Texas Medicaid
Provider Procedures Manual
April 2016

Volumes 1 & 2

The Texas Medicaid & Healthcare Partnership (TMHP) is the claims administrator for Texas Medicaid under contract with the Texas Health and Human Services Commission.

PRELIMINARY INFORMATION

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Welcome: Texas Medicaid Provider Procedures Manual

This manual is a comprehensive guide for Texas Medicaid providers. It contains information about Texas Medicaid fee-for-service benefits, policies, and procedures including medical, dental, and children's services benefits.

Refer to: *The Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*) for information about the Medicaid Managed Care, which is administered by Texas Health and Human Services Commission (HHSC)-contracted managed care organizations (MCOs), dental managed care organizations, and behavioral health organizations (BHOs) across the state.

The *Texas Medicaid Provider Procedures Manual* is updated monthly on the TMHP website at www.tmhp.com to include revisions to policies and procedures that went into effect in the prior month. The manual is available in portable document format (PDF) as a complete book and as individual sections and handbooks. A hypertext markup language (HTML) version is also be available.

The current version of the manual always appears prominently on the Texas Medicaid Provider Procedures Manual web page. All previously published annual editions of the *Texas Medicaid Provider Procedures Manual* have been archived. Users can access the archives through links on the Texas Medicaid Provider Procedures Manual web page.

Providers can determine what has changed each month by following the Release Notes link on the Texas Medicaid Provider Procedures Manual web page. The release notes include the sections and handbooks that have changed for the current month and the nature of the changes. Most changes have been previously announced in news articles on the TMHP website, and, where appropriate, the release notes link to prior website articles.

Publishing the manual monthly has eliminated the need for the *Texas Medicaid Bulletin*, which was discontinued following the publication of the September/October 2012 *Texas Medicaid Bulletin*, No. 243. Special bulletins, such as the annual Healthcare Common Procedure Coding System (HCPCS) bulletin, which is published in January of each year, will continue to be published on an as-needed basis.

The *Texas Medicaid Provider Procedures Manual* is divided into two volumes as follows:

- Volume I: General Information

  Volume 1 applies to all health-care providers who are enrolled in Texas Medicaid and provide services to Texas Medicaid fee-for-service clients. The sections in Volume 1 include general information for enrolling in the program, receiving appropriate reimbursement, prior authorizations, claim submissions and appeals for services rendered.

- Volume 2: Provider Handbooks

  Each handbook in Volume 2 covers Medicaid policies, procedures, and claims filing requirements for specific products or services. Volume 2 includes the following handbooks:

  - *Ambulance Services Handbook*
  - *Behavioral Health, Rehabilitation, and Case Management Services Handbook*
  - *Children's Services Handbook*
  - *Clinics and Other Outpatient Facility Services Handbook*
  - *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook*
  - *Expanded Primary Healthcare Program Handbook*
  - *Gynecological and Reproductive Health and Family Planning Services Handbook*
  - *Inpatient and Outpatient Hospital Services Handbook*
  - *Medicaid Managed Care Handbook*

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- *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*
- *Medical Transportation Program Handbook*
- *Nursing and Therapy Services Handbook*
- *Radiology and Laboratory Services Handbook*
- *Telecommunications Services Handbook*
- *Vision and Hearing Services Handbook*

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Ambulance Services Handbook

Behavioral Health, Rehabilitation, and Case Management Services Handbook

Children's Services Handbook

Clinics and Other Outpatient Facility Services Handbook

Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook

Gynecological and Reproductive Health and Family Planning Services Handbook

Inpatient and Outpatient Hospital Services Handbook

Medicaid Managed Care Handbook

Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook

Medical Transportation Program Handbook

Nursing and Therapy Services Handbook

Radiology and Laboratory Services Handbook

Telecommunication Services Handbook

Vision and Hearing Services Handbook

Introduction

Medicaid Program Administration

The Texas Medical Assistance (Medicaid) Program was implemented on September 1, 1967, under the provisions of Title XIX of the federal *Social Security Act* and Chapter 32 of the *Texas Human Resources Code*.

The state of Texas and the federal government share the cost of funding Texas Medicaid. The Health and Human Services Commission (HHSC), the single state Medicaid agency, is responsible for the Title XIX Program. The administration of the program is accomplished through contracts and agreements with the following:

- Medical providers
- Texas Medicaid & Healthcare Partnership (TMHP), the fee-for-service claims administrator
- MAXIMUS, the enrollment broker
- Various managed care organizations (MCOs) and dental managed care organization (dental plans), that administer Medicaid Managed Care benefits.
- The Institute for Child Health Policy (ICHP), the quality monitor
- State agencies

Texas Medicaid providers are reimbursed for services through contracts with health-insuring contractors, fiscal agents, or direct vendor payments.

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By signing an HHSC Medicaid Provider Agreement (through the enrollment process) and submitting Medicaid claims, each enrolled provider agrees to abide by the policies and procedures of Medicaid, published regulations, and the information and instructions in manuals, bulletins, and other instructional material furnished to the provider.

Refer to: "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*) for addresses and telephone numbers of HHSC and Department of State Health Services (DSHS) regional offices.

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Section 1: Provider Enrollment and Responsibilities

Texas Medicaid Provider Procedures Manual: Vol. 1

April 2016

TEXAS
Health and Human
Services Commission

SECTION 1: PROVIDER ENROLLMENT AND RESPONSIBILITIES

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1.1 Provider Enrollment and Reenrollment

To be eligible for Texas Medicaid reimbursement, a provider of health-care services (including an out-of-state provider) must:

- Meet all applicable eligibility criteria.
- Be approved by the Texas Health and Human Services Commission (HHSC) for enrollment.
- Obtain a National Provider Identifier (NPI) from the National Plan and Provider Enumeration System (NPPES).

Refer to: Subsection 1.1.1, "NPI and Taxonomy Codes" in this section.

- File with the Texas Medicaid & Healthcare Partnership (TMHP) the required Texas Medicaid enrollment application ensuring that the application is correct, complete, and includes all required attachments and additional information.
- Provide any additional information requested by TMHP, HHSC, or the HHSC Office of Inspector General (OIG) in connection with the processing of the application.
- Be approved by HHSC for enrollment and enter into a written provider agreement with HHSC.

Providers can use the online provider enrollment on the portal (PEP) tool to enroll electronically through the TMHP website at www.tmhp.com by clicking "Enroll Today!" at the top of most web pages.

Refer to: Subsection 1.1.2, "Online Enrollment" in this section.

Paper versions of the enrollment applications are also available for download from the Forms section of the TMHP website.

Refer to: Subsection 1.1.3, "Paper Application Enrollment" in this section.

After receipt of all information necessary to process the application, the entire application process can typically take up to 60 days. This may be extended in special circumstances. Requests for exceptions to the enrollment process, risk category, and provider types that require additional state approval may extend the length of the application process.

All providers must be enrolled in Texas Medicaid before enrollment can be approved for any other service or program, including, but not limited to, Medicaid managed care.

Certain provider types are required to enroll in Medicare as a prerequisite for enrolling in Texas Medicaid. During the Texas Medicaid enrollment process, with HHSC approval, the Claims Administrator may waive the mandatory prerequisite for Medicare enrollment for certain providers whose type of practice will never serve Medicare-eligible individuals (e.g., pediatrics, obstetrician/gynecologist [OB/GYN]).

Providers must maintain a valid, current license or certification to be entitled to Texas Medicaid reimbursement. Providers cannot enroll in Texas Medicaid if their license or certification is due to expire within 30 days of application. A current license or certification must be submitted, if applicable.

Refer to: Subsection 1.1.9.11, "Copy of License, Temporary License, or Certification" in this section.

A provider identifier is issued when a determination has been made that a provider qualifies for participation.

Refer to: Subsection 1.9, "Enrollment Criteria for Out-of-State Providers" in this handbook for additional criteria that out-of-state providers must meet to enroll in Texas Medicaid.

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1.1.1 NPI and Taxonomy Codes

The NPI final rule, Federal Register 45, Code of Federal Regulations (CFR) Part 162, established the NPI as the standard unique identifier for health-care providers and requires covered health-care providers, clearinghouses, and health plans to use this identifier in Health Insurance Portability and Accountability Act (HIPAA)-covered transactions. An NPI is a 10-digit number assigned randomly by the NPPES. An NPI must be obtained before a provider can enroll as a Texas Medicaid provider.

An NPI is not required for enrollment for certain provider types; however, the provider must submit a signed letter on company letterhead that attests that they are not a health-care provider and are unable to obtain an NPI.

The Health Care Provider Taxonomy Code Set is an external, non-medical collection of alphanumeric codes designed to classify health-care providers by provider type and specialty. Providers may have more than one taxonomy code. (Taxonomy codes can be obtained from the Washington Publishing Company website at www.wpc-edi.com).

During the enrollment process, providers must select a primary and, if applicable, secondary taxonomy code associated with their provider type. Providers will be supplied a list of taxonomy codes to choose from that correspond to the services rendered by the type of provider they wish to enroll as. Only the code will be displayed. Due to copyright laws, TMHP is unable to publish the taxonomy description. Therefore, providers must verify the taxonomy code associated with their provider type and specialty before beginning the online attestation process.

1.1.2 Online Enrollment

The following provider types can use PEP to enroll and reenroll:

- Texas Medicaid providers
- Home and Community Based Services – Adult Mental Health (HCBS-AMH) providers
- Ordering/referring-only providers
- Children with Special Health Care Needs (CSHCN) Services Program providers
- Texas Health Steps (THSteps) dental services provider, including fee-for-service dental providers and managed care
- THSteps medical checkup providers

Important: *Upon completion of the Texas Medicaid provider application, qualified providers are automatically enrolled as THSteps medical checkup providers and CSHCN Services Program providers unless they choose to opt out of one or both as prompted in the application. Providers who opt out can enroll in the CSHCN Services Program and in THSteps at a future date using the online PEP tool.*

Providers can begin the enrollment process on the Provider Enrollment page of the TMHP website.

Online enrollment has the following advantages:

- Applications are validated immediately to ensure that all fields have been completed.
- Most of the application can be completed online so that only a few forms need to be printed, completed, and mailed to TMHP.
- Applicants can view both incomplete and complete applications that have been submitted online.
- Some form fields are automatically completed, reducing the amount of information that has to be entered.
- Providers can complete the Provider Information Change (PIC) form online.

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- Providers will receive email notifications when messages or deficiency notices about their applications are posted online. The messages can be viewed on the secured access portion of the website. Providers may opt out of email communication and receive messages or deficiency letters by mail.
- Providers can create templates, which make it easier to submit multiple enrollment applications.
- Providers who enroll as a group can assign portions of the application to performing providers to complete. Performing providers can complete their portion of a group application by logging into the online PEP tool with their unique user name and password.
- Providers can navigate to completed sections of the application without having to click through all pages of the application.
- Information that is on file for owners and subcontractors of the applying provider are auto-populated in the application.

Before submitting an application to TMHP for processing, providers are required to review a portable document format (PDF) copy of the application and verify it is complete. Providers are able to edit submitted applications to correct identified deficiencies.

Enrolling online promotes accurate submissions, decreases processing time, and enables immediate feedback on the status of the application.

1.1.3 Paper Application Enrollment

As an alternative to applying for enrollment online, a provider may file a paper enrollment application with TMHP. Providers may download the Texas Medicaid Provider Enrollment Application at www.tmhp.com or request a paper application form by contacting TMHP directly at 1-800-925-9126. Enrollment applications are updated periodically. When an application has been updated, the older version will no longer be accepted and will not be available on the website. It is recommended that the provider check the website regularly for updates and notifications.

A paper enrollment application may also be requested from and must be submitted to the following address:

Texas Medicaid & Healthcare Partnership
Provider Enrollment
PO Box 200795
Austin, TX 78720-0795

Note: *The Texas Medicaid Provider Enrollment Application must include the physical address where the provider renders services to Medicaid clients.*

1.1.4 Provider Enrollment Identification

Providers are required to identify the type of entity for which they are requesting enrollment. Providers can choose from one of the following on each application they submit (only one per application is allowed):

- *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 number or federal tax identification number of the individual. An individual may also enroll as an employee, using the federal tax identification number of the employer. Certain provider types must enroll as individuals, including dieticians, licensed vocational nurses, occupational therapists, registered nurses, 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 federal tax identification number of the

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legal entity. For any group enrollment application other than as a THSteps medical checkup provider group, there must also be at least one enrolling performing provider. THSteps providers are only enrolled at the group level.

During the PEP process, the available taxonomy code list is populated with either taxonomy code 193200000X or 193400000X for a clinic/group practice, depending on which specialty is chosen. The taxonomy codes for clinic/group practice providers are accurate and have been approved by HHSC. The most appropriate taxonomy codes should be selected for any performing providers that will be enrolled according to their specific performing provider type and specialty.

- *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. If a health-care professional is required to enroll as an individual, as explained above, but the person is an employee and payment is to be made to the employer, the health-care professional does not enroll as a performing provider. Instead, the health-care professional enrolls as an individual provider under the federal tax identification number of their employer.
- *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 or the supervising licensed practitioner who is assuming responsibility for the facility's operation. For this reason, facility enrollment does not require enrollment of performing providers. However, certain provider types must enroll as facilities, including the following:
  - Ambulance and air ambulance
  - Ambulatory surgical center (ASC) and hospital-based ambulatory surgical center (HASC)
  - Birthing center
  - Catheterization lab
  - Chemical dependency treatment facility (licensed by the Texas Commission on Alcohol and Drug Abuse)
  - Consumer Directed Services Agency
  - County Indigent Health Care Program
  - Community mental health center
  - Comprehensive health center
  - Comprehensive outpatient rehabilitation facility/outpatient rehabilitation facility
  - Department of Assistive and Rehabilitative Services Division for Blind Services
  - Durable medical equipment (DME)
  - Early Childhood Intervention
  - Federally Qualified Health Center (FQHC)
  - Freestanding psychiatric facility
  - Freestanding rehabilitation facility
- Home and Community Based Services – Adult Mental Health (HCBS-AMH) providers
  - Home Health/Home and community support services agency
  - Hospital/critical access hospital/out-of-state hospital
  - Military hospital

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- Hyperalimentation
- Independent diagnostic testing facility/physiological lab
- Indian Health Services
- Independent laboratory
- Maternity services clinic
- Mental health/mental retardation case management
- Mental health rehabilitation case management
- Mental retardation diagnostic services case management
- Milk bank donor
- Personal care services
- Pharmacy
- Portable X-ray
- Prescribed Pediatric Extended Care Centers (PPECC)
- Radiation treatment center
- Radiological laboratory
- Renal dialysis facility
- Rural health center (RHC)
- School health and related services (SHARS)/non-school SHARS
- Service responsibility option
- Skilled nursing facility
- Vision medical supplier
- Women, Infant and Children

Providers must submit a separate Texas Medicaid Provider Enrollment Application for each enrollment type that they request unless otherwise approved as a dual enrollment. For example, enrolled hospital providers will be issued a hospital provider identifier that is specific to hospital services and a separate HASC provider identifier that is specific to ambulatory surgical services unless the provider is subject to restricted reimbursement. However, a health-care professional who is already enrolled with Texas Medicaid as an individual with his or her own practice, and who wishes to bill for services provided in connection with a group, must submit a separate enrollment application and be approved as a performing provider with the group. Similarly, a health-care professional who is enrolled as a performing provider with one group, but who wishes to bill for services provided in connection with another group, must submit a separate enrollment application and be approved as a performing provider with the other group.

Note: *A separate provider identifier is issued for each enrollment type that is approved. The provider is authorized to use the provider identifier only to bill for services provided as indicated in the approved enrollment application. It is a program violation for a provider to use a provider identifier for any purpose other than billing for the types of services, and under the type of enrollment, for which that provider identifier was issued. Improper use of a provider identifier constitutes program abuse and/or fraud.*

Refer to: Subsection 1.10, "Medicaid Waste, Abuse, and Fraud Policy" in this section for additional information.

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1.1.4.1 Ordering- or Referring-Only Providers

Individual providers who are not currently enrolled in Texas Medicaid and whose only relationship with Texas Medicaid is to order or refer supplies or services for Texas Medicaid-eligible clients must enroll in Texas Medicaid as participating providers. This requirement is in accordance with provisions of the Affordable Care Act of 2010 (ACA), 42 CFR §455.410(b), which requires all ordering or referring physicians or other professionals who order or refer supplies and services under the Medicaid State plan, or under a waiver of the plan, to enroll in Medicaid as participating providers.

These providers can enroll online using the PEP tool by clicking the check box for Ordering/Referring Provider, or they can use the streamlined paper Texas Medicaid Provider Enrollment Application Ordering and Referring Providers Only, which is available for download on the TMHP website at www.tmhp.com.

The ordering or referring-only enrollment application is for individual providers who are not currently enrolled as a billing or performing provider in Texas Medicaid or the CSHCN Services Program and who do not currently have an active Texas Medicaid or CSHCN Services Program billing provider Texas Provider Identifier (TPI).

Important: *Individual providers who are currently enrolled in Texas Medicaid or the CSHCN Services Program and who currently have an active Texas Medicaid or CSHCN Services Program billing provider TPI can use their current TPI for ordering/referring services and do not need to obtain an ordering/referring TPI. A current provider's active TPI will be deactivated if the provider enrolls as an ordering or referring-only provider.*

Providers who enroll in Texas Medicaid as ordering- and referring-only providers receive one TPI that can be used for orders and referrals for both Texas Medicaid clients and CSHCN Services Program clients. Although ordering- and referring-only providers do not submit claims to TMHP for rendered services, the ordering or referring provider's NPI is required on claims that are submitted by the providers that render the supplies or services.

Refer to: Subsection 6.4.2.4, "Ordering or Referring Provider NPI" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for information about filing claims that require an ordering- and referring-only provider NPI.

1.1.5 Affordable Care Act of 2010 (ACA) Enrollment Requirements

Providers are required to fulfill certain requirements for enrollment in order to comply with the provisions of ACA. Providers that are enrolled in Texas Medicaid and have fulfilled the ACA requirements through their Texas Medicaid enrollment are considered ACA-compliant for all programs in which they are enrolled.

Refer to: TMHP website at www.tmhp.com for additional information about ACA requirements.

In accordance with Section 6401 of ACA, the following requirements apply:

- Upon initial enrollment and upon re-enrollment, all participating providers are screened based on their categorical risk level. (complies with 42 CFR §§455.410 and 455.450)
- All providers are required to re-enroll at least every three to five years based on provider type.
- Institutional providers who are enrolling or re-enrolling are required to pay an application fee if one has not already been paid to Medicare or another state's Medicaid program or Children's Health Insurance Program (CHIP).
- Ordering and referring-only providers are required to enroll in Texas Medicaid as participating providers.

Refer to: Subsection 1.1.4.1, "Ordering- or Referring-Only Providers" in this section.

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1.1.5.1 Provider Screening Requirement

In compliance with ACA, all providers must be screened, which includes:

- Providers who submit a provider enrollment application for new enrollment, a new practice location, or other type of enrollment or re-enrollment.
- Providers who are currently enrolled in Texas Medicaid and are required to revalidate their enrollment by re-enrolling in Texas Medicaid.

1.1.5.2 Provider Re-enrollment

In compliance with the 42 CFR §455.414, all providers are required to re-enroll at least every three to five years:

- DME providers are required to revalidate enrollment information at least once every three years.
- All other provider types must revalidate their enrollment information at least once every five years.

During re-enrollment, the provider screening will be repeated.

1.1.5.3 Application Fee

Under ACA, institutional providers are subject to an application fee for applications, including initial applications, applications for new practice locations, and re-enrollment applications. Upon completion of the PEP online application, providers will be notified whether they are required to pay an application fee. The amount of the application fee is subject to change every calendar year.

Providers that complete the paper Texas Medicaid Provider Enrollment Application can refer to the TMHP website for the list of provider types that are required to pay the application fee.

Note: *Providers that are required to pay the application fee but have already paid the fee to Medicare or another state's Medicaid program or CHIP have fulfilled the fee requirement and do not have to submit the fee to Texas Medicaid. Proof of payment must be submitted with the application. Providers who are enrolled in Medicare must provide documentation that specifies whether or not they have completed the ACA rescreening process with Medicare.*

1.1.5.4 Ordering- or Referring-Only Providers Search on the Online Provider Lookup (OPL)

Providers can verify that an ordering- or referring-only provider is enrolled in Medicaid by using either the basic or advanced provider search function of the OPL.

1.1.6 Surety Bond Enrollment Requirement

All newly enrolling and re-enrolling DME and non-government-operated ambulance providers must, as a condition of enrollment and continued participation into Texas Medicaid, obtain a surety bond that complies with Title 1, Texas Administrative Code (TAC) §352.15.

DME providers can refer to subsection 2.1.2, "Surety Bond Requirements" in the *Durable Medical Equipment, Medical Supplies, and Nutritional Supplies Handbook*, (*Vol. 2, Provider Handbooks*).

Ambulance providers can refer to subsection 1.1.6.1, "Ambulance Providers" in this hand book.

Important: *Surety bonds obtained for the purpose of accreditation in the Medicare program, which lists the Centers for Medicare & Medicaid Services (CMS) as obligee, do not fulfill the surety bond requirement for Texas Medicaid.*

The surety bond submitted to Texas Medicaid must meet the following requirements:

- A bond in an amount of no less than $50,000 must be provided for each enrolled location.

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- The bond must be submitted on the State of Texas Medicaid Provider Surety Bond Form. No other form will be accepted. The use of this form designates HHSC as the sole obligee of the bond. Instructions are included with the form.
- The bond must be issued for a term of 12 months. Bonds for longer or shorter terms are not acceptable.
- The bond must be in effect on the date that the provider enrollment application is submitted to TMHP for consideration. The effective date stated on the bond must be:
  - No later than the date that the provider enrollment application is submitted.
  - No earlier than 12 months before the date that the provider enrollment application is submitted.
- The bond must be a continuous bond. A continuous bond remains in full force and effect from term to term unless the bond is canceled.

Important: *An annual bond that specifies effective and expiration dates for the bond is not acceptable.*

At the time of enrollment or re-enrollment, providers must submit the surety bond form with original signatures and a copy of the Power of Attorney document from the surety company that issued the bond.

Note: *Surety companies may refer to Texas Department of Insurance (TDI) file #9212562912 or TDI link #132456 when filing the bond.*

DME and non-government-operated ambulance providers must maintain a current surety bond to continue participation in Texas Medicaid. To avoid losing Medicaid enrollment status, providers must submit proof of continuation to TMHP Provider Enrollment before the expiration date of the bond currently on file. The completed proof of continuation document must include the bond number, original signatures of the authorized corporate representative of the DME or ambulance provider (principal), the attorney-in-fact of the surety company, date of the original bond, and new "good through" date. Providers may submit a copy of the proof of continuation (scan, fax, photocopy) pending the submission of the original document.

Refer to: The State of Texas Medicaid Provider Surety Bond Form in the Forms section of the TMHP website at www.tmhp.com.

1.1.6.1 Ambulance Providers

Ambulance providers that participate in Texas Medicaid fee-for-service, managed care programs, or the CHIP must, as a condition of emergency medical services (EMS) provider license renewal, obtain a surety bond that complies with 1 TAC §352.15 and submit the bond to TMHP according to the requirements listed above. A copy of the bond must be included with their application to the Department of State Health Services (DSHS) to renew their emergency services provider license.

Providers can refer to the DSHS website for additional information.

Ambulance providers that are directly operated by a governmental entity are exempt from the surety bond requirement.

1.1.7 Provider Enrollment Application Determinations

An application for provider enrollment may be approved for a 3- to 5-year enrollment depending on provider type, approved with conditions, or denied. The provider applicant is issued a notice of the enrollment determination.

Refer to: Subsection 1.1.5, "Affordable Care Act of 2010 (ACA) Enrollment Requirements" in this handbook for additional information about the ACA 3- to 5-year re-enrollment requirement.

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When an application for enrollment is approved with conditions, the applicant has no right of appeal or administrative review of the enrollment determination. The types of conditional enrollment include, among other things:

- An application may be approved for time-limited enrollment, meaning the provider is granted a contract to participate in Medicaid for a specific period of time. In this case, the provider is sent a notice that includes the deactivation date of the contract. It is the provider's responsibility, if the provider chooses to seek continued Medicaid participation, to file a complete and correct reenrollment application before the deactivation date of the provider's current contract. It is recommended that the provider submit a reenrollment application at least 60 days before the current contract deactivation date, to ensure that the reenrollment application is complete and correct before the deactivation date. This may avoid a lapse between the provider's current contract and the new contract, if a new contract is granted.
- An application may be approved subject to restricted reimbursement, meaning the provider is eligible to have only certain types of claims paid. This includes, among other things, reimbursement of only Medicare crossover claims (i.e., claims with respect to "dual eligible" recipients who are covered by both Medicare and Medicaid).

An application may be denied, in which case a denial notice that explains the basis for denial is sent. The notice also explains the right to make a written request for an administrative review of the denial decision, and the procedures for filing such a request. Any administrative review request must be received within 20 days of the date on the letter and filed in accordance with the instructions provided in the denial notice. HHSC will conduct the administrative review and render a final enrollment determination. The HHSC determination following administrative review is not subject to further appeal or reconsideration.

The enrollment date is the day on which a new TPI was issued. This date impacts claims filing deadlines.

Refer to: Subsection 6.1.4.2, "Claims for Newly Enrolled Providers" in Section 6, "Claims Filing" (*Vol. 1, General Information*). for timely-filing guidelines for newly enrolled providers.

HHSC determines effective dates as follows:

- For providers who are required to enroll in Medicare, the Medicaid effective date will be the Medicare effective date or the license, certification, contract, or program implementation effective date, whichever is most current.
- For providers who are not required to enroll in Medicare, the Medicaid effective date will be one year prior to the receipt of the complete application or the license, certification, contract, or program implementation effective date, whichever is most current.

Notification letters that contain the new enrollment information are printed the following business day and mailed to the physical address listed on the application. The enrollment date and effective dates do not change when revalidating or reactivating an existing TPI, so new enrollment notification letters are not generated.

1.1.8 Enrollment in Medicaid Managed Care Programs

To be reimbursed for services rendered to Medicaid managed care clients, providers must be enrolled in Texas Medicaid and then must enroll with the client's health plan to be eligible for reimbursement for services rendered.

Refer to: Subsection 2.2, "Provider Enrollment and Responsibilities" in the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

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1.1.9 Required Enrollment Forms

To enroll in Texas Medicaid, providers must complete and submit the appropriate Texas Medicaid enrollment application, including all required forms as indicated in the application.

Note: *All paper documents must be signed by the person who is applying for enrollment. If the applicant is an entity, a principal of the entity must sign the application.*

Whether they are completing the online application or a paper application, providers can refer to the checklist in the paper Texas Medicaid Provider Enrollment Application for information about required forms and other documentation. This checklist explains, by provider type, the documents and information that must be provided with the application. Applications must be complete in order to process and issue a provider identifier.

Note: *If enrolled in Medicare, the provider must submit a copy of the Medicare enrollment letter to enroll in Texas Medicaid. Otherwise the enrollment application will be considered incomplete.*

When prompted to enter a tax identification number (tax ID) on either a paper or electronic copy of an enrollment application, the applicant should list the entity's nine-digit federal tax identification number.

Providers can call the TMHP Contact Center at 1-800-925-9126, Option 2, for help with completing the application. Providers should retain a copy of the original application for future reference.

All pages of the application (excluding instructions) must be present even if the forms are left blank because they are not pertinent to the provider's situation. Providers will be notified of incomplete applications and will have 30 business days to provide the requested missing information. If the information is not provided within 30 business days, TMHP will terminate the enrollment process. If the provider wants to enroll at a later date, a new enrollment application must be submitted. Providers are required to review their enrollment application for correctness and completeness before submitting it to TMHP.

By signing the HHSC Medicaid Provider Agreement, a provider is certifying that all information submitted in connection with the application for enrollment is complete and correct. Any false, misleading, or incomplete information submitted in connection with an enrollment application constitutes a Medicaid program violation, and may result in administrative, civil, or criminal liability.

Refer to: Subsection 1.10, "Medicaid Waste, Abuse, and Fraud Policy" in this section.

1.1.9.1 Application Payment Form

All providers who are required to pay an application fee to participate in the Medicaid Program must submit an Application Payment Form. The application cannot be processed if the application fee is required and is not submitted with the application.

Refer to: Subsection 1.1.5.3, "Application Fee "in this section.

1.1.9.2 HHSC Medicaid Provider Agreement

The HHSC Medicaid Provider Agreement must be submitted by all providers who enroll in Texas Medicaid and must be signed by the provider who is applying for enrollment. If the applicant is an entity, a principal of the entity who has the authority to bind the entity to the requirements of the HHSC Provider Agreement must sign the agreement. "Principal" is defined in the following section.

Refer to: Subsection 1.1.9.8, "Corporate Board of Directors Resolution" in this section for information about corporations.)

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If the provider is city- or government-owned, the agreement must be signed by a person who is authorized under the city or government charter. This form is an agreement between HHSC and the provider performing services under the State Plan wherein the provider agrees to certain provisions as a condition of participation.

Note: *The person who signs the HHSC Medicaid Provider Agreement is certifying that all of the information in the application packet, including every completed Provider Information Form (PIF-1) and Principal Information Form (PIF-2), is complete and correct. This includes a certification that every person who is required to complete a PIF-2 has done so, and all required PIF-2s are included with the application.*

TMHP must receive all of the pages of the HHSC Medicaid Provider Agreement in a single submission for a valid contract. If corrections are required on any page within the agreement, a new agreement with an original signature and date is required.

1.1.9.3 Provider Information Form (PIF-1)

The PIF-1 must be completed by, or on behalf of, the provider that is applying for enrollment. If the provider is an entity, the PIF-1 must be completed on behalf of the entity.

1.1.9.4 Principal Information Form (PIF-2)

A PIF-2 must be completed by each principal/creditor, subcontractor, and creditor of the provider that is applying for enrollment with the following exceptions:

- Performing providers who are applying to join a group that is already enrolled
- THSteps provider applications that are received within one year of the TPI enrollment date
- Individuals who enrolled using their own Social Security number and an entity type of Individual/Sole Proprietorship

Principals of the provider include all of the following:

- An owner with a direct or indirect ownership or control interest of 5 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
- All individuals, companies, firms, corporations, employees, independent contractors, entities, or associations that have been expressly granted the authority to act for or on behalf of the provider
- All individuals who are able to act on behalf of the provider because their authority is apparent
- An individual or entity with a security interest in a debt that is owed by the provider if the creditor's security interest is protected by at least 5 percent of property listed in Section III(c) of the Disclosure of Ownership

A subcontractor of the provider is defined as follows:

- An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
- An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies

Note: *This includes the on-site manager, supervising licensed practitioner, or medical director for each physical location of the provider in Texas.*

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1.1.9.5 Disclosure of Ownership and Control Interest Statement

The Disclosure of Ownership and Control Interest Statement must be submitted as part of the enrollment application for all types of enrollment, except in the case of a performing provider who is applying to join an already enrolled group, THSteps provider applications received within one year of the TPI enrollment date, or SHARS providers. This form provides TMHP Provider Enrollment with the appropriate information to enroll the provider as a sole proprietor, corporation, partnership, or nonprofit organization. This information determines whether other enrollment forms are required.

This form also contains questions that must be answered under federal law. Failure to provide complete and accurate information as instructed on this form will constitute an incomplete application, which may result in denial of enrollment. Incomplete or inaccurate information on this form constitutes a violation of the rules of Medicaid and may also result in administrative, civil, or criminal liability.

Refer to: Subsection 1.10, "Medicaid Waste, Abuse, and Fraud Policy" in this section.

Note: *Providers are required to submit any change in ownership, corporate officers, or directors to TMHP Provider Enrollment within 10 calendar days of the change.*

Refer to: Subsection 1.6.2, "Maintenance of Provider Information" in this section.

1.1.9.6 Internal Revenue Service (IRS) W-9 Form

The IRS W-9 Form must be completed and submitted for all types of enrollment, except in the case of performing providers seeking to join an already enrolled group.

1.1.9.7 Medicaid Audit Information Form

The Medicaid Audit Information Form is required by facilities that file cost reports such as hospitals, home health agencies, FQHCs, RHCs, and dialysis facilities.

1.1.9.8 Corporate Board of Directors Resolution

All providers who indicate that they are a corporation on the Disclosure of Ownership and Control Interest Statement are required to submit the Corporate Board of Directors Resolution. This form indicates the individual (by name) who is authorized by the corporation to sign the agreement forms. The secretary of the corporation must sign the Corporate Board of Directors Resolution and have it notarized. If a business is city or government-owned, this form is not required.

1.1.9.9 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 www.window.state.tx.us/taxinfo/coasintr.html.

Providers who have a 501(c)(3) Internal Revenue Exemption are not required to submit the Franchise Tax Account Status Page, but they must submit the IRS exemption letter.

1.1.9.10 Certificate of Formation or Certificate of Filing/Articles or Certificate of Incorporation/Certificate of Fact

When enrolling as a "Corporation" type of entity, providers must submit the Certificate of Formation or Certificate of Filing form. Obtain the form from the Office of the Secretary of State of Texas. The name on this form must exactly match the legal name shown on the W-9 form.

The following certificates also apply for corporations:

- For corporations formed prior to January 1, 2006, Articles or Certificate of Incorporation/Certificate of Authority/Certificate of Fact
- For corporations formed on or after January 1, 2006, Certificates of Formation or Certificate of Filing

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- For corporations registered in a state other than Texas, Certificate of Authority or Certificate of Filing

The Certificate and any required certifications to provide certain services in Texas must be submitted when a corporation is registered in a state other than Texas. The form identifies the legal name of the corporation and is proof that the corporation is registered to do business in Texas.

Note: *Out-of-state providers that do not provide services in the state of Texas are exempt from submitting this form.*

1.1.9.11 Copy of License, Temporary License, or Certification

Providers cannot enroll in Texas Medicaid 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 providers' 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 Texas Medicaid 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)
- Texas State Board of Dental Examiners (TSBDE)

If a license cannot be verified due to a delay in obtaining the board licensing information, providers must request a letter from the licensing board for their individual provider information and submit it to TMHP by the deadline indicated in the reminder letter. The letter must contain the provider's specific identification information, license number, and licensure period.

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

Important: *Providers are also required to submit to TMHP, within 10 days of occurrence, notice that the provider's license or certification has been partially or completely suspended, revoked, or retired. Not abiding by this license and certification update requirement may impact a provider's qualification to continued participation in Texas Medicaid.*

Refer to: Subsection 1.1.9.14, "Licensure Renewal" in this section.

1.1.9.12 Federally Qualified Health Center Affiliation Affidavit

All FQHC must identify and attest that all contractual affiliation agreements with contracted providers have been submitted to and approved by the Bureau of Primary Health Care (BPHC).

- Texas Medicaid defines an affiliate agreement as a contract between an FQHC and another provider for the provision of FQHC services for which the FQHC will bill Medicaid under the FQHC prospective payment system (PPS).
- Affiliations do not include contracts for the direct employment of providers or staff.

Refer to: Federally Qualified Health Center Affiliation Affidavit on the TMHP website at www.tmhp.com.

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1.1.9.13 Physician's Letter of Agreement

Upon initial enrollment and upon revalidation, Certified Nurse Midwife (CNM) or Licensed Midwife (LM) providers must complete and submit to TMHP with the Medicaid provider enrollment application the Physician's Letter of Agreement affirming the CNM's supervising physician arrangement or the LM's referring or consulting physician arrangement.

- According to HHSC rules, 1 TAC §354.1253(c), and 1 TAC §354.1252(3), CNM providers and LM providers are required to inform HHSC in writing of the identity of a licensed physician or group of physicians with whom the CNM or LM has arranged for referral and consultation in the event of medical complications. For purposes of this rule, "consultation" means discussion of patient status, care, and management.
- A separate agreement must be submitted for each physician with whom an arrangement is made. This agreement must be signed by the CNM or LM and the physician.

A new agreement must also be completed and submitted to TMHP when a new arrangement is made and when changes to an arrangement are made.

Refer to: Subsection 1.4.2, "Provider Status (Individual, Group, Performing Provider, or Facility)" in this section.

1.1.9.14 Licensure Renewal

Not abiding by the license and certification update requirement may impact a provider's qualification for continued participation in Texas Medicaid. If a provider's license has expired, a deactivation letter will be sent to the provider, and all claims filed on and after the expiration date will be denied.

To have claims payments resumed, updated information must be sent to the applicable licensing board to renew the license. Payment will be considered for dates of service on or after the date of license renewal. Claims denied due to an inactive license may be appealed, and payment will be considered for dates of service on or after the date of return to active license status. Payment deadline rules for the fiscal agent arrangement must be met.

Refer to: Subsection 6.1.5, "HHSC Payment Deadline" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

1.1.9.15 Medicare Participation

Under federal law, Medicaid is the payor of last resort, so Medicare-covered services must first be billed to and paid by Medicare. Therefore, in order to be eligible to enroll in Texas Medicaid, a provider must be a Medicare participating provider. Certain types of providers, however, are not required to meet the Medicare participation requirement, including:

- Pediatric providers
- Family planning providers
- Case Management for Children and Pregnant Women program providers
- CCP providers
- Early Childhood Intervention (ECI) providers
- Licensed professional counselors (LPCs)
- Licensed marriage and family therapists (LMFTs)
- OB/GYN providers
- THSteps medical and dental services providers

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Some provider types may apply for a waiver of the Medicare certification requirement of the application process if they do not serve Medicare-eligible individuals. The following provider types are eligible to apply for this waiver:

- Audiologist
- Dentist (D.D.S. or D.M.D.)
- Nurse practitioner/clinical nurse specialist (NP/CNS)
- Optometrist (OD)
- Orthotists
- Physician (DO)
- Physician (MD)
- Physician assistant (PA)
- Prosthetist

Each provider seeking enrollment must include a valid and current Medicare number in the Texas Medicaid Provider Enrollment Application, and must include with the application a copy of the provider's notice of Medicare participation.

Each group and each performing provider of a Medicare group must have a current Medicare number. The group enrollment application must include the current and valid Medicare number for the group and for each performing provider in the group, as well as a copy of the notice of Medicare enrollment for the group and for each performing provider in the group.

Each group enrolling as a Medicaid-only does not need to submit a current Medicare number for the group. Performing providers added to this Medicaid-only group also do not require a current Medicare number.

1.1.9.16 Group Information Changes

If additions or changes occur in a group's enrollment information (for example, a performing provider leaves or enters the group, changes an address, or a provider is no longer licensed) after the enrollment process is completed, the provider group must notify Texas Medicaid in writing within 10 calendar days of occurrence of the changes. Failure to provide this information may lead to administrative action by HHSC. Filing claims and receiving payment without having followed this requirement constitutes a program violation and may also result in administrative, civil, or criminal liability.

Refer to: Subsection 1.10, "Medicaid Waste, Abuse, and Fraud Policy" in this section for additional information.

1.2 Payment Information

Texas Medicaid reimbursements are available to all enrolled providers by check or electronic funds transfer (EFT). Providers are strongly encouraged to utilize EFT, which allows for more rapid reimbursement.

1.2.1 Using EFT

As a result of the 76th legislature, House Bill (H.B.) 2085 recommends that all Texas Medicaid providers receive payment by EFT. EFT is a method for directly depositing funds into a designated bank account. EFT does not require special software, and providers can enroll immediately.

1.2.2 Advantages of EFT

Advantages of EFT include:

- Electronically-deposited funds are available more quickly than with paper checks.

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- Providers do not have to worry about lost or stolen checks.
- TMHP includes provider and Remittance and Status (R&S) Report numbers with each transaction submitted. If the bank's processing software captures and displays the information, both numbers would appear on the banking statement.

1.2.3 EFT Enrollment Procedures

The Electronic Funds Transfer (EFT) Notification can be found on the TMHP website at www.tmhp.com. Completed EFT forms can be faxed to 1-512-514-4214, or mailed to:

Texas Medicaid & Healthcare Partnership
Attn: Provider Enrollment
PO Box 200795
Austin, TX 78720-0795

To enroll for EFT, providers must submit a completed Electronic Funds Transfer (EFT) Authorization Agreement to TMHP. A voided check or letter on bank letterhead, containing the bank routing and account information, must be attached to the enrollment form. One completed form must be filled out for each billing provider identifier, including an original signature of the provider.

After the Electronic Funds Transfer (EFT) Authorization Agreement has been processed, 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 will begin receiving EFT transactions with the third cycle following the enrollment form processing. Providers will continue to receive paper checks until they begin to receive EFT transactions.

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

Refer to: Electronic Funds Transfer (EFT) Notification on the TMHP website at www.tmhp.com.

1.2.4 Stale-Dated Checks

Stale-dated checks (i.e., checks that are older than 180 days) that have not been cashed are voided and/or applied to any outstanding accounts receivable. If the balance on a stale-dated check after it has been applied to accounts receivable is over $5,000, written notification is sent to the provider 30 days before the void occurs.

1.3 Provider Deactivation/Disenrollment

Payment denial codes are applied to a TPI that has had no claim activity for a period of 24 months or more. The TPI will be considered inactive and will not be able to be used to submit claims.

A courtesy letter will be sent to all providers whose TPIs have been identified as not having any claims activity over the previous 18 months. Providers will have six months to submit claims and prevent the TPI from being deactivated. If the provider is enrolled in both Medicaid and the CSHCN Services Program, the provider identifiers for both programs will be examined to determine whether claims activity has occurred.

After 24 months without claim activity, providers will be sent a deactivation letter, and a payment denial code will be applied to their provider identifier. If a provider's Medicaid TPI is deactivated, any enrollments associated with the inactive TPI with the CSHCN Services Program will also be deactivated. Claims that are submitted for a deactivated TPI after the payment denial code has been applied will be denied.

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To have the payment denial code removed from a provider identifier, providers must submit a completed application for the state health-care program in which they wish to enroll, and the application must be approved. The information on this application must match exactly the information currently on the provider's file for the payment denial code to be removed.

1.3.1 Excluded Entities and Providers

The United States Health and Human Services (HHS)-OIG and the HHSC-OIG exclude certain individuals and entities from participation in all federal or state health-care programs. The exclusions restrict individuals from receiving any reimbursement for items or services furnished, ordered, or prescribed.

All current providers and providers who are applying to participate in state health-care programs must screen their employees and contractors every month to determine whether they are excluded individuals or entities. These screenings are a condition of the provider's enrollment or re-enrollment into state health-care programs.

Providers can determine whether an individual or entity is excluded by searching the List of Excluded Individuals/Entities (LEIE) website at www.oig.hhs.gov/fraud/exclusions.asp. A downloadable version of the database is available but it does not include Social Security Numbers (SSNs) or Employer Identification numbers (EINs). The Texas HHSC-OIG website is found at https://oig.hhsc.state.tx.us/Exclusions/Search.aspx. If a name matches a name on the exclusion list, it can be verified online with a SSN or EIN.

Providers must search the LEIE website monthly to capture any exclusions or reinstatements that have occurred since the last search. Providers must immediately report to HHS-OIG any exclusion information they discover when searching the LEIE database.

CFR section 1003.102(a)(2), states that civil monetary penalties may be imposed against Medicaid providers and managed care entities (MCEs) that employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid clients. In addition, no Medicaid payments can be made for any items or services directed or prescribed by an excluded provider or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded.

1.4 Provider Reenrollment

Providers must submit a new application and a new provider identifier must be issued when there are changes in the Medicare number.

The new application may be submitted electronically using PEP or by submitting a completed paper Texas Medicaid Provider Enrollment Application. A new application is required when one of the following changes:

1.4.1 Medicare Number

If Medicare has issued a new Medicare number, the provider must complete and submit a Texas Medicaid Provider Enrollment Application in order to enroll with the new information.

1.4.2 Provider Status (Individual, Group, Performing Provider, or Facility)

Providers leaving group practices must send a signed letter or a Provider Information Change Form to TMHP that states the date of deactivation. The letter should include the provider identifier, effective date of deactivation, and the group's provider identifier. The letter should be signed by an authorized representative of the group or the individual provider leaving the group. If the provider is joining a new group practice has changed from a group practice to an individual enrollment or vice versa, the provider must complete and submit a new Texas Medicaid Provider Enrollment Application to request enrollment with the new status information.

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1.4.3 Physical Address

If a provider has changed an address and the address is within the same Medicare locality, the provider must update the address information within 10 days. Updates may be made using the online provider lookup update screen located in the administrator section of TMHP's website at www.tmhp.com. Alternately, the provider may update the address information by completing and submitting a Provider Information Change Form. A W9 is required if the provider is changing the mailing address using a PIC form. If the address is not within the Medicare locality and Medicare has issued a new Medicare number, the provider must complete and submit a Texas Medicaid Provider Enrollment Application in order to enroll the new location. Dental providers must complete a TMHP Dental Provider Enrollment Application for each practice location.

1.4.4 Change in Principal Information

As defined in subsection 1.1.9.4, "Principal Information Form (PIF-2)" in this section, change in principal information includes a change in corporate officers or directors, professional association membership, and managing employees. The change must be reported to TMHP within 10 calendar days of when it occurs.

Refer to: Subsection 1.6.2.2, "Online Provider Lookup (OPL)" in this section.

Providers must contact the Electronic Data Interchange (EDI) help desk directly and request an Electronic Remittance & Status (ER&S) Report each time a new provider identifier is issued to the provider. This form must be completed and returned to EDI with unique identifying information related to the new provider identifier to ensure there is no suspension in the provider's ability to access their ER&S statement on the secure provider portal through www.tmhp.com.

Providers must also contact any third party EDI vendors with whom they are contracted to add any new provider identifiers to their ER&S Report. To obtain a PDF copy of the ER&S Report on the TMHP Home Page, the provider must create an administrator account for each provider identifier belonging to them.

Providers that have been issued a new provider identifier through the TMHP enrollment or re-enrollment process must ensure that any prior authorizations affected have been updated to reflect the new provider identifier.

1.5 Change of Ownership Requirements

The new owner must do the following:

- Obtain recertification as a Title XVIII (Medicare) facility under the new ownership
- Submit CMS Acknowledgement of Change of Ownership Letter
- 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)
- Provide a separate change of ownership and Texas Medicaid provider enrollment application for all of the provider identifiers affected by the change of ownership
- Submit any new enrollment application relating to a change in ownership to TMHP Provider Enrollment within 10 calendar days of the change

When the change of ownership has been processed, the original TPI used by the provider to bill claims will be deactivated, and the provider will lose the ability to download R&S Reports from the TMHP portal as well as the ability to verify client eligibility online. Claims status inquiries through the TMHP

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portal will also be unavailable. After a TPI has been deactivated, the provider can call the contact center to check on client eligibility and the status of claims. Paper R&S Reports can be printed by the TMHP Contact Center, and delivered to providers, up to 30 days from the date the TPI is deactivated.

Important: *Providers must adhere to claim filing deadlines throughout the enrollment process. Claims should be submitted without a provider identifier until notified by TMHP of final enrollment determination. Note that claims for services that are rendered to Texas Medicaid clients are subject to a filing deadline from the date of service of 95 days for in-state providers and 365 days for out-of-state providers. For clients with retroactive eligibility, the 95-day deadline is based on the date of service or the date the client eligibility information is added to the TMHP eligibility file, whichever is later. For clients with dual Medicare and Medicaid eligibility, when a service is a benefit of both Medicare and Medicaid, the claim must be filed with Medicare first. In this case the 95-day deadline is based on the date of Medicare disposition.*

Refer to: Subsection 6.1.4, "Claims Filing Deadlines" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

1.6 Provider Responsibilities

1.6.1 Compliance with Texas Family Code

1.6.1.1 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/agreements with governmental entities or nonprofit corporations.

The required statement has been incorporated into the Texas Medicaid Provider Agreement.

The law also requires that payments be stopped when notified that the contractor/provider is more than 30 days delinquent in paying child support. Medicaid payments are placed on hold when it is discovered that a currently enrolled provider is delinquent in paying child support. A provider application may be denied or terminated if the provider is delinquent in paying child support.

1.6.1.2 Reporting Child Abuse or Neglect

The Texas Family Code Sec. 261.101 states: (a) A person having cause to believe that a child's physical or mental health or welfare has been adversely affected by abuse or neglect by any person shall immediately make a report as provided by this subchapter; (b) If a professional has cause to believe that a child has been abused or neglected, or may be abused or neglected, or that a child is a victim of an offense under section 21.11, Penal Code, and the professional has cause to believe that the child has been abused as defined by section 261.001 or 261.401, the professional shall make a report no later than the 48th hour after the hour the professional first suspects that the child has been, or may be abused or neglected, or is a victim of an offense under section 21.11, Penal Code. A professional may not delegate to or rely on another person to make the report. In this subsection, *professional* means an individual who is licensed or certified by the state or who is an employee of a facility licensed, certified, or operated by the state and who, in the normal course of official duties or duties for which a license or certification is required, has direct contact with children. The term includes teachers, nurses, doctors, day-care employees, employees of a clinic or health-care facility that provides reproductive services, juvenile probation officers, and juvenile detention or correctional officers.

According to Rider 19 of the General Appropriations Act, 78th Legislative Regular Session, 1999, H.B. 1, all Medicaid providers shall comply with the provisions of state law as set forth in Chapter 261 of the Texas Family Code relating to investigations of reports of child abuse and neglect and the provisions of

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HHSC policy. Reimbursement shall only be made to providers who have demonstrated a good faith effort to comply with child abuse reporting guidelines and requirements in Chapter 261 and HHSC policy. Provider staff shall respond to disclosures or suspicions of abuse or neglect of minors, by reporting to the appropriate agencies as required by law.

All providers shall adopt this policy as their own, report suspected sexual abuse of a child as described in this policy and as required by law, and develop internal policies and procedures that describe how to determine, document, and report instances of sexual or nonsexual abuse.

This information is also available on the HHSC and TMHP websites at www.hhsc.state.tx.us and www.tmhp.com.

1.6.1.3 Procedures for Reporting Abuse or Neglect

Professionals as defined in the law are required to report no later than the 48th hour after the hour the professional first has cause to believe the child has been or may be abused or is the victim of the offense of indecency with a child.

Nonprofessionals shall immediately make a report after the nonprofessional has cause to believe that the child's physical or mental health or welfare has been adversely affected by abuse.

A report shall be made regardless of whether the provider staff suspect that a report may have previously been made.

Reports of abuse or indecency with a child must be made to one of the following:

- Department of Family and Protective Services (DFPS) if the alleged or suspected abuse involves a person responsible for the care, custody, or welfare of the child (the DFPS Texas Abuse/Neglect Hotline, at 1-800-252-5400, operated 24 hours a day, 7 days a week)
- Any local or state law enforcement agency
- The state agency that operates, licenses, certifies, or registers the facility in which the alleged abuse or neglect occurred
- The agency designated by the court to be responsible for the protection of children

The law requires the report to include the following information if known:

- The name and address of the minor
- The name and address of the minor's parent or the person responsible for the care, custody, or welfare of the child if not the parent
- Any other pertinent information concerning the alleged or suspected abuse

Reports can be made anonymously.

A provider may not reveal whether the child has been tested or diagnosed with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS).

If the minor's identity is unknown (e.g., the minor is at the provider's office anonymously to receive testing for HIV or a sexually transmitted disease [STD]), no report is required.

1.6.1.4 Procedures for Reporting Suspected Sexual Abuse

All providers shall ensure that their employees, volunteers, or other staff report a victim of abuse who is a minor 14 years of age or younger who has engaged in sexual activity with any individual to whom the minor is not married. Sexual activity would be indicated if the minor is pregnant or has a confirmed STD acquired in a manner other than through perinatal transmission.

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Sexual activity may include, but is not limited to, the actions described in Penal Code §21.11(a) relating to indecency with a child; §21.01(2) defining *sexual contact*; §43.01(1) or (3)-(5) defining various sexual activities; §22.011(a)(2) relating to sexual assault of a child; or §22.021(a)(2) relating to aggravated sexual assault of a child.

Providers may voluntarily use the HHSC checklist for monitoring all clients who are 14 years of age or younger, unmarried, and sexually active. The checklist, if used, as well as any report of child abuse, shall be retained as part of the client's record by each provider and made available during any monitoring conducted by HHSC.

Refer to: Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information on the TMHP website at www.tmhp.com.

1.6.1.5 Training

All providers must develop training for all staff on the policies and procedures in regard to reporting child abuse. New staff must receive this training as part of their initial training/orientation. Training must be documented. As part of the training, staff must be informed that the staff person who conducts the screening and has cause to suspect abuse has occurred is legally responsible for reporting. A joint report may be made with the supervisor.

1.6.1.6 Reporting Abuse and Neglect of the Elderly or Disabled

ARTICLE 2. ADULT PROTECTIVE SERVICES SECTION 2.01. Subchapter B, Chapter 40, Human Resources Code, Section. 48.051. REPORT state: (a) Except as prescribed by Subsection (b), a person having cause to believe that an elderly or disabled person is in the state of abuse, neglect, or exploitation, including a disabled person receiving services as described by Section 48.252, shall report the information required by Subsection (d) immediately to the Department of Health and Human Services and Department of Protective and Regulatory Services.(b) If a person has cause to believe that an elderly or disabled person, other than a disabled person receiving services as described by Section 48.252, has been abused, neglected, or exploited in a facility operated, licensed, certified, or registered by a state agency, the person shall report the information to the state agency that operates, licenses, certifies, or registers the facility for investigation by that agency.(c) The duty imposed by Subsections (a) and (b) applies without exception to a person whose knowledge concerning possible abuse, neglect, or exploitation is obtained during the scope of the person's employment or whose professional communications are generally confidential, including an attorney, clergy member, medical practitioner, social worker, and mental health professional.

(d) The report may be made orally or in writing. It shall include:

- The name, age, and address of the elderly or disabled person;
- The name and address of any person responsible for the elderly or disabled person's care;
- The nature and extent of the elderly or disabled person's condition;
- The basis of the reporter's knowledge; and
- Any other relevant information.

(e) If a person who makes a report under this section chooses to give self-identifying information, the caseworker who investigates the report shall contact the person if necessary to obtain any additional information required to assist the person who is the subject of the report.

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1.6.1.7 Procedures for Reporting Abuse or Neglect of the Elderly or Disabled

Sec. 48.151. ACTION ON REPORT states: (a) Not later than 24 hours after the department receives a report of an allegation of abuse, neglect, or exploitation under Section 48.051, the Department of Health and Human Services and Department of Protective and Regulatory Services shall initiate a prompt and thorough investigation as needed to evaluate the accuracy of the report and to assess the need for protective services, unless the department determines that the report:

- Is frivolous or patently without a factual basis; or
- Does not concern abuse, neglect, or exploitation, as those terms are defined by rules adopted by the executive commissioner under Section 48.002(c), except that if the executive commissioner has not adopted applicable rules under that section, the statutory definitions of those terms under Section 48.002(a) shall be used.

(b) The Department of Health and Human Services and Department of Protective and Regulatory Services have adopted rules for conducting investigations under this chapter.

(c) The Department of Human Services and Department of Protective and Regulatory Services by rule may assign priorities and prescribe investigative procedures for conducting investigations according to the degree of severity and immediacy of the alleged harm to the individual. Notwithstanding Subsection (a), the department's priorities and procedures may provide that an investigation is not required to be initiated within 24 hours in all cases.

(d) The Department of Human Services and Department of Protective and Regulatory Services shall prepare and keep on file a report of each investigation conducted by the department.

(e) This section does not apply to investigations conducted under Subchapter F or H.

1.6.2 Maintenance of Provider Information

Within 10 calendar days of occurrence, providers must report changes in address (physical location or accounting), telephone number, name, federal tax ID, and any other information that pertains to the structure of the provider's organization (for example, performing providers). Changes in address, office telephone or fax number, and email address should be updated online using the OPL update page. Alternately, providers may update their address information using the PIC Form referenced below on the TMHP website. A W9 is required if the provider is changing the mailing address. A copy of the Medicare approval letter listing the additional location or site must be submitted when adding alternate physical addresses.

Refer to: Subsection 1.6.2.2, "Online Provider Lookup (OPL)" in this section.

Provider Information Change Form on the TMHP website at www.tmhp.com.

If the physical address is not within the same Medicare locality and Medicare has issued a new Medicare number, the provider must complete and submit a Texas Medicaid Provider Enrollment Application in order to enroll the new location.

Refer to: Subsection 1.4.1, "Medicare Number" in this section.

Providers are notified when they have an invalid address on file with TMHP. Account administrators who log onto their accounts through the TMHP website at www.tmhp.com are notified when they have an invalid address on file for any of the TPIs associated with their NPI.

The Check Status Amount Search screen on the provider's secure homepage of the TMHP website will alert providers when payments are pending because of inaccurate or incomplete provider information. R&S Reports that are viewed on the TMHP website also notify the provider of pending payments.

Pending payments are released in the financial cycle of the following week after the address information has been updated. Payments that are pending for more than 180 days will be voided.

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Other changes (in name, ownership status, federal tax ID, etc.) must be reported in writing to TMHP Provider Enrollment. Failure to notify TMHP of changes affects accurate processing and timely claims payment. In addition, failure to timely report such changes is a violation of the rules of Medicaid, and may result in administrative, civil, or criminal liability.

Refer to: Subsection 1.10, "Medicaid Waste, Abuse, and Fraud Policy" in this section.

Providers will be prompted to verify their address(es) and make necessary changes at least once a year.

After the PIC form has been completed, it can be faxed to 1-512-514-4214, Attn: Provider Enrollment, or mailed to the address below for processing.

Texas Medicaid & Healthcare Partnership
Provider Enrollment
PO Box 200795
Austin, TX 78720-0795

Providers should keep a copy of the completed form for their records.

1.6.2.1 NPI Verification

TMHP verifies NPIs with NPPES to ensure that the NPI is active. If the NPI is shown by NPPES to be inactive, TMHP will notify the provider by letter.

The provider will be allowed a 60-day grace period to contact NPPES and resolve their NPI status. If the inactive NPI has not been reinstated within the 60-day grace period, TMHP will disenroll all TPIs associated with the inactive NPI.

1.6.2.2 Online Provider Lookup (OPL)

The OPL is available on the public access portion of the TMHP website at www.tmhp.com. Provider information can be viewed by providers, clients, and anyone who accesses the TMHP website.

Providers with certain provider types must verify and update key demographic information every six months in the Provider Information Management System (PIMS) to ensure their information is correct in the OPL. Affected provider types include, but are not limited to, physicians, nurses, dentists, and durable medical equipment providers.

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

If access to the secure portal has been blocked because of needed verification, nonadministrative users are not able to perform work functions on NPIs listed on the Review Required page. Nonadministrative users are advised to notify users with administrative rights so that they can verify demographic information and remove the block.

The *My Account* page has a link to the Provider Demographic Update web page. Current information will be displayed with a button to allow editable fields to be changed. Demographic information may be updated only by authorized administrators. This authorization is controlled through the Permissions Management link, also located on the *My Account* page. Fields that can be updated online include the following:

- Primary physical address:
  - Street address lines 1 and 2
  - City, state, ZIP Code
  - County

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- Telephone numbers
- Email address
- Office hours
- Accepting new clients, current clients only, or not accepting new clients
- Additional sites where services are provided
- Languages spoken
- Additional services offered
- Medicaid waiver programs
- Client age or gender limitations
- Counties served

The following enhancements have also been made to the OPL to increase overall functionality:

- Clients are able to search for providers in up to 5 counties in a single search.
- Doing business as (DBA) names appear for providers or provider groups.
- The State of Texas Access Reform (STAR) Health program has been added as a searchable health plan.
- The default ZIP Code radius for provider search has been increased to 10 miles from 5 miles.
- Providers who make address updates may receive a confirmation email from TMHP after the address has been verified and if their email address has been provided.
- Users will be able to search for providers within a ZIP Code that crosses multiple counties.

Each provider specialty and subspecialty listed in the OPL now has a corresponding definition. Users can view the definitions by clicking "more information" on either the basic or advanced search page or by hovering over the specialty on the results page. The definitions have been added to help clients locate the correct type of provider.

Providers are able to self-declare as many as three subspecialties to identify the services they offer. Providers may declare only subspecialties that are within the scope of their practice. Users are able to search for a provider on the OPL using these subspecialties.

Clients using the OPL will use drop-down boxes to select search criteria. An initial list will display all providers that meet the specified search criteria. Clicking on any name in that list will display the provider's specific information, including a map of the office location.

Links to health maintenance organization (HMO) websites are also provided, enabling clients to search each HMO's network of participating providers. The OPL supports both English and Spanish language users, and search results can be printed.

1.6.2.3 Updating NPI and Taxonomy Codes

Providers are required to provide their NPI in the enrollment application. During the enrollment process, providers must also select a primary and, if applicable, secondary taxonomy codes associated with their provider type. Due to copyright restrictions, TMHP is unable to publish the taxonomy descriptions. Providers must verify the taxonomy codes associated with their provider type and specialty before beginning the enrollment process.

Refer to: Subsection 1.1.1, "NPI and Taxonomy Codes" in this section.

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Providers must maintain and update their NPI and/or taxonomy code information with Texas Medicaid. Provider attestation can be completed under the "I would like to…" web page, which is accessed from most provider web pages on the TMHP website at www.tmhp.com. The available taxonomy code selections are auto populated according to the provider type and specialty associated with the TPI entered. The taxonomy code options may not match the taxonomy code listed in the confirmation letter received from NPPES. Providers must contact the TMHP Contact Center at 1-800-925-9126, Option 2, to validate their provider type and specialty associated with their TPIs.

Refer to: Subsection 1.6.2.4, "Updating Provider Specialty" in this section if a taxonomy code that you want to use is not available for the enrolled provider type or specialty.

Important: *The taxonomy code that is included in electronic transactions must match a taxonomy code that is included in the attestation record. Secondary taxonomy codes included during the attestation process are used as additional matching criteria for claims and authorization processing.*

1.6.2.4 Updating Provider Specialty

Providers that have made a change in their specialty must submit their updated specialty information to Texas Medicaid. The forms that must be submitted to Texas Medicaid depend on the provider's enrollment, as follows:

- Medicare-enrolled providers whose Medicare number has not changed must submit a copy of the Medicare letter listing the updated specialty along with a PIC Form to Texas Medicaid. Providers may submit the form by fax to TMHP (Attention Provider Enrollment) at 1-512-514-4214 or by mail to:

  Texas Medicaid & Healthcare Partnership
  Provider Enrollment
  PO Box 200795
  Austin, TX 78720-0795

- Providers that are not enrolled in Medicare or whose Medicare number has changed must submit a new application

Refer to: Provider Information Change Form on the TMHP website at www.tmhp.com.

Subsection 1.4, "Provider Reenrollment" in this section for more information about provider reenrollment in Texas Medicaid.

1.6.3 Retention of Records and Access to Records and Premises

The provider must maintain and retain all necessary documentation, records, R&S Reports, and claims to fully document the services and supplies provided and delivered to a client with Texas Medicaid coverage, the medical necessity of those services and supplies, costs included in cost reports or other documents used to determine a payment rate or fee, and records or documents necessary to determine whether payment for those items or services was due and was properly made for full disclosure to HHSC and its designee. A copy of the claim or R&S Reports without additional documentation will not meet this requirement.

The documentation includes the following, without limitation:

- Patient clinical health records
- Other records pertaining to the patient
- Any other records of services, items, equipment, or supplies provided to the patient and payments made for those services
- Diagnostic tests

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- Documents related to diagnosis
- Charting
- Billing records
- Invoices
- Treatments
- Services
- Laboratory results
- X-rays
- Documentation of delivery of items, equipment, and supplies

Accessible information must include information that is necessary for the agencies specified in this section to perform statutory functions.

> ***Note:*** *The required information may also include, without limitation, business and accounting records with backup support documentation, statistical documentation, computer records and data, and patient sign-in sheets and schedules. Additionally, it includes all requirements and elements described in 1 TAC §§371.1607 and 371.1667 (definition of "failure to grant immediate access").*

The provider is required to submit original documents, records, and accompanying business records affidavits to representatives of the organizations listed in this section. These records should also be provided to any agents and contractors related to the organizations. At the discretion of the requestor, the provider may be permitted to instead provide copies notarized with the required business records affidavit. Requested records must be provided promptly and at no cost to the state or federal agency. If the provider was originally requested to provide original documents and subsequent requests for copies of these records are made by the provider, any and all costs associated with copying or reproducing any portion of the original records will be at the expense of the provider. This applies to any request for copies made by the provider at any point in the investigative process until such time as the agency deems the investigation to be finalized. A method of payment for the copying charge, approved by the agency, would be used to pay for the copying of the records. If copies of records are requested from the provider initially, the provider must submit copies of such records at no cost to the requestor's organization.

The provider must provide immediate access to the provider's premises and records for purposes of reviewing, examining, and securing custody of records, documents, electronic data, equipment, or other requested items, as determined necessary by the requestor to perform statutory functions. Nothing in this section will in any way limit access otherwise authorized under state or federal law. If, in the opinion of the Inspector General or other requestor, the documents may be provided at the time of the request or in less than 24 hours or the Inspector General or other requestor suspects the requested documents or other requested items may be altered or destroyed, the response to the request must be completed by the provider at the time of the request or in less than 24 hours as allowed by the requestor. If, in the opinion of the Inspector General or other requestor, the requested documents and other items requested cannot be completely provided on the day of the request, the Inspector General or requestor may set the deadline for production at 24 hours from the time of the original request.

Failure to supply the requested documents and other items, within the time frame specified, may result in payment hold to the provider's Medicaid payments, recoupment of payments for all claims related to the missing records, contract cancellation, and/or exclusion from Texas Medicaid.

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As directed by the requestor, the provider or person will relinquish custody of the requested documents and other items and the requestor will take custody of the records, removing them from the premises. If the requestor should allow longer than "at the time of the request" to produce the records, the provider will be required to produce all records completed, at the time of the completion or at the end of each day of production, as directed by the requestor who will take custody of the requested items.

If the provider places the required information in another legal entity's records, such as a hospital, the provider is responsible for obtaining a copy of these requested records for use by the requesting state and federal agencies.

These documents and claims must be retained for a minimum period of five years from the date of service or until all audit questions, appeal hearings, investigations, or court cases are resolved. Freestanding RHCs must retain their records for a minimum of six years, and hospital-based RHCs must retain their records for a minimum of ten years. These records must be made available immediately at the time of the request to employees, agents, or contractors of HHSC OIG, the Office of the Attorney General (OAG) Medicaid Fraud Control Unit (MFCU) or Antitrust and Civil Medicaid Fraud Section, TMHP, DFPS, the Department of Aging and Disability Services (DADS), DSHS, Department of Assistive and Rehabilitative Services (DARS), U.S. Department of Health and Human Services (HHS) representative, any state or federal agency authorized to conduct compliance, regulatory, or program integrity functions on the provider, person, or the services rendered by the provider or person, or any agent, contractor, or consultant of any agency or division delineated above. In addition, the provider must meet all requirements of 1 TAC §371.1667.

The records must be available as requested by each of these entities, during any investigation or study of the appropriateness of the Medicaid claims submitted by the provider.

1.6.3.1 Payment Error Rate Measurement (PERM) Process

CMS assesses Texas Medicaid using the PERM process to measure improper payments in Texas Medicaid. Providers will be required to provide medical record documentation to support the medical reviews that the federal review contractor will conduct for Texas Medicaid fee-for-service and Primary Care Case Management Medicaid and State Children's Health Insurance Program (SCHIP) claims.

Under the PERM process, if a claim is selected in a sample for a service that a provider rendered to a Medicaid client, the provider will be contacted to submit a copy of the medical records that support the medical review of the claim. All providers should check the TMHP system to ensure their current telephone number and addresses are correct in the system. If the information is incorrect or incomplete, providers must request a change immediately to ensure the PERM medical record request can be delivered. Client authorization for release of this information is not required.

Once a provider receives the request for medical records, the provider must submit the information electronically or in hard copy within 60-calendar days. It is important that providers cooperate by submitting all requested documentation in a timely manner because no response or insufficient documentation will count against the state as an error. This can ultimately negatively impact the amount of federal funding received by Texas for Medicaid.

1.6.4 Release of Confidential Information

Information regarding the diagnosis, evaluation, or treatment of a client with Texas Medicaid coverage by a person licensed or certified to diagnose, evaluate, or treat any medical, dental, mental/emotional disorder, or drug abuse, is confidential information that the provider may disclose only to authorized persons. Family planning information is sensitive, and confidentiality must be ensured for all clients, especially minors.

Only the client may give written permission for release of any pertinent information before client information can be released, and confidentiality must be maintained in all other respects. If a client's medical records are requested by a licensed Texas health-care provider or a provider licensed by any state, territory, or insular possession of the United States or any State or province of Canada, for purposes of

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emergency or acute medical care, a provider must furnish such records at no cost to the requesting provider. This includes records received from another physician or health-care provider involved in the care or treatment of the patient. If the records are requested for purposes other than for emergency or acute medical care, the provider may charge the requesting provider a reasonable fee and retain the requested information until payment is received.

The client's signature is not required on the claim form for payment of a claim, but HHSC recommends the provider obtain written authorization from the client before releasing confidential medical information. A release may be obtained by having the client sign the indicated block on the claim form after the client has read the statement of release of information that is printed on the back of the form. The client's authorization for release of such information is not required when the release is requested by and made to DADS, HHSC, DSHS, TMHP, DFPS, DARS, HHSC OIG, the MFCU or Antitrust and Civil Fraud Division, or HHS.

1.6.5 Compliance with Federal Legislation

HHSC complies with HHS regulations that protect against discrimination. All contractors must agree to comply with the following:

- Title VI of the Civil Rights Act of 1964 (Public Law 88-352), section 504 of the Rehabilitation Act of 1973 (Public Law 93-112), The Americans with Disabilities Act of 1990 (Public Law 101-336), Title 40, Chapter 73, of the TAC, all amendments to each, and all requirements imposed by the regulations issued pursuant to these acts. The laws provide in part that no persons in the United States (U.S.) shall, on the grounds of race, color, national origin, age, sex, disability, political beliefs, or religion, be excluded from participation in or denied any aid, care, service, or other benefits provided by federal and/or state funding, or otherwise be subjected to any discrimination
- Health and Safety Code 85.113 as described in "Model Workplace Guidelines for Businesses, State Agencies, and State Contractors" on page G-2 (relating to workplace and confidentiality guidelines on AIDS and HIV)

Exception: *In the case of minors receiving family planning services, only the client may consent to release of health-care information. Providers must comply with the laws and regulations concerning discrimination. Payments for services and supplies are not authorized unless the services and supplies are provided without discrimination on the basis of race, color, sex, national origin, age, or disability. Send written complaints of noncompliance to the following address:*

Executive Commissioner
1100 West 49th Street
Austin, TX 78756-3172

Reminder: *Each provider must furnish covered Medicaid services to eligible clients in the same manner, to the same extent, and of the same quality as services provided to other patients. Services made available to other patients must be made available to Texas Medicaid clients if the services are benefits of Texas Medicaid.*

1.6.6 Tamper-Resistant Prescription Pads

Providers are required by federal law (Public Law 110-28) to use a tamper-resistant prescription pad when writing a prescription for any drug for Medicaid clients.

Providers must take necessary steps to ensure that tamper-resistant pads are used for all written prescriptions provided to Medicaid clients. Providers may also use compliant, non-written alternatives for transmitting prescriptions such as by telephone, fax, or electronic submittal. Pharmacies are required to ensure that all written Medicaid prescriptions submitted for payment to the Vendor Drug Program are written on a compliant tamper-resistant pad.

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If a prescription is not submitted on a tamper-resistant prescription form, a pharmacy may fill the prescription and obtain a compliant prescription by fax, electronic prescription, or re-written on tamper-resistant paper within 72 hours after the date the prescription was filled.

Providers may purchase tamper-resistant prescription pads from the vendor of their choice.

Special copy-resistant paper is not a requirement for prescriptions printed from electronic health records (EHRs) or ePrescribing generated prescriptions. These prescriptions may be printed on plain paper and will be fully compliant with all three categories of the tamper-resistant regulations, provided they contain at least one feature from each of the three following categories:

- Prevents unauthorized copying of completed or blank prescription forms.
- Prevents erasure or modification of information written on the prescription form.
- Prevents the use of counterfeit prescription forms.

1.6.7 Utilization Control — General Provisions

Title XIX of the Social Security Act, sections 1902 and 1903, mandates utilization control of all Texas Medicaid services under regulations found at Title 42 CFR, Part 456. Utilization review activities required by Texas Medicaid are completed through a series of monitoring systems developed to ensure the quality of services provided, and that all services are both medically necessary and billed appropriately. Both clients and providers are subject to utilization review monitoring. Utilization control procedures safeguard against the delivery of unnecessary services, monitor quality, and ensure payments are appropriate and according to Texas Medicaid policies, rules, and regulations. All providers identified as a result of utilization control activities are presented to HHSC-OIG to determine any and all subsequent actions.

The primary goal of utilization control activity is to identify providers with practice patterns inconsistent with the federal requirements and Texas Medicaid scope of benefits, policies, and procedures. The use of utilization control monitoring systems allows for identification of providers whose patterns of practice and use of services fall outside of the norm for their peer groups. Providers identified as exceptional are subject to an in-depth review of all Texas Medicaid billings. These review findings are presented to the HHSC-OIG to determine any necessary action. Medical records may be requested from the provider to substantiate the medical necessity and appropriateness of services billed to Texas Medicaid. Inappropriate service utilization may result in recoupment of overpayments and/or sanctions, or other administrative actions deemed appropriate by the HHSC-OIG. There are instances when a training specialist may be directed to communicate with the provider to offer assistance with the technical or administrative aspects of Texas Medicaid.

At the direction of the HHSC-OIG, a provider's claims may be manually reviewed before payment. Parameters are developed for prepayment review based on the specific areas of concern identified in each case. As part of the prepayment review process, providers are required to submit paper claims, rather than electronic claims, along with supporting medical record documentation (e.g., clinical notes, progress notes, diagnostic testing results, other reports, superbills, X-rays, and any related medical record documentation) attached to each claim for all services billed. This documentation is used to ascertain that the services billed were medically necessary, billed appropriately, and according to Texas Medicaid requirements and policies. Services inconsistent with Texas Medicaid requirements and policies are adjudicated accordingly. Claims submitted initially without the supporting medical record documentation will be denied. Additional medical record documentation submitted by the provider for claims denied as a result of the prepayment review process is not considered at a later time. A provider is removed from prepayment review only when determined appropriate by the HHSC-OIG. Once removed from prepayment review, a follow-up assessment of the provider's subsequent practice patterns is performed to monitor and ensure continued appropriate use of resources. Noncompliant providers are subject to administrative sanctions up to and including exclusion and contract cancellation, as deemed appropriate by the HHSC-OIG as defined in the rules in 1 TAC §§371.1701, 371.1703,

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371.1705, 371.1707, 371.1709, 371.1711, 371.1713, and 371.1715. Providers placed on prepayment review must submit all paper claims and supporting medical record documentation to the following address:

Texas Medicaid & Healthcare Partnership
Attention: Prepayment Review MC-A11 SURS
PO Box 203638
Austin, Texas 78720-3638

1.6.8 Provider Certification/Assignment

Texas Medicaid service providers are required to certify compliance with or agree to various provisions of state and federal laws and regulations. After submitting a signed claim to TMHP, the provider certifies the following:

- Services were personally rendered by the *billing provider* or under supervision of the billing provider, if allowed for that provider type, or under a substitute arrangement.
- The information on the claim form is true, accurate, and complete.
- All services, supplies, or items billed were medically necessary for the client's diagnosis or treatment. Exception is allowed for special preventive and screening programs (for example, family planning and THSteps).
- Health records document all services billed and the medical necessity of those services.
- All billed charges are usual and customary for the services provided. The charges must not be higher than the fees charged to private-pay patients.
- The provider will not bill Texas Medicaid for services that are provided or offered to non-Medicaid patients, without charge, discounted or reduced in any fashion including, but not limited to, sliding scales or advertised specials. Any reduced, discounted, free, or special fee advertised to the public must also be offered to Texas Medicaid clients.
- Services were provided without regard to race, color, sex, national origin, age, or handicap.
- The provider of health care and services files a claim with Texas Medicaid agreeing to accept the Medicaid reimbursement as payment in full for those services covered under Texas Medicaid. In accordance with 1 TAC §354.1005, the reimbursement for services covers the costs for a covered service, and any function incidental to the provision of a covered service (refer to subsection 1.6.9, "Billing Clients" for more information). The client with Medicaid coverage, or others on their behalf, must not be billed for the amount above that which is 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. However, the client may be billed for noncovered services for which Texas Medicaid does not make any payment. Before providing services, providers should *always* inform clients of their liability for services that are not a benefit of Texas Medicaid, including use of the Client Acknowledgment Statement.
- The provider understands that endorsing or depositing a Texas Medicaid check is accepting money from federal and state funds and that any falsification or concealment of material fact related to payment may be grounds for prosecution under federal and state laws.

Providers must not bill for, and agree not to bill for, any service provided for which the client bears no liability to pay (i.e. free services). The only exceptions to this ban on billing for services that are free to the user are:

- Services offered by or through the Title V agency when the service is a benefit of Texas Medicaid and rendered to an eligible client

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- Services included in the Texas Medicaid client's individualized education plan (IEP) or individualized family service plan (IFSP) if the services are covered under the Title XIX state plan, even though they are free to the users of the services

Refer to: Subsection 7.2, "Services, Benefits, Limitations, and Prior Authorization" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 1.6.8.1, "Delegation of Signature Authority" in this section.

1.6.8.1 Delegation of Signature Authority

A provider delegating signatory authority to a member of the office staff or to a billing service *remains responsible* for the accuracy of all information on a claim submitted for payment. A provider's employees or a billing service and its employees are equally responsible for any false billings in which they participated or directed.

If the claim is prepared by a billing service or printed by data processing equipment, it is permissible to print "Signature on File" in place of the provider's signature. When claims are prepared by a billing service, the billing service must obtain and keep a letter on file that is signed by the provider authorizing claim submission.

1.6.9 Billing Clients

A provider cannot require a down payment before providing Medicaid-allowable services to eligible clients, bill, nor take recourse against eligible clients for denied or reduced claims for services that are within the amount, duration, and scope of benefits of Texas Medicaid if the action is the result of any of the following provider-attributable errors:

- Failure to submit a claim, including claims not received by TMHP
- Failure to submit a claim to TMHP for initial processing within the 95-day filing deadline (or the initial 365-day deadline, if applicable)
- Submission of an unsigned or otherwise incomplete claim such as omission of the Hysterectomy Acknowledgment Statement or Sterilization Consent Form with claims for these procedures
- Filing an incorrect claim
- Failure to resubmit a corrected claim or rejected electronic media claim within the 120-day resubmittal period
- Failure to appeal a claim within the 120-day appeal period. Errors made in claims preparation, claims submission, or appeal process
- Failure to submit a claim to TMHP within 95 days of a denial by the DSHS Family Planning Program for family planning services
- Failure to submit a claim within 95 days from the disposition date from Medicare or a primary third party insurance resource
- Failure to obtain prior authorization for services that require prior authorization under Texas Medicaid

Providers must certify that no charges beyond reimbursement paid under Texas Medicaid for covered services have been, or will be, billed to an eligible client. Federal regulations prohibit providers from charging clients a fee for completing or filing Medicaid claim forms. Providers are not allowed to charge TMHP for filing claims. The cost of claims filing is part of the usual and customary rate for doing business.

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Medicaid reimbursement is considered as payment in full for those services covered under Texas Medicaid. In accordance with 1 TAC §354.1005, the reimbursement for services is intended to cover the costs for a covered service, or any function incidental to the provision of a covered service, including, but not limited to:

- Signing, completing, or providing a copy of a health assessment form, such as a physical examination form required for the eligible client's enrollment in school or participation in school or other activities;
- Providing a copy of a medical record requested:
  - By or on behalf of any health care practitioner for purposes of medical care or treatment of the eligible client;
  - As a supplement to a health assessment form or other form provided incidental to a covered service; or
  - By an eligible client, for any reason, for the first time in a one-year period; and
- Providing a copy of any subsequent amendment, supplement, or correction to a medical record requested by or on behalf of the eligible client.
- If the provider has already provided the eligible client a free copy of the medical record within a one-year period, the provider is required to provide only the amended, supplemented, or corrected portion of the record, if requested, without having to copy the entire record.

Completion of required forms submitted by a nursing facility to the physician for signature is also considered incidental to a covered service. It is not acceptable for the physician to charge Texas Medicaid clients, their family, or the nursing facility for telephone calls, telephone consultations, or signing forms.

In accordance with current federal policy, Texas Medicaid and Texas Medicaid clients cannot be charged for the client's failure to keep an appointment. Only billings for services provided are considered for payment. Clients may not be billed for the completion of a claim form, even if it is a provider's office policy.

Letters of inquiry about client billing are sometimes sent to providers in lieu of telephone calls from TMHP representatives. In either case, it is mandatory that the questions be answered with the requested pertinent information. Upon receipt, TMHP forwards these letters to HHSC. HHSC uses the information to resolve client billing/liability issues. It is mandatory that these letters be signed, dated, and returned within ten business days.

Refer to: The *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about spell-of-illness.

Subsection 4.6, "Medically Needy Program (MNP)" in Section 4, "Client Eligibility" (*Vol. 1, General Information*).

Private Pay Agreement on the TMHP website at www.tmhp.com.

1.6.9.1 Client Acknowledgment Statement

Texas Medicaid only reimburses services that are medically necessary or benefits of special preventive and screening programs such as family planning and THSteps. Hospital admissions denied by the Texas Medical Review Program (TMRP) also apply under this policy.

The provider may bill the client only if:

- A specific service or item is provided at the client's request.
- The provider has obtained and kept a written Client Acknowledgment Statement signed by the client that states:

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- "I understand that, in the opinion of (*provider's name*), the services or items that I have requested to be provided to me on (*dates of service*) may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the HHSC or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."
- "Comprendo que, según la opinión del (*nombre del proveedor*), es posible que Medicaid no cubra los servicios o las provisiones que solicité (*fecha del servicio*) por no considerarlos razonables ni médicamente necesarios para mi salud. Comprendo que el Departamento de Salud de Texas o su agente de seguros de salud determina la necesidad médica de los servicios o de las provisiones que el cliente solicite o reciba. También comprendo que tengo la responsibilidad de pagar los servicios o provisiones que solicité y que reciba si después se determina que esos servicios y provisiones no son razonables ni médicamente necesarios para mi salud."

A provider is allowed to bill the following to a client without obtaining a signed Client Acknowledgment Statement:

- Any service that is not a benefit of Texas Medicaid (for example, cellular therapy).
- All services incurred on noncovered days because of eligibility or spell of illness limitation. Total client liability is determined by reviewing the itemized statement and identifying specific charges incurred on the noncovered days. Spell of illness limitations do not apply to medically necessary stays for Medicaid clients who are 20 years of age and younger.
- The reduction in payment that is due to the Medically Needy Program (MNP) is limited to children who are 18 years of age and younger and pregnant women. The client's potential liability would be equal to the amount of total charges applied to the spend down. Charges to clients for services provided on ineligible days must not exceed the charges applied to spend down.
- All services provided as a private pay patient. If the provider accepts the client as a private pay patient, the provider must advise clients that they are accepted as private pay patients at the time the service is provided and responsible for paying for all services received. In this situation, HHSC strongly encourages the provider to ensure that the client signs written notification so there is no question how the client was accepted. Without written, signed documentation that the Texas Medicaid client has been properly notified of the private pay status, the provider cannot seek payment from an eligible Texas Medicaid client.
- The client is accepted as a private pay patient pending Texas Medicaid eligibility determination and does *not* become eligible for Medicaid retroactively. The provider is allowed to bill the client as a private pay patient if retroactive eligibility is not granted. If the client becomes eligible retroactively, the client notifies the provider of the change in status. Ultimately, the provider is responsible for filing timely Texas Medicaid claims. If the client becomes eligible, the provider *must* refund any money paid by the client and file Medicaid claims for all services rendered.

