.6, "Clinical Laboratory Improvement Amendments (CLIA) of 1988" in Chapter 2, "Provider Enrollment and Responsibilities."

Section 25.1.1, "Clinical Laboratory Improvement Amendments (CLIA) of 1988" in Chapter 25, "Laboratory Services" for additional information regarding CLIA regulations.

31.2.29 Magnetoencephalography (MEG)

MEG is a benefit of the CSHCN Services Program when used in pre-surgical planning for clients with intractable focal epilepsy, brain tumors, or vascular malformations.

Procedure codes 95965, 95966, and 95967 may be reimbursed for MEG services that are provided in the office, inpatient hospital, and outpatient hospital settings. Procedure code 95967 must be submitted along with primary procedure code 95966 on the same day, by the same provider.

Physicians may be reimbursed for the professional component of MEG services and the lower of the billed amount or the amount allowed by Texas Medicaid.

31.2.29.1 Authorization Requirements

Prior authorization is required for MEG procedures and must be obtained prior to the date of service. Requests for MEG must be submitted on the CSHCN Services Program Authorization and Prior Authorization Request Form to the TMHP CSHCN Services Program Authorization Department.

The provider must complete and submit a prior authorization request, which should include all required documentation through any CSHCN approved method. A copy of the prior authorization request and all submitted documentation must be maintained in the client's medical record.

Note: *All prior authorization requests must be submitted with the ordering practitioner's signature.*

To facilitate a determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the service(s) requested.

Documentation must support the medical need of pre-surgical planning for clients with intractable focal epilepsy, brain tumors, or vascular malformations, and must include the following, as applicable:

- Evidence of intractable focal epilepsy, neoplasm, or arterial venous malformations (AVMs), and
- Evidence of prior treatment failures with antiepileptic drugs, if applicable, and
- Evidence demonstrating failure of previous brain surgery or failure of more traditional testing to locate the epileptic foci, and
- Evidence of current and past diagnostic studies indicating the need for MEG.

Note: *Requests for repeat MEG scans must include the date of the previous MEG and documentation supporting the medical necessity for the repeat scan.*

If the service is medically necessary, 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 Authorization and 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.

Prior authorization and medical review is required for all other indications. Documentation for consideration must include 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 CSHCN Services Program Medical Director or designee.

31.2.29.2 Documentation Requirements

All services are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided. Documentation in the client's medical record must be maintained by the physician and support the medical necessity for the services provided. Services not supported by documentation are subject to recoupment.

Providers may be asked to provide additional documentation to clarify a prior authorization request or to clarify medical necessity of the client.

31.2.29.3 Exclusions

MEG is not a stand-alone test, and is not the first order test after clinical and routine EEG diagnosis of epilepsy, and cannot replace, but may guide, the placement of intracranial EEG.

Services and procedures that are investigational or experimental are not benefits of the CSHCN Services Program.

31.2.30 Neurostimulator Devices and Supplies

Neurostimulator devices and supplies are benefits of the CSHCN Services Program.

Refer to: Chapter 27, "Neurostimulators and Neuromuscular Stimulators" for information about benefits for neurostimulator devices and supplies.

31.2.31 Ophthalmological Services

Ophthalmological services are benefits of the CSHCN Services Program.

Refer to: Chapter 40, "Vision Services" for additional information about reimbursement for ophthalmology.

31.2.31.1 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.*

31.2.31.2 Vitrasert Ganciclovir Implant

Procedure code 67027 is a benefit with diagnosis code B251, B258, B259, H3090, H3091, H3092, or H3093. 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.

31.2.32 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" for more information about OMT services.

31.2.33 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" 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									
97012	97016	97018	97022	97024	97026	97028	97032	97033	97034
97035	97036	97110	97112	97113	97116	97124	97140	97150	97161
97162	97163	97164	97165	97166	97167	97168	97530	97535	97537
97542	97750	97755	97760	97761	97762	97799			

Physical therapy services must be billed with the GP modifier.

31.2.34 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)" in Chapter 28, "Orthotic and Prosthetic Devices" and Section 28.3.7.2, "Prescription Shoes" in Chapter 28, "Orthotic and Prosthetic Devices" 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" for detailed information about authorization and prior authorization requirements.

31.2.35 Psychological Testing

Psychological testing (procedure codes 96130, 96131, 96136 and 96137), neurobehavioral status exams (procedure codes 96116 and 96121), and neuropsychological testing (procedure codes 96132, 96133, 96136, and 96137) are benefits of the CSHCN Services Program and may be reimbursed up to 4 hours per day and 8 hours per calendar year, per client, for any provider. Providers must bill the units of each half hour of testing and indicate that number of units on the claim form. Claim submissions for over 4 hours per day and 8 hours per calendar year must include documentation of medical necessity. Add-on procedure codes 96121, 96131, 96133, and 96137 must be billed with their corresponding primary procedure code 96116, 96130, 96132, or 96136 on the same day, by the same provider.

Procedure codes 96121, 96130, 96131, 96132, 96133, 96136, and 96137 are included in the system limitation of 12 hours of behavioral health services per day, per provider.

Reimbursement of psychological testing, neuropsychological testing, and neurobehavioral status exams include testing scoring and interpretation of results. 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 or neurobehavioral status exam 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 (procedure codes 96130, 96131, 96136 and 96137) and neurobehavioral testing (procedure codes 96132, 96133, 96136, and 96137) may be reimbursed on the same date of service as procedure code 90791 or procedure code 90792.

Testing procedure codes 96116, 96121, 96130, 96131, 96132, 96133, 96136, and 96137 count towards the 30 per calendar year limitation.

Psychological testing (procedure codes 96130, 96131, 96136 and 96137), neurobehavioral status exams (procedure codes 96116 and 96121), and neuropsychological testing (procedure codes 96132, 96133, 96136, and 96137) will not be reimbursed on the same date of service by the same provider.

Refer to: Section 24.3.1.3, "Inpatient Behavioral Health" in Chapter 24, "Hospital" for additional information about behavioral health services.

Chapter 29, "Outpatient Behavioral Health" for additional information about behavioral health services.

31.2.36 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 HHSC, 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.

31.2.37 Skin Therapy

Procedure codes 96900, 96910, 96912, and 96913 are benefits of the CSHCN Services Program for the following diagnosis codes:

Diagnosis Codes							
A672	B070	B081	B550	B551	B552	B559	C8401
C8402	C8403	C8404	C8405	C8406	C8407	C8408	C8409
H02731	H02732	H02734	H02735	L100	L101	L102	L103
L104	L105	L1081	L1089	L120	L121	L122	L128
L130	L131	L138	L139	L14	L200	L2081	L2082
L2084	L2089	L209	L210	L211	L218	L219	L22
L230	L231	L232	L233	L234	L235	L236	L237
L2381	L2389	L239	L240	L241	L242	L243	L244
L245	L246	L247	L2481	L2489	L249	L250	L252
L258	L259	L270	L271	L272	L278	L279	L300
L302	L308	L309	L401	L560	L561	L562	L563
L564	L565	L570	L571	L572	L573	L574	L575
L580	L581	L589	L598	L599	L700	L701	L702
L703	L704	L705	L708	L730	L80	L811	L812
L813	L815	L816	L818				

31.2.38 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 https://aasm.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.

31.2.38.1 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 Codes							
E662	F5101	F5102	F5103	F5104	F5109	F5111	F5112
F5113	F5119	F513	F514	F515	F518	F519	F984
G253	G2589	G259	G26	G4700	G4701	G4710	G4711
G4712	G4713	G4714	G4719	G4720	G4721	G4722	G4723
G4724	G4725	G4726	G4727	G4729	G4730	G4731	G4733
G4734	G4735	G4736	G4737	G4739	G47411	G47419	G47421
G47429	G4750	G4751	G4752	G4753	G4754	G4759	G4761
G4769	G478	G479	J9610	J9611	J9612	R0600	R0609
R063	R0683	R0689	R069	R0901			

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.

31.2.38.2 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 Codes							
E662	G4700	G4710	G4711	G4712	G4720	G4733	G47411
G47419	G47421	G47429	G478	G479			

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.

31.2.38.3 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 Codes							
K2080	K2081	K2090	K2091	K2100	K2101	K219	K220
P220	P228	P229	P270	P271	P278	P279	P282
P2830	P2831	P2832	P2833	P2839	P2840	P2841	P2842
P2843	P2849	P285	P2881	P2889	P84	R0600	R0609
R062	R063	R0681	R0682	R0683	R0689	R069	R6813

Pediatric pneumograms are payable to physicians in office, inpatient hospital, and outpatient hospital settings. A pediatric pneumogram is limited to two services per lifetime without authorization based on the diagnoses listed above. Authorization is required for more than two pneumograms. Requests for prior authorization must be submitted using the CSHCN Services Program Authorization and Prior Authorization Request form.

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.

31.2.38.4 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 G4733.

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.

31.2.39 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.

31.2.39.1 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.

31.2.39.2 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.

31.2.39.3 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.

31.2.39.4 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 31.2.39.11, "Cleft/Craniofacial Procedures" in this chapter and Section 31.2.42.2, "Transplants - Nonsolid Organ" in this chapter.

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.

31.2.39.5 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.

31.2.39.6 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.

> ***Note:*** *Note: All unlisted surgical procedure codes have a 42-day global period assigned 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.

31.2.39.6.1 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

Modifiers Related to Surgical Fees	
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.

31.2.39.6.2 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.*

31.2.39.6.3 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.

31.2.39.6.4 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.

31.2.39.6.5 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.

31.2.39.6.6 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.

31.2.39.7 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.

31.2.39.8 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.

31.2.39.9 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.

> ***Note:*** *All unlisted surgical procedure codes have a 42-day global period assigned by the CSHCN Services Program.*

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: Section 31.2.1, "Authorization and Prior Authorization Requirements" in this chapter for specific information on procedures that must be performed by an approved specialty team/center.

Section 31.2.39.11, "Cleft/Craniofacial Procedures" in this chapter for specific information on procedures that must be performed by an approved specialty team/center.

Section 31.2.42.2, "Transplants - Nonsolid Organ" in this chapter for specific information on procedures that must be performed by an approved specialty team/center.

31.2.39.10 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 4.3, "Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" 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.

31.2.39.11 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 (acpacares.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

31.2.40 Diagnostic and Surgical/Reconstructive Breast Therapies

The following services are benefits of the CSHCN Services Program:

- Breast therapies
  - Diagnostic
  - Surgical
  - Reconstructive
  - Treatment of complications of breast reconstruction
  - External breast prostheses

- Corrective procedures

Surgical, reconstructive, and corrective procedures must be medically necessary.

Only new, unused durable medical equipment will be purchased for CSHCN clients.

Diagnostic and surgical/reconstructive breast therapies and corrective procedures include:

- Diagnostic procedures for the breast
- Mastectomy for the treatment of breast cancer
- Prophylactic mastectomy
- Mastectomy for gynecomastia
- Reconstructive procedures
- Treatment of complications of breast reconstruction
- External breast prostheses
- Corrective procedures

The following provider types, services and settings apply:

- Diagnostic and surgical/reconstructive breast therapies may be provided by physicians, physician assistants, and advanced practice registered nurses, in the office, outpatient and inpatient hospital settings.
- Corrective procedures may be provided by physicians, dentists, podiatrists, physician assistants, and advanced practice registered nurses, in office, inpatient and outpatient hospital settings.
- Breast prostheses which are considered DME and may be provided by DME providers in the home setting.

To be considered for reimbursement, a LT or RT modifier must be appropriately appended to the procedure codes submitted for diagnostic and surgical/reconstructive breast therapies, external breast prostheses, or corrective procedures.

31.2.40.1 Breast Therapies

31.2.40.1.1 Diagnostic Breast Procedures

Diagnostic breast procedures are a benefit of the CSHCN Services Program for a diagnosis of a condition or malignancy of the breast.

Diagnostic procedures may include:

- Puncture aspiration
- Mastotomy
- Injection procedure for ductogram or galactogram
- Percutaneous biopsy, with or without imaging guidance
- Incisional biopsy
- Nipple exploration

Excision of the following:

- Lactiferous duct fistula
- Benign or malignant breast lesion
- Chest wall tumor

The following procedure codes may be reimbursed for diagnostic procedures:

Procedure Codes									
19000	19001	19020	19030	19081	19082	19083	19084	19085	19086
19100	19101	19110	19112	19120	19125	19126	19281	19282	19283
19284	19285	19286	19287	19288	21601	21602	21603		
***Procedure code 21603 is limited to one procedure per lifetime.**									

The following procedure codes are add-on codes and must be billed with the appropriate primary procedure code, on the same day, by the same provider:

Add-on Procedure Codes								
19001	19082	19084	19086	19126	19282	19284	19286	19288

31.2.40.2 Surgical Breast Procedures

31.2.40.2.1 Mastectomy

Mastectomy and partial mastectomy (e.g., lumpectomy, tylectomy, quadrantectomy, or segmentectomy) is a benefit of the CSHCN Services Program when it is medically necessary to remove a breast or portion of a breast for conditions including, but not limited to:

- Developmental abnormality
- Congenital defect
- Trauma or injury to chest wall
- Primary or secondary malignancy of the breast
- Carcinoma in situ of the breast

The following mastectomy procedure codes are benefits of the CSHCN Services Program for male and female clients of all ages:

Procedure Codes	Limitations
Partial Mastectomy	
19301, 19302	One left breast per lifetime One right breast per lifetime
Simple, Subcutaneous, Radical, and Modified Radical Mastectomy	
19303 19305, 19306, 19307	One left breast per lifetime One right breast per lifetime

31.2.40.2.2 Prophylactic Mastectomy

Prophylactic mastectomy is a benefit of the CSHCN Services Program and is limited to clients who are at moderate or high-risk for the development of breast cancer and have one or more of the following conditions:

- Personal history
  - Current or previous history of breast cancer
  - Lobular carcinoma in situ (LCIS)
  - Radiation therapy to the chest before the age of 30
- Family history of breast or ovarian cancer in mother, sister, or daughter

- Presence of any of the following genetic mutations:
  - Breast cancer gene 1 (BRCA1)
  - Breast cancer gene 2 (BRCA2)
  - Tumor protein 53 (TP 53)
  - Phosphatase and tensin homolog (PTEN)

Note: *The above risk factors are identified by the National Cancer Institute and the National Comprehensive Cancer Network.*

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

31.2.40.2.3 Mastectomy for Gynecomastia

Surgery to correct gynecomastia is a benefit of the CSHCN Services Program for males who are 20 years of age or younger, when the criteria is met.

Procedure code 19300 may be reimbursed when billing for a mastectomy for pubertal gynecomastia.

31.2.40.2.4 Breast Reconstruction

Breast reconstruction is a benefit of the CSHCN Services Program when performed to correct or repair abnormal structures of the breast caused by one or more of the following:

- Mastectomy or a history of complications of mastectomy
- 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 or injury to the chest wall

Breast reconstruction may be performed using one of the following:

- Implants (saline or silicone)
- Tissue transfers, including, but not limited to:
  - Latissimus dorsi flap
  - Transverse rectus abdominis myocutaneous (TRAM) flap
  - Deep inferior epigastric perforator (DIEP) flap
  - Superficial inferior epigastric artery (SIEA) flap
- Nipple or areola reconstruction
- Reduction mammaplasty

- Mastopexy
- Tattooing to correct color defects of the skin
- Treatment for complications of breast reconstruction

Breast reconstruction may be performed as single or 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. All of the following criteria must be met for breast reconstruction following a medically necessary mastectomy.

- The client is eligible for CSHCN Services Program at the time of the breast reconstruction.
- The client has a documented history of a mastectomy.
- The client meets age and gender criteria for the requested procedure.

The following procedure codes may be reimbursed for breast reconstruction:

Procedure Code	Client Gender and Ages	Limitation
11920	Male and female clients	Two procedures per lifetime
11921	Male and female clients	Two procedures per lifetime
11922	Male and female clients	Two procedures per lifetime
11970	Male and female clients	
11971	Male and female clients	
19316	Female clients	
19318	Female clients	
19325	Female clients	
19340	Female clients	
19342	Female clients	
19350	Male and female clients	
19355	Male and female clients	
19357	Female clients	
19361	Male and female clients	
19364	Male and female clients	
19367	Male and female clients	
19368	Male and female clients	
19369	Female clients	
19396	Female clients	
S2068	Male and female clients	

Tattooing (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.

Denied claims for tattooing may be appealed with supporting documentation stating the date of breast reconstruction.

Denied claims for breast reconstruction may be appealed with supporting documentation which includes the date of mastectomy.

31.2.40.2.5 Excision or Destruction of Benign Lesions

The client must have a documented history of mastectomy or a history of complications of mastectomy performed while eligible for the CSHCN Services Program.

Documentation supporting medical necessity for treatment of a benign lesion, cyst, or lipoma must be maintained in the client's medical record and identify that the lesion requiring treatment is one or more of the following:

- Inflamed
- Infected
- Irritated
- Bleeding
- Increasing in size
- Obstructing vision
- Interfering with oral function
- Located in an area that could affect motion or function

When a lesion is suspicious for malignancy, documentation supporting medical necessity for excision or destruction of the lesion must be maintained in the client's medical record.

For blepharoplasty procedures (procedure codes 15820, 15821, 15822, and 15823) additional documentation of medical necessity must be submitted with both of the following:

- Photographs of the eyelid problem
- Visual field measurements

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 31.2.39.6, "Global Fees" in this chapter and Section 31.2.39.7, "Multiple Surgeries" in this chapter for additional information about global surgery and multiple surgery fees.

31.2.40.2.6 Treatment for Complications of Breast Reconstruction

The following procedure codes are benefits of the CSHCN Services Program for the treatment of complications of breast reconstruction:

Procedure Codes				
19328*	19330*	19370*	19371*	19380
*** A benefit for female clients only**				

Regardless of the client's eligibility at the time of the original breast reconstruction, the treatment of complications is considered for reimbursement when medical criteria are met.

31.2.40.2.7 Reduction Mammaplasty

Procedure code 19318 may be reimbursed with prior authorization for reduction mammaplasty. This procedure is limited to two per lifetime.

31.2.40.2.8 External Breast Prostheses

External breast prostheses must be provided by a durable medical equipment (DME) provider to a female client with a history of a medically necessary mastectomy procedure.

External breast prostheses may be reimbursed if the client has a documented history of breast surgery in the past.

Refer to: Chapter 17, "Durable Medical Equipment (DME)" for breast prosthesis benefits and limitations.

31.2.40.3 Prior Authorization and Authorization Requirements

All prior authorization and authorization requests must be submitted with documentation of medical necessity.

Prior authorization requests must be submitted using a CSHCN Services Program Authorization and Prior Authorization Request form. Prior authorization requests that do not contain required information are considered incomplete and will be denied. The requesting provider may be asked for additional information to clarify or support the authorization request.

Prior authorization requests for external breast prostheses must be submitted using the CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form and Instructions.

Requests must include the physician's original signature and the date signed. Stamped signatures and dates will not be accepted. Requests will be considered incomplete without this information.

Requests for DME quantities exceeding limitations must be prior authorized by the CSHCN medical director and must be submitted with documentation of medical necessity.

Procedure code 15828 requires prior authorization. All requests must be reviewed by the CSHCN Services Program Medical Director or designee.

31.2.40.4 Prior Authorization and Authorization Requirements for Mastectomy, Breast Reconstruction, and External Prostheses

Prior authorization is not required when:

- The client is 18 years of age or older, meets gender criteria and the procedure is a mastectomy or breast reconstruction, or
- The client is 18 years of age or older, meets gender criteria, and the request is for one of the following external breast prosthesis procedure codes:

Procedure Codes						
L8000	L8001	L8002	L8010	L8015	L8020	L8030

- Partial mastectomy, procedure codes 19301 and 19302 are exceptions. Procedure codes 19301 and 19302 are eligible for reimbursement regardless of the client's age, and therefore they do not require prior authorization.

Prior authorization is required for the following:

- Mastectomy or breast reconstruction when the client does not meet criteria
- Mastectomy for pubertal gynecomastia
- Unlisted breast procedure code 19499
- Tattooing for clients without an established history of breast reconstruction during eligibility for the CSHCN Services Program
- External breast prosthesis procedure codes L8035 and L8039

31.2.40.4.1 Mastectomy and Breast Reconstruction

Prior authorization for mastectomy, prophylactic mastectomy, or breast reconstruction is required for one or more of the following:

- The client is 17 years of age or younger, or
- The client does not meet the gender criteria for the requested procedure, as required by the CSHCN Services Program, or
- The client does not have an established history of related services while eligible for the CSHCN Services Program.