A provider attempting to bill or recover money from a client in violation of the above conditions may be subject to exclusion from Texas Medicaid.

Important: *Ancillary services must be coordinated and pertinent eligibility information must be shared. The primary care provider is responsible for sharing eligibility information with others (e.g., emergency room staff, laboratory staff, and pediatricians).*

1.6.10 General Medical Record Documentation Requirements

The Administrative Simplification Act of HIPAA mandates the use of national coding and transaction standards. HIPAA requires that the American Medical Association's (AMA) Current Procedural Terminology (CPT) system or the American Dental Association's (ADA) Current Dental Terminology (CDT)

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system be used to report professional services, including physician and dental services. Correct use of CPT and CDT coding requires using the most specific procedure code that matches the services provided based on the procedure code's description. Providers must pay special attention to the standard CPT descriptions for the evaluation and management services. The medical record must document the specific elements necessary to satisfy the criteria for the level of service as described in CPT. Reimbursement may be recouped when the medical record does not document that the level of service provided accurately matches the level of service claimed. Furthermore, the level of service provided and documented must be medically necessary based on the clinical situation and needs of the patient.

HHSC and TMHP routinely perform retrospective reviews of all providers. HHSC ultimately is responsible for Texas Medicaid utilization review activities. This review includes 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.*

Note: *Health-care documentation that is maintained by a provider in a client's record can be maintained in a language other than English; however, when TMHP, HHSC, or any other state/federal agency requests a written record or conducts a documentation review, this health-care documentation must be provided in English and in a timely manner.*

- (Mandatory) All entries are legible to individuals other than the author, dated (month, day, and year), and signed by the performing provider.
- (Mandatory) Medicaid-enrolled providers must submit claims with their own TPI except when under the agreement of a substitute provider or *locum tenens*.
- (Mandatory) Each page of the medical record documents the patient's name and Texas Medicaid number.
- (Mandatory) A copy of the actual authorization from HHSC or its designee (e.g., TMHP) is maintained in the medical record for any item or service that requires prior authorization.
- (Mandatory) Allergies and adverse reactions (including immunization reactions) are prominently noted in the record.
- (Mandatory) The selection of evaluation and management codes (levels of service) is supported by the client's clinical record documentation. Providers must follow either the 1995 or 1997 Documentation Guidelines for Evaluation and Management Services published by CMS, when selecting the level of service provided.
- (Mandatory) The history and physical documents the presenting complaint with appropriate subjective and objective information.
- (Mandatory) The services provided are clearly documented in the medical record with all pertinent information regarding the patient's condition to substantiate the need and medical necessity 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) Necessary follow-up visits specify time of return by at least the week or month.
- (Mandatory) Unresolved problems are noted in the record.
- (Desirable) Immunizations are noted in the record as *complete* or *up-to-date.*

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- (Desirable) Personal data includes address, employer, home/work telephone numbers, sex, marital status, and emergency contacts.

Note: *An unenrolled provider that renders services and attempts to use the TPI of a provider who is enrolled in Medicaid will not be reimbursed for the services. During retrospective review, any services that were rendered by a provider that was not enrolled in Texas Medicaid and were billed using the provider identifier of a Medicaid-enrolled provider are subject to recoupment.*

1.6.11 Informing Pregnant Clients About CHIP Benefits

Section 24, S.B. 1188, 79th Legislature, Regular Session, 2005, requires that Medicaid providers rendering services to a pregnant Medicaid client must inform the client of the health benefits for which the client or the client's child may be eligible under the CHIP.

CHIP is available to children whose families have low to moderate income, who earn too much money to qualify for Texas Medicaid, and who do not have private insurance. Some clients may have to pay an enrollment fee.

To qualify for CHIP, a child must be:

- A Texas resident
- 18 years of age or younger
- A citizen or legal permanent resident of the United States
- Must meet all income and resource guidelines

CHIP benefits include:

- Physician, hospital, X-ray, and lab services
- Well-baby and well-child visits
- Immunizations
- Prescription drugs
- Dental services
- DME
- Prosthetic devices (with a $20,000 limit per 12-month period)
- Case coordination and enhanced services for children with special health-care needs and children with disabilities
- Physical, speech, and occupational therapy
- Home health services
- Transplants
- Mental health services
- Vision services
- Chiropractic services

Individuals may apply for CHIP by downloading and completing the application found on the CHIP Apply Now page of the HHSC website or by calling the toll-free CHIP number at 1-800-647-6558.

1.7 Electronic Health Records (EHR) Incentive Program

The Texas Medicaid EHR Incentive Program provides incentive payments to health-care providers and hospitals when they adopt and meaningfully use certified electronic health record technology.

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The program is designed to encourage Texas health-care professionals and hospitals to make the transition to electronic health records and help build what eventually will be a statewide health information network where patient records can be shared among offices electronically.

Individual professionals and hospitals can qualify for incentive payments by adopting certified electronic health record technology that meets federal standards, then using that technology in ways that improve quality, safety, and effectiveness of patient care.

There will be three stages of meaningful use over the six-year life of the program. Providers must meet the criteria for each stage to continue receiving incentive payments.

To learn more about the program and how to participate, providers can visit www.texasehrincentives.com for a user-friendly e-learning tool, and www.tmhp.com/Pages/HealthIT/HIT_Home.aspx for the latest program news and resource documents.

For additional assistance on this and other aspects of the Texas Medicaid EHR Incentive Program, providers can email HealthIT@tmhp.com or call the TMHP Contact Center at 1-800-925-9126 (option 4). Providers can find a complete list of HealthIT forms on the HealthIT forms page of the TMHP website at www.tmhp.com.

1.7.1 Attesting to Meaningful Use: Required Documentation for Texas Medicaid EHR Incentive Program

Providers must maintain auditable records to support attestations made by eligible professionals (EPs) moving forward in the Texas Medicaid EHR Incentive Program from Adopt/Implement/Upgrade (AIU) to Meaningful Use (MU) Stage 1 and beyond.

To receive MU incentives, EPs must show that they are meaningfully using the certified EHR technology by reporting on MU and clinical quality measures.

The following are the required documents that must be uploaded into the Texas Medicaid EHR Incentive Program portal at the time of MU attestation:

- Numerator / Denominator Measures (Core and Menu): For the numerator/denominator measures, providers must upload into the portal an EHR-generated summary MU report, if available, that shows the numerator and denominator for each measure reported. If some measures are not included in the summary report, providers must generate separate reports or other auditable documentation for those measures. For example, screenshots showing an MU dashboard with reported measures/values would also be acceptable. Providers must ensure that the report date matches the EHR reporting period and that the report data values are for the attesting provider only.

  Measures that are reported with the numerator and denominator include:

  - Computerized Physician Order Entry (CPOE)
  - Maintain problem list
  - E-prescribing
  - Active medication list
  - Medication allergy list
  - Record demographics
  - Record vital signs
  - Record smoking status
  - Provide electronic copy of health information
  - Provide clinical summaries
  - Incorporate clinical lab test results

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- Patient reminders
- Patient electronic access
- Patient-specific education resources
- Medication reconciliation
- Transition of care summary

- Yes/No Measures (Core and Menu): For the yes/no measures, Texas Medicaid requires documentation for the following measures:
  - Drug/drug and drug/allergy interaction checks enabled - Providers must include documentation, such as a screenshot or configuration page, that shows this functionality has been turned on at the time of attestation.
  - Clinical Decision Support (CDS) rule implemented - Providers must include documentation, such as a screenshot, that shows a CDS rule has been configured. For example, an upload of a screenshot from an EP's EHR configuration panel showing a CDS rule has been implemented.
  - Conduct security risk analysis: Provide a copy or documentation of a security risk analysis.
  - Generate patient lists: Provide a screenshot of the list or upload the actual list.

  Note: *Personal health information (PHI) must first be removed in all cases.*

  - Public health registry tests - For immunization, electronic lab reporting (ELR) and syndromic surveillance, providers must include documentation, such as an email or letter, from the public health agency that acknowledges the test or ongoing submission. For immunization, the IMMTRAC ID number must also be provided.
  - Drug formulary checks: - Documentation is not required at the time of attestation; however, EPs should maintain an auditable record that demonstrates this measure was achieved.
- Clinical Quality Measures (CQMs): EPs may upload documentation for reported CQMs; however, it is not required during attestation.

1.7.2 How to Return an Electronic Health Records (EHR) Payment

Providers that have received an EHR incentive payment that they do not want or that must be returned to satisfy an EHR accounts receivable must follow the steps below to ensure that the returned payment is credited properly:

1) Download and print the Texas Medicaid Refund Information Form.
2) Fill out the top portion designated for provider information. This information should correspond to the Payee (recipient) of the EHR incentive payment, even if the recipient is different than the attesting provider. The Payee will supply information on the attesting provider in the section below.
3) Skip the claims information section.
4) Fill out the "Reason for the Refund" portion by placing an "X" next to "Other" and providing the following information:
   - "EHR incentive payment refund"
   - Amount
   - Check number on the check you will be sending
   - Name, NPI, and TPI of the attesting provider

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5) Mail the completed form with the check and a copy of the Medicaid Remittance and Status (R&S) Report that shows the EHR payment to the following address:

Texas Medicaid & Healthcare Partnership
Financial Department
12357-B Riata Trace Parkway
Suite 150
Austin, TX 78727

1.7.3 EHR Notification and Appeal Process

HHSC follows policies and procedures defined in 1 TAC Part 15, §354.1450 (Audits of Medicaid Providers) for notification and appeal of audit findings related to overpayments of Texas Medicaid EHR Incentive payments. Providers should refer to the TAC rule for official guidance, definitions, and rules.

Note: *Providers may submit an informal appeal of the findings in the draft audit report by email to HHSC at the following address: EHR_audit_appeals@hhsc.state.tx.us.*

1.8 Computer-Based Training Courses for Providers

TMHP has created a web page to simplify the process of accessing the computer-based training courses that are available on the TMHP Learning Management System (LMS).

The new Computer-Based Training (CBT) web page lists all of the CBT courses that TMHP makes available free of charge to all providers. The web page arranges the CBT titles by the programs they support. Each CBT title has a link to a description of the curriculum and a link to the CBT itself, which resides on the TMHP LMS. Clicking one of the View CBT Now links takes the provider to the LMS where, after the provider logs in, the CBT starts immediately.

The procedure that providers follow to access a CBT has changed to the following:

1) Click **Provider Educatio**n in the left navigation panel of any provider web page. The Provider Education home page appears.
2) Click **Computer-Based Training** in the left navigation panel. The CBT web page appears.
3) Click **View CBT Now** in the same row as the name of the CBT that you want to view. The LMS appears in a new window.
4) Log in to an existing account or create a new account. New visitors to the LMS can take courses immediately after they register. The selected CBT begins as soon as the login is complete.

Additional Improvement to Training Experience

TMHP is taking additional steps to make it easier for providers to get answers to their questions more quickly, including the following:

- TMHP has started to create single-topic "training snapshots" to provide quick training to answer specific needs. Currently, there is only one training snapshot, but more are planned.
- As CBT courses are revised, TMHP is converting many of them to a series of single-topic modules, which are selected from the Main Menu slide for the CBT course. The modular structure makes it easier for providers to get the specific training that they need.

Note: *Even if a CBT course has not yet been converted to modules, providers can jump to a specific section after the course begins by clicking on the Outline tab and selecting a slide from the list that appears.*

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1.9 Enrollment Criteria for Out-of-State Providers

Texas Medicaid covers medical assistance services provided to eligible Texas Medicaid clients while in a state other than Texas, as long as the client does not leave Texas to receive out-of-state healthcare that can be received in Texas. Services provided outside the state are covered to the same extent medical assistance is furnished and covered in Texas.

Note: *Border state providers (providers rendering services within 50 miles driving distance of the Texas border) are considered in-state providers.*

The administrative rules governing the enrollment of out-of-state providers are found in Title 1, Texas Administrative Code (TAC) §352.17. The rule provides that a Medicaid applicant or re-enrolling provider is considered out-of-state if any of the following criteria are met:

- The physical address where services are or will be rendered is located outside the Texas state border and within the United States.
- The physical address where the services or products originate or will originate is located outside the Texas state border and within the United States when providing services, products, equipment, or supplies to a Medicaid recipient in the state of Texas.
- The physical address where services are or will be rendered is located within the Texas state border, but:
  - The applicant or re-enrolling provider maintains all patient records, billing records, or both, outside the Texas state border and
  - The applicant or re-enrolling provider is unable to produce the originals or exact copies of the patient records or billing records, or both, from the location within the Texas state border where services are rendered.

An applicant or re-enrolling provider that is considered out-of-state is ineligible to participate in Medicaid unless HHSC or its designee approves the enrollment on the basis that the applicant has provided, is providing, or will provide services under one or more of the following criteria:

- The services are medically necessary emergency services to a recipient who is located outside of the state.

  Note: *An out-of-state provider seeking enrollment under this criterion must include with the enrollment application a copy of the claim that contains the diagnosis that indicates emergency care or medical record documentation. The documentation must demonstrate that emergency care was provided to a Texas Medicaid client. Providers enrolled under this criterion will be given a time limited enrollment not to exceed one year.*

- The services are medically necessary to a recipient who is located outside of the state, and in the expert opinion of the recipient's attending or other provider, the recipient's health would be or would have been endangered if the recipient were required to travel to Texas.

  Note: *An out-of-state provider seeking enrollment under this criterion must include supporting clinical records, signed by the attending provider, explaining why the client's health would be or would have been endangered if the client had been required to travel to Texas. Providers enrolled under this criterion will be given a time limited enrollment not to exceed one year.*

- The services are medically necessary and more readily available to a recipient in the state where the recipient is located.

  Note: *An out-of-state provider that seeks enrollment under this criterion must include supporting clinical records, signed by the attending provider, explaining why the services are more readily available in the state where the client in located. Providers that are enrolled under this criterion may be enrolled for a limited period of time.*

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- The services are medically necessary to a recipient who is eligible on the basis of participation in an adoption assistance or foster care program administered by the Texas Department of Family and Protective Services under Title IV-E of the Social Security Act.

  Note: *An out-of-state provider that seeks enrollment under this criterion must include documentation showing that the client is an adopted child or is in a foster care program and/or is receiving adoption subsidies through the programs listed in this criterion. Providers that are enrolled under this criterion may be enrolled for a limited period of time.*

- The services are medically necessary and have been prior authorized by HHSC or its designee, and documented medical justification indicating the reasons the recipient must obtain medical care outside Texas is furnished to HHSC or its designee before providing the services and before payment.

  Note: *An out-of-state provider that seeks enrollment under this criterion must include documentation showing that the service has been prior authorized by HHSC or its designee (TMHP, or MCO), or supporting clinical documentation (signed by the attending provider) indicating the reasons why the recipient must obtain medical care outside of Texas. Providers that are enrolled under this criterion may be enrolled for a limited period of time.*

- The services are medically necessary and it is the customary or general practice of Medicaid recipients in a particular locality within Texas to obtain services from the out-of-state provider, if the provider is located in the United States and within 50 miles driving distance from the Texas state border, or as otherwise demonstrated on a case-by-case basis.

  Note: *An out-of-state provider does not meet the criterion in this paragraph merely on the basis of having established business relationships with one or more providers that participate in Medicaid. Attach signed letter from the provider stating why it is customary or general practice of clients in a particular locality within Texas to obtain services from the out-of-state provider. Providers that are enrolled under this criterion may be enrolled for a limited period of time.*

- The services are medically necessary and the nature of the service is such that providers for this service are limited or not readily available within the state of Texas.

  Note: *An out-of-state provider that seeks enrollment under the criterion must include documentation showing that the services provided by the applicant are medically necessary and are limited or not readily available within the state of Texas.*

- The services are medically necessary services to one or more dually eligible recipients (i.e., recipients who are enrolled in both Medicare and Medicaid) and the out-of-state provider may be considered for reimbursement of co-payments, deductibles, and co-insurance, in which case the enrollment will be restricted to receiving reimbursement only for the Medicaid-covered portion of Medicare crossover claims.

  Note: *An out-of-state provider that seeks enrollment under this criterion must include documentation for why this criterion applies, Medicare EOB or MRAN, with documented medical justification as well as any additional information requested by HHSC or its designee. Providers that are enrolled under this criterion may be enrolled for a limited period of time.*

- The services are provided by a pharmacy that is a distributor of a drug that is classified by the U.S. Food and Drug Administration (FDA) as a limited distribution drug.

  Note: *An out-of-state provider that seeks enrollment under this criterion must include with the enrollment application documentation for why this criterion applies with documented medical justification as well as any additional information requested by HHSC or its designee. Attach signed letter from the provider stating that the enrolling pharmacy is a distributor of a drug that is classified by FDA as a limited distribution drug, include a letter from the FDA stating that the aforementioned drug is considered a limited distribution drug. Providers that are enrolled under this criterion may be enrolled for a limited period of time.*

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- The services are medically necessary and one or more of the following exceptions for good cause exist and can be documented:
  - Texas Medicaid enrolled providers rely on the services provided by the applicant.
  - Applicant maintains existing agreements as a participating provider through one or more Medicaid managed care organizations (MCO) and enrollment of the applicant leads to more cost-effective delivery of Medicaid services.
- A laboratory may participate as an in-state provider under any program administered by a health and human services agency, including HHSC, that involves laboratory services, regardless of the location where any specific service is performed or where the laboratory's facilities are located if:
  - The laboratory or an entity that is a parent, subsidiary, or other affiliate of the laboratory maintains laboratory operations in Texas;
  - The laboratory and each entity that is a parent, subsidiary, or other affiliate of the laboratory, individually or collectively, employ at least 1,000 persons at places of employment located in this state; and
  - The laboratory is otherwise qualified to provide the services under the program and is not prohibited from participating as a provider under any benefits programs administered by a health and human services agency, including HHSC, based on conduct that constitutes fraud, waste, or abuse.

Out-of-state provides that seek enrollment under one or more of the above criteria must submit an enrollment application and be approved for enrollment.

TMHP must receive claims from out-of-state providers within 365 days from the date of service.

Refer to: Subsection 10.2.1, "Prior Authorization" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)*.

1.10 Medicaid Waste, Abuse, and Fraud Policy

The OIG has the responsibility to identify and investigate cases of suspected waste, abuse, and fraud in Medicaid and other health and human services programs. This responsibility, granted through state and federal law, gives the OIG the authority to pursue administrative sanctions and to refer cases to prosecutors, licensure and certification boards, and other agencies. Additionally, Texas Medicaid is required to disenroll or exclude any provider who has been disenrolled or excluded from Medicare or any other state health-care program.

Anyone participating in Texas Medicaid must understand the requirements for participation. Available methods both to learn and stay up to date on program requirements include the following:

- *Provider education*. Attendance at educational workshops and training sessions. Regular training opportunities are offered by TMHP.
- *Texas Medicaid publications*. These include the *Texas Medicaid Provider Procedures Manual* and banner messages, which are included in R&S Reports.
- *All adopted agency rules*. These include those related to fraud, waste, and abuse contained in 1 TAC Chapter 371.
- *State and federal law*. Statutes and other law pertinent to Texas Medicaid and fraud, waste, and abuse within Texas Medicaid.

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In addition, providers are responsible for the delivery of health-care items and services to Medicaid clients in accordance with all applicable licensure and certification requirements and accepted health care professionals' community standards. Such standards include those related to medical record and claims filing practices, documentation requirements, and records maintenance. The TAC requires providers to follow these standards. For more information, consult 1 TAC §371.1659.

Texas Medicaid providers must follow the coding and billing requirements of the *Texas Medicaid Provider Procedures Manual* (TMPPM). However, if coding and billing requirements for a particular service are not addressed in the TMPPM, and if coding and billing requirements are not otherwise specified in program policy (such as in provider bulletins or banners), then providers must follow the most current coding guidelines. These include:

- CPT as set forth in the American Medical Association's most recently published "CPT books", "CPT Assistant" monthly newsletters, and other publications resulting from the collaborative efforts of American Medical Association with the 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 the CMS and as explained in the NCCI Policy and Medicare Claims Processing Manuals. NCCI consists of procedure code combinations 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 use of modifiers some of which are not currently recognized by Texas Medicaid. See the list of modifiers utilized by Texas Medicaid in subsection 6.3.5, "Modifiers" in* Section 6, "Claims Filing" (*Vol. 1, General Information*).

- *Current Dental Terminology* (CDT) as published by the American Dental Association (ADA).
- Other publications resulting from the collaborative efforts of the ADA with dental societies.
- *International Classification of Diseases*, 9th Revision, Clinical Modification (ICD-9-CM).
- *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (DSM-IV-TR).

Failure to comply with the guidelines provided in these publications may result in a provider being found to have engaged in one or more program violations listed in 1 TAC §371.1659.

All providers are held responsible for any claims preparation or other activities that may be performed under the provider's authority. For example, providers are held responsible for any omissions and the accuracy of submitted information, even if those actions are performed by office staff, contractors, or billing services. This, however, does not absolve these other individuals for their participation in any documents provided to the state or designee with false, inaccurate, or misleading information; or pertinent omissions.

HHSC-OIG may impose one or any combination of administrative actions or administrative sanctions on Texas Medicaid providers or other persons when fraud, waste, or abuse is determined. Those who may be sanctioned include:

- Those furnishing services or items directly or indirectly.
- Those billing for services.
- Those violating any of the provisions delineated in this section.
- Affiliates of a provider or person violating any of the provisions delineated in this section.

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Administrative sanctions include, without limitation:

- Exclusion from program participation for a specified period of time, permanently, or indefinitely. Anyone excluded from Texas Medicaid is also automatically excluded from all programs under Titles V and XX of the Social Security Act.
- Suspension of Medicaid payments (payment hold) to a provider.
- Recoupment of Medicaid overpayments, including any overpayments determined through statistical sampling and extrapolation.
- Restricted Medicaid reimbursement (specific services will not be reimbursed to an individual provider during the time the provider is on restricted reimbursement; however, reimbursement for other services may continue).
- Cancellation of the Medicaid provider agreement (however, a deactivation in accordance with the agreement itself is not considered a sanction).
- Exclusion or suspension under the authority of the CFR.

Administrative actions include:

- Amending a provider agreement so that it will deactivate on a specific date.
- Granting an agreement or transferring a provider to an agreement with special terms or conditions, including a probationary agreement.
- Required attendance at provider education sessions.
- Prior authorization of selected services.
- Pre-payment review.
- Post-payment review.
- Required attendance at informal or formal provider corrective action meetings.
- Submission of additional documentation or justification that is not normally required to accompany submitted claims. (Failure to submit legible documentation or justification requested will result in denial of the claim.)
- Oral, written, or personal educational contact with the provider.
- Posting of a surety bond or providing a letter of credit.
- Having a subpoena served to compel an appearance for testimony or the production of relevant evidence, as determined by the HHSC-OIG.

Anyone facing an administrative sanction has a right to formal due process. This formal due process may include a hearing before an administrative law judge. Conversely, anyone facing an administrative action is not entitled to formal due process. People who induce, solicit, receive, offer, or pay any remuneration (including, but not limited to, bribes, kickbacks, or rebates) directly or indirectly in relation to referrals, purchases, leases, or arrangements of services covered by Medicare or Texas Medicaid may be in violation of state statutes and guilty of a federal felony offense. State law also allows for the suspension of providers convicted of a criminal offense related to Medicare or Texas Medicaid. The commission of a felony in Medicaid or Medicare programs may include fines or imprisonment ranging from five years to life in prison. Examples of inducements include a service, cash in any amount, entertainment, or any item of value.

As stated in 1 TAC §§371.1651-371.1669, following is a nonexclusive list of grounds or criteria for the Inspector General's administrative enforcement and/or referral for criminal, civil, or licensure or certification investigation and judicial action regarding program violations by any provider or person. Violations result from a provider or person who knew or should have known the following were viola-

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tions. The headings of each group listed below are provided solely for organization and convenience and are not elements of any program violation.

1) Claims and Billing.

   a) Submitting or causing to be submitted a false statement or misrepresentation, or omitting pertinent facts when claiming payment under the Texas Medicaid or other HHS program or when supplying information used to determine the right to payment under the Texas Medicaid or other HHS program;

   b) Submitting or causing to be submitted a false statement, information or misrepresentation, or omitting pertinent facts to obtain greater compensation than the provider is legally entitled to;

   c) Submitting or causing to be submitted a false statement, information or misrepresentation, or omitting pertinent facts to meet prior authorization requirements;

   d) Submitting or causing to be submitted under Title XVIII (Medicare) or a state health-care program claims or requests for payment containing unjustified charges or costs for items or services that substantially exceed the person's usual and customary charges or costs for those items or services to the public or the private pay patients unless otherwise authorized by law;

   e) Submitting or causing to be submitted claims with a pattern of inappropriate coding or billing that results in excessive costs to the Texas Medicaid or other HHS program;

   f) Billing or causing claims to be filed for services or merchandise that were not provided to the recipient;

   g) Submitting or causing to be submitted a false statement or misrepresentation that, if used, has the potential of increasing any individual or state provider payment rate or fee;

   h) Submitting or causing to be submitted to the Texas Medicaid or other HHS program a cost report containing costs not associated with Texas Medicaid or other HHS program or not permitted by Texas Medicaid or other HHS program policies;

   i) Presenting or causing to be presented to an operating agency or its agent a claim that contains a statement or representation that the person knows or should have known to be false;

   j) Billing or causing claims to be submitted to the Texas Medicaid or other HHS program for services or items furnished personally by, at the medical direction of, or on the prescription or order of a person who is excluded from Texas Medicaid, other HHS program, or Medicare or has been excluded from and not reinstated within Texas Medicaid, other HHS program, or Medicare;

   k) Billing or causing claims to be submitted to the Texas Medicaid or other HHS program for services or items that are not reimbursable by the Texas Medicaid or other HHS program;

   l) Billing or causing claims to be submitted to the Texas Medicaid or other HHS program for a service or item which requires a prior order or prescription by a licensed health-care practitioner when such order or prescription has not been obtained;

   m) Billing or causing claims to be submitted to the Texas Medicaid or other HHS program for an item or service substituted without authorization for the item or service ordered, prescribed or otherwise designated by the Texas Medicaid or other HHS program;

   n) Billing or causing claims to be submitted to the Texas Medicaid or other HHS program by a provider or person who is owned or controlled, directly or indirectly, by an excluded person; *and*

   o) Billing or causing claims to be submitted to the Texas Medicaid or other HHS program by a provider or person for charges in which the provider discounted the same services for any other type of patient.

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2) Records and Documentation.

a) Failing to maintain for the period of time required by the rules relevant to the provider in question records and other documentation that the provider is required by federal or state law or regulation or by contract to maintain in order to participate in the Texas Medicaid or other HHS program or to provide records or documents upon request for any records or documents determined necessary by the Inspector General to complete their statutory functions related to a fraud and abuse investigation. Such records and documentation include, without limitation, those necessary:

i) To verify specific deliveries, medical necessity, medical appropriateness, and adequate written documentation of items or services furnished under Title XIX or Title XX;

ii) To determine in accordance with established rates appropriate payment for those items or services delivered;

iii) To confirm the eligibility of the provider to participate in the Texas Medicaid or other HHS program; e.g., medical records (including, without limitation, X-rays, laboratory and test results, and other documents related to diagnosis), billing and claims records, cost reports, managed care encounter data, financial data necessary to demonstrate solvency of risk-bearing providers, and documentation (including, without limitation, ownership disclosure statements, articles of incorporation, by-laws, and corporate minutes) necessary to demonstrate ownership of corporate entities; *and*

iv) To verify the purchase and actual cost of products;

b) Failing to disclose fully and accurately or completely information required by the Social Security Act and by 42 CFR Part 455, Subpart B; 42 CFR Part 420, Subpart C; 42 CFR §1001.1101; and 42 CFR Part 431;

c) Failing to provide immediate access, upon request by a requesting agency, to the premises or to any records, documents, and other items or equipment the provider is required by federal or state law or regulation or by contract to maintain in order to participate in the Texas Medicaid or other HHS program (see subparagraphs (a) and (b) of this paragraph), or failing to provide records, documents, and other items or equipment upon request that are determined necessary by the Inspector General to complete their statutory functions related to a fraud and abuse investigation, including without limitation all requirements specified in 1 TAC §§371.1701, 371.1703, 371.1705, 371.1707, 371.1709, 371.1711, 371.1713, and 371.1715 of this subchapter. "Immediate access" is deemed to be within 24 hours of receiving a request, unless the requesting agency has reason to suspect fraud or abuse or to believe that requested records, documents, or other items or equipment are about to be altered or destroyed, thereby necessitating access at the actual time the request is presented or, in the opinion of the Inspector General, the request may be completed at the time of the request and/or in less than 24 hours;

d) Developing false source documents or failing to sign source documents or to retain supporting documentation or to comply with the provisions or requirements of the operating agency or its agents pertaining to electronic claims submittal; *and*

e) Failing as a provider, whether individual, group, facility, managed care or other entity, to include within any subcontracts for services or items to be delivered within Texas Medicaid all information that is required by 42 CFR §434.10(b).

3) Program-Related Convictions.

a) Pleading guilty or nolo contendere, agreeing to an order of probation without adjudication of guilt under deferred adjudication, or being a defendant in a court judgment or finding of guilt for a violation relating to performance of a provider agreement or program violation of Medicare, Texas Medicaid, other HHS program, or any other state's Medicaid program;

b) Pleading guilty or being convicted of a violation of state or federal statutes relating to dangerous drugs, controlled substances, or any other drug-related offense;

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c) Pleading guilty of, being convicted of, or engaging in conduct involving moral turpitude;

d) Pleading guilty or being convicted of a violation of state or federal statutes relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct relating to the delivery of a health-care item or service or relating to any act or omission in a program operated or financed by any federal, state, or local government agency;

e) Being convicted in connection with the interference with or obstruction of any investigation into any criminal offense that would support mandatory exclusion under 1 TAC §371.1705 of this subchapter or any offense listed within paragraph (3) of this subsection regarding program-related convictions; *and*

f) Being convicted of any offense that would support mandatory exclusion under 1 TAC §371.1705 of this subchapter.

4) Provider Eligibility.

a) Failing to meet standards required for licensure, when such licensure is required by state or federal law, administrative rule, provider agreement, or provider manual for participation in the Texas Medicaid or other HHS program;

b) Being excluded, suspended or otherwise sanctioned within any federal program involving the provision of health care;

c) Being excluded, suspended or otherwise sanctioned under any state health-care program for reasons bearing on the person's professional competence, professional performance or financial integrity;

d) Failing to fully and/or correctly complete a Provider Enrollment Agreement, Provider Re-enrollment Agreement or other enrollment form prescribed by the relevant operating agency or its agent for enrollment; *and*

e) Loss or forfeiture of corporate charter.

5) Program Compliance.

a) Failing to comply with the terms of the Texas Medicaid or other HHS program contract or provider agreement, assignment agreement, the provider certification on the Texas Medicaid or other HHS program claim form, or rules or regulations published by the Commission or a Medicaid or other HHS operating agency;

b) Violating any provision of the Human Resources Code, Chapter 32 or 36, or any rule or regulation issued under the Code;

c) Submitting a false statement or misrepresentation or omitting pertinent facts on any application or any documents requested as a prerequisite for the Texas Medicaid or other HHS program participation;

d) Refusing to execute or comply with a provider agreement or amendments when requested;

e) Failing to correct deficiencies in provider operations after receiving written notice of them from an operating agency, the commission or their authorized agents;

f) Failing to abide by applicable federal and state law regarding handicapped individuals or civil rights;

g) Failing to comply with the Texas Medicaid or other HHS program policies, published Texas Medicaid or other HHS program bulletins, policy notification letters, provider policy or procedure manuals, contracts, statutes, rules, regulations, or interpretation previously sent to the provider by an operating agency or the commission regarding any of the authorities listed above, including statutes or standards governing occupations;

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h) Failing to fully and accurately make any disclosure required by the Social Security Act, §1124 or §1126;

i) Failing to disclose information about the ownership of a subcontractor with whom the person has had business transactions in an amount exceeding $25,000 during the previous 12 months or about any significant business transactions (as defined by HHS) with any wholly-owned supplier or subcontractor during the previous five years;

j) Failing, as a hospital, to comply substantially with a corrective action required under the Social Security Act, §1886(f)(2)(B);

k) Failing to repay or make arrangements that are satisfactory to the commission to repay identified overpayments or other erroneous payments or assessments identified by the commission or any Texas Medicaid or other HHS program operating agency;

l) Committing an act described as grounds for exclusion in the Social Security Act, §1128A (civil monetary penalties for false claims) or §1128B (criminal liability for health care violations);

m) Defaulting on repayments of scholarship obligations or items relating to health profession education made or secured, in whole or in part, by HHS or the state when they have taken all reasonable steps available to them to secure repayment;

n) Soliciting or causing to be solicited, through offers of transportation or otherwise, Texas Medicaid or other HHS program recipients for the purpose of delivering to those recipients health-care items or services;

o) Marketing, supplying or selling confidential information (e.g., recipient names and other recipient information) for a use that is not expressly authorized by the Texas Medicaid or other HHS program; *and*

p) Failing to abide by applicable statutes and standards governing providers.

Important: *Providers must comply with their applicable licensing agency's laws and regulations, including any related to marketing and advertising, and any applicable state and federal laws and regulations, contractual requirements, and other guidance documents. Providers are encouraged to review the "Provider Marketing Guidelines," which are available on the TMHP website at www.tmhp.com.*

6) Delivery of Health-Care Services.

a) Failing to provide health-care services or items to Texas Medicaid or other HHS program recipients in accordance with accepted medical community standards or standards required by statute, regulation, or contract, including statutes and standards that govern occupations;

b) Furnishing or ordering health-care services or items for a recipient-patient under Title XVIII or a state health-care program that substantially exceed the recipient's needs, are not medically necessary, are not provided economically or are of a quality that fails to meet professionally recognized standards of health care; *and*

c) Engaging in any negligent practice that results in death, injury, or substantial probability of death or injury to the provider's patients.

7) Improper Collection and Misuse of Funds.

a) Charging recipients for services when payment for the services was recouped by the Texas Medicaid or another HHS program for any reason;

b) Misapplying, misusing, embezzling, failing to promptly release upon a valid request, or failing to keep detailed receipts of expenditures relating to any funds or other property in trust for a Texas Medicaid or other HHS program recipient;

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c) Failing to notify and reimburse the relevant operating agency or the commission or their agents for services paid by the Texas Medicaid or other HHS programs if the provider also receives reimbursement from a liable third party;

d) Rebating or accepting a fee or a part of a fee or charge for a Texas Medicaid or other HHS program patient referral;

e) Requesting from a recipient in payment for services or items delivered within the Texas Medicaid or other HHS program any amount that exceeds the amount the Texas Medicaid or other HHS program paid for such services or items, with the exception of any cost-sharing authorized by the program; *and*

f) Requesting from a third party liable for payment of the services or items provided to a recipient under the Texas Medicaid or other HHS program, any payment other than as authorized at 42 CFR §447.20.

8) Licensure Actions.

a) Having a voluntary or involuntary action taken by a licensing or certification agency or board that requires the provider or employee to comply with professional practice requirements of the board after the board receives evidence of noncompliance with licensing or certification requirements; *and*

b) Having its license to provide health care revoked, suspended, or probated by any state licensing or certification authority, or losing a license or certification, because of action based on assessment of the person's professional competence, professional performance, or financial integrity, non-compliance with Health and Safety Code, statutes governing occupations, or surrendering a license or certification while a formal disciplinary proceeding is pending before licensing or certification authorities when the proceeding concerns the person's professional competence, professional performance, or financial integrity.

9) MCOs and Persons Providing Services or Items Through Managed Care.

Note: *This paragraph includes those program violations that are unique to managed care; paragraphs (1) through (8) and (11) of this section also apply to managed care.*

a) Failing, as an MCO, or an association, group or individual health-care provider furnishing services through an MCO, to provide to recipient enrollee a health-care benefit, service or item that the organization is required to provide under its contract with an operating agency;

b) Failing, as an MCO or an association, group or individual health-care provider furnishing services through an MCO, to provide to an individual a health-care benefit, service or item that the organization is required to provide by state or federal law, regulation or program rule;

c) Engaging, as an MCO, in actions that indicate a pattern of wrongful denial or payment for a health-care benefit, service or item that the organization is required to provide under its contract with an operating agency;

d) Engaging, as an MCO, in actions that indicate a pattern of wrongful delay of at least 45 days or a longer period specified in the contract with an operating agency, not to exceed 60 days, in making payment for a health-care benefit, service or item that the organization is required to provide under its contract with an operating agency;

e) Engaging, as an MCO or an association, group or individual health-care provider furnishing services through managed care, in a fraudulent activity in connection with the enrollment in the organization's managed care plan of an individual eligible for medical assistance or in connection with marketing the organization's services to an individual eligible for medical assistance;

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f) Discriminating against enrollees or prospective enrollees on any basis, including, without limitation, age, gender, ethnic origin or health status;

g) Failing, as an MCO, to comply with any term within a contract with a Texas Medicaid or other HHS program operating agency to provide healthcare services to Texas Medicaid or HHS program recipients; and

h) Failing, as an MCO, reasonably to provide to the relevant operating agency, upon its written request, encounter data and/or other data contractually required to document the services and items delivered by or through the MCO to Texas Medicaid or other HHS program recipients.

10) Cost-Report Violations.

a) Reporting noncovered or nonchargeable services as covered items; e.g., incorrectly apportioning or allocating costs on cost reports; including costs of noncovered services, supplies or equipment in allowable costs; arrangements between providers and employees, related parties, independent contractors, suppliers, and others that appear to be designed primarily to overstate the costs to the program through various devices (such as commissions or fee splitting) to siphon-off or conceal illegal profits;

b) Reporting costs not incurred or which were attributable to nonprogram activities, other enterprises or personal expenses;

c) Including unallowable cost items on a cost report;

d) Manipulating or falsifying statistics that result in overstatement of costs or avoidance of recoupment, such as incorrectly reporting square footage, hours worked, revenues received, or units of service delivered;

e) Claiming bad debts without first genuinely attempting to collect payment;

f) Depreciating assets that have been fully depreciated or sold or using an incorrect basis for depreciation; *and*

g) Reporting costs above the cost to the related party.

11) Kickbacks and Referrals.

a) Violating any of the provisions specified in 1 TAC §371.1655 (30) of this subchapter relating to kickbacks, bribes, rebates, referrals, inducements, or solicitation;

b) As a physician, referring a Texas Medicaid or other HHS program patient to an entity with which the physician has a financial relationship for the furnishing of designated health services, payment for which would be denied under Title XVIII (Medicare) pursuant to §1877 and §1903(s) of the Social Security Act (Stark I and II). Neither federal financial participation nor this state's expenditures for medical assistance under the state Medicaid plan may be used to pay for services or items delivered within the program and within a relationship that violates Stark I or II. The Commission hereby references and incorporates within these rules the federal regulations promulgated pursuant to Stark I and II, and expressly recognizes all exceptions to the prohibitions on referrals established within those rules;

c) Failing to disclose documentation of financial relationships necessary to establish compliance with Stark I and II, as set forth in subparagraph (b) of this paragraph; *and*

d) Offering to pay or agreeing to accept, directly or indirectly, overtly or covertly any remuneration in cash or in kind to or from another for securing or soliciting a patient or patronage for or from a person licensed, certified, or registered or enrolled as a provider or otherwise by a state health-care regulatory or health and human service agency.

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Involvement in any of these practices may result in provider exclusion or suspension from Texas Medicaid. Providers are notified in writing of any actions taken as well as procedures for appeal and reinstatement. The written notification will specify the date on which Medicaid program participation may resume. The reinstated person may then apply for a contract or provider agreement.

Providers and individuals who have been excluded from Texas Medicaid may be reinstated only by HHSC-OIG. If HHSC-OIG approves an individual's request for reinstatement, a written notice will be sent to that individual. The provider must first be reinstated into Medicaid and receive written notification specifying the date on which Medicaid program participation may resume. Once the provider has been reinstated into Medicaid, the provider may then apply for a contract or provider agreement.

Full investigation of criminal Medicaid fraud is the MFCU's responsibility and may result in a felony or misdemeanor criminal conviction.

1.10.1 Reporting Waste, Abuse, and Fraud

Anyone with knowledge about suspected Medicaid waste, abuse, or fraud of provider services must report the information to the HHSC-OIG. To report waste, abuse, or fraud, visit www.hhs.state.tx.us and select **Reporting Waste, Abuse, and Fraud**. Waste, abuse, and fraud may also be reported by calling the OIG hotline at 1-800-436-6184. All reports of waste, abuse, or fraud received through either channel remain confidential.

HHSC-OIG encourages providers to voluntarily investigate and report fraud, waste, abuse, or inappropriate payments of Medicaid funds in their own office. Providers are required to report these activities to HHSC-OIG when identified. HHSC-OIG will work collaboratively with self-reporting providers. More information about provider self-reporting is available on the OIG website at https://oig.hhsc.texas.gov/providers.

1.10.2 Suspected Cases of Provider Waste, Abuse, and Fraud

HHSC-OIG is responsible for minimizing waste, abuse, and fraud by Medicaid providers. HHSC-OIG has established and continues to refine criteria for identifying cases of possible waste, abuse, or fraud and recouping provider overpayments. When HHSC-OIG identifies fraud, waste, and abuse, a case may be referred to the MFCU or Antitrust and Civil Medicaid Fraud Section, or result in administrative enforcement.

1.10.3 Employee Education on False Claims Recovery

United States Code (U.S.C.), Title 42, §1396a(a)(68) requires any entity that receives or makes annual Medicaid payments of at least $5,000,000 to establish written policies that provide detailed information about each employee's role in preventing and detecting waste, fraud, and abuse in federal health-care programs. These written policies, which must apply to all employees of the entity (including management) as well as the employees of any contractor or agent of the entity, must address:

- The federal False Claims Act (31 U.S.C. §§ 3729-3733).
- Administrative remedies for false claims and statements as provided in 31 U.S.C. §3802.
- Texas law relating to civil and criminal penalties for false claims (including Chapter 36 of the Human Resources Code; section 35A.02 of the Penal Code; Title 1, Chapter 371, Subchapter G of the TAC; and other applicable law).
- Whistleblower protections under the above laws (including section 36.115 of the Human Resources Code).

In addition, these written policies must include detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse. The entity must also include a specific discussion of the following in all employee handbooks:

- The above laws

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- The entity's policies and procedures for detecting and preventing fraud, waste, and abuse
- The rights of employees to be protected as whistleblowers

TMHP sends a yearly letter to each provider that receives over $5,000,000 in Medicaid payments. This letter requires providers to verify that they have educated their staff on the False Claims Act. Failure to return this letter, signed by the provider, may result in an administrative hold on the provider's Texas Medicaid payments.

1.10.4 Managed Care Organization (MCO) Special Investigative Unit (SIU)

All MCOs that contract with HHSC to administer managed care benefits to Texas Medicaid clients are required to establish and maintain an SIU that works in cooperation with HHSC-OIG and the OAG.

Refer to: 1 TAC §533.012, §531.113, §531.1131, §353.501-353.505, and 370.501-370.505 for additional information.

The MCO and SIU will do the following:

- The MCO must maintain the SIU within the MCO or contract with another entity for any investigation.
- The established SIU will identify and investigate cases of suspected waste, abuse, and fraud in Texas Medicaid in accordance with Title 1, Chapter 353, Subchapter F of the TAC.
- The MCO and SIU (as applicable) must submit the following:
  - An annual plan that has been adopted by the MCO and approved by HHSC-OIG describing how it will prevent and reduce fraud and abuse in accordance with 1 TAC, §§353.501 and 353.502.
  - A monthly open case list to OIG Medicaid Program Integrity and the MFCU.

The MCO will refer a case to both HHSC-OIG and MFCU in the following situations:

- When waste, abuse or fraud is discovered in the Medicaid or CHIP programs. (The MCO SIU must immediately notify the HHSC-OIG and MFCU and begin payment recovery efforts, unless HHSC-OIG or MFCU notifies the MCO to stop the recovery effort, as provided in Texas Government Code §531.1131.)
- When possible waste, abuse, or fraud is discovered in the Medicaid or CHIP programs. (The MCO SIU must refer the alleged fraud or abuse to HHSC-OIG within 30 working days of completing a review. The SIU report and referral must completely and accurately detail its findings in accordance with 1 TAC §353.502.)
- When there is reason to believe that a delay in the referral may result in:
  - Harm or death to patients
  - Loss, destruction, or alteration of valuable evidence
  - Significant monetary loss that may not be recoverable
  - Hindrance of an investigation or criminal prosecution of the offense

1.11 Texas Medicaid Limitations and Exclusions

Medicaid pays for services on behalf of clients to the provider of service according to Texas Medicaid's limitations and procedures. TMHP does not make Medicaid payments directly to clients.

The following services, supplies, procedures, and expenses are not benefits of Texas Medicaid. This list is *not* all inclusive.

- Autopsies

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- Care and treatment related to any condition for which benefits are provided or available under Workers' Compensation laws
- Cellular therapy
- Chemolase injection (chymodiactin, chymopapain)
- Dentures or endosteal implants for adults
- Ergonovine provocation test
- Excise tax
- Fabric wrapping of abdominal aneurysms
- Hair analysis
- Heart–lung monitoring during surgery
- Histamine therapy–intravenous
- Hyperthermia
- Hysteroscopy for infertility
- Immunizations or vaccines unless they are otherwise covered by Texas Medicaid (These limitations do not apply to services provided through the THSteps Program.)
- Immunotherapy for malignant diseases
- Infertility
- Inpatient hospital services to a client in an institution for tuberculosis, mental disease, or a nursing section of public institutions for persons with intellectual disabilities
- Inpatient hospital tests that are not specifically ordered by a provider who is responsible for the diagnosis or treatment of the client's condition
- Intragastric balloon for obesity
- Joint sclerotherapy
- Keratoprosthesis/refractive keratoplasty
- Laetrile
- Mammoplasty for gynecomastia
- More than $200,000 per client per benefit year (November 1 through October 31) for any health-care and remedial care services provided to a hospital inpatient by the hospital (If the $200,000 amount is exceeded because of an admission for an approved organ transplant, the allowed amount for that claim is excluded from the computation. This limitation does not apply to clients eligible for CCP or clients with an organ transplant.)
- More than 30 days of inpatient hospital stay per spell of illness (Each spell of illness must be separated by 60 consecutive days during which the client has not been an inpatient in a hospital.)

Important: *CCP provides medically necessary, federally allowable treatment for Medicaid/THSteps clients who are 20 years of age and younger. Some health-care services that usually would not be covered under Medicaid may be available to CCP-eligible clients. An additional 30-day spell of illness begins with the date of specified covered organ transplant. No spell-of-illness limitation exists for Medicaid THSteps clients who are 20 years of age and younger.*

- Obsolete diagnostic tests

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- Oral medications, except when claims are submitted by a hospital for services that are provided given in the emergency room or the inpatient setting (Hospital take-home drugs or medications given to the client are not a benefit.)

Important: *Outpatient prescription medications are covered through the Medicaid Vendor Drug Program. See Appendix B: Vendor Drug Program for more information.*

- Orthoptics (except CCP)
- Outpatient and nonemergency inpatient services provided by military hospitals
- Outpatient behavioral health services performed by a licensed chemical dependency counselor (LCDC), psychiatric nurse, mental health worker, non-licensed clinical social worker (LCSW), or psychological associate (excluding a Masters-level licensed psychological associate [LPA]) regardless of physician or licensed psychologist supervision
- Oxygen (except CCP and home health)
- Parenting skills
- Payment for eyeglass materials or supplies regardless of cost if they do not meet Texas Medicaid specifications
- Payment to physicians for supplies (All supplies, including anesthetizing agents such as *Xylocaine*, inhalants, surgical trays, or dressings, are included in the surgical payment.)
- Podiatry, optometric, and hearing aid services in long term care facilities, unless ordered by the attending physician
- Private room facilities except when:
  - A critical or contagious illness exists that results in disturbance to other patients and is documented as such.
  - It is documented that no other rooms are available for an emergency admission.
  - The hospital only has private rooms.
- Procedures and services considered experimental or investigational
- Prosthetic and orthotic devices (except CCP)
- Prosthetic eye or facial quarter
- Psychiatric services:
  - Outpatient behavioral health services for which no prior authorization has been given

Refer to: Section 4, "Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), and Licensed Professional Counselor (LPC)" in the *Behavioral Health, Rehabilitation, and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*).

Section 6, "Physician, Psychologist, and Licensed Psychological Associate (LPA) Providers" in the *Behavioral Health, Rehabilitation, and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*).

- Quest test (infertility)
- Recreational therapy
- Review of old X-ray films
- Routine cardiovascular and pulmonary function monitoring during the course of a surgical procedure under anesthesia

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- Separate fees for completing or filing a Medicaid claim form (The cost of claims filing is to be incorporated in the provider's usual and customary charges to all clients.)
- Services and supplies to any resident or inmate in a public institution
- Services or supplies for which benefits are available under any other contract, policy, or insurance, or which would have been available in the absence of Texas Medicaid
- Services or supplies for which claims were not received within the filing deadline
- Services or supplies that are not reasonable and necessary for diagnosis or treatment
- Services or supplies that are not specifically provided by Texas Medicaid
- Services or supplies provided in connection with cosmetic surgery except:
  - As required for the prompt repair of accidental injury
  - For improvement of the functioning of a malformed body member
  - When prior authorized for specific purposes by TMHP (including removal of keloid scars)
- Services or supplies provided outside of the U.S., except for deductible or coinsurance portions of Medicare benefits as provided for in this manual
- Services or supplies provided to a client after a finding has been made under utilization review procedures that these services or supplies are not medically necessary
- Services or supplies provided to a Texas Medicaid client before the effective date of his or her designation as a client, or after the effective date of his or her denial of eligibility
- Services that are payable by any health, accident, other insurance coverage, or any private or other governmental benefit system, or any legally liable third party
- Services that are provided by an interpreter (except sign language interpreting services requested by a physician)
- Services that are provided by ineligible, suspended, or excluded providers
- Services that are provided by the client's immediate relative or household member
- Services that are provided by Veterans Administration facilities or U.S. Public Health Service Hospitals
- Sex change operations
- Silicone injections
- Social and educational counseling except for certain health and disability related and counseling services
- Sterilization reversal
- Sterilizations (including vasectomies) unless the client has given informed consent 30 days before surgery, is mentally competent, and is 21 years of age or older at the time of consent (This policy complies with 42 CFR §441.250, Subpart F.)
- Take-home and self-administered drugs except as provided under the Vendor Drug or family planning pharmacy services or for clients being treated for a substance use disorder
- Tattooing (commercial or decorative only)
- Telephone calls with clients or pharmacies (except as allowed for case management)
- Thermogram

- Treatment of flatfoot conditions for solely cosmetic purposes, the prescription of supportive devices (including special shoes), and the treatment of subluxations of the foot

Refer to the applicable handbooks in Volume 2 of this manual for additional information.

1.12 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Authorization to Release Confidential Information
Authorization to Release Confidential Information (Spanish)
Child Abuse Reporting Guidelines
Child Abuse Reporting Guidelines--Checklist for HHSC Monitoring
Disclosure of Ownership
Electronic Funds Transfer (EFT) Notification
Electronic Health Record (EHR) Incentive Program Limited Provider Enrollment Application
HHSC Medicaid Provider Agreement
Meaningful User Attestation Instructions - Stage 1
Physician Assistants in FQHCs and RHCs: PA-Led Attestation Form
Physician's Letter of Agreement
Private Pay Agreement
Provider EVV Vendor Selection Form
Provider Information Form (PIF-1)
Provider Information Change Form
Texas Medicaid Group Volume Consent Form

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Section 2: Texas Medicaid Fee-for-Service Reimbursement

Texas Medicaid Provider Procedures Manual: Vol. 1

April 2016

TEXAS
Health and Human
Services Commission

SECTION 2: TEXAS MEDICAID FEE-FOR-SERVICE REIMBURSEMENT

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2.1 Payment Information

Texas Medicaid reimbursements are available to all enrolled providers by check or electronic funds transfer (EFT).

Refer to: Subsection 1.2, "Payment Information" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

2.2 Fee-for-Service Reimbursement Methodology

Texas Medicaid reimburses providers using several different reimbursement methodologies, including fee schedules, reasonable cost with interim rates, hospital reimbursement methodology, provider-specific encounter rates, reasonable charge payment methodology, and manual pricing. Each Texas Medicaid service describes the appropriate reimbursement for each service area.

Note: *If a client is covered by a Medicaid managed care organizations (MCO) or dental plan, providers must contact the client's MCO or dental plan for reimbursement information. The MCOs and dental plans are not required to follow the Texas Medicaid fee schedules, so there may be some differences in reimbursement based on decisions made by the individual health and dental plans.*

2.2.1 Online Fee Lookup (OFL) and Static Fee Schedules

Texas Medicaid reimburses certain providers based on rates published in the OFL and static fee schedules. These rates are uniform statewide and by provider type. According to this type of reimbursement methodology, the provider is paid the lower of the billed charges or the Medicaid rate published in the applicable static fee schedule or OFL.

Providers can obtain fee information using the OFL functionality on the TMHP website at www.tmhp.com.

The online OFL can be used to:

- Retrieve real-time fee information.
- Search for procedure code reimbursement rates individually, in a list, or in a range.
- Search and review contracted rates for a specific provider (provider must login).
- Retrieve up to 24 months of history for a procedure code by searching for specific dates of service within that 2-year period.
- Search for benefit limitations for dental and durable medical equipment (DME) procedure codes.

Providers can obtain the static fee schedules as *Microsoft Excel*® spreadsheets or portable document format (PDF) files from the TMHP website at www.tmhp.com.

Type of service (TOS) codes payable for each procedure code are available on the OFL and the static fee schedules.

The following provider types are reimbursed based on rates published with the rates calculated in accordance with the referenced reimbursement methodology as published in the Texas Administrative Code (TAC), Part 1 Administration, Part 15 Texas Health and Human Services Commission (HHSC), and Chapter 355 Reimbursement Rates.

- *Ambulance.* The Medicaid rates for ambulance services are calculated in accordance with 1 TAC §355.8600.
- *Ambulatory Surgical Center (ASC).* The Medicaid rates for ASCs are calculated in accordance with 1 TAC §355.8121.
- *Case Management for Children and Pregnant Women*. The Medicaid rates for this service are calculated in accordance with 1 TAC §355.8401.

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- *Targeted Case Management for Early Childhood Intervention (ECI)*. The Medicaid rate for this service is reimbursed in accordance with 1 TAC §§355.8421.
- *Specialized Skills Training for ECI*. The Medicaid rate for this service is reimbursed in accordance with 1 TAC § 355.8422
- *Certified Nurse-Midwife (CNM)*. The Medicaid rates for CNMs are calculated in accordance with 1 TAC §355.8161.
- *Certified Registered Nurse Anesthetist (CRNA)*. According to 1 TAC §355.8221, the Medicaid rate for CRNAs is 92 percent of the rate reimbursed to a physician anesthesiologist for the same service.
- *Certified Respiratory Care Practitioner (CRCP) Services.* The Medicaid rate per daily visit for 99503 is calculated in accordance with 1 TAC §355.8089.
- *Chemical Dependency Treatment Facility (CDTF)*. The Medicaid rates for CDTF services are calculated in accordance with 1 TAC §355.8241.
- *Chiropractic Services*. The Medicaid rates for chiropractic services are calculated in accordance with 1 TAC §355.8081 and 1 TAC §355.8085.
- *Dental*. The Medicaid rates for dentists are calculated as access-based fees in accordance with 1 TAC §355.8081, 1 TAC §355.8085, 1 TAC §355.8441(11), and 1 TAC §355.455(b).
- *Durable Medical Equipment (DME)*. Home health agencies are reimbursed for DME and expendable supplies in accordance with 1 TAC §355.8021 (b). Comprehensive Care Program (CCP) is reimbursed for DME and expendable supplies in accordance with 1 TAC §355.8441 (2)(3).
- *Family Planning Services*. The Medicaid rates for family planning services are calculated in accordance with 1 TAC §355.8581.
- *Genetic Services*. The procedure codes and Medicaid rates for genetic services are listed in the OFL or the Physician - Genetics fee schedule on the TMHP website at www.tmhp.com.
- *Hearing Aid and Audiometric Evaluations*. Newborn hearing screenings are provided at the birthing facility before hospital discharge and, as such, are reimbursed in accordance with the reimbursement methodology for the specific type of birthing facility. Outpatient hearing screening and diagnostic testing services for children are provided by physicians and are reimbursed in accordance with the reimbursement methodology for physician services at 1 TAC §355.8085, 1 TAC §355.8141, and 1 TAC §355.8441.
- *Texas Medicaid (Title XIX) Home Health Services*. The reimbursement methodology for professional services delivered by home health agencies are statewide visit rates calculated in accordance with 1 TAC §355.8021(a).
- *Independent Laboratory*. The Medicaid rates for independent laboratories are calculated in accordance with 1 TAC §355.8081 and §355.8610, and the Deficit Reduction Act (DEFRA) of 1984. By federal law, Medicaid payments for a clinical laboratory service cannot exceed the Medicare payment for that service. Early Periodic Screening, Diagnosis, and Treatment (EPSDT)/Texas Health Steps medical and newborn screening laboratory services provided by the Department of State Health Services (DSHS) Laboratory are reimbursed based on the Medicare payment for that service.
- *Indian Health Services*. The reimbursement methodology for services provided in Indian Health Services Facilities operating under the authority of Public Law 93-638 is located at 1 TAC §355.8620.
- *In-Home Total Parenteral Nutrition (TPN) Supplier*. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8087.

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- *Licensed Clinical Social Worker (LCSW)*. According to 1 TAC §355.8091, the Medicaid rate for LCSWs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085.
- *Licensed Marriage and Family Therapist (LMFT)*. According to 1 TAC §355.8091, the Medicaid rate for LMFTs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085.
- *Licensed Midwife (LM).* According to 1 TAC §355.8161, covered professional services provided by an LM and billed under the LM's own provider number are reimbursed the lesser of the LM's billed charges or 70 percent of the reimbursement for the same professional service paid to a physician (M.D. or D.O.).
- *Licensed Professional Counselor (LPC)*. According to 1 TAC §355.8091, the Medicaid rate for LPCs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085.
- *Maternity Service Clinic (MSC)*. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8081.
- *Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS).* According to Title 1 TAC §355.8281, the Medicaid rate for NPs and CNSs is 92 percent of the rate paid to a physician (doctor of medicine [MD] or doctor of osteopathy [DO]) for the same service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections.
- *Physical Therapists/Independent Practitioners*. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8081 and §355.8085.
- *Physician*. The Medicaid rates for physicians and other practitioners are calculated in accordance with 1 TAC §355.8085.
- *Physician Assistant (PA)*. According to 1 TAC §355.8093, the Medicaid rate for PAs is 92 percent of the rate paid to a physician (MD or DO) for the same service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections.
- *Psychologist*. The Medicaid rates for psychologists are calculated in accordance with 1 TAC §355.8081 and §355.8085.
- *Radiological and Physiological Laboratory and Portable X-Ray Supplier*. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8081 and §355.8085.
- *Renal Dialysis Facility*. The Medicaid rates for these providers are composite rates based on calculations specified by the Centers for Medicare & Medicaid Services (CMS).
- *School Health and Related Services (SHARS)*. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8443.
- THSteps reimburses by provider type in accordance with 1 TAC §355.8441. Approved providers enrolled in Texas Medicaid are reimbursed for THSteps services in the same manner as they are reimbursed for other Medicaid services. THSteps CCP reimburses for DME and expendable supplies in accordance with 1 TAC §355.8441(2)(3).
- *Tuberculosis (TB) Clinics*. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8081.
- *Vision Care (Optometrists, Opticians)*. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355. 8001, §355.8081, and §355.8085.

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2.2.1.1 Non-emergent and Non-urgent Evaluation and Management (E/M) Emergency Department Visits

Section 104 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 requires that Medicare and Medicaid limit reimbursement for those physician services furnished in outpatient hospital settings (e.g., clinics and emergency situations) that are ordinarily furnished in physician offices. The limit is 60 percent of the Medicaid rate for the non-emergency service furnished in physician offices.

Reimbursement for non-emergent and non-urgent services that are rendered by the facility during the emergency room visit will be limited to 125 percent of the adult, physician office visit fee for procedure code 99202. Reimbursement will not be reduced for those services that were rendered to address conditions that meet any of the following criteria:

- Problems of high-severity
- Problems that require urgent evaluation by a physician
- Problems that pose immediate and significant threats to physical or mental function
- Critically ill or critically injured

Non-emergent and non-urgent services that are rendered by rural hospitals will be reimbursed at 65 percent of the allowed rates.

Non-rural hospitals will receive a flat rate which is limited to 125 percent of the adult, physician office visit fee for procedure code 99202.

Diagnostic services, such as laboratory and radiology, will not be reduced by 40 percent.

Refer to: Subsection 9.2.58.3, "Physician Services Provided in the Emergency Department" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)* and subsection 4.2.2.1, "Emergency Department Payment Reductions" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about non-emergent and non-urgent services rendered in the emergency department.

These procedures are designated with note code "1" in the current fee schedule or OFL on the TMHP website at www.tmhp.com.

The following services are excluded from the 60-percent limitation:

- Services furnished in rural health clinics (RHCs)
- Surgical services that are covered ASC/hospital-based ambulatory surgical center (HASC) 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 could reasonably be expected to result in one of the following:
  - Serious jeopardy to the client's health
  - Serious impairment to bodily functions
  - Serious dysfunction of any bodily organ or part

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2.2.1.2 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: Subsection 3.7.3.8, "Payment Window Reimbursement Guidelines" of the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about the payment window reimbursement guidelines.

2.2.1.3 Drugs and Biologicals

Physician-administered drugs and biologicals are reimbursed under Texas Medicaid as access-based fees under the physician fee schedule in accordance with 1 TAC §355.8085. Physicians and other practitioners are reimbursed for physician-administered drugs and biologicals at the lesser of their usual and customary or billed charges and the Medicaid fee established by the HHSC. The Medicaid fee is an estimate of the provider's acquisition cost for the specific drug and biological. An invoice must be submitted when it is in the provider's possession. Submission of an invoice will document that the provider is billing the lesser of the usual and customary charge or the access-based fee.

HHSC reserves the option to use other data sources to determine Medicaid fees for drugs and biologicals when AWP or ASP calculations are determined to be unreasonable or insufficient.

Prescriptions are covered under the Texas Medicaid Vendor Drug Program (VDP). The reimbursement methodology for pharmacy services is located at 1 TAC §§355.8541–355.8551.

2.2.2 Cost Reimbursement

Medicaid providers who are cost reimbursed are subject to cost reporting, cost reconciliation, and cost settlement processes, including time study requirements.

The following providers are cost reimbursed in accordance with the noted TAC rules:

- 1 TAC §355.743—Mental health (MH) case management
- 1 TAC §355.746—Mental retardation (MR) service coordination
- 1 TAC §355.781—MH rehabilitative services
- 1 TAC §355.8443—School Health and Related Services (SHARS)
- 1 TAC §355.8061—Outpatient Hospital Reimbursement
- 1 TAC §355.8052—Inpatient Hospital Reimbursement
- 1 TAC §355.8056—State-Owned Teaching Hospital Reimbursement Methodology

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2.2.3 Reasonable Cost and Interim Rates

Outpatient hospital services are reimbursed in accordance with 1 TAC §355.8061. The reimbursement methodology is based on reasonable costs, and providers are reimbursed at an interim rate based on the provider's most recent Medicaid cost report settlement. To determine the provider's payable amount, the interim rate is applied to the claim details allowed amount.

2.2.4 Hospitals

Inpatient hospital services are reimbursed as follows:

- 1 TAC §355.8052—Inpatient Hospital Reimbursement
- 1 TAC §355.8052—Inpatient Hospital Reimbursement
- 1 TAC §355.8056—State-Owned Teaching Hospital Reimbursement Methodology
- 1 TAC §355.8058—Inpatient Direct Graduate Medical Education (GME) Reimbursement
- 1 TAC §355.8060—Reimbursement Methodology for Freestanding Psychiatric Facilities
- 1 TAC §355.8061—Outpatient Hospital Reimbursement
- 1 TAC §355.8064—Reimbursement Adjustment for Hospitals Providing Inpatient Services to SSI and SSI-Related Clients
- 1 TAC §355.8065—Disproportionate Share Hospital (DSH) Reimbursement Methodology
- 1 TAC §355.8068—Supplemental Payments to Certain Urban Hospitals
- 1 TAC §355.8069—Supplemental Payments to Certain Rural Public Hospitals
- 1 TAC §355.8070—Supplemental Payments to Private Hospitals
- 1 TAC §355.8071—Supplemental Payments to Children's Hospitals
- 1 TAC §355.8072—Supplemental Payments to State-Owned Hospitals

2.2.5 Provider-Specific Visit Rates

Medicaid provider-specific prospective payment system (PPS) visit rates for RHCs are calculated in accordance with 1 TAC §355.8101, and those for federally qualified health centers (FQHCs) are calculated in accordance with 1 TAC §355.8261.

Refer to: Section 4, "Federally Qualified Health Center (FQHC)" and Section 7, "Rural Health Clinic" in the *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*).

2.2.6 Manual Pricing

When services or products do not have an established reimbursement amount, the detail or claim is manually reviewed to determine an appropriate reimbursement. The manual pricing methodology for DME and expendable supplies is included with the reimbursement methodology for these products.

2.3 Reimbursement Reductions

Texas Medicaid implemented mandated rate reductions for certain services. The Online Fee Lookup (OFL) and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

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2.4 Using Payouts to Satisfy Accounts Receivables Across Programs and Alternate Provider Identifiers

The TMHP accounts receivable process identifies funds that a provider owes to TMHP and subtracts these funds from payments to the provider. TMHP satisfies outstanding accounts receivables using all available funds from the providers' Medicaid payouts, as well as managed care payouts, until the accounts receivables have been recovered. Outstanding balances are recovered as follows:

- For outstanding fee-for-service accounts receivables, TMHP first recovers funds from any available *fee-for-service* payments. If there is still an accounts receivable balance for that week's financial cycle, TMHP recovers funds from any available *managed care* payments.
- For outstanding managed care accounts receivables, TMHP first recovers funds from any available *managed care* payments. If there is still an accounts receivable balance for that week's financial cycle, TMHP will recover funds from any available *fee-for-service* payments

1099 Reports

Providers receive one 1099 report for each provider identifier. The 1099 report has combined information for both fee-for-service and managed care programs.

Paper Remittance and Status (R&S) Report

The summary page of the R&S report has combined information from the fee-for-service and managed care programs.

The Financial Transactions Sub-Owner Recoupment page has accounts receivable for both programs. A column on the page identifies the program (Medicaid [fee-for-service] or Managed Care) from which the funds were recouped.

The Financial Transactions Accounts Receivable page has the accounts receivable for both programs. A column identifies the program (Medicaid [fee-for-service] or Managed Care) from which the funds were recouped.

The Original Date in the Accounts Receivable section of the R&S Report reflects the date on which the accounts receivable first appeared on the R&S Report.

ER&S Report

The Pending and Non-Pending ER&S Reports have combined information for both programs.

2.4.1 HHSC Recoupment of Accounts Receivables from Alternate Provider Identifiers

HHSC recoups the outstanding accounts receivable balances of all existing Medicaid and managed care Texas Provider Identifiers (TPIs) from alternate TPIs that use the same Tax ID or National Provider Identifier (NPI).

If a Medicaid or managed care provider has a TPI that is no longer active or has been terminated and that TPI has an outstanding accounts receivable balance, the balance is recouped from future payments made to any and all TPIs that have the same Tax ID or NPI. Recoupments are reflected on future R&S Reports.

Note: *This process affects only managed care claims that are submitted to TMHP.*

Refer to: Subsection 2.2.5, "Accounts Receivable" and subsection 2.6.4, "Providers With Unsatisfied Medicaid Accounts Receivables" in the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*) for additional information about managed care claims and outstanding accounts receivables.

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2.4.2 Medicaid Funds May Be Used to Satisfy Children with Special Health Care Needs (CSHCN) Services Program Accounts Receivables

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 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 accounts receivable, the provider's Medicaid claim payouts are used to satisfy the CSHCN Services Program accounts receivable.

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

2.5 Additional Payments to High-Volume Providers

High volume provider payments are made to outpatient hospitals per1 TAC §355.8061 and ASCs/HASCs per 1 TAC §355.8121.

Outpatient hospital services are those services provided by outpatient hospitals and ASCs/HASCs. The definition of a high-volume outpatient hospital provider is one that was paid a minimum of $200,000 during the qualifying period.

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The reimbursement rate for non-high-volume hospitals is as follows with the application of the hospital specific interim rate:

Non-high-volume Provider	Current Allowable Rate
Children's hospitals	72.27 percent of the allowable charges
Rural hospitals	100 percent of the allowable charges
State-owned teaching hospitals	72.27 percent of the allowable charges
Other hospitals	68.44 percent of the allowable charges

The reimbursement rate for high-volume hospitals is as follows with the application of the hospital specific interim rate:

High-volume Provider	Current Allowable Rate
Children's hospitals	76.03 percent of the allowable charges
Rural hospitals	100 percent of the allowable charges
State-owned teaching hospitals	76.03 percent of the allowable charges
Other hospitals	72 percent of the allowable charges
ASCs/HASCs that qualify as high-volume providers	Additional 5.2 percent increase in payment rates

2.6 Out-of-State Medicaid Providers

Texas Medicaid covers medical assistance services provided to eligible Texas Medicaid clients while in a state other than Texas, as long as the client does not leave Texas to receive out-of-state medical care that can be received in Texas. Services provided outside the state are covered to the same extent medical assistance is furnished and covered in Texas when the service meets one or more requirements of 1 TAC §354.1440 (a). TMHP must receive claims from out-of-state providers within 365 days from the date of service.

Note: *Border state providers (providers rendering services within 50 miles of the Texas border) are considered in-state providers for Texas Medicaid.*

Refer to: Subsection 1.9, "Enrollment Criteria for Out-of-State Providers" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

2.7 Medicare Crossover Claim Reimbursement

2.7.1 Part A

Providers must accept Medicare assignment to receive Medicaid payment for any portion of the coinsurance and deductible amounts for services rendered to Qualified Medicare Beneficiary (QMB) and Medicaid Qualified Medicare Beneficiary (MQMB) clients. If a provider has accepted a Medicare assignment, the provider may receive, on behalf of the QMB or MQMB client, payment for deductible or coinsurance according to current payment guidelines.

Any payments made by Medicare and Medicaid must be considered payment in full. Providers that accept Medicare or Medicaid assignment cannot legally require the client to pay the Medicare coinsurance or deductible amounts or any remaining amount after Medicaid payment has been made.

The payment of the Medicare Part A coinsurance and deductibles for Medicaid clients who are Medicare beneficiaries is based on the following:

- If the Medicare payment amount equals or exceeds the Medicaid payment rate, Medicaid does not pay the Medicare Part A coinsurance/deductible on a Medicare crossover claim.

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- If the Medicare payment amount is less than the Medicaid payment rate, Medicaid pays the Medicare Part A coinsurance/deductible, but the amount of the payment is limited to the lesser of the coinsurance/deductible or the amount remaining after the Medicare payment amount is subtracted from the Medicaid payment rate.

2.7.2 Part B

Texas Medicaid reimburses coinsurance liability for MQMB clients on valid, assigned Medicare claims that are within the amount, duration, and scope of the Medicaid program and, if Medicare did not exist, would be covered by Medicaid.

For Medicare crossover claims, Texas Medicaid reimburses the lesser of the following:

- The coinsurance and deductible payment
- The amount remaining after the Medicare payment amount is subtracted from the allowed Medicaid fee or encounter rate for the service (If this amount is less than the deductible, then the full deductible is reimbursed instead.)

If the Medicare payment is equal to or exceeds the Medicaid allowed amount or encounter payment for the service, Texas Medicaid does not make a payment for coinsurance.

Important: *Medicaid payment of a client's coinsurance/deductible liabilities satisfies the Medicaid obligation to provide coverage for services that Medicaid would have paid in the absence of Medicare coverage. The client has no liability for any balance or Medicare coinsurance and deductible related to Medicaid-covered services.*

2.7.3 Part C: Medicare Advantage Plans (MAPs)

2.7.3.1 Contracted MAPs

HHSC makes a per-client-per-month payment to MAPs that contract with HHSC. The payment to the MAP includes all costs associated with the Medicare coinsurance and deductible for a client who is dually eligible for Medicare and Medicaid. TMHP does not reimburse the coinsurance or deductible amounts for these claims. These costs must be billed to the MAP and must not be billed to TMHP or the Medicaid client.

Refer to: A list of MAPs that are contracted with HHSC is available on the TMHP website at www.tmhp.com/Pages/EDI/EDI_MAP.aspx. The list is updated as additional plans receive approved contracts.

2.7.3.2 Noncontracted MAPs

Texas Medicaid reimburses professional and outpatient facility crossover claims the lesser of the following:

- The coinsurance and deductible amounts
- The amount remaining after the Medicare payment amount is subtracted from the allowed Medicaid fee or encounter rate for the service

For Medicare Part B cost sharing obligations, all deductible obligations will be reimbursed at 100 percent of the deductible amount owed, even if the cost sharing comparison results in a lower payment. For all other cost sharing obligations (including Medicare Part A and Part B coinsurance, and C), the cost sharing comparison is performed according to current guidelines.

Exception: *Texas Medicaid will reimburse coinsurance liability for MQMB clients on valid, assigned Medicare claims that are within the amount, duration, and scope of the Medicaid program, and would be covered by Medicaid when the services are provided, if Medicare did not exist.*

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If the Medicare payment is equal to or exceeds the allowed Medicaid fee or encounter rate for the service, Texas Medicaid will not make a payment for coinsurance and deductible.

Important: *Medicaid payment of a client's coinsurance/deductible liabilities satisfies the Medicaid obligation to provide coverage for services that Medicaid would have paid in the absence of Medicare coverage. The client has no liability for any balance or Medicare coinsurance and deductible related to Medicaid-covered services.*

2.7.4 Exceptions

2.7.4.1 Full Amount of Part B and Part C Coinsurance and Deductible Reimbursed

Texas Medicaid reimburses the full amount of the Medicare Part B and Part C (noncontracted MAPs only) coinsurance and deductible for the following services:

- All ambulance services
- Services rendered by psychiatrists, psychologists, and licensed clinical social workers
- Procedure codes R0070 and R0075 for services rendered by physicians

2.7.4.2 Nephrology (Hemodialysis, Renal Dialysis) and Renal Dialysis Facility Providers

Texas Medicaid pays the Medicare coinsurance less 5 percent and full Medicare deductible for Medicare crossover claims that are submitted by nephrology (hemodialysis, renal dialysis) and renal dialysis facility providers.

2.8 Federal Medical Assistance Percentage (FMAP)

The Federal Medical Assistance Percentages (FMAPs) are used in determining the amount of Federal matching funds for State expenditures for assistance payments for certain social services and State medical and medical insurance expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the FMAPs each year.

The "Federal Medical Assistance Percentages" are for Medicaid. Section 1905(b) of the Act specifies the formula for calculating Federal Medical Assistance Percentages.

"Enhanced Federal Medical Assistance Percentages" are for the State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act. Section 2105(b) of the Act specifies the formula for calculating Enhanced Federal Medical Assistance Percentages. The FMAPs are subject to change.

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Section 3: TMHP Electronic Data Interchange (EDI)

Texas Medicaid Provider Procedures Manual: Vol. 1

April 2016

TEXAS
Health and Human
Services Commission

SECTION 3: TMHP ELECTRONIC DATA INTERCHANGE (EDI)

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3.1 TMHP EDI Overview

The Texas Health and Human Services Commission (HHSC) and the Texas Medicaid & Healthcare Partnership (TMHP) encourage providers to submit claims using electronic methods. 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 (ANSI) ASC X12 5010 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 at www.tmhp.com, TexMedConnect, vendor software, and third party billing agents. Providers may also submit claims using paper forms.

3.1.1 Advantages of Electronic Services

- *It's fast.* No more waiting by the mailbox or 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, Medicaid billing, and many other topics, including those for the Children with Special Health Care Needs (CSHCN) Services Program, and Long Term Care, as well as a large library of reference materials and manuals on www.tmhp.com.
- *It's safe.* TMHP EDI services use VPN and SSL connections, just like the United States government, banks, and other financial institutions, for maximum security.
- *It's accurate.* TexMedConnect and most vendor software programs 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 check client eligibility, retrieve Electronic Remittance and Status (ER&S) Reports, perform claim status inquiries, and archive claims. TexMedConnect can generate and print reports on everything it sends, receives, and archives.

3.1.2 Electronic Services Available

- Eligibility verification
- Claims submission
- Claim status inquiry (CSI)
- ER&S Reports
- Appeals (also known as correction and resubmission)

3.1.3 Paper Remittance and Status (R&S) Reports No Longer Available

TMHP no longer produces or distributes paper R&S Reports. This initiative saves the state of Texas the cost of printing and mailing Paper R&S Reports.

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All R&S Reports are now available online through the secure portion of the TMHP website at www.tmhp.com. Providers who receive an ER&S Report with third party software are not affected by this change.

Online R&S Reports are available as a portable document format (PDF) file every Monday morning—four days earlier than paper R&S Reports were available. Providers must have a provider administrator account on the TMHP website to receive R&S Reports. Providers who do not have a provider administrator account should create one to avoid delays or interruptions to business processes.

Providers can follow the instructions in the TMHP Portal Security Training Guide to setup a provider administrator account.

3.2 Electronic Billing

Providers who want to transition from paper billing to electronic billing must decide how they will submit their claims to TMHP. Providers can use TexMedConnect on the TMHP website at www.tmhp.com, vendor software that submits files directly to TMHP, or they may use a third party billing agent (e.g., billing companies and clearinghouses) who submit files on the provider's behalf.

3.2.1 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:

- An internet service provider (ISP)
- Microsoft® Internet Explorer®
- Google Chrome®
- Mozilla Firefox®

A broadband connection is recommended but not required. Providers that use TexMedConnect can find the online TexMedConnect manuals for Acute Care and Long Term Care on the TexMedConnect Info web page in the EDI section of the TMHP website at www.tmhp.com/Pages/EDI/EDI_TexMedConnect.aspx.

3.2.2 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 on the EDI Vendor Testing List, which is located in the EDI section of the TMHP website at www.tmhp.com. There are hundreds of software vendors that have a wide assortment of services and 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 details on 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 has been certified with TMHP.

3.2.3 Third Party Billing Agents

Billing agents are companies or individuals who 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 who processes it and transmits it to TMHP and other institutions. A complete list of billing agents who have completed the testing process and been certified by TMHP can be found on the EDI Vendor Testing List, which is located in the EDI section of the TMHP website at www.tmhp.com.

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TMHP does not make billing agent recommendations or provide any assistance for billing agents' software or services. 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.

3.3 Gaining Access

Providers must setup their software or billing agent services to access the TMHP EDI Gateway. Providers who use billing agents or software vendors should contact those organizations for information about 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, Option 3. Providers that use a billing agent do not need a submitter ID.

Providers may receive an ER&S Report by completing the Electronic Remittance and Status (ER&S) Agreement and submitting it to the EDI Help Desk after setting up access to the TMHP EDI Gateway.

Refer to: Electronic Remittance Advice (ERA) Agreement on the TMHP website at www.tmhp.com.

3.4 Training

Providers should contact the TMHP Contact Center at 1-800-925-9126 for billing and training questions. Information about training opportunities is available in the Provider Education section of the TMHP website at www.tmhp.com. Providers may also use the many reference materials and workbooks available on the website. The TMHP EDI Help Desk provides technical assistance and does not provide training.

3.5 Electronic Transmission Reports

Providers are required to retain all claim and electronic file transmission records. Providers must verify that all claims submitted to TMHP are received and accepted. Providers must also track claims submissions against their claims payments to detect and correct all claim errors.

Refer to: Subsection 1.6.3, "Retention of Records and Access to Records and Premises" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*), for more information about provider responsibility and electronic submissions.

If an electronic file transmission record is missing, providers can request that the transmission report file be reset by contacting the TMHP EDI Help Desk at 1-888-863-3638, Option 3. The TMHP EDI Help Desk will then reset the files for the production submitter ID provided. Requests for transmission reports produced in the previous 30 days will be provided at no cost to providers. Requests for transmission reports produced more than 30 days before the request will result in a charge of $500 plus 8.25 percent sales tax of $41.25 for a total charge of $541.25. Providers that hold a tax-exempt certificate will not be assessed the sales tax. This cost is per transmission report.

3.6 Provider Check Amounts Available Online

Acute care providers can search, view, and print on the TMHP website at www.tmhp.com all payment amounts issued during the previous year.

The features of the online check amount include:

- The ability to search information up to one year before the date of the search.
- All results are displayed on a single screen.

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- 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 an administrative 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 logging into their accounts from the TMHP website and then pressing **View Payment Amounts**.

Provider check amounts are also available through the automated inquiry system (AIS) telephone line and ER&S Reports.

3.7 Third Party Vendor Implementation

TMHP requires all software vendors and billing agents to complete EDI testing before access to the production server is allowed. Vendors that wish to begin testing may either call the EDI Help Desk at 1-888-863-3638, Option 3, or visit the Edifecs testing site at editesting.tmhp.com and use the *TMHP Support* link. An Edifecs account will be created for the vendor to begin testing EDI formats once they have enrolled for testing. After the successful completion of Edifecs testing and the submission of a Trading Partner Agreement, vendors must then 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 software vendor or billing agent will be added to the EDI Submitter List. Providers and billing agents may then order production submitter IDs for use with the vendor's software. Companion guides and vendor specifications are available on the EDI page of the TMHP website at www.tmhp.com.

3.7.1 Automated Maintenance Process for All Electronic Submitters

All submitter folders have a maximum limit of 7500 files, and no files can be more than 30 days old. Files that exceed these limits will be purged by TMHP on a daily basis. Providers should review, retrieve, and backup their electronic response files within 30 days. Files not retrieved within the 30-day time period or files that exceed a maximum file count of 7500 will be purged by TMHP. All electronic submitters are responsible for the maintenance of their submitter folders. 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.

Requests for transmission reports produced after the 30-day period, or resulting from a purge of over 7500 files will require fees, as outlined in subsection 3.5, "Electronic Transmission Reports" of this section.