Documentation for a mastectomy must be submitted for conditions, including but not limited to:

- Developmental abnormality
- Congenital defect
- Trauma or injury to chest wall
- Primary or secondary malignancy of the breast
- Carcinoma in situ of the breast

31.2.40.4.2 Breast Reconstruction

Documentation must be submitted which identifies one or more of the following:

- Mastectomy or a history of complications of mastectomy
- 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 or injury to the chest wall

31.2.40.4.3 Mastectomy for Gynecomastia

Prior authorization is required for procedure code 19300, which indicates mastectomy for pubertal gynecomastia. The following documentation must be submitted with all prior authorization requests:

- Gynecomastia is classified as Grade II, III or IV per the American Society of Plastic Surgeons classification.
- Puberty is at or near completion, as evidenced by documentation of the following:
  - 95 percent of adult height based on bone age, and
  - Tanner stage V
- Glandular breast tissue confirming true gynecomastia is documented on physical examination or mammography.
- Hormonal causes, including hyperthyroidism, estrogen excess, prolactinomas and hypogonadism, have been excluded by appropriate laboratory testing. If present, hormonal causes must have been treated for at least one year and are resolved, as supported by appropriate laboratory test results.
- Medical documentation must be submitted with a prior authorization request for a client that has used gynecomastia inducing drugs or other substances, when identified as the cause of gynecomastia. The documentation must indicate that the client has been off the drugs or other substances for a minimum of one year and must include the dates that the client has been off such substances.

- Psychological and psycho-social effects which were identified in the pre-surgical history and physical.
- Identification of left breast, right breast or both breasts, which require mastectomy.

31.2.40.4.4 Reduction Mammaplasty

Prior authorization is required for procedure code 19318, which indicates reduction mammaplasty.

When requesting prior authorization for procedure code 19318, the following documentation must be submitted with all prior authorization requests:

- Surgeons are required to include the following information documenting medical necessity when 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 National Provider Identifier (NPI) number, and
  - Name and address of facility where services are to be performed and the provider's NPI.

31.2.40.4.5 Unlisted Procedure

Prior authorization is required for procedure code 19499, which indicates an unlisted breast procedure.

When requesting a prior authorization for procedure code 19499, the following documentation must be submitted to determine coverage:

- A clear, concise description of the procedure to be performed
- Reason for recommending this particular procedure
- A CPT or HCPCS procedure code, which is comparable to the procedure being requested
- Documentation this procedure is not investigational or experimental
- Place of service the procedure is to be performed, and
- The provider's intended fee for this procedure.

Prior authorization requests must be submitted using a CSHCN Services Program Authorization and Prior Authorization Request form.

Prior authorization requests that do not contain the required information are considered incomplete and will be denied.

31.2.40.4.6 Breast Prostheses

Prior authorization requests for external breast prostheses must be submitted using the CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form and Instructions.

External breast prostheses of the same type will be considered for coverage at any time, through the prior authorization process, if it is lost, stolen, or irreparably damaged.

An external breast prosthesis that is a replacement or a different type will be considered for coverage at any time, through the prior authorization process, if the prosthesis is needed due to a change in the client's medical condition.

Prior authorization is required for procedure codes L8035 and L8039 when the request is for new or replacement external breast prosthesis. The following documentation of medical necessity must be submitted with the prior authorization request:

- The client's diagnosis
- Prior treatment for this diagnosis, and
- Medical necessity of the requested prosthesis.

When requesting a prior authorization for procedure code L8039, the following additional information must also be submitted in order to determine coverage:

- A clear, concise description of the prosthesis which is requested
- Reason for recommending this particular prosthesis
- A CPT or HCPCS procedure code, which is comparable to the prosthesis requested
- Documentation that this prosthesis is not investigational or experimental
- Provider's place of service, and
- The provider's intended fee for this prosthesis.

31.2.40.5 Documentation Requirements

In addition to documentation requirements outlined in the Prior Authorization and Authorization Requirements section, the following requirements apply:

- All services are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided, and
- Services not supported by documentation are subject to recoupment.

31.2.40.6 Reconstructive and Corrective Procedures (Not Related to Breast Therapies)

Reconstructive and corrective procedures are performed on structures of the body for any of the following purposes:

- Improving or restoring bodily functions
- Correcting significant deformity resulting from:
  - Disease
  - Trauma
  - Previous surgical procedure
  - Congenital or developmental anomalies

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 that could affect motion or function

Excision or destruction of a lesion may be a benefit when there is suspicion of malignancy.

The following procedure codes may be reimbursed for corrective procedures:

Procedure Codes									
10040	11200	11201	11300	11301	11302	11303	11305	11306	11307
11308	11310	13111	11312	11313	11400	11401	11402	11403	11404
11406	11420	11421	11422	11423	11424	11426	11440	11441	11442
11443	11444	11446	11760	11762	11960	15781	15782	15783	15786
15787	15788	15789	15792	15793	15820	15821	15822	15823	15830
15847	17000	17003	17004	17106	17107	17108	17110	17111	17311
17312	17313	17314	17315	21555	21740	21742	21743	21930	21931
22900	22901	22902	22903	23071	23073	23075	23076	23077	23078
24071	24073	24075	24076	24077	24079	25075	26115	27043	27045
27047	27048	27049	27327	27328	27337	27339	27618	27619	27634
28039	28041	28043	28045	28313	40818	54660			

The following procedure codes are add-on codes and must be billed with the appropriate primary procedure code, on the same day, by the same provider:

Add-on Procedure Codes							
11201	15777	15787	15847	17003	17312	17314	17315

31.2.40.7 Prior Authorization and Authorization for Corrective Procedures

31.2.40.7.1 Oral Procedures

Procedures that are performed as part of cleft-craniofacial surgery require prior authorization.

Refer to: Section 31.2.39.11, "Cleft/Craniofacial Procedures" in this chapter for information about CSHCN Services Program cleft-craniofacial benefits and limitations.

31.2.40.7.2 Dermatological and Blepharoplasty Procedures

Acne surgeries, dermabrasion, and chemical peel, and blepharoplasty procedures (procedure codes 10040, 15781, 15782, 15783, 15788, 15789, 15792, 15793, 15820, 15821, 15822, and 15823) require prior authorization, and must meet one of the following criteria:

- Correction or repair of severe disfigurement due to disease or accidental injury (photographic documentation is required), or
- Restoration of physical function resulting from disease or accidental injury (specific function must be detailed in prior authorization request).

31.2.40.7.3 Panniculectomy and Abdominoplasty

Procedure codes 15830 and 15847 are benefits for panniculectomy and abdominoplasty procedures.

Panniculectomy and abdominoplasty procedures are limited to once per lifetime, by the same provider.

Panniculectomy and abdominoplasty procedure codes 15830 and 15847 require prior authorization. The following documentation supporting medical necessity must be submitted with all prior authorization requests:

- Photographic documentation that the panniculus hangs below the level of the pubis,

- The panniculus is the result of weight loss of at least 75 pounds that has been sustained for over one year, and
- Documentation of one or more of the following conditions which directly impairs physical function:
  - Interference with ambulation, urination or other activities of daily living, or
  - 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.

31.2.40.7.4 Noncovered Services

The following services are not a benefit of the CSHCN Services Program:

- Alteration of a natural, undamaged, or unimpaired body part, except as specifically outlined in this chapter.

The following cosmetic procedures are not a benefit of the CSHCN Services Program:

- Rhytidectomies (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)

31.2.40.8 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 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" 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 Codes						
G800	G801	G802	G808	G809	G835	G8389

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.

31.2.40.9 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 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" 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

31.2.41 Therapeutic Apheresis

Therapeutic apheresis does not require authorization.

Reimbursement for procedure codes 36511, 36512, 36513, 36514, and 36516 is limited to the following diagnosis codes:

Diagnosis Codes							
C8800	C8801	C8820	C8821	C8830	C8831	C8880	C8881
C9000	C9002	C9010	C9012	C9020	C9022	C9030	C9032
C9100	C9102	C9110	C9112	C9130	C9132	C9140	C9142
C9150	C9152	C9160	C9162	C9190	C9192	C91A0	C91A2
C91Z0	C91Z2	C9200	C9202	C9210	C9220	C9230	C9232
C9240	C9242	C9250	C9252	C9260	C9262	C9290	C9292
C92A0	C92A2	C92Z0	C92Z2	C9300	C9302	C9310	C9312
C9330	C9332	C9390	C9392	C93Z0	C93Z2	C9400	C9402
C9420	C9422	C9430	C9432	C9440	C9442	C9480	C9482
C9500	C9502	C9510	C9512	C9590	C9592	D45	D472
D473	D474	D5700	D5701	D5702	D5703	D5704	D5709
D571	D5720	D57211	D57212	D57213	D57214	D57218	D57219
D5780	D57811	D57812	D57813	D57818	D57819	D588	D589
D590	D5910	D5911	D5912	D5913	D5919	D592	D5930
D5931	D5932	D5939	D594	D599	D6182	D65	D682
D68311	D688	D690	D691	D692	D693	D6941	D6942
D6949	D696	D698	D699	D72828	D740	D748	D749
D750	D751	D7589	D759	D761	D762	D763	D77
D890	D8940	D8941	D8942	D8943	D8949	D892	E0842
E0942	E1042	E1142	E7800	E7801	E7841	E7849	G603
G610	G6181	G6182	G6189	G620	G621	G622	G6281
G6282	G63	G64	G650	G7000	G7001	G731	I00
I010	I012	I018	I019	I773	I776	I7789	K716
K7200	K7201	K7581	K759	K760	K762	K7689	K77
L100	L101	L102	L103	L104	L105	L1081	L1089
L109	L900	L940	L941	L943	M05011	M05012	M05021

Diagnosis Codes							
M05022	M05031	M05032	M05041	M05042	M05051	M05052	M05061
M05062	M05071	M05072	M0509	M05411	M05412	M05421	M05422
M05431	M05432	M05441	M05442	M05451	M05452	M05461	M05462
M05471	M05472	M0549	M05611	M05612	M05621	M05622	M05631
M05632	M05641	M05642	M05651	M05652	M05661	M05662	M05671
M05672	M0569	M069	M08011	M08012	M08021	M08022	M08031
M08032	M08041	M08042	M08051	M08052	M08061	M08062	M08071
M08072	M0809	M080A	M083	M08411	M08412	M08421	M08422
M08431	M08432	M08441	M08442	M08451	M08452	M08461	M08462
M08471	M08472	M0848	M084A	M08832	M08841	M08842	M08851
M08852	M08861	M08931	M08932	M08941	M08942	M08951	M08952
M08961	M08962	M089A	M310	M3110	M3111	M3119	M320
M3210	M3219	M328	M3300	M3301	M3302	M3309	M3310
M3311	M3312	M3319	M3320	M3321	M3322	M3329	M3390
M3391	M3392	M3399	M340	M341	M342	M3481	M3482
M3483	M3489	N000	N001	N002	N003	N004	N005
N006	N007	N008	N00A	N010	N011	N012	N013
N014	N015	N016	N017	N018	N01A	N02B1	N02B2
N02B3	N02B4	N02B5	N02B6	N02B9	N032	N034	N035
N037	N03A	N040	N0420	N0421	N0422	N0429	N044
N045	N046	N047	N048	N049	N04A	N052	N053
N054	N055	N056	N058	N059	N05A	N08	N171
N172	T8690	T8691	T8692	T8699			

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 (such as Liposorber® LA 15) or the protein A immunoadsorption columns (such as Prosorba®).

Claims for apheresis services must be submitted with procedure codes 36511, 36512, 36513, 36514, 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.

31.2.42 Transplants

31.2.42.1 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" in Chapter 2, "Provider Enrollment and Responsibilities."

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

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.

31.2.42.2 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" in Chapter 2, "Provider Enrollment and Responsibilities."

The following surgery procedure codes should be used to submit claims for reimbursement of transplantation and post-transplantation cellular infusion procedures:

Procedure Codes								
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 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" 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.

31.2.42.2.1 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.*

31.2.43 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
- More than 10 applications of skin substitute grafts per episode of wound care in a 12- week period of care per rolling year, which will begin on the first day of the first skin substitute application
- Separately billed repeated use of the skin substitute product after 12 weeks for a single wound or episode
- Skin substitute grafting for partial thickness loss with the retention of epithelial appendages as epithelium will repopulate the deficit from the appendages, negating the benefit of over grafting
- Skin substitute products not billed concurrently with procedure codes 15271, 15272, 15273, 15274, 15275, 15276, 15277, and 15278 are not separately reimbursed.

31.2.43.1 First-Line Wound Care Therapy

First-line wound care therapy includes the following:

- Cleaning, antibiotics, and pressure off-loading
- Compression
- Debridement
- Dressings may include wet and dry dressings (Dressings applied to the wound are considered part of the service for wound debridement)
- Whirlpool for burns

31.2.43.1.1 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 or off-loading performed as part of wound care management may be reimbursed when billed with procedure codes 29445, 29580, or 29581.

31.2.43.1.2 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	11045	11046	11047	16020	16025
16030	97597	97598	97602						

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, 11044, 11045, 11046, and 11047 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

31.2.43.2 Second-Line Wound Care Therapy

Second-line wound care therapy is limited to chronic Stage 3 or 4 wounds and is a benefit only after first-line therapy has been tried for at least 30 days without measurable signs of improved healing. First-line wound care therapy may continue as appropriate, with the addition of second-line wound care measures as indicated by the client's medical condition. Second-line wound care therapy includes the following:

- Application of metabolically active skin equivalents/skin substitutes
- Pulsatile jet irrigation
- Whirpool

31.2.43.2.1 Pulsatile-Jet Irrigation

Pulsatile-jet irrigation is a benefit for the treatment of Stage 3 or 4 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.

31.2.43.2.2 Application of Metabolically Active Skin Equivalents and Wound Preparation

Metabolically active skin equivalents/skin substitutes may be a benefit when 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, which 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 application of skin substitutes may be a benefit for the treatment of chronic Stage 3 or 4 wounds that have failed to respond to standard wound care treatment after 30 days. A failed response is defined as a wound that has increased in size or depth, or has not changed in baseline size or depth, and shows no measurable signs of healing improvements after 30 days of appropriate wound-care measures.

Use of the appropriate specific skin substitute product(s) for the episode of each documented wound is expected. Compliance with the Food and Drug Administration (FDA) assessments and submitted guidelines for the specific skin substitute product(s) used is expected.

Wound care services that include the use of skin substitutes must be provided in accordance with the FDA-approved package label and applied according to the manufacturer's instructions for use. Skin substitute products not used within the scope of the FDA's intended use and indications are considered experimental and or investigational.

Procedure codes 15271, 15272, 15273, 15274, 15275, 15276, 15277, and 15278 are a benefit for the application of skin substitute grafts.

Procedure codes 15002, 15003, 15004, 15005, 15040, and 15050 are a benefit for surgical wound preparation.

31.2.43.3 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 location
    - 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.

All wound treatments involving the application of skin substitutes must include, but are not limited to, documentation of the following:

- Wound treatments are accompanied by the appropriate adjunctive measures, and identify the specific adjunctive therapies being provided to the client as part of the wound treatment regimen.

- All wounds must be free of infection, necrotic tissue, or exudate and any underlying conditions that compromise wound healing. The documentation in the client's record must reflect the conditions have been treated and resolved.
- Clients who use tobacco will have ceased smoking or have refrained from systemic tobacco intake for at least 4 weeks prior to beginning skin substitute applications and during the conservative wound care.
- Adequate circulation/oxygenation to support tissue growth/wound healing must be present as evidenced by physical examination (e.g., Ankle-Brachial Index [ABI] of no less than 0.60, toe pressure greater than 30 millimeters of mercury [mmHg]).
- The wound has a skin deficit at least 1.0 square centimeter in size.
- For diabetic foot ulcers, the client's medical record reflects a diagnosis of Type 1 or Type 2 diabetes. Partial or full thickness ulcers must have a clean granular base without tendon and or muscle involvement, bone exposure, or sinus tracts.
- Documentation of the wound's response to the treatment is required at least every 30 days for each treatment episode. The documentation requirements must include measurements of the initial wound, measurements at the completion of appropriate wound care every 30 days, and measurements immediately prior to placement and with each subsequent placement of the skin substitute.

Documentation maintained in the client's medical record must support the need for skin substitute applications and the product used.

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 for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

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

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

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper 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/resources/rate-and-code-updates/rate-changes.

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

Refer to: Section 31.2.5, "Anesthesia Services" in this chapter 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.

Note: *Rural hospital outpatient imaging services may be reimbursed at 65 percent of the allowed amount for nonemergent services provided by physician providers in an outpatient setting (POS 5).*

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.

PHYSICIAN ASSISTANT (PA)

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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 Provider Enrollment and Management System (PEMS). 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 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

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

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" for detailed information about authorization and prior authorization requirements.

Section 31.2.12, "Clinician-Directed Care Coordination Services" in Chapter 31, "Physician" 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 41, "TMHP Electronic Data Interchange (EDI)" for information about electronic claims submissions.

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

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper 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/resources/rate-and-code-updates/rate-changes.

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

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.

PRESCRIBED PEDIATRIC EXTENDED CARE CENTERS

CSHCN SERVICES PROGRAM PROVIDER MANUAL

APRIL 2025

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PRESCRIBED PEDIATRIC EXTENDED CARE CENTERS

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33.1 Enrollment

To enroll in the Children with Special Health Care Needs (CSHCN) Services Program, Prescribed Pediatric Extended Care Centers (PPECC) 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. The provider must be licensed as a PPECC facility by the Texas Health and Human Services Commission (HHSC). Providers cannot be enrolled if their license is due to expire within 30 days.

Out-of-state PPECC providers must meet all applicable enrollment requirements, and be located in the United States, within 50 miles of the Texas state border.

PPECCs may enroll or reenroll as CSHCN Services Program providers by completing the provider enrollment application available through the Provider Enrollment and Management System (PEMS). For assistance with the application process, call the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413, Option 2.

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 with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (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.

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

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

33.2 Benefits, Limitations, and Authorization Requirements

PPECC services are a benefit of the CSHCN Services Program for medically fragile clients who are 20 years of age and younger who have a chronic medically complex or fragile condition or disability that requires extended and complex skilled nursing interventions and monitoring beyond the level of Home Health skilled nursing and Home Health aide services and require the routine use of a medical device or assistive technology to compensate for the loss of a body function needed to participate in activities of daily living.

Chronic medically fragile conditions include, but are not limited to:

- Cerebral palsy
- Cystic fibrosis
- Muscular dystrophy, or

- Other diagnoses which may be considered on a case by case basis

Medically dependent and medically fragile clients live with an ongoing risk of deterioration of their clinical condition, loss of function, risk to health status due to medical fragility and/or death.

PPECCs provide nonresidential facility based care as an alternative to extended skilled nursing services for individuals who require ongoing technology based skilled nursing care to avert death or further disability and who require the routine use of a medical device to compensate for a deficit in a life sustaining body function.

Stable, controlled, or occasional medical conditions that do not require ongoing skilled nursing services do not meet the medical necessity requirements for PPECC services.

Note: *PPECC clients require ongoing skilled nursing services for treatment of chronic conditions which are not expected to resolve in 60 calendar days or less and who require the routine use of a medical device or assistive technology.*

A PPECC offers physician prescribed services that meet the client's medical, nursing, psychosocial, therapeutic, and developmental needs.

PPECC services include the following:

- Skilled nursing services
- Personal care services to assist with activities of daily living
- Functional developmental services
- Nutritional and dietary services including nutritional counseling
- Psychosocial services
- Transportation services needed by a client to access PPECC services (as applicable)
- Caregiver training
- Therapies, i.e., speech, physical, occupational, and certified respiratory care practitioner services

Note: *Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST), Certified Respiratory Care Practitioner services (CRCP), and hospice services that are provided at the PPECC must be billed separately by CSHCN enrolled service providers.*

Note: *Nonemergency ambulance transports are not reimbursed when the physician prescribes transportation services to and from the PPECC. The client must be able to utilize transportation services provided by the PPECC. A Registered Nurse (RN) or Licensed Vocational Nurse (LVN) employed by the PPECC will be on board the transport vehicle.*

Note: *A client may decline PPECC transportation and choose to be transported by other means including transportation by the client's responsible adult to and from the PPECC.*

PPECC services are limited to 12 hours in a 24 hour period and are limited to 400 hours per calendar year.

CSHCN clients who meet PPECC medical necessity criteria must be stable for outpatient medical services and not present significant risk to other clients or personnel at the center.