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3.7.2 Supported File Types

TMHP EDI supports the following electronic HIPAA-compliant ANSI ASC X12 5010 transaction types:

Electronic Transaction Types	
270	Eligibility request
271	Eligibility response
276	Claim status inquiry
277	Claim status inquiry response
835	ER&S Report
837D	Dental claims
837I	Institutional claims
837P	Professional claims

Note: *Dental providers who submit American National Standards Institute, Accredited Standards Committee X12 (ANSI ASC X12N) 837D transactions through the TMHP Electronic Data Interchange (EDI) are required to include the header date of service (HDOS) to comply with International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) claims processing guidelines.*

3.8 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Electronic Remittance Advice (ERA) Agreement
Claim Status Inquiry Authorization

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Section 4: Client Eligibility

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4.1 General Medicaid Eligibility

A person may be eligible for medical assistance through Medicaid if the following conditions are met:

- The applicant must be eligible for medical assistance at the time the service is provided. It is not mandatory that the process of determining eligibility be completed at the time service is provided; the client can receive retroactive eligibility. Services or supplies *cannot* be paid under Texas Medicaid if they are provided to a client before the effective date of eligibility for Medicaid or after the effective date of denial of eligibility. Having an application in process for Medicaid eligibility does *not* guarantee the applicant will be eligible.
- The service must be a benefit and determined medically necessary (except for preventive family planning, annual physical exams, and Texas Health Steps [THSteps] medical or dental checkup services) by Texas Medicaid and must be performed by an approved provider of the service.
- Applicants for medical assistance potentially are eligible for Medicaid coverage up to three calendar months before their application for assistance, if they have unpaid or reimbursable Medicaid-covered medical bills and have met all other eligibility criteria during the time the service was provided. The provision also includes deceased individuals when a bona fide agent requests application for services. An application for retroactive eligibility must be filed with the Health and Human Services Commission (HHSC); it is not granted automatically. The applicant must request the prior coverage from an HHSC representative and complete the section of the application about medical bills.

Clients who are not eligible for Medicaid but meet certain income guidelines may receive family planning services through other family planning funding sources. Clients not eligible for Medicaid are referred to a family planning provider. Clients seeking other services may be eligible for state health-care programs, some of which are described in this section.

Refer to: Department of State Health Services (DSHS) website at www.dshs.state.tx.us/famplan/ for information about family planning and the locations of family planning clinics that receive DSHS Family Planning Program funding.

4.1.1 Your Texas Benefits Medicaid Card

Clients receive a Your Texas Benefits Medicaid Card that can be used to verify the client eligibility for various state-funded programs, including Medicaid.

The front of the card includes the client's name, member ID, the ID of the agency that issued the card, and the date on which the card was sent.

The back of the card provides:

- An eligibility verification contact number. The number can be used to determine:
  - Program eligibility dates.
  - Retroactive eligibility (when applicable).
  - Eligible services (when applicable).
  - Medicaid managed care eligibility.
- An eligibility website address for clients and non-pharmacy providers.
- A non-managed care pharmacy claims assistance contact number.
- The Medicaid Client Hotline contact number.

Client TPR and other insurance information can also be verified using the benefit card.

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Refer to: Subsection 4.2, "Eligibility Verification" in this section for additional ways to verify client eligibility.

Your Texas Benefits Medicaid Card (English and Spanish) on the TMHP website at www.tmhp.com.

4.1.2 Retroactive Eligibility

Medicaid coverage may be assigned retroactively for a client. For claims for an individual who has been approved for Medicaid coverage but has not been assigned a Medicaid client number, the 95-day filing deadline does not begin until the date the notification of eligibility is received from HHSC and added to the TMHP eligibility file.

The date on which the client's eligibility is added to the TMHP eligibility file is the add date. To ensure the 95-day filing deadline is met, providers must verify eligibility and add date information by calling the Automated Inquiry System (AIS) or using the TMHP Electronic Data Interchange (EDI) electronic eligibility verification.

If a person is not eligible for medical services under Texas Medicaid on the date of service, reimbursement for all care and services provided must be resolved between the provider and the client receiving the services. Providers are not required to accept Medicaid for services provided during the client's retroactive eligibility period and may continue to bill the client for those services. This guideline does not apply to nursing facilities certified by the Department of Aging and Disability Services (DADS).

If it is the provider's practice not to accept Medicaid for services provided during the client's retroactive eligibility period, the provider must apply the policy consistently for all clients who receive retroactive eligibility. Providers must inform the client about their policy before rendering services. If providers accept Medicaid assignment for the services provided during the client's retroactive eligibility period and want to submit a claim for Medicaid-covered services, providers must refund payments received from the client before billing Medicaid for the services.

The provider should also check the eligibility dates electronically through TexMedConnect or the Your Texas Benefits Medicaid card website at www.YourTexasBenefitsCard.com to see whether the client has retroactive eligibility for previous bills. Retroactive eligibility and the retroactive eligibility period may be verified by visiting www.YourTexasBenefitsCard.com. Texas Medicaid considers all services between the Eligibility Date and the Good Through date for reimbursement. Providers can determine whether a client has retroactive eligibility for previous bills by verifying eligibility on www.tmhp.com, transmitting an electronic eligibility request, or calling AIS or the TMHP Contact Center.

Examples of Medicaid identification forms are found at the end of this section. Actual Medicaid forms can be identified by a watermark.

Refer to: Your Texas Benefits Medicaid Card (English and Spanish) on the TMHP website at www.tmhp.com.

4.1.3 Expedited Eligibility (Applies to Medicaid-eligible Pregnant Women Throughout the State)

HHSC processes Medicaid applications for pregnant women within 15 business days of receipt. Once eligibility has been certified, a Your Texas Benefits Medicaid card will be issued to verify eligibility and to facilitate provider reimbursement.

4.1.4 * Medicaid Buy-In Program for Employed Individuals with Disabilities

The Medicaid Buy-In (MBI) Program allows employed individuals with disabilities to receive Medicaid services by paying a monthly premium. Some MBI participants, based on income requirements, may be determined to have a $0 premium amount and therefore are not required to make a premium payment. Individuals with earnings of less than 250 percent of the federal poverty income limits (FPIL) may be eligible to participate in the program. Applications for the program are accepted through HHSC's regular Medicaid application process.

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Participants will receive the Your Texas Benefits Medicaid card. MBI participants in urban service areas will be served through Texas Medicaid fee-for-service.

4.1.5 Newborn Eligibility

A newborn child may be eligible for Medicaid for up to 1 year if:

- The child's mother received Medicaid at the time of the child's birth.
- The child's mother is eligible for Medicaid or would be eligible if pregnant.
- The child resides in Texas.

If the newborn is eligible for Medicaid coverage, providers must not require a deposit for newborn care from the guardian. The hospital or birthing center must report the birth to HHSC Eligibility Services at the time of the child's birth.

If the hospital or birthing center notifies HHSC Eligibility Services that a newborn child was born to a Medicaid-eligible mother, then the hospital caseworker, mother, and attending physician (if identified) should receive a Medicaid Eligibility Verification (Form H1027) from HHSC a few weeks after the child's birth. Form H1027 includes the child's Medicaid identification number and effective date of coverage. After the child has been added to the HHSC eligibility file, a Your Texas Benefits Medicaid card is issued. Newborn clients will receive the Your Texas Benefits Medicaid card approximately two weeks after birth.

Providers can verify eligibility though the Medicaid eligibility verification website at www.YourTexasBenefitsCard.com. After the newborn becomes a Medicaid client, the card website shows that client as eligible, even if the card has not been produced yet.

Note: *Claims submitted for services provided to a newborn eligible for Medicaid must be filed using the newborn client's Medicaid number. Claims filed with the mother's Medicaid number cause a delay in reimbursement.*

The Medicaid number on the Medicaid Eligibility Verification (Form H1027) may be used to identify newborns eligible for Medicaid.

Refer to: Your Texas Benefits Medicaid Card (English and Spanish) on the TMHP website at www.tmhp.com.

4.1.6 Potential Supplemental Security Income (SSI)/Medicaid Eligibility for Premature Infants

The Supplemental Security Income (SSI) program includes financial and Medicaid benefits for people who are disabled. When determining eligibility for SSI, the Social Security Administration (SSA) must establish that the person meets financial and disability criteria. When determining financial eligibility for a newborn child, SSA does not consider the income and resources of the child's parents until the month following the month the child leaves the hospital and begins living with the parents. Determinations of disability are made by the state's Disability Determination Services and may take several months. Federal regulations state that infants with birth weights less than 1,200 grams are considered to meet the SSI disability criteria.

The SSA issued a policy to local SSA offices to make presumptive SSI disability decisions and payments for these children, making it possible for a child to receive SSI and Medicaid benefits while waiting for a final disability determination to be made by Disability Determination Services. The child's parent or legal guardian must file an SSI application with the SSA. It is in the child's best interest that the application with the SSA be filed as soon as possible after birth. The SSA accepts a birth certificate with the child's birth weight or a hospital medical summary as evidence for the presumptive disability decision.

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Providers should not change their current newborn referral procedures to HHSC for children who are born to mothers who are eligible for Medicaid as described in this section. However, providers are encouraged to refer parents and guardians of low birth weight newborns to the local SSA office for an SSI application.

4.1.7 Foster Care

Most children in the state of Texas foster care program are automatically eligible for Medicaid.

Extended health-care coverage is also available for some former foster care youth clients enrolled in an institution of higher education through the Former Foster Children in Higher Education (FFCHE) program.

To ensure that these children have access to the necessary health-care services for which they are eligible, providers can accept the Medicaid Eligibility Verification (Form H1027) as evidence of Medicaid eligibility. Although this form may not list the client's Medicaid identification number, it is an official state document that establishes Medicaid eligibility.

Providers should honor the Medicaid Eligibility Verification (Form H1027) as proof of Medicaid eligibility and must bill Texas Medicaid as soon as a Medicaid ID number is assigned. Medicaid ID numbers will be assigned approximately one month from the issue date of the Medicaid Eligibility Verification (Form H1027). The form includes a Department of Family and Protective Services (DFPS) client number that provides an additional means of identification and tracking for children in foster care.

Note: *The DFPS client number is accepted by Medicaid Vendor Drug Program (VDP)-enrolled pharmacies to obtain outpatient prescribed drug benefits. VDP pharmacies must submit subsequent pharmacy claims with the Medicaid ID number after it has been assigned.*

Reminder: *Adoption agencies/foster parents are not considered third party resources (TPRs). Medicaid is primary in these circumstances.*

4.1.8 Former Foster Care

Texas Health and Human Services Commission (HHSC) provides Medicaid health-care coverage to former foster care youth who:

- Are 18 through 25 years of age.
- Were in Texas foster care on their 18th birthday or older and were receiving Medicaid when they aged out of Texas foster care.
- Are U.S. citizens or have a qualified alien status (i.e., green card).

4.1.9 Medicaid Managed Care Eligibility

All clients who are determined to be eligible for Texas Medicaid are first enrolled as fee-for-service clients. Specific client groups within the Texas Medicaid population are eligible for managed care based on criteria such as age, location, and need. A client who is determined to be eligible for Medicaid managed care is enrolled in the appropriate managed care organization (MCO) or dental plan with a separate eligibility date. In most cases, Medicaid managed care enrollment is not retroactive.

Refer to: *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*) for more information about managed care eligibility and enrollment.

4.2 Eligibility Verification

To verify a client's Texas Medicaid eligibility, use the following options:

- Verify electronically through TMHP EDI. Providers may inquire about a client's eligibility by electronically submitting one of the following for each client:

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  - Medicaid or Children with Special Health Care Needs (CSHCN) Services Program identification number.
  - One of the following combinations: Social Security number and last name; Social Security number and date of birth; or last name, first name, and date of birth. Providers can narrow the search by entering the client's county code or sex.
- Submit electronic verifications in batches limited to 5,000 inquiries per transmission.
- Verify the client's Medicaid eligibility using the Medicaid Eligibility Verification (Form H1027) or or by accessing the Your Texas Benefits Medicaid card website at www.YourTexasBenefitsCard.com.
- Contact the TMHP Contact Center or AIS at 1-800-925-9126 or 1-512-335-5986.
- Submit a hard-copy list of clients to TMHP. This service is only used for clients with eligibility that is *difficult* to verify. A charge of $15 per hour plus $0.20 per page, payable to TMHP, applies to this eligibility verification. The list includes names, gender, and dates of birth if the Social Security and Medicaid ID numbers are unavailable. TMHP can check the client's eligibility manually, verify eligibility, and provide the Medicaid ID numbers. Mail the lists to the following address:

  Texas Medicaid & Healthcare Partnership Contact Center
  12357-A Riata Trace Parkway
  Suite 100
  Austin, TX 78727

Note: *Providers can obtain client eligibility information for a client whois enrolled in a Medicaid managed care organization (MCO) from the MCO's web page. Providers can also check the MCO's web page for submission of electronic claims, prior authorization requests, claim appeals and reconsiderations, exchange of clinical data, and other documentation necessary for prior authorization and claim processing.*

4.2.1 Advantages of Electronic Eligibility Transactions

Eligibility transactions through TexMedConnect or EDI have the following advantages:

- Submissions are available 24-hours a day 7 days a week.
- Submission of EDI batches of 5000 per transmission.
- Submission of client group lists through TexMedConnect. Providers can create lists of clients to verify eligibility. Each client group can contain up to 250 clients, providers can create up to 100 groups for each National Provider Identifier (NPI).

Electronic eligibility responses contain:

- Restrictions applicable to the client's eligibility such as lock-in, emergency, or womens health.
- Medicare eligibility and effective dates, including Part A, B, and C.
- Complete other insurance information, including name and address, and effective dates. EDI transactions also indicate the patient relationship to policy holder.

4.2.2 Contract with Outside Parties

The *State Medicaid Manual*, Chapter 2, "State Organization," (Section 2080.18) allows states to contract with outside agents to confirm for providers the eligibility of a Medicaid client. Medicaid providers may contract with these agents for eligibility verification with a cost to the provider. The provider remains responsible for adhering to the claims filing instructions in this manual. The provider, not the agent, is responsible for meeting the 95-day filing deadline and other claims submission criteria.

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4.3 Medicaid Identification and Verification

Providers are responsible for requesting and verifying current eligibility information from clients by using the methods listed in subsection 4.2, "Eligibility Verification" in this section or by asking clients to produce their Your Texas Benefits Medicaid card or Medicaid Identification form (H1027).

Providers may verify client eligibility electronically through TexMedConnect or through the Medicaid eligibility verification website at www.YourTexasBenefitsCard.com from which website providers can print a copy of a client's proof of eligibility.

Providers must accept either of these forms as valid proof of eligibility. Providers should retain a copy for their records to ensure the client is eligible for Medicaid when the services are provided. Clients should share eligibility information with their providers.

Providers should request additional identification if they are unsure whether the person presenting the form is the person identified on the form.

Providers should check the Eligibility Date to see whether the client has possible retroactive eligibility for previous bills.

Only those clients listed on the Medicaid Eligibility form or the Your Texas Benefits Medicaid card are eligible for Medicaid. If a person insists he or she is eligible for Medicaid but cannot produce a current Your Texas Benefits Medicaid card or Medicaid Eligibility Verification (Form H1027), has lost it, or has forgotten to bring it to the appointment, providers can verify eligibility through the methods listed in subsection 4.2, "Eligibility Verification" in this section. Providers must document this verification in their records and treat these clients as if they had presented a Your Texas Benefits Medicaid card or Medicaid Eligibility Verification (Form H1027).

When a client's Your Texas Benefits Medicaid care has been lost or stolen, HHSC issues a temporary Medicaid verification Form H1027. The following is a sample of forms:

- *Form H1027-A*. Medicaid eligibility verification is used to indicate eligibility for clients who receive regular Medicaid coverage.
- *Form H1027-B*. Medicaid Qualified Medicare Beneficiary (MQMB) is issued to clients eligible for MQMB coverage.
- *Form H1027-C*. Qualified Medicare Beneficiary (QMB) is issued to clients who are eligible for QMB coverage only.
- *Form H1027-F*. Temporary Medicaid identification for clients receiving Former Foster Care in Higher Education (FFCHE) health care.

Refer to: Subsection 4.11.1, "QMB/MQMB Identification" in this section.

The Medicaid Eligibility Verification (Form H1027) is acceptable as evidence of eligibility during the eligibility period specified unless the form contains limitations that affect the eligibility for the intended service. Providers must accept any of the documents listed above as valid proof of eligibility. If the client is not eligible for medical assistance or certain benefits, the client is treated as a private-pay patient.

Refer to: Subsection 4.2, "Eligibility Verification" in this section.

Providers must review limitations identified on the Medicaid electronic eligibility file, AIS, the Your Texas Benefits Medicaid card website at www.YourTexasBenefitsCard.com, or the Medicaid Eligibility Verification (Form H1027). Clients may be required to use a designated primary provider or pharmacy. QMB clients will be limited to Medicaid coverage of the Medicare Part A premiums, if any, Medicare Part B premiums, and Medicare coinsurance or deductible according to current payment guidelines.

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If the client is identified as eligible and no other limitations of eligibility affect the intended service, proceed with the service. Eligibility during a previous month does not guarantee eligibility for the current month. The Medicaid Eligibility Verification (Form H1027) and the Your Texas Benefits Medicaid card are the only documents that are honored as verification of Medicaid eligibility.

Refer to: Subsection 4.12, "Third Party Liability (TPL)" in this section.

In accordance with current federal policy, Texas Medicaid and Texas Medicaid clients cannot be charged for the client's failure to keep an appointment. Only claims for services provided are considered for payment. Clients may not be billed for the completion of a claim form, even if it is a provider's office policy.

4.4 Restricted Medicaid Coverage

The following sections are about limitations that may appear on the Your Texas Benefits Medicaid card, indicating that the client's eligibility is restricted to specific services. Unless "LIMITED" appears on the form, the client is not locked into a single provider.

4.4.1 Emergency Only

The word "EMERGENCY" on the form indicates the client is restricted to coverage for an emergency medical condition. **"**Emergency medical condition" is defined in subsection 4.4.2.2, "Exceptions to Lock-in Status" in this section.

Certification for emergency Medicaid occurs after the services have been provided. The coverage is retroactive and limited to the specific dates that the client was treated for the emergency medical condition.

Clients limited to emergency medical care are not eligible for family planning, THSteps, or Comprehensive Care Program (CCP) benefits. Only services directly related to the emergency or life-threatening situations are covered.

Undocumented aliens and aliens with a nonqualifying entry status are identified for emergency Medicaid eligibility by the classification of type programs (TPs) 30, 31, 32, 33, 34, 35, and 36. Under Texas Medicaid, undocumented aliens are only eligible for emergency medical services, including emergency labor and delivery.

Any service provided after the emergency medical condition is stabilized is not a benefit.

If a client is not eligible for Medicaid and is seeking family planning services, providers may refer the client to one of the clinics listed on the DSHS website at www.dshs.state.tx.us/famplan.

4.4.2 Client Lock-in Program

Texas Medicaid fee-for-service clients can be required to use a designated primary care provider and/or a primary care pharmacy.

The client is assigned to a designated provider for access to medical benefits and services when one of the following conditions exists:

- The client received duplicative, excessive, contraindicated, or conflicting health-care services, including drugs.
- A review indicates abuse, misuse, or fraudulent actions related to Medicaid benefits and services.

After analysis through the neural network component of the Medicaid Fraud and Abuse Detection System (MFADS), qualified medical personnel validate the initial identification and determine candidates for lock-in status. The validation process includes consideration of medical necessity. For the lock-in status designation, medical necessity is defined as the need for medical services to the amount and frequency established by accepted standards of medical practice for the preservation of health, life, and the prevention of more impairments.

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Except for specialist consultations, services rendered to a client by more than one provider for the same or similar condition during the same time frame may not be considered medically necessary.

4.4.2.1 Lock-in Medicaid Identification

Clients with lock-in status receive the Your Texas Benefits Medicaid card with "Lock-in" printed on the card. The designated provider and pharmacy names are printed on the card under the word "Lock-in."

When a Texas Medicaid fee-for-service client in the Lock-in Program attempts to obtain nonemergency services from someone other than their designated lock-in primary care provider, the provider must do one of the following:

- Verify the lock-in status online on the TMHP website or by calling AIS or the TMHP Contact Center at 1-800-925-9126.
- Attempt to contact the client's designated lock-in primary care provider for a referral. If the provider is unable to obtain a referral, the provider must inform clients that they are financially responsible for the services.

4.4.2.2 Exceptions to Lock-in Status

Lock-in clients may go to any provider for the following services or items:

- Ambulance services
- Anesthesia
- Annual well-woman checkup
- Assistant surgery
- Case management services
- Chiropractic services
- Counseling services provided by a chemical dependency treatment facility
- Eye exams for refractive errors
- Eyeglasses
- Family planning services (regardless of place of service [POS])
- Genetic services
- Hearing aids
- Home health services
- Laboratory services (including interpretations)
- Licensed clinical social worker (LCSW) services
- Licensed professional counselor (LPC) services
- Mental health rehabilitation services
- Mental retardation diagnostic assessment (MRDA) performed by an MRDA provider
- Nursing facility services
- Primary home care
- Psychiatric services
- Radiology services (including interpretations)
- School Health and Related Services (SHARS)

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- Comprehensive Care Program (CCP)
- THSteps medical and dental services

For referrals or questions, contact:

HHSC
Office of Inspector General
Lock-in Program - MC 1323
PO Box 85200
Austin, TX 78708
1-800-436-6184

If an emergency medical condition occurs, the lock-in restriction does not apply. The term 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 the client's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Important: *A provider who sends in an appeal because a claim was denied with explanation of benefits (EOB) 00066 must include the performing provider identifier, not just a name or group provider identifier. Appeals without a performing provider identifier are denied. The NPI of the designated provider must be entered in the appropriate paper or equivalent electronic field for nonemergency inpatient and outpatient claims to be considered for reimbursement.*

Note: *Only when the designated provider or designated provider representative has given permission for the client to receive nonemergency inpatient and/or outpatient services, including those provided in an emergency room, can the facility use the designated provider's NPI for billing.*

4.4.2.3 Selection of Designated Provider and Pharmacy

Texas Medicaid fee-for-service clients identified for lock-in status can participate in the selection of one primary care provider, primary care pharmacy, or both from a list of participating Medicaid providers. Eligible providers cannot be under administrative action, sanction, or investigation. In general, the designated primary care provider's specialty is general practice, family practice, or internal medicine. Other specialty providers may be selected on a case-by-case basis. Primary care providers can include, but are not limited to the following:

- A physician
- Physician assistant
- Physician group
- Advanced practice nurse
- Outpatient clinic
- Rural health clinic (RHC)
- Federally qualified health center (FQHC)

If the client does not select a primary care provider or primary care pharmacy, HHSC selects one for the client.

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When a candidate for the designated provider is determined, HHSC contacts the provider by letter. The designated provider receives a confirmation letter from HHSC that verifies the name of the client confirming the name of the client, primary care provider or primary care pharmacy, and the effective date of the lock-in arrangement.

4.4.2.4 Pharmacy services

The primary care pharmacy helps the Lock-in Program ensure that prescriptions that are filled for clients with lock-in status are written either by the primary care provider or other health-care providers to whom the primary care provider has referred the client. HHSC has identified by therapeutic class those medications that require additional monitoring. When a medication that requires additional monitoring is prescribed by an emergency room provider, the primary care pharmacy may be reimbursed for dispensing up to 72 hours or three business days of the prescribed dosage, which allows for holidays and weekends. The primary care pharmacy may dispense the remainder of the medication after receiving approval by the primary care provider or the other providers that HHSC deems to be appropriate.

Some circumstances allow a client to be approved to receive medications from a pharmacy other than the primary care pharmacy. A pharmacy override occurs when the Lock-in Program approves an individual client's request to obtain medication at an alternate pharmacy other than the lock-in pharmacy. The Lock-in Program is notified when the client or pharmacist calls the HHSC-OIG Hotline telephone number at 1-800-436-6184 to request a pharmacy override.

The Lock-in Program staff refers the client to the notification letter titled "What You Need to Know About the Lock-in Program," which was sent at initial lock-in. This letter explains the pharmacy override process. The client is instructed to have the alternate pharmacy call the Lock-in Program to request the override.

The following are allowable circumstances for pharmacy override approval:

- The recipient moved out of the geographical area (more than 15 miles from the lock-in pharmacy).
- The lock-in pharmacy does not have the prescribed medication, and the medication will remain unavailable for more than two to three days.
- The lock-in pharmacy is closed for the day, and the recipient needs the medication urgently.
- The lock-in pharmacy does not carry the medication and is either unable to order it or unwilling to stock it.
- The lock-in pharmacy no longer wants to be the designated pharmacy for a particular lock-in client.
- The client has valid complaints against the lock-in pharmacy or its staff.

For questions about pharmacy services for clients that are locked into a primary care pharmacy, contact the Lock-in Program by calling the HHSC OIG Hotline at 1-800-436-6184.

4.4.2.5 Duration of Lock-in Status

The Lock-in Program duration of lock-in status is the following:

- Initial lock-in status period–minimum of 36 months.
- Second lock-in status period–additional 60 months.
- Third lock-in status period–will be for the duration of eligibility and all subsequent periods of eligibility.
- Clients who have been arrested for, indicted for, convicted of, or admitted to a crime that is related to Medicaid fraud will be assigned lock-in status for the duration of eligibility and subsequent periods of eligibility.

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HHSC uses the same time frames for clients with a lock-in status as noted by the word "LIMITED" on the Your Texas Benefits Medicaid card website at www.YourTexasBenefitsCard.com.

Clients are removed from lock-in status at the end of the specified limitation period if their use of medical services no longer meets the criteria for lock-in status. A medical review also may be initiated at the client's or provider's request. Clients or providers can reach the Lock-in Program by calling the HHSC OIG Hotline at 1-800-436-6184 to request this review.

Providers may request to no longer serve as a client's designated provider at any time during the lock-in period by contacting the Lock-in Program by calling the HHSC OIG Hotline at 1-800-436-6184. Providers are asked to serve or refer the client until another arrangement is made. New arrangements are made as quickly as possible.

4.4.2.6 Referral to Other Providers

Texas Medicaid fee-for-service clients with a lock-in status may be referred by their designated provider to other providers. For the referred provider to be paid, the provider identifier of the referring designated provider must be in the referring provider field of the claim form. Claims submitted electronically (see subsection 6.2, "TMHP Electronic Claims Submission" in Section 6, "Claims Filing" [*Volume 1, General Information*]) must have the NPI of the referring designated provider in the Referring Provider Field. Providers must consult with their vendor for the location of this field in the electronic claims format.

4.4.2.7 Hospital Services

An inpatient hospital claim for a lock-in Medicaid fee-for-service client is considered for reimbursement if the client meets Medicaid eligibility and admission criteria. Hospital admitting personnel are asked to check the name of the designated provider for the client that is noted on the Your Texas Benefits Card website at www.YourTexasBenefitsCard.com and inform the admitting physician of the designated provider's name if the two are different.

Provider claims for nonemergency inpatient services for lock-in Texas Medicaid fee-for-service clients are considered for payment *only* when the designated provider identifier appears on the claim form as the billing, performing, or referring physician.

Providers can get information about claim reimbursement for lock-in clients by calling the TMHP Contact Center at 1-800-925-9126.

4.4.2.8 Lock-in Status Claims Payment

Payment for services to a lock-in Medicaid client is made to the designated provider only, unless the services result from a designated provider referral or emergency. An automated review process determines if the claim includes the lock-in primary care provider's provider identifier as the billing, performing, or referring provider. If the lock-in primary care provider's provider identifier is not indicated on the claim, the claim is not paid. Exceptions to this rule include emergency care and services that are included in subsection 4.4.2.2, "Exceptions to Lock-in Status" in this section. Appeals for denied claims are submitted to TMHP and must include the designated Medicaid provider identifier for reimbursement consideration.

Claims for provider services for Texas Medicaid fee-for-service clients must include the provider identifier for the designated primary care provider as the billing or performing provider or a referral number in the prior authorization number (PAN) field.

4.4.3 Hospice Program

DADS manages the Hospice Program through provider enrollment contracts with hospice agencies. These agencies must be licensed by the state and Medicare-certified as hospice agencies. Coverage of services follows the amount, duration, and scope of services specified in the Medicare Hospice Program. Hospice pays for services related to the treatment of the client's terminal illness and for certain physician services (not the treatments).

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Medicaid Hospice provides palliative care to all Medicaid-eligible clients (no age restriction) who sign statements electing hospice services and are certified by physicians to have six months or less to live if their terminal illnesses run their normal courses. Hospice care includes medical and support services designed to keep clients comfortable and without pain during the last weeks and months before death.

Texas Medicaid clients who are 21 years of age and older and who elect hospice coverage waive their rights to all other Medicaid services related to their terminal illness. They do not waive their rights to Medicaid services that are unrelated to their terminal illness.

Texas Medicaid clients who are 20 years of age and younger and who elect hospice care are not required to waive their rights to concurrent hospice care and treatment of the terminal illness. They do not waive their rights to Medicaid services that are unrelated to their terminal illness.

Medicare and Medicaid clients must elect both the Medicare and Medicaid Hospice programs.

Concurrent hospice care and treatment services include:

- Services related or unrelated to the client's terminal illness
- Hospice care (palliative care and medical and support services related to the terminal illness.

Direct policy questions about the hospice program to DADS at 1-512-438-3519. Direct all other general questions related to the hospice program, such as billing, claims, rate key issues, and authorizations to DADS at 1-512-438-2200.

DADS pays the provider for a variety of services under a per diem rate for any particular hospice day in one of the following categories:

- Routine home care
- Continuous home care
- Respite care
- Inpatient care

4.4.3.1 Hospice Medicaid Identification

Individuals who elect hospice care are issued a Your Texas Benefits Medicaid card. Hospice status may be verified by visiting the Your Texas Benefits Medicaid card website at www.YourTexasBenefitsCard.com. Clients may cancel their election at any time.

4.4.3.2 Physician Oversight Services

Physician oversight is defined as "physician supervision of clients under the care of home health agencies or hospices that require complex or multidisciplinary care modalities." These modalities involve regular physician client status review of related laboratory and other studies, communication with other health professionals involved in patient care, integration of new information into medical treatment plans, and adjustment of medical therapy. Medicaid hospice does not reimburse for physician oversight services.

4.4.3.3 Medicaid Services Unrelated to the Terminal Illness

When services are unrelated to the Medicaid Hospice client's terminal illness, Medicaid (TMHP) pays its providers directly. Providers of services that are unrelated to the terminal illness are required to follow Medicaid prior authorization and claims filing deadlines.

Refer to: Section 5: Fee-for-Service Prior Authorizations (*Vol. 1, General Information*) for more information about prior authorizations for Medicaid hospice clients.

Section 6: Claims Filing (*Vol. 1, General Information*) for more information about filing claims for Medicaid Hospice Clients.

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4.4.4 Presumptive Eligibility

Presumptive eligibility allows qualified hospitals and entities to determine whether an individual can get short-term Medicaid. Clients who have PE receive immediate, short-term Medicaid eligibility while their regular Medicaid application is processed. PE eligibility categories receive full coverage with the exception of pregnant women who receive ambulatory care services only.

4.4.4.1 PE Medicaid Identification

"PE" on a Your Texas Benefits Medicaid card indicates that a client has presumptive eligibility. PE clients may be identified by visiting the Your Texas Benefits Medicaid card web site at www.YourTexasBenefitsCard.com. An individual who is certified for Presumptive Eligibility receives the regular Your Texas Benefits Medicaid card, with the exception of pregnant women. Pregnant women receive a separate YourTexasBenefits Medicaid card that indicates that they receive services for pregnant women.

4.4.4.2 Services

Presumptive eligibility provides full coverage for all PE types of assistance with the exception of pregnant women. Pregnant women only receive ambulatory care services. Labor, delivery, inpatient services, and THSteps medical are not covered during the PE period for pregnant women. If the woman is determined to be eligible for regular Medicaid for the same period of time, regular Medicaid coverage overlays the PE period and provides a full range of services. Client eligibility for PE coverage must be determined by a qualified hospital or qualified entity. Once eligibility has been determined, services may be obtained from any enrolled Medicaid provider. The claims filing procedures for clients who have PE are the same as those for all other Medicaid clients.

There are five client type programs that provide full Medicaid coverage through presumptive eligibility. Services reimbursed under the presumptive eligibility process are fee-for-service only.

The following client type programs are eligible for presumptive eligibility:

- 74—Children under 1 year of age presumptive
- 75—Children 1–5 years of age presumptive
- 76—Children 6–18 years of age presumptive
- 83—Former Foster Care Children presumptive
- 86—Parents and caretaker relatives presumptive
- 42—Pregnant women presumptive

The length of coverage depends on several factors:

- If the individual submits an application for regular Medicaid, the PE Medicaid coverage ends the date the state makes a determination for regular Medicaid.
- If the individual does not submit an application for regular Medicaid, the PE coverage ends the last day of the month following the PE determination.

4.4.4.3 Qualified Provider Enrollment

To make PE determinations, the provider must be a qualified hospital or qualified entity. A qualified hospital:

- Is a Medicaid provider.
- Notifies HHSC of its intent to make presumptive eligibility determinations.
- Agrees to make presumptive eligibility determinations according to HHSC policies and procedures.
- Can make presumptive eligibility determinations for pregnant women, children, former foster care children, and parents and other caretakers.

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- Helps individuals complete and submit online applications for regular Medicaid.
- Helps individuals understand which documents to send to the state to determine whether they qualify for regular Medicaid.
- Has not been disqualified.

A qualified entity meets the same criteria as a qualified hospital, except that a qualified entity:

- Can be a hospital, clinic, school, or other entity.
- May only make presumptive eligibility determinations for pregnant women.

For more information on how to become a qualified hospital or entity, visit www.TexasPresumptiveEligibility.com.

4.4.4.4 Process

A qualified provider designated by HHSC requests that the pregnant woman complete a Medicaid application form. The qualified provider determines eligibility for PE coverage based on verification of pregnancy and a determination that the family's income is at or below the current Medicaid limit for pregnant women.

The same application used to determine the woman's PE is forwarded to the local HHSC office for determination of regular Medicaid coverage for the pregnant woman and any other household members. The pregnant woman must follow through with the regular Medicaid application process and be eligible under those requirements to continue receiving Medicaid.

The period of PE begins on the date the qualified provider makes the determination and ends when HHSC makes the final Medicaid determination.

4.5 CHIP Perinatal Program

The Children's Health Insurance Program (CHIP) Perinatal Program provides CHIP perinatal benefits for 12 months to the unborn children of non-Medicaid-eligible women. This program allows pregnant women who are ineligible for Medicaid because of income or immigration status to receive prenatal care and provides CHIP benefits to the child upon delivery for the duration of the coverage period. Continuous Medicaid coverage for 12 months is provided from birth to CHIP Perinatal newborns whose mothers received Emergency Medicaid for the labor and delivery. The 12 months of continuous Medicaid coverage for the newborn is available *only* if the mother received Medicaid for labor and delivery.

4.5.1 Program Benefits

CHIP Perinatal benefits are provided by select CHIP health plans throughout the state. Benefits for the unborn child include:

- Up to 20 prenatal visits:
  - First 28 weeks of pregnancy—one visit every four weeks.
  - From 28 to 36 weeks of pregnancy—one visit every two to three weeks.
  - From 36 weeks to delivery—one visit per week.
  - Additional prenatal visits are allowed if they are medically necessary.
- Pharmacy services, limited laboratory testing, assessments, planning services, education, and counseling.
- Prescription drug coverage based on the current CHIP formulary.
- Hospital facility charges and professional services charges related to the delivery. Preterm labor that does not result in a birth and false labor are not covered benefits.

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Program benefits after the child is born include:

- Two postpartum visits for the mother.
- Medicaid benefits for the newborn.

4.5.2 Claims

Providers who serve CHIP Perinatal clients must follow the claims filing guidelines in subsection 6.19.1, "CHIP Perinatal Newborn Transfer Hospital Claims" in Section 6, "Claims Filing" (*Vol.1 General Information*).

4.5.3 Client Eligibility Verification

The *State Medicaid Manual*, Chapter 2, "State Organization," (Section 2080.18) allows states to contract with outside agents to confirm for providers the eligibility of a Medicaid client. Medicaid providers may contract with these agents for eligibility verification with a cost to the provider. The provider remains responsible for adhering to the claims filing instructions in this manual. The provider, not the agent, is responsible for meeting the 95-day filing deadline and other claims submission criteria.

A number is issued for the baby based on the submission of the Emergency Medical Services Certification Form H3038 or CHIP Perinatal - Emergency Medical Services Certification, Form H3038P for the mother's labor with delivery.

Establishing Medicaid for the newborn requires the submission of the Emergency Medical Services Certification Form H3038 or CHIP Perinatal - Emergency Medical Services Certification, Form H3038P for the mother's labor with delivery. If Form H3038 or H3038P is not submitted, Medicaid cannot be established for the newborn from the date of birth for 12 continuous months of Medicaid coverage. Once enrolled, clients are identified as type program (TP) 36 for the mother and TP 45 for the newborn.

Establishing Medicaid (and issuance of a Medicaid number) can take up to 45 days after Form H3038 or H3038P is submitted. Medicaid eligibility for the mother and infant can be verified using the online lookup on the TMHP website at www.tmhp.com or by calling AIS at 1-800-925-9126.

For clients enrolled in the CHIP Program, the CHIP health plan assigns a client ID to be used for billing. Providers should contact the CHIP health plan for billing information.

Newborns whose mother received Medicaid including emergency Medicaid are eligible to receive Medicaid benefits beginning at the date of birth and will not be assigned a client ID from the CHIP health plan.

HHSC requires the expectant mother's provider to fill out the Emergency Medical Services Certification (Form H3038 or H3038P).

The expectant mother will receive this form from HHSC before her due date, along with a letter reminding her to send information about the birth of her child after delivery. The letter will instruct the expectant mother to take the form to her provider, have the provider fill out the form, then mail the form back to HHSC in a preaddressed, postage-paid envelope. In many cases this activity will occur after delivery when the mother is being discharged from the hospital.

Once HHSC receives the completed Emergency Medical Services Certification (Form H3038 or H3038P), Emergency Medicaid coverage will be added for the mother for the period of time identified by the health care provider. The Emergency Medical Services Certification (Form H3038 or H3038P) is the same form currently required to complete Emergency Medicaid certification.

The CHIP perinatal mother whose income is at or below pregnant women's Medicaid FPIL will not be required to fill out a new application or provide new supporting documentation to apply for Emergency Medicaid. HHSC will determine the woman's eligibility for Emergency Medicaid by using income and other information the mother to-be provided when she was determined to be eligible for CHIP perinatal coverage, as well as information included on the Emergency Medical Services Certification (Form H3038 or H3038P).

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If a woman fails to return the completed Emergency Medical Services Certification (Form H3038 or H3038P) within a month after her due date, HHSC will send her another Emergency Medical Services Certification Form H3038 or H3038P with a postage-paid envelope. If the woman fails to submit Emergency Medical Services Certification (Form H3038 or H3038P), and the hospital cannot locate a Type Program 36 for her in the TMHP online provider lookup tool, then the hospital can bill her for facility fees incurred during her stay.

4.5.3.1 Confirming Receipt of Form H3038 or H3038P

Providers who would like to confirm receipt of form H3038 or H3038P can contact MAXIMUS at 1-877-KIDS-NOW (1-877-543-7669), prompt #6 (for reporting changes) after 48 hours from fax submission. If the submission is by regular mail, providers should allow five business days before contacting MAXIMUS. When calling this number, providers should be prepared to provide the following information:

- National Provider Identifier (NPI)
- Provider name
- Name of person calling
- CHIP perinatal case number (Without the case number, MAXIMUS cannot provide confirmation of receipt. Confirmation of receipt cannot be provided based on client name or address.)

Each form H3038 or H3038P should be faxed one at a time, rather than in a batch. It is important that the form be filled out completely and accurately. If the form is not filled out accurately, it will delay processing and MAXIMUS may not be able to confirm receipt after 48 hours from fax submission.

4.5.3.2 Eligibility Verification for Clients Without a Medicaid ID

Providers should first attempt to verify if a Medicaid number has been issued by calling TMHP at 1-800-925-9126 and using the prompt for AIS or speaking to a representative. Providers can also use TexMedConnect to check client eligibility. If a provider is unable to locate a Medicaid number for the mother or infant 45 days after form H3038 or H3038P was faxed, the provider can contact the HHSC Central Processing Center (CPC) in one of the following ways:

- By email at CPC@hhsc.state.tx.us
- By telephone at 1-866-291-1258

CPC needs the following information to respond to requests or inquiries. Providers should submit the information only once. All submissions must be sent in a secure manner. If there are multiple inquiries that are over 45 days, providers can submit them together.

Required information includes the following:

- CHIP perinatal case number
- Mother's name as it appears on her CHIP Perinatal card
- Dates of service
- Date Form H3038 or H3038P was faxed to MAXIMUS
- Baby's first and last name
- Baby's date of birth
- Name and telephone number of the person completing the request

CPC will research inquiries and respond to the provider within 10 business days. This time frame is an approximation and may only apply if all information, including complete contact information, is provided and fewer than 25 names were submitted.

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4.5.3.3 Mother's eligibility

For mothers who currently receive CHIP perinatal and have an income at or below the pregnant women's Medicaid FPIL, and who receive Emergency Medicaid coverage, providers can check eligibility by performing an eligibility verification on the TMHP website at www.tmhp.com or by calling the TMHP AIS at 1-800-925-9126.

4.5.3.4 Newborn's eligibility

For CHIP Perinatal newborns with a family income at or below pregnant women's Medicaid limits FPIL, providers can obtain eligibility information and the newborn's PCN by performing an eligibility verification on the TMHP website or by calling the TMHP Contact Center at 1-800-925-9126.

TMHP cannot provide CHIP Perinatal Program eligibility information for the newborn or mother, regardless of the client's income level. For CHIP Perinatal Program eligibility information, contact the CHIP health plan.

A report of birth remains an important step to ensure timely Medicaid eligibility for the newborn. A birth must be reported to the state through the typical birth registry process (e.g., use of Texas Electronic Registration system [TER]). In TER, the screen containing the Medicaid/CHIP number should continue to be populated with the mother's alpha-numeric CHIP Perinatal Program number (e.g., J12345678). In addition, a mother can report the birth by calling 1-877-KIDS-NOW (1-877-543-7669).

4.5.4 Submission of Birth Information to Texas Vital Statistics Unit

Hospital providers must submit birth registry information to the DSHS Vital Statistics Unit in a timely manner. Once received by the Vital Statistics Unit, birth information is transmitted to the state's eligibility systems, so a PCN (Medicaid number) can be issued for newborns whose mothers were at or below the pregnant women's FPIL. Hospitals should use the CHIP Perinatal health plan ID to enter the mother's CHIP perinatal coverage ID number in the Medicaid/CHIP number field on the Texas Electronic Registration (TER) screen. This number will appear as an alpha-numeric combination, starting with a letter followed by eight digits. For example, G12345678.

For more information, go to the HHSC website at www.hhsc.state.tx.us/chip/perinatal/VitalStatisticsInstructions_062807.pdf, or call Texas Vital Statistics at 1-800-452-9115.

4.6 Medically Needy Program (MNP)

The MNP with spend down is limited to children 18 years of age and younger and pregnant women.

The MNP provides Medicaid benefits to children (18 years of age and younger) and pregnant women whose income exceeds the eligibility limits under Temporary Assistance for Needy Families (TANF) or one of the Medical Assistance Only (MAO) programs for children but is not enough to meet their medical expenses. Coverage is available for services within the amount, duration, and scope of Texas Medicaid. Individuals are considered adults beginning the month following their 19th birthday.

Medicaid benefits, including family planning and THSteps preventive services through the MNP, are available to:

- Pregnant women.
- Children 18 years of age and younger.

MNP provides access to Medicaid benefits. Applications are made through HHSC. HHSC determines eligibility for the appropriate Medicaid program.

If spend down is applicable, HHSC issues a Medical Bills Transmittal (Form H1120) to the MNP applicant that indicates the spend down amount, months of potential coverage (limited to the month of application and any of the three months before the application month that the applicant has unpaid medical bills), and HHSC contact information.

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The applicant is responsible for paying the spend down portion of the medical bills. The TMHP Medically Needy Clearinghouse (MNC) determines which bills may be applied to the applicant's spend down according to state and federal guidelines. No Medicaid coverage may be granted until the spend down is met.

Newborns of mothers who must meet a spend down before becoming eligible for Medicaid are *not* automatically eligible for the full year of newborn coverage. The newborn and mother are eligible for the birth month and the two following months. Hospitals and other providers that complete newborn reporting forms should continue to follow the procedures in subsection 3.2.4, "Newborn Care" in *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for these newborns.

4.6.1 Spend Down Processing

Applicants are instructed to submit their medical bills or completed claim forms for application toward their spend down to TMHP MNC along with the Medical Bills Transmittal/Insurance Information Form H1120. Charges from the bills or completed claim forms are applied in date of service order to the spend down amount, which is met when the accumulated charges equal the spend down amount.

Providers can assist medically needy clients with their applications by giving them current, itemized statements or completed claim forms to submit to MNC. MNC holds manually completed claim forms used to meet spend down for ten calendar days preceding the completion of the spend down case, then forwards them to claims processing. The prohibition against billing clients does not apply until Medicaid coverage is provided.

Current itemized statements or completed claim forms must include the following:

- Statement date
- Provider name
- Client name
- Date of service
- All services provided and charges
- Current amount due
- Any insurance or client payments with date of payment (the date and amount of any insurance or payments)

Important: *Amounts used for spend down are deducted from the total billed amount by the provider. Using older bills may provide earlier eligibility for the client.*

Bills for past accounts must be current, itemized statements (dated within the last 60 days) that are from the provider and that verify the outstanding status of the account and the current balance due. Accounts that have had payments made by an insurance carrier, including Medicare, must be accompanied by the carrier's EOB or Remittance Advice and show the specific services covered and amounts paid.

Unpaid bills incurred before the month of potential eligibility (the month with spend down) may be used to meet spend down. Itemized statements must be dated within 60 days of the date they are received at TMHP MNC.

The unpaid balance on currently due accounts may be applied toward the spend down regardless of the date of service. All bills or completed claim forms must be itemized showing the provider's name, client's name, dates of service, statement date, services provided, charge for each service, total charges, amounts and dates of payments, and total due.

Clients have 30 days to submit their bills or completed claim forms. Thirty-day extensions are available to the client as necessary to gather all needed information. The provider can assist by furnishing the additional information to the applicant.

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All communication about submission of billing information is carried out between MNC and the applicant; however, providers can assist clients by:

- Providing clients with current itemized statements or completed claim forms.
- Encouraging clients to submit *all* of their medical bills or completed claim forms incurred from *all* providers at the same time.
- Submitting manual claim forms directly to MNC or to applicants for the MNP, that can be used to meet spend down.

Bills or claim forms submitted to MNC are for application toward the spend down only. Submitting a bill or claim forms for spend down is *not* a claim for reimbursement. *No* claims reimbursement is made from such submittals unless the claim form is complete. The provider must file a Medicaid claim after eligibility has been established to have reimbursement considered by Texas Medicaid. If the provider assisted the client with submission of a claim form, the MNC retains all claim forms for ten calendar days preceding the completion of the spend down case. The MNC then forwards all claim forms directly to claims processing to have reimbursement considered by Texas Medicaid.

MNC informs the applicant and HHSC when the spend down is met. HHSC certifies the applicant for Medicaid and sends the Medicaid Identification form to the applicant when Medicaid eligibility is established. The TMHP MNC mails notification letters to providers when clients have met spend down and TMHP has not yet received any claim for the client's bills. The notification letter states 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 encouraged to inform medical providers of their Medicaid eligibility and make arrangements to pay the charges used to meet the spend down amount. When notified of Medicaid eligibility, the provider asks if the client has retroactive eligibility for previous periods. All bills submitted to MNC are returned to the client, except for claim forms. An automated letter specific to the client's spend down case is attached, indicating which:

- Bills and charges were used to meet the spend down.
- Bills and charges the client is responsible for paying in part or totally.
- Bills the provider may submit to Medicaid for reimbursement consideration.
- Claims have been received and forwarded to TMHP claims processing.

Providers may inquire about status, months of potential eligibility, Medicaid or case number, and general case information by calling the TMHP Contact Center at 1-800-925-9126.

Medically needy applicants who have a case pending or have not met their spend down are considered private-pay clients and may receive bills and billing information from providers. No claims are filed to Medicaid. A claim that is inadvertently filed is denied because of client ineligibility.

4.6.2 Closing an MNP Case

Medically needy cases are closed by MNC for the following reasons:

- Bills were not received within the designated time frame (usually 30 days from the date on which the case is established by the HHSC worker).
- The client failed to provide requested additional case/billing information within 30 days of the MNC request date.
- Insufficient charges were submitted to meet spend down, and the client did not respond to a request for additional charges to be submitted within 30 days of the notification letter.

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Charges submitted after the spend down has been met will not reopen the case automatically. The client must call the Client Hotline at 1-800-335-8957.

Note: *For information regarding the Medically Needy Program for CSHCN Services Program clients refer to the CSHCN Services Program Provider Manual.*

4.7 Medicaid Buy-in for Children (MBIC) Program

The MBIC program is mandated by S.B. 187, 81st Legislature, Regular Session, 2009, to provide acute care Medicaid coverage for children who are 18 years of age and younger and have disabilities. This program creates a state option for children who are ineligible for Supplemental Security Income (SSI) for reasons other than disability.

Children with disabilities must meet the following requirements to be eligible for MBIC:

- Be 18 years of age or younger.
- Have a family income that is no more than 300 percent of FPL before allowable deductions.
- Meet citizenship, immigration, and residency requirements.
- Be unmarried.
- Not reside in a public institution.

Exception: *Clients who are enrolled in the MBIC program before they enter a nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) will continue to receive MBIC benefits until eligibility for the appropriate institutional Medicaid program is determined.*

MBIC clients will be enrolled as Medicaid fee-for-service. MBIC clients are identified by Type Program (TP) 88 on the Your Texas Benefits Medicaid card. MBIC clients have access to the same benefits as Medicaid clients who have disabilities. Claims and prior authorization requests for MBIC clients may be submitted according to current guidelines for Medicaid fee-for-service as indicated in this manual.

MBIC benefits are available to enrolled clients through the end of the month that contains their nineteenth birthday. Clients whose birthday falls on the last day of February of a leap year (e.g., February 29, 2004) will be eligible for benefits through the end of March following their nineteenth year.

4.8 Texas Medicaid Wellness Program

High-cost/high-risk fee-for-service (FFS) and managed care clients may be eligible to receive targeted care management services through the Texas Medicaid Wellness Program. The Wellness Program replaces the Disease Management program that was mandated by Human Resources Code 32.057 & 059. The Wellness Program administrator is McKesson Health Solutions.

The goal of the Wellness Program is to promote improved health outcomes by supporting and sustaining the client-provider relationship. The Wellness Program will contact Medicaid high-cost/high-risk clients to provide comprehensive care management services regardless of disease condition. The Wellness Program also has a diabetes self-management training (DSMT) component and will offer 10 hours of DSMT plus 3 hours nutritional counseling to all clients who have diabetes. Additionally, clients who have a body mass index (BMI) above 25 will receive vouchers for a weight loss program.

The Wellness Program offers the following:

- Provider portal
- Practice support facilitators
- Collaborative learning

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- Support for practice transformation initiatives

Providers must submit claims and prior authorization requests for Wellness Program clients following the guidelines for Medicaid FFS services as defined in this manual or modified by website articles.

Providers may refer potential clients to the Wellness Program at 1-877-530-7756.

4.9 Texas Women's Health Program (TWHP)

The goal of the TWHP is to expand access to family planning services that reduce unintended pregnancies in the eligible population.

TWHP provides an annual family planning exam, family planning services, contraception, and treatment for certain sexually transmitted infections (STIs) for women who meet the following qualifications:

- Must be 18 through 44 years of age
- Must be a United States citizen or eligible immigrant
- Must be a resident of Texas
- Does not currently receive full Medicaid benefits including Medicaid for pregnant women, Children's Health Insurance Program (CHIP), or Medicare Part A or B.
- Does not have other insurance that covers family planning services, or has insurance that covers family planning services, but filing a claim on the health insurance would cause physical, emotional, or other harm from a spouse, parent, or other person
- Has a household income at or below 185 percent of the federal poverty level
- Is not pregnant
- Is not sterile, infertile, or unable to get pregnant because of medical reasons

Note: *Women who have received a sterilization procedure, but have not been confirmed to be sterile, may be eligible for sterilization follow-up services.*

Refer to: Subsection 3.1, "Texas Women's Health Program (TWHP) TWHP Overview" in the *Gynecological and Reproductive Health and Family Planning Services Handbook* (*Vol. 2, Provider Handbooks*).

4.10 Medicaid for Breast and Cervical Cancer (MBCC)

The MBCC program provides full Medicaid benefits to women who meet the program's eligibility requirements. The goal of the program is to improve timely access to breast and cervical cancer treatment for uninsured women who are screened and identified by the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) of the Centers for Disease Control and Prevention (CDC). Additionally, the Texas State Legislature provided funding in 2007 to expand the pool of providers who provide screening and diagnostic services to women so that any provider can diagnose a woman for breast or cervical cancer and she may become eligible for Medicaid through MBCC.

DSHS receives funds from the CDC and awards the funds to providers across the state to perform breast and cervical cancer screenings and diagnostic services under the Breast and Cervical Cancer Services (BCCS) program.

4.10.1 Initial MBCC Program Enrollment

The woman must be diagnosed and in need of treatment for one of the following biopsy-confirmed breast or cervical cancer diagnoses:

- Grade 3 cervical intraepithelial neoplasia (CIN III)

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- Severe cervical dysplasia
- Cervical carcinoma in situ
- Primary cervical cancer
- Ductal carcinoma in situ
- Primary breast cancer

A woman may also be eligible for MBCC if she has a diagnosis of metastatic or recurrent breast or cervical cancer and a need for treatment.

Eligibility is determined by a BCCS contractor, DSHS, and HHSC as follows:

- The BCCS contractor screens the client for eligibility if she has a qualifying diagnosis and, if applicable, helps the woman to complete Form H1034, Medicaid for Breast and Cervical Cancer application. The BCCS contractor reviews and collects all of the required eligibility documentation. The woman cannot apply for MBCC at a local HHSC eligibility office.
- DSHS verifies the client's qualifying diagnosis and submits Form 1034 to HHSC.
- HHSC Centralized Benefits Services staff makes the final Medicaid eligibility determination.

Refer to: The Breast and Cervical Cancer Treatment Information page of the DSHS website for more information about the enrollment process.

4.10.2 MBCC Program Eligibility

To be eligible for MBCC, a woman must be:

- 64 years of age or younger and have been screened for breast or cervical cancer and found to need treatment for either breast or cervical cancer.
- A U.S. citizen or eligible immigrant.
- Uninsured or otherwise not eligible for Medicaid.
- A resident of Texas.

A woman who is eligible to receive Texas Medicaid under MBCC receives full Medicaid benefits beginning the day after she received a qualifying diagnosis and for the duration of her cancer treatment. Services are not limited to the treatment of breast and cervical cancer.

4.10.3 Continued MBCC Program Eligibility

After a woman is enrolled in the MBCC program, eligibility may *continue* if she meets one of the following criteria:

- She is being treated for active disease as defined above,
- She has completed active treatment while in MBCC and is currently receiving hormonal treatment,
- She has completed active treatment while in MBCC and is currently receiving active disease surveillance for TNRBC.

A woman may continue to receive Medicaid benefits as long as she meets the eligibility criteria and provides proof that she is receiving active treatment for breast or cervical cancer. Women who are no longer in MBCC may reapply if they are diagnosed with a new breast or cervical cancer or a metastatic or recurrent breast or cervical cancer.

Note: *Active disease surveillance (for the purposes of determining eligibility for MBCC) is periodically monitoring disease progression in order to quickly treat cancerous and precancerous conditions that arise from the presence of a previously diagnosed TNRBC.*

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If the client's cancer is in remission and the physician determines that the client requires only routine health screening for a breast or cervical condition (e.g. annual breast examinations, mammograms, and Pap tests as recommended by the American Cancer Society and the U.S. Preventative Services Task Force), the client is not considered to be receiving treatment; and MBCC coverage will not be renewed. A client who is subsequently diagnosed with a new, metastatic, or recurrent breast or cervical cancer may reapply for MBCC benefits.

4.11 Medicare and Medicaid Dual Eligibility

Medicaid clients who are also eligible for Medicare Part A (inpatient coverage), Part B (medical coverage), or Part C (noncontracted Medicare Advantage Plans [MAPs]), may be covered by Texas Medicaid as follows:

- QMB clients are eligible for coinsurance and deductible payments according to the current payment guidelines.
- MQMB clients are eligible for coinsurance and deductible payments according to the current payment guidelines, and receive Medicaid benefits for services that are not a benefit of Medicare or exceed Medicare benefit limitations.

Medicare Part A and Part C (Noncontracted MAPs Only)

For QMB and MQMB clients who are eligible for Medicare Part A, including clients enrolled in MAPs, claims may be reimbursed to providers for the client's Medicare coinsurance and deductible up to the Medicaid allowed amount for the service less the amount paid by Medicare.

For Medicare Part C, the coinsurance and deductible payment guidelines apply for noncontracted MAPs only.

Medicare Part B

For QMB and MQMB clients who are eligible for Medicare Part B, Texas Medicaid reimburses the lesser of the following to providers:

- The coinsurance and deductible payment.
- The amount remaining after the Medicare payment amount is subtracted from the allowed Medicaid fee or encounter rate for the service (If this amount is less than the deductible, then the full deductible is reimbursed instead.)

If the Medicare payment is equal to, or exceeds the Medicaid allowed amount or encounter payment for the service, Texas Medicaid does not make a payment for coinsurance.

> ***Note:*** *If the Medicare payment is equal to or exceeds the Medicaid allowed amount or encounter payment for the service, no additional payment is made for coinsurance and deductible.*

QMB clients are not eligible for Medicaid coverage for benefits that are not covered by Medicare, and QMB clients are not eligible for THSteps or CCP Medicaid benefits.

QMB and MQMB coverage guidelines do not impact clients who are living in nursing facilities and who receive a vendor rate for client care through DADS.

Claims for Medicare copayments can also be submitted to TMHP.

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Refer to: Subsection 2.7.4, "Exceptions" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for information about exceptions for Medicare Part B and Part C (noncontracted MAPs).

Subsection 6.12.2.2, "Health Maintenance Organization (HMO) Copayments" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for information about HMO copayments.

Section 6: Claims Filing (*Vol. 1, General Information*) for more information about filing claims for MQMBs and QMBs.

4.11.1 QMB/MQMB Identification

The term "QMB" or "MQMB" on the Your Texas Benefits Medicaid card website indicates the client is a Qualified Medicare Beneficiary or a Medicaid Qualified Medicare Beneficiary. The Medicare Catastrophic Coverage Act of 1988 requires Medicare premiums, deductibles, and coinsurance payments to be paid for individuals determined to be QMBs or MQMBs who are enrolled in Medicare Part A and meet certain eligibility criteria (see 1 TAC §§358.201 and 358.202).

Refer to: Your Texas Benefits Medicaid Card (English and Spanish) on the TMHP website at www.tmhp.com.

4.11.2 Medicare Part B Crossovers

The following qualify as Medicare Part B crossover claims: QMB, MQMB, and client TPs 13 or 14, with base plan 10, and category R.

If the provider has not accepted Medicare assignment, the provider may receive payment of the Medicare deductible or coinsurance according to current guidelines on behalf of the QMB, MQMB, client TPs 13 or 14, base plan 10, and category R client. If the provider has collected money from the client and also received reimbursement from TMHP, the provider is required to refund the client's money.

The Social Security Act requires that Medicaid payment for physician services under Medicare Part B be made on an assignment-related basis.

If Medicaid does not reimburse all or a part of the deductible or coinsurance, the provider is not allowed to bill the client.

Refer to: Subsection 2.7, "Medicare Crossover Claim Reimbursement" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

4.11.3 Clients Without QMB or MQMB Status

Medicare is primary to Medicaid, and providers must bill Medicare first for their claims. Medicaid's responsibility for coinsurance and deductibles is determined in accordance with the Medicaid benefits and limitations including the 30-day spell of illness. TMHP denies claims if the client's coverage reflects Medicare Part A coverage and Medicare has not been billed first.

Providers must check the client's Medicare card for Part A coverage before billing Texas Medicaid.

Refer to: Subsection 2.7, "Medicare Crossover Claim Reimbursement" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

4.11.4 Medicare Part C

Providers can receive information about a client's Medicare Part C eligibility through TexMedConnect or EDI. In response to an eligibility inquiry, providers receive the client's Medicare Part C eligibility effective date, end date, and add date.

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HHSC contracts with some Medicare Advantage Plans (MAPs) and offers a per-client-per-month payment. The payment to the MAP includes all costs associated with the Medicaid cost sharing for dual-eligible clients. MAPs that contract with HHSC will reimburse providers directly for the cost sharing obligations that are attributable to dual-eligible clients enrolled in the MAP. These payments are included in the capitated rate paid to the HMO and must not be billed to TMHP or a Medicaid client.

TMHP now processes certain claims for clients enrolled in a Medicare Advantage Plan (Part C).

Refer to: Subsection 6.13, "Filing Medicare Primary Claims" in Section 6, "Claims Filing" (*Vol.1, General Information*).

A list of MAPs that have contracted with HHSC is available in the "EDI" section of the TMHP website at www.tmhp.com. The list will be updated as additional plans initiate contracts.

4.12 Third Party Liability (TPL)

Federal and state laws require the use of Medicaid funds for the payment of most medical services only after all reasonable measures have been made to use a client's third party resources (TPR) or other insurance.

To the extent allowed by federal law, a health-care service provider must seek reimbursement from available third party insurance that the provider knows about or should know about before billing Texas Medicaid. All claims for clients with other insurance coverage must reference the information (see subsection 6.12, "Other Insurance Claims Filing" in Section 6, "Claims Filing" [*Vol. 1, General Information*]), regardless of whether a copy of the EOB from the insurance company is submitted with the claim.

Refer to: Subsection 7.2, "Refunds to TMHP" in Section 7, "Appeals" (*Vol. 1, General Information*) for information regarding refunds to TMHP resulting from other insurance payments and conditions surrounding provider billing of third party insurers.

Eligible clients enrolled in private HMOs must not be charged the co-payment amount because the provider has accepted Medicaid assignment.

A provider who furnishes services and participates in Texas Medicaid may not refuse to furnish services to an eligible client because of a third party's potential liability for payment of the services.

A TPR is a source of payment for medical services other than Medicaid, the client, and non-TPR sources. TPR includes payments from any of the following sources:

- Other health insurance including assignable indemnity contracts
- Health maintenance organization (HMO)
- Public health programs available to clients with Medicaid such as Medicare and Tricare
- Profit and nonprofit health plans
- Self-insured plans
- No-fault automobile insurance such as personal injury protection (PIP) and automobile medical insurance
- Liability insurance
- Life insurance policies, trust funds, cancer policies, or other supplemental policies
- Workers' Compensation
- Other liable third parties

Reminder: *Adoption agencies/foster parents are no longer considered a TPR. Medicaid is primary in these circumstances.*

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Refer to: Subsection 4.12.4, "THSteps TPR Requirements" in this section for THSteps TPR exceptions.

Family planning (including Title XIX and the DSHS Family Planning Program) services providers cannot bill a client's TPRs before filing the claim with TMHP. Federal regulations protect the client's confidential choice of birth control and family planning services. Confidentiality is jeopardized when seeking information from TPRs.

SHARS providers are not required to file claims with private insurance before billing Medicaid.

Early Childhood Intervention (ECI) providers are not required to file claims with private insurance before billing Medicaid for Targeted Case Management services.

Case Management for Children and Pregnant Women providers are not required to file claims with other health insurance before filing with Medicaid.

Non-TPR sources are secondary to Texas Medicaid and may only pay benefits after Texas Medicaid. The following are the most common non-TPR sources. If providers have questions about others not listed, they may contact a provider relations representative.

- DARS, Blind Services
- Texas Kidney Health Care Program
- Crime Victims' Compensation Program
- Muscular Dystrophy Association
- CSHCN Services Program
- Texas Band of Kickapoo Equity Health Program
- Maternal and Child Health
- DSHS Family Planning Program
- State Legalization Impact Assistance Grant (SLIAG)
- Adoption Agencies
- Home and Community-based Waivers Programs through DADS

Note: *Claims for clients who are seeking disability determination must be submitted to DARS for consideration of reimbursement. Refer to the DARS website at www.dars.state.tx.us for additional information about disability determinations and claims filing.*

Denied claims or services that are not a benefit of Medicaid may be submitted to non-TPR sources.

If a claim is submitted inadvertently to a non-TPR source listed above before submission to TMHP, the claim may be submitted to TMHP using the filing deadlines identified under subsection 6.1.4, "Claims Filing Deadlines" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

If a non-TPR source erroneously makes a payment for a dual-eligible client for services also covered by Medicaid, the payment is refunded to the non-TPR source.

Any indemnity insurance policy that pays cash to the insured for wages lost or for days of hospitalization rather than for specific medical services is considered a TPR *if the policy is assignable to someone else*. HHSC has assignment to any Medicaid applicant's or client's right of recovery from a third party health insurer, to the extent of the cost of medical care services paid by Medicaid. Texas Medicaid requires a provider take all reasonable measures to use a client's TPR before billing Medicaid.

Medicaid-eligible clients may not be held responsible for billed charges that are in excess of the TPR payment for services covered by Texas Medicaid. If the TPR pays less than the Medicaid-allowable amount for covered services, the provider should submit a claim to TMHP for any additional allowable amount.

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4.12.1 Your Texas Benefits Medicaid Card

Client TPR and other insurance information may be verified using the Your Texas Benefits Medicaid card website at www.YourTexasBenefitsCard.com.

To ensure receipt of TPR disposition of payment or denial, providers must obtain an assignment of insurance benefits from the client at the time of service. Providers are asked not to provide claim copies or statements to the client.

Providers that are aware that a client has other health insurance that is not indicated on the Your Texas Benefit Medicaid card website must notify TMHP of the details concerning the type of policy and scope of benefits.

Providers can notify TMHP by calling TPR at 1-800-846-7307, Option 2, sending a fax to (512) 514-4225, or submitting the Other Insurance Form to the following address:

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

4.12.2 Workers' Compensation

Payment of covered services under Workers' Compensation is considered reimbursement in full. The client must not be billed. Services not covered by Workers' Compensation must be billed to TMHP.

4.12.3 Adoption Cases

- TMHP/Medicaid, not the adoption agency, should be billed for all medical services that are a benefit of Texas Medicaid.
- If a claim is inadvertently sent to the adoption agency before it is sent to TMHP, TMHP must receive the claim within 95 days of the date of disposition from the adoption agency denial, payment, request for refund or recoupment, to be considered for payment.
- If the adoption agency inadvertently makes a payment for services covered by Medicaid, the provider should refund the payment to the agency.

Refer to: Subsection 6.1.4, "Claims Filing Deadlines" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

A copy of the non-TPR disposition must be submitted with the claim and received at TMHP within 95 days from the date of the disposition (denial, payment, request for refund, or recoupment of payment by the non-TPR source).

4.12.4 THSteps TPR Requirements

THSteps medical and dental providers are not required to bill other insurance before billing Medicaid. If the provider is aware of other insurance, however, the provider must choose whether or not to bill the other insurance. The provider has the following options:

- If the provider chooses to bill the other insurance, the provider must submit the claim to the client's other insurance before submitting the claim to Medicaid.
- If the provider chooses to bill Medicaid and not the client's other insurance, the provider is indicating acceptance of the Medicaid payment as payment in full. Medicaid then has the right to recovery from the other insurance. The provider does not have the right to recovery and cannot seek reimbursement from the other insurance after Medicaid has made payment.
- If the provider learns of other insurance coverage after Medicaid has paid, the provider must refund Medicaid before billing the other insurance.

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Refer to: Subsection 4.5.2, "Third Party Resources (TPR)" in the *Children's Services Handbook (Vol. 2, Provider Handbooks)* for more information.

4.12.5 Accident-Related Claims

TMHP monitors all accident claims to determine whether another resource may be liable for the medical expenses of clients with Medicaid coverage. Providers are requested to ask clients whether medical services are necessary because of accident-related injuries. If the claim is the result of an accident, providers enter the appropriate code and date in Block 10 of the CMS-1500 paper claim form, and Blocks 31-34 on the UB-04 CMS-1450 paper claim form.

If payment is immediately available from a known third party such as Workers' Compensation or PIP automobile insurance, that responsible party must be billed before Medicaid, and the insurance disposition information must be filed with the Medicaid claim. If the third party payment is substantially delayed because of 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. Include the following information on these claims:

- Name and address of the liable third party
- Policy and claim number
- Description of the accident including location, date, time, and alleged cause
- Reason for delayed payment by the liable third party

4.12.5.1 Accident Resources, Refunds

Acting on behalf of HHSC, TMHP has specific rights of recovery from any settlement, court judgment, or other resources awarded to a client with Medicaid coverage (Texas Human Resources Code, Chapter 32.033). In most cases, TMHP works directly with the attorneys, courts, and insurance companies to seek reimbursement for Medicaid payments. If a provider receives a portion of a settlement for services also paid by Medicaid, the provider must make a refund to TMHP. Any provider filing a lien for the entire billed amount must contact the TPL/Tort Department at TMHP for Medicaid postpayment activities to be coordinated. A provider may not file a lien for the difference between the billed charges and the Medicaid payment. A lien may be filed for services not covered by Medicaid. A lien is the liability of the client with Medicaid coverage.

Providers should contact the TPL/Tort Department at TMHP after furnishing an itemized statement and/or claim copies for any accident-related services billed to Medicaid if they received a request from an attorney, a casualty insurance company, or a client.

The provider furnishes TMHP with the following information:

- Client's name
- Medicaid ID number
- Dates of service involved
- Name and address of the attorney or casualty insurance company (including the policy and claim number)

This information enables TMHP to pursue reimbursement from any settlement. Providers must use the Tort Response Form to report accident information to TMHP. When the form is completed, providers must remit it to the TMHP TPL/Tort Department (the address and fax number are on the form).

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Providers may contact the TMHP TPL/Tort Department by calling 1-800-846-7307, Option 3, sending a fax to 1-512-514-4225, or mailing to the following address:

Texas Medicaid & Healthcare Partnership
TPL/Tort Department
PO Box 202948
Austin, TX 78720-2948

4.12.6 Third Party Liability - Tort

HHSC contracts with TMHP to administer third party liability cases. To ensure that Texas Medicaid is the payer of last resort, TMHP performs postpayment investigations of potential casualty and liability cases. TMHP also identifies and recovers Medicaid expenditures in casualty cases involving Medicaid clients.

The Human Resources Code, chapter 32, section 32.033 establishes automatic assignment of a Medicaid client's right of recovery from personal insurance as a condition of Medicaid eligibility.

Investigations are a result of referrals from many sources, including attorneys, insurance companies, health-care providers, Medicaid clients, and state agencies. Referrals should be submitted to the following address:

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

Referrals must be submitted on Authorization for Use and Release of Health Information on the TMHP website at www.tmhp.com.

TMHP releases Medicaid claims information when an HHSC Authorization for Use and Release of Health Information Form is submitted. The form must be signed by the Medicaid client. Referrals are processed within ten business days.

Refer to: Authorization for Use and Release of Health Information on the TMHP website at www.tmhp.com.

An attorney or other person who represents a Medicaid client in a third party claim or action for damages for personal injuries must send written notice of representation. The written notice must be submitted within 45 days of the date on which the attorney or representative undertakes representation of the Medicaid client, or from the date on which a potential third party is identified. The following information must be included:

- The Medicaid 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 asserted for injuries to the Medicaid client.
- The name and address of any health-care provider that has asserted a claim for payment for medical services provided to the Medicaid client for which a third party may be liable for payment, whether or not the claim was submitted to or paid by TMHP.

If any of the information described above is unknown at the time the initial notice is filed, it should be indicated on the notice and revised if and when the information becomes known.

An authorization to release information about the Medicaid client directly to the attorney or representative may be included as a part of the notice and must be signed by the Medicaid client. The HHSC Authorization for Use and Release of Health Information Form must be used.

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

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Providers may direct third party liability questions to the TMHP TPL/Tort Contact Center at 1-800-846-7307, Option 3.

4.12.6.1 Providers Filing Liens for Third Party Reimbursement

Any provider filing a lien for the entire billed amount must contact the TMHP TPL/Tort Department for Medicaid postpayment activities to be coordinated.

A provider may file a lien for the entire billed amount only after meeting the criteria in 1 TAC §354.2322, summarized below. Providers who identify a third party, within 12 months of the date of service, and wish to submit a bill or other written demand for payment or collection of debt to a third party after a claim for payment has been submitted and paid by Medicaid must refund any amounts paid before submitting a bill or other written demand for payment or collection of debt to the third party for payment, and they must comply with the provisions set forth in 1 TAC §354.2322, which states:

Providers may retain a payment from a third party in excess of the amount Medicaid would otherwise have paid only if the following requirements are met:

- The provider submits an informational claim to TMHP within the claims filing deadline. (See Informational Claims below.)
- The provider gives notice to the client or the attorney or representative of the client that the provider may not or will not submit a claim for payment to Medicaid and the provider may or will pursue a third party, if one is identified, for payment of the claim. The notice must contain a prominent disclosure that the provider is prohibited from billing the client or a representative of the client for any Medicaid-covered services, regardless of whether there is an eventual recovery or lack of recovery from the third party or Medicaid.
- The provider establishes the right to payment separate of any amounts claimed and established by the client.
- The provider obtains a settlement or award in its own name separate from a settlement obtained by or on behalf of the client or award obtained by or on behalf of the client, or there is an agreement between the client or attorney or representative of the client and the provider, that specifies the amount that will be paid to the provider after a settlement or award is obtained by the client.

4.12.6.2 Informational Claims

If providers determine that a third party may be liable for a Medicaid client's accident-related claim, they can submit an informational claim to the TMHP Tort Department to indicate that a third party is being pursued for payment. This allows providers to secure the 95-day claims filing deadline in the event that the payment is not received from the third party.

TMHP processes informational claims for all claims administered by TMHP, including fee-for-service claims and carve-out services. TMHP does not process informational claims for managed care claims that are administered by the client's MCO or dental plan.

4.12.6.3 Submission of Informational Claims

Providers must submit informational claims to TMHP:

- On a CMS-1450 UB-04 or CMS-1500 paper claim form. Informational claims cannot be submitted to TMHP electronically or by fax.
- On an Informational Claims Submission Form. Providers should complete only one form per client, regardless of how many separate informational claims are being submitted with the form.
- By certified mail.
- Within the 95-day claims filing deadline. Informational claims will not be accepted after the 95-day claims filing deadline.

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Refer to: Informational Claims Submission Form on the TMHP website at www.tmhp.com.

Providers must complete either the Insurance Information field (liable third party) or the Attorney Information field on the Informational Claims Submission Form.

Providers must send the informational claims and the Informational Claims Submission Form by certified mail to TMHP at:

TMHP TPL/Tort Department
PO Box 202948
Austin, TX 78720-2948

TMHP will send providers a letter to confirm that the informational claim was received. The letter will provide the date on which TMHP must receive a request from the provider to convert the informational claim to a claim for payment. If TMHP receives an informational claim that cannot be processed, TMHP will notify the provider of the reason.

Providers can inquire about the status of an informational claim by calling the TMHP TPL/Tort Department at 1-800-846-7307, Option 3. If a provider has not received confirmation that TMHP has received the informational claim within 30 days, the provider should contact the TMHP TPL/Tort Department at 1-800-846-7307, Option 3 to validate the status of the request.

4.12.6.4 Informational Claim Converting to Claims for Payment

If providers have submitted an informational claim to TMHP but have not received payment from the liable third party, they must make one of the following determinations and notify TMHP within 18 months of the date of service:

- Providers can continue to pursue a claim for payment against the third party and forego the right to convert an informational claim to a claim for payment by Texas Medicaid.
- Providers can submit a request to convert to the informational claim to a claim for payment consideration from Texas Medicaid.

Providers that decide to convert an informational claim to a claim for payment consideration must submit a request to TMHP. The request must be submitted:

- On provider letterhead.
- With the client's name and Medicaid ID, the date of service, and total billed amount that was originally submitted on the UB-04 CMS-1450 or CMS-1500 paper claim form
- By fax or by mail to:

TMHP/Tort Department
P0 Box 202948
Austin, TX 78720-2948
Fax: 1-512-514-4225

TMHP will not accept any conversion request that is submitted more than 18 months after the date of service, regardless of whether an informational claim was submitted timely to TMHP. All payment deadlines are enforced regardless of whether the provider decides to pursue a third party claim. The conversion of informational claims to actual claims is not a guarantee of payment by TMHP.

4.13 Health Insurance Premium Payment (HIPP) Program

The HIPP Program reimburses for the cost of medical insurance premiums. A Medicaid client is eligible for the HIPP Program when Medicaid finds it more cost effective to reimburse a Medicaid client's group health insurance premiums than to reimburse his or her medical bills directly through Medicaid.

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By ensuring access to employer sponsored health insurance, individuals who are eligible for the HIPP Program may receive services that are not normally covered through Medicaid. Also, members of the family who are not eligible for Medicaid may be eligible for the HIPP Program.

Providers can benefit from this program by helping the uninsured population, saving money for the state of Texas, and receiving a higher payment from the group health insurance carrier. Providers can increase HIPP Program enrollment by displaying brochures to educate their Medicaid clients about the program.

For more information, call the TMHP-HIPP Program at 1-800-440-0493 or visit www.gethipptexas.org.

4.14 Long-Term Care Providers

A nursing facility, home health services provider, or any other similar long-term care services provider that is Medicare-certified must:

- Seek reimbursement from Medicare before billing Texas Medicaid for services provided to an individual who is eligible to receive similar services under the Medicare program.
- Appeal Medicare claim denials for payment, as directed by the department.

A nursing facility, home health services provider, or any other similar long-term care services provider that is Medicare-certified is not required to seek reimbursement from Medicare before billing Texas Medicaid for a person who is Medicare-eligible and has been determined to not be homebound.

4.15 State Supported Living Centers

Inpatient hospital care for individuals who are eligible for Supplemental Security Income (SSI) Medicaid and reside in a State Supported Living Center (SSLC) must be billed to TMHP. Medicaid providers who render off-campus acute care services to Medicaid-eligible SSLC residents are also required to submit claims directly to Medicaid. This is applicable only to residents of the SSLCs operated by DADS.

Claims and prior authorization requests for acute care services that are rendered to these clients must be submitted directly to Medicaid.

Providers may contact DADS for assistance or information about billing procedures for state school services.

4.16 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Your Texas Benefits Medicaid Card (English and Spanish)
Informational Claims Submission Form
Other Insurance Form
Authorization for Use and Release of Health Information
Authorization for Use and Release of Health Information (Spanish)
Tort Response Form

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Section 5: Fee-for-Service Prior Authorizations

Texas Medicaid Provider Procedures Manual: Vol. 1

April 2016

TEXAS
Health and Human
Services Commission

SECTION 5: FEE-FOR-SERVICE PRIOR AUTHORIZATIONS

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5.1 * General Information About Prior Authorization

Some fee-for-service Medicaid services require prior authorization as a condition for reimbursement. Information about whether a service requires prior authorization, as well as prior authorization criteria, guidelines, and timelines for the service, is contained in the handbook within Volume 2 that contains the service.

Prior authorization is not a guarantee of payment. Even if a procedure has been prior authorized, reimbursement can be affected for a variety of reasons, e.g., the client is ineligible on the date of service (DOS) or the claim is incomplete. Providers must verify client eligibility status before providing services.

In most instances prior authorization must be approved before the service is provided. Prior Authorization for urgent and emergency services that are provided after business hours, on a weekend, or on a holiday may be requested on the next business day. TMHP considers providers' business hours as Monday through Friday, from 8 a.m. to 5 p.m., Central Time. Prior authorization requests that do not meet these deadlines may be denied.

To avoid unnecessary denials, the request for prior authorization must contain correct and complete information, including documentation of medical necessity. The documentation of medical necessity must be maintained in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for prior authorization.

Prior authorization requests may be submitted to the TMHP Prior Authorization Department by mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

Refer to: Subsection 6.1.4, "Claims Filing Deadlines" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for the TMHP-approved holidays.

Note: *Authorization requests for services administered by a client's managed care organization (MCO) or dental plan must be submitted to the client's MCO or dental plan according to the guidelines that are specific to the plan under which the client is covered.*

Refer to: *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*) for additional information about managed care prior authorizations.

5.1.1 Prior Authorization Requests for Clients with Retroactive Eligibility

Retroactive eligibility occurs when the effective date of a client's Medicaid coverage is before the date the client's Medicaid eligibility is added to TMHP's eligibility file, which is called the "add date."

For clients with retroactive eligibility, prior authorization requests must be submitted after the client's add date and before a claim is submitted to TMHP.

When an authorization request is submitted for a client who has received retroactive Texas Medicaid eligibility, providers should notify TMHP to avoid potential delays. Providers can notify TMHP of the retroactive client eligibility in one of the following ways:

- Add a comment in the additional comments field for authorization requests that are submitted online on the TMHP website at www.tmhp.com or on the eviCore website at www.medsolutionsonline.com (for radiological imaging authorizations only).
- Add a comment on the cover sheet or the authorization request form for authorizations that are faxed to TMHP or eviCore (for radiological imaging authorizations only).

If the authorization request is made by telephone, the caller can indicate to the representative at TMHP or eviCore (for radiological imaging authorizations only) that the client has retroactive Texas Medicaid eligibility.

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For services provided to fee-for-service Medicaid clients during the client's retroactive eligibility period, i.e., the period from the effective date to the add date, prior authorization must be obtained within 95 days from the client's add date and before a claim for those services is submitted to TMHP. For services provided on or after the client's add date, the provider must obtain prior authorization within 3 business days of the date of service.

The provider is responsible for verifying eligibility. The provider is strongly encouraged to access the Automated Inquiry System (AIS) or TexMedConnect to verify eligibility frequently while providing services to the client. Client eligibility can also be verified through the Your Texas Benefits Medicaid card website at www.YourTexasBenefitsCard.com. If services are discontinued before the client's add date, the provider must still obtain prior authorization within 95 days of the add date to be able to submit claims.

Refer to: Section 4: Client Eligibility (*Vol. 1, General Information*).

5.1.2 Prior Authorization Requests for Newly Enrolled Providers

TMHP cannot issue a prior authorization before Medicaid enrollment is complete. Upon notice of Medicaid enrollment, by way of issuance of a provider identifier, the provider must contact the appropriate TMHP Authorization Department to request prior approval before providing services that require prior authorization. Regular prior authorization procedures are followed after the TMHP Prior Authorization Department has been contacted.

Retroactive authorizations are not issued unless the regular authorization procedures for the requested services allow for authorizations to be obtained after services are provided. Providers should refer to specific handbook sections for details about authorization requirements, claims filing, and timeframe guidelines for authorization request submissions. Retroactive authorizations may be granted according to the timeframe guidelines for the specific service requested, and do not exceed those timeframes.

Note: *All claims must adhere to the claims filing deadlines as outlined in this manual. Retroactive authorizations cannot exceed the claims filing deadline, and are not issued if the date of services is more than 95 days from the date the new provider identifier is issued as identified by the add date.*

Refer to: Section 1: Provider Enrollment and Responsibilities (*Vol. 1, General Information*).