PPECC services must be furnished in a manner not primarily intended for the convenience of the client, the client's responsible adult, or the provider.

The CSHCN Services Program will not authorize services that duplicate services that are the legal responsibility of the school districts.

Refer to: Chapter 21, "Home Health Services" for additional information about home health services.

Chapter 22, "Home Health (Skilled Nursing) Care" for additional information about home health skilled nursing care services.

Chapter 13, "Certified Respiratory Care Practitioner (CRCP)" for additional information about CRCP services.

Chapter 37, "Speech-Language Pathology (SLP) Services" for additional information about SLP services.

Chapter 30, "Physical Medicine and Rehabilitation" for additional information about physical and occupational therapy services.

Chapter 23, "Hospice" for additional information about hospice services.

33.2.1 Prior Authorization and Authorization Requirements

Prior authorization is required for PPECC. Prior authorization requests must be submitted on the CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request form to the TMHP CSHCN Services Program Prior Authorization Department.

Medical necessity documentation must be submitted with the request. To avoid unnecessary denials, the PPECC and the ordering/prescribing physician must submit correct and complete information. Providers may be asked to provide additional documentation to clarify a prior authorization request or to clarify medical necessity of the client as outlined in the Documentation Requirements section of this chapter. All prior authorization requests will be reviewed by the CSHCN Services Program.

Note: *A separate prior authorization is required for therapy, respiratory care, and hospice services.*

Verbal orders are not accepted. The prior authorization form must be signed and dated by the ordering/prescribing physician and the PPECC provider. All signatures must be current, unaltered, original, and handwritten.

To complete the prior authorization process electronically, the ordering/prescribing physician and the PPECC provider must complete and submit the prior authorization requirements documentation through any approved electronic method.

To complete the prior authorization process by paper, the ordering/prescribing physician and the PPECC provider must complete and submit the prior authorization requirements documentation through fax or mail.

33.2.1.1 Initial Prior Authorization Requests

Initial prior authorization requests may be authorized for a maximum of 90 calendar days.

Prior authorization must be obtained before the delivery date or start of care (SOC) of the service.

If the service is medically necessary, 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 Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request form, a PPECC Plan of Care, and a PPECC nursing assessment must be received within these deadlines for prior authorization to be considered. Extensions to these deadlines are not given by the CSHCN Services Program to correct incomplete prior authorization requests.

Note: *PPECC providers may submit a form developed by the PPECC for the POC and the nursing assessment. The forms must contain all criteria specified in this chapter.*

Home health aide (procedure codes G0156, G0299, and G0300) services will not be authorized when the client is receiving PPECC services.

Medical nutritional therapy procedure codes 97802 and 97803 and nutritional counseling procedure code S9470 will not be reimbursed when the client is receiving PPECC services.

Note: *The request for services (as noted above) with language to deny authorization or reimbursement must be reviewed by the CSHCN Services Program before a denial is issued.*

Services must be provided according to an individualized written Plan of Care (POC) which is reviewed, signed, and dated by the ordering/prescribing physician who will provide ongoing supervision of the client and the POC.

The ordering/prescribing physician must be familiar with the client and the client's medical condition(s) and must have examined the client within 30 days prior to initiation of PPECC services.

Physician orders must be submitted on the CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request form and include the following:

- Client name, date of birth, gender, and CSHCN Services Program identification number
- Ordering/prescribing physician name, address, contact information, National Provider Identifier (NPI) number
- Date client last seen by the ordering/prescribing physician
- Diagnoses and description of current medical condition(s) and documentation of medical necessity that the client requires ongoing extended skilled nursing services beyond the level of Home Health skilled nursing and Home Health aide services, and the client has a chronic medically complex or fragile condition, which requires the routine use of medical device or assistive technology.
- Attestation that the client's medical condition is stable and will allow for safe delivery of PPECC services in accordance with the PPECC POC.
- Nursing Services required
- Medication administration, if applicable
- Dietary and nutritional needs
- Permitted activities
- Therapies, if applicable
- Transportation authorization, if applicable
- Other services as needed

The POC must be developed in conjunction with the client and/or the client's responsible adult. A signed and dated copy of the POC must be submitted with the Prior Authorization request. The POC must be signed before the SOC date by the ordering/prescribing physician who ordered PPECC services. The SOC date must be documented in the POC. Providers are required to deliver the requested services from the SOC date agreed to by the ordering/prescribing physician, the PPECC, the client, and/or the client's responsible adult.

An initial nursing assessment that is signed and dated by a PPECC RN must be completed no earlier than three business days before the client's SOC at the PPECC and must be submitted with the PA request. The initial nursing assessment is used to establish the POC and must support medical necessity for the client to receive ongoing skilled nursing care.

The assessment must include but is not limited to the following:

- Complexity and intensity of the client's condition.
- Frequency of the client's need for skilled nursing care.
- Stability and predictability of the client's condition.

- Description of the client's wounds if present.
- Comprehension level of the client and the client's responsible adult.
- Receptivity to training and ability level of the client and the client's responsible adult.
- The client's equipment needs and if the PPECC is adequate to accommodate use of the equipment.
- Identified medical, nursing, psychosocial, therapeutic, nutritional/dietary, functional/developmental, and educational needs and goals and any training needs for the client's caregiver or the client's responsible adult.

The POC must be initiated and signed and dated by a qualified individual, e.g., RN, APRN, PA, or physician employed by the PPECC in coordination with the interdisciplinary team, the client, and/or the client's responsible adult prior to the SOC and include all of the following:

- The client's name, date of birth, gender, CSHCN number, the ordering/prescribing physician's license number, and the PPECC provider's NPI
- Date the PPECC nursing assessment was completed
- The name, title, credentials, and signature of the team member preparing the POC
- Date the client was last seen by the ordering/prescribing physician
- The SOC date for PPECC services, including scheduled days, and hours of attendance
- All diagnoses and known allergies
- Prognosis
- Nursing Services to be provided including amount, duration, and frequency
- The client's mental status
- The types of therapies requested including amount, duration, and frequency including how the therapies are accessed and who will provide the service.
- Equipment and supplies needed
- Rehabilitation potential
- Prior and current functional limitations
- Activities permitted
- Nutritional requirements including type, method of administration, and frequency
- Medications including dose, route, and frequency
- Treatments including amount and frequency
- Wound care orders and measurements
- Individualized client goals and objectives
- Safety measures to protect against injury
- Method of transportation to the PPECC
- Discharge Plan
- Responsible adult training needs

The PPECC must ensure the requested services are supported by the client assessment, the POC, and the ordering/prescribing physician orders, and the PPECC must maintain the following in the client's medical record:

- A signed consent by the client or the client's responsible adult for PPECC services.

- Emergency contact information.
- A contingency plan for client emergencies and a plan when PPECC services are not available which has been signed by the client or the client's responsible adult.
- List of services the client receives in the home and in the school setting.
- Documentation of interdisciplinary team meetings at least every 90 calendar days or more frequently if there is a change in the client's condition or needs.

  Note: *The PPECC must convene an interdisciplinary conference for the initial development of the POC as well as for any reauthorizations and when the POC is changed.*
- Documentation of the client's and/or the client's responsible adult's participation in the interdisciplinary team meetings.
- Documentation that the client and/or the client's responsible adult has reviewed and agrees with the PPECC POC.
- Transportation needs of the client.

  Note: *If a client or PPECC provider discontinues services during an existing PPECC prior authorization period and the client requests services through a new PPECC provider, the ordering/prescribing physician and the new PPECC provider must submit a new prior authorization form, POC, nursing assessment, and all required documentation as specified under the Initial Prior Authorization section of this chapter before the client's SOC. A change of provider letter is required documenting the date the client ended PPECC services with the previous provider, the name of the new provider, and an explanation why providers were changed. The letter must be signed and dated by the client or the client's responsible adult. A change of provider is treated as a request for initial prior authorization.*

33.2.1.2 Revisions to the POC

The PPECC provider may request a revision to the POC at any time during the prior authorization period due to a change in the client's condition or due to a change in the schedule of the client or the client's responsible adult that affects the amount and duration of PPECC services.

Note: *A prior authorization request for a revision to the POC must fall within the current authorization period. All revision requests will be reviewed by the CSHCN Services Program.*

A nursing reassessment (completed by a PPECC RN) is required when changes in the client's condition occur during the course of the prior authorization period that impact the amount and duration of PPECC services.

Revision requests must be submitted on a new CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request Form for PPECC Services along with a revised POC and a revised nursing assessment.

The revised POC, nursing reassessment, and new prior authorization request form must be submitted to the TMHP CSHCN Prior Authorization Department as soon as the need is identified but no later than three business days from the date of the revision.

The ordering physician must sign and date the revised POC and prior authorization request form prior to submission to TMHP.

A nursing reassessment, revised POC, and a new prior authorization request form is also required when there is an unexpected change in the client or the responsible adult's schedule even if there is no change in the client's condition. A reason for the revision request must be provided, and medical necessity to

support continued PPECC services must be documented on a new CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request Form for PPECC services as soon as the need is identified but no later than three business days from the date of the revision request.

Note: *Requests received after the three business days allowed will be denied for dates of service that occurred before the revision is approved.*

The ordering physician must sign and date the new prior authorization request form prior to submission to TMHP.

Note: *Schedule changes that affect previously ordered medical services to the client and a disruption of clinical services provided to the client such as nursing services or therapy services require updated medical orders addressing the client's needs which must be submitted along with the revision request.*

33.2.1.3 Extension of PPECC Services

Requests to extend PPECC services must be submitted on a new CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request Form for PPECC Services. Extension requests will be reviewed by the CSHCN Services Program.

A current signed and dated copy of the POC and a current nursing assessment must be submitted with the extension request.

Extensions may be granted for up to a maximum of 180 days.

PPECC services must not exceed 400 hours per calendar year.

Extension requests must be received before the end of the current prior authorization period but no sooner than 30 days before and no less than 7 days before the current prior authorization expires.

Note: *Extension requests that are received after the current prior authorization expires will be denied for dates of service that occur before the extension request is approved.*

The ordering/prescribing physician must sign and date the extension request and the POC.

If there is no change in the client's condition the POC must document medical necessity as defined in the Statement of Benefits to support continuing PPECC services.

33.3 Documentation Requirements

In addition to the documentation requirements outlined in the Prior Authorization and Authorization Requirements section the following requirements apply:

- All services outlined in this chapter are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.
- Services not supported by documentation are subject to recoupment.
- The ordering/prescribing physician must retain a copy of all signed orders, the POC, and the nursing assessment in the client's medical record.
- The PPECC must retain a copy of all signed orders, the POC, and the nursing assessment in the client's medical record.
- If the client utilizes PPECC transportation the responsible adult must sign, date, and indicate the time that the client was put on the vehicle and must also sign, date, and indicate the time when the client was returned to the responsible adult's care.
- The PPECC must sign, date, and indicate the arrival time of the client at the PPECC and must also sign, date, and indicate the time when the client is put on the vehicle to return the client to their place of residence.

- If a responsible adult provides the transportation, the responsible adult must sign and indicate the date and time that the client is dropped off and picked up from a PPECC. The PPECC provider must document and retain arrival and departure times from the PPECC.

  Note: *The PPECC provider may use any reliable method to record times, dates, and signatures provided that is accurate and allows for an auditable review of the records, including electronic census, timestamp, scanning, and signature records.*

- The PPECC must maintain documentation in the client's medical record of the notification provided to the client and/or the client's responsible adult of an intent to transfer or discharge the client as follows:
  - A copy of the written notification provided.
  - Documentation of the personal contact with the client and/or the client's responsible adult.
  - Documentation that the client's prescribing physician was notified of the date of transfer or discharge.

Documentation must be maintained in the client's medical record that a written one page summary of services provided to the client has been provided to the client's responsible adult for each day the client is at the PPECC.

Documentation must be maintained in the client's medical record of all discrepancies between approved weekly service hours scheduled and the service hours provided, (e.g., the PPECC was closed for a day, the client is hospitalized, or the responsible adult's schedule changed).

33.4 Coordination of Services

A PPECC must ensure appropriate coordination of services between the client and providers rendering services to the client (if known by the PPECC) including, but not limited to, Home Health extended skilled nursing, PT, OT, ST, CRCP, and Hospice providers not employed or contracted by the PPECC.

Documentation must be maintained in the client's medical record that reflects coordination of services that includes the effective exchange of information, reporting, and coordination of the client's services.

The PPECC may not duplicate or provide services that conflict with a client's plan of care, or service plan with another provider.

The PPECC and the provider must have a written agreement for the provision of services that will be provided by a Home Health Agency therapist or independent therapist at the PPECC. The written agreement must address how the providers will coordinate care related to the client's POC, (e.g., participation in the client's interdisciplinary team meetings and inclusion in planning activities for the client).

The PPECC, client, and or the client's responsible adult must agree that the provision of services by the provider is appropriate.

The written agreement must include the provider's compliance with PPECC policies and procedures.

33.5 Exclusions

Examples of services not covered under PPECC reimbursement include, but are not limited to, the following:

- Services that have not been prior authorized
- Services that have been requested for the sole purpose of the responsible adult's training needs
- Routine baby food or formula
- PPECC services for clients related to the PPECC owner by blood, marriage, or adoption

- Skilled home health nursing and home health aide services for medical conditions expected to resolve within 60 days or less will not be authorized at the same time PPECC services are authorized.
- Dietary and nutritional counseling services will not be authorized at the same time PPECC services are authorized.
- Services intended to provide respite care or childcare
- Services covered separately by the CSHCN Services Program such as:
  - Occupational, speech, physical and certified respiratory care practitioner services
  - Behavioral health services
  - Durable medical equipment (DME), medical supplies, nutritional products provided to the client by a CSHCN DME and/or medical supply providers

33.6 Reimbursement

PPECC services may be reimbursed when billed with procedure codes T1026 and T2002.

Procedure code T1026 is limited to 12 hours per day and to 400 hours per calendar year.

A minimum of 15 minutes of service is required to round up to a full hour for procedure code T1026 after the first hour of service.

Procedure Code T2002 is reimbursed once per day when the PPECC transports the client. Procedure code T2002 is not allowed without a PPECC service procedure code billed on the same day by the same provider.

PT, OT, ST, CRCP services and hospice services require separate prior authorization subject to the prior authorization requirements of CSHCN therapy, certified respiratory care practitioner services and hospice policies. These services may be rendered at a PPECC but are not included in the reimbursement rate for T1026.

> ***Note:*** *Therapy and respiratory care services and hospice services may be provided by CSHCN-enrolled providers contracted with or employed by a PPECC or by CSHCN enrolled providers not employed or contracted with a PPECC.*

All therapy, respiratory care services and hospice services must meet prior authorization and policy requirements as specified by the CSHCN Services Program.

Transportation and the time the client spends in transit to and from the PPECC are billed with procedure code T2002 when the client utilizes PPECC transportation.

Transportation time does not count towards the 400 hour per year limitation.

> ***Note:*** *A nonemergency ambulance may not be billed and will not be reimbursed to transport a client to and from home to a PPECC.*

Services begin when the client is boarded onto PPECC transportation or when the client is brought to the PPECC by the client's responsible adult.

Extended skilled nursing procedure codes S9123 and S9124 may not be billed on the same date of service as PPECC services procedure code T1026, any provider.

33.7 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.

RADIATION THERAPY SERVICES

CSHCN SERVICES PROGRAM PROVIDER MANUAL

APRIL 2025

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RADIATION THERAPY SERVICES

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34.1 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 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

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

34.2 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 radiation therapies

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" 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.*

34.2.1 Prior Authorization Requirements

Prior authorization is required for stereotactic radiation therapies, 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" for more information about authorizations and prior authorizations.

34.2.2 Clinical Brachytherapy

The following surgical procedure codes for brachytherapy may be reimbursed:

Surgery Procedure Codes									
10035	10036	19296	19297	19298	31626	31643	32553*	49327*	49411
49412	55860	55862*	55865*	55874	55875	55876	57156	58346	61770
92974									
***Assistant surgeons also may be reimbursed for procedure codes 32553, 49327, 55862, and 55865.**									

Add-on procedure codes 10036, 19297, 49327, 49412 and 92974 must be billed with the appropriate primary procedure code, on the same day, by the same provider.

The following radiation therapy procedure codes may be reimbursed:

Radiation Therapy Procedure Codes									
77321	77470	77750*	77761*	77762*	77763*	77767	77768	77770	77771
***Total component only.**									

Radiation Therapy Procedure Codes			
77772	77778*	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.

34.2.3 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.

Procedure code 77293 will be denied if not billed on the same date of service by the same provider as either procedure code 77295 or 77301.

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								
77331	77336	77370	77600	77605	77610	77615	77620	77790

34.2.4 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.

34.2.5 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								

34.2.6 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

Procedure Codes				
77520	77522	77523	77525	S8030
Neutron-Beam				
77423				

34.2.6.1 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:

34.2.6.1.1 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

34.2.6.1.2 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" for more information about authorizations and prior authorizations.

34.2.7 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**	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.

34.2.7.1 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.

34.2.8 Stereotactic Radiosurgery

The surgical component of the following procedure codes may be reimbursed for stereotactic radiosurgery services (SRS) and stereotactic body radiation therapy (SBRT):

Surgery Procedure Codes									
32701	61781	61782	61783	61796	61797	61798	61799	61800	63620
63621									

Add-on procedure codes 61781, 61782, 61783, 61797, 61799, 61800, and 63621 must be billed with the appropriate primary procedure code, on the same day, by the same provider.

The total radiation therapy component of the following procedure codes may be reimbursed for SRS and SBRT:

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 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 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.
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 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.

34.2.8.1 Prior Authorization Requirements

Prior authorization will be considered for SRS and SBRT procedure codes with a diagnosis 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

  Note: *SRS and SBRT are considered investigational and not a benefit of the CSHCN Services Program for all other indications including, but not limited to, epilepsy, chronic pain, and pancreatic adenocarcinoma.*

Providers must use the CSHCN Services Program Authorization and Prior Authorization Request form to submit requests for prior authorization.

Documentation that supports the provision of special procedures must be maintained in the client's medical record and made available to the CSHCN Services Program upon request.

Refer to: Chapter 4, "Prior Authorizations and Authorizations" for more information about authorizations and prior authorizations.

34.2.9 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 Codes							
C50011	C50012	C50019	C50021	C50022	C50029	C50111	C50112
C50119	C50121	C50122	C50129	C50211	C50212	C50219	C50221
C50222	C50229	C50311	C50312	C50319	C50321	C50322	C50329
C50411	C50412	C50419	C50421	C50422	C50429	C50511	C50512
C50519	C50521	C50522	C50529	C50611	C50612	C50619	C50621
C50622	C50629	C50811	C50812	C50819	C50821	C50822	C50829
C50911	C50912	C50919	C50921	C50922	C50929	C61	C7951
C7952							

34.2.10 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.

34.3 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."

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 for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

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

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

Chapter 5, "CMS-1500 Paper Claim Form Instructions" and Section 5.7.2.7, "Instructions for Completing the UB-04 CMS-1450 Paper Claim Form" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper 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.

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

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

34.5 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.

Renal Dialysis

CSHCN Services Program Provider Manual

April 2025

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RENAL DIALYSIS

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35.1 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 26 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 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

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

35.2 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.

35.3 Benefits, Limitations, and Authorization Requirements

The following services are a benefit of renal dialysis centers billing under Reimbursement Methodology Consolidated Billing:

Revenue Codes - Hemodialysis

Revenue Code	Description
821	Hemodialysis (outpatient/home) - composite or other rate. Use for maintenance.
829	Hemodialysis (outpatient/home) - other. Use for training.

Revenue Codes - Intermittent Peritoneal Dialysis (IPD)

Revenue Code	Description
831	Peritoneal Dialysis (outpatient/home) - composite or other rate. Use for maintenance.
839	Peritoneal Dialysis (outpatient/home) - other. Use for training.

Revenue Codes - Continuous Cycling Peritoneal Dialysis (CCPD)

Revenue Code	Description
851	CCPD (outpatient/home) - composite or other rate. Use for maintenance.
859	CCPD (outpatient/home) - other. Use for training.

Revenue Codes - Ultrafiltration

Revenue Code	Description
881	Miscellaneous dialysis - ultrafiltration

The following physician services are a benefit for physician supervision of end-stage renal disease (ESRD) dialysis services and are restricted to chronic kidney disease stage 5 (diagnosis code N185) and ESRD (diagnosis code N186).