5.1.3 Prior Authorization for Services Rendered Out-of-State

Texas Medicaid covers medical assistance services that are provided to eligible Texas Medicaid clients while they are in a state other than Texas; however, clients are not covered if they leave Texas to receive out-of-state medical care that can be received in Texas. Services that are provided outside of the state are covered by Texas Medicaid to the same extent that medical assistance is furnished and covered in Texas when the service meets one or more requirements of Texas Administrative Code (TAC) Title 1 §352.17.

Note: *Border state providers (providers that render services within 50 miles of the Texas border) are considered in-state providers for Texas Medicaid.*

Services that are rendered outside of the state must be prior authorized by Texas Medicaid, and TMHP must receive claims from out-of-state providers within 365 days of the date of service. Out-of-state providers that seek reimbursement for services that are rendered outside of the state must submit a Texas Medicaid Provider Enrollment application and be approved for enrollment in Texas Medicaid.

Transplant services that are provided out-of-state but available in Texas will not be reimbursed by Texas Medicaid. When requesting an out-of-state prior authorization for a pre-transplant evaluation, the provider must submit a copy of the transplant evaluation performed by a Texas facility to support the need for an out-of-state pre-transplant evaluation.

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Medical assistance and transplant services that are provided to eligible Texas Medicaid clients must meet the criteria included in subsection 1.9, "Enrollment Criteria for Out-of-State Providers" (*Vol. 1, General Information*). If services are rendered to eligible Texas Medicaid clients that do not meet the criteria, the services are not a benefit of Texas Medicaid and will not be considered for reimbursement.

Refer to: Subsection 1.9, "Enrollment Criteria for Out-of-State Providers" in Section 1, "Provider Enrollment and Responsibilities" (*Vol.1, General Information*).

Subsection 2.6, "Out-of-State Medicaid Providers" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol.1, General Information*).

5.1.4 Prior Authorization Requests for Clients with Private Insurance

If a client's primary coverage is private insurance and Medicaid is secondary but prior authorization is required for Medicaid reimbursement, providers must follow the guidelines and requirements listed in the handbook for that service.

5.1.5 Prior Authorization Requests for Clients with Medicare/Medicaid

If a client's primary coverage is Medicare, providers must always confirm with Medicare whether a service is a Medicare benefit for the client.

If a service that requires prior authorization from Medicaid is a Medicare benefit and Medicare approves the service, prior authorization from TMHP is not required for reimbursement of the coinsurance or deductible. If Medicare denies the service, then prior authorization is required. TMHP must receive a prior authorization request within 30 days of the date of Medicare's final disposition. The Medicare Remittance Advice and Notification (MRAN) that contains Medicare's final disposition must accompany the prior authorization request.

If a service requires prior authorization through Medicaid and the service is not a benefit of Medicare, providers may request prior authorization from TMHP before receiving the denial from Medicare.

Note: *Refer to the appropriate handbooks in this manual for additional prior authorization guidelines for clients with dual eligibility.*

5.1.6 Prior Authorizations for Personal Care Services (PCS)

Before sending a prior authorization request for personal care services to TMHP, the Texas Department of State Health Services (DSHS) will fax the communication tool to the provider. The provider must verify that the information listed on the tool is accurate. If any information on the communication tool is inaccurate, the provider must call the DSHS case manager listed on the tool within three business days of receipt to explain the inaccuracy. The DSHS case manager will correct the communication tool and will fax the updated tool to the provider. The provider must review the updated communication tool and call the DSHS case manager if any inaccuracies remain.

If the provider does not contact the DSHS case manager within three business days of receipt of the communication tool, the case manager will send a prior authorization request to TMHP to have the authorization issued with the information provided on the communication tool.

Important: *If a provider fails to notify the DSHS case manager of inaccurate information within three business days of receipt of the communication tool, HHSC will not consider making changes to authorizations for past dates of service.*

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It is the PCS provider's responsibility to know the prior authorization period for each client who has an open authorization and to ensure that, before the authorization expires, a DSHS case manager has conducted a reassessment and extended the authorization through TMHP. If a provider has not received an updated provider notification letter from TMHP within 30 days of the authorization's expiration date, the provider should do one of the following:

- Call the TMHP PCS Prior Authorization Inquiry Line at 1-888-648-1517 and ask whether an authorization is in process.
- Call the TMHP PCS Client Line at 1-888-276-0702, Option 2, and ask for a referral to have DSHS conduct a reassessment.
- Call the DSHS regional office, and notify the DSHS case manager that a new authorization has not been received.

Clients can experience a gap in service if an authorization is not updated before it expires. Providers will not be reimbursed for services provided after an authorization has expired and before a new authorization has been issued.

Providers must retain current client information on file.

5.1.6.1 Authorizations for Multiple PCS Clients Within the Same Household

DSHS case managers synchronize PCS authorizations within households that have multiple clients who are receiving PCS.

Synchronization of authorizations within households are made as PCS reassessments come due. When clients are due for reassessment, the DSHS case manager assess all eligible clients in the home and submit authorizations for all eligible clients in the household for the same 52-week authorization period. Some authorizations within a household may be shortened or closed and then reinstated to be in alignment with other clients in the same household. DSHS case managers communicate with the provider about the actions that are being taken using the existing Communication Tool.

Note: *There should be no lapse in services to the client.*

5.1.6.2 Verifying the Texas Provider Identifier (TPI) on PCS Authorizations

When an authorization notification letter is received by a PCS provider, the provider should verify that the correct TPI was used on the prior authorization for the PCS client. Providers must verify that the TPI on the prior authorization is correct for the location at which the client is receiving services.

Providers who provide services through the Agency option or the Consumer Directed Services (CDS) option must ensure that the TPI on the prior authorization is accurate for the option the client is using. If a provider discovers that the TPI used on the prior authorization is incorrect, the provider should contact the DSHS case manager and ask for the correct TPI to be submitted to TMHP.

5.1.7 Prior Authorization for Outpatient Self-Administered Prescription Drugs

Refer to: Subsection B.1.4, "Obtaining Outpatient Prescribed Drug Prior Authorization for FFS Clients" in Appendix B: Vendor Drug Program (*Vol. 1, General Information*).

5.1.8 Prior Authorization for Nonemergency Ambulance Transport

According to 1 TAC §354.1111, nonemergency transport is defined as ambulance transport provided for a Medicaid client to or from a scheduled medical appointment, to or from a licensed facility for treatment, or to the client's home after discharge from a hospital when the client has a medical condition such that the use of an ambulance is the only appropriate means of transportation (i.e., alternate means of transportation are medically contraindicated).

Refer to: *Ambulance Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about ambulance services.

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According to Human Resource Code (HRC) §32.024 (t), a Medicaid-enrolled physician, nursing facility, health-care provider, or other responsible party is required to obtain authorization before an ambulance is used to transport a client in circumstances not involving an emergency.

HRC states that a provider of nonemergency ambulance transport is entitled to payment from the nursing facility, health-care provider, or other responsible party that requested the service if payment under the Medical Assistance Program is denied because of lack of prior authorization and the ambulance provider submits a copy of the claim for which payment was denied.

Refer to: Subsection 5.1.8.1, "Appealing Non-Emergent Ambulance Claims Denied for Missing Prior Authorization Number" in this section for more information about appeals.

Medical Transportation Program Handbook (*Vol. 2, Provider Handbooks*) for more information about the Medical Transportation Program.

TMHP responds to nonemergency transport prior authorization requests within 2 business days of receipt of requests for 60 days or less. Providers should submit all requests for a prior authorization number (PAN) in sufficient time to allow TMHP to issue the PAN before the date of the intended transport.

If the client's medical condition is not appropriate for transport by ambulance, nonemergency ambulance services are not a benefit. Prior authorization is a condition for reimbursement but is not a guarantee of payment. The client and provider must meet all of the Medicaid requirements, such as client eligibility and claim filing deadlines.

Medicaid providers who participate in one of the Medicaid Managed Care health maintenance organization (HMO) plans must follow the HMO's prior authorization requirements.

The TMHP Ambulance Unit reviews the prior authorization request to determine whether the client's medical condition is appropriate for transport by ambulance. Incomplete information may cause the request to be suspended for additional medical information or be denied.

The following information helps TMHP determine the appropriateness of the transport:

- An explanation of the client's physical condition that establishes the medical necessity for transport. The explanation must clearly state the client's condition requiring transport by ambulance.
- The necessary equipment, treatment, or personnel to be used during the transport.
- The origination and destination points of the client's transport.

Prior authorization is required when an extra attendant is needed for any nonemergency transport.

When a client's condition changes, such as a need for oxygen or additional monitoring during transport, the prior authorization request must be updated.

Refer to: Subsection 2.4.8, "Extra Attendant" in *Ambulance Services Handbook* (*Vol. 2, Provider Handbooks*).

5.1.8.1 Appealing Non-Emergent Ambulance Claims Denied for Missing Prior Authorization Number

Medicaid fee-for-service ambulance providers can appeal claims that have been denied for a missing prior authorization number that was not provided by the requesting physician, facility, or hospital for nonemergent transport. The ambulance provider must include proper documentation with the appeal.

An ambulance provider is required to maintain documentation that represents the client's medical condition and other clinical information to substantiate medical necessity, the level of service, and the mode of transportation requested. This supporting documentation is limited to documents developed or maintained by the ambulance provider.

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The Appeals Process

The ambulance provider must submit the appeal as soon as it is realized that the requesting provider did not obtain the prior authorization. The appeal must be submitted according to all filing deadlines.

Refer to: "Section 7: Appeals" (*Vol. 1, General Information*) for information about filing deadlines.

The following documentation must be included with the appeal to support the need for transport:

- Documentation representing the client's medical condition.
- Other clinical information to support medical necessity.
- Level of service given.
- Mode of transportation requested.
- A copy of the run sheet, which must be signed by the emergency medical technician (EMT) in attendance, and which must also include the name and telephone number of the employee requesting the service for the physician, facility, or hospital.

5.1.8.2 * Prior Authorization Types, Definitions

One-Time, Nonrepeating

One-time, nonrepeating requests are reserved for those clients who require a one-time transport. The request must be signed and dated by a physician, physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), registered nurse (RN), or discharge planner with knowledge of the client's condition. Without a signature and date, the form is considered incomplete.

Recurring

Recurring requests, up to 60 days, are reserved for those clients whose transportation needs are not anticipated to last longer than 60 days. The request must be signed and dated by a physician, PA, NP, or CNS. Without a signature and date, the form is considered incomplete. The request must include the approximate number of visits needed for the repetitive transport (e.g., dialysis, radiation therapy).

Refer to: Non-emergency Ambulance Prior Authorization Request on the TMHP website at www.tmhp.com.

5.1.8.3 Nonemergency Prior Authorization Process

To obtain prior authorization, providers must submit a completed Nonemergency Ambulance Prior Authorization Request Texas Medicaid and CSHCN Services Program form by fax to the TMHP Ambulance Unit at 512-514-4205. Prior authorization can also be requested through the TMHP website at www.tmhp.com.

The Nonemergency Ambulance Prior Authorization Form must not be modified. If the form is altered in any way, the request may be denied. The form must be filled out by the facility or the physician's staff that is most familiar with the client's condition. The ambulance provider must not assist in completing any portion of this form.

Refer to: Non-emergency Ambulance Prior Authorization Request on the TMHP website at www.tmhp.com.

Medicaid providers may request prior authorization using one of the following methods:

- The client's physician, nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID), health-care provider, or other responsible party completes the online prior authorization request on the TMHP website at www. tmhp.com.
- Hospitals may call TMHP at 1-800-540-0694 to request prior authorization Monday through Friday, 7 a.m. to 7 p.m., Central Time. A request may be submitted up to 60 days before the date on which the nonemergency transport will occur.

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A request for a one-day transport may be submitted on the next business day following the transport in some circumstances; however, every attempt should be made to obtain prior authorization before the transport takes place. Authorization requests for one day transports submitted beyond the next business day will be denied.

A request for a recurring transport must be submitted before the client is transported by ambulance.

After a prior authorization request has been approved, if the client's condition deteriorates or the need for equipment changes so that additional procedure codes must be submitted for the transport, the requesting provider must submit a new Nonemergency Ambulance Prior Authorization Request form.

Clients who require a hospital-to-hospital or hospital-to-outpatient medical facility transport are issued a PAN for that transport only.

Refer to: Subsection 4.2.1, "Prior Authorization Requirements" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for more information on nonemergency prior authorization for hospitals.

TMHP reviews all of the documentation it receives. An online prior authorization request submitted through the TMHP website is responded to with an online approval or denial. Alternately, a letter of approval or denial is faxed to the requesting provider. The client is notified by mail if the authorization request is denied or downgraded. Reasons for denial include documentation that does not meet the criteria of a medical condition that is appropriate for transport by ambulance, or the client is not Medicaid-eligible for the dates of services requested. Clients may appeal prior authorization request denials by contacting TMHP Client Notification at 1-800-414-3406. Providers may not appeal prior authorization request denials.

The requesting provider must contact the transporting ambulance provider with the PAN and the dates of service that were approved.

Refer to: Subsection 5.5.1, "Prior Authorization Requests Through the TMHP Website" in this section for additional information, including mandatory documentation requirements and retention.

Providers are not required to fax medical documentation to TMHP; however, in certain circumstances, TMHP may request that the hospital fax the supporting documentation. Incomplete online or faxed request forms are not considered a valid authorization request and are denied.

A nonemergency transport will be denied when a claim is submitted with a Nonemergency Ambulance Prior Authorization Request Texas Medicaid and CSHCN Services Program form that is completed and signed after the service is rendered. In addition, a Nonemergency Ambulance Prior Authorization Request Texas Medicaid and CSHCN Services Program form that is completed and signed after the service is rendered will not be accepted on appeal of the denial.

The hospital must maintain documentation of medical necessity, including a copy of the authorization from TMHP in the client's medical record for any item or service that requires prior authorization. The services provided must be clearly documented in the medical record with all pertinent information regarding the client's condition to substantiate the need and medical necessity for the services.

Refer to: Subsection 4.2.1, "Prior Authorization Requirements" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*).

5.1.8.4 * Nonemergency Ambulance Exception Request

Clients whose physician has documented a debilitating condition and who 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, providers must submit all of the following documentation:

- A completed Nonemergency Ambulance Exception form that is signed and dated by a physician. Without a physician's signature and date, the form is considered incomplete.

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- Medical records that support the client's debilitating condition, which may include, but is not limited to:
  - Discharge information.
  - Diagnostic images (e.g., MRI, CT, X-rays)
  - Care plan.

Note: *Documentation submitted with statements similar to "client has a debilitating condition" are insufficient.*

5.1.8.5 Documentation of Medical Necessity and Run Sheets

5.1.8.5.1 Documentation of Medical Necessity

Retrospective review may be performed to ensure documentation supports the medical necessity of the transport.

Documentation to support medical necessity must include one of the following:

- 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 the use of respiratory equipment). The functional, physical, and mental limitations that have rendered the client 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 (e.g., injury, surgery, or the use of respiratory equipment).
- The client is a direct threat to himself or herself or others, which requires the use of restraints (chemical or physical) or trained medical personnel during transport for client and staff safety (e.g., suicidal).

When physical restraints are needed, documentation must include, but is not limited to, the following:

- Type of restraint
- Time frame of the use of the restraint
- Client's condition

Note: *The standard straps used in an ambulance transport are not considered a restraint.*

5.1.8.5.2 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 that was 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 Texas Medicaid.

The ambulance provider may decline the transport if the client's medical or mental health condition does not meet the medical necessity requirements.

It is the responsibility of the ambulance provider to maintain (and furnish to Texas Medicaid 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 means of transport.

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Coverage will not be allowed if the trip record does not contain a sufficient description of the client's condition at the time of the transfer for Texas Medicaid 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 or opinions such as the following:

- "Patient is nonambulatory."
- "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 "paint a picture" of the client's condition and must be consistent with documentation found in other supporting medical record documentation (including the nonemergency prior authorization request.)

5.1.8.6 Nonemergency Prior Authorization and Retroactive Eligibility

Retroactive eligibility occurs when the effective date of a client's Medicaid coverage is before the eligibility "add date," which is the date the client's Medicaid eligibility is added to TMHP's eligibility file.

For clients with retroactive eligibility, prior authorization requests must be submitted after the client's add date and before a claim is submitted to TMHP.

For services that are provided to fee-for-service Medicaid clients during a client's retroactive eligibility period (i.e., the period from the effective date to the add date), providers must obtain prior authorization within 95 days of the client's add date and before submitting a claim for those services to TMHP.

For services provided on or after the client's add date, the provider must obtain prior authorization within three business days of the date of service.

The provider is responsible for verifying eligibility. The provider is strongly encouraged to verify client eligibility through the Automated Inquiry System (AIS) or TMHP electronic data interchange (EDI) frequently while providing services to the client. If services are discontinued before the client's add date, the provider must still obtain prior authorization within 95 days of the add date to be able to submit claims.

If a client's Medicaid eligibility is pending, a PAN must be requested before a nonemergency transport. Initially this request will be denied for Medicaid eligibility. When Medicaid eligibility is established, the requestor has 95 days from the date on which the eligibility was added to TMHP's files to contact the TMHP Ambulance Unit and request that authorization be considered.

To inquire about Medicaid eligibility, providers can contact AIS at 1-800-925-9126.

5.1.9 Nonemergency Transport Authorization for Medicare and Medicaid Clients

Providers should simultaneously request prior authorization for the nonemergency transport from TMHP for an Medicaid Qualified Medicare Beneficiary (MQMB) client in the event the service requested is denied by Medicare as a non-covered service.

Note: *Qualified Medicare Beneficiary (QMB) clients are not eligible for Medicaid benefits. Providers can contact Medicare for the Medicare prior authorization guidelines.*

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5.2 Authorization Requirements for Unlisted Procedure Codes

Providers have the option to obtain prior authorization before rendering the service if all of the required information is available. When requesting a fee-for-service prior authorization for an unlisted procedure code, providers must submit the following information with the prior authorization request:

- Client's diagnosis.
- Medical records that show the prior treatment for this diagnosis and the medical necessity of the requested procedure.
- A clear, concise description of the procedure to be performed.
- Reason for recommending this particular procedure
- A procedure code that is comparable to the procedure being requested.
- Documentation that this procedure is not investigational or experimental.
- Place of service in which the procedure is to be performed.
- The physician's intended fee for this procedure including the manufacturer's suggested retail price (MSRP) or other payment documentation.

If any of this information is unavailable at the time the prior authorization is requested, the request will be returned as incomplete; however, this is not a denial of reimbursement. If the required information becomes available before the service is performed, the prior authorization request can be resubmitted, or the required medical necessity and payment documentation can be submitted with the claim after the service is provided to be considered for reimbursement.

The prior authorization number must appear on the claim when it is submitted to TMHP. Claims submitted without the appropriate prior authorization will be denied.

5.3 Benefit Code

A benefit code is an additional data element that identifies a state program.

Providers that participate in the following programs must use the associated benefit code when they submit prior authorizations:

Program	Benefit Code
Comprehensive Care Program (CCP)	CCP
Texas Health Steps (THSteps) Medical	EP1
THSteps Dental	DE1
Family Planning Agencies*	FP3
Hearing Aid Dispensers	HA1
Maternity	MA1
County Indigent Health Care Program	CA1
Early Childhood Intervention (ECI) providers	EC1
Tuberculosis (TB) Clinics	TB1
Texas Medicaid Home Health Durable Medical Equipment (DME)	DM2
Case Management Mental Retardation (MR) providers	MH2
***Agencies only—Benefit codes should not be used for individual family planning providers.**	

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5.4 Submitting Prior Authorization Forms

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 has missing, incorrect, or illegible information, TMHP returns 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 of the request receipt date.

TMHP uses 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 are not considered when determining the start date of service.

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

Prior to denying an incomplete request, TMHP's Prior Authorization department will attempt to get the correct information from the requesting provider. The Prior Authorization department will make a minimum of three attempts to contact the requesting provider before sending a letter to the client about the status of the request and the need for additional information.

If the information that is necessary to make a prior authorization determination is not received within 14 business days of 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.

For fee-for-service (FFS) Medicaid requests that require a physician review before a final determination can be made, TMHP's Physician Reviewer will complete the review within three business days of receipt of the completed prior authorization request. An additional three business days will be allowed for requests that require a peer-to-peer review with the client's prescribing physician.

For Children with Special Health Care Needs (CSHCN) Services Program requests that do not appear to meet CSHCN medical policy, the TMHP prior authorization nurse will refer those requests to the CSHCN Services Program for review and determination. The CSHCN Services Program will complete the review within three business days of receipt of the completed prior authorization request.

> ***Note:*** *Providers may resubmit a new, complete request after receiving a denial for an incomplete request; however, the timeliness submission requirements will apply.*

Essential fields contain information needed to process a prior authorization request and include the following:

- Client name
- Client Medicaid number (patient control number [PCN])
- Client date of birth
- Provider name
- TPI
- National Provider Identifier (NPI)
- *Current Procedural Terminology* (CPT) or Healthcare Common Procedure Coding System (HCPCS) procedure code

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- Quantity of service units requested based on the CPT or HCPCS code requested

5.4.1 Recreating TMHP Prior Authorization and Authorization Forms to Fill Out Electronically

Providers are allowed to recreate a Texas Medicaid or CSHCN Services Program prior authorization or authorization form in order to transfer it to an electronic format only if there are no alterations in the form's content or placement of information (field location).

To ensure that the most current version of the form is utilized, all forms submitted to the prior authorization department for processing must include the form number, effective date and revision date, if applicable, as it appears on the original TMHP form that is published on the TMHP Forms web page.

Important: *Prior authorization and authorization forms recreated and filled out electronically on the provider's computer must continue to be printed and faxed or submitted by mail. To submit prior authorization and authorization requests electronically, providers must use the prior authorization tool available on the TMHP website by clicking "**I would like to…**" and "**Submit a prior authorization request**."*

5.5 Prior Authorization Submission Methods

Prior authorization requests can be submitted by fax, mail, telephone, and online through the TMHP website at www.tmhp.com. The methods to use to request the prior authorization depends on the service being requested.

5.5.1 Prior Authorization Requests Through the TMHP Website

Online prior authorization requests for some services in the following areas can be submitted through the TMHP website at www.tmhp.com:

- Home Health
- Home Telemonitoring
- Comprehensive Care Inpatient Psychiatric (CCIP)
- CCP
- Ambulance
- Substance Use Disorder (SUD) (Abuse and Dependence) services

The benefits of submitting prior authorization requests through the TMHP website include:

- Online editing to ensure that the required information is being submitted correctly.
- The prior authorization number is issued within seconds of submission and confirms that the prior authorization request was accepted. Before providing services, providers must confirm that the prior authorization was approved.
- Notification of approvals and denials are available more quickly.
- Extension requests and status checks can be performed online for prior authorization requests that were submitted online.

Providers can access online prior authorization requests from the "I would like to..." links located on the right-hand side of homepage of the TMHP website at www.tmhp.com. Select **Submit a prior authorization request** to submit a new request or **Search for/extend an existing prior authorization** to check the status of or extend a prior authorization request that was previously submitted through the TMHP website.

Instructions for submitting prior authorization requests on the TMHP website are located in the Help section at the bottom of the Prior Authorization page.

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Prior authorizations that are submitted online will be processed using the same guidelines as prior authorizations submitted by other methods.

Before providers can submit online prior authorization requests, providers must register on the TMHP website and assign an administrator for each Texas Provider Identifier (TPI) and National Provider Identifier (NPI), if one is not already assigned. Users who are configured with administrator rights automatically have permission to submit prior authorization requests.

The TPI administrator can assign submission privileges for nonadministrator accounts. Billing services and clearinghouses must obtain access to protected health-care information through the appropriate administrator of each TPI/NPI provider number for which they are contracted to provide services.

5.5.1.1 Duplicate Validation Check

Prior authorizations submitted to TMHP electronically on the TMHP website are subject to a duplicate validation check. Prior authorizations that are duplicates of a previously submitted authorization return an immediate response with an associated duplicate submission error message.

The error message instructs providers to either update or remove details of the prior authorization submission.

If there is a modifier needed for authorization or claims processing, providers should indicate the primary modifier in the field labeled "Modifier 1."

The appropriate modifier that identifies the type of therapy being requested needs to be used when providers submit requests for physical, occupational, and speech therapy.

5.5.1.2 * Document Requirements and Retention

If information provided in the online request is insufficient to support medical necessity, TMHP Prior Authorization staff may ask the provider to submit additional paper documentation to support the medical necessity for the service being requested.

Submission of prior authorization requests on the secure pages of the TMHP website does not replace adherence to and completion of the paper forms/documentation requirements outlined in this manual and other publications.

Documentation requirements include, but are not limited to, the following:

- Documentation that supports the medical necessity for the service requested.
- Completion and retention in the client's medical record of all required prior authorization forms
- Adherence to signature and date requirements for prior authorization forms and other required forms that are kept in the client record, including the following:
  - All prior authorization forms completed and signed before the online prior authorization request is made
  - Original handwritten or electronic signatures (Stamped signatures and images of wet signatures are not accepted by Texas Medicaid.)
- A printed copy of the Online Request Form, which must be retained in the client's medical record

Any provider, client, or client's responsible adult who is required to sign a prior authorization form or any supporting documentation may do so using a wet or electronic signature. Any electronic signature technologies that are used must comply with all federal and state statutes and administrative rules.

Any required documentation that is missing from the client's medical record subjects the associated payments for services to be recouped.

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5.5.1.2.1 Acknowledgement Statement

Before submitting each prior authorization request, providers (and submitters on behalf of providers) must affirm that they have read, understood, and agree to the certification and terms and conditions of the prior authorization request.

Providers and submitters are separately held accountable for their declarations after they have acknowledged their agreement and consent by checking the "We Agree" checkbox after reviewing the certification statement and terms and conditions.

5.5.1.2.2 Certification Statement

"The Provider and Authorization Request Submitter certify that the information supplied on the prior authorization form and any attachments or accompanying information constitute true, correct, and complete information. The Provider and Authorization Request Submitter understand that payment of claims related to this prior authorization will be from federal and state funds, and that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and/or state law. Fraud is a felony, which can result in fines or imprisonment.

"By checking 'We Agree' you agree and consent to the Certification above and to the TMHP `Terms and Conditions.'"

5.5.1.2.3 Terms and Conditions

"I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or U.S. Dept. of Health and Human Services may request. I further agree to accept, as payment in full, the amount paid by Medicaid for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, copayment or similar cost-sharing charge. I certify that the services listed above are/were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

"Notice: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim, based on information provided on the Prior Authorization form, will be from federal and state funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable federal or state law."

Omission of information or failure to provide true and accurate information or notice of changes to the information previously provided may result in termination of the provider's Medicaid enrollment and/or personal exclusion from Texas Medicaid.

5.5.2 * Prior Authorization Requests to TMHP by Fax, Telephone, or Mail

When submitting prior authorization requests through fax or mail, providers must submit the requests on the approved form. If necessary, providers may submit attachments with the form. Providers must follow the guidelines and requirements listed in the handbook for the service. Providers can refer to the provider handbooks for the guidelines and requirements listed for a specific service.

Prior authorization requests must be signed and dated by a physician or dentist who is familiar with the client's medical condition before the request is submitted to TMHP. When allowed, prior authorizations must be signed and dated by an advanced practice registered nurse (APRN) or PA who is familiar with the client's medical condition before the request is submitted to TMHP. Prior authorization requests for services that may be signed by a licensed health-care provider other than a physician, dentist, or when allowed by an APRN and PA, do not require handwritten signatures and dates. Electronic signatures from an RN or therapist are acceptable when submitting therapy requests for CCP.

All signatures must be electronic, digital or handwritten. An electronic or digital signature must be derived using software that creates a digital signature logo with a system-generated date and time stamp or includes the logo of the digital software used. Photocopy or ink stamp of a handwritten signature or

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a typed signature without a digital stamp are not permitted. TMHP will not authorize any dates of services on the request earlier than the date of the provider's signature. The prior authorization request that contains the original signature must be kept in the client's medical record for future access and possible retrospective review. These documentation requirements also apply to telephone authorizations. To avoid delays, providers are encouraged to have all clinical documentation at the time of the initial telephone authorization request.

Note: *Obstetric (OB) services providers are no longer allowed to initiate prior authorization requests or ultrasound extension requests over the telephone.*

To initiate a new prior authorization request or to request an extension of an existing prior authorization, OB services providers are required to submit the request online using the TMHP secure provider portal or on paper by faxing or mailing the applicable prior authorization form to TMHP.

Providers can continue to use the Prior Authorization telephone line to inquire about the status of the prior authorization requests that have been submitted to TMHP online, by fax, or mail.

5.5.2.1 Prior Authorization Calls

Initial prior authorization calls are handled by the TMHP Contact Center. If the contact center representative determines that a prior authorization inquiry can be better handled by the TMHP Prior Authorization department, the TMHP Contact Center representative will transfer the call to a Prior Authorization Clinician.

Note: *This does not impact the timeframes for the resolution of more complex issues.*

5.5.2.2 TMHP Prior Authorization Requests by Fax

Providers who fax new prior authorization requests, resubmitted requests, or additional information to complete a request must include:

- A working fax number on the prior authorization form, so that they can receive faxed responses and correspondence from TMHP.
- The last four digits of the client's Medicaid identification number on the fax coversheet.

Contact	Fax Number
Ambulance Authorization (includes out-of-state transfers)	1-800-540-0694
Ambulance Authorization Fax	1-512-514-4205
Home Health Services Fax	1-512-514-4209
CCP Fax	1-512-514-4212
CCIP	1-512-514-4211
CCIP Fax	1-512-514-4211
Outpatient Psychiatric Fax	1-512-514-4213
TMHP Special Medical Prior Authorization (SMPA) Fax (including transplants)	1-512-514-4213

5.5.2.3 TMHP Prior Authorization Requests by Telephone

Contact	Telephone Number
Ambulance Authorization (including out-of-state transfers)	1-800-540-0694

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5.5.2.4 TMHP Prior Authorization Requests by Mail

Contact	Address
Ambulance (includes out-of-state transfers)	Texas Medicaid & Healthcare Partnership Ambulance Prior Authorizations PO Box 200735 Austin, TX 78720-0735
CCP	Texas Medicaid & Healthcare Partnership Comprehensive Care Program (CCP) Prior Authorization PO Box 200735 Austin, TX 78720-0735
Dental	Texas Medicaid & Healthcare Partnership Dental Prior Authorization PO Box 204206 Austin, TX 78720-4206
Home Health Services	Texas Medicaid & Healthcare Partnership Home Health Services Prior Authorization PO Box 202977 Austin, TX 78720-2977
SMPA	Texas Medicaid & Healthcare Partnership Special Medical Prior Authorization 12357-B Riata Trace Parkway Austin, TX 78727 Fax: 1-512-514-4213

5.5.3 Home Health Services Prior Authorizations

Home health services providers cannot initiate new prior authorization requests or request extensions over the telephone. The following home health services are affected:

- Skilled nursing and home health aide visits
- Physical and occupational therapy
- Durable medical equipment (DME)
- Expendable medical supplies

Home health services providers must initiate new prior authorization requests or request extension of existing prior authorizations online using the TMHP secure provider portal or on paper by faxing or mailing TMHP the appropriate paper prior authorization form.

Home health services providers can use telephone number 1-800-925-8957 for follow-up and status inquiry of prior authorizations.

5.5.4 Radiology Prior Authorizations Through eviCore

eviCore, Inc., performs radiology prior authorization services on behalf of TMHP.

Refer to: Subsection 3.2.6, "Authorization Requirements for CT, CTA, MRI, fMRI, MRA, PET, and Cardiac Nuclear Imaging Services" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) to determine which radiology services require a prior authorization through eviCore.

5.5.4.1 Online Prior Authorizations Through eviCore

Radiology prior authorization requests may be submitted through the eviCore website at www.medsolutionsonline.com. The TMHP website at www.tmhp.com also has links to the eviCore website.

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5.5.4.2 Prior Authorizations to eviCore by Fax, Telephone, or Mail

When submitting radiology prior authorization requests to eviCore by fax or mail, providers must use the approved Radiology Prior Authorization Request Form on the TMHP website at www.tmhp.com.

Telephone: 1-800-572-2116
Fax: 1-800-572-2119
Mail: Texas Medicaid & Healthcare Partnership
730 Cool Springs Blvd., Suite 800
Franklin, TN 37067

5.5.4.3 Retroactive Authorization Requests

Retroactive authorization requests for outpatient diagnostic computed tomography (CT), magnetic resonance (MR), positron emission tomography (PET) and cardiac nuclear imaging services for Texas Medicaid fee-for-service clients must be submitted online to eviCore. The retroactive authorizations requests must be submitted to eviCore no later than 14 calendar days after the day on which the study was completed, regardless of the method of submission. If the retroactive authorization request is submitted after the allotted time, the authorization request will not be processed. Providers can refer to the TMHP website for eviCore's contact information and methods of submission.

5.6 Verifying Prior Authorization Status

Prior authorizations are processed based on the date the request is received. Requests with all required information can take up to three business days after the date of receipt for TMHP to complete the authorization process.

Providers can check the status of prior authorizations requested online through the TMHP website at www.tmhp.com.

Providers may also check status of prior authorizations that are issued by TMHP by using the following numbers.

Contact	Telephone Number
Personal Care Services (PCS) Prior Authorization Inquiry Line	1-888-648-1517
CCP and Home Health Status Line	1-800-846-7470
All other authorization requests	1-800-925-9126

To check the status of radiology prior authorization requests that are submitted to eviCore, providers should contact eviCore directly at www.medsolutionsonline.com or 1-800-572-2116.

5.7 Prior Authorization Notifications

TMHP sends a notification to the provider when the prior authorization is approved, denied, or modified. If TMHP receives prior authorization requests with incomplete or insufficient information, TMHP will ask the requesting provider to furnish the additional documentation needed before TMHP can make a decision on the request. If the requesting provider does not respond to the request for additional information, the prior authorization request will be denied. It is the requesting provider's responsibility to contact the appropriate provider, when necessary, to obtain the additional documentation.

5.8 Prior Authorization Denials Appeals Process

Prior authorizations that are denied by TMHP can be resubmitted to the TMHP Prior Authorization Department with new or additional information for reconsideration.

If the request is denied a second time, or if the provider has no new or additional information, the provider may file an Administrative Appeal to HHSC. Providers must include a copy of the denial letter.

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It is strongly recommended that providers maintain a list that details the prior authorizations, including:

- Client's name
- Client's Medicaid number
- Date of service
- Provider Identifier
- Items submitted

This information will be required if a provider needs to file an administrative review.

5.9 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.

5.10 Submitting Claims for Services That Require Prior Authorization

Claims submitted for services that require prior authorization must indicate the authorization number, provider identifier, procedure codes, dates of service, required modifiers, number of units, and the amount for manually priced procedure codes as detailed on the authorization letter. If the prior authorization letter shows itemized details and the provider rendered all services listed, the details on the claim must match the details on the prior authorization letter.

Important: *Claims processing and payment may be delayed if the detailed information on the authorization letter and the claim details do not match exactly.*

Claims for prior authorized services must contain only one prior authorization number per claim. Prior authorization numbers must be indicated on the applicable electronic fields or in the following blocks for paper claim forms:

Paper Claim Form	Block for Prior Authorization Number
CMS-1500 (professional) claim form	Block 23
UB-04 CMS-1450 (institutional) claim form	Block 63
American Dental Association (ADA) claim form	Block 2
2017 claim form	Block 30

Refer to: Subsection 6.1.3, "TMHP Paper Claims Submission" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

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5.10.1 Authorization and Manually Priced Claims

If prior authorization has been obtained for services that use manually priced procedure codes, providers must submit claims for them using the MSRP that was submitted with the authorization request and the following information that is listed on the authorization letter:

- Authorization number
- Provider identifier
- Procedure codes
- Dates of service
- Types of service
- Required modifiers

If the authorization letter shows itemized details, the claim must include all rendered services as they are itemized on the authorization letter and the MSRP rate for each of those services. The procedure codes and MSRP rates that are detailed on the claim must match the procedure codes that are detailed in the authorization letter and the MSRP rates that were submitted with the authorization request. Claims processing and payment may be delayed if there is not an exact match between the detailed information on the authorization letter, the approved authorization, and the information that was submitted on the claim.

Important: *For appropriate processing and payment, the Pay Price that is indicated on the authorization letter should not be billed on the claim.*

Prior authorization is a condition of reimbursement; it is not a guarantee of payment.

5.11 Guidelines for Procedures Awaiting Rate Hearing

For procedure codes that require prior authorization but are awaiting a rate hearing, providers must follow the established prior authorization process as defined in the applicable provider handbook. Providers must obtain a timely prior authorization for services provided. Providers must not wait until the rate hearing process for the procedure codes is completed to request prior authorization. In this situation, retroactive prior authorization requests are not granted; the requests are denied as late submissions. Providers are also responsible for meeting the initial 95-day filing deadline and for ensuring that the prior authorization number is on the claim the first time it is submitted to TMHP for consideration of reimbursement.

Claims for procedure codes awaiting a rate hearing are denied. TMHP automatically reprocesses affected claims; providers are not required to appeal the claims unless they are denied for additional reasons after the claims reprocessing is complete. If the required prior authorization number is not on the claim at the time of reprocessing, the claim is denied for lack of prior authorization.

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Section 6: Claims Filing

Texas Medicaid Provider Procedures Manual: Vol. 1

April 2016

TEXAS
Health and Human
Services Commission

SECTION 6: CLAIMS FILING

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6.1 Claims Information

Providers that render services to Texas Medicaid fee-for-service and managed care clients must file the assigned claims. Texas Medicaid does not make payments to clients. Federal regulations prohibit providers from charging clients a fee for completing or filing Medicaid claim forms. Providers are not allowed to charge TMHP for filing claims. The cost of claims filing is part of the usual and customary rate for doing business. Providers cannot bill Texas Medicaid or Medicaid clients for missed appointments or failure to keep an appointment. Only claims for services rendered are considered for payment.

Medicaid providers are also required to complete and sign authorized medical transportation forms (e.g., Form 3103, Individual Driver Registrant (IDR) Service Record, or Form 3111, Verification of Travel to Healthcare Services by Mass Transit) or provide an equivalent (e.g., provider statement on official letterhead) to attest that services were provided to a client on a specific date. The client presents these forms to the provider.

Providers are not allowed to bill clients or Texas Medicaid for completing these forms.

6.1.1 TMHP Processing Procedures

TMHP processes claims for services rendered to Texas Medicaid fee-for-service clients and carve-out services rendered to Medicaid managed care clients.

Note: *Claims for services rendered to a Medicaid managed care client must be submitted to the managed care organization (MCO) or dental plan that administers the client's managed care benefits. Only claims for those services that are carved-out of managed care can be submitted to TMHP.*

Refer to: *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*) for more information about carve-out services.

Medicaid claims are subject to the following procedures:

- TMHP verifies all required information is present.
- Claims filed under the same provider identifier and program and ready for disposition at the end of each week are paid to the provider with an explanation of each payment or denial. The explanation is called the Remittance and Status (R&S) Report, which may be received as a downloadable portable document format (PDF) version or on paper. A Health Insurance Portability and Accountability Act (HIPAA)-compliant 835 transaction file is also available for those providers who wish to import claim dispositions into a financial system.

  An R&S Report is generated for providers that have weekly claim or financial activity with or without payment. The report identifies pending, paid, denied, and adjusted claims. If no claim activity or outstanding account receivables exist during the time period, an R&S Report is not generated for the week.
- For services that are billed on a claim and have any benefit limitations for providers, the date of service determines which provider's claims are paid, denied, or recouped. Claims that have been submitted and paid may be recouped 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.

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6.1.1.1 Fiscal Agent

TMHP acts as the state's Medicaid fiscal agent. A fiscal agent arrangement is one of two methods allowed under federal law and is used by all other states that contract with outside entities for Medicaid claims payment. Under the fiscal agent arrangement, TMHP is responsible for paying claims, and the state is responsible for covering the cost of claims.

Note: *The fiscal agent arrangement does not affect Long Term Care (LTC) and Department of State Health Services (DSHS) Family Planning providers.*

Provider Designations

The fiscal agent arrangement requires that providers be designated as either public or nonpublic. By definition, public providers are those that are owned or operated by a city, state, county, or other government agency or instrumentality, according to the Code of Federal Regulations. In addition, any provider or agency that performs intergovernmental transfers to the state would be considered a public provider. This includes those agencies that can certify and provide state matching funds, (i.e., other state agencies). New providers self-designate (public or private) on the provider enrollment application.

The fiscal agent:

- Rejects all claims not payable under Texas Medicaid rules and regulations.
- Suspends payments to providers according to procedures approved by HHSC.
- Notifies providers of reduction in claim amount or rejection of claim and the reason for doing so.
- Collects payments made in error, affects a current record credit to the department, and provides the department with required data relating to such error corrections.
- Prepares checks or drafts to providers, except for cases in which the department agrees that a basis exists for further review, suspension, or other irregularity within a period not to exceed 30 days of receipt and determination of proper evidence establishing the validity of claims, invoices, and statements.
- Makes provisions for payments to providers who have furnished eligible client benefits.
- Withholds payment of claim when the eligible client has another source of payment.
- Employs and assigns a physician, or physicians, and other professionals as necessary, to establish suitable standards for the audit of claims for services delivered and payment to eligible providers.
- Requires eligible providers to submit information on claim forms.

6.1.1.2 Payment Error Rate Measurement (PERM)

The Improper Payments Information Act (IPIA) of 2002 directs federal agency heads, in accordance with the Office of Management and Budget (OMB) guidance, to annually review agency programs that are susceptible to significant erroneous payments and to report the improper payment estimates to the U.S. Congress.

Every three years the CMS will assess the Texas Medicaid Program using the PERM process to measure improper payments in the Texas Medicaid Program and the Children's Health Insurance Program (CHIP).

CMS uses PERM to measure the accuracy of Medicaid and CHIP payments made by states for services rendered to clients. Under the PERM program, CMS will use three national contractors to measure improper payments in Medicaid and CHIP:

- The statistical contractor will provide support to the program by identifying the claims to be reviewed and by calculating each state's error rate.
- The data documentation contractor will collect medical policies from the State and medical records from providers.

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- The review contractor will perform medical and data processing reviews of the selected claims in order to identify any improper payments.

Providers are required to provide medical record documentation to support the medical reviews that the federal review contractor will conduct for Texas Medicaid fee-for-service and CHIP claims.

Note: *The federal review contractor will also conduct reviews for Primary Care Case Management (PCCM) claims that were submitted to TMHP with dates of service on or before February 29, 2012.*

Past studies have shown that the largest cause of error in medical reviews is lack of documentation or insufficient documentation. It is important that information be sent in a timely and complete manner, since a provider's failure to timely submit complete records in support of the claims filed can result in a higher payment error rate for Texas, which in turn can negatively impact the amount of federal funding received by Texas for Medicaid and CHIP.

Providers must submit the requested medical records to the data documentation contractor and HHSC within 60 calendar days of the receipt of the written notice of request. If providers have not responded within 15 days, the data documentation contractor and possibly state officials will initiate reminder calls and letters to providers. The data documentation contractor and possibly state officials will also initiate reminder calls and letters to providers after 35 days. If providers have not responded in 60 days, the data documentation contractor will submit a letter to the provider and the state PERM director indicating a "no documentation error." After the provider's submittal of requested information, the data documentation contractor may request additional information to determine proper payment. In this instance, the provider is given 15 days to provide additional documentation.

If medical records are not received within 60 calendar days, the data documentation contractor will identify the claim as a PERM error and classify all dollars associated with the claim as an overpayment. Providers will be required to reimburse the overpayment in accordance with state and federal requirements.

A provider's failure to maintain complete and correct documentation in support of claims filed or failure to provide such documentation upon request can result in the provider being sanctioned under Title 1, Texas Administrative Code (TAC) Part 15, Chapter 371. Sanction actions may include, but are not limited to, a finding of overpayment for the claims that are not sufficiently supported by the required documentation. Sanctions may include, but are not limited to, a finding of overpayment for the claims that are not sufficiently supported by the required documentation.

6.1.2 Claims Filing Instructions

This manual references paper claims when explaining filing instructions. HHSC and TMHP encourage providers to submit claims electronically. TMHP offers specifications for electronic claim formats. These specifications are available from the TMHP website and include a cross-reference of the paper claim filing requirements to the electronic format.

Providers can participate in the most efficient and effective method of submitting claims to TMHP by submitting claims through the TMHP Electronic Data Interchange (EDI) claims processing system using TexMedConnect or a third party vendor. The proceeding claim filing instructions in this manual apply to paper and electronic submitters. Although the examples of claims filing instructions refer to their inclusion on the paper claim form, claim data requirements apply to all claim submissions, regardless of the media. Claims must contain the provider's complete name, address, and provider identifier to avoid unnecessary delays in processing and payment.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on accessing the TMHP website.

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6.1.2.1 Wrong Surgery Notification

Providers are required to notify TMHP when a wrong surgery or other invasive procedure is performed on a Texas Medicaid client. Notification is mandated by Senate Bill (SB) 203, Section 3, Regular Session, 81st Texas Legislature, which covers preventable adverse events (PAE) and reimbursement for services associated with PAE.

Professional, inpatient, and outpatient hospital claims that are submitted for the wrong surgery or invasive procedure will be denied. Any corresponding procedures that are rendered to the same client, on the same dates of service (for professional and outpatient hospital claims), or the same date of surgery (for inpatient hospital claims) will be denied. Claims that have already been reimbursed will be recouped.

The law requires providers that are submitting claims for services rendered to Texas Medicaid clients to indicate whether any of the following situations apply to the claim:

- The incorrect operation or invasive procedure was performed on the correct client.
- The operation or invasive procedure was performed on the incorrect client.
- The incorrect operation or invasive procedure was performed on the incorrect body part.

Providers must notify Texas Medicaid of a wrong surgery or invasive procedure by submitting one of the following nonspecific injury, poisoning and other consequences of external causes diagnosis codes or modifiers with the procedure code for the rendered service:

Code	Description	Type of Claim
Injury, Poisoning and Other Consequences of External causes Diagnosis Codes		
Y6551	Performance of wrong procedure (operation) on correct patient	Inpatient hospital
Y6552	Performance of procedure (operation) on patient not scheduled for surgery	
Y6553	Performance of correct procedure (operation) on wrong side or body part	
Modifiers		
PA	Surgical or other invasive procedure on wrong body part	Professional or outpatient hospital
PB	Surgical or other invasive procedure on wrong patient	
PC	Wrong surgery or other invasive procedure on patient	

Professional or outpatient hospital claims must include a valid diagnosis with up to seven-digit specificity, the procedure code that identifies the service rendered, and the PA, PB, or PC modifier that describes the type of "wrong surgery" performed.

Inpatient hospital claims must be submitted with type of bill (TOB) 110 as an inpatient hospital-nonpayment claim when a "wrong surgery" is reported. If other services or procedures that are unrelated to the "wrong surgery" are provided during the same stay as the "wrong surgery," the inpatient hospital must submit a claim for the "wrong surgery" and a separate claim or claims for the unrelated services rendered during the same stay as the "wrong surgery."

The "wrong surgery" claim must include TOB 110, the appropriate diagnosis code, the surgical procedure code for the surgical service rendered, and the date of surgery. The "wrong surgery" claim will be denied.

The unrelated services rendered during the same stay as the "wrong surgery" must include TOB 111, 112, 113, 114, or 115 on a claim separate from the "wrong surgery" claim. The unrelated services that are benefits of Texas Medicaid may be reimbursed by Texas Medicaid.

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A claim that is denied for wrong surgery will have one of the following EOB codes:

EOB Code	Message
01167	Claim detail denied due to wrong surgery performed on client
01168	Claim denied due to wrong surgery performed on client
01185	Claim denied due to wrong surgery claim found in history for the same PCN and DOS
01186	Claim detail denied due to wrong surgery claim found in history for the same PCN and DOS
PCN = Patient Control Number (also known as the client's Medicaid number) DOS = Date of service	

6.1.2.2 Maximum Number of Units allowed per Claim Detail

The total number of units per claim detail can not exceed 9,999. 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.

6.1.2.3 Tips on Expediting Paper Claims

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

General requirements

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

Data Fields

- Print claim data within defined boxes on the claim form.
- Use black ink, but not a black marker. Do not use red ink or highlighters.
- Use all capital letters.
- Print using 10-pitch (12-point) Courier font. Do not use fonts smaller or larger than 12 points. Do not use proportional fonts, such as Arial or Times Roman.
- Use a laser printer for best results. Do not use a dot matrix printer, if possible.
- Do not use dashes or slashes in date fields.

Attachments

- Use paper clips on claims or appeals if they include attachments. Do not 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 attachments or multiple claims for the same client (e.g., 1 of 2, 2 of 2).
- Do not total the billed amount on each claim form when submitting multi-page claims for the same client.

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- Use the CMS-approved Medicare Remittance Advice Notice (MRAN) printed from Medicare Remit Easy Print (MREP) (professional services) or PC-Print (institutional services) when sending a Remittance Advice from Medicare or the paper MRAN received from Medicare or a Medicare intermediary. You may also download the TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template from the TMHP website at www.tmhp.com.
- Submit claim forms with MRANs and R&S Reports.

6.1.3 TMHP Paper Claims Submission

All paper claims must be submitted with a Texas Provider Identifier (TPI) and National Provider Identifier (NPI) for the billing and performing providers. All other provider fields on the claim forms require an NPI only. If an NPI and TPI are not included in the billing and performing provider fields, or if an NPI is not included on all other provider identifier fields, the claim will be denied.

6.1.4 Claims Filing Deadlines

For claims payment to be considered, providers must adhere to the time limits described in this section. Claims received after the following claims filing deadlines are not payable because Texas Medicaid does not provide coverage for late claims.

Exception: *Unless otherwise stated below, claims must be received by TMHP within 95 days of each DOS. Appeals must be received by TMHP within 120 days of the disposition date on the R&S Report on which the claim appears. A 95-day or 120-day appeal filing deadline that falls on a weekend or a holiday is extended to the next business day following the weekend or holiday.*

Only the following holidays extend the deadlines in 2014 and 2015:

Date	Holiday
January 1, 2014	New Year's Day
January 20, 2014	Martin Luther King, Jr. Day
February 17, 2014	Presidents Day
May 26, 2014	Memorial Day
July 4, 2014	Independence Day
September 1, 2014	Labor Day
October 3, 2014*	Columbus Day (federal holiday)
November 11, 2014	Veteran's Day
November 27, 2014	Thanksgiving Day
November 28, 2014	Day After Thanksgiving
December 24, 2014	Christmas Eve Day
December 25, 2014	Christmas
December 26, 2014	Day After Christmas
January 1, 2015	New Year's Day
January 19, 2015	Martin Luther King, Jr. Day
February 6, 2015	Presidents Day
May 25, 2015	Memorial Day
July 4, 2015	Independence Day

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

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The following are time limits for submitting claims:

- Inpatient claims that are filed by the hospital must be received by TMHP within 95 days of the discharge date or last DOS on the claim.
  - Hospitals that are reimbursed according to diagnosis-related group (DRG) payment methodology may submit an interim claim because the client has been in the facility 30 consecutive days or longer. A total stay claim is needed after discharge to ensure accurate calculation for potential outlier payments for clients who are 20 years of age and younger.
  - Hospitals that are reimbursed according to Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 methodology may submit interim claims before discharge and must submit an interim claim if the client remains in the hospital past the hospital's fiscal year end.
- When medical services are rendered to a Medicaid client in Texas, TMHP must receive claims within 95 days of the DOS on the claim.
- Re-enrolling providers who are assigned their previous TPI must submit claims so that they are received by TMHP within 95 days of the date of service.
- Providers that are enrolling in Texas Medicaid for the first time or are making a change that requires the issuance of a new TPI, such as a change of ownership, can submit claims within 95 days from the date their TPI is issued as long as claims are submitted within 365 days of the date of service.
- TMHP must receive claims from out-of-state providers within 365 days from the DOS. The DOS is the date the service is provided or performed.
- TMHP must receive claims on behalf of an individual who has applied for Medicaid coverage but has not been assigned a Medicaid number on the DOS within 95 days from the date the eligibility was added to the TMHP eligibility file (add date) and within 365 days of the date of service or from the discharge date for inpatient claims.
- Providers should verify eligibility and add date by contacting TMHP (Automated Inquiry System [AIS], TMHP EDI's electronic eligibility verification, or TMHP Contact Center) when the number is received. Not all *applicants* become eligible *clients*. Providers that submit claims electronically within the 365-day federal filing deadline for services rendered to individuals who do not currently have a Texas Medicaid identification number will receive an electronic rejection. Providers can use the TMHP rejection report as proof of meeting the 365-day federal filing deadline and submit an administrative appeal.

Important: *Providers should request and keep hard copies of any Medicaid Eligibility Verification (Form H1027) submitted by clients or proof of client eligibility from the Your Texas Benefits Medicaid card website at www.YourTexasBenefitsCard.com. A copy is required during the appeal process if the client's eligibility becomes an issue.*

- If a client becomes retroactively eligible or loses Medicaid eligibility and is later determined to be eligible, the 95-day filing deadline begins on the date that the eligibility start date was added to TMHP files (the add date). However, the 365-day federal filing deadline must still be met.
- When a service is a benefit of Medicare and Medicaid, and the client is covered by both programs, the claim must be filed with Medicare first. TMHP *must* receive Medicaid claims within 95 days of the date of Medicare disposition.

  Providers must submit a paper MRAN received from Medicare or a Medicare intermediary, the computer-generated MRANs from the CMS-approved software application MREP for professional services or PC-Print for institutional services, or the TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template with a completed claim form to TMHP.

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- When a client is eligible for Medicare Part B only, the inpatient hospital claim for services covered as Medicaid only is sent directly to TMHP and is subject to the 95-day filing deadline (from date of discharge).

  Note: *It is strongly recommended that providers who submit paper claims keep a copy of the documentation they send. It is also recommended that paper claims be sent by certified mail with a return receipt requested. This documentation, along with a detailed listing of the claims enclosed, provides proof that the claims were received by TMHP, which is particularly important if it is necessary to prove that the 95-day claims filing deadline has been met. TMHP will accept certification receipts as proof of the 95-day or 120-filing deadline. If a certified receipt is provided as proof, the certified receipt number must be indicated on the detailed listing along with the Medicaid number, billed amount, DOS, and a signed claim copy. The provider needs to keep such proof of multiple claims submissions if the provider identifier is pending.*

- If the provider is attempting to obtain prior authorization for services performed or will be performed, TMHP must receive the claim according to the usual 95-day filing deadline.
- The provider bills TMHP directly within 95 days from the DOS. However, if a non-third party resource (TPR) is billed first, TMHP must receive the claim within 95 days of the claim disposition by the other entity.

  Note: *The provider submits a copy of the disposition with the claim. A non-TPR is secondary to Texas Medicaid and may only pay benefits after Texas Medicaid.*

Refer to: Subsection 4.12, "Third Party Liability (TPL)" in Section 4, "Client Eligibility" (*Vol. 1, General Information*) for examples of non-TPRs.

- When a service is billed to another insurance resource, the filing deadline is 95 days from the date of disposition by the other resource.
- When a service is billed to a third party and no response has been received, Medicaid providers must allow 110 days to elapse before submitting a claim to TMHP. However, the 365-day federal filing deadline requirement must still be met.
- A Compass21 (C21) process allows a DSHS Family Planning claim to be paid by Title XIX (Medicaid) if the client is eligible for Title XIX when those services are provided and billed under the DSHS Family Planning Program. In this instance, the Medicaid 95-day filing deadline is in effect and must be met or the claim will be denied.
- For claims re-submitted to TMHP with additional detail charges (i.e., quantity billed), the additional details are subject to the 95-day filing deadline.

  Note: *In accordance with federal regulations, all claims must be initially filed with TMHP within 365 days of the DOS, regardless of provider enrollment status or retroactive eligibility.*

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Refer to: Subsection 6.1.2, "Claims Filing Instructions" in this section.

Subsection 1.1, "Provider Enrollment and Reenrollment" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for information on the provider enrollment process.

Subsection 7.1, "Appeal Methods" in Section 7, "Appeals" (*Vol. 1, General Information*) for information on the process for submitting appeals.

Subsection 6.1.4.3, "Exceptions to the 95-Day Filing Deadline" in this section.

Subsection A.12.3, "Automated Inquiry System (AIS)" in "State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*) to learn how to retrieve client eligibility information by telephone.

Subsection 4.12, "Third Party Liability (TPL)" in Section 4, "Client Eligibility" (*Vol. 1, General Information*).

Subsection 4.2, "Eligibility Verification" in Section 4, "Client Eligibility" (*Vol. 1, General Information*).

Subsection 6.11.6, "Provider Inquiries—Status of Claims" in this section.

6.1.4.1 Claims for Clients with Retroactive Eligibility

Claims for clients who receive retroactive eligibility must be submitted within 95 days of the date that the client's eligibility was added to the TMHP eligibility file (add date) and within 365 days of the DOS.

Title 42 of the Code of Federal Regulations (42 CFR), at 447.45 (d) (1), states "The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service." The 12-month filing deadline applies to all claims. Claims not submitted within 365 days (12 months) from the date of service cannot be considered for payment.

Retroactive eligibility does not constitute an exception to the federal filing deadline. Even if the patient's Medicaid eligibility determination is delayed, the provider must still submit the claim within 365 days of the date of service. A claim that is not submitted within 365 days of the date of service will not be considered for payment.

To submit a claim for services provided to a patient who is not yet eligible for Medicaid, Texas Medicaid allows providers to submit claims using a pseudo recipient identification number such as 999999999 or 000000000. Although TMHP will deny the claim, providers should retain the denial or electronic rejection report for proof of timely filing, especially if the eligibility determination occurs more than 365 days after the date of service. Claims denied for recipient ineligibility may be resubmitted when the patient becomes eligible for the retroactive date(s) of service. Texas Medicaid may then consider the claim for payment because the initial claim was submitted within the 365-day federal filing deadline and the denial was not the result of an error by the provider.

If the 365-day federal filing deadline requirement has passed, providers must submit the following to TMHP within 95 days from the add date:

- A completed claim form.
- One of the following dated within 365 days from the date of service:
  - A page from an R&S Report documenting a denial of the claim.
  - An electronic rejection report of the claim that includes the Medicaid recipient's name and date of service.

Providers that have submitted their claims electronically can provide proof of timely filing by submitting a copy of an electronic claims report that includes the following information:

- Client name or Medicaid identification number (PCN)

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- 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.*

6.1.4.2 Claims for Newly Enrolled Providers

Claims submitted by newly enrolled providers must be received within 95 days of the date that the new provider identifier is issued, and within 365 days of the date of service. Providers with a pending application should submit any claims that are nearing the 365-day deadline from the date of service. Claims will be rejected by TMHP until a provider identifier is issued. Providers can use the TMHP rejection report as proof of meeting the 365-day deadline and submit an appeal.

Refer to: Subsection 1.1.9.11, "Copy of License, Temporary License, or Certification" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

All claims for services rendered to Texas Medicaid clients who do not have Medicare benefits are subject to a filing deadline from the date of service of:

- 95 days for in-state providers.
- 365 days for out-of-state providers.

TMHP cannot issue a prior authorization before Medicaid enrollment is complete. Upon notice of Medicaid enrollment, by way of issuance of a provider identifier, the provider must contact the appropriate TMHP Authorization Department before providing services that require a prior authorization number to Medicaid clients. Regular prior authorization procedures are followed after the TMHP Prior Authorization Department has been contacted.

Retroactive authorizations will not be issued unless the regular authorization procedures for the requested services allow for authorizations to be obtained after services are provided. For these services, providers have 95 days from the add date of the client's retroactive eligibility in TMHP's system to obtain authorization for services that have already been performed. Providers should refer to the specific manual section for details on authorization requirements, claims filing, and timeframe guidelines for authorization request submissions.

Providers who have not been assigned a provider identifier and have general claim submission questions may refer to this section for assistance with claim submission. If additional general information is needed, providers may call the TMHP Contact Center at 1-800-925-9126 to obtain information. Due to HIPAA privacy guidelines, specific client and claim information cannot be provided.

Providers who have already been assigned a provider identifier and have questions about submitting claims may call the same number and select the option to speak with a TMHP Contact Center representative.

6.1.4.3 Exceptions to the 95-Day Filing Deadline

TMHP is not responsible for appeals about exceptions to the 95-day filing deadline. These appeals must be submitted to the HHSC Claims Administrator Operations Management. TAC allows HHSC to consider exceptions to the 95-day filing deadline under special circumstances.

6.1.4.4 Appeal Time Limits

All appeals of denied claims and requests for adjustments on paid claims must be received by TMHP within 120 days from the date of disposition, the date of the R&S Report on which that claim appears. If the 120-day appeal deadline falls on a weekend or holiday, the deadline will be extended to the next business day.

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Refer to: Subsection 6.1.2, "Claims Filing Instructions" in this section.

Hospitals appealing final technical denials, admission denials, DRG changes, continued-stay denials, or cost/day outlier denials refer to Section 7: Appeals (*Vol. 1, General Information*) for complete appeal information.

6.1.4.5 Claims with Incomplete Information and Zero Paid Claims

Claims listed on the R&S Report with $0 allowed and $0 paid may be resubmitted as electronic appeals. Previously, these claims were only accepted as paper claims and were not accepted as electronic appeals. Appeals may be submitted through a third party biller or through TexMedConnect.

Zero-paid claims that are still within the 95-day filing deadline should be submitted as new day claims, which are processed faster than appeals. Electronic appeal for these claims must be submitted within the 120-day appeal deadline. Electronic claims can be resubmitted past the 95-day deadline as new day claims if the following fields have not changed:

- Provider identifiers
- Client Medicaid number
- Dates of service
- Total billed amount

Claims that are past the 95-day filing deadline and require changes to the fields listed above must be appealed on paper, with a copy of the R&S report. All other appeal guidelines remain unchanged.

Important: *Initial zero-paid claims and appeal submissions must meet the 95-day deadline and 120-day appeal deadline outlined in subsection 6.1.4, "Claims Filing Deadlines" in this section.*

6.1.4.6 Claims Filing Reminders

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.

The provider should allow TMHP 45 days to receive a Medicare-paid claim automatically transmitted for payment of deductible or coinsurance.

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.

Certain claims, including those that were submitted for newborn services or that might be covered under Medicare, are suspended for review so that other state agencies can verify information. This review may take longer than 60 days.

These suspended claims will appear on the provider's R&S Report under "The following claims are being processed" with a message indicating that the client's eligibility is being investigated. Providers must wait until the claim is finalized and appears under "Paid or Denied" or "Adjustment to Claims" on the R&S Report before appealing the claim. If the claim does not appear on the R&S Report, providers must resubmit the claim to TMHP to ensure compliance with filing and appeal deadlines.

6.1.5 HHSC Payment Deadline

Payment deadline rules, as defined by HHSC, affect all providers with the exception of LTC and the DSHS Family Planning Program. The HHSC payment deadline rules for the fiscal agent arrangement ensure that state and federal financial requirements are met.

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TMHP is required to finalize and pay claims within 24 months of:

- Each date of service on a claim.
- Discharge date for inpatient claims.

Texas Medicaid and Children with Special Health Care Needs (CSHCN) Service Program payments, excluding crossovers, cannot be made after 24 months. Claims and appeals that are submitted after the designated payment deadlines are denied.

Note: *Providers may appeal HHSC Office of Inspector General (OIG) initiated claims adjustments (recoupments) after the 24-month deadline but must do so within 120 days from the date of the recoupment. Refer to subsection 7.1.4, "Paper Appeals" in Section 7, "Appeals"* (Vol. 1, General Information) *for instructions. All appeals of OIG recoupments must be submitted by paper, no electronic or telephone appeals will be accepted.*

6.1.6 Filing Deadline Calendars

The most current filing deadline calendars are available on the the TMHP website at www.tmhp.com:

- Filing Deadline Calendar for 2015
- Filing Deadline Calendar for 2016

6.2 TMHP Electronic Claims Submission

TMHP uses the HIPAA-compliant American National Standards Institute (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 EDI Gateway.

Providers must retain all claim and file transmission records. They may be required to submit them for pending research on missing claims or appeals.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*).

6.2.1 Benefit and Taxonomy Codes

Providers must submit the Benefit Code field (when applicable), Address field, and Taxonomy Code Field and all other required fields. These fields must be completed before submitting electronic claims.

Taxonomy codes do not affect pricing or the level of pricing, but rather are used to crosswalk the NPI to a TPI. It is critical that the taxonomy code selected as the primary or secondary taxonomy code during a providers enrollment with TMHP is included on all electronic transactions.

Billing providers that are not associated with a group are required to submit a taxonomy code on all electronic claims. Claims submitted without a taxonomy code may be rejected.

Medicare does not require a taxonomy code for Part B claims. Therefore, some claims submitted to TMHP from Medicare for payment of deductible or coinsurance may not include the taxonomy code needed for accurate processing by TMHP.

6.2.2 Electronic Claim Acceptance

Providers should verify that their electronic claims were accepted by Texas Medicaid for payment consideration by referring to their Claim Response report, which is in the 27S batch response file (e.g., file name E085LDS1.27S). Providers should also check their Accepted and Rejected reports in the rej and acc batch response files (e.g., E085LDS1.REJ and E085LDS1.ACC) for additional information. Only claims that have been accepted on the Claim Response report (27S file) will be considered for payment and made available for claim status inquiry. Claims that are rejected must be corrected and resubmitted for payment consideration.

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Refer to: Subsection 3.2, "Electronic Billing" in Section 3, "TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*), visit www.tmhp.com, or call the EDI Help Desk at 1-888-863-3638 for more information about electronic claims submissions.

6.2.3 Electronic Rejections

The most common reasons for electronic professional claim rejections are:

- *Client information does not match.* Client information does not match the PCN on the TMHP eligibility file. The name, date of birth, sex, and nine-digit Medicaid identification number must be an exact match with the client's identification number on TMHP's eligibility record. If using TexMedConnect, send an interactive eligibility request to obtain an exact match with TMHP's record. If not using TexMedConnect, verify through the TMHP website or call AIS at 1-800-925-9126 to verify client information. A lack of complete client eligibility information causes a rejection and possibly delayed payment. To prevent delays when submitting claims electronically:
  - Always include the first and last name of the client on the claim in the appropriate fields.
  - Always enter the client's complete, valid nine-digit Medicaid number. Valid Medicaid numbers begin with 1, 2, 3, 4, 5, 6 or 7. CSHCN Services Program client numbers begin with a 9.
  - When submitting claims for newborns, use the guidelines in the following section.
- *Referring/Ordering Physician field blank or invalid.* The referring physician's NPI must be present when billing for consultations, laboratory, or radiology. Consult the software vendor for this field's location on the electronic claims entry form.
- *Performing Physician ID field blank or invalid.* When the billing provider identifier is a *group* practice, the performing provider identifier for the physician who performed the service must be entered. Consult the software vendor for this field's location on the electronic claim form.
- *Facility Provider field blank or invalid.* When place of service (POS) is anywhere other than home or office, the facility's provider identifier must be present. If the provider identifier is not known, enter the name and address of the facility. Consult the software vendor for this field's location on the electronic claims entry form.
- *Invalid Type of Service or Invalid Type of Service/Procedure code combination.* In certain cases some procedure codes will require a modifier to denote the procedure's type of service (TOS).

  Note: *The C21 claims processing system can accept only 40 characters (including spaces) in the Comments section of electronic submissions for ambulance and dental claims. If providers include more than 40 characters in that field, C21 will accept only the first 40 characters; the other characters will not be imported into C21. Providers must ensure that all of the information that is required for the claim to process appropriately is included in the first 40 characters.*

Refer to: Subsection 6.2.5, "Modifier Requirements for TOS Assignment" in this section for TMHP EDI modifier information.

6.2.3.1 Newborn Claim Hints

The following are to be used for newborns:

- If the mother's name is "Jane Jones," use "Boy Jane Jones" for a male child and "Girl Jane Jones" for a female child.
- Enter "Boy Jane" or "Girl Jane" in first name field and "Jones" in last name field. *Always* use "boy" or "girl" first and then the mother's full name. An exact match must be submitted for the claim to process.
- Do not use "NBM" for newborn male or "NBF" for newborn female.

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The following are the most common reasons for electronic hospital UB-04 CMS-1450 claim rejections:

- *Admit hour outside allowable range* (such as 24 hours).
- *Billed amount blank.*
- *Health coverage ID blank or invalid.* This number *must* be the valid nine-digit Medicaid client number. *Incorrect data* includes: a number less than nine digits; PENDING; 999999999; and Unknown.
- *Referring physician information on outpatient claim is blank* when laboratory/radiology services are ordered or a surgical procedure is performed. The referring physician's NPI is required in Fields 78–79. Consult the software vendor for the location of this field on the electronic claims entry form.

6.2.4 TMHP EDI Batch Numbers, Julian Dates

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

- *JJJ – Julian date.* The three J characters represent the Julian date that the file was received by the TMHP EDI Gateway. The first character (J) is displayed as a letter, where E = 0, F = 1, G = 2, and H = 3. The last two characters (JJ) are displayed as numbers. All three characters (JJJ) together represent the Julian date. For example, a Julian date of 143 would be F43.
- *Y – Year.* The Y character represents the last digit of the calendar year when the TMHP EDI Gateway receives the file. For example, a "2" in this position indicates the year 2012.
- *SSSS* = The unique 4-character sequence number assigned by EDI to the batch filed.

6.2.5 Modifier Requirements for TOS Assignment

Modifiers for TOS assignment are not required for Texas Health Steps (THSteps) Dental claims (claim type 021) and Inpatient Hospital claims (claim type 040). Additionally, procedures submitted by specific provider types such as genetics, eyeglass, and THSteps medical checkup are assigned the appropriate TOS based on the provider type or specific procedure code, and will not require modifiers.

Most procedure codes do not require a modifier for TOS assignment, but modifiers *are* required for *some* services submitted on professional claims (claim type 020) and outpatient hospital claims (claim type 023). Services that *require* a modifier for TOS assignment are listed in the sections below.

6.2.5.1 Assistant Surgery

For assistant surgical procedures, use one of the following modifiers: 80, 81, 82, and AS. Using these modifiers results in TOS 8 being assigned to the procedure.

6.2.5.2 Anesthesia

For anesthesia procedures, use one of the following modifiers: AA, AD, QK, QS, QX, QY, and QZ. Using these modifiers results in TOS 7 being assigned to the procedure.

6.2.5.3 Interpretations

For interpretations or professional components of laboratory, radiology, or radiation therapy procedures, use modifier 26. Using modifier 26 results in TOS I being assigned to the procedure.

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6.2.5.4 Technical Components

For technical components of laboratory, radiology, or radiation therapy procedures, use modifier TC. Using this modifier results in TOS T being assigned to the procedure.

Exception: *Outpatient hospitals do not include the TC modifier when they provide technical components of lab and radiology services. These services automatically have TOS 4 or 5 assigned and are subject to the facility's interim reimbursement rate or the clinical lab rate.*

6.2.6 Preferred Provider Organization (PPO)

PPO discounts are not considered a part of other insurance payments. Electronic submitters must supply the PPO discount amount when submitting other insurance information; however, this information is not included in the total other insurance payment during claims processing. Paper submitters are not required to add the PPO discount to the other insurance payment.

6.3 Coding

Electronic billers must code all claims. TMHP encourages all providers to code their paper claims. Claims are processed fast and accurately if providers furnish appropriate information. By coding claims, providers ensure precise and concise representation of the services provided and are assured reimbursement based on the correct code. If providers code claims, a narrative description is not required and does not need to be included unless the code is a not an otherwise classified code.

Important: *Claims for anesthesia must have the CPT anesthesia procedure code narrative descriptions or CPT surgical codes; if these codes are not included, the claim will be denied.*

The carrier for the Texas Medicare Program has coding manuals available for physicians and suppliers with codes not available in CPT. To order a CPT Coding Manual, write to the following address:

American Medical Association
Book and Pamphlet Fulfillment
PO Box 2964
Milwaukee, WI 53201

6.3.1 * Diagnosis Coding

Texas Medicaid requires providers to provide *International Classification of Diseases, Tenth Revision, Clinical Modification* (ICD-10-CM) diagnosis codes on their claims. The *only* diagnosis coding structure accepted by Texas Medicaid is the ICD-10-CM. Diagnosis codes must be to the highest level of specificity available. In most cases a written description of the diagnosis is not required.

All diagnosis codes that are submitted on a claim must be appropriate for the age of the client as identified in the ICD-10-CM description of the diagnosis code. Claims that are denied because one or more of the diagnosis codes submitted on the claim are not appropriate for the age of the client may be appealed with the correct diagnosis code or documentation of medical necessity to justify the use of the diagnosis code.

Diagnosis codes in the following categories are not valid as primary or referenced diagnosis:

- Nonspecific injury, poisoning and other consequences of external causes
- Diagnosis in the International Classification of Diseases for Oncology, 3rd Edition (ICD-O-3)
- Factors influencing health status and contact with health services, unless otherwise directed in this manual.
- External causes of morbidity

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6.3.1.1 Place of Service (POS) Coding

The POS identifies where services are performed. Indicate the POS by using the appropriate code for each service identified on the claim.

Important: *Attention ambulance providers: POS 41 and 42 are accepted by Texas Medicaid for ambulance claims processing. The two-digit origin and destination codes are still required for claims processing.*

Use the following codes for POS identification where services are performed:

POS	2-Digit Numeric Codes (Electronic Billers)	1-Digit Numeric Codes (Paper Billers)
Office	11, 15, 20, 49, 50, 60, 65, 71, 72	1
Home	12	2
Inpatient hospital	21, 51, 52, 55, 56, 61	3
Outpatient hospital	22, 23, 24, 62	5
Birthing center	25	7
Other location	01, 03, 04, 05, 06, 07, 08, 16, 26, 34, 41, 42, 53, 57, 99	9
Skilled nursing facility, intermediate care facility, intermediate care facility for mentally retarded	13, 31, 32, 54	4
Extended care facility (rest home, domiciliary or custodial care, nursing facility boarding home)	14, 33	8
Independent lab	81	6
Destination of ambulance	Indicate destination using above codes	Indicate destination using above codes

Note: *Family planning and THSteps medical services performed in a rural health clinic (RHC) are billed using national POS code 72.*

6.3.2 Type of Service (TOS)

The TOS identifies the specific field or specialty of services provided.

To determine the TOS payable for each procedure code, providers may refer to the online fee lookup (OFL) or the static fee schedules, both are available on the TMHP website at www.tmhp.com.

Refer to: Subsection 6.2.5, "Modifier Requirements for TOS Assignment" in this section for TMHP EDI modifier information.

6.3.2.1 TOS Table

Important: *TOS codes are not used for claim submissions, but they do appear on R&S Reports.*

TOS	Description
0	Blood
1	Medical Services
2	Surgery
3	Consultations

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

6.3.3 Procedure Coding

Texas Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS provides health-care providers and third-party payers a common coding structure that uses codes designed around a five-character numeric or alphanumeric base. The procedure codes are updated annually and quarterly.

HCPCS consists of two levels of codes:

- Level I—Current Procedural Terminology (CPT®) Professional Edition
  - Numeric, five digits
  - Makes up 80 percent of HCPCS
  - Maintained by AMA, which updates it annually
  - Updates by the AMA are coordinated with CMS before modifications are distributed to third-party payers
  - Anesthesia codes from CPT
- Level II—HCPCS
  - Approved and released by CMS
  - Codes for both physician and non-physician services not contained in CPT (for example, ambulance, DME, prosthetics, and some medical codes)
  - Maintained and updated by the CMS Maintenance Task Force
  - Alphanumeric, a single alpha character (A through V) followed by four digits
  - The single alpha character represents one of the following:

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Alpha	Description
A	Supplies, ambulance, administrative, miscellaneous
B	Enteral and parenteral therapy
E	DME and oxygen
G	Procedures/professional (temporary)
H	Rehab and behavioral health services
J	Drugs (administered other than orally)
K	Durable Medical Equipment Regional Carriers (DMERC)
L	Orthotic and prosthetic procedures
M	Medical
P	Laboratory
Q	Temporary procedures
R	Radiology
S	Private payer
T	State Medicaid agency
V	Vision and hearing services

6.3.3.1 HCPCS Updates

TMHP updates HCPCS codes on both an annual and quarterly basis. Major updates are made annually and minor updates are made quarterly.

Most of the procedure codes that do not replace a discontinued procedure code must go through the rate hearing process. HHSC conducts public rate hearings to provide an opportunity for the provider community to comment on the Medicaid proposed payment rate, as required by Chapter 32 of the Human Resources Code, §32.0282, and Title 1 of the Texas Administrative Code, §355.201.

6.3.3.1.1 Annual HCPCS

Annual HCPCS updates apply additions, changes, and deletions that include the program and coding changes related to the annual HCPCS, Current Dental Terminology (CDT), and CPT updates. These updates ensure that the coding structure is up-to-date by using the latest edition of the CPT and the nationally established HCPCS codes that are released by CMS.

6.3.3.1.2 Quarterly HCPCS

Quarterly HCPCS updates apply HCPCS additions, changes, and deletions that are released by CMS.

6.3.3.1.3 Rate Hearings for New HCPCS Codes

HHSC holds rate hearings for new HCPCS codes on a regular basis. Rate hearings are announced on the HHSC website at www.hhsc.state.tx.us.

Claims for services that are provided before the rates are adopted through the rate hearing process are denied as pending a rate hearing (EOB 02008) until the applicable reimbursement rate is adopted. The client cannot be billed for these services.

Providers are responsible for meeting the initial 95-day filing deadline. Providers must submit the procedure codes that are most appropriate for the services provided, even if the procedure codes have not yet completed the rate hearing process and are denied by Texas Medicaid as pending a rate hearing.

Once the reimbursement rates are established in the rate hearing and applied, TMHP automatically reprocesses affected claims. Providers are not required to appeal the claims unless they are denied for other reasons after the claims reprocessing is complete.

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Refer to: Subsection 5.11, "Guidelines for Procedures Awaiting Rate Hearing"in Section 5, "Prior Authorization" (Vol. 1, General Information) for more information about the authorization guidelines for procedure codes that are awaiting a rate hearing.

6.3.4 National Drug Code (NDC)

The NDC is an 11-digit number on the package or container from which the medication is administered. All Texas Medicaid fee-for-service and Family Planning providers must submit an NDC for professional or outpatient claims submitted with physician-administered prescription drug procedure.

N4 must be entered before the NDC on claims.

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 are required.*

6.3.4.1 Paper Claim Submissions

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*

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CMS-1500

Block No.	Description	Guidelines
24A	Dates of service	In the shaded area, enter the: • 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). ***Example:*** *N400409231231*
24D	Procedures, services, or supplies	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).
24G	Days or units	In the shaded area, enter the NDC unit of measurement code. There are 5 allowed values: F2, GR, ML, UN or ME.

2017 Claim Form

Block No.	Description	Guidelines
32A	Dates of service	In the shaded area, enter the: • 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). ***Example:*** *N400409231231*
32D	Procedures, services, or supplies Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) Modifier	In the shaded area, enter the NDC quantity of units administered (up to 12 digits, including the decimal point.). A decimal point must be used for fractions of a unit (e.g., 0.025).
32F	Days or units	In the shaded area, enter the NDC unit of measurement code. There are 5 allowed values: F2, GR, ML, UN or ME.

National Drug Unit

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

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

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6.3.4.2 NDC Requirements for Dual Eligible Clients

The 11-digit NDC, NDC quantity, and NDC Unit of measure information is required on all professional and outpatient clinician-administered drug claims for dual-eligible clients. These drug claims are submitted to Medicare, which will cross over to Medicaid for consideration of coinsurance and deductible liabilities.

Important: *Claims which cross over without this required information may be denied due to missing, incomplete, or invalid NDC information. This information applies to all Medicaid providers who serve Medicare-Medicaid dual-eligible clients.*

Providers may refer to Section 6.3.4, "National Drug Code (NDC)" for more information on NDC requirements. The Texas NDC-to-HCPCS Crosswalk identifies relationships between HCPCS codes.

6.3.4.3 Drug Rebate Program

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

CMS maintains a list of participating manufacturers and their rebate-eligible drug products, which is updated quarterly on the CMS website. TMHP will republish this list quarterly in a more accessible format.

Refer to: Rebatable National Drug Codes on the TMHP website at www.tmhp.com.

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.

Note: *Texas Medicaid managed care organizations (MCOs) have their own policies and procedures regarding clinician-administered drugs. Providers must contact the client's MCO for benefit and limitation information.*

Providers can find a complete, downloadable list of procedure codes and the corresponding descriptions on the Vendor Drug Program website at www.txvendordrug.com/downloads/CADR/HCPCS-Requiring-Rebateable-NDCs.xls.

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: *Texas Medicaid does not pay for drug wastage.*

6.3.5 Modifiers

Modifiers describe and qualify the services provided by Texas Medicaid. A modifier is placed after the five-digit procedure code. Up to two modifiers may apply per service. Examples of frequently used modifiers are listed in the following table. Refer to the service-specific sections for additional modifier requirements.

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Modifier	Special Instructions/Notes (if applicable)
340B Drug Rebate Program	
U8	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). Providers can refer to the HRSA website at www.hrsa.gov/opa/index.html for more information about the 340B Drug Pricing Program.
Ambulance	
ET	Use for all emergency transport services.
GY	Use to indicate that no medical necessity existed for a transport.
Surgeons	
53	Use for physician reporting of a discontinued procedure. For outpatient/ASC reporting of a discontinued procedure, see modifier 73 and 74.
54+	Surgeon who performs the surgical procedure only must bill the surgical code with modifier 54 and is reimbursed 70% of the global fee.
55+	Provider who performs the postoperative care only must bill the surgical code with modifier 55 and is reimbursed 20% of the global fee.
56+	Providers who perform the preoperative care only must bill the surgical code with modifier 56 and is reimbursed 10 percent of the global fee.
58+	Staged or related procedure or services by the same physician during the postoperative period.
62+	Cosurgery. Two surgeons perform the specific procedure(s).
76+	Use modifier 76 or 77 for transplant procedures if it is a second transplant of the same organ.
77+	Use modifier 76 or 77 for transplant procedures if it is a second transplant of the same organ.
78+	Return to the operating room for a related procedure during the postoperative period.
79+	Unrelated procedure or service by the same physician during the postoperative period.
Assistant Surgeons	
80 *and* KX+	Use modifier 80 and KX together to indicate an assistant surgeon in a teaching facility: • In a case involving exceptional medical circumstances such as emergency or life-threatening situations requiring immediate attention. • When the primary surgeon has a policy of never, without exception, involving a resident in the preoperative, operative, or postoperative care of one of his or her patients. • In a case involving a complex surgical procedure that qualifies for more than one physician.

+ Modifier is required for accurate claims processing.
*** Description is defined by the state.**

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Modifier	Special Instructions/Notes (if applicable)
AS	Use when the physician assistant is not enrolled as an individual provider and provides assistance at surgery.
Sterilizations	
PM	Use to indicate post-menopausal.
PS	Use to indicate previously sterilized.
Excision of Lesions/Masses	
KX+	Use modifier KX if the excision/destruction is due to one of the following signs or symptoms: inflamed, infected, bleeding, irritated, growing, limiting motion or function. Use of this modifier is subject to retrospective review.
Injections	
AT	Use to indicate acute conditions.
JA	Administered intravenously.
JB	Administered subcutaneously.
KX+	Use modifier KX to indicate the injection was due to: • Oral route contraindicated or an acceptable oral equivalent is not available. • Injectable medication is the accepted treatment of choice. Oral medication regimens have proven ineffective or are not available. • Patient has a temperature over 102 degrees (documented on the claim) and a high level of antibiotic is needed quickly. • Injection is medically necessary into joints, bursae, tendon sheaths, or trigger points to treat an acute condition or the acute flare up of a chronic condition.
Visits	
76+	Use to indicate the repeated non-clinical procedure.
FP+	Use to indicate that the service was part of an annual family planning examination.
TH+	Use with external causes of injury and poisoning (E Codes) procedures and morphology of neoplasms (M Codes) procedures to specify antepartum or postpartum care.
25	Use to describe circumstances in which an office visit was provided at the same time as other separately identifiable services. Refer to the CMS NCCI website for additional information.
Anesthesia	
One of the following modifier combinations must be used by anesthesiologists directing non-CRNA qualified professionals.	
AA and U1	Use to indicate that the anesthesia services were performed personally by the anesthesiologist.
AD and U1 (Emergency circumstances only)	Use when directing five or more concurrent procedures provided by non-CRNA qualified professionals. Used in emergency circumstances only and limited to 6 units (90 minutes) per case for each occurrent requiring five or more concurrent procedures.
QK an U1	Use when directing two, three, or four concurrent procedures provided by non-CRNA qualified professionals.
QY and U1	Use when directing one procedure provided by a non-CRNA qualified professional.
One of the following modifier combinations must be used by anesthesiologists directing CRNAs.	
+ Modifier is required for accurate claims processing. *** Description is defined by the state.**	

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Modifier	Special Instructions/Notes (if applicable)
AD and U2 (Emergency circumstances only)	Use when directing five or more concurrent procedures involving CRNA (s). Used in emergency circumstances only and limited to 6 units (90 minutes) per case for each occurrence requiring five or more concurrent procedures.
QK and U2	Use when directing two, three, or four concurrent procedures involving CRNAs.
QY and U2	Use when directing one procedure by a CRNA.
One of the following modifier combinations must be used by CRNAs.	
QX and U2	Use to indicate the anesthesia was medically directed by the anesthesiologist.
QZ and U1	Use to indicate the anesthesia was directed by the surgeon.
DME	
For DME, use one of the following modifiers:	
NU	For DME purchase new
RR	For DME rental- monthly
UE	For DME other-purchase-used
FQHC and RHC	
Services provided by a health-care professional require one of the following modifiers:	
AH	Use to indicate that the services were performed by a clinical psychologist.
AJ	Use to indicate that the services were performed by a clinical social worker.
AM	Use to indicate that the services were performed by a physician or team member service (includes clinical psychiatrist).
SA	Use to indicate that the services were performed by an advanced practice registered nurse (APRN) or CNM rendering services in collaboration with a physician.
TD	For home services performed by a RN and provided in areas with a shortage of home health agencies.
TE	For home services performed by an LVN and provided in areas with a shortage of home health agencies.
TS	Use to indicate a case management follow-up service.
U1	Licensed professional counselor
U2	Licensed marriage and family therapist
U7*	Physician assistant services for other than assistant at surgery
The following modifiers may be used in addition to the modifier identifying the health-care professional that rendered the service:	
EP	Use to indicate THSteps services (FQHC only).
FP	Use to indicate that the service was part of an annual family planning examination.
TH	Use to indicate the encounter is for antepartum care or postpartum care.
U5*	State-defined modifier for use with case management services.
Abortion	
G7	Use by performing physicians, facilities, anesthesiologists, and CRNAs (with appropriate procedure code) when requesting reimbursement for abortion procedures that are within the scope of the rules and regulations of Texas Medicaid.
Vision	
+ Modifier is required for accurate claims processing. *** Description is defined by the state.**	

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Modifier	Special Instructions/Notes (if applicable)
RB	Use modifier RB to indicate replacement of prosthetic or nonprosthetic eyeglasses or contact lenses.
VP+	Use when billing prosthetic eyeglasses or contact lenses with a diagnosis of aphakia.
Laboratory/Radiology	
26+	Use for laboratory interpretations and radiological procedures.
59-	Code to indicate the procedure or service was independent from other services performed on the same day. Refer to the CMS NCCI website for additional information.
91+	Use for repeat laboratory clinical test.
76	Use for repeat laboratory nonclinical test.
SU+	Indicates necessary equipment is in physician's office for RAST/MAST testing or Pap smears.
TC+	The modifier TC is used for technical radiological procedures.
Q4+	Use for lab/radiology/ultrasound interps by other than the attending physician.
Therapy	
AT+	Must be used to indicate the necessity of an acute condition for occupational therapy (OT), physical therapy (PT), osteopathic manipulation treatment (OMT), or chiropractic services.
GN	Use to indicate outpatient speech language pathology.
GO	Use to indicate outpatient occupational therapy.
GP	Use to indicate outpatient PT.
U4*	Reassessment
THSteps Medical	
AM	Physician, team member service
EP	FQHCs must use modifier EP for services provided under THSteps.
SA	Nurse practitioner rendering service in collaboration with a physician
U5*	Intermediate oral examination with dental varnish
U7*	Physician assistant services for other than assistant at surgery
TD	Registered nurse
THSteps Exceptions to Periodicity	
SC	Medically necessary service or supply
23	Unusual Anesthesia: Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding the modifier *23* to the procedure code of the basic service or by use of the separate five-digit modifier code 09923
32	Mandated Services: Services related to mandated consultation or related services (e.g., peer review organization [PRO], third party payer, governmental, legislative or regulatory requirement) may be identified by adding the modifier 32 to the basic procedure or the service may be reported by use of the five digit modifier 09932
Physicians	
Q5	Informal reciprocal arrangement (period not to exceed 14 continuous days)
Q6	Locum tenens or temporary arrangement (up to 90 days)

+ Modifier is required for accurate claims processing.
*** Description is defined by the state.**

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Modifier	Special Instructions/Notes (if applicable)
Radiology Services	
U6	CT, CTA, MRI, MRA, Cardiac Nuclear Imaging, and PET Scan studies provided in the emergency department. Obstetric ultrasounds provided in the emergency department or during a hospital observation stay.
Durable Medical Equipment	
NU	Use to indicate purchased equipment.
RR	Use to indicate leased equipment.
Telemedicine	
GT	Use with appropriate evaluation and management codes.
+ Modifier is required for accurate claims processing. *** Description is defined by the state.**	

Other Common Modifiers									
AE	AF	AG	AK	AR	CB	CD	CE	CF	CG
KC	KD	KF	LT	M2	RD	RT	SW	SY	TL
U1	U2	U3	UN	UP	UQ	UR	US		

The following modifiers may appear on R&S Reports (they are not entered by the provider):

- *PT.* The DRG payment was calculated on a per diem basis for an inpatient stay because of patient transfer.
- *PS.* The DRG payment was calculated on a per diem basis because the patient exhausted the 30-day inpatient benefit limitation during the stay.
- *PE.* The DRG payment was calculated on a per diem basis because the patient was ineligible for Medicaid during part of the stay. Also used to adjudicate claims with adjustments to outlier payments.

6.3.6 Benefit Code

A benefit code is an additional data element used to identify state programs.

Providers that participate in the following programs must use the associated benefit code when submitting claims and authorizations:

Program	Benefit Code
Comprehensive Care Program (CCP)	CCP
THSteps Medical	EP1
THSteps Dental	DE1
Family Planning Agencies*	FP3
Hearing Aid Dispensers	HA1
Maternity	MA1
County Indigent Health Care Program	CA1
Early Childhood Intervention (ECI) Providers	EC1
Tuberculosis (TB) Clinics	TB1
***Agencies only—Benefit codes should not be used for individual family planning providers.**	

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Program	Benefit Code
Texas Medicaid Program Home Health DME	DM2
Case management mental retardation (MR) providers	MH2
***Agencies only—Benefit codes should not be used for individual family planning providers.**	

6.4 Claims Filing Instructions

This section contains instructions for completion of Medicaid-required claim forms. When filing a claim, providers should review the instructions *carefully* and complete *all* requested information. A correctly completed claim form is processed faster.

This section provides a sample claim form and its corresponding instruction table for each acceptable Texas Medicaid claim form.

All providers, except those on prepayment review, should submit paper claims to TMHP to the following address:

Texas Medicaid & Healthcare Partnership
Claims
PO Box 200555
Austin, TX 78720-0555

Providers on prepayment review must submit all paper claims and supporting medical record documentation to the following address:

Texas Medicaid & Healthcare Partnership
Attention: Prepayment Review MC–A11 SURS
PO Box 203638
Austin, TX 78720-3638

6.4.1 National Correct Coding Initiative (NCCI) Guidelines

The Patient Protection and Affordable Care Act (PPACA) mandates that all claims that are submitted to TMHP be filed in accordance with the NCCI guidelines, including claims for services that have been prior authorized or authorized with medical necessity documentation.

The CMS NCCI and MUE guidelines can be found in the NCCI Policy and Medicare Claims Processing manuals, which are available on the CMS website.

The NCCI guidelines consist of HCPCS or CPT procedure code pairs that must not be reported together and MUEs that determine whether procedure codes are submitted in quantities that are unlikely to be correct.

The NCCI and MUE spreadsheets are published and updated by CMS and are available on the CMS Medicaid NCCI Coding web page under "NCCI and MUE Edits" as follows:

- NCCI edit spreadsheets. The website contains the Medicaid NCCI edit spreadsheet for hospital services and the Medicaid NCCI edit spreadsheet for practitioner services. The spreadsheets list the procedure code pairs that will not be reimbursed separately if they are billed by the same provider with the same date of service. Column 1 procedure codes may be reimbursed and Column 2 procedure codes will be denied. The spreadsheets also contain a column that indicates whether or not a modifier is allowed for services that may be reimbursed separately.

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- MUE edit spreadsheets. The website contains the Medicaid MUE edit spreadsheets for hospital services, practitioner services, and supplier services. The spreadsheets list procedure codes and the number of units that may be reimbursed for each procedure code. Units that are submitted beyond these limitations will be denied.

  Note: *Providers are required to comply with NCCI and MUE guidelines as well as the guidelines that are published in the Texas Medicaid Provider Procedures Manual, all currently published website articles, fee schedules, and all other application information published on the TMHP website at www.tmhp.com. In instances when Texas Medicaid medical policy is more restrictive than NCCI or MUE guidance, Texas Medicaid medical policy prevails.*

HHSC continue to implement and enforce correct coding initiatives. Providers may see additional claim denials related to NCCI and MUE edits including those services that were prior authorized or authorized with medical necessity documentation.

If a rendered service does not comply with a guideline as defined by NCCI, 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.*

Claims that were submitted with dates of service from October 1, 2010, through June 30, 2013, will not be reprocessed in accordance with the NCCI guidelines; however, any claims with dates of service on or after October 1, 2010, that are appealed or reprocessed for reasons other than NCCI auditing will be subject to NCCI auditing guidelines.

6.4.1.1 NCCI Processing Categories

The following coding rule categories are applied to claims that are submitted with dates of service on or after October 1, 2010:

Coding Rule Category	Description
Maximum units	CMS has assigned to all procedure codes a maximum number of units that may be submitted for a client per day, regardless of the provider. The maximum number of units for each procedure code is based on the following criteria: • Procedure code description • Anatomical site • CMS sources • Clinical guidelines ***Important:*** *If the maximum number of units has been exceeded on a particular line item, the line item will be denied. The line item will not be cut back to the allowable quantity. The line item may be appealed with the appropriate quantity for consideration*

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Coding Rule Category	Description
NCCI	NCCI is a collection of bundling edits created and sponsored by CMS that are separated into two major categories: Column I and Column II procedure code edits (previously referred to as "Comprehensive" and "Component") and Mutually Exclusive procedure code edits. NCCI edits are applied to services that are performed by the same provider on the same date of service only and do not apply to services that are performed within the global surgical period. 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.

6.4.1.2 CPT and HCPCS Claims Auditing Guidelines

Claims with dates of service on or after October 1, 2010, 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.*

The following coding rule categories apply to claims submissions:

Coding Rule Category	Description
Add-on codes	Certain services are commonly carried out in addition to the rendering of the primary procedure and are associated with the primary procedures. These additional or supplemental procedures are referred to as "add-on" procedures. Add-on codes are identified in the CPT Manual with a plus mark ("+") symbol and are also listed in Appendix D of the CPT Manual. Add-on codes are always performed in addition to a primary procedure, and should never be reported as a stand-alone service. When an add-on code is submitted and the primary procedure has not been identified on either the same or different claim, then the add-on code will be denied as an inappropriately-coded procedure. If the primary procedure is denied for any reason, then the add-on code will be denied also.
Deleted HCPCS codes	Procedure codes undergo revision by the AMA and CMS on a regular basis. Revisions typically include adding new procedure codes, deleting procedure codes, and redefining the description of existing procedure codes. These revisions are normally made on an annual basis by the governing entities with occasional quarterly updates. Claims that are received with deleted procedure codes will be validated against the date of service. If the procedure code is valid for the date of service, the claim will continue processing. If the procedure code is invalid for the date of service, the invalid procedure code will be denied.

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Coding Rule Category	Description
Diagnosis validity	ICD-10-CM diagnosis codes undergo revision by the Centers for Disease Control and Prevention (CDC) and CMS on a regular basis. Revisions typically include adding new diagnosis codes, deleting diagnosis codes, and redefining the description of existing diagnosis codes. These revisions are normally made on an annual basis. Claims that are received with invalid diagnosis codes will be validated against the date of service. If the diagnosis code is valid for the date of service, the claim will continue processing. If the diagnosis code is invalid for the date of service, the procedure that is referenced to the invalid diagnosis code will be denied.
Diagnosis-age	Certain diagnosis codes are age-specific. If a diagnosis code that is billed does not match the age of the client on that date of service, all services associated with that diagnosis code will be denied.
Diagnosis-gender	Certain diagnosis codes are gender-specific. If the diagnosis code that is billed does not match the gender of the client, all services associated with that diagnosis code will be denied.
Duplicate claim	A duplicate claim is defined as a claim or procedure code detail that exactly matches a claim or procedure code detail that has been reimbursed to the same provider for the same client. Duplicate claims or details include the same date of service, procedure code, modifier, and number of units. Duplicate claims or procedure code details will be denied. ***Note:*** *Modifiers may be used to identify separate services.*
Evaluation and Management (E/M) services	The AMA defines new and established patients as follows: • A new patient is "one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years." • An established patient is "one who has received a professional service from the physician or another physician of the same specialty who belongs to the same group practice within the past three years." Only one E/M procedure code may be reimbursed for a single date of service by the same provider group and specialty, regardless of place of service. Providers may refer to subsection 9.2.58, "Physician Evaluation and Management (E/M) Services" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol.2, Provider Handbooks)* for additional information about physician E/M services.
Procedure code definition	The CPT manual assigns each procedure code a specific description or definition to describe the service that is rendered. In order to support correct coding, the procedure code definition rules will deny procedure codes based on the appropriateness of the code selection as directed by the definition and nature of the procedure code.
Procedure code guideline	The CPT manual includes specific reporting guidelines that are located throughout the manual and at the beginning of each section. In order to ensure correct coding, these guidelines provide reporting guidance and must be followed when submitting specific procedure codes.
Procedure-age	Certain procedure codes, by definition or nature of the procedure, are limited to the treatment of a specific age or age group. For example, procedure code 99382 is limited to clients who are 1 through 4 years of age.
Procedure-gender	Certain procedure codes, by definition or nature of the procedure, are limited to the treatment of one gender. For example, hysterectomy procedure code 58150 is limited to female clients.

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Coding Rule Category	Description
Total, professional interpretation, and technical services	Diagnostic tests and radiology services are procedure codes that include two components: professional interpretation and technical. The professional interpretation component describes the physician's interpretation and report services and is billed with modifier 26. The technical component describes the technical portion of a procedure, such as the use of equipment and staff needed to perform the service, and is billed with modifier TC. If the professional interpretation and technical components are rendered by the same provider, the total component may be billed using the appropriate procedure code without modifiers 26 and TC. Reimbursement of diagnostic tests and radiology services is limited to no more than the amount for the total component. Providers must refer to the appropriate Texas Medicaid fee schedules to determine payable components for diagnostic and radiology services. Procedure codes that are submitted with an inappropriate modifier will be denied.

6.4.2 Claim Form Requirements

6.4.2.1 Provider Signature on Claims

Every paper CMS-1500, 2012 American Dental Association (ADA) Dental Claim Form, and 2017 Claim Form must submitted with the provider's or an authorized representative's handwritten signature (or signature stamp) in the appropriate block of the claim form. Signatory supervision of the authorized representative is required. Providers delegating signature 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. Initials are only acceptable for first and middle names. The last name must be spelled out. An acceptable example is J.A. Smith for John Adam Smith. An unacceptable example is J.A.S. for John Adam Smith. Typewritten names must be accompanied by a handwritten signature; in other words, a typewritten name with signed initials is not acceptable. The signature must be contained within the appropriate block of the claim form. Claims prepared by computer billing services or office-based computers may have "Signature on File" printed in the signature block, but it must be in the same font that is used in the rest of the form. For claims prepared by a billing service, the billing service must retain a letter on file from the provider authorizing the service.

Printing the provider's name instead of "Signature on File" is unacceptable. Because space is limited in the signature block, providers should not type their names in the block. Claims not meeting these specifications appear in the "Paid or Denied Claims" sections of the R&S Reports.

Refer to: Sample Letter XUB Computer Billing Service Inc on the TMHP website at www.tmhp.com.

6.4.2.2 Group Providers

Providers billing as a group must give the performing provider identifier on their claims as well as the group provider identifier. This requirement excludes THSteps medical providers.

6.4.2.3 Supervising Physician Provider Number Required on Some Claims

The supervising physician provider number is required on 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 to a Texas Medicaid client is based on a client evaluation that was performed by the supervised provider, the billing provider's claim must include the names and NPIs of both the ordering provider and the supervising provider. The billing provider must obtain all of the required information from the ordering or referring provider before submitting the claim to TMHP.

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Providers who submit TexMedConnect electronic claims for professional, ambulance, or vision services can provide the claim information in the designated field for the supervising provider of the referring or ordering provider.

Providers can refer to TexMedConnect instructions on the TMHP website at www.tmhp.com for details about the "Referring/Other Supervising Provider" field for professional, ambulance, and vision electronic claims.

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

6.4.2.4 Ordering or Referring Provider NPI

All Texas Medicaid 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 Texas Medicaid as a billing or performing provider, the billing or performing provider NPI must be used on the claim as the ordering or referring provider.
- If the ordering or referring provider is not currently enrolled in Texas Medicaid as a billing or performing provider, the provider must enroll to receive an ordering or referring-only TPI. After the ordering or referring provider is enrolled, the ordering or referring provider's NPI must be used on the claim as the ordering or referring provider.

Important: *The billing provider is 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 and claims submitted with an NPI for a provider who is not enrolled in Texas Medicaid may be subject to retrospective review and denial for a missing or invalid NPI.

Note: *Providers who enroll in Texas Medicaid as ordering- and referring-only providers receive a TPI that can be used for orders and referrals for Texas Medicaid clients and CSHCN Services Program clients.*

6.4.2.5 Prior Authorization Numbers on Claims

Claims filed to TMHP must contain only one prior authorization number per claim. Prior authorization numbers must be indicated on the appropriate electronic field, or on the paper claim forms as indicated below:

- CMS-1500—Block 23
- UB-04 CMS-1450—Block 63
- ADA—Block 2
- Family Planning—Block 30

6.4.2.6 Newborn Clients Without Medicaid Numbers

If a Medicaid eligible newborn has not been assigned a Medicaid number on the DOS, the provider must wait until a Medicaid client number is assigned to file the claim. The provider writes the number instead of "Pending." The 95-day filing period begins on the "add date," which is the date the eligibility is received and added to the TMHP eligibility file. Providers verify eligibility and add date through TexMedConnect or by calling AIS or the TMHP Contact Center at 1-800-925-9126 after the number is received.

Providers must check Medicaid eligibility regularly to file claims within the required 95-day filing deadline.

Refer to: Section 4: Client Eligibility (*Vol. 1, General Information*).

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6.4.2.7 Multipage Claim Forms

6.4.2.7.1 Professional Claims

The approved electronic claims 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 on a paper claim, 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.

Note: *Providers who submit professional claims for inpatient services are required to include only the facility's NPI on the CMS-1500 paper claim form or electronic equivalent. The CMS-1500 paper claim form and electronic equivalents do not have a field for the facility's TPI.*

6.4.2.7.2 Institutional Claims

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 for inpatient claims 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.

An EDI approved electronic format of the UB-04 CMS-1450 is designed to list 71 lines. C21 merges like revenue codes together to reduce the lines to 28 or less.

Providers submitting electronic claims using TexMedConnect may not submit more than 28 lines. If the services exceed the 28 lines, the provider may submit another claim for the additional lines or merge codes.

The paper UB-04 CMS-1450 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.

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.

TEFRA hospitals are required to submit all charges.

6.4.2.7.3 Inpatient Hospital Claims

Medicaid present-on-admission (POA) reporting is required for all inpatient hospital claims that are paid under prospective payment basis methodology. No hospitals are exempt from this POA requirement.

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Medicare crossover hospital claims must also comply with the Medicaid requirement to include the POA values. Claims submitted without the POA indicators are denied. POA values are:

POA Value	Description	Payment
Y	Diagnosis was present at the time of admission.	Payment will be made by Texas Medicaid when a hospital acquired condition (HAC) is present.
N	Diagnosis was not present at the time of admission.	No payment will be made by Texas Medicaid when an HAC is present.
U	Documentation was insufficient.	No payment will be made by Texas Medicaid when an HAC is present.
W	Clinically undetermined.	Payment will be made by Texas Medicaid when an HAC is present.
Blank	Exempt from POA Reporting	Exempt from POA Reporting

Note: *Texas Medicaid follows Medicare guidelines for payments referenced in the above table.*

Depending on the POA indicator value, the DRG may be recalculated, which could result in a lower payment to the hospital facility provider. If the number of days on an authorization is higher than the number of days allowed as a result of a POA DRG recalculation, the lesser of the number of days is reimbursed.

Refer to: *Federal Register*, Vol. 76, No. 108 (for CMS).

6.4.2.8 Attachments to Claims

To expedite claims processing, providers must supply all information on the claim form itself and limit attachments to those required by TMHP or necessary to supply information to properly adjudicate the claim. The following claim form attachments are required when appropriate:

- All claims for services associated with an elective sterilization must have a valid Sterilization Consent Form attached or on file at TMHP.
- Nonemergency ambulance transfers must have documentation of medical necessity including out-of-locality transfers.
- For fee-for-service clients, providers filing to TMHP for Medicaid payment of Medicare coinsurance and deductible according to current payment guidelines must attach the paper MRAN received from Medicare or a Medicare intermediary or the computer generated MRANs from the CMS-approved software applications MREP for professional services or PC-Print for institutional services. Providers that submit paper crossover claims must submit only one of the approved MRAN formats.
- For MAP clients, providers filing to TMHP for Medicaid payment of Medicare coinsurance and deductible according to current payment guidelines must submit with the paper claim the TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template with the MAP EOB. If the template and MAP EOB contain conflicting information, the claim will not be processed and will be returned to the provider.
- Medically necessary abortions performed (on the basis of a physician's professional judgement, the life of the mother is endangered if the fetus were carried to term), or abortions provided for pregnancy related to rape or incest must have a signed and dated physician certification statement. Elective abortions are *not* benefits of Texas Medicaid.
- Hysterectomies must have a Hysterectomy Acknowledgment Statement attached or on file at TMHP.

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Refer to: Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information on the TMHP website at www.tmhp.com.

6.4.2.9 Clients with a Designated or Primary Care Provider

Claims for clients with a primary care provider or designated provider (i.e., Texas Medicaid fee-for-service clients enrolled as Limited Program clients) must indicate the primary care provider or designated provider identifiers in the billing or performing provider fields.

When clients receive services from a different provider, such as a specialist, the primary care provider or designated provider's information must be included in the referring provider fields on the claim.

6.5 CMS-1500 Paper Claim Filing Instructions

The following providers bill for services using the ANSI ASC X12 837P 5010 electronic specifications or the CMS-1500 paper claim form:

Providers
Ambulance
ASC (freestanding)
Case Management for Blind and Visually Impaired Children (BVIC), Case Management for Early Childhood Intervention (ECI), and Case Management for Children and Pregnant Women
Certified nurse-midwife (CNM)
Certified registered nurse anesthetist (CRNA)
Certified respiratory care practitioner (CRCP)
Chemical dependency treatment facilities
Chiropractor
Clinical nurse specialist (CNS)
Dentist (doctor of dentistry practicing as a limited physician)
DME
Family planning agency that does not also receive funds from the DSHS Family Planning Program
FQHC
Genetic service agency
Hearing aid
In-home total parenteral nutrition (TPN) supplier
Laboratory
Licensed dietitian (CCP only)
Licensed clinical social worker (LCSW)
Licensed professional counselor (LPC)
Maternity service clinic (MSC)
Mental health (MH) rehabilitative services
Nurse practitioner (NP)
Occupational therapist (CCP only)
Optician/optometrist/ophthalmologist
Orthotic and prosthetic supplier (CCP only)
Pharmacy
Physical therapist

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Providers
Physician (group and individual)
Physician assistant (PA)
Podiatrist
Private duty nurse (PDN) (CCP only)
Psychologist
Radiology
Rural Health Clinics rendering services to THSteps clients
School Health and Related Services (SHARS)
Speech language pathologist (CCP only)
THSteps medical
Tuberculosis clinic

Providers obtain copies of the CMS-1500 paper claim form from a vendor of their choice; TMHP does not supply them.

6.5.1 CMS-1500 Electronic Billing

Electronic billers must submit CMS-1500 paper claim forms with TexMedConnect or approved vendor software that uses the ANSI ASC X12 837P 5010 format. Specifications are available to providers developing in-house systems, software developers, and vendors on the TMHP website at www.tmhp.com/Pages/EDI/EDI_Technical_Info.aspx. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 1-888-863-3638.

Refer to: Subsection 3.2, "Electronic Billing" in Section 3, "TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information about electronic billing.

6.5.2 CMS-1500 Claim Form (Paper) Billing

Claims must contain the billing provider's complete name, address, and a provider identifier. Claims without a provider name, address, and provider identifier cannot be processed. Each claim form must have the appropriate signatory evidence in the signature certification block.

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. Providers can find examples of completed claim forms on the Claim Form Examples page of the TMHP website at www.tmhp.com.

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

6.5.3 CMS- 1500 Provider Definitions

The following definitions apply to the provider terms used on the CMS-1500 paper claim form:

Referring Provider

The referring provider is the individual who directed the patient for care to the provider that rendered the services being submitted on the claim form.

Examples include, but are not limited to the following:

- A primary care provider referring to a specialist

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- An orthodontist referring to an oral and maxillofacial surgeon
- A physician referring to a physical therapist
- 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 paper claim form.

Examples include, but are not limited to, a provider ordering diagnostic tests, 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 paper 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 the following:

- 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 antimarkup rule

In the case where a substitute provider is used, that individual is not considered a purchased service provider.

6.5.4 CMS-1500 Instruction Table

The instructions describe what information 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.

Block No.	Description	Guidelines
1a	Insured's ID No. (for program checked above, include all letters)	Enter the client's nine-digit patient number from the Medicaid identification form. 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 Medicaid 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.

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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 gender 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 code).
9	Other insured's name	For special situations, use this space to provide additional information such as: If the client is deceased, enter "DOD" in block 9 and the time of death in 9a if the services were rendered on the date of death. Enter the date of death in block 9b.
10a 10b 10c	Is 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 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 MRAN to the claim form. • For Workers Compensation and other property and casualty claims: (Required if known) Enter Workers' Compensation or property and 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 patient.
14	Date of current	Enter the first date (MM/DD/YYYY) of the present illness or injury. For pregnancy enter the date of the last menstrual period. If the client has chronic renal disease, enter the date of onset of dialysis treatments. Indicate the date of treatments for PT and OT.

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Block No.	Description	Guidelines
17	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: 1. Referring Provider 2. Ordering Provider 3. 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 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.
17b	NPI	Enter the NPI number of the referring, ordering, or supervising provider.
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 Medicaid number. **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 provider identifier of the facility that performed the service in block 32.
21	Diagnosis or nature of illness or injury	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. 9 = ICD-9-CM 0 = ICD-10-CM Enter the patient's diagnosis and/or condition codes. List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field.

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Block No.	Description	Guidelines
23	Prior authorization number	Enter the PAN issued by TMHP. For Workers Compensation and other property and casualty claims, this is 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 six 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 multi-page 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. If more than one date of service is for a single procedure, each date must be given on a separate line. **NDC** In the shaded area, enter the: • 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). ***Example:*** *N400409231231* ***Refer to:*** Subsection 6.3.4, "National Drug Code (NDC)" in this section.
24b	Place of service	Select the appropriate POS code for each service from the table under subsection 6.3.1.1, "Place of Service (POS) Coding" in this section.
24c	EMG (THSteps medical checkup condition indicator)	Enter the appropriate condition indicator for THSteps medical checkups. ***Refer to:*** Subsection 5.3.6, "THSteps Medical Checkups" in *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).
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. **NDC** In the shaded area, enter a 1- through 12-digit NDC quantity of unit. A decimal point must be used for fractions of a unit (e.g., 0.025). ***Refer to:*** Subsection 6.3.4, "National Drug Code (NDC)" in this section.

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Block No.	Description	Guidelines
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.* **NDC** In the shaded area, enter the NDC unit of measurement code. There are 5 allowed values: F2, GR, ML, UN or ME. ***Refer to:*** Subsection 6.3.4, "National Drug Code (NDC)" in this section.
24j	Rendering provider ID # (performing)	Enter the provider identifier of the individual rendering services unless otherwise indicated in the provider specific section of this manual. Enter the TPI in the shaded area of the field. Entered the NPI in the unshaded area of the field.
26	Patient's account number	**Optional:** Enter the client identification number if it is different than the subscriber/insured's identification number. Used by provider's office to identify internal client account number.
27	Accept assignment	**Required** All providers of Texas Medicaid must accept assignment to receive payment by checking **Yes**.
28	Total charge	Enter the total charges. For multi-page claims enter "continue" on initial and subsequent claim forms. Indicate the total of all charges on the last claim. ***Note:*** *Indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form.*
29	Amount paid	Enter any amount paid by an insurance company or other sources known at the time of submission of the claim. Identify the source of each payment and date in block 11. If the client makes a payment, the reason for the payment must be indicated in block 11.

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Block No.	Description	Guidelines
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:*** Subsection 6.4.2.1, "Provider Signature on Claims" in this section.
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 code of the facility where the service was provided. This is a required field for services provided in a facility. The facility provider number, name, and address are not optional.
32A	NPI	Enter the NPI of the service facility location.
33	Billing provider info & PH #	Enter the billing provider's name, street, city, state, ZIP+4 code, and telephone number.
33A	NPI	Enter the NPI of the billing provider.
33B	Other ID #	Enter the TPI number of the billing provider.

6.6 UB-04 CMS-1450 Paper Claim Filing Instructions

The following provider types may bill electronically or use the UB-04 CMS-1450 paper claim form when requesting payment:

Provider Types
ASCs (hospital-based)
Comprehensive outpatient rehabilitation facilities (CORFs) (CCP only)
FQHCs ***Note:*** *Must use CMS-1500 when billing THSteps.*
Home health agencies
Hospitals • Inpatient (acute care, rehabilitation, military, and psychiatric hospitals) • Outpatient
Indian Health
Renal dialysis center
Personal Care Services (PCS)
RHCs (freestanding and hospital-based) ***Note:*** *Must use CMS-1500 when billing THSteps.*

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If a service is rendered in the facility setting but the facility's medical record does not clearly support the information submitted on the facility claim, the facility may request additional information from the physician before submitting the claim to ensure the facility medical record supports the filed claim.

Note: *In the case of an audit, facility providers will not be allowed to submit an addendum to the original medical records for finalized claims.*

6.6.1 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: Subsection 3.2, "Electronic Billing" in Section 3, "TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for more information about electronic billing.

Note: *The maximum number of electronic claim details that will be accepted electronically is 71. Only 28 details will be processed.*

6.6.2 UB-04 CMS-1450 Claim Form (Paper) Billing

Providers obtain the UB-04 CMS-1450 paper claim forms from a vendor of their choice.

Note: *To avoid claim denial, only the provider's NPI should be placed in form locators 76-79 of the UB-04 CMS-1450 paper claim form or in the referring provider field on the electronic claim unless the client is a limited client.*

Completed UB-04 CMS-1450 claims must contain the billing provider's full name, address, and provider identifier (TPI/NPI in the appropriate fields). Claims *without* a provider name, address, and provider identifier in the appropriate fields *cannot* be processed.

Refer to: The Institutional paper claim form (CMS-1450) 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. Providers can find examples of completed claim forms on the Claim Form Examples page of the TMHP website at www.tmhp.com.

Subsection 6.6.3, "UB-04 CMS-1450 Instruction Table" in this section.

6.6.3 UB-04 CMS-1450 Instruction Table

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

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

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Block No.	Description	Guidelines
4	Type of bill (TOB)	Enter a TOB code. First Digit—Type of Facility: 1 Hospital 2 Skilled nursing 3 Home health agency 7 Clinic (rural health clinic [RHC], federally qualified health center [FQHC], and renal dialysis center [RDC]) 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) 7 Intermediate care Second Digit—Bill Classification (clinics only): 1 Rural health 2 Hospital-based or independent renal dialysis center 3 Free standing 5 CORFs 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 patient identification number if it is different than the subscriber/insured's identification number. Used by providers office to identify internal patient account number.
8b	Patient name	Enter the patient's last name, first name, and middle initial as printed on the Medicaid identification form.
9a–9b	Patient address	Starting in 9a, enter the patient's complete address as described (street, city, state, and ZIP+4 Code).
10	Birthdate	Enter the patient's date of birth (MM/DD/YYYY).
11	Sex	Indicate the patient's gender 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. Providers that receive a transfer patient from another hospital must enter the actual dates the patient was admitted into each facility.
13	Admission hour	Use military time (00 to 23) for the time of admission for inpatient claims or time of treatment for outpatient claims.

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Block No.	Description	Guidelines
14	Priority (Type) of Admission or Visit	Providers can refer to the National Uniform Billing Code website at www.nubc.org for the current list of Priority (Type) of Admission or Visit codes.
15	Point of Origin for Admission or Visit	Providers can refer to the National Uniform Billing Code website at www.nubc.org for the current list of Point of Origin for Admission or Visit codes.
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 (patient status of "30"), leave the block blank.
17	Patient Discharge Status	Providers can refer to the National Uniform Billing Code website at www.nubc.org for the current list of Patient Discharge Status Codes.
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 patient.
29	ACDT state	**Optional:** Accident state.
31-34	Occurrence codes and dates	Providers can refer to the National Uniform Billing Code website at www.nubc.org for the current list of Occurrence Codes.
35-36	Occurrence span codes and dates	For inpatient claims, enter code "71" if this hospital admission is a readmission within seven days of a previous stay. Enter the dates of the previous stay.
39-41	Value codes	Accident hour–For inpatient claims, if the patient 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.

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Block No.	Description	Guidelines
		NDC 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* ***Refer to:*** Subsection 6.3.4, "National Drug Code (NDC)" in this section.
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. **Home Health Services** Outpatient claims must have the appropriate revenue code and, if appropriate, the corresponding HCPCS code or narrative description. ***Refer to:*** Section 4.5.5, "Outpatient Hospital Revenue Codes" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information on which revenue codes require HCPCs codes. **Outpatient:** Outpatient claims must have the appropriate Healthcare Common Procedure Coding System (HCPCS) code.
		Refer to: Section 4.5.5, "Outpatient Hospital Revenue Codes" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information on which revenue codes require HCPCs codes. 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 paper claim form is limited to 28 items per inpatient and outpatient claim.* *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.*

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Block No.	Description	Guidelines
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.
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 and the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form.*
48	Noncovered charges	If any of the total charges are noncovered, enter this amount.
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 32, 61, 62, and 80 as required.
56	NPI	Enter the NPI of the billing provider.
57	Other identification (ID) number	Enter the TPI number (non-NPI number) of the billing provider.
58	Insured's name	If other health insurance is involved, enter the insured's name.
60	Medicaid identification number	Enter the patient's nine-digit Medicaid 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 patient's employer if health care might be provided.
66	Diagnosis/ Procedure Code Qualifier	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. 9 = ICD-9-CM 0 = ICD-10-CM
67	Principal diagnosis (DX) code and present on admission (POA) indicator	Enter the ICD-10-CM diagnosis code in the unshaded area for the principal diagnosis to the highest level of specificity available. **Required:** POA Indicator—Enter the applicable POA indicator in the shaded area for inpatient claims. ***Refer to:*** Subsection 6.4.2.7.3, "Inpatient Hospital Claims" in this section for POA values.

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Block No.	Description	Guidelines
67A-67Q	Secondary DX codes and POA indicator	Enter the ICD-10-CM diagnosis code in the unshaded area to the highest level of specificity available for each additional diagnosis. Enter one diagnosis per block, using Blocks A through J only. A diagnosis is not required for clinical laboratory services provided to nonpatients (TOB "141"). ***Exception:*** *A diagnosis is required when billing for estrogen receptor assays, plasmapheresis, and cancer antigen CA 125, immunofluorescent studies, surgical pathology, and alphafetoprotein.* ***Note:*** *ICD-10-CM diagnosis codes entered in 67K–67Q are not required for systematic claims processing.* **Required:** POA indicator—Enter the applicable POA indicator in the shaded area for inpatient claims. ***Refer to:*** Subsection 6.4.2.7.3, "Inpatient Hospital Claims" in this section for POA values.
69	Admit DX code	Enter the ICD-10-CM diagnosis code indicating the cause of admission or include a narrative ***Note:*** *The admitting diagnosis is only for inpatient claims.*
70a-70c	Patient's reason DX	**Optional:** New block indicating the patient'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 indication	**Optional:** Enter the ICD-10-CM diagnosis code in the unshaded area to the highest level of specificity available for each additional diagnosis. **Required:** POA indicator—Enter the applicable POA indicator in the shaded area for inpatient claims. ***Refer to:*** Subsection 6.4.2.7.3, "Inpatient Hospital Claims" in this section for POA values.
74	Principal procedure code and date	Enter the ICD-10-CM procedure code for each surgical procedure and the date (MM/DD/YYYY) each was performed.
74a-74e	Other procedure codes and dates	Enter the ICD-10-CM procedure code for each surgical procedure and the date (MM/DD/YYYY) each was performed.
76	Attending provider	Enter the attending provider name and identifiers. NPI number of the attending provider. Services that required an attending provider are defined as those listed in the ICD-10-CM coding manual volume 3, which includes surgical, diagnostic, or medical procedures.
77	Operating	Enter operating provider's name (last name and first name) and NPI number of the operating provider.

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Block No.	Description	Guidelines
78-79	Other	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. 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.*
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 patient 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. • Request for 110-day rule for a third party insurance.
81A-81D	Code code (CC)	**Optional:** Area to capture additional information necessary to adjudicate the claims. required when, in the judgment of the provider, the information is needed to substantiate the medical treatment and is not support elsewhere on the claim data set.

6.6.4 Filing Tips for Outpatient Claims

The following are outpatient claim filing tips:

- Use HCPCS codes in Block 44 when available and give a narrative description in Block 43 for all services and supplies provided.

Important: *Services and supplies that exceed the 28 items per claim limitation must be submitted on an additional UB-04 CMS-1450 paper claim form and will be assigned a different claim number by TMHP.*

- Combine central supplies and bill as one item. IV supplies may be combined and billed as one item. Include appropriate quantities and total charges for each combined procedure code used. Using combination procedure codes conserves space on the claim form.

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- The 28-item limitation per claim: a UB-04 CMS-1450 paper claim form submitted with 28 or fewer items is given an internal control number (ICN) by TMHP. Multipage claim forms are processed as one claim for that client *if all* pages contain 28 or fewer items.
- Itemized Statements: Itemized statements are not used for assignment of procedure codes. HCPCS codes or narrative descriptions of procedures *must* be reflected on the face of the UB-04 CMS-1450 paper claim form. Attachments will only be used for clarification purposes.

Refer to: The Children's Services Handbook *(Vol. 2, Provider Handbooks)* and the Nursing and Therapy Services Handbook *(Vol. 2, Provider Handbooks)* for information about PT/OT/ST services.

Subsection 6.3.3, "Procedure Coding" in this section.

6.7 2012 American Dental Association (ADA) Dental Claim Filing Instructions

Providers billing for dental services and Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) dental services may bill electronically or use the 2012 ADA claim form.

Note: *TMHP is responsible for reimbursing all THSteps dental services provided by dentists.*

6.7.1 2012 ADA Dental Claim Electronic Billing

Electronic billers must submit THSteps 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.

Note: *Dental providers who submit American National Standards Institute, Accredited Standards Committee X12 (ANSI ASC X12N) 837D transactions through the TMHP Electronic Data Interchange (EDI) are required to include the header date of service (HDOS) to comply with International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) claims processing guidelines.*

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for more information about electronic filing.

6.7.2 ADA Dental Claim Form (Paper) Billing

All participating THSteps dental providers are required to submit a 2012 ADA Dental claim form for paper claim submissions to Texas Medicaid. These forms may be obtained by contacting the ADA at 1-800-947-4746.

Claims must contain the billing provider's complete name, address and a provider identifier. Claims without a provider name, address, and provider identifier cannot be processed.

6.7.3 2012 ADA Dental Claim Form

Samples of the ADA Dental Claim form can be found on the ADA website at www.ada.org.

6.7.4 2012 ADA Dental Claim Form Instruction Table

The following table is an itemized description of the questions appearing on the form. Thoroughly complete the 2012 ADA Dental claim form according to the instructions in the table to facilitate prompt and accurate reimbursement and reduce follow-up inquiries.

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ADA Block No.	ADA Description	Instructions
1	Type of Transaction	For Texas Medicaid, check the Statement of Actual Services Box. The other two boxes are not applicable. Do not use the 2012 ADA Dental Claim Form as a Texas Medicaid Program Prior Authorization form. ***Refer to:*** THSteps Dental Mandatory Prior Authorization Request Form on the TMHP website at www.tmhp.com.
2	Predetermination/ Preauthorization Number	Enter prior authorization number if assigned by Medicaid.
3	Company/Plan Name, Address, City, State, ZIP Code	Enter TMHP and the address. ***Refer to:*** Subsection A.11, "Written Communication With TMHP" in "State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*).
4	Other Dental or Medical Coverage	Check No if no other dental or medical coverage (skip Blocks 5-11). Check Yes if dental or medical coverage is available other than Texas Medicaid coverage, and complete Blocks 5-11.
5-11	Other Coverage Information	General notes: • Enter the information for non-Medicaid insurance coverage. • Enter the information for the policyholder or subscriber, not necessarily the patient. May be a parent or legal guardian of the patient receiving treatment.
5	Name of Policy-holder/Subscriber in # 4	Enter the policyholder/subscriber name.
6	Date of Birth (MM/DD/CCYY)	Enter policyholder/subscriber eight-digit date of birth (MM/DD/YYYY).
7	Gender	Check the appropriate box for the policyholder/subscriber gender
8	Policy-holder/Subscriber ID	Enter policyholder/subscriber identifier.
9	Plan/Group Number	Enter policyholder/subscriber plan/group number.
10	Patient's Relationship to Person Named in # 5	Enter the patient's relationship to policyholder/subscriber.
11	Other Insurance Company/Dental Benefit Plan Name, Address, City, State, ZIP Code	Enter the contact information for the insurance company providing the non-Medicaid coverage.
12	Policy-holder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code	Enter the Medicaid patient's last name, first name, and middle initial as printed on the Medicaid identification form.

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ADA Block No.	ADA Description	Instructions
13	Date of Birth (MM/DD/CCYY)	Enter the Medicaid patient's date of birth (MM/DD/YYYY).
14	Gender	Check the appropriate box for the Medicaid patient's gender.
15	Policy-holder/Subscriber ID	Enter nine-digit patient number from the Medicaid identification form.
16	Plan/Group/Number	Enter the billing or performing provider's benefit code, if applicable.
17	Employer Name	Not applicable to Texas Medicaid.
18	Relationship to Policy-holder/ Subscriber in # 12 Above	Not applicable to Texas Medicaid.
19	Reserved for Local Use	Leave blank and skip to Item 20. (Field was previously used to report "Student Status")
20	Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code	Not applicable to Texas Medicaid.
21	Date of Birth (MM/DD/CCYY)	Not applicable to Texas Medicaid.
22	Gender	Not applicable to Texas Medicaid.
23	Patient ID/Account # (Assigned by Dentist)	**Optional**: Enter the patient identification number if it is different than the subscriber/insured's identification number. Used by dental office to identify internal patient account number.
24	Procedure Date (MM/DD/CCYY)	Enter the eight-digit date of service (MM/DD/YYYY).
25	Area of Oral Cavity	Not applicable to Texas Medicaid.
26	Tooth System	Not applicable to Texas Medicaid.
27	Tooth Number(s) or Letter(s)	Enter the Tooth ID as required for procedure code. ***Refer to:*** Subsection 4.2.11, "Tooth Identification (TID) and Surface Identification (SID) Systems" in *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).
28	Tooth Surface	Enter Surface ID as required for procedure code. ***Refer to:*** Subsection 4.2.11, "Tooth Identification (TID) and Surface Identification (SID) Systems" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).
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".

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ADA Block No.	ADA Description	Instructions
30	Description	Provide a brief description of the service provided (e.g., abbreviation of the procedure code's nomenclature). Field length reduced by 8 characters to provide space for added items 29a and 29b.
31	Fee	Enter usual and customary charges for each service listed. Charges must not be higher than the fees charged to private pay clients.
31a	Other Fee(s)	When other changes 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.
32	Total Fee	Enter the sum of all fees in Block 31. 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.*
33	Missing Teeth Information	Mark an "X" on each missing tooth. For identifying missing permanent dentition only. Report missing teeth when pertinent to periodontal, prosth-odontic (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: B= ICD-9-CM (for dates of service on or before September 30, 2015) AB= ICD-10 (for dates of service on or after October 1, 2015)
34a	Diagnosis Codes(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 this space for: • Explanation of exception to periodicity. • The facility name and address and NPI if the place of treatment indicated in Block 38 is not the provider's office. • Explanation of emergency if indicated in Block 45. • To provide more information such as reports for local orthodontia codes, 999 codes, multiple supernumerary teeth, or remarks.
36	Patient/Guardian signature	Not applicable to Texas Medicaid.
37	Subscriber signature	Not applicable to Texas Medicaid.

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ADA Block No.	ADA Description	Instructions
38	Place of Treatment	Enter the 2-digit place of service (POS) code for professional claims, which is a Health Insurance Portability and Accountability Act (HIPAA) standard. Frequently used POS codes include the following: • 11=Office • 12=Home • 21=Inpatient hospital • 22= Outpatient hospital • 31=Skilled nursing facility • 32= Nursing facility
39	Enclosures	Enter a "Y" or "N" to indicate whether or not there are enclosures of any type included with the claim submission (e.g., radiographs, oral images, models).
40	Is Treatment for Orthodontics?	Check Yes or No as appropriate.
41	Date Appliance Placed	Not applicable to Texas Medicaid.
42	Months of Treatment Remaining	Not applicable to Texas Medicaid.
43	Replacement of Prosthesis?	Not applicable to Texas Medicaid.
44	Date Prior Placement	Not applicable to Texas Medicaid.
45	Treatment Resulting from (Check applicable box)	Providers are required to 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.
46	Date of Accident (MM/DD/CCYY)	Not applicable to Texas Medicaid.
47	Auto Accident State	Not applicable to Texas Medicaid.
48	Name, Address, City, State, ZIP Code	Enter the name and address of the billing group or individual provider. Do not enter the name and address of a provider employed within a group.
49	NPI	Enter the billing provider's NPI for a group or an individual. Do not enter the NPI for a provider employed within a group.
50	License Number	Not applicable to Texas Medicaid.
51	Social Security Number (SSN) or Tax Identification Number (TIN)	Not applicable to Texas Medicaid.
52	Telephone Number	Enter the area code and number for the billing group or individual Do not enter the telephone number of a provider employed within a group.
52A	Additional Provider ID	Enter the nine-digit TPI assigned to the billing dentist or dental entity. Do not enter the TPI for a provider employed within a group.

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ADA Block No.	ADA Description	Instructions
53	Signed (Treating Dentist)	Required-Signature of treating dentist or authorized personnel. 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:*** Subsection 6.4.2.1, "Provider Signature on Claims" in this section.
54	NPI	Enter the NPI for the dentist enrolled as part of a group who treated the patient. Does not apply to individual providers.
55	License Number	Not applicable to Texas Medicaid.
56	Address, City, State, ZIP Code	Not applicable to Texas Medicaid.
56A	Provider Specialty Code	This block is optional.
57	Telephone Number	Not applicable to Texas Medicaid.
58	Additional Provider ID	**Required:** Enter the TPI for the dentist's enrolled as part of a group who treated the patient. Does not apply to individual providers.

6.8 Family Planning Claim Filing Instructions

The following providers bill for services using the ANSI ASC X12 837P 5010 electronic specifications or the CMS-1500 paper claim form:

Providers
Clinical nurse specialist (CNS)
Family Planning title agencies contracted with DSHS
Federally Qualified Health Center (FQHC)
Nurse practitioner (NP)
Physician
Physician assistant (PA)

6.8.1 Family Planning Electronic Billing

Electronic billers must submit family planning claims with TexMedConnect or approved vendor software that uses the ANSI ASC X12 837P 5010 format. Specifications are available to providers developing in-house systems, software developers, and vendors on the TMHP website at www.tmhp.com/Pages/EDI/EDI_Technical_Info.aspx. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 1-888-863-3638.

Refer to: Subsection 3.2, "Electronic Billing" in Section 3, "TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information about electronic billing.

6.9 Family Planning Claim Form (Paper Billing)

Claims must contain the billing providers complete name, address, and a provider identifier. Claims without a provider name, address, and provider identifier cannot be processed.

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6.9.1 2017 Claim Form

A copy of a blank 2017 Claim Form and copies of example completed claim forms are available on the Claim Form Examples page of the TMHP website at www.tmhp.com.

6.9.2 2017 Claim Form Instruction Table

The instructions describe what information must be entered in each of the block numbers of the 2017 Claim Form.

Block No.	Description	Guidelines	Required (Paper)
1	Program	Check the box for the specific program to which these services are billed: • Family Planning Program: XIX (Check this box for Title XIX family planning services and for TWHP services) • DSHS Family Planning Program (DFPP) • Primary Health Care (PHC) Program • Expanded Primary Health Care (EPHC) program	XIX, DFPP, PHC, EPHC (All)
2a	Billing provider TPI	Enter the billing provider's nine-digit TPI.	All
2b	Billing provider NPI	Enter the billing provider's NPI.	All
3	Provider name	Enter the provider's name as enrolled with TMHP.	All
4	Eligibility date (DFPP, PHC, or EPHC)	Enter the date (MM/DD/CCYY) this client was designated eligible for DFPP, PHC, or EPHC services. For DFPP, PHC, or EPHC, the eligibility date can be found on the following forms: • INDIVIDUAL Eligibility Form (EF05-14215) • HOUSEHOLD Eligibility Form (EF05-14214) • HOUSEHOLD Eligibility Worksheet (EF05-13227) • An approved DSHS substitute	DFPP, PHC, EPHC
5	DSHS Client no. (Medicaid PCN if XIX)	If previous DFPP, PHC, or EPHC claims or encounters have been submitted to TMHP, enter the client's nine-digit DSHS client number, which begins with "F." If the client has Title XIX Medicaid, enter the client's nine-digit client number from the Medicaid Identification form. If this is a new client, without Medicaid, leave this block blank and TMHP will assign a DSHS client number for the client.	XIX
6	Patient's name (last name, first name, middle initial)	Enter the client's last name, first name, and middle initial as printed on the Medicaid Identification Form, if Title XIX, or as printed in the provider's records, if DFPP, PHC, or EPHC.	All

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Block No.	Description	Guidelines	Required (Paper)
7	Address (street, city, state)	Enter the client's complete home address as described by the client (street, city, and state). This reflects the location where the client lives.	All
7a	ZIP Code	Enter the client's ZIP Code.	All
8	County of residence	Enter the county code that corresponds to the client's address. Please use the HHSC county codes.	All
9	Date of birth	Enter numerically the month, day, and year (MM/DD/CCYY) the client was born.	All
10	Sex	Indicate the client's sex by checking the appropriate box.	All
11	Patient status	Indicate if this is the client's first visit to this provider (new patient) or if this client has been to this provider previously (established patient). If the provider's records have been purged and the client appears to be new to the provider, check "New Patient."	All
12	Patient's Social Security number	Enter the client's nine-digit Social Security number (SSN). If the client does not have a SSN, or refuses to provide the number, enter 000-00-0001.	All
13	Race (code #)	Indicate the client's race by entering the appropriate race code number in the box. Aggregate categories used here are consistent with reporting requirements of the Office of Management and Budget Statistical Direction. Race is independent of ethnicity and all clients should be self-categorized as White, Black or African American, American Indian or Native Alaskan, Asian, Native Hawaiian or other Pacific Islander, or Unknown or Not Reported. An "Hispanic" client must also have a race category selected.	All
13a	Ethnicity	Indicate whether the client is of Hispanic descent by entering the appropriate code number in the box. Ethnicity is independent of race and all clients should be counted as either Hispanic or non-Hispanic. The Office of Management and Budget defines Hispanic as "a person of Mexican, Puerto Rican, Cuban, Central, or South American culture or origin, regardless of race."	All
14	Marital status	Indicate the client's marital status by entering the appropriate marital code number in the box.	All

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Block No.	Description	Guidelines	Required (Paper)
15	Family income (all)	DFPP, PHC, or EPHC: Use the gross monthly income calculated and reported on the INDIVIDUAL Eligibility Form (EF05-14215), the HOUSEHOLD Eligibility Form (EF05-14214), or the HOUSEHOLD Eligibility Worksheet (EF05-13227). Title XIX: Enter the gross monthly income reported by the client. Be sure to include all sources of income If income is received in a lump sum, or if it is for a period of time greater than a month (e.g., for seasonal employment), divide the total income by the number of months included in the payment period. If income is paid weekly, multiply weekly income by 4.33. If paid every two weeks, multiply amount by 2.165. If paid twice a month, multiply by 2. Enter $1.00 for clients not wishing to reveal income information.	All
15a	Family size	DFPP, PHC, or EPHC: Use the family size reported on the eligibility assessment tool. Title XIX providers: Enter the number of family members supported by the income listed in Box 15. Must be at least "one."	All
16	Number times pregnant	Enter the number of times this client has been pregnant. If male, enter zero.	XIX, DFPP
17	Number live births	Enter the number of live births for this client. If male, enter zero.	XIX, DFPP
18	Number living children	Enter the number of living children this client has. This also must be completed for male clients.	XIX, DFPP
19	Primary birth control method before initial visit	Enter the appropriate code letter (a through r) in the box.	XIX, DFPP
20	Primary birth control method at end of this visit	Enter the appropriate code letter (a through r) in the box.	XIX, DFPP
21	If no method used at end of this visit, give reason (required only if #20=r)	If the primary birth control method at the end of the visit was "no method" (r), you must complete this box with an appropriate code letter from this block (a through g).	XIX, DFPP (only if #20=r)
22	Is there other insurance available?	Check the appropriate box.	Optional
23	Other insurance name and address	Enter the name and address of the health insurance carrier.	Optional

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Block No.	Description	Guidelines	Required (Paper)
24a	Insured's policy/group no.	Enter the insurance policy number or group number.	Optional
24b	Benefit code	Benefit code, if applicable for the billing or performing provider.	Optional
25	Other insurance paid amount	Enter the amount paid by the other insurance company. If payment was denied, enter "Denied" in this block.	Optional
25a	Date of notification	Enter the date of the other insurance payment or denial in this block. This must be in the format of MM/DD/CCYY.	Optional
26	Name of referring provider	If a non-family planning service is being billed, and the service requires a referring provider, enter the provider's name.	XIX (if available)
27b	Referring NPI	If a non-family planning service is being billed and the service requires a referring provider identifier, enter the referring provider's NPI.	XIX
28	Level of practitioner	Enter the level of practitioner that performed the service. • Primary care or generalist physicians and specialists are correctly classified as "Physicians." • Certified nurse-midwives, nurse practitioners, clinical nurse specialists, and physician assistants providing encounters are correctly categorized as "Midlevel." • Encounters provided by a registered nurse or a licensed vocational nurse would be categorized as "Nurse." • Encounters provided by staff not included in the preceding classifications would be correctly categorized as "Other." If a client has encounters with staff members of different categories during one visit, select the highest category of staff with whom the client interacted. Optional for agencies not receiving any DFPP, PHC, or EPHC funding.	DFPP, PHC, EPHC
29	Diagnosis code (Relate Items A-L to service line 32E)	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. 9 = ICD-9-CM 0 = ICD-10-CM Enter the patient's diagnosis and/or condition codes. List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field.	All
30	Authorization number	Enter the authorization number for the client, if appropriate.	Optional

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Block No.	Description	Guidelines	Required (Paper)
31	Date of occurrence	Use this section when billing for complications related to sterilizations, contraceptive implants, or intrauterine devices (IUDs). This block should contain the date (MM/DD/CCYY) of the original sterilization, implant, or IUD procedure associated with the complications currently being billed.	All, if billing complications
32A	Dates of service	Enter the dates of service (DOS) for each procedure provided in a MM/DD/CCYY format. If more than one DOS is for a single procedure, each date must be given (such as 3/16, 17, 18/2010). Electronic Billers Medicaid does not accept multiple (to-from) dates on a single-line detail. Bill only one date per line. **NDC** In the shaded area, enter the: • 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). ***Example:*** *N400409231231*	All
32B	Place of service	Enter the appropriate POS code for each service from the POS table in the Texas Medicaid Provider Procedures Manual. If the client is registered at a hospital, the POS must indicate inpatient or outpatient status at the time of service.	All
32C	Reserved for local use	Leave this block blank. ***Note:*** *TOS codes are no longer required for claims submission.*	Optional
32D	Procedures, services, or supplies CPT/HCPCS modifier	Enter the appropriate CPT or HCPCS procedure codes for all procedures/services billed. **NDC** 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.	All
32E	Dx. ref. (29)	Enter the diagnosis line item reference (A-L) for each service or procedure as it relates to each ICD diagnosis code identified in Block 29. 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 29 only. Do not enter diagnosis codes in Form Field 32E.	All

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Block No.	Description	Guidelines	Required (Paper)
32F	Units or days (quantity)	If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed). **NDC** In the shaded area, enter the NDC unit of measurement code. There are 5 allowed values: F2, GR, ML, UN or ME.	All
32G	$ Charges	Indicate the charges for each service listed (quantity multiplied by reimbursement rate). Charges must not be higher than fees charged to private-pay clients.	All
32H (a)	Performing provider number (XIX only)-TPI	Members of a group practice (except pathology and renal dialysis groups) must identify the nine-digit TPI of the provider within the group who performed the service. ***Note:*** *To avoid unnecessary denials, DFPP, PHC, and EPHC providers should include the performing provider's TPI on the claim. Although not required for DFPP, PHC, and EPHC claims, if a claim or encounter that was submitted through DFPP, PHC, or EPHC is later determined eligible to be paid under Title XIX, the claim will be denied if the performing provider information is missing.*	XIX
32H (b)	Performing provider number (XIX only)-NPI	**Optional:** Members of a group practice (except pathology and renal dialysis groups) must identify NPI of the provider within the group who performed the service. ***Note:*** *To avoid unnecessary denials, DFPP, PHC, and EPHC providers should include the performing provider's NPI on the claim. Although not required for DFPP, PHC, and EPHC claims, if a claim or encounter that was submitted through DFPP, PHC, or EPHC is later determined eligible to be paid under Title XIX, the claim will be denied if the performing provider information is missing.*	XIX
33	Federal tax ID number/EIN (optional)	Enter the federal TIN (Employer Identification Number [EIN]) that is associated with the provider identifier enrolled with TMHP. ***Note:*** *To avoid unnecessary denials, PHC and EPHC providers should include the federal tax ID on the claim. Although not required for PHC and EPHC claims, if a claim or encounter that was submitted through PHC or EPHC is later determined eligible to be paid under Title XIX, the claim will be denied if the tax ID information is missing.*	XIX, DFPP
34	Patient's account number (optional)	Enter the client's account number that is used in the provider's office for its payment records.	Optional

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Block No.	Description	Guidelines	Required (Paper)
35	Patient copay assessed (DFPP, PHC, or EPHC)	If the client was assessed a copayment (DFPP, PHC, or EPHC), enter the dollar amount assessed. If no copay was assessed, enter $0.00. Copay cannot be assessed for Title XIX clients. Copayment must not exceed $30.00 for DFPP patients or $40.00 for PHC or EPHC patients.	DFPP, PHC, EPHC
36	Total charges	Enter the total of separate charges for each page of the claim. Enter the total of all pages on last claim if filing a multipage claim.	All
37	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 and dated by the provider authorizing this practice. When providers enroll to be an electronic biller, the "Signature on file" requirement is satisfied during the enrollment process.	All
38	Name and address of facility where services were rendered (if other than home or office)	If the services were provided in a place other than the client's home or the provider's facility, enter name, address, and ZIP Code, of the facility (such as the hospital or birthing center) where the service was provided. Independently practicing health-care professionals must enter the name and number of the school district/cooperative where the child is enrolled (SHARS). For laboratory specimens sent to an outside laboratory for additional testing, the complete name and address of the outside laboratory should be entered. The laboratory should bill Texas Medicaid for the services performed.	XIX
38a	NPI	Enter the NPI of the provider where services were rendered (if other than home or office).	XIX
39	Physician's, supplier's billing name, address, ZIP Code, and telephone number	Enter the billing provider name, street, city, state, ZIP Code, and telephone number.	Optional

6.10 Vision Claim Form

All vision services must be billed on a CMS-1500 paper claim form or the appropriate electronic formats. Vision claims submitted on other forms are denied with EOB 01145, "Claim form not allowed for this program."

For eyewear claims beyond program benefits, (e.g., replacing lost or destroyed eye wear), providers must have the patient sign the "Patient Certification Form" and retain in their records. Do not submit form to TMHP.

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Refer to: Vision Care Eyeglass Patient (Medicaid Client) Certification Form on the TMHP website at www.tmhp.com.

The following table shows the blocks required for vision claims on a CMS-1500 paper claim form.

Block No.	Description
1a	Enter the patient's nine-digit client number from the Your Texas Benefits Medicaid card.
2	Enter the patient's last name, first name, and middle initial as printed on the Your Texas Benefits Medicaid card.
3	Enter numerically the month, day, and year (MM/DD/YYYY) the client was born. Indicate the patient's sex by checking the appropriate box.
5	Enter the patient's complete address as described (street, city, state, and ZIP Code).
9 and 9a–9d	Other insurance or government benefits
10	Was condition related to: a. Patient's employment b. Auto accident c. Other accident
11	Medicare HIC number
12	Patient's or authorized person's signature
13*	Insured or authorized person's signature
17 Name of referring physician or other source 17b NPI	Name, provider identifiers, and address of prescribing medical doctor or doctor of optometry
21	Diagnosis or nature of illness or injury
24A	DOS
24B	POS
24D	Describe procedures, medical services, or supplies furnished for each date given
24D, Line "5" for new prescription 24D, Line "6" for old prescription	Prescription/description of lenses and frames
24E	Diagnosis pointer
24F	Charges
26*	The account number for the patient that is used in the provider's office for its billing records.
27 Check "YES" or "NO"	Accept assignment
28	Total charges
29	Amount paid by other insurance
31	Signature of physician or supplier
32	Name and address of facility where services were rendered if other than home or office
33	Telephone number
33	Physician's or supplier's name, address, city, state, and ZIP code

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Block No.	Description
No longer used	Referral from screening program (THSteps)

6.11 Remittance and Status (R&S) Report

The R&S Report provides information on pending, paid, denied, and adjusted claims. TMHP provides weekly R&S Reports to give providers detailed information about the status of claims submitted to TMHP. The R&S Report also identifies accounts receivables established as a result of inappropriate payment. These receivables are recouped from claim submissions. All claims for the same provider identifier and program processed for payment are paid at the end of the week, either by a single check or with Electronic Funds Transfer (EFT). If no claim activity or outstanding account receivables exist during the cycle week, the provider does not receive an R&S Report. Providers are responsible for reconciling their records to the R&S to determine payments and denials received.

Note: *Providers receive a single R&S Report that details Texas Medicaid activities and provides individual program summaries. Combined provider payments are made based on the provider's settings for Texas Medicaid fee-for-service.*

Providers must retain copies of all R&S Reports for a minimum of five years. Providers must not use R&S Report originals for appeal purposes, but must submit copies of the R&S Reports with appeal documentation.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

6.11.1 R&S Report Delivery Options

TMHP offers two options for the delivery of the R&S Report:

- A PDF version that is available on the TMHP website through the secure provider portal.
- An Electronic Remittance and Status (ER&S) Report that is available through EDI.

The PDF version of the R&S Report is available through TexMedConnect, and can be downloaded by registered users of the TMHP website at www.tmhp.com. The report is available each Monday morning, immediately following the weekly claims cycle. Payments associated with the R&S Report are released the next Friday following the weekly claims cycle. Newly-enrolled providers are initially set up to receive the PDF version of the R&S Report.

The EDI delivery method is also available. Using HIPAA-compliant EDI standards, the (ER&S 835 file) can be downloaded through the TMHP EDI Gateway using third party software. The ER&S Report is available on Thursday the week the provider payments are released

Note: *In rare instances, payments and R&S delivery may be delayed due to a system outage or holiday.*

In addition to the PDF R&S Report, an optional R&S Report delivery method is also available. Using HIPAA-compliant EDI standards, the ER&S Report can be downloaded through the TMHP EDI Gateway using TexMedConnect or third party software. The ER&S Report is also available each Monday after the completion of the claims processing cycle.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for more information about EDI formats and enrollment for the ER&S Report.

6.11.2 Banner Pages

Banner pages serve two purposes:

- They identify the provider's name and address.
- They are used to inform providers of new policies and procedures.

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The title pages include the following information:

- TMHP address for submitting paper appeals
- Provider's name, address, and telephone number
- Unique R&S Report number specific to each report
- Provider identifier (TPI, NPI, and atypical provider identifier [API])
- Report sequence number (indicates the week number of the year)
- Date of the week being reported on the R&S Report
- Tax Identification Number
- Page number (R&S Report begins with page 1)
- AIS telephone number
- Taxonomy code

6.11.3 R&S Report Field Explanation

- *Patient name.* Lists the client's last name and first name, as indicated on the eligibility file.
- *Claim number.* The 24-digit Medicaid ICN for a specific claim. The format for the TMHP claim number is expanded to PPP/CCC/MMM/CCYY/JJJ/BBBBB/SSS.

Acronym	Description
PPP	Program
CCC	Claim type
MMM	Media source (region)
CCYY	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

Program Type

PPP	Program
001	Long Term Care
100	Medicaid
200	Managed Care (for carve-out services administered by TMHP and PCCM claims with dates of service before March 1, 2012)
300	Family Planning (DSHS Family Planning Program)
400	CSHCN Services Program
999	Default/summary for all media regions

Claim Type

Claim Type	Description
020	Physician/supplier (Medicaid only) (genetics agencies, THSteps [medical only], FQHC, optometrist, optician)
021	THSteps (dental)
023	Outpatient hospital, home health, RHC, FQHC

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Claim Type	Description
030	Physician crossovers
031	Hospital outpatient crossovers, home health crossovers, RHC crossovers
040	Inpatient hospital
050	Inpatient crossover
056	DSHS Family Planning Program
058	Family Planning Title XIX

Media Source (MMM)

Region	Description
010	Paper
011	Paper adjustment
030	Electronic (including TexMedConnect)
031	Electronic adjustment (including TexMedConnect)
041	AIS adjustment
051	Mass adjustment
054	DSHS Expanded Primary Health Care (EPHC)
061	Crossover adjustment
071	Retroactive eligibility adjustment
080	State Action Request
081	State Action Request adjustment
090	Telephone
100	Fax
110	Mail
120	Encounter
121	Encounter Adjustment

- *Medicaid #.* The client's Medicaid number.
- *Patient Account #.* If a patient account number is used on the provider's claim, it appears here.
- *Medical Record #.* If a medical record number is used on the provider's claim, it appears here.
- *Medicare #.* If the claim is a result of an automatic crossover from Medicare, the last ten digits of the Medicare claim number appears directly under the TMHP claim number.
- *Diagnosis.* Primary diagnosis listed on the provider's claim.
- *Service Dates.* Format MMDDYYYY (month, day, year) in "From" and "To" dates of service.
- *TOS/Proc.* Indicates by code the specific service provided to the client. The one-digit TOS appears first followed by a HCPCS procedure code. A three-digit code represents a hospital accommodation or ancillary revenue code. For claims paid under prospective payment methodology, it is the code of the DRG.
- *Billed Quantity.* Indicates the quantity billed per claim detail.
- *Billed Charge.* Indicates the charge billed per claim detail.
- *Allowed Quantity.* Indicates the quantity TMHP has allowed per claim detail.

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- *Allowed Charge.* Indicates the charges TMHP has allowed per claim detail. For inpatient hospital claims, the allowed amount for the DRG appears.
- *POS Column.* The R&S Report includes the POS to the left of the Paid Amount. A one-digit numeric code identifying the POS is indicated in this column. Refer to subsection 6.3.1.1, "Place of Service (POS) Coding" in this section for the appropriate cross-reference among the two-digit numeric POS codes (Medicare), alpha POS codes, and one-digit numeric code on the R&S Report. Providers using electronic claims submission should continue using the same POS codes.
- *Paid Amt.* The final amount allowed for payment per claim detail. The total paid amount for the claim appears on the claim total line.
- *EOB Codes and Explanation of Pending Status (EOPS) Codes.* These codes explain the payment or denial of the provider's claim. The EOB codes are printed next to or directly below the claim. The EOPS codes appear only in "The Following Claims Are Being Processed" section of the R&S Report. The codes explain the status of pending claims and are not an actual denial or final disposition. An explanation of all EOB and EOPS codes appearing on the R&S Report are printed in the Appendix at the end of the R&S Report. Up to five EOB codes are displayed.
- *Total TEFRA Billed and Allowed Charges.* Indicates claim details that have been denied or reduced.
- *Benefit.* Indicates the three digit benefit code associated with the claim.
- *Modifier.* Modifiers have been developed to describe and qualify services provided. For THSteps dental services two modifiers are printed. The first modifier is the TID and the second is the SID.

6.11.4 R&S Report Section Explanation

6.11.4.1 Claims – Paid or Denied

The heading *Claims – Paid or Denied Claims* is centered on the top of each page in this section. Claims in this section finalized the week before the preparation of the R&S Report. The claims are sorted by claim status, claim type, and by order of client names. The reported status of each claim will not change unless further action is initiated by the provider, HHSC, or TMHP.

The following information is provided on a separate line for all inpatient hospital claims processed according to prospective payment methodology:

- *Age.* Client's age according to TMHP records
- *Sex.* Client's sex according to TMHP records: M = Male, F = Female, U = Unknown
- *Pat-Stat.* Indicates the client's status at the time of discharge or the last DOS on the claim (refer to instructions for UB-04 CMS-1450 paper claim form, Block 17)
- *Proc.* ICD-9-CM code indicates the primary surgical procedure used in determining the DRG

Important: *Only paper claims appear in this section of the R&S Report. Claims filed electronically without required information are rejected. Users are required to retrieve the response file to determine reasons for rejections.*

TMHP cannot process incomplete claims. Incomplete claims may be submitted as original claims only if the resubmission is received by TMHP within the original filing deadline.

Refer to: Subsection 6.1, "Claims Information" in this section for a description of different claim types.

6.11.4.2 Adjustments to Claims

Adjustments – Paid or Denied is centered at the top of each page in this section. Adjustments are sorted by claim type and then patient name and Medicaid number. Media types 011, 021, 031, 041, 051, 061, 071, and 081 appear in this section. An adjustment prints in the same format as a paid or denied claim.

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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. Immediately below is the claim as originally processed. An accounts receivable is created for the original claim total as noted by EOB 00601, "A receivable has been established in the amount of the original payment: $XXX,XXX,XXX.XX. Future payments will be reduced or withheld until such amount is paid in full." prints below the claim indicating the amount to be recouped. This amount appears under the heading, "Financial Transactions Accounts Receivable." EOB 06065, "Account Receivable is due to the adjusted claim listed. For details, refer to your R&S Report for the date listed within the original date field."

Claims adjusted as a result of a rate change will be listed on the R&S Report with EOB 01154 "This adjustment is a result of a rate change."

Refer to: Subsection 6.2.5, "Modifier Requirements for TOS Assignment" in this section for a list of the most commonly used modifiers.

6.11.4.3 Financial Transactions

All claim refunds, reissues, voids/stops, recoupments, backup withholdings, levies, and payouts appear in this section of the R&S Report. The Financial Transactions section does not use the R&S Report form headings. Additional subheadings are printed to identify the financial transactions. The following descriptions are types of financial items.

6.11.4.3.1 Accounts Receivable

This label identifies money subtracted from the provider's current payment owed to TMHP. Specific claim data are not given on the R&S Report unless the accounts receivable control number is provided which should be referenced when corresponding with TMHP. Accounts receivable appear on the R&S Report in the following format:

- *Control Number.* A number to reference when corresponding with TMHP.
- *Recoupment Rate.* The percentage of the provider's payment that is 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. This area is blank if the provider elects to have a percentage withheld each week.
- *Original Date.* The date the financial transaction was processed originally.
- *Original Amount.* The total amount owed TMHP.
- *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.
- *Balance.* Indicates the total outstanding accounts receivable (AR) balance that remains due to TMHP.
- *FYE.* The fiscal year end (FYE) for cost reports.
- *EOB.* The EOB code that corresponds to the reason code for the accounts receivable.
- *Patient Name.* The name of the patient on the claim, if the accounts receivable are claim-specific.
- *Claim Number.* The ICN of the original claim, if the accounts receivable are claim-specific.
- *Backup Withholding Penalty Information.* A penalty assessed by the Internal Revenue Service (IRS) for noncompliance due to a B-Notice. Although the current payment amount is lowered by the amount of the backup withholding, the provider's 1099 earnings are not lowered.
- *Control Number.* TMHP control number to reference when corresponding with TMHP.

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- *Original Date.* The date the backup withholding was set up originally.
- *Withheld Amount.* Amount withheld (31 percent) of the provider's checkwrite.

6.11.4.3.2 IRS Levies

The payments withheld from a provider's checkwrite as a result of a notice from the IRS of a levy against the provider appear in the "IRS Levy Information" 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:

- *Control Number.* TMHP control number to reference when corresponding with TMHP.
- *Maximum Recoupment Rate.* The percentage of the provider's payment that is withheld each week, unless the provider elects to have a specific amount withheld each week.
- *Maximum Recoupment Amount.* The amount to be withheld periodically.
- *Original Date.* The date the levy was set up originally.
- *Original Amount.* The total amount owed to the IRS.
- *Prior Balance.* The amount owed from a previous R&S Report.
- *Prior Date.* The date the last transaction on the levy occurred.
- *Current Amount.* The amount subtracted from the current R&S Report and paid to the IRS.
- *Remaining Balance.* The amount still owed on the levy. (This amount becomes the "previous balance" on the next R&S Report.)

6.11.4.3.3 Refunds

Refunds are identified by EOB 00124, "Thank you for your refund; your 1099 liability has been credited." This statement is verification that dollars refunded to TMHP for incorrect payments have been 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:

- Claim Specific:
  - *ICN.* The claim number of the claim to which the refund was applied this cycle.
  - *Patient Name.* The first name, middle initial, and last name of the patient on the applicable claim.
  - *Medicaid Number.* The patient's Medicaid or CSHCN Services Program number.
  - *Date of Service.* The format MMDDCCYY (month, day, and year) in "From" DOS.
  - *Total Billed.* The total amount billed for the claim being refunded.
  - *Amount Applied This Cycle.* The refund amount applied to the claim.
  - *EOB.* Corresponds to the reason code assigned.
- Nonclaim Specific:
  - *Control Number.* A control number to reference when corresponding with TMHP.
  - *FYE.* The fiscal year for which this refund is applicable.
  - *EOB.* Corresponds to the reason code assigned.

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6.11.4.3.4 Payouts

Payouts are dollars TMHP owes to the provider. TMHP processes two types of payouts: system payouts that increase the weekly check amount and manual payouts that result in a separate check being sent to the provider. Specific claim data are not given on the R&S Report for payouts. A control number is given, which should be referenced when corresponding with TMHP. System and manual payouts appear on the R&S Report in the following format:

- *Payout Control Number.* A control number to reference when corresponding with TMHP.
- *Payout Amount.* The amount of the payout.
- *FYE.* The fiscal year for which the payout is applicable.
- *EOB.* Corresponds to the reason code assigned.
- *Patient Name.* Name of the patient (if available).
- *PCN.* Medicaid number of the patient (if available).
- *DOS.* Date of service (if available).

6.11.4.3.5 Reissues

The provider's 1099 earnings are not affected by reissues. A messages states, "Your payment has been increased by the amount indicated below:

- *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.

6.11.4.3.6 Voids and Stops

The provider's 1099 earnings are credited by the amount of the voided/stopped payment.

- *Check Number.* The number of the voided/stopped payment.
- *Check Amount.* The amount of the voided/stopped payment.
- *R&S Number.* The number of the voided/stopped payment.
- *R&S Date.* The date of the voided/stopped payment.

6.11.4.4 Claims Payment Summary

This section summarizes all payments, adjustments, and financial transactions listed on the R&S Report. The section has two categories: one for amounts "Affecting Payment This Cycle" and one for "Amount Affecting 1099 Earnings."

If the provider is receiving a check on this particular R&S Report, the following information is given: "Payment summary for check XXXXXXXXX in the amount of XXX,XXX,XXX.XX." If the payment is EFT: "Payment summary for direct deposit by EFT XXXXXXXXX in the amount of XXX,XXX,XXX.XX." The check number also is printed on the check that accompanies the R&S Report.

Headings for the Payment Summary for "Affecting Payment This Cycle" and "Amount Affecting 1099 Earnings"

- *Claims Paid.* Indicates the number of claims processed for the week and the year-to-date total.
- *System Payouts.* The total amount of system payouts made to the provider by TMHP.
- *Manual Payouts (Remitted by separate check or EFT).* The total amount of manual payouts made to the provider by TMHP.

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- *Amount Paid to IRS for Levies.* The amount remitted to IRS and withheld from the provider's payment due to an IRS levy.
- *Amount Paid to IRS for Backup Withholding.* The amount paid to the IRS for backup withholding.
- *Accounts Receivable Recoupments.* The total amount withheld from the provider's payment due to accounts receivable.
- *Amounts Stopped/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.
- *Claim Related Refunds.* 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.
- *Approved to Pay/Deny Amount.* The total amount of claim payments that were approved to pay/deny within the week. (This column will not be used at this time.)
- *Pending Claims.* The total amount billed for claims in process as of the cutoff date for the report.

6.11.4.5 The Following Claims are Being Processed

In the "Following Claims are Being Processed" section, the R&S Report may list up to five EOPS codes per claim. The claims listed in this section are in process and *cannot be appealed for any reason* until they appear in either the "Claims Paid or Denied," or "Adjustments Paid and Denied" sections of the R&S Report. TMHP is listing the pending status of these claims for informational purposes only. *The pending messages should not be interpreted as a final claim disposition.* Weekly, all claims and appeals on claims TMHP has "in process" from the provider are listed on the R&S Report. The Following Claims are Being Processed claim prints in the same format as a paid or denied claim.

6.11.4.6 Explanation of Benefit Codes Messages

This section lists the descriptions of all EOBs that appeared on the R&S Report. EOBs appear in numerical order.

EDI ANSI X12 5010 835 files 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 includes the CARC, CAGC, and RARC explanation codes that are associated with the highest priority detail EOB to provide a clearer explanation for the denial.

6.11.4.7 Explanation of Pending Status Codes Appendix

This section lists the description of all EOPS codes that appeared on the R&S Report. EOPS appear in numerical order.

EOB and EOPS codes may appear on the same pending claim because some details may have already finalized while others may have questions and are pending.

6.11.5 R&S Report Examples

Examples of R&S Reports are available on the TMHP website at www.tmhp.com.

R&S Report Examples
Accounts Receivables R&S Report (For purposes of example, accounts receivables, void, and stop pay appear together.)
Adjustments R&S Report
Appendix R&S Report

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R&S Report Examples
Backup Withholding Penalty Information R&S Report
Banner Page R&S Report
Claims in Process R&S Report
IRS Levy R&S Report
Manual Payouts R&S Report
Paid or Denied Claims (Hospital) R&S Report
Paid or Denied Claims (Physician) R&S Report
Refunds for Managed Care R&S Report
Refunds for Medicaid R&S Report
Reissues R&S Report
Sub-Owner Recoupments R&S Report
Summary R&S Report
System Payouts R&S Report
Void and Stop Pay R&S Report

6.11.6 Provider Inquiries—Status of Claims

TMHP provides several effective mechanisms for researching the status of a claim. Weekly, TMHP provides the R&S Report reflecting all claims with a paid, denied, or pending status. Providers verify claim status using the provider's log of pending claims.

Electronic billers allow ten business days for a claim to appear on their R&S Reports. If the claim does not appear on an R&S Report as paid, pending, or denied, a transmission failure, file rejection, or claims rejection may exist. Providers check records for transmission reports correspondence from the TMHP EDI Help Desk.

The provider allows at least 30 days for a Medicaid paper claim to appear on an R&S Report after the claim has been submitted to TMHP. If a claim has not been received by TMHP and must be submitted a second time, the second claim must also meet the 95-day filing deadline.

The provider allows TMHP 45 days to receive a Medicare-paid claim automatically transmitted for payment of coinsurance or deductible according to current payment guidelines. Claims that fail to cross over from Medicare may be filed to TMHP by submitting a paper MRAN received from Medicare or a Medicare intermediary, the computer generated MRANs from the CMS-approved software applications MREP for professional services or PC-Print for institutional services or, for MAP clients, TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template with the completed claim form.

If the claim does not appear on an R&S Report as paid, pending, or denied, providers can use any of the following procedures to inquire about the status of the claim:

- The provider can use the claim status inquiry function of TexMedConnect on the TMHP website at www.tmhp.com.
- The provider can call AIS at 1-800-925-9126 to determine if the claim is pending, paid, denied, or if TMHP has no record of the claim.
- If any of the three options above indicates that TMHP has no record of the claim, the provider can call the TMHP Contact Center at 1-800-925-9126 and speak to a TMHP contact center representative.