Procedure Codes - Physician Services for End-Stage Renal Dialysis

Procedure Codes									
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

Procedure Codes									
90935	90937	90945	90947						

Physician supervision of outpatient ESRD dialysis includes services rendered by the attending physician during office visits where any of the following occur:

- Routine monitoring of dialysis
- Treatment or follow-up of complications of dialysis, including:
  - 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-contact contracts

All physician, renal dialysis center, and medical supplier supporting documentation is subject to retrospective review.

Renal dialysis services must be submitted with the most appropriate diagnosis code from the following table:

Diagnosis Codes							
N170	N171	N172	N178	N179	N181	N182	N1830
N1831	N1832	N184	N185	N186	N189	N990	T795XXA
T795XXD	T795XXS						

Note: *All services, except ultrafiltration (revenue code 881), are diagnosis restricted as listed in the above table.*

Procedure code G0257 may be reimbursed for services rendered to clients with stage V chronic kidney disease (diagnosis code N185) and end-stage renal disease (ESRD) (diagnosis code N186).

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. Home modifications for use of medical equipment are not a benefit.

35.3.1 Renal Dialysis Facilities - Consolidated Billing

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.

Renal dialysis facilities are reimbursed according to composite rates, which are based on CMS-specified calculations and the Texas Medicaid Reimbursement Methodology (TMRM).

The facility bills an amount that represents the charge for the facility's service to the dialysis client. The facility's charge must not include the charge for the physician's routine supervision.

A revenue code (821, 831, 841, or 851) must be billed for the dialysis facility to receive the composite rate payment.

35.3.1.1 Maintenance Hemodialysis

ESRD facilities furnishing dialysis treatments in-facility are paid for up to three treatments per week. ESRD facilities treating patients at home, regardless of modality, receive payment for three hemodialysis equivalent treatments per week.

35.3.1.2 Maintenance IPD

Maintenance intermittent peritoneal dialysis (IPD) is usually performed in sessions of 10 to 12 hours duration, three times per week. However, it is sometimes performed in fewer sessions of longer duration.

35.3.1.3 Maintenance CAPD and CCPD

For clients undergoing CAPD or CCPD in the home, the number of days of peritoneal dialysis regardless of dialysate exchanges performed each day will be 14 per 31 days.

A combination of HD, IPD, CAPD, CCPD dialysis treatments are limited to 14 sessions within 31 days for any provider. If more than 14 sessions are needed, the provider must supply documentation of medical necessity with the claim. Documentation can include but is not limited to medical records, physicians' notes, and lab results. Records must clearly show why extra sessions are medically required.

The ordering physician must maintain documentation supporting medical necessity in the client's medical record.

The composite rate includes all necessary equipment, supplies, and services for the client receiving dialysis whether in the home or in a facility. The following procedure codes are for ESRD DME supplies:

Procedure Codes									
36000	36430	36591	36593	49421	71045	71046	71047	71048	93005
93040	93041	A4215	A4216	A4217	A4218	A4244	A4245	A4246	A4247
A4248	A4450	A4452	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	A4728
A4730	A4736	A4737	A4740	A4750	A4755	A4760	A4765	A4766	A4770
A4771	A4772	A4773	A4774	A4802	A4860	A4870	A4890	A4911	A4913
A4918	A4927	A4928	A4929	A4930	A4931	A4932	A6204	A6215	A6216
A6250	A6260	A6402	E0210	E0424	E0431	E0434	E0439	E0440	E0441
E0442	E0443	E0444	E0447	E1500	E1510	E1520	E1530	E1540	E1550
E1560	E1570	E1575	E1580	E1590	E1592	E1594	E1600	E1610	E1615
E1620	E1625	E1630	E1632	E1634	E1635	E1636	E1637	E1639	E1699

Procedure codes for equipment and supplies listed in the above DME ESRD Supply HCPCS table are included in the composite rate and are not reimbursed separately.

The Tablo hemodialysis system procedure code (E1629) is excluded from the composite rate and will be paid separately for clients receiving services within the home.

Providers must use procedure code E1629 with revenue code 821.

Laboratory testing may be obtained and processed in the renal dialysis facility or by an outside laboratory. Charges for the following routine laboratory tests are included in the facility's composite rate billed to Medicaid regardless of where tests were processed. Routine laboratory testing processed by an outside laboratory are billed to the facility and billed by the renal dialysis facility unless they are inclusive tests.

The following procedure codes are for labs subjected to ESRD consolidated billing:

Procedure Codes									
80047^	80048^	80051^	80053^	80069^	80076	81050	82040^	82108	82306
^ QW Modifier									

Procedure Codes									
82310^	82330^	82374^	82379	82435^	82565^	82570^	82575	82607	82610
82652	82668	82728	82746	82947	83540	83550	83615	83735	83970
84075^	84100	84132^	84134	84155^	84157	84295^	84450	84466	84520^
84540	84545	85004	85014^	85018^	85025^	85027	85041	85044	85045
85046	85048	85345	85347	85610^	86704	86705	86706	87040	87070
87071	87073	87075	87076	87077	87081	87340	87341	87467	G0306
G0307	G0499								
^ QW Modifier									

Routine laboratory services listed in the procedure codes table for labs subject to ESRD consolidated billing are included in the composite rate and are not reimbursed separately.

All drugs and biologicals used for the treatment of ESRD or acute kidney injury (AKI) (unless specified otherwise) are included in the composite rate payment and are not paid separately. This includes the following drugs, which are subjected to ESRD consolidated billing:

Procedure Codes									
J0360	J0604	J0606	J0620	J0630	J0636	J0670	J0878	J0884	J0887
J0892	J0895	J0899	J0945	J1160	J1200	J1205	J1240	J1265	J1270
J1443	J1444	J1445	J1642	J1643	J1644	J1720	J1740	J1750	J1800
J1940	J1945	J1955	J2150	J2360	J2430	J2501	J2720	J2795	J2993
J2997	J3265	J3364	J3365	J3370	J3410	J3420	J3480	J3489	J7030
J7040	J7042	J7050	J7060	J7070	J7120	J7131	Q0163	Q5105	

Procedure codes for labs or drugs subjected to ESRD consolidated billing will deny if submitted with procedure code G0257 or the following revenue codes:

Revenue Codes								
821	829	831	839	841	849	851	859	880

The following drugs used for the treatment of ESRD are excluded from the composite rate and will be paid separately:

Procedure Codes				
J0882	J1439	J1756	J2916	Q4081

Other drugs and biologicals furnished by an ESRD facility that are not used for the treatment of ESRD may be billed separately.

The ordering physician must maintain documentation supporting medical necessity in the client's medical record.

35.3.2 Maintenance Hemodialysis

35.3.2.1 Training for Hemodialysis, IPD, CCPD, and CAPD

Most self-dialysis training for hemodialysis, IPD, CCPD, and CAPD is provided in an outpatient setting. Dialysis training provided in an inpatient setting will be reimbursed at the same rate as the facility's outpatient training rate.

Reimbursement for hemodialysis, IPD, CCPD, and CAPD training services and supplies provided by the dialysis facility include personnel services, parenteral items routinely used in dialysis, training manuals and materials, and routine dialysis laboratory tests. It may be necessary to supplement the patient's dialysis CAPD training with intermittent peritoneal dialysis or hemodialysis because the client has not mastered the CAPD technique.

Training is limited to once per day. The composite rate will be denied as part of dialysis training when billed for the same date of service.

The following revenue codes may be reimbursed for dialysis training:

Revenue Code	Procedure Description	Limitations
829	Hemodialysis (outpatient/home) - other. Use for training.	18 sessions per lifetime
839	Peritoneal Dialysis (outpatient/ home) - other. Use for training.	18 sessions per lifetime
849	CAPD (outpatient/home) - other. Use for training.	18 sessions per lifetime
859	CCPD (outpatient/home) - other. Use for training.	18 sessions per lifetime

35.3.3 Ultrafiltration

A separate ultrafiltration treatment to remove the excess fluid may be covered.

Ultrafiltration is performed on a day other than the day of a dialysis treatment. The dialysis facility must document in the medical record why the ultrafiltration could not have been performed at the time of dialysis treatment. Ultrafiltration performed on the same day as the dialysis treatment is not separately reimbursed.

Ultrafiltration may be reimbursed using revenue code 881 up to a maximum of 3 times per week:

Revenue Code	Procedure Description	Limitations
881	Miscellaneous dialysis - ultrafiltration	3 per week

Providers can request extra ultrafiltration procedures if they provide attachments that state any of the following:

- Fluid overload (E8771) or diagnosis codes (E8770, E8779, E878) are provided on claim.
- Clotted IV access.
- CRD treatment performed on another day due to holiday.
- Or other reasons why extra ultrafiltration is necessary.

35.3.4 Home Dialysis Items and Services

Texas Medicaid utilizes Medicare's composite rate reimbursement system, Consolidated Billing. Under this reimbursement system, the dialysis facility must assume responsibility for providing all home dialysis equipment, supplies, and home support services.

One of the following revenue codes must be billed for the dialysis facility to receive the composite rate payment for clients being treated in the home:

Revenue Code	Procedure Description	Limitations
821	Hemodialysis (HD) (outpatient/ home) - composite or other rate. Use for maintenance.	3 per week
831	Peritoneal Dialysis (outpatient/ home) - composite or other rate. Use for maintenance.	3 per week
841	CAPD (outpatient/home) - composite or other rate. Use for maintenance.	HD - equivalent sessions
851	CCPD (outpatient/home) - composite or other rate. Use for maintenance.	HD - equivalent sessions

Support services are included in the composite rate. Support services that are specifically applicable to home clients include, but are not limited to:

- Periodic monitoring of a client with a qualified social worker and a qualified dietitian, made in accordance with a plan prepared and periodically reviewed by a professional team, which includes the physician.
- Visits by trained personnel for the client with a qualified social worker and a qualified dietician, made in accordance with a plan prepared and periodically reviewed by a professional team, which includes the physician.
- Client's unscheduled visits to a facility made on an as-needed basis (e.g., assistance with difficult access situations).
- ESRD related laboratory tests covered under the composite rate.
- Providing, installing, repairing, testing, and maintaining home dialysis equipment, including appropriate water testing and treatment.
- Ordering of supplies on an ongoing basis.
- A record keeping system that assures continuity of care.
- Support services specifically applicable to CAPD also include but are not limited to the following:
    - Changing connecting tube/administration set.
    - Watching the client perform CAPD and assuring that is it done correctly and reviewing for the client any aspects of the technique they may have forgotten or informing the client of modifications in apparatus or technique.
    - Documenting whether the client has or has had peritonitis that requires physician intervention or hospitalization (unless there is evidence of peritonitis, a culture for peritonitis is not necessary).
    - Inspection of the catheter site.

35.3.5 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 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.

Procedure code Q4081 is limited to three injections per calendar week (Sunday through Saturday).

Use the following procedure codes when billing for physician supervision of outpatient ESRD dialysis services:

Procedure Codes									
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960
90961	90962	90963	90964	90965	90966	90967	90968	90969	90970

In the circumstances where the client not on home dialysis has had a complete assessment visit during the calendar month and a full month of ESRD-related services are provided, the following procedure codes must be used:

Procedure Codes									
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960
90961	90962								

Note: *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 the client's age.*

When a full calendar month of ESRD-related services are reported for clients on home dialysis, the appropriate procedure code (90963, 90964, 90965, or 90966) must be used.

Report procedure codes 90967, 90968, 90969, and 90970 when ESRD-related services are provided for less than a full month, per day, 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 procedure code 90967, 90968, 90969, or 90970, 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 one of the following procedure codes, which are limited to once per month, any provider:

Procedure Codes									
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960
90961	90962	90963	90964	90965	90966				

The following services may be provided in conjunction with physician supervision of outpatient ESRD dialysis but are considered nonroutine and may be billed separately:

- Declotting of shunts when performed by the physician.
- Dialysis at an outpatient facility other than the usual dialysis setting for a client of a physician who bills the Monthly Capitated Payment (MCP). The physician must bill procedure code 90967, 90968, 90969, or 90970 for each date supervision is provided. The physician may not bill for the days that the client dialyzed elsewhere.
- Physician services beyond those that are related to the treatment of the client's renal condition that causes the number of physician-client contacts to increase. 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.
- Physician services to inpatients.

If a client is hospitalized during a calendar month of ESRD related services before a complete assessment is performed, or the client receives one or more face-to-face assessments, but the timing of inpatient admission prevents the client from receiving a complete assessment, the physician should bill procedure code 90967, 90968, 90969, or 90970 for each date of outpatient supervision and bill the appropriate hospital evaluation and management code for individual services provided on the hospitalized days.

If a client has a complete assessment during a month in which the client is hospitalized, one of the following procedure codes must be reported for the month of supervision, determined by the number of face-to-face physician visits with the client during the month and the client's age:

Procedure Codes									
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960
90961	90962								

Note: *The appropriate inpatient evaluation and management codes should be reported for procedures provided during the hospitalization.*

Procedure codes 90935, 90937, 90945, and 90947 may be reimbursed as follows:

- Inpatient dialysis services for ESRD or non-ESRD clients when the physician is present during dialysis treatment. The physician must be physically present and involved during the course of the dialysis procedure. These codes are not payable for a cursory visit by the physician; hospital visit procedure codes must be used for a cursory visit.
    - The procedure codes are per day procedure codes and include complete care of the client; hospital visits cannot be billed on the same day as these codes.

    - If the physician only sees the client 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.

Inpatient services provided to hospitalized clients for whom the physician has agreed to bill monthly may be reimbursed in one of the following three ways:

- The physician may elect to continue monthly billing, in which case she or he may not bill for individual services provided to the hospitalized clients.
- The physician may reduce the monthly bill by 1/30th for each day of hospitalization and charge fees for individual services provided on the hospitalized days.
- The physician may bill for inpatient dialysis services using the inpatient dialysis procedure codes. The physician must be present and involved with the clients during the course of the dialysis procedure.

Clients may receive dialysis at an outpatient facility other than his or her usual dialysis setting, even if their physician bills for monthly dialysis coordination. The physician must reduce the monthly billed amount by 1/30th for each day the clients is dialyzed elsewhere.

Physician services beyond those related to the treatment of the client's renal condition may be reimbursed on a fee-for-service basis. The physician should provide documentation stating the illness is not related to the renal condition and added visits are required.

Payment is made for physician training services in addition to the MCP for physician supervision rendered to maintenance facility clients.

35.3.6 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.

35.3.7 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

Procedure Codes					
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.

35.3.8 Renal Transplants

Renal transplants are a benefit of the CSHCN Services Program with documentation of end-stage renal disease (ESRD).

Refer to: Section 24.3.1.5, "Renal (Kidney) Transplants" in Chapter 24, "Hospital" and Section 31.2.42.1, "Renal (Kidney) Transplant" in Chapter 31, "Physician" for detailed information about renal transplants.

35.3.9 Prior Authorization Requirements

Authorization is not required for renal dialysis services.

35.4 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 CMS NCCI web page for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

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

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

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" and Section 5.7.2.7, "Instructions for Completing the UB-04 CMS-1450 Paper Claim Form" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

35.5 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 35.3.1, "Renal Dialysis Facilities - Consolidated Billing" in this chapter 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 , "" in this chapter 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/resources/rate-and-code-updates/rate-changes.

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

35.6 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.

RESPIRATORY EQUIPMENT AND SUPPLIES

CSHCN SERVICES PROGRAM PROVIDER MANUAL

APRIL 2025

TEXAS
Health and Human
Services

RESPIRATORY EQUIPMENT AND SUPPLIES

Table of Contents

36.1 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 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

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

36.2 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. Only new, unused equipment will be rented or purchased for clients. The reimbursement of rented equipment includes all supplies, accessories, adjustments, repairs, and replacement parts needed during the rental period. Supplies needed for use with client owned equipment may be considered for purchase.

Respiratory supplies are a benefit when medically necessary and are available without prior authorization up to the stated quantity limitation unless otherwise stated. Prior authorization is required for quantities exceeding the limitation.

Sterile respiratory supplies are a benefit with prior authorization when medically necessary and documentation shows that the client's medical needs cannot be met with non-sterile (clean) supplies.

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.

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 oscillation systems (HFCWO)
  - 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 HFCWO

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 Workforce Commission (TWC).
- 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) system
- Vaporizers
- Room air humidifiers

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
A4216	As needed	A4481	31 per month	A4483	15 per month
A4556	15 per month	A4557	2 per month	A4605	10 per month
A4606	4 per month	A4606 with modifier U5	1 per 6 months	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	A4623 with modifier U3	31 per month	A4624	85 per month

Procedure Code	Maximum Limitation	Procedure Code	Maximum Limitation	Procedure Code	Maximum Limitation
A4627	1 per 6 months	A4628	2 per month	A4629	30 per month
A7000	5 per month	A7002	8 per month	A7003	2 per month
A7004	2 per month	A7005	1 per 6 months	A7006	1 per month
A7007	2 per month	A7009	1 per year	A7010	1 per 2 months
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	A7025	1 per lifetime	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	1 per 3 months	A7035	1 per 6 months
A7036	1 per 6 months	A7037	1 per month	A7038	2 per month
A7039	1 per 6 months	A7520	1 per month	A7520 with U1 modifier	1 per month
A7520 with U2 modifier	1 per month	A7521	1 per month	A7522	4 per year
A7523	1 per 2 years	A7525	4 per month	A7526	20 per month
A9284	1 per 6 months	A9900	As needed	E0424	1 rental per month
E0431	1 rental per month	E0433	1 rental per month	E0434	1 rental per month
E0439	1 rental per month	E0441	1 per month	E0442	1 per month
E0443	1 per month	E0444	1 per month	E0445	1 rental per month
E0445 with modifier U4	1 purchase per 5 years; 1 rental per month	E0457	1 purchase per 5 years; 1 rental per month	E0459	1 purchase per lifetime; 1 rental per month
E0465	1 rental per month	E0466	1 rental per month	E0470	1 purchase per 5 years; 1 rental per month
E0471	1 rental per month	E0472	1 rental per month	E0480	1 purchase per 5 years; 1 rental per month
E0482	1 rental per month	E0483	1 purchase per lifetime; 1 rental per month	E0500	1 purchase per 5 years; 1 rental per month
E0550	1 purchase per 3 years; 1 rental per month	E0561	1 purchase per 5 years; 1 rental per month	E0562	1 purchase per 5 years; 1 rental per month
E0565	1 purchase per 5 years; 1 rental per month	E0570	1 per 5 years	E0574	1 per 5 years

Procedure Code	Maximum Limitation	Procedure Code	Maximum Limitation	Procedure Code	Maximum Limitation
E0575	1 per 5 years	E0580	1 purchase per 3 years; 1 rental per month	E0600	1 per 5 years
E0601	1 purchase per 5 years; 1 rental per month	E0618	1 purchase per 5 years; 1 rental per month	E0619	1 purchase per 5 years; 1 rental per month
E1353	1 per year	E1355	1 per 3 years	E1372	1 per 3 years
E1390	1 per calendar month	E1399	As needed	K0462	1 per month
K0730	1 per 5 years	K0738	1 per month	K0739	2 hours per day
L8501	1 per 6 months	S8101	1 per 6 months	S8185	1 per 5 years
S8189	As needed	S8999	1 per year		

36.2.1 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."

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.*

36.2.2 Noninvasive Positive Pressure Ventilation (NPPV)

Prior authorization is required for rental or purchase of NPPV devices, including CPAP and respiratory assist devices (RADS) which include Bi-Level PAP with or without a set backup respiratory rate when medically necessary primarily for clients requiring treatment of obstructive sleep apnea, restrictive thoracic disorders, severe chronic obstructive pulmonary disease, central sleep apnea, complex sleep apnea, and hypoventilation syndrome. Prior authorization must be submitted on a completed CSHCN Services Program Prior Authorization Request for Continuous Positive Airway Pressure (CPAP) or Respiratory Assist Device (RAD) Form that has been signed and dated by the prescribing physician.

Note: *Other conditions may be considered with prior authorization of medical necessity.*

RADS with a set backup rate are available for rental only when medically necessary.

For client owned devices, proof of ownership of the NPPV device is required when requesting prior authorization for purchase of the associated supplies. A claims history of the purchase of an NPPV device or the associated supplies will meet this requirement. A statement from the ordering physician providing the make and model of the client-owned device will meet this requirement if claims history is not available.

Humidification devices used with continuous positive airway pressure (CPAP), or respiratory assist devices (RAD) such as a bi-level PAP with or without a set backup respiratory rate require prior authorization. Documentation of medical necessity including the diagnosis and expected outcome must be submitted with the request for prior authorization. Prior authorization for heated humidification must include documentation of a medical reason requiring heated humidification.