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- If the TMHP Contact Center has no record of a claim that was submitted within the original filing deadline, the provider can submit a copy of the original claim to TMHP for processing. Electronic billers may refile the claim electronically. For claims submitted by a hospital for inpatient services, the filing deadline is 95 days from the discharge date or the last DOS on the claim. For all other types of providers, the filing deadline is 95 days from each DOS on the claim.
- If the 95-day filing deadline has passed and the claim is still within 120 days of the date of the rejection report or the R&S Report, the provider can submit a signed copy of the claim and all of the documentation that supports the original claim submission, including any electronic rejection reports, to:

Texas Medicaid & Healthcare Partnership
Inquiry Control Unit
12357-A Riata Trace Parkway, Suite 100
Austin, TX 78727

Providers must retain copies of all R&S Reports for a minimum of five years. Providers must not send original R&S Reports back with appeals. Providers must submit one copy of the R&S Report to TMHP per appeal.

Refer to: Subsection A.12.3, "Automated Inquiry System (AIS)" in "State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*).

6.12 Other Insurance Claims Filing

The following information must be provided in the "Other Insurance" field on the paper claim and in the appropriate field of electronic claims. On the CMS-1500 paper claim form, Fields 9 or 11, and 29 must contain the appropriate information:

- Name of the other insurance resource
- Address of the other insurance resource
- Policy number and group number
- Policyholder
- Effective date if available
- Date of disposition by other insurance resource (used to calculate filing deadline)
- Payment or specific denial information

Important: *By accepting assignment on a claim for which the client has Medicaid coverage, providers agree to accept payment made by insurance carriers and Texas Medicaid when appropriate as payment in full. The client cannot be held liable for any balance or copays related to Medicaid-covered services.*

6.12.1 Unbundled Services That Are Prior Authorized and Manually Priced Procedure Codes

Providers that submit prior authorization requests and claims to TMHP must:

- Unbundle any bundled procedure codes that have been submitted to the client's other insurance company.
- Itemize the rates.

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If prior authorization has been obtained for services that use manually priced procedure codes, providers must submit claims for the services using the MSRP that was submitted with the authorization request and the following information that is listed on the authorization letter:

- The authorization number
- The provider identifier
- The procedure codes
- The dates of service
- The types of service
- The required modifiers

If the authorization letter shows itemized details, the claim must include all rendered services as they are itemized on the authorization letter and the MSRP rate for each of those services. The procedure codes and MSRP rates that are detailed on the claim must match the procedure codes that are detailed in the authorization letter and the MSRP rates that were submitted with the authorization request. Claims processing and payment may be delayed if there is not an exact match between the detailed information on the authorization letter, the approved authorization, and the information that was submitted on the claim.

Important: *For appropriate processing and payment, the Pay Price that is indicated on the authorization letter* should not *be submitted on the claim.*

Prior authorization is a condition of reimbursement; it is not a guarantee of payment.

6.12.2 Other Insurance Credits

Providing other insurance payment information, even when no additional payment is expected from TMHP, provides benefit to all parties involved in Texas Medicaid. When a TPR issues a payment or partial payment to a provider, the other insurance credit *must* be indicated on the claim form submitted to TMHP.

This procedure benefits both providers and TMHP even if the TPR payment exceeds the Medicaid allowed amount. Although additional payment may not be issued by TMHP, informing TMHP of the other insurance credit allows TMHP to track the appropriate use of TPRs. Informing TMHP of a TPR credit provides hospitals with a more accurate standard dollar amount (SDA) rate setting and assists the program in tracking recoveries and reducing Medicaid medical expenditures by informing TMHP of liable third parties.

Providers must report TPR payments correctly in the appropriate electronic field or the paper claim form block.

Claim Form	Reference
CMS-1500	Block 29, CMS-1500 Blank Claim Form (subsection 6.5.2 in this section)
UB-04 CMS-1450	Block 54, UB-04 CMS-1450 Blank Claim Form (subsection 6.6.2 in this section)
THSteps Dental	Block 31, 2012 ADA Dental Claim Form (subsection 6.7.3 in this section)

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6.12.2.1 Deductibles

TMHP will consider deductibles for reimbursement when the original third party payor applied the payment amount directly to the clients deductible. The explanation of benefit reflecting the application of the payment by the other insurance (third party payor) and a completed signed claim copy must be submitted to TMHP for consideration.

6.12.2.2 Health Maintenance Organization (HMO) Copayments

TMHP processes and pays HMO copayments for private and Medicare HMOs as well as private and Medicare PPO copayments for clients who are eligible for reimbursement under Medicaid guidelines.

TMHP pays the copayment in addition to the service the HMO or PPO has denied, if the client is eligible for Texas Medicaid and the procedure is reimbursed under Medicaid guidelines. Providers are not allowed to hold the client liable for the copayment.

An office or emergency room (ER) visit (the ER physician is paid only when the ER is not staffed by the hospital) is reimbursed a maximum copayment of $10 per visit. The hospital ER visit is reimbursed at a maximum of $50 to the facility. TMHP pays up to four copayments per day, per client. ER visits are limited to one per day, per client, and are considered one of the four copayments allowed per day.

Important: *By accepting assignment on a claim for which the client has Medicaid coverage, providers agree to accept payment made by insurance carriers and the Texas Medicaid Program when appropriate as payment in full. The client cannot be held liable for any balance related to Medicaid-covered services.*

The following Medicaid codes have been created for copayments, which are considered an atypical service:

POS 1 – Office	Description
CP001	Private HMO copayment—professional
CP002	Private PPO copayment—professional
CP003	Medicare HMO copayment-professional
CP004	Medicare PPO copayment-professional

POS 5 – Outpatient	Description
CP005	Private HMO copayment—outpatient
CP006	Private PPO copayment—outpatient
CP007	Medicare HMO copayment-outpatient
CP008	Medicare PPO copayment-outpatient

6.12.2.3 Verbal Denial

Providers may call the other insurance resource and receive a verbal denial. The other insurance record can either be updated when the provider files the claim or calls the TPL/Tort Customer Service line at 1-800-846-7307. When calling the TPL/Tort Customer Service line and when filing claims to TMHP, the provider must have the following information before any updates are made.

Verbal denial requirements:

- Date of the telephone call to the other insurance resource
- Insurance company's name and telephone number
- Name of the individual contacted at the insurance company
- Policyholder and group information for the client

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- Specific reason for the denial, including the client's type of coverage to enhance the accuracy of future claims processing (for example, a policy that covers inpatient services or physician services only)

Providers that update a client's insurance records through the TMHP TPL/Tort Customer Service line must follow the current appeal process once the other insurance information has been updated on the client's file.

6.12.2.4 110-Day Rule

When a service is billed to a third party and no response has been received, Medicaid providers must allow 110 days to elapse before submitting a claim to TMHP. If a TPR has not responded or delays payment or denial of a provider's claim for more than 110 days after the date the claim was billed, Medicaid considers the claim for reimbursement. However, the 365-day federal filing deadline requirement must still be met. The following information is required:

- Name and address of the TPR
- Date the TPR was billed
- Statement signed and dated by the provider that no disposition has been received from the TPR within 110 days of the date the claim was billed

When TMHP denies a claim because of the client's other coverage, information that identifies the other insurance appears on the provider's R&S Report. The claim is not to be refiled with TMHP until disposition from the TPR has been received or until 110 days have lapsed since the billing of the claim with no disposition from the TPR. A statement from the client or family member which indicates that they no longer have this resource is *not* sufficient documentation to reprocess the claim.

When a provider is advised by a TPR that benefits have been paid to the client, the information must be included 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 verbal denial guidelines above for required information. This enables TMHP to consider the claim for reimbursement.

6.12.2.5 Filing Deadlines

In accordance with federal regulations, all claims must initially be filed with TMHP within 365 days of the DOS. Claims that involve filing to a TPR have the following deadlines:

- Claims with a valid disposition (payment or denial) must be received by TMHP within 95 days of the date of disposition by the TPR and within 365 days of the DOS. Appealed claims that were originally denied with EOB 00260, which indicates that the provider files with a TPR, must be received within 95 days of the date of disposition by the TPR or within 120 days of the date on which TMHP denied the claim.
    - The provider must appeal the claim to TMHP with complete other insurance information, which includes all EOBs and 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. If the other insurance disposition date appears only on the first page of an EOB that has multiple pages and the claim that is being submitted to TMHP is on a subsequent page or pages, the provider must submit the first page that shows the disposition date and all of the pages that show the claim that is being submitted to TMHP.
- If more than 110 days have passed from the date a claim was filed to the TPR without a response, the claim is submitted to TMHP for consideration of payment.

Refer to: Subsection 4.12, "Third Party Liability (TPL)" in Section 4, "Client Eligibility" (*Vol. 1, General Information*).

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6.12.3 Claims Forwarded to Other Insurance Carriers

Federal and state laws require the use of Medicaid funds for the payment of most medical services only after all reasonable measures have been made to use a client's TPR or other insurance. Providers are required to submit clients' known other insurance to TMHP.

TMHP forwards electronic institutional claims for clients suspected of having other insurance to a contractor. The contractor researches the claims to determine the client's possible other insurance information. If it is determined that the client has valid other insurance for the claim's date of service and the insurance carrier is listed below, the contractor will forward the claim to the selected insurance carrier. TMHP has begun forwarding claims to the major insurance carriers for Texas.

Provider will receive a denial EOB from TMHP on the R&S Report that will indicate that the claim was forwarded to the client's other insurance carrier.

If the other insurance carrier denies the claim, the provider should first exhaust all avenues to appeal the claim with the other insurance carrier. If the final disposition is a denial, the provider may appeal the claim to TMHP using the carrier's EOB showing the denial. Providers must review their R&S Reports to ensure that any follow-up action is taken within the appeal deadlines.

TMHP will not forward the following claim types to the contractor:

- Electronic institutional claims that are rejected by TMHP
- Electronic institutional Texas Medicaid fee-for-service adjustments
- Suspended or finalized claims
- Claims that are part of mass adjustments originating from TMHP
- All other electronic claim types (professional and dental)

  Note: *Other claim types (professional and dental) will be eligible for forwarding at a later date.*
- All Medicare crossover claims
- All NPI contingent claims
- All paper claims
- School Health and Related Services (SHARS) claims
- Early Childhood Intervention (ECI) claims
- CSHCN Services Program claims
- County Indigent Health Care Program (CIHCP) claims
- PCS claims
- Case Management for Children and Pregnant Women claims
- Claims that are rejected by the Contractor for HIPAA validation failures
- THSteps medical and dental claims

Refer to: Subsection 4.12, "Third Party Liability (TPL)" in Section 4, "Client Eligibility" (*Vol. 1, General Information*) for information about filing claims for clients with other insurance.

Section 6.12.2.5, "Filing Deadlines" in this section for information about filing deadlines for clients with other insurance.

6.13 Filing Medicare Primary Claims

When a service is a benefit of both Medicare and Medicaid, the claim must be filed to Medicare first.

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Providers should not file a claim with Medicaid until Medicare has dispositioned the claim unless the service is a Medicaid-only service.

Medicaid claims for Qualified Medicare Beneficiary (QMB) and Medicaid Qualified Medicare Beneficiary (MQMB) clients can be filed to Medicaid for consideration of coinsurance and deductible payment as follows:

- Medicare primary claims filed to Medicare Administrative Contractors (MACs) may be transferred electronically to TMHP through a Coordination of Benefits Contractor (COBC).
- Providers can submit crossover claims directly to TMHP using a paper claim form only for the specific circumstances indicated in the section below.

Note: *These guidelines do not apply to services that are rendered to clients who are living in a nursing facility.*

Refer to: Subsection 2.7, "Medicare Crossover Claim Reimbursement" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for information about reimbursement for QMBs and MQMBs.

Subsection 4.11, "Medicare and Medicaid Dual Eligibility" in Section 4 "Client Eligibility" (*Vol. 1, General Information*) for information about MQMBs and QMBs eligibility.

6.13.1 Electronic Crossover Claims

Medicare primary claims filed to MACs may be transferred electronically to TMHP through a COBC for claims that are processed as assigned. Providers should contact their MAC for more information.

This electronic crossover process allows providers to receive disposition from both carriers while only filing the claim once. Providers must allow 60 days from the date of Medicare's disposition for a claim to appear on the Medicaid R&S Report.

If all services on the claim are denied by Medicare, the claim is not automatically transferred to TMHP by the MAC through the COBC. Providers must submit the denied crossover claims to TMHP on paper.

Claims that are submitted to Medicare must include the facility's NPI. Medicare crossover claims must comply with the Medicaid requirement to include a facility NPI. If a Medicare crossover claim includes a service for which Medicaid requires a facility NPI but the claim does not include the facility's NPI number, the claim will be denied by Texas Medicaid.

Important: *TMHP accepts only electronic crossover claims that are automatically transferred to TMHP by the MAC through the COBC. TMHP accepts only paper crossover claims from providers and other entities. TMHP does not accept electronic crossover new day claims or appeals from providers and other entities. TMHP accepts only paper appeals.*

6.13.1.1 Type of Bills Values for Medicare Crossover Claims

Type of bills (TOB) values in the 12x series may be billed to Medicare for Medicare Inpatient Part B services as appropriate, but TOB values in the 12x series are not valid for Medicaid claims.

Reminder: *Texas Medicaid only allows interim billing and late changes to be submitted on inpatient claims.*

6.13.1.2 Medicare Copayments

Claims for Medicare copayments can also be submitted to TMHP.

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Refer to: Subsection 2.7.4.2, "Nephrology (Hemodialysis, Renal Dialysis) and Renal Dialysis Facility Providers" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol.1, General Information*) for information about claims for nephrology (hemodialysis, renal dialysis) and renal dialysis facility providers for Medicare crossover Claims.

Subsection 2.7.4, "Exceptions" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for information about exceptions for Medicare Part A, Part B, and Part C (noncontracted MAPs) reimbursement.

Subsection 6.12.2.2, "Health Maintenance Organization (HMO) Copayments" in this section for information about HMO copayments.

6.13.1.3 Requirement for Group Billing Providers – Professional Claims

The performing provider NPI must be included on the professional electronic claim if the billing provider is a group. Claims are processed using the performing provider NPI that is submitted on the Medicare claim.

Important: *The performing provider who is identified on the claim must be a member of the billing provider's group. If the performing provider is not a member of the billing provider group, the detail line item will be denied.*

A claim is denied if the performing provider NPI is missing, invalid, or is not a member of the billing provider's group. Denied claims may be appealed on paper with the appropriate performing provider information.

6.13.2 Paper Crossovers Claims

TMHP accepts only paper crossover claims or appeals from providers and other entities.

The following paper crossover claims may be submitted to TMHP:

- For QMB and MQMB clients, if a crossover claim is not transferred to TMHP electronically through the COBC, the provider can submit a paper claim to TMHP for coinsurance and deductible reimbursement consideration.
- For MQMB clients, if a claim is denied by Medicare because the services are not a benefit of Medicare or because Medicare benefits have been exhausted, the provider can submit a paper claim to TMHP for coinsurance and deductible reimbursement consideration, and reimbursement consideration for the Medicaid-only services that were denied by Medicare. The Medicare EOB that contains the relevant claim denial must be submitted to TMHP with the completed claim from within 95 days from the Medicare disposition date and 365 days from the date of service. The denied services are processed as Medicaid-only services.

Claims that are submitted to Medicare must include the facility's NPI. Medicare crossover claims must comply with the Medicaid requirement to include a facility NPI. If a Medicare crossover claim includes a service for which Medicaid requires a facility NPI but the claim does not include the facility's NPI number, the claim will be denied by Texas Medicaid.

Important: *Claims that are denied by Medicare for administrative reasons must be appealed to Medicare before they are submitted to Texas Medicaid.*

The paper submission must include all of the following:

- The Medicare Remittance Advice (RA) or Remittance Notice (RN), which is issued by Medicare
- The appropriate, completed paper CMS-1500 or UB-04 CMS-1450 paper claim form
- The appropriate TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template (i.e., MAP template). (The MAP template is optional when certain conditions are met.)

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Providers that receive paper MRANs from Medicare or a Medicare intermediary or MRANs using the CMS-approved software MREP, for professional services, or PC-Print, for institutional services, may submit these MRANs to TMHP.

Providers that submit paper crossover claims must submit only one of the approved MRAN formats—MREP, PC-Print, paper MRAN from Medicare or a Medicare intermediary, or TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template (MAP claims only) along with a completed claim form. Paper crossover claims that contain multiple MRAN forms with conflicting information are returned to the provider or denied.

6.13.2.1 Deductible or Coinsurance Amount Balancing

The Texas Medicaid claims processing system validates that the total Medicare deductible and coinsurance amounts on the claim header match the sum of the detail Medicare deductible and coinsurance amounts.

For paper crossover claims, providers must submit the same information to Texas Medicaid that was received from Medicare.

Texas Medicaid will reimburse Medicare crossover claims up to the Texas Medicaid allowed amount for Medicaid-covered services. System enhancements have been identified to ensure appropriate age restrictions are enforced applicable to the services rendered.

Example: *For a Medicare service provided to an adult client, if that service is only payable to Medicaid for clients who are 20 years of age and younger, the age restriction will be applied and the Medicaid allowed amount will be zero. Since the Medicare payment exceeds the Medicaid allowed amount or encounter payment for the service, Texas Medicaid will not make a payment for coinsurance liabilities.*

Because Medicare reimbursed more than Medicaid allowed, the client has no liability for any balance or Medicare coinsurance related to the rendered services.

6.13.2.2 TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template

The TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template must be submitted for paper MAP claims only. The template must be submitted with the claim form and the MAP EOB.

Note: *Providers must not submit the template for traditional Medicare crossover claims.*

The following guidelines apply for the submission of the TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Templates:

- The Medicare ICN must be included on the form. Claims are denied if the Medicare ICN is omitted.
- For the TMHP Crossover Professional Claim Type 30 form, the performing provider NPI and TPI must be submitted on each detail line item. A detail line item is denied if the performing provider NPI or TPI is omitted, if the performing provider NPI is not associated with the TPI according to the performing provider's enrollment information, or if the performing provider is not a member of the group billing provider.
- For the TMHP Crossover Outpatient Facility Claim Type 31 form, the detail line items are required. Claims are denied if the details are omitted.
- The TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template must be submitted with a completed claim form and MAP EOB, must be legible, and must identify only one client per page. Providers must not submit handwritten MAP templates.

Claims that do not meet these standards are not processed and are returned to the provider.

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By submitting the TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Templates to TMHP, the provider attests that the information included in the template matches the EOB that was received from the MAP. If the information on the template does not exactly match the information on the RA or RN, the claim may be denied.

Refer to: Subsection 6.20, "Forms" in this section, for the TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Templates and instructions.

Subsection 2.7, "Medicare Crossover Claim Reimbursement" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

6.13.2.3 Crossover Paper Claims Filing Deadlines

The paper crossover claim with all required, EOBs, templates, and forms must be received by TMHP within 95 days of the Medicare date of disposition and 365 days from the date of service in order to be considered for processing.

6.13.3 Filing Medicare-Adjusted Claims

TMHP accepts crossover appeals only on paper.

Providers may submit Medicare-adjusted claims by submitting the adjusted Medicare RA/RNs (paper or electronic) and the appropriate TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template. The information on the Medicare RA/RN must exactly match the information submitted on the TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template.

Refer to: Subsection 3.7.1, "Medicaid Relationship to Medicare" in Inpatient and Outpatient Hospital Services Handbook (*Vol. 2, Provider Handbooks*) for additional information on hospital Medicare claims filing requirements.

Important: *TMHP does not accept electronic crossover appeals.*

6.14 Medically Needy Claims Filing

TMHP must receive claims for unpaid bills not applied toward spend down within 95 days from the date eligibility was added to the TMHP client eligibility file (add date). These bills must be on the appropriate claim form (for example, CMS-1500 or UB-04 CMS-1450). Providers are allowed to submit completed CMS claim forms directly to the Medically Needy Clearinghouse (MNC) or to applicants for the Medically Needy Program (MNP) to be used to meet spend down. The completed CMS claim forms used to meet spend down are held for ten calendar days by the MNC, then forwarded to TMHP claims processing. Claims for services provided after the spend down is met must be received within 95 days from the date eligibility is added. Inpatient hospital facility claims must be received within 95 days from the date of discharge or last DOS on the claim. This applies when eligibility is not retroactive.

The client's payment responsibilities are as follows:

- If the entire bill was used to meet spend down, the client is responsible for payment of the entire bill.
- If a portion of one of the bills was used to meet the spend down, the client is responsible for paying the portion applied toward the spend down, unless it exceeds the Medicaid allowable amount.
- The claim must show the *total* billed amount for the services provided. Charges for ineligible days or spend down amounts should *not* be deducted or noncovered on the claim.
- A client's payment toward spend down is *not* reflected on the claim submitted to TMHP.
- A client is not required to pay the spend down amount before a claim is filed to Medicaid.
- Payments made by the client for services not used in the spend down but were incurred during an eligible period must be reimbursed to the client before the provider files a claim to TMHP.

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- Services that require prior authorization and are provided before the client becomes eligible for Medicaid by meeting spend down are not reimbursable by Texas Medicaid.
- If a bill or a completed CMS claim form was not used to meet spend down and the dates of service are within the client's eligible period, submit the total bill to TMHP.

When eligibility has been established, a TP 55 with spend down client can receive the same care and services available to all other Medicaid clients. If eligibility is established through TP 30 with spend down, the client's Medicaid eligibility is restricted to coverage for an emergency medical condition only. Emergency medical condition is defined under Emergency medical condition is defined under Subsection 4.4.2.2, "Exceptions to Lock-in Status" in Section 4, "Client Eligibility" (*Vol. 1, General Information*).

6.15 Claims Filing for Consumer-Directed Services (CDS)

Clients who participate in the CDS option for both PCS and a waiver program, through DADS are required to choose one Financial Management Services Agency (FMSA) to provide services through both programs. FMSAs are permitted to file only the financial management services (FMS) fee, also known as the monthly administrative fee, through one program. The FMSA should file the FMS claim through the program with the highest reimbursement rate. Currently, the waiver programs have a higher reimbursement rate for the FMS fee than the Texas Medicaid PCS benefit, so a FMSA should file claims for the monthly FMS fee through the waiver programs.

The U8 modifier, which is used when submitting claims for the monthly PCS administrative fee, must be prior authorized. The DSHS case managers have two options when sending a prior authorization request for PCS to TMHP:

- If a client is only using the CDS option for Texas Medicaid PCS, a case manager will submit a prior authorization request to TMHP that approves the U8 modifier and either the U7 or UB modifier. In this case, the provider authorization notification letter will include the U8 modifier and the U7 or UB modifier.
- If a client is using the CDS option for both Texas Medicaid PCS and a waiver program, a case manager will submit a prior authorization request to TMHP that approves either the U7 or UB modifier. The U8 modifier will not be prior authorized in this situation.

When a provider authorization notification letter is received by a FMSA, the provider should verify that the correct modifiers have been prior authorized for each PCS client. Providers who think that the approved modifiers are incorrect should contact the DSHS case manager and ask for the correct modifiers to be submitted to TMHP for prior authorization.

6.16 Claims for Medicaid Hospice Clients Not Related to the Terminal Illness

When the services are unrelated to the terminal illness, providers must submit a claim for Medicaid services to TMHP. The claim must include a statement and documentation from the hospice that the services billed are not related to the client's terminal illness.

If TMHP denies the claim, the following information must be submitted with the providers appeal.

- A copy of the R&S Report, with the client or claim number in question circled
- Clinical records, which may be obtained from the hospice provider
- Supporting documentation giving reasons the services billed are not related to the terminal illness

Refer to: Subsection 4.4.3, "Hospice Program" in Section 4, "Client Eligibility" (*Vol. 1, General Information*) for more information related to Medicaid hospice client benefits and eligibility.

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6.16.1 Medical Services When Client is Discharged From Hospice

Submit claims to TMHP for Medicaid services with a statement that the services billed were provided after the client was discharged from the Hospice Program. The provider must obtain a copy of Form 3071, Medicaid Hospice Cancellation, from the Hospice Program to support the discharge.

If TMHP denies the claim, the provider may appeal the decision with the following information:

- A copy of the R&S Report, with the client or claim number in question circled
- Supporting documentation stating that the client was not in hospice at the time

6.16.2 Claims Address for Medicaid Hospice Clients Not Related to the Terminal Illness

Mail paper claims to the following address:

Texas Medicaid & Healthcare Partnership
PO Box 200105
Austin, TX 78720-0105

Appeal claims by writing to the following address:

Texas Medicaid & Healthcare Partnership
PO Box 200645
Austin, TX 78720-0645

6.16.3 Lab and X-Ray

Submit claims for services unrelated to the terminal illness to TMHP. Submit claims for services related to the terminal illness to the hospice provider.

6.17 Claims for Texas Medicaid and CSHCN Services Program Eligible Clients

The CSHCN Services Program is the payer of last resort when clients have other insurance, including Texas Medicaid and private carriers. The CSHCN Services Program does not supplement a client's Texas Medicaid benefits; however, services that are not a benefit of Texas Medicaid, such as hospice and medical foods, may be covered by the CSHCN Services Program.

6.17.1 New Claim Submissions

New claims that are submitted for clients who are eligible for both Texas Medicaid and CSHCN Services Program benefits during the same eligibility period will be processed through the appropriate program and may result in a separate claim for each program. The Medicaid claim number and disposition will be listed under the "Claims – Paid or Denied" section of the Medicaid/Managed Care R&S Report. If the claim includes services that are not benefits of Texas Medicaid but are benefits of the CSHCN Services Program, a claim will be created with a unique claim number that will be listed under the "Claims – Paid or Denied" section of the CSHCN Services Program R&S Report.

Note: *If all of the services that are submitted on the claim are Texas Medicaid benefits, a CSHCN Services Program claim will not be created. Only a Texas Medicaid claim will be created, and the claim number will appear on the provider's Medicaid/Managed Care R&S Report.*

6.17.2 CSHCN Services Program Claims Reprocessing for Retroactive Texas Medicaid Eligibility

Claims that have already been paid by the CSHCN Services Program for clients who received retroactive Texas Medicaid eligibility for dates of service covered on the paid claims will be reprocessed to pay under the appropriate program. The reprocessed CSHCN Services Program claim number will appear under the "Adjustments – Paid or Denied" section of the CSHCN Services Program R&S Report. An accounts receivable will be created for services covered by Texas Medicaid that will be reflected on the "Financial

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Transactions" page under the "Accounts Receivable" section of the CSHCN Services Program R&S Report. The claim will be reprocessed to Texas Medicaid and given a new claim number. The new Texas Medicaid claim number and disposition will appear under the "Claims – Paid or Denied" section of the Medicaid/Managed Care R&S Report.

TMHP will contact providers when it reprocesses claims for services that require a Texas Medicaid prior authorization. Providers will be informed that a Texas Medicaid prior authorization must be submitted within a specified time frame for the claim to be considered for processing through Texas Medicaid.

6.18 Claims for State Supported Living Center Residents (SSLC)

Medicaid providers who render off-campus acute care services to Medicaid-eligible State Supported Living Center (SSLC) residents must submit claims directly to Medicaid. This is applicable only to residents of the SSLCs operated by the Department of Aging and Disability Services (DADS).

Claims and prior authorization requests for acute care services rendered to these individuals must be submitted to Medicaid. These requests must be submitted according to guidelines for acute care services as indicated in this manual.

Refer to: Section 5: Fee-for-Service Prior Authorizations (*Vol. 1, General Information*) for more information on prior authorizations.

6.19 Children's Health Insurance Program (CHIP) Perinatal Claims

Claims for services provided to CHIP Perinatal Program clients are submitted to and considered for reimbursement as follows:

- For women with income at or below 185 percent FPL:
  - Hospital facility charges are paid through Emergency Medicaid and processed by TMHP.
  - Professional service charges are paid through the CHIP Perinatal Program and processed through CHIP.

    Note: *Delivery-related professional services claims denied by the CHIP Perinatal health plan will be considered for reimbursement through Emergency Medicaid and will require the CHIP Perinatal health plan denial notice. These claims should be submitted through the existing Medicaid appeals process within 95 days from the date of the CHIP Perinatal Health plan denial notice. The provider must provide a copy of the complete explanation of benefits that includes the complete description of the reason for denial.*
- For newborns with a family income at or below 185 percent FPL:
  - Hospital facility charges are paid through Medicaid and processed by TMHP.
  - Professional service charges are paid through Medicaid and processed by TMHP.

Inpatient services (limited to labor with delivery) for unborn children and women with income between 186 and 200 percent of FPL will be covered under CHIP Perinatal, and these claims will be paid by the CHIP Perinatal health plan.

6.19.1 CHIP Perinatal Newborn Transfer Hospital Claims

TMHP processes CHIP Perinatal newborn transfer hospital claims even if the claim from the initial hospital stay has not been received.

The hospital transfer must have occurred within 24 hours of the discharge date from the initial delivery hospital stay. This change applies only to CHIP Perinatal newborns with a family income at or below 185 percent of the FPL.

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Transfer claims must be filed with TMHP on an electronic institutional claim or the UB-04 CMS-1450 paper claim form using admission type 1, 2, 3, or 5 in block 14, source of admission code 4 or 6 in block 15, and the actual date and time the client was admitted in block 12 of the UB-04 CMS-1450 paper claim form.

6.20 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
MRAN Form Crossover Claim Type 30 Form and Instructions
MRAN Form Crossover Claim Type 31 Form and Instructions
MRAN Form Crossover Claim Type 50 Form and Instructions
Sample Letter XUB Computer Billing Service Inc

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Section 7: Appeals

Texas Medicaid Provider Procedures Manual: Vol. 1

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SECTION 7: APPEALS

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7.1 Appeal Methods

An appeal is a request for reconsideration of a previously dispositioned claim.

Providers may use three methods to appeal Medicaid fee-for-service and carve-out service claims to Texas Medicaid & Healthcare Partnership (TMHP): electronic, Automated Inquiry System (AIS), or paper.

TMHP must receive all appeals of denied claims and requests for adjustments on paid claims within 120 days from 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.

Standard administrative requests and medical appeals must be sent first to TMHP or the claims processing entity as a first-level appeal. After the provider has exhausted all aspects of the appeals process for the entire claim, the provider may submit a second-level appeal to HHSC.

1) A first-level appeal is a provider's initial standard administrative or medical 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.
2) A second-level appeal is a provider's final medical or standard administrative appeal to HHSC of a claim that meets *all* of the following requirements:
   - It has been denied or adjusted by TMHP.
   - It has been appealed as a first-level appeal to TMHP.
   - It has been denied again for the same reason(s) by TMHP.

This appeal is submitted by the provider to HHSC, which may subsequently require TMHP to gather information related to the original claim and the first-level appeal. HHSC is the sole adjudicator of this final appeal.

All providers must submit second-level administrative appeals and exceptions to the 95-day filing deadline appeals to the following address:

Texas Health and Human Services Commission
HHSC Claims Administrator Operations Management
Mail Code 91X
PO BOX 204077
Austin, Texas 78720-4077

TMHP is not responsible for managing appeals resulting from utilization review (UR) decisions by the HHSC Office of Inspector General (OIG) UR Unit. These must be submitted to HHSC Medical and UR Appeals.

Note: *Appeals for managed care claims must be submitted to the managed care organization (MCO) or dental plan that administers the client's managed care benefits. The only managed care appeals administered by TMHP are those for carve-out services.*

Refer to: Subsection 7.3.3, "Utilization Review Appeals" in this section.

Medicaid Managed Care Handbook (*Vol. 2, Provider Handbooks*) for additional information about managed care appeals.

7.1.1 Electronic Appeal Submission

Electronic appeal submission is a method of submitting appeals using a personal computer. The electronic appeals feature can be accessed by a business organization (e.g., billing agents) interfacing directly with the TMHP Electronic Data Interchange (EDI) Gateway or through TexMedConnect, the free web-based application available from TMHP.

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The Health Insurance Portability and Accountability Act (HIPAA) standard American National Standards Institute (ANSI) ASC X12 837 format is accepted by TMHP EDI.

For other information, contact the TMHP EDI Help Desk at 1-888-863-3638.

7.1.1.1 Advantages of Electronic Appeal Submission

Using electronic appeal submission provides the following advantages to the users:

- Increased accuracy of appeals filed to potentially improve cash flow.
- Maintained audit trails through print and download capabilities.
- Appeal submission windows can be automatically filled in with electronic R&S (ER&S) Report information, thereby reducing data entry time.

7.1.1.2 Disallowed Electronic Appeals

The following claims may *not* be appealed electronically:

- Claims that require supporting documentation (e.g., operative report, medical records, home health, hearing aid, and dental X-rays).
- Diagnosis-related group (DRG) assignment.
- Medicare crossovers.
- 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*.
- Claims with quantity billed changes in the claims details.
- Claims that are the result of a mass adjustment.

Exception: *Inpatient hospital claims denied for lack of a Hysterectomy Acknowledgment Statement or a Sterilization Consent Form may be appealed electronically if the requested form has been faxed according to the instructions in the Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information on the TMHP website at www.tmhp.com.*

Resubmission of TMHP Electronic Data Interchange (EDI) Rejections

TMHP EDI transactions that fail HIPAA edits will be rejected, and the submitter will receive a 277CA claim response file. 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.

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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.

7.1.2 Automated Inquiry System (AIS) Appeals

The following appeals may be submitted using AIS:

- *Client eligibility.* The client's correct Medicaid number, name, and date of birth are required.
- *Provider information (excluding Medicare crossovers).* The correct provider identifier is required for the billing provider, performing provider, referring provider, and limited provider. The name and address of the provider are required for the facility and outside laboratory.
- *Claim corrections.* Providers may correct the:
  - Patient control number (PCN).
  - Date of birth.
  - Date of onset.
  - X-ray date.
  - Place of service (POS).
  - Quantity billed.
  - Prior authorization number (PAN).
  - Beginning date of service (DOS), as long as the new date is within the filing deadline for the claim.
  - Ending date of service, as long as the new date is within the filing deadline for the claim.

The following appeals may *not* be appealed through AIS:

- Claims listed on the R&S Report as Incomplete Claims
- Claims listed on the R&S Report with $0 allowed and $0 paid
- Claims requiring supporting documentation (for example, operative report, medical records, home health, hearing aid, and dental X-rays)
- DRG assignment
- Procedure code, modifier, or diagnosis code
- Medicare crossovers
- Claims listed as *pending* or *in process* with 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)/other insurance

Providers may appeal these denials either electronically or on paper.

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Refer to: Subsection 7.1.1.2, "Disallowed Electronic Appeals" in this section to determine whether these appeals can be billed electronically. If these appeals cannot be billed electronically, a paper claim must be submitted.

Exception: *Inpatient hospital claims denied for lack of a Hysterectomy Acknowledgment Statement or a Sterilization Consent Form may be appealed if the requested form has been faxed according to the instructions under subsection 5.14, "Hysterectomy Services" in the* Gynecological and Reproductive Health and Family Planning Services Handbook (Vol. 2, Provider Handbooks).

7.1.3 Automated Inquiry System Automated Appeals Guide

To access the AIS automated appeals guide, providers can call 1-800-925-9126. Providers may submit up to three fields per claim and 15 appeals per call. If during any step invalid information is entered three times, the call transfers to the TMHP Contact Center for assistance.

7.1.4 Paper Appeals

Claim appeal requests that cannot be appealed electronically or by using AIS may be appealed on paper. Completed claim forms are not required to be submitted with paper appeals. Providers who submit paper appeals must clearly document on the attached R&S Report the information that is being appealed and identify the claim being appealed.

If a provider determines that a claim cannot be appealed electronically or through AIS, the claim may be appealed on paper by completing the following:

1) Submit a copy of the R&S Report page on which the claim is paid or denied. A copy of other official notification from TMHP may also be submitted.
2) Submit one copy of the R&S Report for each claim appealed.
3) Circle only one claim per R&S Report page.
4) Identify the reason for the appeal.
5) If applicable, indicate the incorrect information and provide the corrected information that should be used to appeal the claim.
6) 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.

Note: *It is strongly recommended that providers submitting paper appeals retain a copy of the documentation being sent. It also is recommended that paper documentation be sent by certified mail with a return receipt requested. This documentation, along with a detailed listing of the claims enclosed, provides proof that the claims were received by TMHP, which 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 listing along with the Medicaid number, billed amount, date of service (DOS), and a signed claim copy. The provider may need to keep such proof regarding multiple claims submissions if the provider identifier is pending.*

Medicare crossovers and inpatient hospital appeals related to medical necessity denials or DRG assignment/adjustment *must* be submitted on paper with the appropriate documentation.

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Submit correspondence, adjustments, and appeals (including routine inpatient hospital claims) to the following address:

Texas Medicaid & Healthcare Partnership
Appeals/Adjustments
PO Box 200645
Austin, TX 78720-0645

Exception: *Hospitals appealing HHSC OIG UR Unit final technical denials, admission denials, DRG revisions, continued-stay denials for Tax Equity and Fiscal Responsibility Act (of 1982) (TEFRA) Hospitals, or cost/day outliers must appeal to HHSC at the following address:*

Texas Health and Human Services Commission
Medical and UR Appeals, H-230
PO Box 85200
Austin, TX 78708-5200

All other provider fields on the claim forms (referring, facility, admitting, operating, and other) require only an NPI.

Providers that choose to appeal the claim with NPI information must continue submitting both a TPI and an NPI until the claim is finalized.

7.1.4.1 Texas Medicaid Fee-for-Service DRG Adjustment Appeal

Texas Medicaid fee-for-service hospital providers who are appealing a DRG adjustment (higher weight DRG) must provide the original and revised UB-04 CMS-1450 paper claim form, the complete medical record, and a statement defining the reason for the requested change. Hospitals have 120 days from the date of the R&S Report to request an addition of a diagnosis or procedure resulting in a DRG adjustment. Providers appealing a DRG that has not been revised by the OIG Utilization Review Unit should appeal to TMHP.

Refer to: Subsection 7.3.3, "Utilization Review Appeals" in this section.

7.1.4.2 Medical Necessity Denial Appeals

Appeals of denials relating to medical necessity decisions made for all medical services with the exception of HHSC Inpatient UR cases may be submitted for further review if providers find denials are inappropriate. All necessary documentation must accompany the request for review. Incomplete appeals and adjustment requests are denied by TMHP with an explanation of benefits (EOB) code requesting additional information.

TMHP reviews each appeal (DRG adjustment and medical necessity) and forwards written notice of final action in the form of a letter or an adjustment transaction on the R&S Report.

7.1.4.3 Other Insurance Appeals

To appeal a claim denial due to other insurance coverage, the provider must submit complete other insurance information including the disposition date. The disposition date indicates when the other insurance company processed the payment or denial. An appeal submitted without this information will be denied.

If submitting a paper appeal the provider must submit EOBs containing disposition dates. If the disposition date appears only on the first page of an EOB that has multiple pages and the claim that is being appealed is on a subsequent page, the provider must also include the first page of the EOB that shows the disposition date.

7.1.5 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 facsimile) that does not clearly indicate the reason for submission is returned to the sender for clarification.

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If an appeal is received that may be more appropriately addressed in another department, the appeal is forwarded to the appropriate department for research and response.

If the TMHP Medical Director or designee identifies a pattern of ineffective use of the appeals process, the provider may be referred to a provider relations representative for assistance.

7.2 Refunds to TMHP

The TMHP Cash Reimbursement Unit is responsible for processing financial adjustments when any of the following occur: overpayment, duplicate payment, payment to incorrect providers, and overlapping payments by Medicaid and a third party resource (TPR).

Providers have the option of refunding payments by issuing a check to TMHP or requesting a recoupment through the paper appeal process. The paper appeal process does not require a provider to issue a check because the refund amount is reduced on the R&S Report. To accurately process claim refunds, the TMHP Cash Reimbursement Unit requests that the refund check be accompanied by Texas Medicaid Refund Information Form, with the following information:

- Refunding provider's name and provider identifier.
- Client's name and Medicaid ID number.
- Date of service.
- A copy of the R&S Report showing the claim to which the refund is being applied.
- The specific reason for the refund.
- Name and address of the attorney or casualty insurance company (including the policy and claim number).
- TPR subscriber information.
- Amount of insurance payment.

To request the forms, contact the TMHP Contact Center at 1-800-925-9126, or write to the following address:

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

Refer to: Subsection 4.12, "Third Party Liability (TPL)" in Section 4, "Client Eligibility" (*Vol. 1, General Information*) for additional TPL information.

7.2.1 Refunds Resulting from Other Insurance Payments

Providers are prohibited from receiving payment from Medicaid, billing a TPR, and then refunding the lesser of the two payments to Medicaid.

Refunds owed to TMHP must not be held until the end of an accounting year. If within 12 months of the date of service a provider identifies a TPR and wants to submit a claim for payment, the provider must refund any amounts previously paid by TMHP before submitting the claim to the third party.

If private insurance paid for the services submitted on the claim, the provider must provide the exact amount paid, the insurance company's name and address, and the client's policy number and group number.

Providers are limited to the Medicaid payable amount and are required to accept the amount paid by TMHP as payment in full if:

- A claim for payment has been paid by TMHP.

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- The provider failed to refund the payment to TMHP before submitting a claim for payment to a third party as outlined above.

Third party payments received after receipt of the TMHP payment must be refunded to TMHP in full, even if the amount paid by the third party insurer exceeds the Medicaid payment.

If the amount paid by a third party health insurer is less than the amount payable for the service by Medicaid, providers may bill TMHP for the difference between the amount paid by the third party health insurer and the Medicaid payable amount if the claim is filed timely and in accordance with all the applicable rules.

In accordance with Title 1 Texas Administrative Code (TAC) §§354.2321 [g] and 354.2322 [i], providers that do not follow TPR rules "may be referred for investigation and prosecution for violations of state or federal Medicaid or false claims laws." Providers should refer to the full text of these rules for a full description of payment requirements.

7.3 Appeals to HHSC Texas Medicaid Fee-for-Service

7.3.1 * Administrative Claim Appeals

An administrative appeal is a request for review of (not a hearing on) claims that are denied by TMHP or claims processing entity for technical and nonmedical reasons. There are *two types* of administrative appeals:

- *Exception requests to the 95-day filing deadline or 120-day appeal deadline.* A provider's formal written request for review of (not a hearing on) a claim that is denied or adjusted by TMHP for failure to meet the 95-day filing deadline or 120-day appeal deadline. Exception requests to the 95-day filing deadline should meet one of the five exceptions in subsection 7.3.1.2, "Exceptions to the 95-Day Filing Deadline" in this section. Exceptions to the 120-day appeal deadline should meet one of the situations in subsection 7.3.1.3, "Exceptions to the 120-day Appeal Deadline" in this section.
- *Standard Administrative Appeal.* A provider's formal written request for review of (not a hearing on) a claim or prior-authorization that is denied by TMHP for technical or non-medical reasons.

An administrative claims appeal is a request for a review as defined in Title 1 TAC §354.2201(2).

An administrative appeal must be:

- Submitted in writing to HHSC Claims Administrator Operations Management by the provider delivering the service or claiming reimbursement for the service.
- Received by HHSC Claims Administrator Operations Management after the appeals process with TMHP or the claims processing entity has been exhausted, and must contain evidence of appeal dispositions from TMHP or the claims processing entity:
  - All correspondence and documentation from the provider to TMHP or the claims processing entity including copies of supporting documentation submitted during the appeal process.
  - All correspondence from TMHP or the claims processing entity to the provider including TMHP's final decision letter or such from the claims processing entity.
- Complete and contain all of the information necessary for consideration and determination by HHSC Claims Administrator Operations Management to include the following:
  - A written explanation specifying the reason/request for appealing the claim.
  - Supporting documentation for the request.
  - All R&S Reports identifying the claims/services in question.
  - Identification of the incorrect information and the corrected information that is to be used to appeal the claim.

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- A copy of the original claim, if available. Claim copies are helpful when the appeal involves medical policy or procedure coding issues. Also provide a corrected signed claim.
- A copy of supporting medical documentation that is necessary or requested by TMHP.
- Provider's internal notes and logs or ticket numbers from the TMHP Contact Center when pertinent (cannot be used as proof of timely filing).
- Memos from HHSC, TMHP, or claims processing entity indicating any problems, policy changes, or claims processing discrepancies that may be relevant to the appeal.
- Other documents, such as receipts (i.e., certified mail along with a detailed listing of the claims enclosed), in-service notes, minutes from meetings, if relevant to the appeals. Receipts can be helpful when the issue is late filing.

- Received by HHSC Claims Administrator Operations Management within 120 days from the date of disposition by TMHP or the claims processing entity as evidenced by the weekly R&S Report.

Providers who have submitted their claims electronically must identify the batch submission ID with the date on the electronic claims report. This report must indicate the TMHP assigned batch ID. In addition, this report must include the individual claim that is being appealed. The claim information on the batch report, including date of service and billed amount, must match the information on the claim that is being appealed. This required information constitutes proof of timely filing.

> ***Note:*** *Only reports accepted or rejected from TMHP or the claims processing entity to the vendor will be honored unless the provider is a direct submitter (TexMedConnect). Office notes indicating claims were submitted on time or personal screen prints of claim submissions are not considered proof of timely filing.*

HHSC Claims Administrator Operations Management only reviews appeals that are received within 18 months from the DOS. All claims must be paid within 24 months from the DOS as outlined in 1 TAC §354.1003.

Providers must adhere to all filing and appeal deadlines for an appeal to be reviewed by HHSC Claims Administrator Operations Management. The filing and appeal deadlines are described in 1 TAC §354.1003.

Additional information requested by HHSC Claims Administrator Operations Management must be returned to HHSC Claims Administrator Operations Management within 21 calendar days from the date of the letter from HHSC Claims Administrator Operations Management. If the information is not received within 21 calendar days, the case is closed.

A determination made by HHSC Claims Administrator Operations Management is the final decision for claim appeals. No additional consideration is available. Therefore, ensure that all documents pertinent to the appeal are submitted. *New evidence* is required for an additional appeal to HHSC Claims Administrator Operations Management.

Mail appeal requests to the following address:

Texas Health and Human Services Commission
HHSC Claims Administrator Operations Management
Mail Code-91X
PO Box 204077
Austin, Texas 78720-4077

Providers may request the status of an administrative appeal by sending an email to HHSC at MCD_Administrative_Appeals@hhsc.state.tx.us. The email must include the TPI number, client name, Medicaid number, date of service, and, if available, the case review number.

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7.3.1.1 Requirements for Exception Requests

HHSC Claims Administrator Operations Management makes the final decision on whether claims fall within one of the exceptions to the 95-day or 120-day filing deadlines.

Providers must submit the following documentation for all exception requests:

- Exception requests must be in writing and mailed directly to HHSC.
- Adequate back-up documentation must accompany the exception request. Failure to provide adequate documentation results in the case being closed. Providers are notified of the reason for denial.
- All claims that are to be considered for an exception must accompany the request. HHSC will consider only the claims that are attached to the request.
- Additional claims cannot be added to an exception request after the exception request has been completed by HHSC. Additional claims must be submitted as a separate request and must include all required documentation. Information from a previous request will not be linked by HHSC to process additional claims.
- All exception requests must include an affidavit or statement from the provider stating the details of the cause for the delay, the exception being requested, and verification that the delay was not caused by neglect, indifference, or lack of diligence of the provider or the provider's employee or agent. This affidavit or statement must be made by the person with personal knowledge of the facts.
- Multiple requests submitted simultaneously must be sorted by provider identifier first, and then alphabetically by client name. The orderly submission of exception requests facilitates the review process. Exception requests are returned to the provider if not submitted in the required format.

HHSC may request additional information which must be received within 21 calendar days from the date of the letter from HHSC. If the information is not received within 21 calendar days, the case will remain closed.

HHSC notifies providers about the outcome of the case upon completion of an exception request review.

7.3.1.2 Exceptions to the 95-Day Filing Deadline

HHSC Claims Administrator Operations Management is responsible for reviewing requests for exceptions to the 95-day filing deadline for Texas Medicaid fee-for-service. Only providers can submit exception requests. Requests from billing companies, vendors, or clearinghouses are *not* accepted unless accompanied by a signed authorization from the provider (with each appeal). Without provider authorization, these requests are returned without further action.

HHSC will only consider exceptions to the 95-day filing deadline for claims that are submitted within the 365-day federal filing deadline from the date of service as outlined in 1 TAC §354.1003.

Exceptions to the filing deadline are considered when one of the following situations exists:

- Catastrophic event that substantially interferes with normal business operations of the provider, or damage or destruction of the provider's business office or records by a natural disaster, including, but not limited to, fire, flood, or earthquake; or damage or destruction of the provider's business office or records by circumstances that are clearly beyond the control of the provider, including, but not limited to, criminal activity. The damage or destruction of business records or criminal activity exception does not apply to any negligent or intentional act of an employee or agent of the provider because these persons are presumed to be within the control of the provider. The presumption can only be rebutted when the intentional acts of the employee or agent lead to termination of employment and filing of criminal charges against the employee or agent.

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Providers requesting an exception for catastrophic events must include independent evidence of insurable loss; medical, accident, or death records; or police or fire report substantiating the exception of damage, destruction, or criminal activity.

- Delay or error in the eligibility determination of a client, or delay due to erroneous written information from HHSC, its designee, or another state agency.

  Providers requesting an exception for the delay or error in the eligibility determination of a client or delay due to erroneous written information from HHSC, its designee, or another state agency must include the written document from HHSC or its designee that contains the erroneous information or explanation of the delayed information.

- Delay due to electronic claim or system implementation problems experienced by HHSC, its designee, or Texas Medicaid providers.

  Providers requesting an exception for the delay due to electronic claim or system implementation problems experienced by HHSC, its designee, or Texas Medicaid providers must include the written repair statement, invoice, computer or modem generated error report (indicating attempts to transmit the data failed for reasons outside the control of the provider), or the explanation for the system implementation problems.

  The documentation must include a detailed explanation made by the person making the repairs or installing the system, specifically indicating the relationship and impact of the computer problem or system implementation to claims submission, and a detailed statement explaining why alternative billing procedures were not initiated after the delay in repairs or system implementation was known.

  If the provider is requesting an exception based upon an electronic claim or system implementation problem experienced by HHSC or its designee, the provider must submit a written statement outlining the details of the electronic claim or system implementation problems experienced by HHSC or its designee that caused the delay in the submission of claims by the provider, any steps taken to notify the state or its designee of the problem, and a verification that the delay was not caused by the neglect, indifference, or lack of diligence on the part of the provider or its employees or agents.

- Submission of claims occurred within the 365-day federal filing deadline, but the claim was not filed within 95 days from the date of service because the service was determined to be a benefit of the Medicaid program, and an effective date for the new benefit was applied retroactively.

  Providers requesting an exception for claims that were submitted within the 365-day federal filing deadline, but were not filed within the 95-days of the date of service because the service was determined to be a benefit of Texas Medicaid and an effective date for the new benefit was applied retroactively, must include a written, detailed explanation of the facts and documentation to demonstrate the 365-day federal filing deadline for the benefit was met.

- Client eligibility is determined retroactively and the provider is not notified of retroactive coverage.

  Providers requesting an exception for client eligibility determined retroactively and the provider is not notified of retroactive coverage must include a written, detailed explanation of the facts and activities illustrating the provider's efforts in requesting eligibility information for the client. The explanation must contain dates, contact information, and any responses from the client.

7.3.1.3 Exceptions to the 120-day Appeal Deadline

HHSC must receive a written exception request within 120 days of TMHP's final action. HHSC shall consider exceptions to the 120-day appeal deadline for the situations listed below. This is a one-time exception request; therefore, all claims that are to be considered within the request for an exception must accompany the request. Claims submitted after HHSC's determination has been made for the exception will be denied consideration because they were not included in the original request.

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- An exception request must be received by HHSC within 18 months from the date of service to be considered. This requirement will be waived for the exceptions listed in the following bullets (b) and (c), as well as the situation listed under "Exceptions to the 24-month deadline."
- The following exceptions to the 120-day appeal deadline are considered if the criteria in the previous bullet is met and there is evidence to support one of the bullets below:
  - (a) Errors made by a third party payor that were outside the control of the provider. The provider must submit a statement outlining the details of the cause for the error, the exception being requested, and verification that the error was not caused by neglect, indifference, or lack of diligence of the provider, the provider's employee, or agent. This affidavit or statement should be made by the person with personal knowledge of the facts. In lieu of the above affidavit or statement from the provider, the provider may obtain an affidavit or statement from the third party payor including the same information, and provide this to HHSC as part of the request for appeal.
  - (b) Errors made by the reimbursement entity that were outside the control of the provider. The provider must submit a statement from the original payor outlining the details of the cause of the error, the exception being requested, and verification that the error was not caused by neglect, indifference, or lack of diligence on the part of the provider, the provider's employee, or agent. In lieu of the above reimbursement entity's statement, the provider may submit a statement including the same information and provide this to HHSC as part of the request for appeal.
  - (c) Claims were adjudicated, but an error in the claim's processing was identified after the 120-day appeal deadline. The error is not the fault of the provider. An error occurred in the claims processing system that is identified after the 120-day appeal deadline has passed.

7.3.1.4 Exceptions to the 24-Month Payment Deadline

HHSC shall consider exceptions to the 24-month claims payment deadline for the situations listed below. The final decision about whether a claim falls within one of the following exceptions will be made by HHSC.

- Claims for providers with retroactive adjustments who are reimbursed under a retrospective payment system.
- Claims paid within six months from the Medicare paid date.
- Claims from providers under investigation for fraud or abuse.
- Claims paid at any time in accordance with a court order, to carry out hearing decisions or agency corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it.

Mail exception requests to HHSC at the following address:

Texas Health and Human Services Commission
HHSC Claims Administrator Operations Management
Mail Code 91X
PO Box 204077
Austin, TX 78720-4077

7.3.2 Medical Necessity Appeals

Medical necessity appeals are defined as disputes regarding medical necessity of services. Providers must appeal to TMHP and exhaust the appeal/grievance process before submitting an appeal to HHSC.

Medical necessity appeals related to UR decisions made by the HHSC OIG UR Unit *must* be appealed to HHSC *not* TMHP.

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When filing appeals to HHSC, providers must submit copies of all supporting documentation, including information sent to TMHP.

Refer to: Subsection 7.1.4.1, "Texas Medicaid Fee-for-Service DRG Adjustment Appeal" in this section for additional information.

7.3.3 Utilization Review Appeals

Hospitals may appeal adverse UR decisions made by the HHSC OIG UR Unit to the HHSC Medical and UR Appeals Unit. The written appeal request, with complete medical record and approved Business Records Affidavit Form must be received by the Medical and UR Appeals Unit within 120 days of the date of the original HHSC OIG UR decision letter. If the appeal request with all required documentation is not received within 120 days, the appeal is not conducted, and the HHSC OIG UR decision is considered final. Any claim the facility may have to the Medicaid funds at issue are barred. Extensions of time are not granted for filing the written appeal request and submitting all of the required documentation. The procedures and specific requirements for appealing these decisions can be found in the sections that follow.

Hospitals may appeal adverse HHSC OIG UR Unit determinations to the following address:

HHSC Medical and UR Appeals
Mail Code H-230
PO Box 85200
Austin, TX 78708
or
4900 North Lamar (Express Mail Only)
Austin, TX 78751

7.3.3.1 Admission Denials, Continued Stay Denials for TEFRA Hospitals, DRG Revisions, and Cost/Day Outlier Denials

If a hospital is dissatisfied with the original retrospective review conducted by the HHSC OIG UR Unit, it may submit a written request for an appeal to the HHSC Medical and Utilization Review Appeals Unit.

The request for an appeal must include a copy of the complete medical record, a letter explaining the reasons why the HHSC OIG UR decision is incorrect, a copy of the HHSC OIG UR decision letter, and an original, properly completed, and notarized affidavit in the format approved by HHSC. The affidavit allows the hospital to certify the record as a business and legal document.

Refer to: Business Records Affidavit Form on the TMHP website at www.tmhp.com.

Complete medical records must be provided to HHSC at no charge. A complete medical record must include, but is not limited to, a discharge summary, history and physical, emergency room record, operative report, pathology report, anesthesia record, consultation reports, physician progress notes, physician orders, laboratory reports, X-ray reports, special diagnostic reports, nurses' notes, and medication records.

Any additional information requested by the HHSC Medical and UR Appeals Unit must be returned to the HHSC Medical and UR Appeals Unit within 21 calendar days of the request. If the requested documentation is not received within this time frame, the case is closed without an opportunity for further review and the original HHSC OIG UR decision is considered the final decision.

If a hospital is notified that it failed to submit any required documentation with the initial appeal request, the required information must be returned to the HHSC Medical and UR Appeals Unit within 21 calendar days of the date of notification, or within 120 days of the date of the original HHSC OIG UR decision letter, whichever is sooner. If the required documentation is not received within the time frames, the case is closed without an opportunity for further review and the original HHSC OIG UR decision is considered the final decision. Extensions of time are not granted for filing the written appeal request and submitting all required documentation.

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The HHSC Medical and UR Appeals Unit is responsible for conducting an independent review in response to a provider's appeal. The professional staff uses only the documentation submitted in the medical record to determine whether an inpatient admission was appropriate and whether the diagnoses and procedures were correct. The HHSC UR and Medical Appeals physician or designee performs a complete review for the medical necessity of inpatient admission, DRG validation, quality of care, continued stay medical necessity, and ancillary charges (TEFRA cases) using the medical record documentation submitted on appeal. After completion of the review, the physician or designee renders a final decision on the case. The final decision may include determinations regarding multiple aspects of the admission. The hospital is notified in writing of the final decision. Inpatient admission denials cannot be rebilled as outpatient claims except as noted in section 4.2.4, "Outpatient Observation Room Services" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*).

The HHSC Medical and Utilization Review Unit recognizes that hospital staff may use guidelines, such as the American Hospital Association's Coding Clinic, to assist them in identifying diagnoses or procedures for statistical and billing purposes. However, the HHSC Medical and Utilization Review Appeals Unit determines the appropriate diagnoses or procedures for reimbursement purposes using the documentation in the medical record (submitted on appeal) and the following guidelines:

- *Principal diagnosis assignment.* The diagnosis (condition) established after study to be chiefly responsible for causing the admission of the client to the hospital for care. The principal diagnosis must be treated or evaluated during the admission to the hospital.
- *Secondary diagnosis assignment.* Conditions that affect patient care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, or increased nursing care or monitoring, or, in the case of a newborn (birth through 28 days of age), which the physician deems to have clinically significant implications for future health care needs. Normal newborn conditions or routine procedures should not be considered as complications or comorbidities for DRG assignment.

If the principal diagnosis, secondary diagnoses, or procedures are not substantiated in the medical record, not sequenced correctly, or have been omitted, the codes may be changed, added, or deleted by the HHSC Medical and UR Appeals physician or designee. When it is determined the diagnoses or procedures are substantiated and sequenced correctly, a final DRG assignment is made.

If the hospital is displeased with the appeals decision, the attending physician or medical director of the hospital may request an educational conference with the HHSC Medical and UR Appeals physician or designee. The educational conference is held by telephone between the physician or designee and the hospital medical director or attending physician. This is an opportunity for the physicians to discuss the deciding factors in the case and any hospital billing processes that may have affected the adjudication of the case. The educational conference will not alter the previous appeal decision.

7.3.3.2 Final Technical Denials

Hospitals may submit a request for a written appeal to HHSC Medical and UR Appeals only if the hospital has evidence that the HHSC OIG UR Unit issued a final technical denial in error, or did not provide proper notification of the preliminary technical denial. The request must include a letter explaining the reasons why the HHSC OIG UR decision is incorrect and a copy of the HHSC OIG UR decision letter.

The written appeal request must be received by HHSC Medical and UR Appeals within 120 days of the date of the original HHSC OIG UR decision letter. If the request is not received within the 120 days, the appeal is not conducted and the HHSC OIG UR decision is considered final. Any claim the facility may have to the Medicaid funds at issue are barred. Extensions of time are not granted for filing the written appeal request.

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If the appeal time frame is met, the HHSC Medical and UR Appeals Unit reviews all the documentation and renders a final decision on the case. If it is determined the technical denial was issued correctly by the HHSC OIG UR Unit, HHSC's decision is upheld. The hospital is notified in writing of the decision. This decision is the final decision.

If it is determined that the final technical denial decision should be overturned, the HHSC Medical and UR Appeals Unit will request a copy of the complete medical record and an original, properly completed, notarized affidavit in the format approved by HHSC. The affidavit allows the hospital to certify the record as a business and legal document. The HHSC Medical and UR Appeals physician or designee performs a complete review for the medical necessity of the admission, DRG validation, quality of care or continued stay, and ancillary charges (for TEFRA Hospitals) using only the medical record documentation. After completion of the review, the physician or designee renders a final decision on the case. The hospital is notified in writing of the final decision.

If the requested documentation is not received within the required 21-day time frame, the case is closed without further opportunity for review and the original HHSC OIG UR decision is considered final.

7.3.4 Provider Complaints

TMHP provides for due process for resolving all provider complaints. A *complaint* is defined as any dissatisfaction expressed by telephone or in writing by the provider, or on behalf of that provider, concerning Texas Medicaid. 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 complaints process are designed to identify and resolve provider complaints in a timely and satisfactory manner. Most complaints are resolved within 30 calendar days. Complaints to TMHP may be submitted using the following methods:

- By telephone at 1-800-925-9126
- 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 Contact Center at 1-800-925-9126.

7.3.4.1 Provider Complaint Policy

TMHP takes seriously and acts on each provider complaint. Depending on the level and nature of the complaint, TMHP works with the provider to resolve the issue or directs the complaint to the appropriate department.

The Medical Affairs Division handles complaints that relate to utilization of services (including ER use), denial of continued stay, and all clinical and access issues. This includes provider's appeal of an adverse authorization decision.

If the complaint relates to a medical issue, the Medical Affairs Division staff may assist in resolving the complaint. The provider complaints process applies only to the resolution of disputes within the control of Texas Medicaid, such as administrative or medical issues. The provider complaint process does not apply to allegations of negligence against third parties, including other Texas Medicaid providers. These complaints are referred to HHSC for review and evaluation and are resolved by HHSC.

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7.3.4.2 Provider Complaint Process

The TMHP Complaints Resolution Department Unit handles all provider complaints. The processing of a provider's complaint is described as follows:

- Providers must submit their complaint by telephone or in writing (mail or fax).
- Providers will receive a written acknowledgement letter from TMHP within five business days of receipt of the complaint.
- Referrals to other departments, such as Provider Relations or Medical Affairs, are made when appropriate.
- If the complaint cannot be resolved within 30 calendar days, the provider is notified in writing of the status of the complaint.

Providers who believe they did not receive due process regarding their complaint from TMHP may file a complaint with HHSC. Providers are encouraged to utilize the appeals and grievance process with TMHP before filing a complaint with HHSC.

7.3.4.3 Complaints to HHSC—Texas Medicaid Fee-for-Service

Texas Medicaid fee-for-service providers may file complaints to the HHSC Claims Administrator Operations Management if they find they did not receive full due process from TMHP in the management of their appeal. Texas Medicaid fee-for-service providers must exhaust the appeals and grievance process with TMHP before filing a complaint with the HHSC Claims Administrator Operations Management.

Refer to: Subsection 7.3, "Appeals to HHSC Texas Medicaid Fee-for-Service" in this section for information about submission of an appeal to HHSC.

A *complaint* is defined as any dissatisfaction expressed in writing by the provider, or on behalf of that provider, concerning Texas Medicaid. The term *complaint* does not include the following:

- 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.
- A provider's oral or written dissatisfaction with an adverse determination.

Under the complaint process, the HHSC Claims Administrator Operations Management works with TMHP and providers to verify the validity of the complaint, determine if the established due process was followed in resolving appeals and grievances, and addresses other program and contract issues, as applicable.

Complaints must be in writing and received by the HHSC Claims Administrator Operations Management within 60 calendar days from TMHP's written notification of the final appeal decision.

When filing a complaint, providers must submit a letter explaining the specific reasons they believe the final appeal decision by TMHP is incorrect and copies of the following documentation:

- All correspondence and documentation from the provider to TMHP, including copies of supporting documentation submitted during the appeal process.
- All correspondence from TMHP to the provider, including TMHP's final decision letter.
- All R&S Reports of the claims and services in question, if applicable.
- Provider's original claim or billing record, electronic or manual, if applicable.
- Provider's internal notes and logs when pertinent.
- Memos from HHSC or TMHP indicating any problems, policy changes, or claims' processing discrepancies that may be relevant to the complaint.

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- Other documents, such as certified mail receipts, original date-stamped envelopes, in-service notes, or minutes from meetings if relevant to the complaint. Receipts can be helpful when the issue is late filing.

Complaint requests may be mailed to the following address:

Texas Health and Human Services Commission
HHSC Claims Administrator Operations Management
Mail Code 91X
PO Box 204077
Austin, TX 78720-4077

7.4 Cost Report Settlement Appeal Process

A provider who is dissatisfied with the determination contained in the Notice of Program Reimbursement (NPR) from TMHP Medicaid Audit may request an appeal as follows:

- The request for appeal must be in writing.
- The request for appeal must be filed within 180 calendar days from the date of receipt of the NPR.
- If the amount in controversy is at least $1,000, the request for the appeal must be filed with TMHP Medicaid Audit.
- If the NPR shows that the provider is indebted to Texas Medicaid, TMHP must take the necessary action to recover the overpayment, including a suspension of interim payments. This process will take place even if an appeal has been requested.

7.4.1 Appeals to TMHP Medicaid Audit

A provider's request to appeal his or her NPR must include the following:

- Identify specific individual items in TMHP Medicaid Audit's determination with which the provider disagrees.
- Give the reasons the provider believes these are incorrect.
- Identify the amount in controversy for each item and provide a calculation of that amount.

The appeal may include any materials the provider believes will support its position.

TMHP Medicaid Audit completes a desk review of the appeal within six months of the date of receipt of complete documentation supporting the appeal. TMHP does the following:

- Reviews the materials submitted by the provider.
- Informs the provider if it appears that the request for an appeal was not timely or the amount of controversy is not at least $1,000.
- Reviews the record that formed the basis for the determination of the total payment due to the provider.
- Attempts to resolve as many points in controversy as possible with the provider and inform him or her in writing the issues that have been resolved and those that the provider may appeal to HHSC.
- Ensures all available documentation in support of the provider or TMHP Medicaid Audit is part of the record.

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To appeal to TMHP Medicaid Audit, send the written notice within 120 days of receipt of the NPR letter to the following address:

Texas Medicaid & Healthcare Partnership
Medicaid Audit Operations Director
PO Box 200345
Austin, TX 78720-0345

7.5 Forms

The following linked forms can be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Business Records Affidavit Form
Texas Medicaid Refund Information Form
Credit Balance Refund Worksheet

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Appendix A: State, Federal, and TMHP Contact Information

Texas Medicaid Provider Procedures Manual: Vol. 1

April 2016

TEXAS
Health and Human
Services Commission

APPENDIX A: STATE, FEDERAL, AND TMHP CONTACT INFORMATION

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A.1 Texas Health and Human Services Commission (HHSC) and Texas Department of State Health Services (DSHS) Office Addresses

Use the following address for general inquiries or for any group that is not listed in the table below:

Texas Health and Human Services Commission
PO Box 13247
Austin, TX 78711-3247

Note: *Remember to use the four-digit addition to the ZIP Code.*

Use the following address for the HHSC Inspector General:

Texas Health and Human Services Commission
Office of Inspector General
PO Box 85200
Austin, TX 78708-5200

Note: *Remember to use the four-digit addition to the ZIP Code.*

For the following groups, use the corresponding address and include the group name on the second line of the address.

Address	Group Name
HHSC Medicaid CHIP–H-200 PO Box 85200 Austin, TX 78708	
HHSC Quality Review/Limited Program—1323 PO Box 85200 Austin, TX 78708	
HHSC Third Party Liability (TPL) PO Box 85200 Mail Code 1354 Austin, TX 78708-5200	
HHSC Medical & UR Appeals Mail Code H-230 PO Box 85200 Austin, TX 78708 or 4900 North Lamar (Express Mail Only) Austin, TX 78751	
HHSC Medicaid Vendor Drug H-630 PO Box 85200 Austin, TX 78708	
DSHS (Group Name) (Mail Code) PO Box 149347 Austin, TX 78714-9347	Children with Special Health Care Needs (CSHCN) Services Program (Mail Code 1938) Family Planning (Mail Code 1920) Genetic Services Indigent Health Care (Mail Code 2831) Texas Health Steps (THSteps) (Mail Code 1938) Case Management for Children and Pregnant Women (Mail Code 1938)

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A.2 HHSC Regional Offices of Eligibility Services (OES)

Region	OES Officer	Regional Director			Administrative Assistant
01 Lubbock	Bo Platt	Beth Miller	Office:	1-806-783-6637	Shenaz Haney
	1-512-206-4836	6302 Iola Avenue	FAX:	1-806-783-6630	1-806-783-6632
		Lubbock, TX 79424	Mail Code: 217-1		
		Amarillo: 1-806-356-3151	Toll Free:	1-888-440-5688	
02/09 Abilene	Bo Platt	Jerry Flores	Office:	1-325- 795-5526	Amy Earley
	1-512-206-4836	4601 South First Street	FAX:	1-325-795-5523	1-325-795-5522
		Abilene, TX 79604	Mail Code: 001-1		
		PO Box 521 Abilene, TX 79604	Toll Free:	1-866-480-2553	
03 Grand Prairie	Kathy Cox	Tracy Hays	Office:	1-972-337-6171	Sharon Schwalm
	1-512-206-5656	801 South State Hwy 161	FAX:	1-972-337-6298	1-972-337-6198
		Grand Prairie, TX 75051	Mail Code: 012-5		Michelle McNeil
		PO Box 532089 Grand Prairie, TX 75053-2089	Toll Free:	1-877-236-6500	1-972-337-6173
04 Tyler	Patrick Oyelola	Fay Booker	Office:	1-903-509-5142	Charlotte Wade
	1-512-206-5250	302 East Rieck Road	FAX:	1-903-509-5133	1-903-509-5125
		Tyler, TX 75703	Mail Code: 313-5		
			Toll Free:	1-866-480-2554	
05 Beaumont	Patrick Oyelola	Stephanie Semien	Office:	1-409-951-3425	Michelle Slugher
	1-512-206-5250	285 Liberty, 11th Floor	FAX:	1-409-951-3449	1-409-951-3413
		Beaumont, TX 77701	Mail Code: 028-1		
			Toll Free:	1-866-480-2555	
06 Houston	Cheryl Evans	Gwen Robinson	Office:	1-713-767-2417	Rosie Molano
	1-512-206-5135	5425 Polk Street, Suite 240D	FAX:	1-713-767-2323	1-713-767-2491
		Houston, TX 77023	Mail Code: 178-7		
		PO Box 16017 Houston, TX 77222-6017	Toll Free:	1-800-500-4266	
07 Austin	Kathy Cox	Sandra Dillett	Office:	1-512-832-7617	Melissa Boyd
	1-512-206-5656	4616-1 West Howard Lane, Suite 120	FAX:	1-512-832-7665	1-512-832-7692
		Austin 78728	Mail Code: 016-1		
			Toll Free:	1-866-480-2556	
08 San Antonio	Bo Platt	Grace Moser	Office:	1-210-619-8226	Bertha Ortiz
	1-512-206-4836	11307 Roszell	FAX:	1-210-619-8293	1-210-619-8019
		San Antonio, TX 78217	Mail Code: 279-4		
		PO Box 23990 San Antonio, TX 78223	Toll Free:	1-877-322-3233	

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Region	OES Officer	Regional Director			Administrative Assistant
10 El Paso	Cheryl Evans	Margaret Adame	Office:	1-915-834-7580	Barbara Lopez
	1-512-206-5135	401 East Franklin	FAX:	1-915-834-7582	1-915-834-7581
		El Paso, TX 79901	Mail Code: 111-1		
		PO Box 981017 El Paso, TX 79998-1017	Toll Free:	1-866-480-2557	
11 Edinburg	Patrick Oyelola	Cynthia Pena	Office:	1-956-316-8272	Karina Tovar
	1-512-206-5250	2520 South Veterans Road	FAX:	1-956-316-8175	1-956-316-8277
		Edinburg, TX 78539	Mail Code: 108-1		Benito Narro
		PO Box 960 Edinburg, TX 78540-0960	Toll Free:	1-866-480-2558	1-956-316-8361
ART		Ramon Gamboa (Interim)	Office:	1-806-783-6626	Melissa Coates
		6302 Iola Ave	FAX:	1-806-783-6630	1-281-344-3496
		Lubbock, TX 79424	Mail Code: 270-7		
Customer Care Center	Cheryl Evans	Kelly Ford	Office:	1-903-675-9748	Barbara Wright
	1-512-206-5135	891 West Corsicana	FAX:	1-903-675-1799	1-903-675-9716
		Athens, TX 75751	Mail Code: 120-4		
		Program Includes: CBS/CPC/TWHP/CCC			
Data Integrity	Monica Shepherd	Data Integrity Program Manager Vacant	Office:	1-512-706-7175	Gregory Maxwell 1-512-706-7125
	1-512-206-4842	1106 Clayton Lane, Suite 450E	FAX:	1-512-706-7150	
		Austin, TX 78723	Mail Code: Y-922		
MEPD	Eric McDaniel	**Regions 6, 7, 8, 11, Statewide Centers, and DDU**			
	1-512-206-4564	Cindy Fortress	Office:	1-512-206-5560	Barbara Tejero
		909 West 45th Street	FAX:	1-512-206-5041	1-512-206-5438
		Austin, TX 78751			Mail Code: 992-6
		Regions 1, 2/9, 3, 4, 5, 10, and CCC			
		Patty Seals	Office:	1-903-927-0329	Lisa Coleman
		4105 Victory Drive	FAX:	1-903-927-0249	1-903-927-0280
		Marshall, TX 75672			Mail Code: 227-1

OES can also be contacted by fax at 1-512-206-5273. For additional office information, visit the HHSC website at www.hhsc.state.tx.us.

Refer to: Subsection A.5, "DSHS Health Service Regions Map" in this appendix to identify the regional boundaries.

A.2.1 Telephone Communication with HHSC and DSHS

Contact	Telephone Number
Assessment Utilization Services (limited program) (Option 4)	1-800-436-6184
HHSC Hearing Services for Children (HSC) (hearing aid, evaluations)	1-800-925-9126
DSHS Emergency Medical Services Division	1-512-834-6700
DSHS IMMTRAC Help Desk	1-800-348-9158
DSHS Immunization Branch	1-800-252-9152
DSHS Medical Transportation Program (MTP) Hotline	1-877-633-8747
DSHS THSteps/EPSDT Hotline	1-877-847-8377

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Contact	Telephone Number
Medicaid Vendor Drug Program Pharmacy Provider Resolution Helpdesk (fee-for-service)	1-800-435-4165

A.3 Client Telephone Communication with HHSC

Clients can call the client toll-free number at 1-800-252-8263.