Tubing and filters are considered part of the rental and will not be reimbursed separately.

Headgear, masks, and other client interfaces may be prior authorized separately when requested for the rental of NPPV with documentation of medical necessity.

36.2.2.1 Continuous Positive Airway Pressure (CPAP) System

A CPAP device (procedure code E0601) is used primarily for the treatment of obstructive sleep apnea. Other conditions may be considered based on medical necessity.

The CPAP device may be prior authorized for rental or purchase based on the physician's predicted length of treatment.

The CPAP device may be approved for an initial 3-month rental period based on documentation that supports the medical necessity and appropriateness of the device along with documentation of a sleep study lasting a minimum of 2 hours and when at least one of the following conditions are met for clients who are 18 years of age and older:

- The Sleep Study Respiratory Disturbance Index (RDI) or Apnea/Hypopnea Index (AHI) is greater than or equal to 15 events per hour
- The Sleep Study RDI or AHI is greater than 5 events per hour and at least one of the following is true:
  - Excessive daytime sleepiness (documented by either an Epworth Sleepiness Scale 10 or greater 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 or previous myocardial infarction
  - 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
  - Documented pulmonary hypertension

Polysomnography documentation of AHI greater than one event per hour may be used to establish medical necessity for clients who are 17 years of age and younger.

CPAP may be medically necessary for the treatment of obstructive sleep apnea (OSA) in clients who are younger than 18 years of age when one of the following criteria are met:

- Adenoidectomy or tonsillectomy is contraindicated
- Adenoidectomy or tonsillectomy is delayed
- Adenoidectomy or tonsillectomy has been unsuccessful in relieving symptoms of OSA

Note: *American Academy of Sleep Medicine guidelines indicate that it is clinically appropriate to treat clients who are 18 through 20 years of age using the adult criteria.*

Prior authorization for purchase after a maximum three-month rental period may be granted if the client is continuing to use the equipment at a minimum of four hours in a 24 hour period and symptoms are improved as documented by a physician. This documentation of compliance and effectiveness must be provided with a new completed CSHCN Services Program Prior Authorization Request for Continuous Positive Airway Pressure (CPAP) or Respiratory Assist Device (RAD) Form signed and dated by a physician.

36.2.2.2 Respiratory Assist Devices (RADs), including BiPAP

A RAD with or without a set backup rate may be considered for prior authorization when the client has one of the following conditions as documented by a sleep study and meets criteria for medical necessity for the specific medical condition:

- OSA
- Restrictive thoracic disorders i.e., neuromuscular diseases or severe thoracic cage abnormalities
- Severe chronic obstructive pulmonary disease (COPD)
- Central sleep apnea (CSA)
- Complex sleep apnea (CompSA)
- Hypoventilation syndrome
- Meets criteria for the specific medical condition noted below

36.2.2.2.1 RAD for Treatment of Obstructive Sleep Apnea (OSA)

A RAD without backup may be considered for an initial three month trial period with prior authorization for treatment of OSA when all of the following criteria are met:

- All of the required documentation listed in the CPAP section is submitted with the prior authorization request
- The client meets the criteria for the initial CPAP three month trial
- Documentation supports that CPAP has been tried with documentation of one of the following:
  - The treating practitioner verifies that a CPAP trial failed to be effective in treating the client's OSA
  - CPAP was found to be ineffective during the initial facility based or sleep laboratory titration trial

If a CPAP device is tried and is not effective during an initial facility based titration or home trial; substitution of a RAD does not require a new face to face clinical evaluation or a new sleep test.

36.2.2.2.2 RAD for Treatment of Restrictive Thoracic Medical Conditions

A RAD without a set backup rate may be considered for treatment of thoracic medical conditions with prior authorization when all of the following are met:

- The client is diagnosed with a neuromuscular disorder, (e.g., Duchenne muscular dystrophy, ALS, spinal cord injuries) or has a diagnosis of a severe thoracic cage abnormality, (e.g., severe chest wall deformities) negatively impacting the client's respiratory effort.
- Medical necessity documentation indicates significant respiratory insufficiency documented by one of the following:
  - An arterial blood gas (ABG) PaCO2 > 45mm Hg, obtained while awake and breathing the client's routinely prescribed FI02
  - Sleep oximetry demonstrates oxygen saturation < 88% for > 5 minutes of continuous nocturnal recording time (minimum recording time of 2 hours), done while the client is breathing their routinely prescribed FIO2

For clients who have been diagnosed with a neuromuscular disorder only, documentation must support one of the following:

- Maximal inspiratory pressure is < 60 cm H2
- Forced vital capacity is < 50% of predicted

A RAD with a set back-up rate requires prior authorization and may be considered for the treatment of thoracic medical conditions when all of the following are met:

- The client meets the criteria for use of the RAD without a back-up rate for treatment of a thoracic medical condition
- The ordering physician verifies the following:
  - Client has tried a RAD without a backup rate for at least 60 Days
  - Client was compliant in use of the device using on average 4 or more hrs in a 24 hr day
  - The desired therapeutic respiratory response was not achieved with the RAD without a set back up rate

36.2.2.2.3 RAD for Treatment of Severe COPD

A RAD without a set backup rate may be considered for the treatment of severe COPD with prior authorization when all of the following criteria are met:

- The client's arterial blood gas PaCO2 is less than 52 mm Hg, obtained while awake and when the client is using their routinely prescribed FIO2 or 2LPM of oxygen. The blood gas should be obtained while the client is using whichever concentration of oxygen is the higher of the two.
- Sleep oximetry demonstrates oxygen saturation < 88% for 5 minutes or longer of continuous nocturnal recording time (minimum recording time of 2 hours), done while breathing oxygen at 2LPM or the client's prescribed FIO2 (whichever is higher).
- Prior to initiating therapy, documentation of sleep apnea and that treatment with a CPAP has been considered with an explanation of why it has been ruled out.

To rule out the use of a CPAP, formal sleep testing is not required if there is sufficient information in the client's medical record submitted with the request that demonstrates the client does not have some form of OSA, CSA, or CompSA as the predominant cause of awake hypercapnia or nocturnal arterial oxygen desaturation.

A RAD with a backup feature will be considered with prior authorization for severe COPD when all of the following criteria are met:

- The client meets the criteria for use of the RAD without a backup rate for COPD
- The ordering practitioner verifies that:
  - The client has tried the RAD without a backup rate for at least 60 days.
  - The client was compliant in the use of the device using on average 4 or more hours in a 24 hour day.
  - The desired therapeutic respiratory response was not achieved with the RAD without a set backup rate.

36.2.2.2.4 RAD for Treatment of Central sleep Apnea (CSA) or Complex Sleep apnea (CompSA)

A RAD without a set backup rate will be considered with prior authorization for the treatment of CSA or CompSA when a facility based polysomnogram indicates all of the following:

- The client has a diagnosis of CSA or CompSA
- The sleep study documents one of the following:
  - The sum total of central hypopneas plus central apneas is greater than 50% of the total apneas and hypopneas rate

- A central hypopnea/apnea rate index greater than 5 events per hour and significant improvement of the sleep associated hypoventilation while breathing the client's prescribed FiO2
- Documentation ruling out CPAP as effective therapy if either OSA or CSA is a component of the initially observed sleep associated hypoventilation

A RAD with a backup rate will be considered with prior authorization for the treatment of CSA or CompSA when all of the following are met:

- The client meets the criteria for use of the RAD without a backup rate for the treatment of CSA or CompSA
- The ordering practitioner verifies that all of the following are met:
  - Client has tried a RAD without a backup rate for at least 60 days
  - Client was compliant in the use of the device using on average 4 or more hours in a 24 hour day
  - The desired therapeutic response was not achieved with the RAD without a set backup rate

36.2.2.2.5 RAD for Treatment of Hypoventilation Syndrome

A RAD without a set backup rate may be considered for treatment of hypoventilation syndrome with prior authorization when all of the following criteria are met:

- An initial arterial blood gas PaCO2 is > 45 mm Hg while awake breathing routinely prescribed FIO2
- A spirometry shows a forced expired volume in 1 sec (FEV1) or the forced vital capacity (FVC) is > 70%.
- A facility based polysomnogram demonstrates an oxygen saturation < 88% for 5 minutes or longer of continuous nocturnal recording time (minimum recording time of 2 hrs) not caused by obstructive upper airway events

A RAD with a set backup respiratory rate may be considered with prior authorization for the treatment of hypoventilation syndrome when one of the following are met:

- The client has hypoventilation syndrome as determined by a facility based polysomnogram that demonstrates the desired respiratory therapeutic effects were not achieved with a RAD without a backup rate
- The client meets the criteria for RAD without a backup rate for hypoventilation syndrome and the physician documents the desired respiratory therapeutic effects were not achieved with the RAD without a backup rate

36.2.2.2.6 Extension Request for RAD With or Without a Set Backup Rate

Prior authorization is required for an extension of a RAD with or without a set backup rate.

Purchase of a RAD without a set backup rate or continued rental of a RAD with or without a set backup rate (after the initial rental) may be considered with prior authorization and all of the following:

- The client has completed an initial three month rental period
- Submission of a new CSHCN Services Program Prior Authorization Request for Continuous Positive Airway Pressure (CPAP) or Respiratory Assist Device (RAD) Form that has been signed and dated by the ordering practitioner
- Submission of medical necessity documentation that the client is continuing to use the equipment a minimum of four hours in a 24 hour period
- Medical necessity documentation indicates that client symptoms are improved

When requesting an extension for a RAD with or without a set backup rate documentation of a capillary blood gas (CBG) demonstrating a PaCO2 greater than or equal to 45 mm Hg, obtained while awake and breathing the client's routinely prescribed FI02 may be submitted in lieu of an ABG.

36.2.3 Controlled Dose Inhalation Drug Delivery System

Prior authorization is required for purchase of a controlled dose inhalation drug delivery system (procedure code K0730) and requires documentation of medical necessity for the following conditions:

Conditions
Pulmonary artery hypertension
Chronic pulmonary heart disease
Other chronic pulmonary heart diseases

Other conditions may be considered with prior authorization and documentation of medical necessity.

Note: *The pulmonary hypertension may not be secondary to pulmonary venous hypertension or disorders of the respiratory system.*

36.2.4 Secretion and Mucus Clearance Devices

Secretion and mucus clearing devices are a benefit when medically necessary and are typically needed by clients diagnosed with cystic fibrosis (CF), chronic bronchitis, bronchiectasis, ciliary dyskinesia syndromes, some forms of asthma, neuromuscular degenerative disorders, post-operative atelectasis, or thoracic wall defects.

Secretion and mucus clearing devices may be considered when documentation clearly shows the client has one of the following indications for this form of therapy as described by the American Association for Respiratory Care (AARC) in the Clinical Practices Guidelines for Postural Drainage Therapy (I) (199-1):

- Evidence retained secretions
- Evidence that the client is having difficulty with the secretion clearance
- Presence of atelectasis caused by mucus plugging

The following therapies and devices do not require prior authorization when requested within the benefit limitations:

- Incentive spirometers
- Manual percussion
- Mucus clearance valved chamber (Oscillating Positive Expiratory Pressure (PEP) - Flutter Valve)
- Moisture exchangers (procedure code A4483) for use only when used for mechanically ventilated clients who own their own equipment

These following therapies and devices require prior authorization:

- Insufflation-exsufflation devices, (e.g., Cough Assist, Cofflator)
- Electrical percussors
- High frequency chest wall oscillation (HFCWO) system
- Percussion cup
- Intermittent positive pressure breathing (IPPB) devices

Prior authorization requests for rental or purchase of secretion and mucus clearance devices must be submitted on the CSHCN Services Program Prior Authorization Request for Secretion and Mucus Clearance Devices Form signed and dated by a physician.

Note: *Clients requiring more than one secretion and mucus clearance device must have a pulmonologist as the prescribing physician who submits a signed and dated letter of medical necessity for the need of two devices.*

36.2.4.1 Cough Augmentation Device (Insufflation Devices or Cough Assist Machine)

A cough augmentation device may be considered for prior authorization for rental only for those clients who have chronic pulmonary disease or neuromuscular disorders (including spinal cord injury) that affect the respiratory musculature, causing a weak, ineffectual or absent cough.

Prior authorization for a cough augmentation device may be considered for an initial three-month rental period with all of the following documentation completed, signed, and dated by the client's treating physician:

- Diagnosis and background history including recent illnesses, complications, medications used, history of recent hospitalizations, results of pulmonary function studies (if applicable); due to diagnosis- related complications.
- History of school, work, or extracurricular activity or absences or other clinical evidence supporting deterioration to the level of requiring the use of a cough augmentation device to clear the airways, such as a weak, ineffective cough as demonstrated by pulmonary function studies (PFTs).
- Medical reasons why the client, parent, guardian, or caregiver cannot do chest physiotherapy, or why such therapies were previously ineffective.

Requests for prior authorization recertification must include documentation by the client's treating physician that the client is compliant with the use of the equipment and that the treatment is effective.

36.2.4.2 Electrical Percussors

An electrical percussor may be considered for rental or purchase with documentation of medical necessity on the CSHCN Services Program Prior Authorization Request for Secretion and Mucus Clearance Devices Form including a description of all previous courses of therapy (such as manual percussion and postural drainage (P&PD) and valved devices) and why they did not adequately assist the client in airway mucus clearance.

Note: *Rental period may be considered for a maximum of nine months.*

36.2.4.3 High Frequency Chest Wall Oscillation (HFCWO) System

Prior authorization of a HFCWO system may be considered for clients with one of the following conditions:

- Bronchiectasis when it is confirmed by CT scan and characterized by either a continuous daily productive cough for 6 months or frequent exacerbations of pulmonary infections (i.e., more than 2 times per year) requiring antibiotic therapy
- Cystic Fibrosis or other documented chronic supperative endobronchitis
- Chronic neuromuscular disorder affecting the ability to cough or clear respiratory secretions

A HFCWO system may be considered for prior authorization with documentation of all the following:

- Medical necessity including submission of the CSHCN Services Program Prior Authorization Request for Secretion and Mucus Clearance Devices Form
- Other mechanical devices or chest physiotherapy modalities used by a client, parent, guardian, or caregiver
- Reason why other modalities have not been effective

- If previously used, the device use has not resulted in aspiration, exacerbation of any gastrointestinal or pulmonary issues, nor caused an exacerbations of seizure activity

An initial three-month rental may be prior authorized for the HFCWO system. If the HFCWO system is documented to be effective, at the end of the initial three-month rental, purchase of the system may be prior authorized. If at the end of the initial three-month rental, a determination of purchase cannot be made, an additional three-month rental may be given.

Prior authorization for the initial three-month rental of an HFCWO system generator and vest may be considered with all of the following information:

- Documentation that the client has one of the medical conditions listed above and has used a cough augmentation device for a minimum of three months prior to the request and that this therapy has been ineffective
- Client has a chronic respiratory illness or with exacerbation or change in baseline respiratory condition in the past 6 months (provide additional information in narrative section)
- Client or family unable to do chest physiotherapy or chest physiotherapy is contraindicated (provide medical reasons in narrative section)
- Client has tried other appropriate (age, ability, skill) modes of chest physiotherapy, such as the use of electrical percussor therapy or oscillating positive expiratory pressure valve for a minimum of four months prior to the request and why the therapy has been ineffective (provide information on other therapies and why they are ineffective in narrative section)

Prior authorization for an additional three-month rental may be considered with the above documentation and documentation of compliance with the ordered therapy.

Prior authorization for the purchase of an HFCWO system may be considered based on the outcome of the rental period(s) and the following required documentation:

- Documentation of vest tolerance and positive outcomes or results of therapy, including physician's statement of a trial of the HFCWO in a clinic, hospital, or the home setting documenting the effectiveness and tolerance of the system
- Physician's description and assessment of the effectiveness including:
  - Decreased medication use
  - Shorter hospital length of stay
  - Decreased hospitalizations
  - Fewer school, work, or extracurricular activity absences due to diagnosis- related complications
  - The frequency and compliance graphs from the device for the 6-month period showing use of the system at least 50 percent or 3 months of the maximum time prescribed by the physician for each day
- Diagnosis and background history including:
  - Complications
  - Medications used
  - IV antibiotic therapy with dosage, frequency and duration
  - Recent hospitalizations
  - School, work, and extracurricular activity absences due to diagnosis-related complications
- Evidence of clinical improvement other than pulmonary function tests, including improved work or school attendance or ability to participate in extracurricular activities

- Documentation that the previous use of the HFCWO device has not resulted in aspiration, exacerbation of a gastrointestinal or pulmonary issue, or exacerbation of seizure activity

A HFCWO system purchase will be reimbursed only once per lifetime, due to the lifetime warranty provided by the manufacturer.

Note: *Requests for a vest replacement due to growth or is no longer functional will be considered for prior authorization with appropriate documentation and submission of the CSHCN Services Program Prior Authorization Request for Secretion and Mucus Clearance Devices Form.*

36.2.4.4 Percussion Cup

Requests for purchase of a percussion cup for chest physiotherapy requires submission of the CSHCN Services Program Prior Authorization Request for Secretion and Mucus Clearance Devices Form and documentation of medical necessity. Requests for percussion cups should be requested with the miscellaneous DME procedure code E1399.

36.2.4.5 Intermittent Positive Pressure Breathing (IPPB) Devices

Prior authorization is required for rental or purchase of an IPPB (procedure code E0500) with documentation of ineffective response with use of other modalities (e.g. treatment with a cough assist device) and there is a need to improve lung expansion due to:

- The presence of clinically significant pulmonary atelectasis when other forms of therapy have been unsuccessful or the client is unable to cooperate with the treatment
- Inability to clear secretions due to pathology that severely limits the client's ability to ventilate or cough effectively and failure to respond to other modes of treatment including but not limited to:
  - Neuromuscular disorders or kyphoscoliosis with decreases in lung volume
  - Presence of acute severe bronchospasm or exacerbated COPD that fails to respond to other therapy
  - The need to deliver aerosol medication
- The need to deliver aerosol medications when other methods of delivery have been unsuccessful including but not limited to:
  - Clients with fatigue as a result of ventilary muscle weakness such as neuromuscular disease, kyphoscoliosis or spinal cord injury
  - Clients with severe hyperinflation where IPPB may decrease dyspnea and discomfort during nebulized therapy

Rental of the IPPB device includes all supplies (e.g. humidification and tubing).

36.2.5 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
Large Volume Nebulizer and Supplies				
A7007	A7008	E0585		
Filtered Volume Nebulizer and Supplies				
A7006	E0565			
Ultrasonic Volume Nebulizer and Supplies				
E0574	E0575			

Note: *Prescribed medications for use with aerosol delivery by SVN may be considered under the Vendor Drug Program.*

36.2.5.1 Medications Small Volume Nebulizer

Prior authorization is not required for purchase of a medication small volume nebulizer (SVN) and related supplies for the conditions listed below.

Conditions
Bronchiectasis - any type
Cystic Fibrosis with pulmonary manifestations
Pneumonia - any type
Influenza
Bronchitis - any type
Emphysema - any type
Asthma - any type
COPD - any type
Pneumoconiosis - any type
Acute, Sub-acute or Chronic respiratory conditions
Respiratory conditions due to radiation, smoke, unspecified and specified external agents
Abnormal sputum
Other diseases of the trachea and bronchus
Tracheostomy Status
Attention to tracheostomy
HIV with pulmonary manifestations
Pneumocystis
Complications of a specified or unspecified transplanted organ, bone marrow, or stem cells
Primary Pulmonary Hypertension
Other Chronic Pulmonary Heart Disease

Note: *Prescribed medications for use with aerosol delivery by SVN may be considered under the Vendor Drug Program.*

SVNs for conditions not listed above require prior authorization with documentation of medical necessity.

Sterile water, saline, and dextrose, diluent/flush 10 ml does not require prior authorization when requested within the limitations within this chapter.

Documentation for prior authorization must include frequency and duration of need for the nebulizer treatments ordered.

36.2.5.2 Large Volume Nebulizer

Prior authorization is not required for large volume nebulizers (procedure codes A7007 and A7017) used with compressors in humidification systems and may be considered for purchase when medically necessary. Prior authorization with documentation of medical necessity is required for large volume nebulizers that exceed the limitations in this chapter.

If heat is required, a heating element, such as an immersion element, may be added.

The autoclave nebulizer (procedure code E0580) for use with a regulator or flow meter may be considered with prior authorization and documentation of medical necessity.