A.4 Federal and State Telephone Numbers

Telephone Number	Department/Program
1-800-CDC- INFO 1-800-232-4636)	AIDS Hotline (Nationwide, distributed by Centers for Disease Control and Prevention [CDC], Atlanta, Georgia)
1-800-299-2437	HIV/STD InfoLine
1-800-255-1090	Texas HIV Medication Program
1-800-252-5400	Child/Elder Abuse Intake (Department of Family and Protective Services [DFPS])
1-512-776-7420	Vision and Hearing Screening Program (DSHS)
1-512-834-6650, Ext. 2601	*Clinical Laboratory Improvement Amendments* (CLIA) Certification Line
1-800-458-9858	Client Abuse Hotline for Long Term Care Services and Support— Nursing Facilities (HHSC)
1-800-252-8263	Client Inquiry Hotline (HHSC) (Medicaid questions from clients with Medicaid only)
1-512-776-7745	THSteps Program (DSHS)
1-888-963-7111 ext. 7318 or 1-512-776-7318 Fax: 1-512-776-7294	THSteps Laboratory Services (DSHS)
1-888-963-7111 ext. 7661 or 1-512-776-7661 Fax: 1-512-776-7672	Laboratory Supply Orders (DSHS)
1-888-963-7111 ext. 7578 or 1-512-776-7578	Report of Laboratory Test Results (DSHS)
1-512-776-7796	DSHS Family Planning
1-800-436-6184	Fraud or Abuse of Provider Services (HHSC Office of Inspector General)
1-800-436-6184	Fraud or Abuse/Long Term Care Services and Support—Nursing Facilities/HHSC
1-800-436-6184	Fraud or Abuse/Client/HHSC Office of the Inspector General
1-800-792-1109	Goal-Directed Therapy
1-512-438-3169 or 1-800-252-8010	Hospice Program (HHSC Policy Development division)
1-800-252-9152	Immunization Branch (DSHS)
1-800-925-9126	Medically Needy Spend Down Unit
1-800-MEDICARE or 1-800-633-4227	Medicare/Social Security Administration
1-800- 925-9126	Newborn Screening (DSHS)
1-800-925-9126	HHSC Hearing Services for Children (HSC)
1-800-628-5115	DARS Inquiries Line (for information about ECI or to refer a child.)
1-800-436-6184	Recipient Utilization Control Unit (HHSC) (for limited status review and for referrals from providers for potential client overuti-lization, etc.)
1-512-776-7796	Breast and Cervical Cancer Services (DSHS)
1-713-526-2559	Snellen Letter (Tumbling E Wall Chart)

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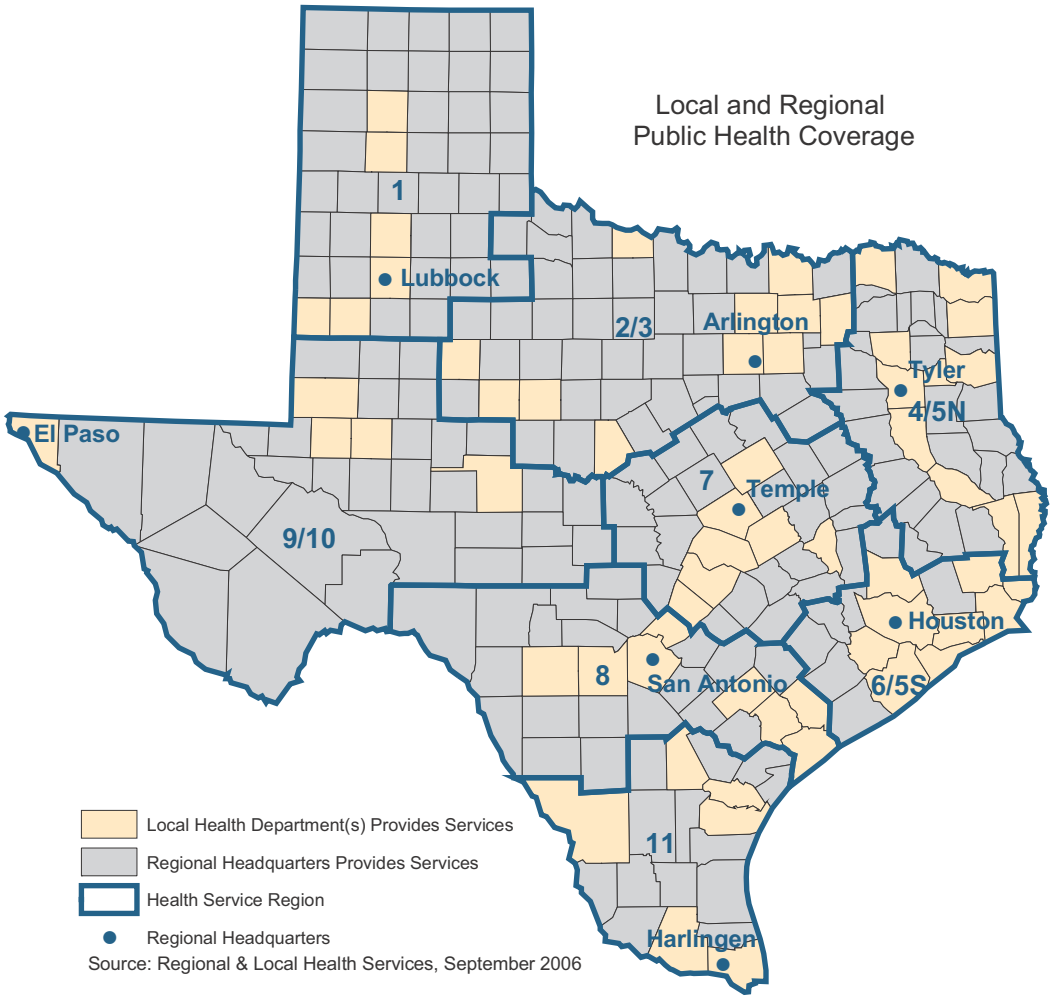
Telephone Number	Department/Program
1-800-435-4165	Medicaid Vendor Drug Program (HHSC) (fee-for-service) (specifically for pharmacy use)
1-877-728-3927	Medicaid Vendor Drugs Prior Authorization Center (fee-for-service)
1-866-993-9972	Texas Women's Health Program Eligibility
1-512-776-7796	Cervical Cancer Screening

A.5 DSHS Health Service Regions Map



A.6 DSHS Health Service Region Contacts

Health Service Region 1 Regional Office (Lubbock)	Health Service Regions 2 & 3 Regional Office (Arlington)
DSHS/PHR 1 6302 Iola Ave. Lubbock, TX 79424 1-806-744-3577 Fax: 1-806-783-6435	DSHS/PHR 2 & 3 1301 S. Bowen, Suite 200 Arlington, TX 76013 1-817-264-4500 Fax: 1-817-264-4506

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Health Service Region 1 Regional Office (Lubbock)	**Health Service Regions 2 & 3 Regional Office (Arlington)**
Regional Medical Director Peter W. Pendergrass, MD, MPH	Regional Medical Director James A. Zoretic, MD
Deputy Regional Director Barry Wilson	Deputy Regional Director (acting) Earlene Quinn
Manager of Social Work Services and Case Management Vacant	Manager of Social Work Services and Case Management Blanca Sanchez, LBSW
Communicable Disease Manager Vacant	Director of Clinic Operations Dorothy Kuhlmann, RN
Immunization Program Manager Keila Johnson	Immunization Program Manager Sonna Sanders
Tuberculosis Team Leader Melanie Lee	Communicable Disease Program Manager Gary Willett
THSteps Operations Lead Elizabeth Stanford	Tuberculosis Team Leader Jeff Ralston
6302 Iola Ave Lubbock, TX 79424 Mail Code: 1899 1-806-783-6445 Fax: 1-806-783-6455	Emergency Preparedness Bryan Flow, DVM
DSHS Regional Family Planning Specialist Patricia Rennie 1101 Camino La Costa Austin, TX 78752 1-512-467-9875 Fax: 1-512-451-1468	THSteps Operations Lead Trellis Grant 1301 S. Bowen Road #200, Mail Code 1905 Arlington, TX 76013 1-817-264-4918 Fax: 1-817-264-4910
DSHS Regional Contract Coordinator (DSHS Family Planning) Cindy Don 1301 S. Bowen Road, Suite 200 Arlington, TX 76013 1-817-264-4743 Fax: 1-817-264-4912	HIV/STD Program Manager Vacant
	DSHS Regional Contract Coordinator (DSHS Family Planning) Cindy Don 1301 S. Bowen Road, Suite 200 Arlington, TX 76013 1-817-264-4743 Fax: 1-817-264-4912

Health Service Regions 4 & 5 (North) Regional Office (Tyler)	**Health Service Regions 6 & 5 (South) Regional Office (Houston)**
DSHS/PHR 4 & 5 North 2521 West Front Street Tyler, TX 75702 1-903-595-3585 Fax: 1-903-593-4187	DSHS 6 & 5 South 5425 Polk Avenue, Suite J Houston, TX 77023 1-713-767-3000 Fax: 1-713-767-3049
Regional Medical Director Dr. Paul K. McGaha, DO, MPH	Regional Medical Director (Acting) John G. Jordan, M.D., MPH
Deputy Regional Director Vacant	Deputy Regional Director Greta Etnyre, MS, RD
Manager of Social Work Services and Case Management Peggy Wooten, LCSW, ACSW	Manager of Social Work Services and Case Management Raymond Turner, MA, LMSW-AP

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Health Service Regions 4 & 5 (North) Regional Office (Tyler)	**Health Service Regions 6 & 5 (South) Regional Office (Houston)**
Director of Nursing Barbara Lay, RN, MSN	Director of Nursing Melinda Denson, RN, MPH
Immunization Program Manager Toni Wright	Immunization Program Manager Angel H. Angco, MBA, RN
HIV/STD Program Manager Charles O'Brien	HIV/STD Program Manager Linda Hollins
Tuberculosis Program Manager Teresa Santiago, RN	Tuberculosis Program Manager Lewis Gonzalez, MD
THSteps Operations Lead Caleb Rackley 2521 W. Front, Mail Code 1358 Tyler, TX 75702 1-903-533-5357 Fax: 1-903-595-4706	THSteps Operations Lead Shannon Jones 5425 Polk Avenue, Suite J, Mail Code 1906 Houston, TX 77023-1497 1-713-767-3105 Fax: 1-713-767-3125
DSHS Regional Contract Coordinator (DSHS Family Planning) Sharon Flournoy 1750 N. Eastman Road, Room 118 Longview, TX 75601 1-903-232-3292 Fax: 1-903-232-3278	DSHS Regional Contract Coordinator (DSHS Family Planning) Sharon Flournoy 1750 N. Eastman Road, Room 118 Longview, TX 75601 1-903-232-3292 Fax: 1-903-232-3278

Health Service Region 7 Regional Office (Temple)	**Health Service Region 8 Regional Office (San Antonio)**
DSHS/PHR 7 2408 S 37th Street Temple, TX 76504-7168 1-254-778-6744 Fax: 1-254-778-4066	DSHS/PHR 8 7430 Louis Pasteur Drive San Antonio, TX 78229 1-210-949-2000 Fax: 1-210-949-2015
Regional Medical Director Lisa Cornelius, MD, MPH	Regional Medical Director Sandra Guerra-Cantu, MD, MPH
Deputy Regional Director Jon Huss	Deputy Regional Director Gail Morrow, MPH
Manager of Social Work Services and Case Management Leesa Ferrero, LMSW	Manager of Social Work Services and Case Management Katherine Velasquez, RN, PhD
Director of Nursing Pauline Culbert, MSN, RN	Director of Nursing Sandra Jones, MSN, CNS
Immunization Program Manager Diane Romnes	Immunization Program Manager Laurie Henefey
HIV/STD Program Manager Al Gonzales	Communicable Disease Program Manager Cherise Rohr-Allegrini, PhD
Tuberculosis Program Manager/Nurse Consultant Dana Schoepf, RN	HIV/STD Program Manager Joanna Nichols, MPH
THSteps Operations Co-leads Kimberly Langley 1-254-760-1176 Suzan Cooper 1-254-563-5412 2408 S. 37th Street, Mail Code 1902 Temple, TX 76504 Fax: 1-254-773-2722	THSteps Operations Lead Velma Stille 7430 Louis Pasteur Drive, Mail Code 5716 San Antonio, TX 78229 1-210-949-2159 Fax: 1-210-949-2041

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Health Service Region 7 Regional Office (Temple)	Health Service Region 8 Regional Office (San Antonio)
DSHS Regional Contract Coordinator (DSHS Family Planning) Carolyn Wachel 2408 South 37th Street Temple, TX 76504 1-254-778-6744 Ext. 2851 Fax: 1-254-773-2722	

Health Service Regions 9 & 10 Regional Office (El Paso)	Health Service Region 11 Regional Office (Harlingen)
DSHS/PHR 9 & 10 401 E. Franklin, Suite 210 El Paso, TX 79901 1-915-834-7682 Fax: 1-915-834-7808	DSHS/PHR 11 601 W. Sesame Drive Harlingen, TX 78550 1-956-423-0130 Fax: 1-956-444-3293
Regional Medical Director James A. Zoretic, M.D., M.P.H., Interim Regional Medical Director	Regional Medical Director Brian Smith, MD, MPH
Deputy Regional Director Blanca Serrano, MPH, RS	Deputy Regional Director Sylvia Garces-Hobbs
Manager of Social Work Services and Case Management Vacant	Manager of Social Work Services and Case Management Angelica Martinez, MS, LBSW
Director of Nursing Sharon Lindsey, RN	Director of Nursing Darlene Farias, RN
Immunization Program Manager Jose Padilla	Immunization Program Manager Ivette Nunez
HIV/STD Program Manager Oscar Hernandez	HIV/STD Program Manager Richard Anguiano
Communicable Disease Manager Gale Morrow, MPH, CHES	Tuberculosis Program Manager Maria San Pedro, MSPHN, RN
THSteps Operations Lead Arturo Diaz, Jr. 401 E. Franklin, Suite 200, Mail Code 1903 El Paso, TX 79901 1-915-834-7735 Fax: 1-915-834-7802	THSteps Operations Lead Ray Garza 601 W. Sesame Drive, Mail Code 1907 Harlingen, TX 78550 1-956-421-5563 Fax: 1-956-444-3293
DSHS Regional Contract Coordinator (DSHS Family Planning) Carolyn Wachel 2408 South 37th Street Temple, TX 76504 1-254-778-6744 Ext. 2852 Fax: 1-254-773-2722	DSHS Regional Contract Coordinator (DSHS Family Planning) Berta Cavazos 601 W. Sesame Drive Harlingen, TX 78550 1-956-423-0130 Fax: 1-956-444-3299

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A.7 State Participating Local Health Departments and Public Health Districts

State Participating Local Health Departments and Public Health Districts	
Abilene Public Health Department Region 2/3 Larry Johnson, Administrator PO Box 6489 (79608-6489) 850 N. 6th Street Abilene, TX 79605 1-325-692-5600 Fax: 1-325-734-5370	Hidalgo County Health Department Region 11 Eduardo Olivarez, Administrator Omar Garza, MD, Director 1304 South 25th Street Edinburg, TX 78539-7205 1-956-383-6221 Fax: 1-956-444-3298
Amarillo Bi-City-County Health District Department of Health Roger Smalligan, MD, Health Authority, Matt Richardson, Director for the City of Amarillo Department of Health 1000 Martin Road Amarillo, TX 79107 1-806-378-6300 Fax: 1-806-378-6306	Houston Health & Human Services Department Region 6/5 S Stephen L. Williams, MD, MPH, Director 8000 North Stadium Drive Houston, TX 77054 1-713-794-9311 Fax: 1-713-798-0862
Andrews City-County Health Department Region 9/10 Robert Garcia, MD, Director 208 NW 2nd street Andrews, TX 79714 1-432-524-1434 Fax: 1-432-524-1461	Jackson County Health Department Region 8 Bain C. Cate, MD, Director 411 North Wells, Room 206 Edna, TX 77957 1-361-782-5221 Fax: 1-361-782-7312
Angelina County & Cities Health District Region 4/5N Sharon Shaw, Administrator John Rudis, MD, Director Lufkin, TX 75904 1-936-632-1139 Fax: 1-936-632-2640	Jasper-Newton County Public Health District Region 4/5 N Danny Brackin 139 West Lamar Street Jasper, TX 75951 1-409-384-6829 Fax: 1-409-384-7861
Atascosa County Health Department Region 8 Gerald B. Phillips, MD, Director 1102 Campbell Avenue Jourdanton, TX 78026 1-830-769-3451 Fax: 1-210-769-2349	Jefferson County Health Authority Cecil A. Walkes, MD 1295 Pearl Street Beaumont, TX 77701 1-409-835-8530 Fax: 1-409-839-2353
Austin Department of Health & Human Services Region 7 Health District David Lurie, Director 7201 Levander Loop, Bldg. E Austin, TX 78744 1-512-927-5010 Fax: 1-512-972-5016	Liberty County Health Authority Steven C. Ellerbe, DO 720 Travis Liberty, TX 77575 1-936-336-6439 Fax: 1-936-336-6517
Beaumont City Health Department Region 5/6 S Ingrid West-Holmes, Director PO Box 3827 950 Washington Blvd Beaumont, TX 77704 1-409-832-4000 Fax: 1-409-832-4270	Live Oak County Health Department Region 11 Alan Crouther, Director Drawer 670 (78022) Live Oak County Courthouse George West, TX 78022 1-361-449-2733 Fax: 1-361-449-1013

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State Participating Local Health Departments and Public Health Districts	
Bell County Public Health District Region 7 Wayne Farrell, Director PO Box 3745 (76505) South 9th Street Temple, TX 76501 1-254-773-4457 Fax: 1-254-773-7535	Lubbock City Health Department Region 1 Nancy Haney, Director PO Box 2548 (79408) 1902 Texas Avenue Lubbock, TX 79405 1-806-775-2899 Fax: 1-806-775-3209
Brazoria County Health Department Region 6/5 S Leo D. O'Gorman, MD, MPH, Director 432 East Mulberry Angleton, TX 77515 1-979-864-1484 Fax: 1-979-756-1456	Maverick County Health Department Region 8 Arturo Batres, MD, Director 490 S. Bibb Eagle Pass, TX 78852 1-830-773-9438 Fax: 1-830-773-6450
Brazos County Health Department Region 7 Ken Bost, Executive Director 201 North Texas Avenue Bryan, TX 77803-5317 1-979-361-4440 Fax: 1-409-823-6993	Marshall-Harrison County Health District Region 4/5 N Robert Palmer, MD, Director 805 Lindsey Drive Marshall, TX 75670 1-903-938-8338 Fax: 1-903-938-8330
Brownwood-Brown County Health Department Region 2/3 Russ Skinner, MD, Director PO Box 1389 Brownwood, TX 76804 1-325-646-0554 Fax: 1-325-643-8157	Medina County Health Department Region 8 John W. Meyer, MD, Director 3103 Avenue G Hondo, TX 78861 1-830-741-6191 Fax: 1-830-426-4202
Calhoun County Health Department Region 8 Bain C. Cate, Director 117 West Ash Port Lavaca, TX 77979 1-361-552-9721 Fax: 1-361-552-9722	Midland County Health Department Region 9/10 Celestino Garcia, RS, Administrator James M. Humphreys, Jr., MD, Director Mailing address: PO Box 4905 Midland, TX 79704 Physical address: 3303 West Illinois St., Space 22 Midland, TX 79703 1-432-681-7613 Fax: 1-432-681-7634
Cameron County Health Department Region 11 Yvette Salinas, Administrator 1390 W. Ex. 83 San Benito, Tx. 78586 1-956-247-3685 Fax: 1-956-361-8280	Milam County Health Department Region 7 Patsy Gaines, Director PO Box 469 (76520) 209 South Houston Street Cameron, TX 76520 1-254-697-7039 Fax: 1-254-697-4809
Cass County Health Department Region 4/5 N R. Bruce LeGrow, MD, Director PO Box 310 (75563) South Kaufman and Rush Linden, TX 75563 1-903-756-7051 Fax: 1-214-796-3976	Montgomery County Health Department Region 6/5 S Vickie Modeland, Director 701 E. Davis, Ste. A Conroe, Tx. 77301 1-936-525-2800 Fax: 1-936-539-4668

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State Participating Local Health Departments and Public Health Districts	
Chambers County Health Department Region 6/5 S William Clay Brown, Director PO Box 670 (77514) 1222 Main Street Anahuac, TX 77514 1-409-267-8356 Fax: 1-409-267-4276 landres@ih2000.net	Orange County Health Department Region 6/5 Howard C. Williams, MD Sheila Cole, Director 2014 North 10th Street Orange, TX 77630 1-409-883-6119 Fax: 1-409-883-3147 Williams@pnx.com
Cherokee County Health Department Region 4/5 N Judy Beck, MD, Director 1209 N. Main Street Rusk, TX 75785 1-903-683-4688 Fax: 1-903-683-4899	Paris-Lamar County Health Department Region 4/5 N Anthony Bethel, Director PO Box 938 (75460) 740 South West 6th Street Paris, TX 75460 1-903-785-4561 Fax: 1-903-737-9924
City of Dallas Department of Environmental & Health Services/Region 2/3 Karen D. Rayzer, Director 1500 Marilla Street, Suite 7AN Dallas, TX 75201 1-214-670-5711 Fax: 1-214-670-3863	Plainview-Hale County Health District Region 1 John Castro, Director 111 East 10th Plainview, TX 79072 1-806-293-1359 Fax: 1-806-293-5741
City of Laredo Health Department Region 11 Hector Gonzalez, Director PO Box 2337 (78044) 2600 Cedar Street Laredo, TX 78040 1-956-723-2051 Fax: 1-956-726-2632	Port Arthur City Health Department Region 6/5 S Yoshi Alexander, Director 449 Austin Avenue Port Arthur, TX 77640 1-409-983-8800 Fax: 1-409-983-8870
Collin County Health Care Services Region 2/3 Candy Blair, Director 825 North McDonald Street, Suite 130 McKinney, TX 75069 1-972-548-5500 Fax: 1-972-548-7221	San Angelo-Tom Green County Health Department Region 9/10 Sandra Villarreal, Director Mailing address: PO Box 1751 (76902) Physical address: 106 S. Chadburne San Angelo, TX 76903 1-325-657-4493 Fax: 1-325-657-4553
Colorado County Health Authority Raymond R. Thomas, MD 610 S. Austin Road Eagle Lake, TX 77434 1-979-234-2551 Fax: 1-979-234-5994	San Antonio Metropolitan Health District Region 8 Fernando Guerra, MD, MPH, Director 332 West Commerce, Suite 307 San Antonio, TX 78205-2489 1-210-207-8730 Fax: 1-210-207-8999
Corpus Christi-Nueces County Public Health District/Region W Annette Rodriguez, Interim Director PO Box 9727 (78469) 1702 Horne Road Corpus Christi, TX 78416 1-361-851-7200 Fax: 1-361-851-7295	San Patricio County Health Department Region 11 Josie Michael, Director James Mobley, MD, Director 313 North Rachal Sinton, TX 78387 1-361-364-6208 Fax: 1-361-364-6117

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State Participating Local Health Departments and Public Health Districts	
Corsicana-Navarro County Public Health District Region 2/3 Kent Rogers, MD, Director 618 North Main Corsicana, TX 75110 1-903-874-6731 Fax: 1-903-872-7215	Scurry County Health Department Region 2/3 Cindy Wright, Director 911 26th Street Snyder, TX 79549 1-325-573-3508 Fax: 1-325-573-0380
Cuero-DeWitt County Health Department Region 8 Bain C. Cate, MD, Director 106 North Gonzales Street Cuero, TX 77954 1-361-275-3461 Fax: 1-361-275-5732	Smith County Public Health District Region 4/5 N George T. Roberts, Jr., F.A.C.H.E., Director 815 North Broadway Tyler, TX 75702-4507 1-903-535-0036 Fax: 1-903-535-0052
Dallas County Health Department Region 2/3 Zachary S.Thompson, Director 2377 Stemmons Freeway Dallas, TX 75207-2710 1-214-819-6070 Fax: 1-214-819-6022	South Plains Public Health District Region 1 Morris S. Knox, MD, Director 919 East Main Street Brownfield, TX 79316 1-806-637-2164 Fax: 1-806-637-4295
Del Rio-Val Verde County Health Department Manuel A. Martinez, BS, MD, Director 400 Pecan Street (3rd Floor) Del Rio, TX 78840 1-830-774-7570 Fax:1-830-774-7642 manuel_martinez@valverdecounty.org	Sweetwater-Nolan County Health Department Region 2/3 Don Ware, RS, Director PO Box 458 (79556) 301 East 12th Street Sweetwater, TX 7z9556 1-915-235-5463 Fax: 1-915-236-6856
Denton County Health Department Region 2/3 Bing Burton, Administrator 306 N. Loop 288, Suite 183 Denton, TX 76209 1-940-349-2900 Fax: 1-940-349-2905	Texarkana-Bowie County Family Health Center Region 4/5 N Kathy Moore, Administrator 902 West 12th Texarkana, TX 75501 1-903-798-3255 Fax: 1-903-793-2289
Ector County Health Department Region 9/10 Gino Solla, Director Nathan Galloway, MD, Director 221 North Texas Odessa, TX 79761 1-432-498-4141 Fax: 1-432-498-4143	Uvalde City-County Health Department Region 8 Liz Barrett, RN, Director 1021 Garnerfield Road Uvalde, TX 78801 1-830-278-1705 Fax: 1-830-278-1881
El Paso City-County Health and Environmental District/Region 9/10 Jorge Magaña, MD, Director 1148 Airway Blvd El Paso, TX 79925-3692 1-915-771-5701 Fax: 1-915-543-3541	Victoria County Health Department Region 8 Bain C. Cate, MD, Director PO Box 2350 (77902) 2805 N. Navarro Victoria, Tx 77901 1-361-578-6281 Fax: 1-361-578-7046

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State Participating Local Health Departments and Public Health Districts	
Fort Bend County Health Department Region 6/5 S Jean Galloway, MD, Director PO Box 668 (77471) 4520 Reading Road, Suite A Rosenberg, TX 77471 1-281-342-6414 Fax: 1-281-342-7371	Waco-McLennan County Public Health District Region 7 Roger Barker, MBA, Director 225 West Waco Drive Waco, TX 76707 1-254-750-5450 Fax: 1-254-750-5452
Fort Worth-Tarrant County Department of Public Health Region 2/3 Daniel B. Reimer, Director Nick Curry, MD, Director 1800 University Drive Fort Worth, TX 76107 1-817-871-7201 Fax: 1-817-871-7335	Walker County Health Authority Region 6/5 S M. Gebre-Selassie, MD 2804 Lake Road, #4 Huntsville, TX 77340 1-936-291-9600 Fax: 1-936-291-1625
Galveston County Health District Region 6/5 S H. Mark Guidry, MD, MPH, Director PO Box 939 (77568) 1207 Oak Street La Marque, TX 77568 1-409-938-2401 Fax: 1-409-938-2243 rmorris@gchd.org	Wichita Falls-Wichita County Public Health District Region 2/3 Lou Franklin, RN, BSN, Director Tom Edmonson, Administrator 1700 Third Street Wichita Falls, TX 76301 1-940-761-7805 Fax: 1-940-767-5242
Grayson County Health Department Region 2/3 Wayne Bell 515 North Walnut Sherman, TX 75090 1-903-893-0131 Fax: 1-903-892-3776	Williamson County and Cities Public Health District Region 7 W.S. Riggins, Jr., MD, MPH, Director PO Box 570 (78627) 100 W. 3rd Street Georgetown, TX 78626 1-512-943-3600 Fax: 1-512-943-1499
Greenville-Hunt County Health Department Region 2/3 Mark Memahan, DO, Director Henry Underwood, DO, Director 4815 King Street, Ste. B Greenville, TX 75401 1-903-455-4433 Fax: 1-903-455-4956	Wilson County Health Department Region 8 Edwin Baker, Director PO Box 396 (78114) Wilson County Courthouse Floresville, TX 78114 1-830-393-8503 Fax: 1-830-393-6031
Hardin County Health Department Region 6/5 S Mary Pastor, Director PO Box 820 (77625) 440 W. Monroe Kountze, TX 77625 1-409-246-5188 Fax: 1-409-246-4373	Wood County Health Department Region 4/5 N David C. Murley, MD, Director Wood County Courthouse PO Box 596 (75783) Quitman, TX 75783 1-903-763-5406 Fax: 1-903-763-2902
Harris County Health Department Region 6/5 S 2223 W. Loop South Houston, TX 77027 1-713-439-6016 Fax: 1-713-439-6080 thyslop@hc.co.harris.tx.us	Zavala County Health Department Region 8 Antonio Rivera, MD, Director 600 North John F. Kennedy Drive Crystal City, TX 78839 1-210-374-3010 Fax: 1-210-374-3007

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State Participating Local Health Departments and Public Health Districts	
Hays County Health Department Region N Larry Birdwell, DO, Director 401-A Broadway Drive San Marcos, TX 78666 1-512-353-4353 Fax: 1-512-396-4656	

A.8 Department of Assistive and Rehabilitative Services (DARS), Blind Services

DARS, Blind Services	
Central Office Administrative Building 4800 North Lamar Administrative Building #110 Austin, TX 78756 1-800-628-5115 1-800-252-5204 (voice or TDD) Fax: 1-512-377-0468	Laredo 313 West Village Blvd., Suite 112 Laredo, TX 78041-2275 1-956-523-8050 1-800-687-7030 Fax: 1-956-523-8088
Abilene 4601 S. 1st Street, Suite M Abilene, TX 79605-1463 1-325-795-5840 1-800-687-7009 Fax: 1-325-795-5850	Lubbock Corporate Center 5121 69th Street, Suite A-5 Lubbock, TX 79424-1631 1-806-783-2930 1-800-687-7032 Fax: 1-806-783-2950
Amarillo 7120 I-40 West, Suite 100 Amarillo, TX 79106-2500 1-806-351-3870 1-800-687-7010 Fax: 1-806-351-3885	Lufkin 3201 South Medford, #5 Lufkin, TX 75901-5796 1-936-630-3960 1-800-687-7033 Fax: 1-936-630-3978
Austin 7517 Cameron Road #120 Austin, TX 78752-2053 1-512-533-7100 1-800-687-7008 Fax: 1-512-459-0200	McAllen 801 Nolana, Suite 115 McAllen, TX 78504-3023 1-956-661-0930 1-800-687-7037 Fax: 1-956-661-0940
Beaumont 550 Eastex Freeway, Suite D Beaumont, TX 77708 1-409-898-8490 1-800-687-7013 Fax: 1-409-924-7360	Odessa 3016 Kermit Hwy., Suite A Odessa, TX 79764 1-432-334-5650 1-800-687-7034 Fax: 1-432-332-3183
Bryan-College Station 1115-A Welsh College Station, TX 77840-4267 1-979-680-5290 1-800-687-7014 Fax: 1-979-680-5287	San Angelo State of Texas Services Center 622 South Oakes, Suite D San Angelo, TX 76903-7035 1-325-659-7920 1-800-687-7038 Fax: 1-325-659-7929

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DARS, Blind Services	
Corpus Christi 410 S. Padre Island Drive, #103 Corpus Christi, TX 78405-4122 1-361-289-8710 1-800-687-7015 Fax: 1-361-289-8737	San Antonio Trinity Building 4204 Woodcock Drive, #274 San Antonio, TX 78228-1324 1-210-785-2750 1-800-687-7039 Fax: 1-210-785-2790
Dallas 6500 Greenville Ave., Suite 250 Dallas, TX 75206-1010 1-214-378-2600 1-800-687-7017 Fax: 1-214-378-2630	Southeast 10060 Fuqua Houston, TX 77089-1337 1-713-948-7960 1-800-687-7036 Fax: 1-713-948-7993
El Paso 401.E. Franklin, Suite #240 El Paso, TX 79901-1210 1-915-834-7004 1-800-687-7020 Fax: 1-915-834-7072	Texarkana 410 Baylor, Suite C Texarkana, TX 75501-3290 1-903-255-3200 1-800-687-7040 Fax: 1-903-255-3209
Fort Worth 4200 South Freeway, #307 Fort Worth, TX 76115-1404 1-817-759-3500 1-800-687-7023 Fax: 1-817-759-3532	Tyler Woodgate Office Park, Building 1 1121 ESE Loop 323, Bldg. 1, #106 Tyler, TX 75701-9660 1-903-279-0970 1-800-687-7042 Fax: 1-903-279-0992
Harlingen 1812 West Jefferson Harlingen, TX 78550-5247 1-956-336-3600 1-800-687-7025 Fax: 1-956-366-3614	Victoria Town Plaza Mall 4102 N. Navarro Street, D-2 Victoria, TX 77901-2600 1-361-580-5700 1-800-687-7043 Fax: 1-361-580-5737
Houston 427 West 20th, #407 Heights Medical Tower Houston, TX 77008-2430 1-713-802-3100 1-800-687-7028 Fax: 1-713-802-3132	Waco 801 Austin Street, Suite 710 Waco, TX 76701-1937 1-254-753-1552 1-800-687-7044 Fax: 1-254-753-1343
	Wichita Falls 3709 Gregory Street, Suite 102 Wichita Falls, TX 76308-1624 1-940-689-2740 1-800-687-7045 Fax: 1-940-689-2749

A.9 HHSC Open Records Requests

Providers who would like to make open records requests should visit the Open Records page of the HHSC website. For general inquiries, such as claim status inquiries, eligibility verification, and prior authorization requests, refer to subsection A.10, "TMHP Telephone and Fax Communication" in this section for contact information.

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A.10 TMHP Telephone and Fax Communication

Contact	PA Request Telephone Number	General Inquiry Telephone Number	Fax Number
General Information			
TMHP Contact Center	N/A	1-800-925-9126 or 1-512-335-5986	
Automated Inquiry System (AIS)	N/A	1-800-925-9126 or 1-512-335-5986	
Provider Enrollment	N/A	TMHP Contact Center	1-512-514-4214
Telephone appeals	N/A	1-800-745-4452	
TMHP Electronic Data Interchange (EDI) Help Desk	N/A	1-888-863-3638	1-512-514-4228 1-512-514-4230
Program and Prior Authorization Information			
Ambulance (Medicaid and CSHCN Services Program)	1-800-540-0694	TMHP Contact Center	1-512-514-4205 Prior Authorization Only
Children with Special Health Care Needs (CSHCN) Services Program	N/A	1-800-568-2413	1-512-514-4222 Prior Authorization Only
Comprehensive Care Program (CCP) (for CCP prior authorization status and general CCP and Home Health Services information)	N/A	1-800-846-7470	1-512-514-4212 Prior Authorization Only
CCP personal care services (PCS)	N/A	1-888-648-1517	N/A
Comprehensive Care Inpatient Psychiatric (CCIP) Unit Option 1 – CCIP Option 2 – Substance abuse	N/A	1-800-213-8877	1-512-514-4211 Prior Authorization Only
Home Health Services Requests for new prior authorization or extensions cannot be made over the telephone.	1-800-925-8957 (follow-up and status inquiry only)		1-512-514-4209 Prior Authorization Only
Obstetric ultrasound	1-800-302-6167	TMHP Contact Center	1-512-302-5039 Prior Authorization Only
Special Medical Prior Authorization (SMPA)	N/A	TMHP Contact Center	1-512-514-4213) Prior Authorization Only
Texas Health Steps (THSteps) dental inquiries	N/A	1-800-568-2460	N/A
THSteps medical inquiries	N/A	1-800-757-5691	N/A
Family Planning (tubal ligation and vasectomy consent forms)	N/A	TMHP Contact Center	1-512-514-4229
Hysterectomy acknowledgment statements	N/A	TMHP Contact Center	1-512-514-4218

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Contact	PA Request Telephone Number	General Inquiry Telephone Number	Fax Number
Other Program and Reimbursement Information			
Health Insurance Premium Payment (HIPP)	N/A	1-800-440-0493	
Long Term Care (LTC) operations	N/A	1-800-626-4117	
LTC—Nursing Facilities	N/A	1-800-727-5436	
Medicaid Audit/Cost Reports	N/A	1-512-506-6117	1-512-506-7811
Third Party Liability (TPL) (Option 2)	N/A	1-800-846-7307	1-512-514-4225
Tort (Option 3)	N/A	1-800-846-7307	1-512-514-4225

A.11 Written Communication With TMHP

All CMS-1500 forms (excluding ambulance, radiology/laboratory, immunization services, rural health, and mental health rehabilitation) sent to TMHP for the first time, as well as claims being resubmitted because they were initially denied as *incomplete claims*, must be sent to the following address:

Texas Medicaid & Healthcare Partnership
Claims
PO Box 200555
Austin, TX 78720-0555

The post office box addresses must be used for the specific items listed in the following table:

Correspondence	Address
Appeals/adjustments of claims (except zero paid/zero allowed on Remittance & Status [R&S] Reports) Electronically rejected claims past the 95-day filing deadline and within 120 days of electronic rejection report	Texas Medicaid & Healthcare Partnership Appeals/Adjustments PO Box 200645 Austin, TX 78720-0645
All first-time claims	Texas Medicaid & Healthcare Partnership Claims PO Box 200555 Austin, TX 78720-0555
Ambulance Authorization (includes out-of-state transfers)	Texas Medicaid & Healthcare Partnership Ambulance Prior Authorizations P O Box 200735 Austin, TX 78720-0735
CCP requests (prior authorization and appeals)	Texas Medicaid & Healthcare Partnership Comprehensive Care Program (CCP) PO Box 200735 Austin, TX 78720-0735
CSHCN Services Program claims	Texas Medicaid & Healthcare Partnership CSHCN Services Program Claims PO Box 200855 Austin, TX 78720-0855
Home Health Services prior authorizations	Texas Medicaid & Healthcare Partnership Home Health Services PO Box 202977 Austin, TX 78720-2977

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Correspondence	Address
Medicaid audit correspondence	Texas Medicaid & Healthcare Partnership Medicaid Audit PO Box 200345 Austin, TX 78720-0345
Medically Needy Clearinghouse (MNC) or Spend Down Unit correspondence	Texas Medicaid & Healthcare Partnership Medically Needy Clearinghouse PO Box 202947 Austin, TX 78720-2947
Provider Enrollment correspondence	Texas Medicaid & Healthcare Partnership Provider Enrollment PO Box 200795 Austin, TX 78720-0795
Other provider correspondence	Texas Medicaid & Healthcare Partnership Provider Relations PO Box 202978 Austin, TX 78720-0978
Send all other written communication to TMHP	Texas Medicaid & Healthcare Partnership (Department) 12357-B Riata Trace Parkway, Suite 100 Austin, TX 78727
TMHP Fee-for-Service and ICF-IID Dental prior authorization requests	Texas Medicaid & Healthcare Partnership Fee-for-Service and ICF-IID Dental PO Box 204206 Austin, Texas 78720-4206
TPL/Tort correspondence	Texas Medicaid & Healthcare Partnership Third Party Liability/Tort PO Box 202948 Austin, TX 78720-2948

A.12 Other TMHP Information

A.12.1 TMHP Website

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

- Provider education information and registration for upcoming education/training sessions (i.e., live workshops, webinars, computer-based training, and audio content).
- Publications, such as bulletins, banner messages, and provider manuals.
- A TMHP News section with announcements of program changes and other important information.
- Real-time and static fee schedules.
- Forums, polls, and questionnaires.
- Online provider enrollment.
- Complete instructions for setting up a Provider Administrator account and the use of online claims status inquiries (CSI), eligibility verification, and Electronic Remittance and Status (ER&S) Reports.

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

- Texas Medicaid enrollment information.
- CSIs.
- Eligibility verification.

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- ER&S Report download option.
- Claims submission.
- Claims appeals.
- Online provider lookup.
- Online fee lookup (OFL) to obtain real-time fee information for an individual or a range of procedure codes. Benefits and limitations for certain services and history up to 2-years is also available.
- Payment amounts search, view, and print capabilities.
- Notification of an invalid address on file for any Texas Provider Identifier (TPI) associated with a provider's National Provider Identifier (NPI).
- Notification of pending payments because of inaccurate or incomplete provider information.
- Manage hospital admission and discharge information on clients residing in an institution for mental diseases (IMD)

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

New services are always being added to the website. Please visit www.tmhp.com for the latest information on TMHP online services.

A.12.2 TMHP Contact Center

The TMHP Contact Center is available from 7 a.m. to 7 p.m., Central Time, Monday through Friday.

The TMHP Contact Center assists with questions such as:

- Provider enrollment procedures
- Claims filing procedures
- Policy information

The TMHP Contact Center is available to assist providers and clients. Please review the telephone and fax communication guides in this section for a list of contact telephone and fax numbers.

Provider calls, including those that were previously made to the Provider Relations territory representatives, are now handled first by the Contact Center. The Contact Center is well equipped to handle most inquiries about benefits and claims.

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.

Resolution of more complex issues that are referred to Provider Relations for further analysis can take up to 30 days from the date of the referral. For these issues, Provider Relations will contact the provider by telephone or e-mail when the issue has been resolved.

For questions or information about Medicaid eligibility, clients are referred to their caseworker or the local HHSC office.

A.12.3 Automated Inquiry System (AIS)

AIS provides the following information and services through the use of a touch-tone telephone:

- Claim status

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- Patient eligibility
- Benefit limitations
- Medically Needy case status
- Family Planning
- Current weekly payment amount
- Claim appeals.

Eligibility and claim status information is available on AIS 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 from 7 a.m. until 7 p.m., Central Time, Monday through Friday. AIS offers 15 transactions per call.

For full instructions on the use and benefits of AIS, refer to the "Automated Inquiry System (AIS) User's Guide" available on www.tmhp.com or call the TMHP Contact Center at 1-800-925-9126 for faxed instructions.

A.12.4 TMHP Provider Relations

The TMHP Provider Relations Department comprises a staff of Austin- and field-based provider relations representatives whose goal is to serve the health-care community by furnishing a variety of services and activities designed to inform and educate health-care providers about Texas Medicaid activities and claim submission procedures.

Provider Relations activities include the following:

- *Provider education through planned events.* Provider Relations representatives conduct a planned program of educational workshops, in-services, webinars, computer-based training (CBT), and other training sessions designed to keep all actively-enrolled providers informed of the latest policies, claim processing procedures, and federal and state regulations affecting Texas Medicaid. Details of all available provider training can be found in the Provider Education section of the TMHP website at www.tmhp.com.
- *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 TMHP 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 Texas Medicaid, the Provider Relations Department maintains a work relationship with these organizations. Also, the Provider Relations Department participates in several events sponsored by Texas health-care associations, such as conventions and conferences.

Call the TMHP Contact Center at 1-800-925-9126 for assistance.

A.12.5 TMHP Electronic Data Interchange (EDI) Help Desk

The TMHP EDI Help Desk assists Medicaid providers with EDI transactions. The TMHP EDI Help Desk is available at 1-888-863-3638 from 7 a.m. to 7 p.m., Central Time, Monday through Friday.

TMHP EDI Help Desk activities and responsibilities include, but are not limited to, the following:

- Enrolling providers for electronic billing
- Qualifying vendors for TMHP EDI production through testing
- Diagnosing claim transmission problems through research
- Consulting with provider billing personnel, billing services, and software vendors regarding TMHP EDI

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TMHP EDI Help Desk staff assists with questions about TMHP EDI, TexMedConnect, and electronic transmissions at 1-888-863-3638.

Providers who employ hardware or software vendors should contact those vendors for the resolution of technical problems.

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Appendix B: Vendor Drug Program

Texas Medicaid Provider Procedures Manual: Vol. 1

April 2016

TEXAS
Health and Human
Services Commission

APPENDIX B: VENDOR DRUG PROGRAM

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B.1 Vendor Drug Program

The Texas Medicaid Vendor Drug Program (VDP) makes payment for prescriptions of covered outpatient drugs to those pharmacy providers contracted with the VDP. In-state pharmacies licensed as Class A or C by the Texas State Board of Pharmacy are eligible for enrollment in the VDP. Out-of-state pharmacies and pharmacies holding any other class of pharmacy license are considered for inclusion in the program on a case-by-case basis, relative to the benefits made available to a client eligible for Texas Medicaid. Contracts are not granted to applicants unless additional benefits to the recipient are established.

VDP provides statewide access to prescription drugs as prescribed by treating physician or other health-care provider for clients eligible for:

- Medicaid fee-for-service
- Children with Special Health Care Needs (CSHCN) Services Program
- Kidney Health Care (KHC)
- Texas Women's Health Program (TWHP)

VDP manages drug formulary for Children's Health Insurance Program (CHIP).

VDP remains responsible as claims processor for Medicaid fee-for-service (FFS) clients and management of Medicaid drug formulary and preferred drug list.

Note: *Pharmacy services rendered to Medicaid managed care clients are administered by the clients' managed care organizations (MCOs).*

Refer to: *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*) for additional information about managed care prescription drug and pharmacy benefits.

B.1.1 VDP Benefits for Medicaid Fee-for-Service (FFS) Clients

The Medicaid drug benefit for Medicaid FFS clients is limited to three prescriptions per month with the following exceptions that have unlimited prescriptions:

- Clients enrolled in waiver programs such as Community Living Assistance (CLASS) and Community-Based Alternatives (CBA)
- Texas Health Steps (THSteps)-eligible clients (clients who are 20 years of age and younger)
- Clients in skilled nursing facilities

Note: *Prescriptions for family planning drugs and supplies are not subject to the three-prescription limit.*

The following categories of drugs do not count against the three prescription per month limit:

- Family planning drugs and supplies
- Smoking cessation drugs
- Insulin syringes

FFS clients can be "locked-in" to a specific pharmacy. FFS clients who are "locked-in" to a primary care pharmacy have "Lock-in" printed on their Your Texas Benefits Medicaid card. Clients who are not "locked-in" to a specific pharmacy may obtain their drugs or supplies from any contracted Medicaid provider of pharmaceutical services.

Refer to: Subsection 4.4.2, "Client Lock-in Program" in Section 4, "Client Eligibility" (*Vol. 1, General Information*) for more information about lock-in limitations.

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Family planning services are excluded from lock-in limitation. Though TMHP reimburses family planning agencies and physicians for family planning drugs and supplies, the following family planning drugs and supplies are also available through the VDP and are not subject to the three-prescription limit:

- Oral contraceptives
- Long-acting injectable contraceptives
- Vaginal ring
- Hormone patch
- Certain drugs used to treat sexually transmitted diseases (STDs)

Refer to: The "Product Search" at the VDP website at www.txvendordrug.com/formulary/index.asp for more information.

The VDP does not reimburse claims for nutritional products (enteral or parenteral), medical supplies, or equipment other than limited home health supplies (LHHS).

B.1.2 Pharmacy Delivery Method for Physician-Administered Drugs

Providers administering physician-administered drugs in an outpatient setting for Medicaid fee-for-service (FFS) and Medicaid Managed Care Organization (MCO) clients can send a prescription to a pharmacy and wait for the drug to be shipped or mailed to their office. This delivery method is called "white-bagging."

Providers should use the following steps for this delivery method:

1) The treating provider identifies a Medicaid-enrolled client.
2) The treating provider or treating provider's agent sends a prescription to a Texas Medicaid-enrolled pharmacy and obtains any necessary prior authorizations.
3) If any prior authorization is approved, the dispensing pharmacy fills the prescription and overnight ships an individual dose of the medication, in the name of the Medicaid client, directly to the treating provider.
4) The treating provider administers the medication to the Medicaid client in the office setting. The provider bills for an administration fee and any medically necessary service provided at time of administration. The provider should not bill Medicaid for the drug.

The pharmacy contacts the provider each month, prior to dispensing any refills, to ensure that the patient was administered all previously dispensed medication. Auto-refills are not allowed.

These medications cannot be used on any other patient and cannot be returned to the pharmacy for credit.

Note: *Physicians who use this delivery method will not have to buy the physician-administered drug, therefore, the physician is allowed to administer the drug and should only bill for the administration of the drug.*

B.1.3 VDP Formulary Information

VDP drug formulary information is available to health-care providers to help their clients efficiently get their medications. Information includes which state health-care program covers the drug, whether a drug is on the Medicaid Preferred Drug List (PDL), whether a Medicaid non-preferred prior authorization or clinical prior authorization is required, and other important drug information. VDP drug formulary information is available:

- Online at www.txvendordrug.com (All state health-care program formulary information with prior authorization type (PDL or clinical) required indicator)

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- Online at www.txvendordrug.com/formulary/enhanced-form-search.shtml. Here providers can find Medicaid drug formulary and PDL information with links attached to selected non-preferred drugs that will guide providers to the preferred drugs in that therapeutic class.
- Providers are eligible to register for Epocrates, which is a free drug information service that can be downloaded to the provider's mobile device. In addition to listing a drug's preferred status, Epocrates includes drug monographs, dosing information, and warnings. For more information, go to www.epocrates.com.

B.1.4 Obtaining Outpatient Prescribed Drug Prior Authorization for FFS Clients

To obtain prior authorization for any VDP medication for FFS clients, prescribing providers or their representatives should call the Texas Prior Authorization Hotline at 1-877-PA-TEXAS (1-877-728-3927). The Hotline is available Monday through Friday, 7:30 a.m. to 6:30 p.m. Central Time. To submit an online VDP prior authorization request for non-preferred drugs, prescribing providers must first register online at https://paxpress.txpa.hidinc.com. For Synagis prior authorization, see subsection B.3, "Palivizumab (Synagis) Available Through the VDP" in this appendix.

Note: *Pharmacists cannot obtain prior authorization for medications. If the client arrives at the pharmacy without prior authorization for a non-preferred drug, the pharmacist will alert the provider's office and ask the provider to get prior authorization.*

B.1.5 Dispensing Life of Prescriptions

Medicaid prescriptions for noncontrolled substances are valid for one year from the date written and up to 11 refills if authorized by prescriber.

Medicaid prescriptions for controlled substances in drug classes C3-C5 are valid for six months from the date written and up to 5 refills if authorized by prescriber provider. Controlled substance prescriptions written by Advanced Practice Registered Nurses and Physicians Assistants are valid for 90 days.

Medicaid prescriptions controlled substances in C2 drug class have no refills and must be dispensed within 21 days of the date on which the prescription was written.

Refer to: VDP *Pharmacy Provider Procedure Manual* at www.txvendordrug.com/about/policy/index.shtml.

Texas State Board of Pharmacy website at www.tsbp.state.tx.us/rules/for rules about issuance of identical sets of C2 prescriptions.

B.1.6 National Drug Code (NDC)

All Texas Medicaid providers must submit a rebateable NDC for professional or outpatient claims submitted to TMHP with a physician-administered prescription drug procedure code.

The NDC is an 11-digit number on the package or container from which the medication is administered. Providers must enter modifier N4 before the NDC code. The NDC unit and the NDC unit of measure must be entered on all professional or outpatient claims that are submitted to TMHP.

Note: *Procedure codes in the A-code series do not require an NDC on claims that are submitted to TMHP.*

A list of drugs that require an NDC for Texas Medicaid reimbursement is available on the TMHP website at www.tmhp.com under the Topics section. Physician-administered drugs that do not have a rebateable NDC will not be reimbursed by Texas Medicaid.

Refer to: Subsection 6.3.4, "National Drug Code (NDC)" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for additional information on claims filing using NDC.

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B.1.7 VDP Contact Information

Vendor Drug Program	Telephone Number
Pharmacy Benefits Access: for questions about outpatient drug and billing (the 800 number is for pharmacy use only and can be used to reach anyone in VDP).	1-800-435-4165
Pharmacy enrollment	1-512-462-6317
Program management	1-512-707-6119
Policy	1-512-707-6108
Drug formulary (Texas listing of national drug codes)	1-512-462-6390
Texas Prior Authorization Center Hotline	1-877-728-3927

B.1.8 72-Hour Emergency Supply

Federal and Texas law allows for a 72-hour emergency supply of a prescribed drug to be provided when a medication is needed without delay and prior authorization is not available. This rule applies to non-preferred drugs on the Preferred Drug List (PDL) and any drug that is affected by a clinical prior authorization edit and needs the prescriber's prior approval. Some preferred drugs on the Medicaid formulary may also be subject to clinical edits that require additional prior authorization. Drugs not on the PDL may also be subject to clinical edits.

Refer to: VDP Pharmacy Provider Procedure Manual at www.txvendordrug.com/about/policy/index.shtml.

B.1.9 Cost Avoidance Coordination of Benefits

Cost avoidance coordination of benefits (COB) for pharmacy claims ensures compliance with the Centers for Medicare & Medicaid Services (CMS) regulations. Under federal rules, Medicaid agencies must be the payer of last resort. The cost avoidance model checks for other known insurance at the point of sale, preventing Medicaid from paying a claim until the pharmacy attempts to obtain payment from the client's third party insurance.

Refer to: VDP *Pharmacy Provider Procedure Manual* at txvendordrug.com/downloads/index.asp.

B.1.10 Schedule II Controlled Substances (CII) through Schedule V Controlled Substances (CV)

Pharmacies must report all CIII, CIV, and CV prescriptions to the Texas Department of Public Safety (DPS) in addition to the CII prescriptions that are already being reported. This DPS process requires reporting by the DPS registration number of the practitioner issuing the prescription. The prescription forms for Schedule CII controlled substances that are issued by the Texas Department of Public Safety (DPS) under the Texas Prescription Program meet the baseline standards set forth above.

Refer to: The DPS website at www.txdps.state.tx.us/RSD/ControlledSubstances/index.htm.

B.1.11 Tamper-Resistant Prescription Pads

Providers are required by federal law (Public Law 110-28) to use a tamper-resistant prescription pad when writing a prescription for any drug for Medicaid clients. Pharmacies are required to ensure that all written Medicaid prescriptions submitted for payment to the VDP were written on a compliant tamper resistant pad.

CMS has stated that special copy-resistant paper is not a requirement for electronic medical records (EMRs) or ePrescribing-generated prescriptions. These prescriptions may be printed on plain paper and will be fully compliant if they contain at least one feature from each of the following three categories:

- Prevents unauthorized copying of completed or blank prescription forms
- Prevents erasure or modification of information written on the prescription form

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- Prevents the use of counterfeit prescription forms

Two features that can be incorporated into computer-generated prescriptions printed on plain paper to prevent passing a copied prescription as an original prescription are as follows:

- Use a very small font that is readable when viewed at 5x magnification or greater and illegible when copied.
- Use a "void" pantograph accompanied by a reverse "Rx," which causes a word such as "Void" to appear when the prescription is photocopied.

Refer to: *VDP Pharmacy Provider Procedure Manual*
www.txvendordrug.com/about/policy/index.shtml.

B.1.12 Requirements for Early Refills of Certain Drugs

Medicaid fee-for-service and the Children with Special Health Care Needs (CSHCN) Services Program clients must exhaust 90 percent of the prescribed of certain controlled substances, including tramadol, before a Medicaid Vendor Drug Program (VDP)- enrolled pharmacy may refill a prescription or fill a new prescription for the same drug.

Note: *Some drugs, such as attention deficit hyperactivity disorder drugs and certain seizure medications, are excluded from this change.*

The 90% Utilization Drug List, which contains a complete list of the affected drugs, is available in the Downloads section of the VDP website at www.txvendordrug.com.

Justifications for early refills include, but are not limited to, the following:

- A verifiable dosage increase
- An anticipated prolonged absence from the state

If a client requests an early refill of a drug on the VDP list, the dispensing pharmacy must contact the VDP Pharmacy Resolution help desk to request an override of the early refill restriction. Prescribing providers may be asked to verify the reason for the early refill by the dispensing pharmacy or VDP staff.

Note: *Providers who are members of Medicaid managed care plans should contact the appropriate managed care organization (MCO) and/or Pharmacy Benefit Manager for specific requirements and processes related to dispensing early refills.*

B.1.13 Free Delivery of Medicaid Prescriptions for FFS Clients

Many Medicaid pharmacies across the state offer free delivery of prescriptions to Medicaid FFS clients. To find out which pharmacies offer home delivery, refer FFS clients to the HHSC website at www.txvendordrug.com/delivery-pharmacies.pdf. Contracted Medicaid pharmacy providers are reimbursed a delivery fee that is included in the medication dispensing fee formula. The delivery fee is paid to HHSC-approved pharmacy providers that have certified that delivery services meet minimum conditions for payment of the delivery fee.

The conditions include:

- Making deliveries to individuals rather than to institutions, such as nursing homes.
- Offering no-charge prescription delivery to all Medicaid clients who request it in the same manner as to the general public.
- Displaying publicly the availability of prescription delivery services at no charge in a prominent place in the pharmacy store (window or door).
- Providing the delivery service without requiring retention of the Your Texas Benefits Medicaid card.

This delivery fee is not applicable for mail-order prescriptions and not available for over-the-counter drugs.

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For more information, call the Vendor Drug Pharmacy Benefits Access Help Desk at 1-800-435-4165 and ask for Pharmacy Contracts.

B.1.14 Delivery of Medicaid Prescriptions for MCO Clients

Medicaid and CHIP MCOs pay local pharmacies to deliver pharmaceuticals to clients. Each MCO develops its own participating pharmacy network for this delivery service. Pharmacies that are interested in receiving payment for the delivery of pharmaceuticals to MCO clients should contact their MCOs to request information on how to apply.

The VDP website at www.txvendordrug.com/managed-care/ has several managed care resources:

- The Pharmacy Enrollment Chart at www.txvendordrug.com/managed-care/downloads/pharmacy-enrollment-chart.pdf includes the pharmacy contract telephone number for each MCO.
- The Prescriber Assistance Chart at www.txvendordrug.com/managed-care/downloads/prescriber-assistance-chart.pdf includes the pharmacy prior authorization call center telephone numbers for each health plan.

B.1.15 Pharmacies Can Dispense Limited Home Health Supplies (LHHS) to Medicaid Clients

Pharmacies that are enrolled with VDP can dispense LHHS that are commonly found in a pharmacy to fee-for-service Medicaid clients. Pharmacies can also dispense LHHS to clients who are enrolled in a Medicaid MCO if the pharmacy is enrolled in the client's MCO.

The home health supplies that can be dispensed include the following:

- Diabetic insulin syringe with needle 1 cc or less
- Diabetic insulin needles
- Diabetic blood glucose test strips
- Diabetic lancets
- Spring-powered device for lancet
- Home glucose disposable monitor (includes test strips)
- Talking diabetic blood glucose monitors
- Aerosol holding chamber
- Oral electrolytes
- Hypertonic saline solution

Claims are subject to post-payment desk reviews to ensure claims from durable medical equipment (DME) providers and pharmacies do not result in either a client who exceeds the maximum quantity or a duplicate payment from HHSC for the same client and LHHS.

More information about the provision of these supplies through a fee-for-service pharmacy can be found on the VDP website at www.txvendordrug.com/formulary/limited-hhs.shtml.

Providers should contact the appropriate MCO or pharmacy benefit manager for more information about providing these supplies to Medicaid clients who are enrolled in a Medicaid managed care plan.

B.1.16 Vitamin and Mineral Products

Pharmacies that are contracted with VDP can dispense some vitamin and mineral products to Texas Medicaid fee-for-service clients who are 20 years of age and younger. Pharmacies can also dispense these covered vitamin and minerals products to clients who are enrolled in a Medicaid MCO, if the pharmacy is enrolled in client's MCO.

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VDP-contracted pharmacies can honor a physician's prescription for covered vitamins and minerals. To help expedite pharmacy claim processing, prescribing providers are encouraged to include the diagnosis on the prescription.

VDP-contracted pharmacies are required to be enrolled with TMHP or have a CCP Prior Authorization Request Form to fill a prescription unless they intend to submit claims to TMHP instead of VDP.

VDP-contracted pharmacies that are not enrolled with TMHP may submit claims for vitamin or mineral products to VDP.

Claims are subject to post-payment desk reviews to ensure claims from DME providers and pharmacies do not result in duplicate payments for the same client or vitamin and mineral and to validate that prescribed products are appropriate for the client's medical condition.

More information about the provision of these products and list of products for fee-for-service clients can be found on the VDP website at http://txvendordrug.com/formulary/index.shtml.

B.2 Medicaid Children's Services Comprehensive Care Program (CCP) Available for Children and Adolescents

Medically necessary drugs and supplies that are not covered by the VDP may be available to children and adolescents (birth through 20 years of age) through the CCP (i.e., some over the counter drugs, nutritional products, diapers, and disposable or expendable medical supplies).

The Prior Authorization fax number is 1-512-514-4212.

Refer to: Subsection 2.6.1.1, "Pharmacies (CCP)" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about pharmacy enrollment in CCP.

B.3 Palivizumab (Synagis) Available Through the VDP

Palivizumab is available to physicians for administering to Medicaid clients only through the VDP. This option enables physicians to have palivizumab shipped directly to their office from a network pharmacy. Physicians will not need to purchase the drug. Physicians who obtain palivizumab through the VDP may not submit claims to Medicaid (TMHP) for the drug.

The administering provider may submit a claim to TMHP for an injection administration fee and any medically necessary office-based evaluation and management service provided at time of injection.

For more information, refer to the HHSC Vendor Drug Synagis Program page at www.txvendordrug.com/dur/synagis.shtml.

B.3.1 Participating Palivizumab Distribution Pharmacies

For a list of participating pharmacies, refer to the HHSC Vendor Drug website at www.txvendordrug.com/pa/rsv/2015/.

Palivizumab forms are updated every year. Providers must use the most current version of the forms to submit prior authorization requests.

The Texas Medicaid/CHIP Vendor Drug Program Fee-For-Service Medicaid Synagis® Request Form for 2015-16 Season is required when the prescribing provider obtains the drug through VDP.

Note: *Palivizumab is also be available to Children with Special Health Care Needs (CSHCN) Services Program clients. Providers can refer to the CSHCN Services Program Provider Manual for details.*

Refer to: Texas Medicaid/CHIP Vendor Drug Program Fee-For-Service Medicaid Synagis® Request Form on the VDP website.

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Appendix C: HIV/AIDS

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APPENDIX C: HIV/AIDS

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C.1 CDC Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings

The revised Centers for Disease Control and Prevention (CDC) recommendations advocate routine voluntary human immunodeficiency virus (HIV) screening as a normal part of medical practice, similar to screening for other treatable conditions. Screening is a basic public health tool used to identify unrecognized health conditions so treatment can be offered before symptoms develop and, for communicable diseases, so interventions can be implemented to reduce the likelihood of continued transmission. HIV screening should be offered as an opt-out test in accordance with CDC testing guidelines, which may be viewed at www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm.

C.1.1 Routine HIV Testing Procedure Codes

The following table lists the procedure codes for routine HIV testing and the corresponding modifiers that must be submitted for rapid testing. Routine HIV testing is covered as a preventative or screening benefit. Medical necessity is not required.

Procedure Code	Rapid Test Modifier
86689	
86701	92
86702	92
86703	92
87389	92
87390	
87534	
87535	
87536	
99211	
99212	
99213	
99214	
99215	
99385	
99386	
99395	
99396	

C.2 Model Workplace Guidelines for Businesses, State Agencies, and State Contractors

C.2.1 Purpose

The purpose of this policy is to protect the employment rights and privileges of individuals infected with HIV and acquired immunodeficiency syndrome (AIDS) through compliance with federal, state, and local laws. This policy will provide Texas employers, especially state agencies, with a uniform approach to developing policies and education programs that address HIV/AIDS in the workplace. The Department of State Health Services (DSHS) encourages all employers to establish workplace policies

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concerning persons with HIV/AIDS. Employers can adapt this model to fit the particular needs of their organization, work force, and clients; however, the content and intent must remain consistent with this document and the Health and Safety Code (HSC).

C.2.2 Authority

Governance for this policy is found in Vernon's Texas Codes Annotated, HSC §85.010, "Educational Course for Employees and Clients of Health Care Facilities"; §85.111, "Education of State Employees"; §85.112, "Workplace Guidelines"; and §85.113, "Workplace Guidelines for State Contractors."

The model workplace guidelines, developed by the DSHS HIV/Sexually Transmitted Disease (STD) Comprehensive Services Branch, as required by HSC §85.012, "Model Workplace Guidelines," and adopted as HIV/STD Policy No. 090.021, are considered the minimum standards for the development of guidelines for state agencies. This policy also serves as the minimum standard for contractors of certain designated state agencies and organizations funded by those state agencies (HSC §85.113).

Refer to: Subsection C.2.7, "State Agencies Listed Under Health and Safety Code (HSC) §85.113" in this appendix.

These guidelines are also the standard for health-care facilities licensed by DSHS and the Department of Aging and Disability Services (DADS) as stated in HSC §85.010, "Educational Course for Employees and Clients of Health Care Facilities."

C.2.3 Who Must Use Workplace Guidelines

C.2.3.1 State Agencies

State law requires that each state agency adopt and carry out workplace guidelines. The agency's workplace guidelines should incorporate, at a minimum, the DSHS model workplace guidelines in this policy.

C.2.3.2 State Contractors

A program that involves direct client contact and that contracts with or is funded by any of the state agencies listed in subsection C.2.7, "State Agencies Listed Under Health and Safety Code (HSC) §85.113" in this appendix will adopt and carry out workplace guidelines as stated in HSC §85.113.

C.2.4 Why Have Guidelines

Employers should develop and carry out policies and education programs concerning potentially limiting medical conditions before a crisis arises. Such policies and education programs help reduce employees' fears and misconceptions about HIV/AIDS and help to:

- Provide current and accurate scientific evidence that people with HIV infection do not pose a risk of transmitting the virus to coworkers through ordinary workplace contact.
- Provide workers with current information about HIV risk reduction for employees and their families.
- Avoid conflict between the infected employee and the employer regarding discrimination or other employment issues.
- Prevent work disruption and rejection of the infected employee by coworkers.
- Inform employees that they have rights regarding work continuation, confidentiality of medical and insurance records, and general health and safety.
- Provide specific and ongoing education and equipment to employees in health-care settings who are at risk of exposure to HIV, and to assure that appropriate infection-control procedures are used.
- Reduce the financial impact, legal implications, and other possible effects of HIV/AIDS in the workplace.

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C.2.5 Development of Workplace Policy Content

Individuals infected with HIV have the same rights and opportunities as other individuals. While some employers prefer a policy specific to HIV/AIDS and its unique issues, others prefer a general policy concerning illnesses and disabilities. A general policy should address HIV/AIDS in the same way as other major illnesses. Use of the following statements in agency policy is encouraged:

- Use of a person's HIV status to decide employment status, service delivery, or to deny services to HIV-infected individuals is not acceptable. Employees who believe that they have been discriminated against because of HIV or AIDS should contact the personnel office to discuss the matter, or initiate action through the agency's grievance procedure. Other legal options may also be available.
- This policy is consistent with current information from public health authorities, such as the CDC of the U.S. Public Health Service, and with state and federal laws and regulations.

While the approach and resolution of each employee's situation may vary, similar issues may arise. A workplace policy should address the following issues about HIV/AIDS and other life-threatening illnesses or disabilities:

- *Discrimination.* The Americans with Disabilities Act of 1990 prohibits discrimination against people with disabilities, which includes HIV and AIDS, in employment, public accommodations, public transportation, and other situations.
  A specific policy statement that no one will be denied employment or employment opportunities because of a disability, satisfies the employer and employee's need to address discrimination. Such a statement might be, "This agency complies with the Americans with Disabilities Act protections of all people with disabilities against discrimination in job application procedures, hiring, promotions, discharge, compensation, job training, and other terms or conditions of employment." Managers may want to define ways in which they will deal with discriminatory actions.
- *Desire and Ability to Work.* A workplace policy should address the infected employee's desire and need to work and the infected employee's value to the workplace. Such a statement reassures employees that the employer supports them.
  The health status of someone with HIV may vary from healthy to critically ill. In the work setting, the ultimate concern is whether or not the employee can satisfy job expectations. A policy statement may say, for example, "Procedures may be adapted to provide reasonable accommodation so that people with disabilities may remain employed and productive for as long as possible. All employees, however, are expected to perform the essential functions of their job with or without reasonable accommodation."
- *Performance Standards.* The Americans with Disabilities Act provides protections for disabled persons *qualified* to perform their jobs. And although an employer may be expected to provide reasonable accommodation to a disabled employee or applicant; employers may terminate employees and refuse to hire individuals who cannot perform the essential functions of the job, with or without the reasonable accommodation.
  One suggested statement is, "While the Americans with Disabilities Act does protect disabled employees from employment discrimination, all employees, those with and without disabilities, have the same performance and conduct standards regarding hiring, promotion, transfer, and dismissal."
- *Reasonable Accommodation.* The Americans with Disabilities Act requires employers to provide reasonable accommodations for employees with disabilities. Employers do not have an obligation to provide any accommodation that imposes an undue hardship on the employer. Specific questions about the issue of reasonable accommodation and undue hardship should be directed to staff responsible for coordinating the requirements of the Americans with Disabilities Act.
  Such a policy statement might read, "The following options may be considered for people with HIV/AIDS: possible assignment or reassignment of job duties, working at home, leaves of absence, and flexible work schedules."

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- *Confidentiality and Privacy.* Organizations that receive funds from a state agency for residential or direct client services or programs shall develop and use confidentiality guidelines to protect their clients' HIV/AIDS-related medical information (HSC §85.115, "Confidentiality Guidelines"). Organizations that fail to adopt and use confidentiality guidelines are ineligible to receive state funds.
  Employees are not required to reveal their HIV status to employers. All medical information that an HIV-infected employee provides to medical or management personnel is confidential and private. Employers may not reveal this information without the employee's knowledge and written consent, except as provided by law (HSC §81.103, "Confidentiality; Criminal Penalty").
  A suggested policy statement might be, "This agency will protect the confidentiality of employee medical records and information. Written consent of the employee must be obtained to share any confidential information with other staff. Those with access to confidential information must maintain strict confidentiality and privacy, separating this information from employees' personnel records. Individuals who fail to protect these employee rights commit a serious offense, which may be cause for litigation resulting in both civil and criminal penalties, and may result in dismissal."
- *Coworker Concerns.* Employers need to be aware of the concerns that coworkers may have about an HIV-infected coworker. A policy statement that acknowledges employee concerns and offers HIV/AIDS education helps to increase awareness and decrease fear. Equally important is a policy statement that clarifies the limits of an employer's response to coworker concerns, e.g., "Employees do not have the right to refuse to work with someone who has any disability."
- *Employee Education.* Any health-care facility licensed by DSHS or DADS must require its employees to complete an educational course about HIV infection (HSC §85.010). A suggested policy statement may be: "All employees will receive education about methods of transmission and prevention of HIV infection and related conditions." In response to HSC, §85.004, "Educational Programs," DSHS developed model education program guidelines. These are available from DSHS, HIV/STD Comprehensive Services Branch, 1100 W. 49th St., Austin, TX. 78756-3199, 1-512-533-3000. Employers may also find the CDC's educational kit, *Business Responds to AIDS*, useful in developing educational courses. HIV/AIDS education should address employee concerns about HIV communicability to themselves, their families, and coworkers. Experience shows that educated coworkers usually respond to persons with HIV/AIDS with support, rather than with fear and ostracism due to misconceptions.
  Education programs must stress that agency employees who provide direct client services may face occupational exposure to a client's blood, semen, vaginal secretions, or other body fluids that are considered to be high-risk for transmission of blood born pathogens, including HIV/AIDS. All individuals receiving direct services are clients and include individuals who are physically or mentally impaired and individuals confined to correctional or residential facilities. All state agencies should have, as part of their employee education program, comprehensive policies and protocols based on universal precautions, body substance isolation, and barrier methods. These precautions prevent the spread of infection in clinical settings. The employer's careful planning will reflect a commitment to the health and well-being of the work force and the community being served.
- *Assistance.* Some employers have designated benefits programs available to employees and family members with HIV infection. Such programs may:
  - Make referrals for testing, counseling, medical, and psychosocial services.
  - Provide HIV/AIDS workplace training for managerial staff.
  - Serve as a liaison between management and the employer's clinical and occupational health programs.
  - Provide counseling for employees who irrationally fear coworkers or clients.

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Employers who have no employee assistance program may consider working with other organizations that provide assistance. Some of these groups include local health departments, AIDS services organizations, American Red Cross chapters, community support groups, clinical treatment and counseling services, and the religious community.

A suggested policy statement might be: "An employee who wants assistance concerning a disability or a life-threatening illness should contact the Personnel Office. This agency offers the following resources to help employees and managers deal with these issues: education and information concerning HIV/AIDS; confidential referral to supportive services for employees and dependents affected by life-threatening illnesses; and benefits consultation to help employees effectively manage health, leave, and other benefits."

C.2.6 Where to Go for Help

Employees may call 2-1-1 for HIV/STD testing locations in Texas. For questions related to issues such as transmission, signs and symptoms, or other concerns about HIV or other sexually transmitted infections, employees may call 1-800-CDC-INFO (English/Español) or 1-888-232-6348 (TTY).

C.2.7 State Agencies Listed Under *Health and Safety Code* (HSC) §85.113

HSC §85.113, "Workplace Guidelines for State Contractors" states "An entity that contracts with or is funded by… to operate a program involving direct client contact shall adopt and implement workplace guidelines similar to the guidelines adopted by the agency that funds or contracts with the entity." H.B. 2292, 78th Leg., abolished 10 of the 12 existing health and human services agencies and transferred their powers and duties to three new state agencies and to HHSC, which rendered the state agency list found in HSC §85.113 obsolete. The list below reflects the state agency consolidation brought about by H.B. 2292 and identifies the state agencies to which HSC §85.113 applies.

- DADS
- Department of Assistive and Rehabilitative Services (DARS)
- DSHS
- Health and Human Services Commission (HHSC)
- Texas Department of Criminal Justice
- Texas Juvenile Probation Commission
- Texas Youth Commission

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Appendix D: Acronym Dictionary

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D.1 Appendix D: Acronym Dictionary

Term	Definition
A/EEG	Ambulatory Electroencephalogram
AAFP	American Academy of Family Physicians
AAP	American Academy of Pediatrics
AAPD	American Academy of Pediatric Dentistry
ABMG	American Board of Medical Geneticists
ABR	Auditory Brainstem Response
ACA	Affordable Care Act of 2010
ACD	Augmentative Communication Device
ACH	Automated Clearinghouse
ACIP	Advisory Committee on Immunization Practices
ADA	American Dental Association
ADL	Activity of Daily Living
AFP	Abdominal Flat Plates
AHA	American Heart Association
AHI	Apnea/Hypopnea Index
AI	Auditory Impairment
AIDS	Acquired Immunodeficiency Syndrome
AIS	Automated Inquiry System
ALS	Advanced Life Support
AMA	American Medical Association
ANSI	American National Standards Institute
API	Atypical Provider Identifier
APRN	Advanced Practice Registered Nurse
ARD	Admission, Review, and Dismissal
ASA	American Society of Anesthesiologists
ASC	Ambulatory Surgical Center
ASHA	American Speech-Language-Hearing Association
ASL	American Sign Language
ASP	Average Sales Price
AWP	Average Wholesale Price
BCCS	Breast and Cervical Cancer Services
BCG	Bacillus Calmette-Guérin
BCVDDP	Blind Children's Vocational Discovery and Development Program
BHO	Behavioral Health Organization
BICROS	Bilateral Contralateral Routing of Offside Signal
BIDS	Border Infectious Disease Surveillance
BiPAP	Bi-level Positive Airway Pressure
BLL	Blood Lead Level
BLS	Basic Life Support

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Term	Definition
BMI	Body Mass Index
BMT	Bone Marrow Transplantation
BON	(Texas) Board of Nursing
BPH	Benign Prostatic Hyperplasia
BRC	Bureau of Radiation Control
BUN	Blood Urea Nitrogen
BVIC	Blind and Visually Impaired Children
BVS	Bureau of Vital Statistics
C21	Compass21
CAH	Critical Access Hospital
CAPD	Continuous Ambulatory Peritoneal Dialysis
CBA	Community-Based Alternatives (Program)
CBC	Complete Blood Count
CBO	Community Based Organization
CCIP	Comprehensive Care Inpatient Psychiatric (Unit)
CCP	Comprehensive Care Program
CCPD	Continuous Cycling Peritoneal Dialysis
CDC	Centers for Disease Control and Prevention
CDT	Current Dental Terminology
CDTF	Chemical Dependency Treatment Facility
CFR	*Code of Federal Regulations*
CHC	Comprehensive Health Centers
CHIP	Children's Health Insurance Program
CIHCP	County Indigent Health Care Program
CLASS	Community Living Assistance and Support Services
CLIA	*Clinical Laboratory Improvement Amendments*
CLPPP	Childhood Lead Poisoning Prevention Program
CMS	Centers for Medicare & Medicaid Services
CMT	Chiropractic Manipulative Treatment
CNM	Certified Nurse-Midwife
CNS	Clinical Nurse Specialist
COP	Condition of Participation
COPD	Chronic Obstructive Pulmonary Disease
CORF	Comprehensive Outpatient Rehabilitation Facility
COTA	Certified Occupational Therapist Assistant
CPAP	Continuous Positive Airway Pressure
CPM	Continuous Passive Motion
CPR	Cardiopulmonary Resuscitation
CPT	Current Procedural Terminology
CRCP	Certified Respiratory Care Practitioner

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Term	Definition
CRF	Chronic Renal Failure
CRNA	Certified Registered Nurse Anesthetist
CSF	Colony Stimulating Factor
CSHCN	Children with Special Health Care Needs (Services Program)
CSI	Claim Status Inquiry
CT	Computed Tomography
DADS	Department of Aging and Disability Services
DARS	Department of Assistive and Rehabilitative Services
dB	Decibel
DBS	Division for Blind Services
DC	Doctor of Chiropractic Medicine
DCN	Dorsal Column Neurostimulator
DDS	Doctor of Dental Surgery
DEA	Drug Enforcement Agency
DEFRA	*Deficit Reduction Act* (of 1984)
DFPS	Department of Family and Protective Services
DMD	Doctor of Medical Dentistry
DME	Durable Medical Equipment
DMERC	Durable Medical Equipment Regional Carrier
DNA	Deoxyribonucleic Acid
DO	Doctor of Osteopathy
DOB	Date of Birth
DOC	Dynamic Orthotic Cranioplasty
DOS	Date of Service
DOT	Directly Observed Therapy
DPC	Diagnostic Procedure Code
DPM	Doctor of Podiatric Medicine
DRG	Diagnosis-Related Group
DSHS	(Texas) Department of State Health Services
DSM-IV-TR	*Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision
DTaP	Diptheria and Tetanus Toxoids and Acellular Pertussis Vaccine
E/M	Evaluation and Management (Services)
EBLL	Elevated Blood Lead Level
ECC	Early Childhood Caries
ECF	Extended Care Facility
ECG	Electrocardiogram
ECI	Early Childhood Intervention
ECMO	Extracorporeal Membrane Oxygenation
EDC	Estimated Date of Confinement

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Term	Definition
EDD	Expected Date of Delivery
EDI	Electronic Data Interchange
EEG	Electroencephalogram
EFT	Electronic Funds Transfer
EGD	Esophagogastroduodenoscopy
EIN	Employer Identification Number
EKG	Electrocardiogram
EMG	Electromyography
EMR	Electronic Medical Record
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
ENT	Ear, Nose, and Throat
EOB	Explanation of Benefits
EOG	Electro-Oculogram
EOPS	Explanation of Pending Status
EPO	Erythropoietin Alfa
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ER	Emergency Room
ER&S	Electronic Remittance and Status Report
ECT	Electroconvulsive Therapy
ERA	Estrogen Receptor Assay
ERCP	Endoscopic Retrograde Cholangiopancreatography
eSP™	eScreener Plus
ESRD	End Stage Renal Disease
FDA	(United States) Food and Drug Administration
FES	Functional Electrical Stimulation
FFP	Federal Financial Participation
FFS	Fee-for-Service
FFY	Federal Fiscal Year
FIUT	Fetal Intrauterine Transfusion
FOC	Frontal Occipital Circumference
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FQS	Federally Qualified Satellite
FY	Fiscal Year
FYE	Fiscal Year End
GAA	Alpha-Glucosidase
GAF	Global Assessment of Functioning
G-CSF	Granulocyte Colony Stimulating Factors
GM-CSF	Granulocyte-Macrophage Colony Stimulating Factor

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Term	Definition
GME	Graduate Medical Education
GNS	Gastric Neurostimulation
GYN	Gynecology/Gynecological
HASC	Hospital-based Ambulatory Surgical Center
H.B.	House Bill
HBOT	Hyperbaric Oxygen Therapy
HBsAG	Hepatitis B Surface Antigen
HBV	Hepatitis B Virus
HCPCS	Healthcare Common Procedure Coding System
HCS	Home and Community-Based Services
HDL	High Density Lipoproteins
HepA	Hepatitis A
HepB	Hepatitis B
HFCWCS	High-Frequency Chest Wall Compression System
HHA	Home Health Aide
HHS	(United States Department of) Health and Human Services
HHSC	(Texas) Health and Human Services Commission
HIC	Health Insurance Claim (Number)
HIPAA	*Health Insurance Portability and Accountability Act*
HIPP	Health Insurance Premium Payment
HIV	Human Immunodeficiency Virus
HLD	Handicapping Labio-Lingual Deviations
HNPCC	Hereditary Non-Polyposis Colorectal Cancer
HPV	Human Papillomavirus
HRC	*Texas Human Resource Code*
HRSA	Health and Human Services Health Resources and Services Administration
HSC	*Texas Health and Safety Code*
IADL	Instrumental Activity of Daily Living
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 (see also SNF and ECF)
ICF-IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
ICHP	Institute for Child Health Policy
ICN	Internal Control Number (in 24-digit Medicaid ICN)
ID	Identification
IDCU/TB	Infectious Disease Control Unit Tuberculosis Program
IDEA	*Individuals with Disabilities Education Act*
IEP	Individualized Education Plan

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Term	Definition
IFSP	Individualized Family Service Plan
IM	Intramuscular
IMD	Institution for Mental Diseases
ImmTrac	Immunization Tracking system
IOL	Intraocular Lens
IPD	Intermittent Peritoneal Dialysis
IPIA	*Improper Payments Information Act* (of 2002)
IPPB	Intermittent Positive-Pressure Breathing
IPV	Intrapulmonary Percussive Ventilation
IRF	Inpatient Rehabilitation Facility
IRS	Internal Revenue Service
ISD	Independent School District
ISP	Internet Service Provider
IUD	Intrauterine Device
IV	Intravenous
JCIH	Joint Committee on Infant Hearing
KUB	Kidneys, Ureters, Bladder
LAIV	Live, Attenuated Influenza Vaccine
LASIK	Laser-Assisted in Situ Keratomileusis
LCDC	Licensed Chemical Dependency Counselor
LCSW	Licensed Clinical Social Worker
LDL	Low Density Lipoprotein
LEA	Local Education Agency
LLC	Limited Liability Company
LMFT	Licensed Marriage and Family Therapist
LMP	Last Menstrual Period
LOS	Length of Stay
LPA	Licensed Psychological Associate
LPC	Licensed Professional Counselor
LPN	Licensed Practical Nurse
LPTA	Licensed Physical Therapist Assistant
LTC	Long Term Care
LTCH	Long Term Care Hospital
LVEF	Left-Ventricle Ejection Fraction
LVN	Licensed Vocational Nurse
LVRS	Lung Volume Reduction Surgery
MAC	Medical Access Card
MAO	Medical Assistance Only
MAST	Multiple Radioallergosorbent Test
MBCC	Medicaid for Breast and Cervical Cancer

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Term	Definition
MCO	Managed Care Organization
MCP	Monthly Capitation Payment
MD	Doctor of Medicine
MDCP	Medically Dependent Children Program
MFADS	Medicaid Fraud and Abuse Detection System
MFCU	Medicaid Fraud Control Unit
MH	Mental Health
MMPI	Minnesota Multiphasic Personality Inventory
MMWR	Morbidity and Mortality Weekly Report
MNC	Medically Needy Clearinghouse
MNP	Medically Needy Program
MPI	Medicaid Program Integrity
MQMB	Medicaid Qualified Medicare Beneficiary
MR	Mental Retardation
MR	Mentally Retarded
MRA	Magnetic Resonance Angiography
MRAN	Medicare Remittance Advice Notice
MRDA	Mental Retardation Diagnostic Assessment
MREP	Medicare Remit Easy Print
MRI	Magnetic Resonance Imaging
MRLA	Mental Retardation Local Authority
MRSA	Methicillin Resistant Staphylococcus Aureus
MRT	Magnetic Resonance Technology
MSAFP	Maternal Serum Alpha-Fetoprotein
MSC	Maternity Service Clinic
MSRP	Manufacturer's Suggested Retail Price
MTP	Medical Transportation Program
MUA	Medically Underserved Area
MUP	Medically Underserved Population
NBCCEDP	National Breast and Cervical Cancer Early Detection Program
NBS	Newborn Screen (Neonatal Screen)
NCCI	National Correct Coding Initiative
NCVIA	*National Childhood Vaccine Injury Act*
NDC	National Drug Code
NETT	National Emphysema Treatment Trial
NF	Nursing Facility
NG	Nasogastric
NMES	Neuromuscular Electrical Stimulation
NMDP	National Marrow Donor Program
NP	Nurse Practitioner

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Term	Definition
NPPES	National Plan and Provider Enumeration System
NPI	National Provider Identifier
NPR	Notice of Program Reimbursement
NSAID	Nonsteriodal Anti-inflammatory Drugs
NUCC	National Uniform Claim Committee
OAE	Otoacoustic Emissions
OB	Obstetrics
OB-GYN	Obstetric and Gynecology
OBRA	*Omnibus Budget Reconciliation Act*
OCR	Office of Civil Rights
OD	Doctor of Optometry
OI	Other Insurance
OIG	Office of Inspector General
OMB	Office of Management and Budget
OMT	Osteopathic Manipulation Treatment
OPT/SP	Outpatient Physical Therapy/Speech Pathology
OPTN	Organ Procurement and Transportation Network
ORF	Outpatient Rehabilitation Facility
OSHA	Occupational Safety and Health Administration
OT	Occupational Therapy, Occupational Therapist
OTC	Over the Counter
PA	Physician Assistant
PaCO2	Partial Pressure of Carbon Dioxide
PACT	Program for Amplification for Children of Texas (Hearing Aids/Services)
PAN	Prior Authorization Number
PaO2	Partial Pressure of Oxygen
PASRR (formerly PASARR)	Preadmission Screening and Annual Resident Review
PC	Personal Computer
PCCM	Primary Care Case Management (Program)
PCN	Patient Control Number
PCS	Personal Care Services
PDA	Personal Digital Assistant
PDF	Portable Document Format
PDL	Preferred Drug List
PDN	Private Duty Nursing
PE	Presumptive Eligibility
PENS	Percutaneous Electrical Nerve Stimulator
PERM	Payment Error Rate Measurement
PET	Positron Emission Tomography

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Term	Definition
PHC	Primary Home Care
PhD	Doctor of Philosophy
PIC	Provider Information Change
PIF	Provider Information Form
PIP	Personal Injury Protection
PKU	Phenylketonuria
P.L.	Public Law
PLP	Provisionally Licensed Psychologist
POC	Plan of Care
POS	Place of Service
PPO	Preferred Provider Organization
PPS	Prospective Payment System
PRK	Photorefractive Keratectomy
PRN	Pro Re Nata (As Needed)
PRO	Peer Review Organization
PT	Physical Therapy, Physical Therapist
PVC	Premature Ventricular Contractions
QA	Quality Assurance
QC	Quality Control
QCC	Qualified Credentialed Counselor
QMB	Qualified Medicare Beneficiary
R&S	Remittance and Status Report
RAST	Radioallergosorbent Test
RBRVS	Resource-Based Relative Value Scale
RDC	Renal Dialysis Center
RDI	Respiratory Disturbance Index
RGO	Reciprocating Gait Orthoses
RHC	Rural Health Clinic
RN	Registered Nurse
RR	Reference Range
RSDI	Retirement Survivors Disability Insurance
RSV	Respiratory Syncytial Virus
RV	Residual Volume
RVU	Relative Value Unit
SA	Service Area
S.B.	Senate Bill
SC	Subcutaneous
SCI	Spinal Cord Injury
SCHIP	State Children's Health Insurance Program
SDA	Standard Dollar Amount

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Term	Definition
SHARS	School Health and Related Services
SID	Surface Identification
SIMV	Synchronized Intermittent Mandatory Ventilation
SLIAG	State Legalization Impact Assistance Grant
SLP	Speech-Language Pathology
SMPA	Special Medical Prior Authorization
SNF	Skilled Nursing Facility (see also ICF and ECF)
SNS	Sacral Nerve Stimulator
SOC	Start of Care (concerning Home Health Services claims)
SQ	Subcutaneous
SRT	Speech Reception Threshold
SSA	Social Security Administration
SSI	Supplemental Security Income (Program)
SSL	Secure Socket Layer
SSN	Social Security Number
ST	Speech Therapy
STAR	State of Texas Access Reform (Program)
STD	Sexually Transmitted Disease
SVT	Supraventricular Tachycardia
TAC	*Texas Administrative Code*
TANF	Temporary Assistance for Needy Families
TB	Tuberculosis
TDD	Telecommunications Device for the Deaf
TEA	Texas Education Agency
TEFRA	*Tax Equity and Fiscal Responsibility Act* (of 1982)
TEHDI	Texas Early Hearing Detection and Intervention
TENS	Transcutaneous Electrical Nerve Stimulator
THKAO	Thoracic-Hip-Knee-Ankle Orthoses
THSteps	Texas Health Steps
TID	Tooth Identification Number
TIN	Tax Identification Number
TMHP	Texas Medicaid & Healthcare Partnership
TMPPM	Texas Medicaid Provider Procedures Manual
TMRM	Texas Medicaid Reimbursement Methodology
TMRP	Texas Medical Review Program
TNF	Tumor Necrosis Factor
TOB	Type of Bill
TOS	Type of Service
TP	Type Program
TPI	Texas Provider Identifier

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Term	Definition
TPL	Third Party Liability
TPN	Total Parenteral Nutrition
TPR	Third Party Resource
TSBDE	Texas State Board of Dental Examiners
TTY	Teletypewriter
TURP	Transurethral Resection of the Prostate
TVFC	Texas Vaccines for Children (Program)
TWHP	Texas Women's Health Program
TxHmL	Texas Home Living
UCB	University of California at Berkeley
UM	Utilization Management
UNOS	United Network for Organ Sharing
UR	Utilization Review
USC	*United States Code*
USDA	United States Department of Agriculture
VA	Veteran's Administration
VAERS	Vaccine Adverse Events Reporting System
VDP	Vendor Drug Program
VDRL	Venereal Disease Research Laboratory
VIS	Vaccine Information Statement
VNS	Vagal Nerve Stimulator
VPN	Virtual Private Network
VRE	Vancomycin-Resistant Enterococci
VSU	Vital Statistics Unit
WAIS-R	Wechsler Adult Intelligence Scale–Revised
WHP	Women's Health Program
WIC	Women, Infants, and Children (Program)

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Ambulance Services Handbook

Texas Medicaid Provider Procedures Manual: Vol. 2

April 2016

TEXAS
Health and Human
Services Commission

AMBULANCE SERVICES HANDBOOK

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1 General Information

The information in this handbook is intended for Texas Medicaid ambulance providers. The handbook provides information about Texas Medicaid's benefits, policies, and procedures applicable to emergency and nonemergency ambulance transports.

Important: *All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: Section 1: Provider Enrollment and Responsibilities (*Vol. 1, General Information*) for more information about enrollment procedures.

The *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 5.1.8, "Prior Authorization for Nonemergency Ambulance Transport" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for more information about nonemergency ambulance transport.

2 Ambulance Services

2.1 Enrollment

To enroll in Texas Medicaid, ambulance providers must operate according to the laws, regulations, and guidelines governing ambulance services under Medicare Part B; equip and operate under the appropriate rules, licensing, and regulations of the state in which they operate; acquire a license from the Texas Department of State Health Services (DSHS) approving equipment and training levels of the crew; and enroll in Medicare.

A hospital-operated ambulance provider must be enrolled as an ambulance provider and submit claims using the ambulance provider identifier, not the hospital provider identifier.