36.2.5.3 Compressors and other DME used with Large Volume Nebulizers

Prior authorization is required for rental or purchase of compressors (procedure code E0565), nebulizer compressors and heaters (procedure code E0585), or large volume ultrasonic nebulizers (procedure code E0575) when the following criteria is met:

- The client has thick, tenacious secretions
- The client has one of the following medical conditions:
  - Cystic fibrosis
  - Bronchitis
  - A tracheostomy
  - A tracheobronchial stent

Equipment used with a large volume nebulizer to create a humidification system may be considered with prior authorization and documentation of medical necessity.

Procedure code E0565 may be considered when all of the following criteria are met:

- The compressor is needed for the administration of pentamide using a filtered nebulizer
- The client has one of the following medical conditions:
  - HIV with pulmonary complications
  - Pneumocystosis
  - Complications of organ transplants

36.2.5.4 Filtered Nebulizer

Prior authorization is required for the administration set with small volume filtered pneumatic nebulizers (procedure code A7006) and must include documentation of medical necessity of one of the following conditions:

- HIV
- Complications of organ transplants, unspecified site

The administration set may be considered for other immunodeficiency conditions with prior authorization and documentation of medical necessity.

36.2.5.5 Ultrasonic Nebulizers

Prior authorization with documentation of medical necessity is required for purchase of ultrasonic nebulizers (procedure code E0574) used for the administration of bronchodilators and other select medication for clients who meet the criteria for a standard nebulizer.

Note: *Speed, convenience, or ease of use is not considered medically necessary.*

The prior authorization request must provide documentation that:

- The client did not have clinical improvement with treatment using a medication small volume nebulizer
- The client was compliant with other nebulizer treatment and medication therapy
- Use of a standard nebulizer has failed to control the client's disease process resulting in emergency room use or hospitalizations

36.2.6 Oxygen Therapy

All oxygen therapy supplies and related equipment requires prior authorization.

Devices used for in-home oxygen therapy including stationary oxygen concentrators, portable compressed gas cylinders, or liquid oxygen reservoir oxygen systems are a benefit when medically necessary and require prior authorization.

Prior authorization may be considered for monthly rental only and must be requested on a completed CSHCN Services Program Prior Authorization Request for Oxygen Therapy Form signed and dated by the client's ordering practitioner. Medical necessity documentation must be submitted with the request.

Oxygen system rental includes, but is not be limited to:

- Oxygen concentrator or oxygen tanks
- Regulator
- Flow meter
- Humidifier
- Cannula or mask
- Tubing

Devices used for in-home oxygen therapy may be considered for the treatment of chronic hypoxemia which may be the result of, but not limited to:

- Bronchopulmonary dysplasia or other respiratory diagnoses due to prematurity.
- Respiratory failure or insufficiency; musculoskeletal weakness, such as that caused by Duchenne's muscular dystrophy or spinal muscle atrophy.
- Diagnosis of cluster headaches.
- Severe lung disease, such as chronic obstructive pulmonary disease (COPD), diffuses interstitial lung disease, cystic fibrosis, bronchiectasis, or widespread pulmonary neoplasm.

Stationary oxygen concentrators are the preferred oxygen therapy home delivery system. If other types of oxygen therapy home delivery systems are required, documentation of medical necessity to support an exception must be provided. The other types of delivery systems include:

- Compressed gas cylinder systems (nonportable tanks).
- Liquid oxygen reservoir systems.

Multiple oxygen types (e.g., liquid and gas) will not be prior authorized concurrently.

Extensive supplemental humidification systems (procedure code E0550) may be prior authorized separately for monthly rental of oxygen equipment with documentation of medical necessity. The documentation must include all of the following:

- The client has a tracheostomy or tracheobronchial stent
- The client has thick tenacious secretions not responsive to normal levels of humidification provided with routine humidifiers used with regulators or flow meters.
- The client is not currently renting a ventilator
- The client is not currently renting a compressor for the delivery of humidification

All other humidification systems are included in the oxygen monthly rental and will not be prior authorized separately.

Supplies and refills (procedure codes E0441, E0442, E0443, E0444, and E0447) may be prior authorized for those clients who own their own oxygen systems.

Prior authorization of home oxygen therapy for an initial three-month rental period may be considered when a CSHCN Services Program Prior Authorization Request for Oxygen Therapy Form is submitted along with medical necessity documentation that meets one of the oxygen coverage categories below:

- Evidence from the client's treating physician of a determination that the client has severe lung disease or hypoxia-related symptoms that are expected to improve with oxygen therapy.
    - The client's medical diagnosis requiring oxygen therapy
    - The oxygen flow rate
    - An estimate of the frequency, duration of use (e.g., 2 liters per minute, 15 minutes per hour, 12 hours per day) and duration of need (e.g., 3 months)
- A qualifying blood gas assessment may be supported by the results of either pulse oximetry or an arterial blood gas and includes all of the following:
    - Date of testing
    - Results of testing
    - If the blood gas assessment occurred during the client's inpatient hospital stay, a blood gas performed no more than two days before discharge is acceptable
    - If a blood gas is obtained while the client is at home, the assessment must be performed while the client is in a stable chronic state (i.e., not during a period of acute illness or an exacerbation of their underlying disease) within the 30-day period prior to the request for service

Oxygen therapy is available for clients with an eligible condition as outlined below.

Prior authorization may be considered for clients of any age with significant hypoxemia with documentation of any of the following:

- An arterial pO2 (partial pressure of oxygen) equal to or less than 55 mm Hg or an arterial oxygen saturation equal to or less than 88 percent, taken at rest, breathing room air
- An arterial pO2 equal to or less than 55 mm Hg or arterial oxygen saturation at or below 88 percent, taken during sleep and lasting for at least 5 continuous minutes for clients who have a pO2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent while awake
- A decrease in arterial pO2 more than 10 mm Hg, or a decrease in arterial oxygen saturation of more than 5 percent, for at least 5 continuous minutes taken during sleep with symptoms or signs reasonably attributable to hypoxemia (e.g., impairment of cognitive processes and nocturnal restlessness or insomnia)

- An arterial pO2 equal to or less than 55 mm Hg or an arterial oxygen saturation at or below 88 percent, taken during exercise for a member who demonstrates a pO2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent during the day while at rest. In this case, supplemental oxygen may be provided for use during exercise if there is evidence the use of oxygen improves the hypoxemia that was demonstrated during exercise when the client was breathing room air

Prior authorization may be considered for clients who are 20 years of age and younger when evidenced by any of the above or the following documentation:

- A neonate, and premature infant of any age who have not reached their 40th week of gestational maturity with an arterial pO2 of less than 60 mmHg or an arterial oxygen saturation level is less than 92 percent
- An infant with chronic neonatal lung disease with an arterial oxygen saturation equal to or less than 92 percent
- Other medical conditions that may be considered on a case by case basis with supporting documentation from the treating physician supporting the need for oxygen therapy. These requests will be reviewed by the CSHCN Services Program Medical Director or designee. Examples include, but are not limited to:
- Infants with bronchopulmonary dysplasia
- Infants with apnea of prematurity or recurrent cyanotic apneic episodes
- Children with severe pulmonary hypotension
- Children who have sickle cell anemia with respiratory conditions
- Infants or children who have idiopathic pulmonary hypertension with sleep associated desaturations or a documented need for an emergent use of oxygen

Coverage for clients of any age whose arterial pO2 is 56-59 Hg or whose arterial blood oxygen saturation is 89 percent with documentation of any of the following:

- Dependent edema suggesting congestive heart failure (CHF)
- Cor Pulmonale (pulmonary hypertension)
- Erythrocythemia with a hematocrit greater than 56 percent

Coverage for clients with a diagnosis of cluster headaches with documentation of all of the following:

- Neurological evaluation with diagnosis of cluster headache
- Documentation of failed medical therapy

For clients whose only diagnosis is Obstructive Sleep Apnea (OSA), documentation must support that the client's oxygen sleep desaturation was not corrected by CPAP or RADs.

For clients not meeting the above blood gas assessment criteria, a request for oxygen therapy may be submitted with the required documentation along with evidenced based documentation supporting the benefits of oxygen therapy for the client's condition, and a letter of medical necessity from the treating practitioner. Submission of the request and the required documentation does not guarantee approval. These requests will be reviewed by the CSHCN Services Program Medical Director or designee.

Prior authorization of oxygen therapy after an initial three-month rental period may be considered for periods of six months a time with the submission of all of the following documentation:

- A new CSHCN Services Program Prior Authorization Request for Oxygen Therapy Form
- Documentation of a continued need for oxygen therapy

- Documentation of the client's compliance with the oxygen therapy by the ordering practitioner

Documentation (date of test and results) of a new blood gas assessment using pulse oximetry or arterial blood gas documentation that the client meets the criteria of any of the above defined oxygen category requirements.

For clients not meeting the above criteria, a request for oxygen therapy renewal may be submitted with all of the required medical necessity documentation along with evidenced based documentation demonstrating the benefit of oxygen therapy for the client's condition. These requests will be reviewed on a case by case basis by the CSHCN Services Program Medical Director or designee.

Note: *The initial CSHCN Services Program Prior Authorization Request for Oxygen Therapy Form cannot be used to request oxygen therapy renewal or extension. A new prior authorization form must be submitted for each request.*

36.2.6.1 Stationary Oxygen Systems

Rental of a stationary oxygen system includes, but is not limited to, the nasal cannula or mask, tubing, and a basic bubble humidification system. These supplies will not be prior authorized separately.

The types of covered stationary oxygen delivery systems include:

- Oxygen concentrators
- Compressed oxygen gas cylinder systems
- Liquid oxygen cylinder systems

36.2.6.2 Portable Oxygen Systems

Portable oxygen therapy may be considered for prior authorization when medical necessity documentation indicates that the client requires the use of oxygen in the home and would benefit from the use of a portable oxygen system when traveling outside of the home environment.

Portable oxygen systems will not be considered for prior authorization for travel outside of the home environment for clients who qualify for oxygen usage based solely on oxygen saturation levels during sleep.

The types of covered portable oxygen and portable oxygen related delivery systems include:

- Portable tanks for compressed oxygen gas cylinder systems
- Portable tanks for liquid oxygen cylinder systems
- Home compressor attachment used on an oxygen compressor to fill oxygen tanks
- Portable gaseous oxygen system home compressor
- Portable concentrator systems

36.2.7 Pulse Oximeters

Pulse oximeters may be considered for short or long term rental or purchase with prior authorization when medically necessary for continuous overnight monitoring. A completed CSHCN Services Program Prior Authorization Request for Pulse Oximeter Form must be submitted with documentation of medical necessity.

A pulse oximeter (procedure code E0445 without modifier U4) required for short-term use, defined as equipment rented up to one per six calendar months, may be a benefit when medically necessary and does not require prior authorization for clients with one of the following conditions:

- When the client is stable and is able to wean from home oxygen or ventilator
- When a change in the client's condition requires an adjustment in the liter flow of their home oxygen treatment

- To determine the client's appropriate home oxygen liter flow for ambulation, exercise, or sleep
- To determine the client's appropriate home oxygen liter flow for those who have neuromuscular disease involving the respiratory muscles, with chronic lung disease, or with severe cardiopulmonary disease

Pulse oximetry for use as a continuous client vital signs monitor or for routine spot checks is not a benefit.

Short-term pulse oximetry that is medically necessary more frequently than once every six months requires prior authorization and documentation of all medical necessity will be considered on a case by case basis. Requests must be submitted on the CSHCN Services Program Prior Authorization Request for Pulse Oximeter Form and include documentation why earlier weaning attempts were unsuccessful and changes in the client's condition since the failed weaning attempt.

A pulse oximeter required for long-term use (procedure code E0445 with modifier U4), defined as periods longer than one calendar month in a six month period, may be a benefit for rental or purchase with documentation of medical necessity. The request must be submitted on a completed CSHCN Services Program Prior Authorization Request for Pulse Oximeter Form.

A long-term pulse oximeter may be prior authorized for monthly rental up to a maximum of six months. Recertification for an additional three-month period may be considered for a maximum of nine months.

Documentation of medical of necessity must include a caregiver or health care provider present who has been trained in use of the oximeter and how to respond to readings in a medically safe and appropriate manner, and the client meets one of the following criteria:

- Client is oxygen or ventilator dependent, is not stable, and therefore has frequent need for changes in oxygen or ventilator settings
- Client frequently experiences respiratory complications and requires equipment that has oxygen saturation monitoring capabilities

Pulse oximeter related supplies are included in the pulse oximeter rental, do not require prior authorization within the defined limits for client-owned equipment, and are limited as follows:

- Disposable pulse oximeter probes (procedure code A4606) are limited to four per month
- Reusable pulse oximeter sensor probes (procedure code A4606 with modifier U5) are limited to one every six months

Pulse oximeter probes (procedure codes A4606 and A4606 with modifier U5) are included in the pulse oximeter equipment rental. Pulse oximeter probes will be denied if billed with pulse oximeter equipment (procedure codes E0445 and E0445 with modifier U4) in the same month of service by any provider.

Prior authorization for purchase of the pulse oximeter at the end of the nine months of rental may be considered, if the continuation of pulse oximeter use is documented to be medically necessary by a physician.

A pulse oximeter may be prior authorized for purchase when a purchase is determined to be more cost effective than leasing the device with supplies.

Pulse oximetry equipment that has been purchased is anticipated to last a minimum of five years. Replacement of equipment may also be considered for prior authorization when loss or irreparable damage has occurred outside the warranty terms, conditions, and limitations. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent reoccurrence must be submitted with the prior authorization request.

36.2.8 Tracheostomy Tubes and Related Supplies

Tracheostomy tubes and related supplies may be a benefit when medically necessary for clients with a tracheostomy.

Tracheostomy supplies, including inner cannulas, are available for purchase when medically necessary without prior authorization within the benefit limits.

A tracheostomy speaking valve (procedure code L8501) is considered a medically necessary accessory that enhances the function of the tracheostomy and is available for purchase without prior authorization when requested within the benefit limits.

Tracheostomy tubes (procedure codes A7520, A7521, and A7522) are medically necessary for clients with a tracheostomy and are available for purchase with prior authorization.

For the initial tracheostomy tube request, two tubes may be considered for prior authorization in the first month of service (two the same size and one smaller for emergencies).

For the remainder of the initial prior authorization period and for subsequent requests, one tracheostomy tube will be prior authorized per month.

More than one tracheostomy tube per month may be considered on a case-by-case basis with medical documentation supporting why the tracheostomy tube must be changed more frequently in order to meet the client's medical needs.

When requesting prior authorization for non-customized or non-specialized tracheostomy tubes without specialized functions, providers must submit the most appropriate procedure code, no modifier is required.

When requesting prior authorization for specialized, but non-customized tracheostomy tubes with specialized functions, providers submit the request with modifier U1.

When requesting prior authorization for customized tracheostomy tubes, providers must submit the request with modifier U2.

With the use of either modifier U1 or U2, the following documentation is required:

- The manufacturer's retail or invoice pricing information
- A physician statement of the reason the client cannot use a standard tracheostomy tube
- The manufacturer's information on the specialized functions of the tracheostomy tube or the order form describing the customization of the tracheostomy tube

A non-in-line humidification system is acceptable for clients using a tracheostomy collar.

Suction machines, suction canisters, suction tubing, tracheal suction tubes, and oropharyngeal suction catheters are a benefit with documentation of medical necessity to have oral, nasopharyngeal, or tracheal suctioning performed.

36.2.8.1 Tracheostomy Tube Inner Cannula

Clients with a tracheostomy tube with a reusable inner cannula (procedure code A4623) are allowed one reusable inner cannula per month without prior authorization.

Reusable inner cannulas are included in the prior authorization for any custom tracheostomy tube that is approved.

Requests for more than one reusable inner cannula per month require prior authorization and medical documentation from the client's physician to support the need for more than one reusable inner cannula per month.

Clients with a tracheostomy tube with a disposable inner cannula (procedure code A4623 with modifier U3) are allowed 31 disposable inner cannulas per month without prior authorization.

If more than 31 disposable inner cannulas per month are needed, prior authorization is required and documentation from the client's ordering practitioner must support the medical need.

A tracheostomy speaking valve (procedure code L8501) is considered a medically necessary accessory that enhances the function of the tracheostomy and is limited to one per six months without prior authorization.

36.2.9 Cardiorespiratory Monitor (CRM)

A cardiorespiratory monitor (CRM) is a benefit when medically necessary and may be considered for clients who require moment to moment cardiac and respiratory monitoring due to the potential for sudden unexpected deterioration. Rental of equipment includes all necessary accessories, supplies, adjustments, repairs, and replacement parts.

A CRM with recording feature (procedure code E0619) may be considered for rental without prior authorization for clients who are four months of age and younger for a maximum of two months with documentation of one of the following conditions:

- Central apnea (respiratory control disorders)
- Cardiac rhythm issues

If a two-month rental has expired for clients who are four months of age and younger, continuation may be considered with prior authorization which must include all of the following:

- The client has on-going, documented cardiorespiratory episodes (e.g., apnea or dysrhythmia)
- A physician interpretation, signed and dated by the physician, of the most recent two month's
- CRM data recorded downloads
- A completed CSHCN Services Program Authorization and Prior Authorization Request for Cardio-respiratory Monitor (CRM) Form must be submitted with documentation of medical necessity

A CRM with or without recording feature (procedure codes E0618 or E0619) may be considered for prior authorization for rental or purchase for clients who are five months of age and older with one of the following conditions:

- An episode of apparent life-threatening event (ALTE) in an infant birth through 12 months of age
- Symptomatic central apnea
- Technology dependence such as:
    - Mechanical ventilation
    - Tracheostomy with a critical airway obstruction
    - Assisted ventilation dependence
    - Cardiac dysrhythmia with significant risk of morbidity or mortality

A CRM may be prior authorized initially for monthly rental up to a maximum of six months. Extension for an additional three month rental may be considered for a maximum total of nine months.

Prior authorization for purchase of the CRM at the end of the nine month rental may be considered if the continued use of the pulse oximeter is documented to be medically necessary by a physician.

Procedure codes A4556 and A4557 for the CRM may be reimbursed for clients with a purchased monitor, procedure code E0618 or E0619, within the last 5 years.

Leads and electrodes for use with a CRM owned by the client must be prior authorized. A physician statement must be submitted with the claim confirming that the client owns the monitor.

36.2.10 Mechanical Ventilation

Positive and negative pressure ventilators and related equipment may be considered for rental only with prior authorization and documentation of medical necessity. All requests must include the ventilator settings. Requests for prior authorization must be completed by the ordering practitioner and submitted on the CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form with documentation of medical necessity.

All ventilators (pressure support with or without invasive interface), related equipment and supplies require prior authorization.

Documentation must support why heated or non-heated humidification (when requested) is medically necessary for use with the mechanical ventilation including the expected outcome.

Mechanical ventilation may be considered for treatment of, but not limited to the following:

- Neuromuscular and/or musculoskeletal diseases and conditions affecting the respiratory muscles
- Thoracic restrictive disease
- Chronic respiratory failure

For rented or client owned ventilators, when heated or non-heated humidification is requested, documentation submitted must support why it is medically necessary for the use with the ventilation.

36.2.11 Negative Pressure Ventilators

Mechanical ventilation may be considered for the treatment of, but not limited to:

- Neuromuscular or musculoskeletal diseases and conditions affecting the respiratory muscles
- Thoracic restrictive diseases
- Chronic respiratory failure

The following table lists covered mechanical ventilation services and benefit limitations for clients who require assisted mechanical ventilation. All items must be requested by the client's treating physician and require prior authorization for rental only:

Service	Rental Limitation
Chest Shell (cuirass or "clam shell" (procedure code E0457)	1 per month
Chest wrap (procedure code E0459)	1 per month
Invasive home ventilator for clients with a trache-ostomy (procedure code E0465)	1 per month
Noninvasive positive pressure or volume control ventilator- for clients without a tracheostomy (procedure code E0466)	1 per month

Rental of a chest shell and chest wrap is limited to once per month for a total of up to six months. Consideration for each additional six months requires prior authorization with documentation of continued medical necessity, client compliance, and maintenance of the client's respiratory status.

A chest shell may be prior authorized for purchase following the initial three-month rental period of the non-invasive negative pressure ventilator depending on the physician's predicted length of treatment and the client's compliance.

A ventilator may be considered for an initial three-month rental period. Following the initial three-month rental period, if the ventilator was effective, it may be considered for ongoing six-month rental periods. A new prior authorization form must be submitted with each request.

The DME provider is responsible for ensuring that there is a contingency plan to manage interruptions in the use of equipment such as emergency situations and mechanical failures that would be life threatening for the client. The contingency plan should include input from the client's physician that takes into account the severity of the client's condition and time restraints in providing emergency support. Back-up ventilators are not paid separately from the primary ventilator in use and are considered to be a part of the primary ventilator DME rental agreement.

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

A home ventilator using an invasive interface (procedure code E0465), a non-invasive interface (procedure code E0466), or a multi-function respiratory device (procedure code E0467) may be prior authorized for a rental of an initial period of three months for clients who require assisted mechanical ventilation.

Requests must be submitted on the CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form and must be completed by the ordering practitioner and submitted with documentation of medical necessity.

Following the initial rental period of three months, additional requests may be considered for six month intervals at a time with prior authorization, documentation of medical necessity, and documentation of client compliance and effectiveness. A new prior authorization form must be submitted for each request.

The monthly ventilator rental includes all ventilator equipment and related supplies regardless of the client's duration of use, whether 24 hours per day or less including but not limited to:

- Internal filters
- External filters
- Ventilator circuits with an exhalation valve
- High and low pressure alarms
- Humidification systems including supplies and solutions, (e.g., sterile or distilled water)
- Compressors and supplies
- Tracheostomy tube filters and humidification devices, such as heat moisture exchangers (HME)
- Humidification device
- Resuscitation bag
- Back up ventilator

Note: *Oxygen rental is not considered a ventilator supply and may be considered for separate prior authorization.*

The DME provider is responsible for ensuring that there is a contingency plan to manage interruptions in the use of equipment such as emergency situations and mechanical failures that would be life threatening for the client. The contingency plan should include input from the client's physician that takes into account the severity of the client's condition and time restraints in providing emergency support. Back-up ventilators are not paid separately from the primary ventilator in use and are considered to be a part of the primary ventilator DME rental agreement.

36.2.13 Repair to Client -Owned Equipment

Repairs to client-owned equipment may be prior authorized as needed with documentation of medical necessity.

Note: *Technician fees are considered part of the cost of the repair.*

The CSHCN Services Program or its designee reserves the right to request additional documentation about the need for repairs when there is evidence of abuse or neglect to equipment by the client, client's family, or caregiver. When there is documented proof of abuse or neglect, requests for repairs will not be authorized.

Providers are responsible for maintaining documentation in the client's medical record specifying the repairs and supporting medical necessity.

Documentation must include all the following:

- The date of purchase
- The serial number of the current equipment (as applicable)
- The cause of the damage or need for repairs
- What steps the client or caregiver will take to prevent further damage if repairs are due to an accident
- The cost of purchasing new equipment as opposed to repairing current equipment

Temporary replacement of client owned equipment during the repair may be considered for prior authorization for one month using procedure code K0462.

Labor for repair of client owned equipment may be considered for prior authorization using procedure code K0739 up to a maximum of two hours per day (maximum quantity of 8 units).

Note: *Routine maintenance of rental equipment is the provider's responsibility.*

36.2.14 Aerosol Treatments

Outpatient nebulized aerosol treatments may be a benefit when medically necessary for worsening of an acute or chronic respiratory condition and evidence that the client's breathing is compromised when billed with revenue code B-412 with one following procedure codes in addition to the code for the primary procedure:

Procedure Codes		
94640	94644	94645

Documentation must be maintained in the client's medical record that supports the need for outpatient aerosol treatment for worsening of the client's respiratory condition and is subject to retrospective review and recoupment.

36.2.15 Diagnostic Testing

Nitric oxide expired gas determination (FeNO) measurement (procedure code 95012) may be a benefit when medically necessary to diagnose or assess asthma and/or to evaluate the client's response to anti-inflammatory therapy. Procedure code 95012 is limited to once per day and must be billed with procedure codes 94010 or 94060.

Revenue code B-419 is a benefit for the hospital when billed with procedure code 95012.

Exhaled NO measurement may be reimbursed when it is utilized to determine responsiveness to anti-inflammatory steroid treatment for clients with chronic respiratory symptoms possibly due to eosinophilic airway inflammation as follows:

- To assist is assessing the etiology of respiratory symptoms
- To help identify the eosinophilic asthma phenotype
- To assess potential response or failure to respond to anti-inflammatory agents, particularly inhaled corticosteroids (ICS)

- To establish a baseline FeNO during non-exacerbations for subsequent monitoring of chronic persistent asthma
- To guide changes in dosing of anti-inflammatory medications: step down dosing, step-up dosing, or discontinuation of anti-inflammatory medications
- To assist in evaluation of compliance with use of anti-inflammatory medications
- To assess whether airway inflammation is contributing to respiratory symptoms

If expired NO determination is measure during an office visit and additional evaluation and management (E&M) components are billed, a separate E&M procedure code may be reimbursed using modifier 25.

Note: *Procedure code 95012 is reimbursed as a global service and cannot be separated into technical and professional components because the instrument produces an exhaled NO value requiring little interpretation.*

36.2.16 Other Equipment

All other respiratory equipment must be authorized. Documentation of medical necessity for the item must accompany the claim.

36.3 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 for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

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

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

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

36.4 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.

Respiratory equipment that has been purchase is anticipated to last a minimum of five years and may be considered for replacement when five years have passed or the equipment is no longer repairable.

Replacement of equipment may also be considered when loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and measures to be taken to prevent reoccurrence must be submitted with the request.

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 atwww.tmhp.com/resources/rate-and-code-updates/rate-changes.

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

36.5 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.

SPEECH-LANGUAGE PATHOLOGY (SLP) SERVICES

CSHCN SERVICES PROGRAM PROVIDER MANUAL

APRIL 2025

TEXAS
Health and Human
Services

SPEECH-LANGUAGE PATHOLOGY (SLP) SERVICES

Table of Contents

37.1 Enrollment

To enroll in the Children with Special Health Care Needs (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 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

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

37.2 Benefits, Limitations, and Authorization Requirements

SLP services are benefits of the 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 SLP 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.*

Speech therapy services must be rendered in accordance with the State Board of Examiners for Speech-Language Pathology and Audiology or performed by a physician within their scope of practice.

The CSHCN Services Program may reimburse licensed speech-language pathologists, physicians, home health agencies, hospitals, and outpatient facilities based on the procedure codes listed in this chapter.

Note: *Therapy services provided by a licensed intern or assistant must be billed by the licensed supervising provider.*

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 the limits outlined in this chapter for each type of therapy.

Therapy evaluations and re-evaluations are a benefit once per 180 days, any provider. Speech 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

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.

Each therapy discipline provided must be of the level of complexity that requires the judgment, knowledge, and skill of a licensed speech-language pathologist, or physician within their scope of practice, to perform or directly supervise.

The documentation maintained in the client's medical record must identify the therapy provider's name and credentials, 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.

37.2.1 Speech Therapy Limitations

Providers should use the following procedure codes for speech therapy services:

Procedure Codes							
92507	92521	92522	92523	92524	92526	92610	S9152

Only one of the following encounter-based speech therapy treatment codes is payable per date of service any provider:

Procedure Codes	
92507	92526

An encounter for speech therapy individual treatment is defined as face-to-face time with the patient and/or caregiver for a length of time compliant with nationally recognized professional speech-language pathology standards for a typical session.

Speech therapy treatment procedure codes should be billed with the GN modifier.

The following modifiers must be used to indicate when treatment services have been rendered by a licensed therapist or physician, or by a licensed therapy assistant under supervision of a licensed therapist:

Modifier	Modifier Description
U5	Services delivered by a licensed therapist or physician
UB	Services delivered by a licensed therapy assistant under supervision of a licensed therapist

Note: *These modifiers are not required for evaluation and re-evaluation procedure codes because those services may not be rendered by licensed therapy assistants.*

SLP evaluations and re-evaluations (procedure codes 92521, 92522, 92523, 92524, 92610, and S9152) are untimed and do not require a modifier.

Re-evaluations of oral and pharyngeal swallowing functions (procedure code 92610) require the U2 modifier.

If an initial evaluation and a re-evaluation from the same therapy discipline are billed for the same date of service by any provider, the re-evaluation will be denied.

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.

An evaluation or re-evaluation performed on the same day as therapy treatment from a different therapy type must be performed at distinctly separate times to be considered for reimbursement.

Outpatient speech therapy treatments will deny if billed on the same date of service by any provider as procedure code G0153.

37.2.2 Authorization Requirements

Speech therapy evaluations and re-evaluations do not require prior authorization.

All other speech therapy services require prior authorization. Only one encounter-based speech therapy treatment procedure code is payable per day per provider. Additional services may be considered with documentation of medical necessity supporting the rationale for exceeding the daily 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.*

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, home, 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.

37.2.2.1 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.

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 ordering practitioner'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.

37.2.2.2 Initial Prior Authorization Request for Therapy Services

The initial request for prior authorization must be approved before the initiation of therapy treatment services. Requests received after therapy treatments start will be denied for dates of service that occurred before the date the request was approved.

Initial prior authorization may be given for a service period not to exceed 180 days. Requests for extensions of ongoing treatment services may be granted up to an additional 180 days for chronic conditions with documentation of medical necessity. Prior authorizations may be approved for a time period less than the established maximum.

37.2.2.2.1 Supporting Documentation

Documentation supporting the medical need for SLP services include all of the following:

- A completed CSHCN Services Program Prior Authorization Request for Initial Outpatient Therapy (TP1) Form. The request form must be signed and dated by the ordering physician, APRN, or PA and therapy providers.

  Note: *A request form that is missing required information is considered incomplete.*

- A current evaluation for each therapy service requested and comprehensive treatment plan with the following:
  - Date of the evaluation
  - Diagnosis(es)
  - Client's medical history and background
  - Client's current and prior functional level, to include current standardized assessment scores or criterion-referenced scores as appropriate for the client's condition
  - Date of onset of the illness, injury, or exacerbation requiring the therapy services
  - Short- and long-term treatment goals for the therapy discipline, and associated disciplines, requested related to the client's individual needs
  - A description of the specific treatment modalities being prescribed and the recommended amount, frequency and duration of services

- Prognosis for improvement
- Requested dates of service
- Date and signature of the licensed therapist

Note: *A therapy evaluation is current when performed within 60 rolling days before the initiation of therapy treatment services. The ordering practitioner must sign and date the treatment plan and request form on or after the date the evaluation was performed.*

37.2.2.3 Prior Authorization Request for Extension of Therapy Services

A prior authorization request for extension of ongoing treatment services must be received and approved no earlier than 30 days before the current authorization expires. Prior authorization requests received after the current authorization expires will be denied for dates of service that occurred before the date the submitted request was approved.

Prior authorization requests for extensions of services may be considered in increments up to 180 days for chronic conditions with documentation supporting medical necessity.

37.2.2.3.1 Supporting Documentation

Documentation supporting medical necessity of the extension of services must include all of the following:

- A new CSHCN Services Program Prior Authorization Request for Extension of Outpatient Therapy (TP2) Form. The request form must be signed and dated by the ordering physician, APRN, or PA and therapy provider(s).

  Note: *A request form that is missing required information is considered incomplete.*

- A current therapy evaluation or re-evaluation for each therapy discipline requested and an updated treatment plan containing the following:
  - Date of the evaluation or re-evaluation
  - Diagnosis(es)
  - Client's medical history and background
  - Client's current and prior functional level, to include current standardized assessment scores or criterion-referenced scores as appropriate for the client's condition
  - Date of onset of the illness, injury, or exacerbation requiring the therapy services
  - Prior and new short- and long-term treatment goals documenting the client's progress towards prior treatment goals
  - A description of the specific treatment modalities being prescribed and the recommended amount, frequency and duration of services
  - Prognosis for improvement
  - Requested dates of service
  - Date and signature of the licensed therapist

  Note: *A therapy evaluation or re-evaluation is current when performed within 60 days before the request for extension of ongoing services. The ordering practitioner must sign and date the updated treatment plan and request form on or after the date that the evaluation or re-evaluation was performed.*

37.2.2.3.2 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 evidence of the following, including all documentation required for an initial request for therapy services:

- 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
  - An explanation 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 4.3, "Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about authorization requirements.

Chapter 10, "Augmentative Communication Devices (ACDs)."

CSHCN Services Program Prior Authorization Request for Initial Outpatient Therapy (TP1) Form

CSHCN Services Program Prior Authorization Request for Extension of Outpatient Therapy (TP2) Form

Note: *Fax transmittal confirmations are not accepted as proof of timely authorization submission.*

37.2.3 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)
- Services provided by unlicensed SLP aides, orderlies, students, or technicians
- Separate reimbursement for VitalStim therapy for dysphagia
- Unattended electrical stimulation
- 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

37.3 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.

37.4 Claims Information

Claims for SLP treatment services must include modifier GN. 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 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 41, "TMHP Electronic Data Interchange (EDI)" for information about electronic claims submissions.

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

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

37.5 Reimbursement

The CSHCN Services Program may reimburse therapy 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 services are 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/resources/rate-and-code-updates/rate-changes.

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

37.6 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.

TELECOMMUNICATION SERVICES

CSHCN SERVICES PROGRAM PROVIDER MANUAL

APRIL 2025

TEXAS
Health and Human
Services

TELECOMMUNICATION SERVICES

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38.1 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 Enrollment and Management System (PEMS) 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 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

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

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

38.2 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.

38.2.1 Patient Health Information Security

All video and data transmissions between the patient site provider and the distant site provider must comply with the Health Insurance Portability and Accountability Act (HIPAA) and the United States Health and Human Services (HHS) rules implementing HIPAA.

Distant and patient site providers should refer to the National Institute of Standards and Technology (NIST) for additional information about HIPAA-compliant health data storage and encryption technologies.

The software system used by both the distant and patient site providers must allow secure authentication of the distant site provider and the client.

The physical environments of the client and the distant site provider must ensure that the client's protected health information remains confidential. A parent or responsible adult may be physically located in the patient site or distant site environment during a telemedicine or telehealth visit with a child.

A parent or responsible adult must provide written or verbal consent to the distant site provider to allow any other individual, other than the distant site provider, the patient site presenter, or a representative of the distant site provider or patient site presenter, to be physically present in the distant or patient site environment during the visit with a child.

An adult client must also provide written or verbal consent to the distant site provider to allow any other individual, other than the distant site provider, the patient site presenter, or a representative of the distant site provider or patient site presenter, to be physically present in the distant or patient site environment during the visit.

Documentation of the written or verbal consent must be maintained in the client's medical record.

38.2.2 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.

38.2.2.1 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:

- Physician
- Advanced Practice Registered Nurse (APRN)
- Physician assistant (PA)

Distant site providers that communicate with clients through email or other electronic methods must provide clients with written notification of their privacy practices prior to evaluation and treatment. A good faith effort must be made to obtain the client's written acknowledgment of the notice, which must be maintained in the client's medical record.

Before providing services, distant site providers who use telemedicine medical services must give their clients notice regarding telemedicine medical services, including the risks and benefits of being treated via telemedicine, how to receive follow-up care or assistance in the event of an emergency or adverse event, or in the event of a technology or equipment failure.

Procedure codes that indicate remote (telemedicine or telehealth) delivery in their description do not need to be billed with the 95 modifier. The following procedure codes, when billed with the 95 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	99202	99203	99204	99205
99211	99212	99213	99214	99215	99242	99243	99244	99245	99252
99253	99254	99255	99417	99418	G0406*	G0407*	G0408*	G0425	G0426
G0427	G0459								

***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, 90838, 99417, and 99418 are add-on codes and must be billed with a primary procedure code on the same day, by the same provider 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.

Refer to: Section 19.2.3, "Telecommunication Services" in Chapter 19, "Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)" for information about billing telemedicine services by FQHC providers.

38.2.2.2 Other Patient Site

For telemedicine medical services provided at a site other than an established medical site for a client's previously diagnosed condition, the following will apply:

- Patient-site presenters are not required for pre-existing conditions previously diagnosed by a physician through a face-to-face visit
- All clients must be seen by a physician for an in-person evaluation at least once a year
- Telemedicine medical services may not be used to treat chronic pain with scheduled drugs at a site other than a medical practice site

- A distant site provider may treat an established client's new symptoms that are unrelated to the client's pre-existing condition. The client must be advised to see a physician in a face-to-face visit within 72 hours. A distant site provider may not provide continuing telemedicine medical services for these new symptoms if the client has not seen a physician within 72 hours. If the client's symptoms are resolved within 72 hours, and continuing treatment for the acute symptoms is no longer necessary, then a follow-up face-to-face visit is not required.

A distant site provider who provides telemedicine services at a site other than an established medical site for a previously diagnosed condition must do one of the following:

- See the client one time in a face-to-face visit before providing telemedicine medical care
- See the client without a face-to-face visit, as long as the client has received an in-person evaluation by another physician who has referred the client for additional care and the referral is documented in the medical record

38.2.2.3 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.

Telemedicine services provided at an established medical site require a defined physician-client relationship. The following communications do not meet the defined physician-client relationship requirement:

- An online questionnaire
- Questions and answers exchanged through email, electronic text, or chat
- Telephonic evaluation or consultation with a client

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

For new conditions, the patient site presenter must be readily available onsite at the established medical site to assist with care.

> ***Note:*** *Readily available means the patient site presenter is in the same room as the client or at the discretion of the licensed or certified professional providing the service, is not in the same room as the client but within the proximity determined by the licensed or certified professional providing the telemedicine service.*

A distant site provider delegating tasks to a patient site presenter must ensure that the patient site presenter is properly supervised when the tasks or activities are delegated.

For follow-up evaluations or treatment of a previously diagnosed condition, the distant site physician will determine if a patient site presenter is necessary.

A client's home may be considered an established medical site when the services provided in the home are limited to mental health services.

If the only services provided are related to mental health services, a patient site presenter is not required, except in cases of behavioral emergencies.

For medical services other than mental health services to be provided in the client's home, the following requirements must be met:

- A patient site presenter is present
- There is a defined physician-client relationship
- The patient site presenter has sufficient communication and remote medical diagnostic technology to allow the physician to carry out an adequate physical examination for the client's presenting condition, while seeing and hearing the client in real time. The physical examination will be held to the same standard of acceptable medical practices as those in traditional clinical settings.

Procedure code Q3014 is not a benefit if the patient site is the client's home.

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.

38.2.3 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 continued 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

38.2.3.1 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 95 modifier, are a benefit for distant-site providers:

Procedure Codes						
90791	90832	90834	90837	97802	97803	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, 90838, 99417, and 99418 are add-on codes and must be billed with a primary procedure code on the same day, by the same provider 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.

38.2.3.2 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.

Telehealth services provided at an established medical site require a defined physician-client relationship. The following communications do not meet the defined physician-client relationship requirement:

- An online questionnaire
- Questions and answers exchanged through email, electronic text, or chat
- Telephonic evaluation or consultation with a client

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 (e.g., behavioral health emergency).

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.

38.2.4 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.

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.

38.2.4.1 Collection and Interpretation of Client Data

The collection and interpretation of a client's data (procedure code 99091) for home telemonitoring services is a benefit and limited to reimbursement once per 30 days. Prior authorization is not required for procedure code 99091.

38.2.4.2 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 S9110 with modifier U1) 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 with procedure code S9110 and one of the appropriate modifiers listed in the table within this section.

Procedure code S9110 (with modifier U1) 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 or documentation of the occurrence of extenuating circumstances.

Home monitoring (procedure code S9110 with the appropriate modifier) is a benefit when services are provided by a home health agency or an outpatient hospital. Hospital providers must submit revenue code 780 with procedure code S9110 and the appropriate modifier for monthly home monitoring. Refer to table below for the appropriate modifier.

Use one of the following modifiers with monthly home monitoring services procedure code S9110 to indicate the number of transmission days per month:

Modifier	Number of Days Per Month
U2	1 through 5 days per month
U3	6 through 10 days per month
U4	11 through 15 days per month
U7	16 through 20 days per month
U8	21 through 25 days per month
U9	26 through 30 days per month

The unit of reimbursement for procedure code S9110 and the appropriate modifier is a rolling month.

Providers must bill the appropriate modifier to indicate the number of days that transmissions of data were received and reviewed for the client within a rolling month.

Monthly home monitoring for transmission of client data will not be prior authorized more than once per rolling month for the length of the prior authorization period.

Providers are not required to submit modifiers U2, U3, U4, U7, U8, or U9 for telemonitoring on the prior authorization request, but are required to submit the appropriate modifier on the claim for reimbursement based on the number of days as outlined in the table.

Claims for procedure code S9110 with any modifier should not be submitted to Medicare. Procedure code S9110 is not reimbursed by Medicare.

38.2.4.3 Prior Authorization Guidelines

Procedure code S9110 with or without modifier U1 requires prior authorization. Telemonitoring services may be requested and approved for up to 90 days per prior authorization request. The initial setup and installation (procedure code S9110 with modifier U1) may be prior authorized once per episode of care, unless the provider submits documentation of extenuating circumstances that require another installation of telemonitoring equipment. 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 available to clients only after the home health agency or hospital has received prior authorization. Dates of service requested before the prior authorization request is received will be denied.

The Home Telemonitoring Services Prior Authorization Request form must be signed and dated by the prescribing provider within 30 days before the start of care. If the form is signed after the start of care, all dates of services before the prescribing provider's signature date will be denied.

An RN, APRN, or PA may sign the prior authorization request form on behalf of the client's physician when the physician delegates this authority to the RN, APRN, or PA. The RN, APRN, or PA must complete Section D, then sign and date the form.

To avoid unnecessary denials, the prescribing physician must provide correct and complete information, including documentation of medical necessity for the equipment and supplies requested.

Home telemonitoring services are a benefit only for clients who are diagnosed with one or more of the following conditions:

- Diabetes
- Hypertension
- Congestive heart failure
- End-stage solid organ disease
- Organ transplant recipient
- Requiring mechanical ventilation

Clients with diabetes or hypertension must exhibit two or more of the following risk factors for approval of telemonitoring services:

- 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.

The home health agency or hospital must maintain documentation of all the following information:

- The telemonitoring equipment meets all the following requirements:
  - The equipment is capable of monitoring any data parameters included in the plan of care
  - The equipment is classified as a Food and Drug Administration Class II hospital-grade medical device
  - The equipment is capable of measuring and transmitting client weight, oxygen levels in blood, glucose levels in blood, or blood pressure data
- The client's medical record, which must include data transmission information that demonstrates the use of monitoring equipment, such as the following:
  - Date of transmission
  - Frequency of transmission
  - Clinical data provided to the client's primary care physician, or his or her designee
- The provider's staff is qualified to install the telemonitoring equipment and to monitor the client data transmitted according to the client's care plan.
- Monitoring of the client's clinical data is not duplicated by any other provider.
- The client's ability to operate the equipment or has a willing and able person to assist in completing electronic transmission of data, unless the equipment does not require active participation from the recipient.
- 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

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

Home Telemonitoring Services Prior Authorization Request Form

38.3 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 for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

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

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

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" and Section 5.7.2.7, "Instructions for Completing the UB-04 CMS-1450 Paper Claim Form" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

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

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.*

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.

Transportation of Deceased Clients

CSHCN Services Program Provider Manual

April 2025

TEXAS
Health and Human
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TRANSPORTATION OF DECEASED CLIENTS

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39.1 Enrollment

Funeral home providers are not required to be actively enrolled in Texas Medicaid or the CSHCN Services Program.

39.2 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 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 34° to 40°F, 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.*

39.2.1 Authorization Requirements

Authorization is not required for the transportation of deceased clients.

39.3 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.

39.4 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

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.

Vision Services

CSHCN Services Program Provider Manual

April 2025

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VISION SERVICES

Table of Contents

40.1 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 26 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 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his/her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

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

40.2 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 medically necessary 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
- Polarization of lenses
- Extended color vision examination
- Dark adaptation examination
- Vision screening
- Contact lenses that correct color vision deficiency
- Services and procedures that are investigational or experimental
- Low vision aids

Note: *Clients in need of low vision aids may be referred to the Texas Health and Human Services Commission (HHSC) 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.

40.2.1 Frames, Lenses, and Contact Lenses

40.2.1.1 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

Dispensing of eyeglasses includes the design, verification, fitting, adjustment, sale, and delivery to the client of fabricated and finished spectacle lenses, frames, or other ophthalmic devices prescribed by and dispensed in accordance with a prescription from a licensed physician or optometrist.

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.

Providers may submit procedure codes V2020 and V2025 for the reimbursement of eyeglass frames.

40.2.1.2 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.

Providers may submit the following procedure codes for the reimbursement of eyeglass lenses. Providers must bill with a quantity of two when billing for bilateral lenses with the same prescription.

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									

40.2.1.3 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 greater than 7.00 diopters or a cylinder greater than 4.00 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			

The following procedure codes will not be reimbursed unless billed with the appropriate lens procedure code by the same provider for the same date of service:

Procedure Codes for Add-On Lenses				
V2410	V2430	V2715	V2755	V2784

Procedure codes V2410, V2430, V2715, V2755, and V2784 will not be reimbursed unless they are billed with the appropriate lens procedure code by the same provider for the same date of service.

Ultraviolet (UV) lenses (procedure code V2755) may be reimbursed when billed with a diagnosis of aphakia. UV lenses will be denied when billed for the same date of service as polycarbonate lenses (procedure code V2784).

40.2.1.4 Contact Lenses

Dispensing of contact lenses includes the fabrication, ordering, adjustment, dispensing, sale, and delivery to the client of the contact lenses prescribed by and dispensed in accordance with a prescription from a licensed physician or optometrist.

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.

Fitting and modification of contact lenses may be reimbursed to providers using the following procedure codes:

Contact Lens Fitting Exam Procedure Codes									
92310	92311	92312	92313	92314	92315	92316	92317	92325	92326

Providers may submit the following procedure codes with a quantity of two for the reimbursement of a pair 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 Codes							
H18601	H18602	H18603	H18611	H18612	H18613	H18621	H18622
H18623	H2701	H2702	H2703	H27111	H27112	H27113	H27121
H27122	H27123	H27131	H27132	H27133	H35101	H35102	H35103
H35141	H35142	H35143	H35151	H35152	H35153	H35161	H35162
H35163	H35171	H35172	H35173	H4421	H4422	H4423	H442A1
H442A2	H442A3	H442A9	H442B1	H442B2	H442B3	H442B9	H442C1
H442C2	H442C3	H442C9	H442D1	H442D2	H442D3	H442D9	H442E1
H442E2	H442E3	H442E9	H5201	H5202	H5203	H5211	H5212
H5213	H52201	H52202	H52203	H52211	H52212	H52213	H52221
H52222	H52223	H5231	H5232	H524	H53001	H53002	H53003
H53011	H53012	H53013	H53021	H53022	H53023	H53031	H53032
H53033	H53041	H53042	H53043	H53049	Q123	Q134	Z961

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.

Refer to: Section 40.2.1.6.2, "Scleral Lenses and Liquid Bandages" in this chapter for detailed information on prior authorization requirements

Providers may bill for the replacement of contact lenses under current prescription due to damage or loss using procedure code 92326 with one of the diagnosis codes above.

If disposable contact lenses are deemed medically necessary and are prior-authorized, procedure code V2599 must be used to bill for their reimbursement.

40.2.1.4.1 Contact Fitting for Corneal Bandage Lens

The fitting of contact lenses for corneal bandages may be reimbursed using procedure codes 92071 and 92072.

Procedure code 92071 may be reimbursed for one service per day, each eye, any provider and must be billed with modifier LT or RT. If both eyes are billed for the same date of service, one procedure may be reimbursed at the full rate and the second procedure may be reimbursed at half rate.

Procedure code 92072 may be reimbursed for one service per day when billed by the same provider when one or both eyes are fitted for keratoconus lenses.

Note: *Follow-up visits should be billed separately using the most appropriate office visit code.*

40.2.1.5 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.

Refer to: Vision Care Eyeglass Client Certificate Form (English) on the TMHP website at www.tmhp.com.

Refer to: Vision Care Eyeglass Client Certificate Form (Spanish) on the TMHP website at www.tmhp.com.

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 0.50 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 40.2.1.4, "Contact Lenses" in this chapter. 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.

The repair of lost or destroyed eyeglass frames, eyeglass lenses, or contact lenses outside of their normal replacement schedule will be allowed only if modifier RB is submitted with the appropriate procedure codes.

40.2.1.6 Services Requiring Authorization

40.2.1.6.1 Contact Lenses, Prescriptions, and Fittings

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 40.2.1.4, "Contact Lenses" in this chapter. 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

40.2.1.6.2 Scleral Lenses and Liquid Bandages

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.)
  - Terrien's 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

40.2.1.7 Services Not Requiring Authorization

Authorization is not required for the following:

- One annual vision exam with refraction
- One medically necessary pair of prescription eyewear per calendar year
- One medically necessary pair of contact lenses 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 4.3, "Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information on prior authorization requirements.

40.2.1.8 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 0.50 diopters or more in any corresponding meridian.
- A cylinder axis change of at least 20 degrees for a cylinder power of 0.50-0.62 diopters.
- A cylinder axis change of at least 15 degrees for a cylinder power of 0.75-0.87 diopters.
- A cylinder axis change of at least 10 degrees for a cylinder power of 1.00-1.87 diopters.
- A cylinder axis change of at least 5 degrees 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.*

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 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information on prior authorization requirements.

40.2.1.9 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.

40.2.2 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 HHSC DBS for evaluation and appropriate resources.

Special vision services, ocular viewing, and diagnostic testing include, but are not limited to, the following:

- Examination and evaluation with general anesthesia
- Ophthalmic ultrasound
- Corneal topography
- Sensorimotor examination
- Orthoptic training
- Ophthalmoscopy

40.2.2.1 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 diagnosis codes Z0100 or Z0101.

Procedure codes S0620 and S0621 will deny if billed on the same date of service as procedure code 92020, 92273, and 92274.

40.2.2.2 Medical Eye Examinations

Medical eye examinations performed for medical reasons may be reimbursed to providers using procedure codes 92002, 92004, 92012, 92014, and 92015. These examinations may be reimbursed as medically necessary with a valid diagnosis code that describes the medical reason for the eye examination.

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.

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, and 92014).

A refractive state (procedure code 92015) will be denied as part of another service when billed with the same date of service by the same provider as a routine vision examination, with refraction (procedure codes S0620 or S0621).

A refractive state (procedure code 92015) may be reimbursed in addition to procedure codes 92002, 92004, 92012, and 92014.

40.2.2.3 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 degrees for a cylinder power of 0.50-0.62 diopters
  - A cylinder axis change of at least 15 degrees for a cylinder power of 0.75-0.87 diopters
  - A cylinder axis change of at least 10 degrees for a cylinder power of 1.00-1.87 diopters
  - A cylinder axis change of at least 5 degrees 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

40.2.3 Special Vision Services

40.2.3.1 Ophthalmological Examination and Evaluation with General Anesthesia

Opthalmological examination and evaluation with general anesthesia (procedure codes 92018 and 92019) may be reimbursed to ophthalmologists if a client has significant injury or cannot otherwise tolerate the procedure while conscious. Opthalmological examination and evaluation with general anesthesia is limited to one service per day by any provider.

40.2.3.2 Ophthalmic Ultrasound

Ophthalmic ultrasound may be reimbursed to providers using the following procedure codes:

Procedure Codes								
76510	76511	76512	76513	76514	76516	76519	76529	76999

Ophthalmic ultrasounds may be reimbursed on the same date of service by the same provider as an eye examination visit or consultation.

Ophthalmic ultrasounds professional components may be reimbursed for services rendered in the office, outpatient, and inpatient hospital settings. The technical component of ophthalmic ultrasounds may be reimbursed for services rendered in the office setting.

Procedure codes 76514, 76516, and 76519 are limited to one service per day, any provider. Procedure codes 76510, 76511, 76512, 76513, 76514, 76516, and 76519 are limited to two services per calendar year by any provider.

Procedure code 76519 may be reimbursed as follows:

- The professional 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 performed on the same date of service by any provider.
- The total component may be reimbursed with an additional professional service when both eyes are performed on the same date of service by any provider.

40.2.3.3 Corneal Topography

Corneal topography (procedure code 92025) may be reimbursed to providers and is limited to one service per day, and two services per calendar year by any provider. Corneal topography is limited to the following diagnosis codes:

Diagnosis Codes							
H10211	H10212	H10213	H10811	H10812	H10813	H10821	H10822
H10823	H10829	H11001	H11002	H11003	H11011	H11012	H11013
H11021	H11022	H11023	H11031	H11032	H11033	H11041	H11042
H11043	H11051	H11052	H11053	H11061	H11062	H11063	H1189
H16001	H16002	H16003	H16011	H16012	H16013	H16021	H16022
H16023	H16031	H16032	H16033	H16041	H16042	H16043	H16051
H16052	H16053	H16061	H16062	H16063	H16071	H16072	H16073
H16101	H16102	H16103	H16111	H16112	H16113	H16121	H16122
H16123	H16131	H16132	H16133	H16141	H16142	H16143	H16201
H16202	H16203	H16211	H16212	H16213	H16221	H16222	H16223
H16231	H16232	H16233	H16251	H16252	H16253	H16261	H16262
H16263	H16291	H16292	H16293	H16301	H16302	H16303	H16311
H16312	H16313	H16321	H16322	H16323	H16331	H16332	H16333
H16391	H16392	H16393	H16401	H16402	H16403	H16411	H16412
H16413	H16421	H16422	H16423	H16431	H16432	H16433	H16441
H16442	H16443	H168	H169	H1701	H1702	H1703	H1711
H1712	H1713	H17811	H17812	H17813	H17821	H17822	H17823

Diagnosis Codes							
H1789	H179	H1811	H1812	H1813	H1820	H18221	H18222
H18223	H18231	H18232	H18233	H1840	H18451	H18452	H18453
H18461	H18462	H18463	H1849	H18501	H18502	H18503	H18509
H18511	H18512	H18513	H18519	H18521	H18522	H18523	H18529
H18531	H18532	H18533	H18539	H18541	H18542	H18543	H18549
H18551	H18552	H18553	H18559	H18591	H18592	H18593	H18599
H18601	H18602	H18603	H18611	H18612	H18613	H18621	H18622
H18623	H1870	H18711	H18712	H18713	H18721	H18722	H18723
H18731	H18732	H18733	H18791	H18792	H18793	H18831	H18832
H18833	H52201	H52202	H52203	H52211	H52212	H52213	L511
L512	L513	Q134	S0521XA	S0521XD	S0521XS	S0522XA	S0522XD
S0522XS	S0531XA	S0531XD	S0531XS	S0532XA	S0532XD	S0532XS	T2611XA
T2611XD	T2611XS	T2612XA	T2612XD	T2612XS	T2661XA	T2661XD	T2661XS
T2662XA	T2662XD	T2662XS	T85310A	T85310D	T85310S	T85311A	T85311D
T85311S	T85318A	T85318D	T85318S	T85320A	T85320D	T85320S	T85321A
T85321D	T85321S	T85328A	T85328D	T85328S	T85390A	T85390D	T85390S
T85391A	T85391D	T85391S	T85398A	T85398D	T85398S	Z48810	Z947
Z9841	Z9842	Z9849	Z9883				

Corneal topography may be reimbursed on the same date of service by the same provider as a medical eye exam or simple refraction (procedure codes 92002, 92004, 92012, 92014, or 92015).

40.2.3.4 Sensorimotor Examination

Sensorimotor examinations (procedure code 92060) may be reimbursed in addition to a medical eye examination or simple refraction.

Sensorimotor examination is limited to once per day and two per calendar year by any provider.

40.2.3.5 Orthoptic Training

Orthoptic training (procedure codes 92065 and 92066) may be reimbursed in addition to a medical eye examination visit.

Orthoptic training is limited to once per day and 36 per year by any provider.

40.2.3.6 Opthalmoscopy

Opthalmoscopy may be reimbursed to providers using the following procedure codes:

Procedure Codes							
92201	92202	92230	92235	92240	92242	92250	92260

Opthalmoscopy, fluorescein angioscopy, indocyanin-green angiography, and fluorescein angiography (procedure codes 92230, 92235, 92240, and 92242) may be reimbursed for a quantity of two if both the left and right eyes are evaluated. Modifiers LT and RT must be included on the claim to identify the eye on which the service was performed.

Ophthalmoscopy, fluorescein angioscopy, indocyanin-green angiography, and fluorescein angiography (procedure codes 92230, 92235, 92240, and 92242) are limited to one service per eye, per day and two services per eye, per calendar year by any provider.

Opthalmoscopy, extended (procedure codes 92201 and 92202) are limited to one service per day and two services per calendar year by any provider.

Fundus photography (procedure code 92250) and opthalmodynamometry (procedure code 92260) are limited to one service per day and two services per calendar year by any provider.

40.2.3.7 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									
92020	92081	92082	92083	92100	92132	92133	92134	92136	92137
92227	92228	92229	92265	92270	92273	92274	92285	92286	92287

Gonioscopy (procedure code 92020) is limited to two services per calendar year by any provider.

Visual field examinations (procedure codes 92081, 92082, and 92083), serial tonometry (procedure code 92100), and computerized ophthalmic diagnostic imaging (procedure codes 92132, 92133, 92134, and 92137) are limited to one service per day and two services per calendar year by any provider.

Ophthalmic biometry (procedure code 92136) is limited to two services per eye, per calendar year by any provider.

Procedure code 92136 may be reimbursed as follows:

- The professional 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 when one or both eyes are performed on the same date of service by any provider.
- The total component may be reimbursed with an additional professional service when both eyes are performed on the same date of service by any provider.

Procedure codes 92227. 92228, and 92229 are limited to two services per calendar year by any provider.

Procedure codes 92265, 92270, 92273, 92274, 92285, 92286, and 92287 are limited to one service per day and two services per calendar year when billed by any provider.

40.3 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 NPI 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 for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

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

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

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

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

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

40.5 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.

TMHP Electronic Data Interchange (EDI)

CSHCN Services Program Provider Manual

April 2025

TMHP ELECTRONIC DATA INTERCHANGE (EDI)

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41.1 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.

41.2 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. TexMed-Connect 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 every-thing it sends, receives, and archives.

41.2.1 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/resources/provider-education-and-training.

41.2.2 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)

41.3 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.

41.3.1 Step 1—Choose How Claims Are Submitted

41.3.1.1 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®
- Google Chrome®
- Mozilla Firefox®

Although many TexMedConnect features will work with earlier versions of Microsoft Internet Explorer, TMHP only offers technical support for TexMedConnect when used with Microsoft Internet Explorer 11. 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.

41.3.1.2 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 41.6, "Third-Party Vendor Implementation" in this chapter*

41.3.1.3 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.

41.3.1.4 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 41.4, "Request for Electronic Transmission Reports" in this chapter.

41.3.2 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.

41.3.3 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/resources/provider-education-and-training. Providers may also use the many reference materials available on the website in the reference materials section.

Refer to: Section 1.2.1, "Publications" in Chapter 1, "TMHP and HHSC Contact Information."

The TMHP EDI Help Desk provides technical assistance, but does not provide training.

41.4 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" in Chapter 2, "Provider Enrollment and Responsibilities" 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.

41.5 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.

41.6 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/index.jsp 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.

41.6.1 EDI Version 5010 Claims Response and Electronic Remittance & Status (R&S) Files

41.6.1.1 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.*

41.6.1.2 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 www.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.

41.6.1.3 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.

41.6.1.4 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.

41.6.1.5 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.

41.7 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

Electronic Transaction Types	
835	ER&S report
837D	Dental claims
837I	Institutional claims
837P	Professional claims

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

41.9 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.

Appendix A: Acronyms and Initialisms Dictionary

CSHCN Services Program Provider Manual

April 2025

TEXAS
Health and Human
Services

A.1 Acronym 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
CHIP	Children's Health Insurance Program
CLIA	*Clinical Laboratory Improvement Amendments*
CML	Chronic Myelogenous Leukemia
CMS	Centers for Medicare & Medicaid Services (formerly HCFA)
CNS	Clinical Nurse Specialist
CPAP	Continuous Positive Airway Pressure
CPR	Cardiopulmonary Resuscitation
CPT	Current Procedural Terminology
CRCP	Certified Respiratory Care Practitioner

Term	Definition
CRNA	Certified Registered Nurse Anesthetist
CSHCN	Children with Special Health Care Needs
CSI	Claim Status Inquiry
CT	Computed Tomography
CVA	Cerebrovascular Accident
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
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

Term	Definition
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
ICD-10-CM	*International Classification of Diseases*, Tenth Revision, Clinical Modification
ICD-10-PCS	*International Classification of Diseases*, Tenth Revision, Procedure Coding System
ICF	Intermediate Care Facility *(*refer to *also SNF)*
ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
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
MD	Doctor of Medicine
MMIS	Medicaid Management Information System

Term	Definition
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
RVU	Relative Value Unit

Term	Definition
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
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