Refer to: Subsection 2.4.3, "Medicare and Medicaid Coverage" in this handbook.

Note: *Air ambulance providers are not required to enroll with Medicare.*

Reminder: *When ambulance providers enroll in Texas Medicaid, they accept Medicaid payment as payment in full. They cannot bill clients for Texas Medicaid-covered benefits.*

2.1.1 Subscription Plans

The Texas Insurance Code does not apply to ambulance providers who finance, in part or in whole, an ambulance service by subscription plan. DSHS's license requirements do not permit providers of membership or subscription programs to enroll Medicaid clients. Emergency Medical Services (EMS) Subscription Programs are regulated by the DSHS-EMS Compliance Group. An EMS provider must have specific approval to operate a subscription program.

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For more information, providers should contact the DSHS Office of EMS/Trauma Systems Coordination at 1-512-834-6700. A list of EMS office and contact information is available at www.dshs.state.tx.us/emstraumasystems/about.shtm.

2.2 Services, Benefits, Limitations, and Prior Authorization

Emergency and nonemergency ambulance transport services are a benefit of Texas Medicaid when the client meets the definition of emergency medical condition or meets the requirements for nonemergency transport.

Cardiopulmonary resuscitation (CPR) is included in ambulance transport when needed and is not a separately billable service. Claims for CPR during transport will be denied. If CPR is performed during a nonemergency transport, the advanced life support (ALS) procedure code must be billed.

Reimbursement for disposable supplies is separate from the established global fee for ambulance transports and is limited to one billable code per trip.

Providers must calculate the number of miles traveled by using the ambulance vehicle odometer reading or an Internet mapping tool. Mileage reported on the claim must be the actual number of miles traveled.

Claims for ground ambulance transports (procedure codes A0426, A0427, A0428, A0429, A0433, A0434, and A0999) must be submitted with mileage procedure code A0425.

Medical necessity and coverage of ambulance services are not based solely on the presence of a specific diagnosis. Medicaid payment for ambulance transportation may be made only for those clients whose condition at the time of transport is such that ambulance transportation is medically necessary. For example, it is insufficient that a client merely has a diagnosis such as pneumonia, stroke, or fracture to justify ambulance transportation. In each of those instances, the condition of the client must be such that transportation by any other means is medically contraindicated. In the case of ambulance transportation, the condition necessitating transportation is often an accident or injury that has occurred giving 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 responsibility to supply the contractor with information describing the condition of the client that necessitated ambulance transportation. Medicaid recognizes the limitations of ambulance personnel in establishing a diagnosis, and recognizes therefore, that diagnosis coding of a client's condition using *International Classification of Diseases*, Tenth Revision, Clinical Modification (ICD-10-CM) codes when reporting ambulance services may be less specific than those reported by other professional providers. Providers who submit diagnosis codes must choose the code that best describes the client's condition at the time of transport. As a reminder to providers of ambulance services, "rule out" or "suspected" diagnoses must not be reported using specific ICD-10-CM codes. In such instances where a diagnosis is not confirmed, it is correct to use a symptom, finding, or injury code.

The ambulance provider may be sanctioned, including nonparticipation in the Medicaid Title XIX programs, for completing or signing a claim form that includes false or misleading representations of the client's condition or the medical necessity of the transport.

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 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.

2.2.1 Emergency Ambulance Transport Services

An emergency ambulance transport service is a benefit when the client has an emergency medical condition. An emergency medical condition is defined, according to 1 TAC §354.1111, as a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient

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severity (including severe pain, psychiatric disturbances, or symptoms of substance abuse) 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 (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Facility-to-facility transport may be considered an emergency if emergency treatment is not available at the first facility and the client still requires emergency care. The transport must be to an appropriate facility, meaning the nearest medical facility equipped in terms of equipment, personnel, and the capacity to provide medical care for the illness or injury of the client involved.

Transports to out-of-locality providers (one-way transfers of 50 or more miles from the point of pickup to the point of destination) are covered if a local facility is not adequately equipped to treat the condition. Transports may be cut back to the closest appropriate facility.

When there are two responders to an emergency, the company that transports the client will be reimbursed for their services.

2.2.1.1 Prior Authorization for Emergency Out-of-State Transport

All emergency out-of-state (air, ground, and water) transports require authorization before the transport is considered for payment.

Prior authorization for emergency transport is required for out-of-state providers with the exception of those providers located within 200 miles of the Texas border.

Refer to: Subsection 2.6, "Out-of-State Medicaid Providers" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for additional information on providers who are not considered out-of-state providers.

To initiate the prior authorization process, providers must call 1-800-540-0694.

Texas Medicaid & Healthcare Partnership (TMHP) is responsible for processing prior authorization requests for all Medicaid clients.

2.2.2 Nonemergency Ambulance Transport Services

According to 1 TAC §354.1111, nonemergency transport is defined as ambulance transport provided for a Medicaid client to or from a scheduled medical appointment, to or from a licensed facility for treatment, or to the client's home after discharge from a hospital when the client has a medical condition such that the use of an ambulance is the only appropriate means of transportation (i.e., alternate means of transportation are medically contraindicated).

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.*

According to Human Resource Code (HRC) §32.024 (t), a Medicaid-enrolled physician, nursing facility, health-care provider, or other responsible party is required to obtain authorization before an ambulance is used to transport a client in circumstances not involving an emergency.

Providers requesting prior authorization 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.

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Medical necessity must be established through prior authorization for all nonemergency ambulance transports. Retrospective review may be performed to ensure that documentation supports the medical necessity of the transport.

Clients who do not meet medical necessity requirements for nonemergency ambulance transport may be able to receive transport through the Medical Transportation Program (MTP).

Transports must be limited to those situations where the transportation of the client is less costly than bringing the service to the client.

The Non-emergency Ambulance Prior Authorization Request form must be filled out and submitted to TMHP by the facility or the physician's staff that is most familiar with the client's condition. The ambulance provider must not assist in completing or submitting any portion of this form.

Refer to: Subsection 5.1.8, "Prior Authorization for Nonemergency Ambulance Transport" in Section 5, "Prior Authorization" (*Vol 1, General Information*) for more information about nonemergency ambulance transport prior authorization requests and appeals.

The *Medical Transportation Program Handbook* (*Vol. 2, Provider Handbooks*) for more information about the Medical Transportation Program.

2.2.3 Levels of Service

Levels of services as defined by Texas Medicaid:

- Basic Life Support (BLS) is emergency care that uses noninvasive medical acts and, if allowed by licensing jurisdiction, may include the establishment of a peripheral intravenous (IV) line.
- Advanced Life Support (ALS) is emergency care that uses invasive medical acts. For Medicaid purposes only, ALS services are divided into two catagories, Level 1 and Level 2.
  - Level 1 ALS includes an ALS assessment or at least an ALS intervention.
  - Level 2 ALS includes either of the following:
    - At least three separate administration of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids); or
    - At least one of the ALS 2 procedures: manual defibrillation/cardioversion; endotracheal intubation; central venous line; cardiac pacing; chest decompression; surgical airway; or intra-osseous line.

2.2.4 Oxygen

Reimbursement for oxygen (procedure code A0422) is limited to one billable code per transport.

2.2.5 Types of Transport

2.2.5.1 Multiple Client Transports

Multiple client transports occur when more than one client with Medicaid coverage is transported simultaneously in the same vehicle. A claim for each client must be billed 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 Medicaid numbers of other Texas Medicaid clients who shared the transfer, or indicate "Not a Medicaid client" in Block 19 of the CMS 1500 paper form. Providers must enter charges on a separate claim for each client. TMHP adjusts the payment to 80 percent of the allowable base rate for each claim and divides mileage equally among the clients who share the ambulance.

Refer to: Subsection 6.4, "Claims Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

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2.2.5.2 Air or Specialized Vehicle Transports

Air ambulance transport services, by means of either fixed or rotary wing aircraft, and other specialized emergency medical services vehicles may be covered only if one of the following conditions exists:

- The client's medical condition requires immediate and rapid ambulance transportation that could not have been provided by standard automotive ground ambulance.
- The point of client pick up is inaccessible by standard automotive ground vehicle.
- Great distances or other obstacles are involved in transporting the client to the nearest appropriate facility.

Claims for air ambulance transports procedure codes A0430 and A0431 must be submitted with the corresponding air mileage procedure code A0435 or A0436.

2.2.5.3 Specialty Care Transport (SCT)

SCT (procedure code A0434) is the interfacility transport 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) or paramedic. SCT is necessary when a client's condition requires ongoing care that must be furnished by one or more health 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.

2.2.5.4 Transports for Pregnancies

Transporting a pregnant woman may be covered as an emergency transfer if the client's condition is documented as an emergency situation at the time of transfer.

Claims documenting an emergency home delivery or delivery en route are considered emergency transfers. Premature labor and early onset of delivery (less than 37 weeks gestation) may also be considered an emergency. Active labor without more documentation of an emergency situation is not payable as an emergency transport.

If the pregnant client is transported in an ambulance for a nonemergency situation, all criteria for nonemergency prior authorization must be met.

2.2.5.5 Transports to or from State Institutions

Ambulance transports to or from a state-funded hospital for admission or following discharge are covered when nonemergency transfer criteria are met. Ambulance transfers of clients while they are inpatients of the institution are not covered. The institution is responsible for routine nonemergency transportation.

2.2.5.6 Not Medically Necessary Transports

Providers must use the GY modifier to submit claims for instances when the provider is aware no medical necessity existed. When billing for this type of transportation, ambulance providers must maintain a signed Client Acknowledgment Statement indicating that the client was aware, prior to service rendered, that the transport was not medically necessary. The Client Acknowledgment Statement is subject to retrospective review.

Refer to: Subsection 1.6.9.1, "Client Acknowledgment Statement" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

2.2.5.7 Transports for Nursing Facility Residents

Nursing facilities are responsible for providing or arranging transportation for their residents. Arranging transportation for Medicaid clients includes obtaining prior authorizations for nonemergency ambulance transports. The Nonemergency Ambulance Prior Authorization Request form must

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be filled out and submitted to TMHP by the facility or the physician's staff that is most familiar with the client's condition. The ambulance provider must not assist in completing or submitting any portion of this form.

Transports from a nursing facility to a hospital are covered if the client's condition meets emergency criteria.

A return trip to a nursing facility following an emergency transport is not considered routine; therefore, transport back to the facility must be requested by the discharging hospital. Nonemergency transport for the purpose of required diagnostic or treatment procedures that are not available in the nursing facility (such as dialysis treatments at a freestanding facility) are also allowable *only* for clients whose medical condition is such that the use of an ambulance is the only appropriate means of transport (e.g., alternate means of transport are medically contraindicated).

The cost of routine nonemergency transportation is included in the nursing facility vendor rate. This nonemergency transport requires the nursing facility to request and obtain a Prior Authorization Number (PAN) from the TMHP Ambulance Unit before contacting the ambulance company for the transport.

Transports of nursing facility residents for rehabilitative treatment (e.g., physical therapy) to outpatient departments or physicians' offices for recertification examinations for nursing facility care are *not* reimbursable ambulance services.

Claims for services to nursing facility residents must indicate the medical diagnosis or problem requiring treatment, the medical necessity for use of an ambulance for the transport, and the type of treatment rendered at the destination (e.g., admission or X-ray).

If a client is returned by ambulance to a nursing facility following inpatient hospitalization, the acute condition requiring hospitalization must be noted on the ambulance claim form. This transport is considered for payment only if the client's medical condition is appropriate for transport by ambulance. This nonemergency transport requires the nursing facility to request and obtain a PAN from the TMHP Ambulance Unit before contacting the ambulance company for the transport.

Ambulance providers may bill a nursing facility or client for a nonemergency ambulance transport only under the following circumstances:

- *Providers may bill the nursing facility* when the nursing facility requests the nonemergency ambulance transport without a PAN.
- *Providers may bill the client* only when the client requests transport that is not an emergency and the client does not have a medical condition such that the use of an ambulance is the only appropriate means of transport (i.e., alternate means of transport are medically contraindicated). The provider must advise the client of acceptance as a private pay patient at the time the service is provided, and the client is responsible for payment of all services. Providers are encouraged to have the client sign the *Private Pay Agreement*.

Providers may refer questions about a nursing facility's responsibility for payment of a transport to the TMHP Contact Center at 1-800-925-9126 or TMHP provider relations representatives.

2.2.5.8 Emergency Transports Involving a Hospital

Hospital-to-hospital transports that meet the definition of an emergency transport do not require prior authorization.

Providers must use modifier ET and one of the facility-to-facility transfer modifiers (HH, HI, or IH) on each procedure code listed on the claim.

Modifier	Transport Type
HH	From hospital to hospital

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Modifier	Transport Type
HI	From hospital to site of transfer
IH	From site of transfer to hospital

2.2.5.9 No Transport

Texas Medicaid does not reimburse ambulance providers for services that do not result in a transport to a facility, regardless of whether any medical care was rendered. If a client contacts an ambulance provider, but the call does not result in a transport, the provider should have the client sign an acknowledgement statement and may bill the client for services rendered.

Texas Medicaid will not reimburse for the return trip of an empty ambulance. Texas Medicaid will not reimburse air or ground mileage when the client is not on board the ambulance.

2.3 Documentation Requirements

The requesting provider, which may include a physician, nursing facility, health-care provider, or other responsible party, is required to maintain the supporting documentation, physician's orders, the Non-emergency Ambulance Prior Authorization Request form and if applicable, the Nonemergency Ambulance Exception form.

An ambulance provider is required to maintain documentation that represents the client's medical condition and other clinical information to substantiate medical necessity, the level of service, and the mode of transportation requested. This supporting documentation is limited to documents developed or maintained by the ambulance provider.

Physicians, nursing facilities, health-care providers, or other responsible parties are required to maintain physician orders related to requests for prior authorization of nonemergency and out-of-state ambulance services. These providers must also maintain documentation of medical necessity for the ambulance transport.

In hospital-to-hospital transports or hospital-to-outpatient medical facility transports, the TMHP Ambulance Unit considers information by telephone from the hospital. Providers are not required to fax medical documentation to TMHP; however, in certain circumstances, TMHP may request that the hospital fax the supporting documentation. Hospitals are allowed to release a client's protected health information (PHI) to a transporting emergency medical services provider for treatment, payment, and health-care operations.

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 hospital must maintain documentation of medical necessity, including a copy of the authorization from TMHP in the client's medical record for any item or service that requires prior authorization. The services provided must be clearly documented in the medical record with all pertinent information regarding the client's condition to substantiate the need and medical necessity for the services.

2.3.1 Medicaid Surety Bond Requirements

Ambulance providers attempting to renew their Emergency Medical Services (EMS) license must submit a surety bond to TMHP for each license they are attempting to renew. A copy of the surety bond must also be attached to an application for renewal of an EMS license when submitted to DSHS.

Refer to: Subsection 1.1.6, "Surety Bond Enrollment" in Section 1, "Provider Enrollment" (Vol. 1 General Information) for more information.

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2.4 Claims Filing and Reimbursement

2.4.1 Claims Information

Emergency and nonemergency claims may be billed electronically. For electronic billers, the hospital's provider identifier must be entered in the Facility ID field. Providers should consult their software vendor for the location of this field on the electronic claim form.

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 the Texas Medicaid medical policy are no longer valid.

The CMS NCCI and MUE guidelines can be found in the NCCI Policy and Medicare Claims Processing manuals, which are available on the CMS website. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

2.4.2 Reimbursement

Ground and air ambulance providers are reimbursed based on the lesser of a provider's billed charges or the maximum fee established by the Texas Health and Human Services Commission (HHSC) in accordance with 1 TAC §355.8600. Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement methodologies.

Subsection 1.11, "Texas Medicaid Limitations and Exclusions" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for information on Medicaid exclusions.

2.4.2.1 Ambulance Disposable Supplies

Ambulance disposable supplies are included in the global fee for specialty care transport and must not be billed separately.

Reimbursement for BLS or ALS disposable supplies (procedure codes A0382 and A0398 respectively) is separate from the established fee for ALS and BLS ambulance transports and is limited to one billable procedure code per transport.

2.4.2.2 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

The three-day and one-day payment window reimbursement guidelines do not apply for ambulance services.

Refer to: Subsection 3.7.3.8, "Payment Window Reimbursement Guidelines" of the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about the payment window reimbursement guidelines.

2.4.3 Medicare and Medicaid Coverage

All ambulance claims are exempt from Medicare equalization, which pays the lesser of the coinsurance and deductible or the remainder of the amount that Medicaid would have paid for the same service minus what Medicare has already paid on Medicare crossover claims.

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All claims for ambulance services provided to dual-eligible clients are reimbursed the full amount of the Medicare coinsurance and deductible for Part B claims and Part C claims from non-contracted Medicare Advantage Plans.

Medicaid prior authorization is not required for ambulance services for Qualified Medicare Beneficiary (QMB) clients because QMB clients are not eligible for Medicaid benefits. Providers can contact Medicare for the Medicare prior authorization guidelines.

Medicaid Qualified Medicare Beneficiary (MQMB) clients are eligible for all Medicaid benefits; therefore, the provider should simultaneously request prior authorization for the nonemergency transport from TMHP for the MQMB client in the event the service requested is denied by Medicare as a non-covered service.

Refer to: Subsection 4.11, "Medicare and Medicaid Dual Eligibility" in Section 4, "Client Eligibility" (*Vol. 1, General Information*).

Subsection 2.7, "Medicare Crossover Claim Reimbursement" (*Vol. 1, General Information*), for additional information about Medicare coinsurance and deductible payments and exceptions.

2.4.3.1 Medicare Services Paid

Assigned claims filed with and paid by Medicare should automatically transfer to TMHP for payment of the deductible and coinsurance liability. According to current guidelines, providers must submit Medicare-paid claims that do not cross over to TMHP for the coinsurance and deductible. Providers must send the Medicare Remittance Advice Notice (MRAN) with the client information circled in black ink.

2.4.3.2 Medicare Services Denied

A Medicare ambulance claim that has been denied must go through the appropriate Medicare claim appeals process with a decision by the administrative law judge before TMHP will process the ambulance claim. MQMB ambulance claims that have exhausted the Medicare third level of appeal by the administrative law judge (ALJ) must be submitted to TMHP with the disposition letter from the ALJ along with all other required documents for an appeal.

An assigned claim that was denied by Medicare because the client has no Part B benefits or because the transport destination is not allowed can be submitted to TMHP for consideration. Providers must send claims to TMHP on a CMS-1500 paper claim form with the ambulance provider identifier, unless they are a hospital-based provider. Hospital-based ambulance providers must send Medicare denied claims to TMHP on a CMS-1500 paper claim form with the ambulance provider identifier and a copy of the MRAN.

Note: *All claims for STAR+PLUS clients with Medicare and Medicaid must follow the same requirements used for obtaining prior authorization for Medicaid-only services from TMHP. The STAR+PLUS HMO is not responsible for reimbursement of these services.*

2.4.4 Ambulance Claims Coding

Providers must submit claims for emergency transport with the ET modifier on each procedure code submitted. Any procedure code submitted on the claim for emergency transport without the ET modifier will be subject to prior authorization requirements.

2.4.4.1 Place of Service Codes

The place of service (POS) for all ambulance transports is considered the destination.

POS codes 41 and 42 (other) are national POS codes that are accepted by Texas Medicaid only for electronic claims. POS code 9 is accepted by Texas Medicaid for ambulance claims submitted on paper.

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2.4.4.2 Origin and Destination Codes

All claims submitted on paper or electronically must include the two-character origin and destination codes for every claim line. The origin is the first character, and the destination is the second character.

The following are the origin and destination codes accepted by Texas Medicaid:

Origin and Destination Code	Description
D	Diagnostic or therapeutic site/freestanding facility (e.g., radiation therapy center) other than P or H
E	Residential/domiciliary/custodial facility (e.g., nonskilled facility)
G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital (e.g., inpatient or outpatient)
I	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
J	Non-hospital-based dialysis facility
N	Skilled Nursing Facility (SNF) (swingbed is considered an SNF)
P	Physician's office (includes HMO and nonhospital facility)
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)

Nonemergency claims filed electronically must include the PAN in the appropriate field. For nonemergency hospital-to-hospital transfers, indicate the services required from the second facility and unavailable at the first facility in Block 19 of the CMS-1500 paper claim form. If the destination is a hospital, enter the name and address and the provider identifier of the facility in Block 32.

For nonemergency transports, ambulance providers must enter the ICD-10-CM diagnosis code to the highest level of specificity available for each diagnosis observed in Block 21 of the claim form.

Reminder: *Providers must submit multiple transports for the same client on the same date of service through one claim submission. Additional claims information can be found within individual topics in this section.*

Providers should consult their software vendor for the location of the field on the electronic claim form. Providers must submit ambulance services to TMHP on a CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from a 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 information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

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2.4.4.3 Transports Billed Without Mileage

Ambulance transport claims with a billed mileage amount of $0.00 will be reimbursed. To qualify for reimbursement, the transport claim must include a mileage quantity that is greater than zero.

Providers may not include a mileage charge as part of the transport charge or as part of any other charges on the claim.

Payments for ambulance transports are only made if the client is actually transported and the mileage quantity billed is greater than zero. Mileage charges greater than zero will be considered for reimbursement when a transport procedure code is included on the claim.

2.4.5 Air or Specialized Vehicle Transports

Procedure codes A0430 and A0435, or A0431 and A0436 are used to bill air transport. Procedure code A0999 is used to bill for specialized vehicle transports. Transport claims may be submitted electronically with a short description of the client's physical condition in the comment field. If the client's condition cannot be documented, providers must file a paper claim with supporting documentation.

Refer to: Subsection 2.2.5.2, "Air or Specialized Vehicle Transports" in this handbook for more information about how to meet the specific criteria for reimbursement consideration for air or specialized transport claims.

2.4.6 Emergency Transport Billing

Emergency transport is a benefit when billed with the ET modifier and the most appropriate emergency medical condition codes. The ET modifier is required for every detail on an emergency transport claim, but is not required to be listed in the first position on the claim line.

The following procedure codes are for emergency transport:

Procedure Codes									
A0382	A0398	A0422	A0424	A0425*	A0427	A0429	A0430	A0431	A0433
A0434	A0435	A0436	A0999						
***A0425 is denied if it is billed without procedure code A0427, A0429, A0433, or A0434.**									

One of the following emergency medical condition code is required on all emergency ambulance claims and must be listed in Box 21 of the CMS-1500 claim form:

Emergency Medical Condition Codes							
B9689	B999	E869	F068	F10929	F19939	F29	G4489
G8929	H579	I469	I499	J9600	J984	M549	O2690
R002	R0602	R0689	R079	R092	R0989	R100	R109
R238	R4182	R4189	R4589	R509	R52	R55	R569
R58	R6889	R7309	S0590XA	T07	T148	T17300A	T300
T50904A	T59891A	T5994XA	T672XXA	T675XXA	T68XXXA	T699XXA	T7500XA
T751XXA	T754XXA	T782XXA	T7840XA	T8189XA	T82519A	T887XXA	Y710
Y828	Z209	Z7401	Z779	Z9181	Z9981	Z9989	

While ICD-10-CM codes are not precluded from use on ambulance claims, they are currently not required (per the Health Insurance Portability and Accountability Act [HIPAA] of 1996) on most ambulance claims and the use of these codes generally does not trigger a payment or a denial of a claim.

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Claims for emergency transports that are denied for not meeting the emergency criteria will be considered on appeal with additional documentation to support the emergency nature of the transport. Claims that have denied for not meeting emergency transport criteria cannot be appealed for reimbursement as a nonemergency claim.

Refer to: Subsection 2.2.1, "Emergency Ambulance Transport Services" in this handbook.

2.4.7 Nonemergency Transport Billing

The following procedure codes are used when billing for nonemergency ambulance services:

Procedure Codes									
A0382	A0398	A0420	A0422	A0424	A0425*	A0426	A0428	A0430	A0431
A0433	A0434	A0435	A0436						
***A0425 is denied if it is billed without procedure code A0426, A0428, A0433, or A0434.**									

2.4.8 Extra Attendant

The use of additional attendants (procedure code A0424) must be related to extraordinary circumstances when the basic crew is unable to transport the client safely.

An extra attendant on a nonemergency transport must be prior authorized. On an emergency transport, the billing provider's medical documentation must clearly indicate the services the attendant performs along with a rationale for the services to indicate medical necessity of the attendant.

The information supporting medical necessity must be kept in the billing provider's medical record and is subject to retrospective review.

Situations when an extra attendant may be required beyond the basic crew include, but are not limited to:

- Necessity of additional special medical equipment or treatment en route to destination (describe what special treatment and equipment is required and why it requires an attendant).
- Client behavior that may be a danger to self or ambulance crew or that requires, or may require, restraints.
- Extreme obesity of client (provide weight and client's functional limitations).
- The extra attendant must be certified by DSHS to provide emergency medical services.
- The use of an extra attendant for air transport is not a benefit of Texas Medicaid. Claims submitted with procedure code A0424 will be denied if billed with air transports (procedure code A0430 or A0431).

2.4.8.1 Emergency Transports

Emergency transports that use an extra attendant do not require prior authorization. Modifier ET must be billed with the extra attendant procedure code A0424.

The billing provider's medical documentation must clearly indicate the services the attendant performed along with rationale for the services to indicate the medical necessity of having the attendant. The billing provider must keep the information that supports medical necessity in the client's medical record, which will be 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 who is being transported requires medical attention or close monitoring.

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2.4.8.2 Nonemergency Transports

Prior authorization is required when an extra attendant is needed for any nonemergency transport. When a client's condition changes, such as a need for oxygen or an extra attendant for transport, the prior authorization request must be updated.

To receive prior authorization, the requesting provider must prove medical necessity and identify attendant services that could not be provided by the basic crew. The information supporting medical necessity must be kept in the requesting provider's medical record and is subject to retrospective review.

Texas Medicaid does not reimburse for an extra attendant based only on an ambulance provider's internal policy.

2.4.9 Night Call

Texas Medicaid does not reimburse an extra charge for a night call.

2.4.10 Waiting Time

Procedure code A0420 may be billed when it is the general billing practice of local ambulance companies to charge for unusual waiting time (longer than 30 minutes). Providers must use the following procedures:

- Separate charges must be billed for all clients, Medicaid and non-Medicaid, for unusual waiting time.
- The circumstances requiring waiting time and the exact time involved must be documented in Block 24 of the CMS-1500 paper claim form.
- The amount charged for waiting time must not exceed the charge for a one-way transfer.

Important: *Waiting time is reimbursed up to one hour.*

2.4.11 Appeals

Only a denial of prior authorization may be appealed. Clients may appeal prior authorization request denials by contacting TMHP Client Notification at 1-800-414-3406. The Non-emergency Ambulance Prior Authorization Request form is not considered to be documentation after the service has been rendered.

Claims denied due to an inappropriate emergency medical condition code may be resubmitted with the appropriate emergency medical condition code.

On appeal, supporting documentation is critical for determining the client's condition at the time of transport. Ambulance providers who file paper claims must include all information that supports the reason for the transport and attach a copy of the run sheet to the claim. The EMT who transported the client must sign the documentation.

Refer to: Subsection 2.3, "Documentation Requirements" in this handbook.

Medicaid clients have the right to request a Fair Hearing within 90 days of the date of the denial action.

2.4.12 Relation of Service to Time of Death

Medicaid benefits cease at the time of the client's death. However, if the client dies in the ambulance while en route to the destination, Texas Medicaid covers the transport. If a physician pronounces the client dead after the ambulance is called, Texas Medicaid covers the ambulance service (base rate plus mileage) to the point of pick up. Providers must indicate the date and time the client died in Block 19 of the CMS-1500 paper claim form. If a physician or coroner pronounces the client dead before the ambulance is called, the service is not covered.

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Equipment and nondisposable supplies are included in the base rate. These items are not separately reimbursable and are considered part of another procedure. Therefore, equipment and supplies cannot be billed to the client.

2.5 Claims Resources

Providers may refer to the following sections or forms when filing claims:

Resource	Location
Appendix D: Acronym Dictionary	"Appendix D: Acronym Dictionary" (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	TMHP Telephone and Fax Communication (*Vol. 1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5 in Section 6, "Claims Filing" (*Vol. 1, General Information*)
Appendix A: State, Federal, and TMHP Contact Information	Appendix A (*Vol. 1, General Information*)
Section 3: TMHP Electronic Data Interchange (EDI)	Section 3 (*Vol. 1, General Information*)

2.6 Contact TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.

3 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Non-emergency Ambulance Prior Authorization Request

4 Claim Form Examples

The following linked claim form examples can also be found on the Claim Form Examples page of the Provider section of the TMHP website at www.tmhp.com:

Claim Form Examples
Ambulance Non-emergency Transport
Ambulance Emergency Transport from Residence to Hospital
Ambulance Emergency Transport from Scene of Accident to Hospital

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Behavioral Health, Rehabilitation, and Case Management Services Handbook

Texas Medicaid Provider Procedures Manual: Vol. 2

April 2016

TEXAS
Health and Human
Services Commission

BEHAVIORAL HEALTH, REHABILITATION, AND CASE MANAGEMENT SERVICES

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1 General Information

The information in this handbook is intended for the Case Management for the Blind Children's Vocational Discovery and Development Program (BCVDDP), Case Management for Children and Pregnant Women, and services provided by a licensed clinical social worker (LCSW), licensed marriage and family therapist (LMFT), licensed professional counselor (LPC), Mental Health and Mental Retardation Center (MHMR), or psychologist.

All providers are required to report suspected child abuse or neglect as outlined in subsection 1.6.1.2, "Reporting Child Abuse or Neglect" and subsection 1.6.1.5, "Training" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

Important: *All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure to deliver, at all times, health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: Section 1: Provider Enrollment and Responsibilities (*Vol. 1, General Information*).

Appendix B: Vendor Drug Program (*Vol. 1, General Information*) for information about outpatient prescription drugs and the Medicaid Vendor Drug Program.

1.1 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: Subsection 3.7.3.8, "Payment Window Reimbursement Guidelines" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about the payment window reimbursement guidelines.

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2 Blind Children's Vocational Discovery and Development Program (BCVDDP)

2.1 Overview

BCVDDP services are provided to help children who are blind and visually impaired to develop their individual potential. This program offers a wide range of services that are tailored to each child and their family's needs and circumstances. By working directly with the entire family, this program can help children develop the concepts and skills needed to realize their full potential.

BCVDDP services include the following:

- Assisting the client in developing the confidence and competence needed to be an active part of their community
- Providing support and training to children in understanding their rights and responsibilities throughout the educational process
- Assisting family and children in the vocational discovery and development process
- Providing training in areas like food preparation, money management, recreational activities, and grooming
- Supplying information to families about additional resources

2.2 Enrollment

The Department of Assistive and Rehabilitative Services (DARS) Division for Blind Services (DBS) is the Medicaid provider of case management for clients who are 21 years of age and younger and blind or visually impaired. Providers must meet educational and work experience requirements that are commensurate with their job responsibilities and must be trained in DBS case management activities.

Refer to: Subsection 1.1, "Provider Enrollment and Reenrollment" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about procedures for enrolling as a Medicaid provider.

2.3 Services, Benefits, Limitations, and Prior Authorization

Services eligible for reimbursement are limited to one contact per month, per client, regardless of the number of contacts that are made during the month. DARS DBS providers should bill procedure code G9012.

A contact is defined as "an activity performed by a case manager with the client or with another person or organization on behalf of the client to locate, coordinate, and monitor necessary services."

Refer to: Subsection A.8, "Department of Assistive and Rehabilitative Services (DARS), Blind Services" of Appendix A, "State and Federal Offices Communication Guide" (*Vol. 1, General Information*).

2.3.1 Prior Authorization

Prior authorization is not required for BCVDDP case management services.

2.4 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including BCVDDP services.

BCVDDP services are subject to retrospective review and recoupment if documentation does not support the service billed.

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2.5 Claims Filing and Reimbursement

BCVDDP case management 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. Providers must *not* submit a claim when or after the client turns 21 years of age.

Claims may be submitted up to 365 days from the date of service in accordance with 1 TAC §354.1003.

Any child who has a suspected or diagnosed visual impairment may be referred to BCVDDP. DARS DBS assesses the impact the visual impairment has on the child's development and provides blindness-specific services to increase the child's skill level in the areas of independent living, communication, mobility, social, recreational, and vocational discovery and development. For more information, visit the DARS website at www.dars.state.tx.us.

Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied.

Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Subsection 6.1, "Claims Information" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

Subsection 2.8, "Federal Medical Assistance Percentage (FMAP)" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for federal matching percentage.

3 Case Management for Children and Pregnant Women

3.1 Overview

Case management services are provided to help eligible clients gain access to necessary medical, social, educational, and other services. Case managers assess a client's need for these services and then develop a service plan to address those needs.

3.1.1 Eligibility

To be eligible for services, a person must:

- Be eligible for Texas Medicaid.
- Be a pregnant woman who has a high-risk condition or a child (birth through 20 years of age) who has a health condition or health risk.
- Need assistance in gaining access to necessary medical, social, educational and other services related to their health condition, health risk, or high-risk condition.

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- Want to receive case management services.

Pregnant women who have a high-risk condition are defined as those who have a medical or psycho-social condition that places them and their fetuses at a greater than average risk for complications, either during pregnancy, delivery, or following birth. Children with a health condition are defined as children who have a health condition or health risk or children who have or are at risk for a medical condition, illness, injury, or disability that results in the limitation of function, activities, or social roles in comparison with healthy same-age peers in the general areas of physical, cognitive, emotional, or social growth and development.

3.1.2 Referral Process

To refer a Medicaid client for Case Management for Children and Pregnant Women services, providers may do one of the following:

- Visit www.dshs.state.tx.us/caseman/default.shtm to obtain a Case Management for Children and Pregnant Women referral form and fax the completed form to the Texas Health Steps (THSteps) Special Services Unit at 1-512-533-3867.
- Call THSteps toll free at 1-877-847-8377 from 8 a.m. to 8 p.m., Central Time, Monday through Friday.
- Contact a Case Management for Children and Pregnant Women provider directly at www.dshs.state.tx.us/caseman/providerRegion.shtm. A case management provider will contact the family to offer a choice of providers and obtain information necessary to request prior authorization for case management services.

A referral for Case Management for Children and Pregnant Women services can be received from any source.

3.2 Enrollment

Enrollment for Case Management for Children and Pregnant Women providers is a two-step process.

Step 1

Potential providers must submit a Department of State Health Services (DSHS) Case Management for Children and Pregnant Women provider application to the DSHS Health Screening and Case Management Unit.

Both registered nurses who have an associate's, bachelor's, or advanced degree and social workers who have a bachelor's or advanced degree are eligible to become case managers if they are currently licensed by their respective Texas licensure boards and the license is not temporary in nature. Registered nurses with associate degrees must also have at least two years of cumulative, paid, full-time work experience or two years of supervised full-time, educational, internship/practicum experience in the past ten years. The experience must be with pregnant women or with children who are 20 years of age and younger. The experience must include assessing psychosocial and health needs and making community referrals for these populations. Registered nurses with bachelor or advance degrees and social workers do not have to meet any experience requirements.

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For more information about provider qualifications and enrollment, contact DSHS at 1-512-458-7111, Ext. 2168, visit the case management website at www.dshs.state.tx.us/caseman/default.shtm, or write to the following address:

Department of State Health Services
Case Management for Children and Pregnant Women
PO Box 149347, MC 1938
Austin, TX 78714-9347

Note: *Before providing services, each case manager must attend DSHS case manager training. Training is conducted by DSHS regional staff.*

Step 2

Upon approval by DSHS, potential providers must enroll as a Medicaid provider for Case Management for Children and Pregnant Women and submit a copy of their DSHS approval letter. Facility providers must enroll as a Case Management for Children and Pregnant Women group, and each eligible case manager must enroll as a performing provider for the group. Federally Qualified Health Center (FQHC) facilities that provide Case Management for Children and Pregnant Women services will use their FQHC number and should not apply for an additional provider number for Case Management for Children and Pregnant Women.

Refer to: Subsection 1.1, "Provider Enrollment and Reenrollment" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about the procedures for enrolling as a Medicaid provider.

3.3 Services, Benefits, Limitations, and Prior Authorization

Case Management for Children and Pregnant Women services are limited to one contact per day per client. Additional provider contacts on the same day are denied as part of another service rendered on the same day.

Procedure code G9012 is to be used for all Case Management for Children and Pregnant Women services. Modifiers are used to identify which service component is provided.

Service	Contact Code
Comprehensive visit	G9012 *with* modifier U5 *and* modifier U2
Follow-up face-to-face	G9012 *with* modifier U5 *and* modifier TS
Follow-up telephone	G9012 *with* modifier TS

Providers must adhere to Case Management for Children and Pregnant Women program rules, policies, and procedures.

Note: *Case Management for Children and Pregnant Women providers are not required to file claims with other health insurance before filing with Medicaid.*

Reminder: *Billable services are defined in program rule 25 TAC §27.11.*

Case Management for Children and Pregnant Women services are not billable when a client is an inpatient at a hospital or other treatment facility.

Reimbursement will be denied for services rendered by providers who have not been approved by the DSHS Health Screening and Case Management Unit.

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3.3.1 Prior Authorization

All services must be prior authorized. One comprehensive visit is approved for all eligible clients. Follow-up visits are authorized based on contributing factors. Additional visits can be requested and may be authorized based on a continuing need for services. A prior authorization number is required on all claims for Case Management for Children and Pregnant Women services.

Note: *Prior authorization is a condition of reimbursement, not a guarantee of payment.*

Approved case management providers may submit requests for prior authorization from DSHS on the DSHS website at www.dshs.state.tx.us/caseman/subpaweb.shtm.

3.4 Technical Assistance

Providers may contact DSHS program staff as needed for assistance with program concerns. Providers should contact TMHP provider relations staff as needed for assistance with claims problems or concerns.

3.4.1 Assistance with Program Concerns

Providers who have questions, concerns, or problems with program rule, policy, or procedure may contact DSHS program staff. Contact names and numbers can be obtained from the case management website at www.dshs.state.tx.us/caseman/default.shtm, or by calling 1-512-458-7111, Ext. 2168.

Regional staff make routine contact with providers to ensure providers are delivering services as required.

3.5 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including Case Management for Children and Pregnant Women services.

Case Management for Children and Pregnant Women services are subject to retrospective review and recoupment if documentation does not support the service billed.

3.6 Claims Filing and Reimbursement

3.6.1 Claims Information

Case Management for Children and Pregnant Women 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.

Case Management for Children and Pregnant Women providers are reimbursed in accordance with 1 TAC §355.8401. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied.

Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

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Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Subsection 6.1, "Claims Information" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

3.6.2 Managed Care Clients

Case Management for Children and Pregnant Women services are carved out of Medicaid managed care and must be billed to TMHP for payment consideration. Carved-out services are those that are rendered to Medicaid managed care clients, but are administered by TMHP and not the client's managed care organization (MCO).

4 Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), and Licensed Professional Counselor (LPC)

4.1 Enrollment

4.1.1 LCSW

To enroll in Texas Medicaid, whether as an individual or as part of a group, an LCSW must be licensed by the Texas State Board of Social Worker Examiners. LCSWs must also be enrolled in Medicare or obtain a pediatric practice exemption from TMHP Provider Enrollment. If a pediatric-based LCSW is enrolling as part of a Medicare-enrolled group, then the LCSW must also be enrolled in Medicare. Providers that hold a temporary license are not eligible to enroll in Medicaid. LCSWs cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

4.1.2 LMFT

To enroll in Texas Medicaid, whether as an individual or as part of a group, an LMFT must be licensed by the Texas State Board of Examiners of Licensed Marriage and Family Therapists. LMFTs are covered as Medicaid-only providers; therefore, enrollment in Medicare is not a requirement. LMFTs can enroll as part of a clinic/group practice whether or not they are enrolled in Medicare. Providers that hold a temporary license are not eligible to enroll in Medicaid. LMFTs cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

4.1.3 LPC

To enroll in Texas Medicaid, whether as an individual or as part of a group, an LPC must be licensed by the Texas Board of Examiners of Professional Counselors. LPCs are covered as Medicaid-only providers; therefore, enrollment in Medicare is not a requirement. LPCs can enroll as part of a clinic/group practice whether or not they are enrolled in Medicare. Providers that hold a temporary license are not eligible to enroll in Medicaid. LPCs cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

Refer to: Subsection 1.1, "Provider Enrollment and Reenrollment" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about procedures for enrolling as a Medicaid provider.

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4.2 Services, Benefits, Limitations, and Prior Authorization

Psychotherapy and counseling services that are provided by LCSWs, LMFTs, and LPCs are benefits of Texas Medicaid for clients of any age who are experiencing a significant behavioral health issue that is causing distress, dysfunction, or maladaptive functioning as a result of a confirmed or suspected psychiatric condition as defined in the most current edition of the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

LCSWs, LMFTs, and LPCs must bill therapy or counseling services with procedure code 90832, 90834, 90837, 90847, or 90853.

Note: *LMFTs must use modifier U8 when billing these procedure codes.*

Psychotherapy and counseling services can be provided in the office, home, skilled nursing or intermediate care facility (SNF/ICF), outpatient hospital, extended care facility (ECF), or in other locations.

Family psychotherapy is defined as therapy that focuses on the dynamics of family unit where the goal is to strengthen the family's problem solving and communication skills.

Individual psychotherapy is defined as therapy that focuses on the client buy may include others in the session with the goals of treatment focused on the client versus others in attendance.

LCSWs, LMFTs, and LPCs must not bill for services that were provided by people under their supervision, including services provided by students, interns, and licensed professionals. Services may only be billed to Texas Medicaid if they were provided by a licensed LCSW, LMFT, or LPC who is a Medicaid-enrolled practitioner. LCSWs, LMFTs, and LPCs who are employed by or remunerated by another provider may not bill Texas Medicaid directly for counseling services if that billing would result in a duplicate payment for the same services.

If more than one type of session is provided on the same date of service (outpatient individual, group, or family psychotherapy or counseling), each session type will be reimbursed individually. The only services that can be reimbursed are those provided to the Medicaid-eligible client per session.

Services that are provided by a psychiatric nurse, mental health worker, psychiatric assistant, or psychological assistant (excluding a Masters-level licensed psychological associate [LPA]) are not covered by Texas Medicaid and cannot be billed under the provider identifier of any other outpatient behavioral health provider.

Documentation of the face-to-face time with the client must be maintained in the client's medical record to support the procedure code billed. All entries must be documented clearly, be legible to individuals other than the author, and be dated (month/date/year) and signed by the performing provider.

Documentation must include the following:

- The times at which the session began and ended
- All of the pertinent information about the client's condition that is necessary to substantiate the need for services, including, but not limited to, the following:
    - A current DSM diagnosis
    - Background, symptoms, impression
    - Narrative description of the assessment
    - Behavioral observations made during the session
    - Narrative description of the counseling session
    - Treatment plan and recommendations

All payments are subject to recoupment if the required documentation is not maintained in the client's medical record.

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Family psychotherapy and counseling is reimbursed for only one Medicaid-eligible client per session, regardless of the number of family members present during that session. When providing family counseling services, the Texas Medicaid client and a family member must be present during the face-to-face encounter or visit. Regardless of the number of family members present per outpatient session, family counseling and psychotherapy (procedure code 90847) is reimbursed for only one Medicaid-eligible client per session.

According to the definition of "family" provided by HHSC Household Determination Guidelines, only specific relatives are allowed to participate in family counseling services. These guidelines also address the roles of relatives in the supervision and care of children with Temporary Assistance for Needy Families (TANF). The following specific relatives are included in family counseling services:

- Father
- Mother
- Grandfather
- Grandmother
- Brother
- Sister
- Uncle
- Aunt
- Nephew
- Niece
- First cousin
- First cousin once removed
- Stepfather
- Stepmother
- Stepbrother
- Stepsister
- Foster parent
- Legal guardian

Behavioral health services are limited to a total of four hours per client, per day, regardless of the provider.

Outpatient behavioral health services are limited to 30 encounters or visits per client, per calendar year (January 1 through December 31) regardless of provider, unless prior authorized. This limitation includes encounters or visits by all practitioners. School Health and Related Services (SHARS) behavioral rehabilitation services, Mental Health Targeted Case Management and Mental Health Rehabilitation services, laboratory, radiology, and pharmacological management services are not counted toward the 30-encounter or visit limitation. An encounter or visit is defined as any and all behavioral health services (such as examinations, therapy, psychological or neuropsychological testing) by any provider, in the office, outpatient hospital, nursing home, or home settings. This limitation includes encounters or visits by all behavioral health practitioners.

Each individual practitioner is limited to performing a combined total of 12 hours of behavioral health services per day. Claims submitted with a prior authorization number are not exempt from the 12-hour limitation.

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HHSC and TMHP routinely perform retrospective review of all providers' billing practices. Retrospective review may include all behavioral health procedure codes included in the 12-hour system limitation.

Behavioral health services subject to the 12-hour system limitation and retrospective review will be based on the provider's Texas Provider Identifier (TPI) base (the first 7 digits of the TPI). The location where the services occurred will not be a basis for exclusion of hours. If a provider practices at multiple locations and has a different suffix for the various locations, but has the same TPI base, all services identified for restriction to the provider 12-hour limit will be counted regardless of whether they were performed at different locations.

Refer to: Subsection 6.3, "The 12-Hour System Limitation" in this handbook for details about the 12-hours-per-day behavioral health services limitation.

Psychotherapy or counseling services (procedure codes 90832, 90834, 90837, 90847, and 90853) must be submitted with one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
F0390	F0391	F04	F05	F060	F061	F062	F0630
F0631	F0632	F0633	F0634	F064	F068	F070	F09
F1010	F10121	F1014	F10150	F10151	F10159	F10180	F10181
F10182	F10188	F1019	F1020	F1021	F10221	F10230	F10231
F10232	F10239	F1024	F10250	F10251	F10259	F1026	F10280
F10281	F10282	F10288	F1029	F10921	F1094	F10950	F10951
F10959	F1096	F10980	F10981	F10982	F10988	F1099	F1110
F11120	F11121	F1114	F11150	F11151	F11159	F11181	F11182
F11188	F1119	F1120	F1121	F11220	F11221	F11222	F11229
F1123	F1124	F11250	F11251	F11259	F11281	F11282	F11288
F1129	F11920	F11921	F11922	F11929	F1193	F1194	F11950
F11951	F11959	F11981	F11982	F11988	F1199	F1210	F12120
F12121	F12122	F12129	F12150	F12151	F12159	F12180	F12188
F1219	F1220	F1221	F12220	F12221	F12222	F12229	F12250
F12251	F12259	F12280	F12288	F1229	F12920	F12921	F12922
F12929	F12950	F12951	F12959	F12980	F12988	F1299	F13120
F13121	F13129	F1314	F13150	F13151	F13159	F13180	F13181
F13182	F13188	F1320	F1321	F13220	F13221	F13229	F13230
F13231	F13232	F13239	F1324	F13250	F13251	F13259	F1326
F13280	F13281	F13282	F13288	F13920	F13921	F13929	F13930
F13931	F13932	F13939	F1394	F13950	F13951	F13959	F1396
F13980	F13981	F13982	F13988	F1399	F1410	F14120	F14121
F14122	F14129	F1414	F14150	F14151	F14159	F14180	F14181
F14182	F14188	F1419	F1420	F1421	F14220	F14221	F14222
F14229	F1423	F1424	F14250	F14251	F14259	F14280	F14281
F14282	F14288	F1429	F14920	F14921	F14922	F14929	F1494
F14950	F14951	F14959	F14980	F14981	F14982	F14988	F1499
F1510	F15120	F15121	F15122	F15129	F1514	F15150	F15151

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
F15159	F15180	F15181	F15182	F15188	F1519	F1520	F1521
F15220	F15221	F15222	F15229	F1523	F1524	F15250	F15251
F15259	F15280	F15281	F15282	F15288	F1529	F15920	F15921
F15922	F15929	F1593	F1594	F15950	F15951	F15959	F15980
F15981	F15982	F15988	F1599	F1610	F16120	F16121	F16122
F16129	F1614	F16150	F16151	F16159	F16180	F16183	F16188
F1619	F1620	F16220	F16221	F16229	F1624	F16250	F16251
F16259	F16280	F16283	F16288	F1629	F16920	F16921	F16929
F1694	F16950	F16951	F16959	F16980	F16983	F16988	F1699
F17208	F17209	F17218	F17219	F17228	F17229	F17298	F17299
F1810	F18120	F18121	F18129	F1814	F18150	F18151	F18159
F18180	F18188	F1819	F1820	F1821	F18220	F18221	F18229
F1824	F18250	F18251	F18259	F18280	F18288	F1829	F18920
F18921	F18929	F1894	F18950	F18951	F18959	F18980	F18988
F1899	F1910	F19120	F19121	F19122	F19129	F1914	F19150
F19151	F19159	F1916	F19180	F19181	F19182	F19188	F1919
F1920	F1921	F19220	F19221	F19222	F19229	F19230	F19231
F19232	F19239	F1924	F19250	F19251	F19259	F1926	F19280
F19281	F19282	F19288	F1929	F19920	F19921	F19922	F19930
F19931	F19932	F19939	F1994	F19950	F19951	F19959	F1996
F19980	F19981	F19982	F19988	F1999	F200	F201	F202
F205	F2081	F209	F21	F22	F23	F24	F250
F251	F258	F259	F29	F3010	F3011	F3012	F3013
F302	F303	F304	F309	F310	F3110	F3111	F3112
F3113	F312	F3130	F3131	F3132	F314	F315	F3160
F3161	F3162	F3163	F3164	F3173	F3174	F3175	F3176
F3177	F3178	F3181	F319	F320	F321	F322	F323
F324	F325	F329	F330	F331	F332	F333	F3341
F3342	F339	F340	F341	F39	F4001	F4002	F4010
F4011	F40210	F40218	F40220	F40228	F40230	F40231	F40232
F40233	F40240	F40241	F40242	F40243	F40248	F40290	F40291
F40298	F408	F410	F411	F419	F42	F430	F4310
F4311	F4312	F4320	F4321	F4322	F4323	F4324	F4325
F438	F439	F440	F441	F444	F445	F446	F447
F4481	F449	F450	F451	F4520	F4521	F4522	F4529
F4541	F4542	F458	F459	F481	F482	F488	F489
F5000	F5001	F5002	F502	F508	F509	F5101	F5102
F5103	F5104	F5105	F5109	F5111	F5112	F5113	F5119
F513	F514	F515	F518	F519	F520	F521	F5221
F5222	F5231	F5232	F524	F525	F526	F529	F54

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
F551	F553	F600	F602	F603	F604	F605	F606
F607	F6081	F609	F630	F631	F632	F633	F6381
F6389	F639	F641	F642	F648	F649	F650	F651
F652	F653	F654	F6551	F6552	F6581	F6589	F659
F66	F6810	F6811	F6812	F6813	F69	F70	F72
F73	F79	F800	F801	F802	F809	F8181	F819
F82	F840	F842	F845	F849	F900	F901	F902
F908	F909	F911	F912	F913	F918	F919	F930
F938	F939	F940	F941	F948	F950	F951	F952
F959	F980	F981	F9821	F9829	F983	F984	F989
G3184	G44209	G4720	G4721	G4722	G4723	G4724	G4725
G4726	G4727	G4729	R413	R41840	R41841	R41842	R41843
R41844	R4189	R45850	T7402XA	T7402XD	T7402XS	T7411XA	T7411XD
T7411XS	T7412XA	T7412XD	T7412XS	T7421XA	T7421XD	T7421XS	T7422XA
T7422XD	T7422XS	T7602XA	T7602XD	T7602XS	T7611XA	T7611XD	T7611XS
T7612XA	T7612XD	T7612XS	T7621XA	T7621XD	T7621XS	T7622XA	T7622XD
T7622XS	Z0389	Z561	Z600	Z608	Z609	Z6331	Z6332
Z634	Z635	Z638	Z644	Z655	Z658	Z69010	Z69020
Z69021	Z6982	Z72810	Z72811	Z736	Z781	Z8651	Z9183

4.2.1 Prior Authorization

4.2.1.1 Initial Prior Authorization Request for Encounters or Visits Beyond the 30 Encounter or Visit Limit

Each Medicaid client is limited to 30 encounters or visits per calendar year. It is anticipated that this limitation, which allows for 6 months of weekly therapy or 12 months of biweekly therapy, is adequate for 75 to 80 percent of clients. Clinicians should plan therapy with this limit in mind, and the documentation must support the medical necessity of the behavioral therapy for the duration of the therapy from beginning to end. However, it may be medically necessary for some clients to receive extended encounters or visits. In these situations, prior authorization is required.

Providers with established clients must request prior authorization when they determine the client is approaching 30 encounters or visits to all behavioral health providers for the calendar year and more visits are needed to accomplish goals of treatment. If the client changes providers during the year and the new provider is unable to obtain complete information on the client's encounters or visits, providers are encouraged to obtain prior authorization before rendering services.

After the 30 encounter or visit annual limitation has been met, prior authorization will be considered in increments of up to 10 additional encounters or visits per request. All requests for prior authorization of extensions beyond the 30 initial encounter or visit annual limit must be submitted on a completed Outpatient Psychotherapy/Counseling Request Form, which must include the following:

- Client name and Medicaid number, date of birth, age, and sex
- Provider name and identifier
- A current DSM diagnosis
- History of substance abuse

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- Current medications
- Current living condition
- Clinical update, including specific symptoms and response to past treatment, treatment plan (measurable short term goals for the extension, specific therapeutic interventions to be used in therapy, measurable expected outcomes of therapy, length of treatment anticipated, and planned frequency of encounters or visits)
- Number and type of services requested
- Dates for services requested (based on the frequency of encounters or visits for services that will be provided)
- Date on which the current treatment is to begin
- Indication of court-ordered or Department of Family and Protective Services (DFPS)-directed services, when appropriate

Refer to: Outpatient Psychotherapy/Counseling Request Form on the TMHP website at www.tmhp.com.

Note: *All areas of the request form must be completed with the required information as stated on the form. If additional room is needed for a particular section of the form, providers may state "see attached," in that section and attach the additional pages to the form. The attachment must contain the specific information required in that section of the form.*

A request for outpatient behavioral health services must be submitted no sooner than 30 days before the date of service being requested and no later than the date of service being requested so that the most current information is provided.

Prior authorization requests will be reviewed by a mental health professional. The number of encounters or visits authorized will be dependent upon the client's symptoms and response to past treatment. If the client requires additional extensions, the provider must submit a new request for prior authorization at the end of each extension period. The additional requests must include new documentation concerning the client's current condition.

4.2.1.1.1 Client Condition Requirements

The following documentation requirements indicating the client's condition must be submitted when requesting prior authorization of initial outpatient services beyond the 30-encounter or visit annual limitation:

- A description of why treatment is being sought at the present time
- A mental status examination that verifies that a diagnosis is listed in the current DSM
- A description of any existing psychosocial or environmental problems
- A description of the current level of social and occupational or educational functioning

4.2.1.1.2 Initial Assessment Requirements

There must be a pertinent history containing the following assessment requirements:

- A chronological psychiatric, medical or substance use disorder history with time frames of prior treatment and the outcomes of that treatment
- A social and family history
- An educational and occupational history

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4.2.1.1.3 Active Treatment Plan Requirements

The treatment plan must contain the following:

- A description of the primary focus of the treatment
- Clearly defined discharge goals that indicate that treatment can be successfully accomplished
- The expected number of sessions it will take to reach the discharge goals, which must be based on the standards of practice for the client's diagnosis
- Family therapy services are appropriately planned unless there are valid clinical contraindications

4.2.1.1.4 Discharge Plan Requirements

Discharge planning must reflect the following:

- A plan for concluding the client's treatment based on an assessment of the client's progress in meeting the discharge goals
- Identification of the client's aftercare needs that includes a plan for transition

4.2.1.2 Subsequent Prior Authorization Request for Encounters or Visits after the Initial Prior Authorized Encounters

4.2.1.2.1 Client Condition Requirements

The following documentation requirements indicating the client's condition must be submitted when requesting prior authorization for subsequent encounters or visits.

All of the requirements for the initial authorized treatment sessions must be met in addition to an assessment of the client's response to treatment, which indicates one of the following:

- The client has not achieved the discharge goals necessary to conclude treatment, but the client's progress indicates that treatment can be concluded within a short period of time.
- The client's psychiatric condition has not responded to a trial of short-term outpatient therapy and there is potential for serious regression or admission to a more intensive setting without ongoing outpatient management (requiring several months or longer of outpatient therapy).
- The client's condition is one that includes long-standing, pervasive symptoms or patterns of maladaptive behavior.

4.2.1.2.2 Active Treatment Plan Requirements

There must be an assessment that explains why the client was unable to achieve the expected treatment objectives that were previously set. The assessment must address the following:

- Factors that interfered or are interfering with the client's ability to make progress as expected
- The continued appropriateness of the treatment goals
- The continued appropriateness of the type of therapy being utilized
- The need for obtaining consultation
- The current diagnosis and the need for revisions or additional assessments
- The ongoing treatment plan must reflect the initial treatment plan requirements, and the additional information must include:
    - Changes in primary treatment focus or discharge goals have been identified and are consistent with the client's current condition
    - The expected progress toward the discharge goals is described within the extended time frame

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- Appropriate adjustments have been made in the medication regimen based on the client's therapeutic response
- No contraindications to the use of the prescribed medications are present

4.2.1.2.3 Discharge Plan Requirements

Discharge planning must reflect the following:

- A plan for concluding the client's treatment based on an assessment of the client's progress in meeting the discharge goals
- An identification of the client's aftercare needs that includes a plan for transition

4.2.1.3 Prior Authorization for Court-Ordered and Department of Family and Protective Services (DFPS)-Directed Services

A request for prior authorization of court-ordered or DFPS-directed services must be submitted no later than seven calendar days after the date on which the services began.

Specific court-ordered outpatient behavioral health services for evaluations, psychological or neuropsychological testing, or treatment may be prior authorized as mandated by the court. Prior authorization requests must be accompanied by a copy of the court document signed by the judge. If the requested services differ from or go beyond the court order, the additional services will be reviewed for medical necessity.

Specific DFPS-directed services for outpatient behavioral health services may be prior authorized as directed. Prior authorization requests must be accompanied by a copy of the directive or summary signed by the DFPS employee. If the requested services differ from or go beyond the DFPS direction, the additional services will be reviewed for medical necessity.

Court-ordered or DFPS-directed services must be submitted with modifier H9.

Mail or fax prior authorization request to:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax: 1-512-514-4213

Providers can submit requests for extended outpatient psychotherapy or counseling through the TMHP website at www.tmhp.com.

Refer to: Subsection 5.5.1, "Prior Authorization Requests Through the TMHP Website" in Section 5, "Prior Authorization" (*Vol. 1, General Information*) for additional information, including mandatory documentation and retention requirements.

4.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including behavioral health services. The documentation must support the medical necessity of the behavioral therapy for the duration of the therapy from beginning to end.

Behavioral health services are subject to retrospective review and recoupment if documentation does not support the service billed.

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4.4 Claims Filing and Reimbursement

Providers must bill Medicare before Medicaid when clients are eligible for services under both programs. Medicaid's responsibility for the coinsurance or deductible is determined in accordance with Medicaid benefits and limitations. Providers must check the client's Medicare card for Part B coverage before billing Medicaid. When Medicare is primary, it is inappropriate to bill Medicaid without first billing Medicare.

Note: *Texas Medicaid may reimburse the full amount of the Medicare coinsurance and deductible for services rendered by licensed clinical social worker (LCSW) providers.*

Refer to: Subsection 2.7.2, "Part B" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

Subsection 4.11.2, "Medicare Part B Crossovers" in Section 4, "Client Eligibility" (*Vol. 1, General Information*) for information about how coinsurance and deductibles may be reimbursed by Texas Medicaid.

LCSW, LMFT, and LPC 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: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Subsection 6.1, "Claims Information" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

According to 1 TAC §355.8091, the Texas Medicaid rate for LCSWs, LMFTs, and LPCs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com. Under 1 TAC §355.8261, an FQHC is reimbursed according to its specific prospective payment system (PPS) rate per visit for LCSW services.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied.

Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Note: *Texas Medicaid may reimburse the full amount of the Medicare coinsurance and deductible for services rendered by licensed clinical social worker (LCSW) providers.*

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

Subsection 6.3, "The 12-Hour System Limitation" in this handbook for details about the 12-hours-per-day behavioral health services limitation.

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5 Mental Health Rehabilitation, Mental Health Case Management, and Intellectual Disability Service Coordination

5.1 Enrollment

To enroll in Texas Medicaid, mental health (MH) providers must contact DSHS at 1-512-206-5810.

Qualified MH providers are eligible to enroll for MH rehabilitative services with the approval of DSHS.

5.1.1 Local Authority (LA) Providers

An LA provider who is authorized by the Department of Aging and Disability Services (DADS) to provide coordination services, must be enrolled as a Long Term Care provider, and must submit claims through the Long Term Care system.

Local authorities are the only entities that provide targeted case management (service coordination) services to clients who have an intellectual disability.

Refer to: The TMHP website at www.tmhp.com for additional information about Long Term Care enrollment and billing requirements.

5.2 Services, Benefits, Limitations, and Prior Authorization

5.2.1 Service Coordination

Texas Medicaid provides the following service coordination services:

- Service coordination for people who have an intellectual disability or a related condition (adult or child). Persons who have a related condition are eligible if they are being enrolled into the home and community based waiver (HCS); the Texas Home Living Waiver; or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) facility.
- Service coordination for persons who have an intellectual disability or a related condition who are enrolled in HCS or Texas Home Living waiver programs.

Service coordination funded by Medicaid as TCM is reimbursed by encounter.

There are two types of encounters:

- *Comprehensive encounter (Type A):* A face-to-face contact with an individual to provide service coordination. The comprehensive encounter is limited to one billable encounter per individual per calendar month. DADS will not authorize payment for a comprehensive encounter that exceeds the cap of one encounter per individual per calendar month.
- *Supportive encounter (Type B):* A face-to-face, telephone, or telemedicine contact with an individual or with a collateral on the individual's behalf to provide service coordination.

An LA is allowed up to three Type B encounters per calendar month for each Type A encounter that has occurred within the calendar month.

The Type B encounters are not limited to three per individual. Rather, the allowed Type B encounters may be delivered to any individual who needs a Type B encounter. These Type B encounters are allowable as long as the individual who received the Type B encounter also received a Type A encounter that same month.

For example, Sam and Mary receive a Type A encounter in June. It is allowable for the LA to bill for one Type B encounter for Sam in June and five Type B encounters for Mary in June.

Payment for an individual's Type B encounter is contingent on that individual having a Type A encounter within the same calendar month.

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Within the calendar month, the Type A encounter does not have to occur on a date before any of the Type B encounters occur.

5.2.2 * Mental Health Targeted Case Management

Texas Medicaid provides the following case management services:

- Case management for people who have serious emotional disturbance (child, 3 through 17 years of age), which includes routine and intensive case management services.
- Case management for people who have severe and persistent mental illness (adult, 18 years of age or older).

Providers must use the following procedure code and applicable modifiers for MH targeted case management:

Service	Procedure Code	Modifiers	Limitations
Routine case management (adult)	T1017	TF - Routine care HZ -Funded by criminal justice agency (as appropriate)	32 units (8 hours) per calendar day for clients who are 18 years of age and older
Intensive case management for YES Waiver (adult)	T1017	TG - Intensive care HZ -Funded by criminal justice agency (as appropriate)	32 units (8 hours) per calendar day for clients who are 18 years of age
Routine case management (child and adolescent)	T1017	TF - Routine care HA-Child/adolescent program HZ -Funded by criminal justice agency (as appropriate)	32 units (8 hours) per calendar day for clients who are 17 years of age and younger
Intensive case management (child and adolescent)	T1017	TG - Intensive care HA-Child/adolescent program HZ -Funded by criminal justice agency (as appropriate)	

Note: *Intensive case management services for individuals who are enrolled in the YES Waiver are available for clients who are 18 years of age. Intensive case management for YES Waiver clients must be authorized by DSHS.*

An MH case management reimbursable contact is the provision of a case management activity by an authorized case manager during a face-to-face meeting with an individual who is authorized to receive that specific type of case management. A billable unit of case management is 15 continuous minutes of contact.

Service coordination and case management services are not reimbursable when they are provided to a client who is eligible for Medicaid and who receives services through the HCS waiver. These services are included in the waiver. Claims submitted to TMHP for people who receive services under the HCS waiver are identified quarterly by DADS and payments are recouped.

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Texas Medicaid must *not* be billed for service coordination except for the purpose of discharge planning or waiver enrollments up to 180 days prior to the discharge for persons in ICF-IID facilities or state supported living centers, or case management services provided to people who are residents or inpatients of:

- Nursing facilities (residents who have not been identified through the Preadmission Screening and Resident Review [PASRR] process as needing specialized mental health services.).
- An ICF-IID.
- State-supported living centers.
- State MH facilities.
- Title XIX participating hospitals, including general medical hospitals.
- Private psychiatric hospitals.
- A Texas Medicaid-certified residence not already specified. Texas Medicaid must not be billed for ID service coordination provided to people enrolled in Community Living Assistance and Support Services (CLASS), Community-Based Alternatives (CBA), Program of All-inclusive Care for the Elderly (PACE), Deaf-Blind Multiple Disabilities (DBMD) or Medically Dependent Children Program (MDCP).
- An institution for mental diseases, such as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing the diagnosis, treatment, or care of people who have mental diseases, including medical attention, nursing care, and related services.
- A jail or public institution.

Note: *A contact by the service coordinator to assist in the discharge planning of some of the above may be reimbursed, if it is provided within 180 days before discharge. Service coordination services provided to people who are on predischarge furlough to the community from a nursing facility, intermediate care facility, or state-supported living centers may be reimbursed. Service coordination services provided to people who are on trial placement from a state MR facility to the community may be reimbursed if the person remains eligible for Texas Medicaid upon release from the facility and receives regular Texas Medicaid coverage.*

Texas Medicaid must *not* be billed for MH case management services provided before the establishment of a diagnosis of mental illness and the authorization of services.

Note: *For more information about billing for MH Case Management, providers should refer to 25 TAC, Part 1, Chapter 412, Subchapter I and the Mental Health Case Management Billing Guidelines available through the DSHS Mental Health and Substance Abuse Program Services Division.*

5.2.3 MH Rehabilitative Services

The following rehabilitative services may be provided to individuals who satisfy the criteria of the MH priority population and who require rehabilitative services as determined by an assessment:

- Adult Day Program
- Medication Training and Support
- Crisis Intervention
- Skills Training and Development
- Psychosocial Rehabilitative Services

These services may be provided to a person who has a single severe mental disorder (excluding MR, pervasive developmental disorder, or substance abuse) or a combination of severe mental disorders as defined in the most current DSM.

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The following modifiers must be billed with the most appropriate procedure code as indicated in the sections below:

Modifier	Description
ET	Emergency treatment
HA	Child/adolescent program
HQ	Group setting
HZ*	Funded by criminal justice agency
TD	RN
***Note: Modifier HZ must be used in addition to the modifiers indicated in the sections below if the service is funded by a criminal justice agency.**	

Important: *If multiple modifiers are indicated for a specific service as shown below, all applicable modifiers must be included on the claim with the most appropriate procedure code.*

5.2.3.1 Day Program

Procedure code G0177 may be reimbursed for up to 6 units (4.5 to 6 hours) per calendar day, in any combination, for clients who are 18 years of age and older.

Service	Procedure Code	Modifier 1	Modifier 2
Adult Day Program for Acute Needs	G0177	-	-

5.2.3.2 Medication Training and Support

Procedure code H0034 may be reimbursed for up to 8 units (2 hours) per calendar day in any combination.

Service	Procedure Code	Modifier 1	Modifier 2
Individual services for the adult	H0034	-	-
Group services for the adult	H0034	HQ	-
Individual services for the child and adolescent (with or without other individual)	H0034	HA	-
Group services for the child and adolescent (with or without other group)	H0034	HA	HQ

5.2.3.3 Crisis Intervention

Procedure code H2011 may be reimbursed for up to 96 units (24 hours) per calendar day in any combination.

Service	Procedure Code	Modifier 1	Modifier 2
Adult services	H2011	-	-
Child and adolescent services	H2011	HA	-

5.2.3.4 Skills Training and Development

Procedure code H2014 may be reimbursed for up to 16 units (4 hours) per calendar day, in any combination.

Service	Procedure Code	Modifier 1	Modifier 2
Individual services for the adult	H2014	-	-
Group services for the adult	H2014	HQ	-

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Service	Procedure Code	Modifier 1	Modifier 2
Individual services for the child and adolescent (with or without other individual) ***Note:*** *These services are rendered to the child or to the parent, guardian or legally authorized representative (LAR) on behalf of the child as clinically indicated in the child's individualized treatment plan.*	H2014	HA	-
Group services for the child and adolescent	H2014	HA	HQ

Claims for managed care clients must be submitted to to client's MCO. Targeted case management and psychiatric rehabilitation services that are funded by by a criminal justice agency (submitted with modifier HZ) are carved out and must be submitted to TMHP.

5.2.3.5 Psychosocial Rehabilitative Services

Procedure code H2017 for nonemergency services may be reimbursed for up to 16 units (4 hours) per calendar day, in any combination, for clients who are 18 years of age and older.

Emergency services may be reimbursed for up to 96 units (24 hours) per calendar day, in any combination.

Service	Procedure Code	Modifier 1	Modifier 2
Individual services	H2017	-	-
Individual services rendered by an RN	H2017	TD	-
Group services	H2017	HQ	-
Group services rendered by an RN	H2017	HQ	TD
Individual crisis services	H2017	ET	-

5.2.3.6 Rehabilitative Services Limitations

Texas Medicaid must *not* be billed for the following:

- Rehabilitative services provided:
  - Before the establishment of a diagnosis of mental illness and authorization of services.
  - Rehabilitative services provided to individuals who reside in an institution for mental diseases.
  - Rehabilitative services provided to general acute care hospital inpatients.
- Vocational services
- Educational services
- Nursing facility residents who have not been identified through the Preadmission Screening and Resident Review (PASRR) process as needing specialized mental health services.
- Services provided to individuals in jail or a public institution

With the exception of Crisis Intervention Services and Psychosocial Rehabilitation Services delivered in a crisis situation, no reimbursement is available for a combination of MH rehabilitative services delivered in excess of eight hours per individual, per day.

Refer to: 25 TAC, Part I, Chapter 416, Subchapter A and the Medicaid MH rehabilitative billing guidelines, which are available through the DSHS Mental Health and Substance Abuse Division, for more information.

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5.2.3.7 Billing Units

All claims for reimbursement for rehabilitative services are based on the actual amount of time the eligible individual or primary caregiver or legal guardian of an eligible individual is engaged in face-to-face contact with a service provider. The billable units are individual, group (15 continuous minutes), and day programs (45 to 60 continuous minutes). No reimbursement is available for partial units of service.

5.2.4 Prior Authorization

Prior authorization is not required for intellectual disability services.

The following Mental Health Rehabilitative Services require prior authorization:

- Mental Health Rehabilitative Services must be authorized in accordance with 25 TAC §419.456.
- Mental Health Targeted Case Management Services must be pre-authorized in accordance with 25 TAC §412.406

5.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including MH and MR services.

MH and MR services are subject to retrospective review and recoupment if documentation does not support the service billed.

5.4 Claims Filing and Reimbursement

MR coordination services and MH case management and rehabilitative services must be submitted to TMHP in an approved electronic claims 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 them.

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.

MHMR are cost reimbursed in accordance with 1 TAC §§355.743, 355.746, and 355.781. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

5.4.1 Managed Care Clients

Claims for managed care clients must be submitted to the client's MCO. Targeted case management and psychiatric rehabilitation services that are funded by by a criminal justice agency (submitted with modifier HZ) are carved out and must be submitted to TMHP.

5.4.2 Reimbursement Reductions

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied.

Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

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Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.

Subsection 6.1, "Claims Information" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement and the federal matching percentage.

6 Physician, Psychologist, and Licensed Psychological Associate (LPA) Providers

6.1 Enrollment

6.1.1 Physicians

To enroll in Texas Medicaid to provide medical services, physicians (doctor of medicine [MD] or doctor of osteopathy [DO]) and doctors (doctor of dental medicine [DMD], doctor of dental surgery [DDS], doctor of optometry [OD], and doctor of podiatric medicine) must be authorized by the licensing authority of their profession to practice in the state where the services are performed at the time they are provided.

Providers cannot be enrolled in Texas Medicaid if their licenses are due to expire within 30 days. A current Texas license must be submitted.

Important: *The Centers for Medicare & Medicaid Services (CMS) guidelines mandate that physicians who provide durable medical equipment (DME) products such as spacers or nebulizers are required to enroll as Texas Medicaid DME providers.*

All physicians except gynecologists, pediatricians, pediatric subspecialists, pediatric psychiatrists, and providers performing only Texas Health Steps (THSteps) medical or dental checkups must be enrolled in Medicare before enrolling in Medicaid. TMHP may waive the Medicare enrollment prerequisite for pediatricians or physicians whose type of practice and service may never be billed to Medicare.

6.1.2 Psychologists

To enroll in Texas Medicaid, whether as an individual or as part of a group, a psychologist must be licensed by the Texas State Board of Examiners of Psychologists (TSBEP). Psychologists must also be enrolled in Medicare or obtain a pediatric practice exemption from TMHP Provider Enrollment. If a pediatric-based psychologist is enrolling as part of a Medicare-enrolled group, then the psychologist must also be enrolled in Medicare. Psychologists cannot be enrolled if they have a license that is due to expire within 30 days. A current license must be submitted. Texas Medicaid accepts temporary licenses for psychologists.

Refer to: Subsection 1.1, "Provider Enrollment and Reenrollment" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about procedures for enrolling as a Medicaid provider.

6.1.3 Licensed Psychological Associate (LPA)

LPAs must be licensed by TSBEP. LPAs are expected to abide by their scope and standards of practice.

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Services performed by an LPA are a Medicaid-covered benefit when the following conditions are met:

- The services must be performed under the direct supervision of a licensed, Medicaid-enrolled psychologist.
- The supervising psychologist must be in the same office, building, or facility when the service is provided and must be immediately available to furnish assistance and direction.
- The LPA performing the behavioral health service must be an employee of either the licensed psychologist or the legal entity that employs the licensed psychologist.

The TSBEP requires an LPA to work under the direct supervision of a licensed psychologist and does not allow an LPA to engage in independent practice. Therefore, an LPA will not be independently enrolled in the Medicaid program and must provide services under the delegating psychologist's provider identifier.

LPAs may perform the same outpatient behavioral health services as licensed psychologists when the licensed psychologist delegates the services and directly supervises the LPA. These services include psychiatric diagnostic evaluations, psychological and neuropsychological testing, and psychotherapy or counseling (including individual, group, or family counseling.) A modifier must be used to identify whether the psychologist or the LPA performed the service.

Psychological services provided by a psychologist or LPA must be billed with a modifier. Any claim submitted without a modifier will be denied. Psychological services provided by an LPA must be billed under the supervising psychologist's Medicaid identifier or the Medicaid identifier of the legal entity employing the supervising psychologist.

The following modifiers are to be used with procedure codes for licensed psychologist services:

Modifier	Description
AH	Identifies services provided by a clinical psychologist
U9	Identifies services provided by a PLP
UC	Identifies services provided by an LPA

Claims for services that were performed by an LPA must be submitted with modifier UC and must include the LPA's license number. Claims that are submitted with modifier UC but without the LPA's license number are subject to retrospective review.

Retrospective review may be performed to validate that services performed on the same client are not billed for the same time and date of service, and that modifiers billed match the provider performing the services.

Services performed by the LPA will be reduced to 70 percent of the psychologist reimbursement fee schedule rate.

6.1.4 Provisionally Licensed Psychologist (PLP)

Outpatient behavioral health services that are performed by a provisionally licensed psychologist (PLP) is a benefit of Texas Medicaid when all of the following conditions are met:

- The services must be performed under the direct supervision of a licensed psychologist in accordance with the Texas State Board of Examiners of Psychologists (TSBEP) guidelines.
- The supervising psychologist must be in the same office, building, or facility when and where the service is provided and must be immediately available to furnish assistance and direction.
- The PLP who is performing the behavioral health service must be an employee of either the licensed psychologist or the legal entity that employs the licensed psychologist.

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PLPs are expected to abide by their scopes and standards of practice. A PLP may perform all of the services that are benefits of Texas Medicaid when the services are performed by a psychologist. Providers may refer to Section 6, "Physician, Psychologist, and Licensed Psychological Associate (LPA) Providers" of this handbook for guidelines, procedure codes, and diagnosis codes for services that can be performed by a psychologist.

PLPs are not independently enrolled in Texas Medicaid; therefore, they do not have a provider identifier. Claims for services that are provided by a PLP must be submitted with modifier U9 under the provider identifier of the supervising psychologist and must include the license number of the PLP. Claims that are submitted with modifier U9 but without the PLP's license number will be subject to retrospective review.

All providers are limited to performing a combined total of 12 hours of behavioral health services per day. The 12-hour-per-day system limitation will not apply to claims that are submitted with modifier U9 because a psychologist can delegate to multiple PLPs.

Individual PLPs who perform services under the direct supervision of a psychologist will be subject to retrospective review of claims for behavioral health services that are submitted in excess of 12 hours per day.

PLP services will be reimbursed at 70 percent of the psychologist fee.

6.2 Services, Benefits, Limitations, and Prior Authorization

6.2.1 Physicians

Behavioral health services, including diagnostic evaluations, psychotherapy or counseling (including individual, group, or family counseling), psychological and neuropsychological testing, and pharmacological management are benefits of Texas Medicaid when these services are provided to clients who are experiencing a significant behavioral health issue that is causing distress, dysfunction, or maladaptive functioning as a result of a confirmed or suspected psychiatric condition, as defined in the most current edition of the DSM.

6.2.2 Psychologists, LPAs, and PLPs

Psychologists who are licensed by the TSBEP and enrolled as Medicaid providers and LPAs and PLPs who are under the direct supervision of a psychologist are authorized to perform counseling and testing for mental illness or debility. Treatment does not include the practice of medicine.

The services provided by a social worker, psychiatric nurse, or mental health worker are not covered by Texas Medicaid and cannot be billed under the provider identifier of any other outpatient behavioral health provider.

Psychologists must not bill for services performed by students, interns, or licensed professionals under their supervision except for services provided by LPAs and PLPs. For mental health services, only the licensed psychologist and other Medicaid enrolled provider actually performing the service may bill Texas Medicaid. The services provided by an LCSW, LPC, or LMFT are reimbursable directly to the LCSW, LPC, or LMFT.

6.3 The 12-Hour System Limitation

The following provider types are limited in the Medicaid claims processing system to reimburse for a maximum combined total of 12-hours per day, per provider system limitation for inpatient and outpatient behavioral health services:

- Psychologist
- APRN
- PA

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- LCSW
- LMFT
- LPC
- PLP

Because MDs and DOs can delegate and may submit claims in excess of 12 hours per day, they are not subject to the 12-hour system limitation.

Providers who perform group therapy may possibly submit claims in excess of 12 hours in a given day due to the manner in which group therapy is billed.

Because a psychologist can delegate to multiple LPAs and PLPs and may submit claims for LPA services in excess of 12 hours per day, LPAs and PLPs are not subject to the 12-hour system limitation.

All providers, including MDs and DOs and each provider to whom they delegate, are subject to retrospective review as outlined below, including the following:

- MDs and DOs and each provider to whom they delegate.
- LPAs performing services under the direct supervision of a psychologist.

Court-ordered and DFPS services are not subject to the 12-hour system limitation per provider, per day when billed with modifier H9.

6.3.1 Retrospective Review of Behavioral Health Services Billed in Excess of 12 Hours per Day

No single behavioral health services provider may be reimbursed for more than 12 hours of behavioral health services per day. HHSC and TMHP routinely perform retrospective review of all providers. In addition, all provider types including MDs and DOs and each provider to whom they delegate are subject to retrospective review for the total hours of services performed and billed in excess of 12 hours per day.

Retrospective review of any behavioral health provider may include:

- All behavioral health procedure codes included in the 12-hour system limitation
- All evaluation and management (E/M) procedure codes, including those listed in the E/M section of the *Current Procedural Terminology* (CPT), billed with a psychiatric diagnosis
- All remaining behavioral health procedure codes not included in the 12-hour system limitation such as group therapy and pharmacological management

Documentation requirements for all services billed are listed for each individual specialty in this handbook. All documentation is subject to retrospective review. If inappropriate payments are identified on retrospective review for any provider type, the reimbursement will be recouped.

Behavioral health services subject to the 12-hour system limitation and retrospective review will be based on the provider's TPI base (the first seven digits of the TPI). The location where the services occurred will not be a basis for exclusion of hours. If a provider practices at multiple locations and has a different suffix for the various locations, but has the same TPI base, all services identified for restriction to the provider 12-hour limit will be counted regardless of whether they were performed at different locations.

6.3.2 Procedure Codes Included in the 12-Hour System Limitation

The table below lists the inpatient and outpatient behavioral health procedure codes included in the system limitation, along with the time increments the system will apply based on the billed procedure code. The time increments applied will be used to calculate the 12-hour per day system limitation.

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Procedure Code	Time Assigned by Procedure Code Description	Time Applied
90791	60 minutes	60 minutes
90792	60 minutes	60 minutes
90832	30 minutes	30 minutes
90833*	30 minutes	30 minutes
90834	45 minutes	45 minutes
90836*	45 minutes	45 minutes
90837	60 minutes	60 minutes
90838*	60 minutes	60 minutes
90847	N/A	50 minutes
96101	60 minutes	60 minutes
96110	N/A	30 minutes
96111	N/A	60 minutes
96116	60 minutes	60 minutes
96118	60 minutes	60 minutes
N/A= Not Applicable *** Note: Procedure codes 90833, 90836, and 90838 are add-on procedure codes to be billed with the most appropriate E/M procedure code.**		

If a cutback occurs for procedure codes included in the system limitation, the quantity allowed per service session designated is rounded up to one decimal point or rounded down to one decimal point following standard rounding procedures (as shown in the following example):

Total Time	Rounded Time
11.71 hours 11.72 hours 11.73 hours 11.74 hours	11.7 hours
11.75 hours 11.76 hours 11.77 hours 11.78 hours 11.79 hours	11.8 hours

6.3.3 Formula Applied

For client L on the table below, 80 billed minutes are applied, but the provider only has 40 available minutes before reaching the 12-hour daily limit (720 minutes); therefore, only 40 minutes are considered for reimbursement. The 40 allowed minutes are divided into the 80 applied minutes to get an allowed unit of 0.5 for payment.

TPI Base	TPI Suffix	Client	Code Billed	Amount Applied*	Total Time Paid	Qty.
1234567	01	A	99201/90836	45	45	1
1234567	02	B	90837	60	60	1
1234567	01	C	99211/90836	45	45	1

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TPI Base	TPI Suffix	Client	Code Billed	Amount Applied*	Total Time Paid	Qty.
1234567	03	D	90837	60	60	1
1234567	01	E	99213/90838	60	60	1
1234567	01	F	90837	60	60	1
1234567	02	G	99213/90838	60	60	1
1234567	01	H	99211/90836	45	45	1
1234567	01	J	90837	60	60	1
1234567	02	K	90837	60	60	1
1234567	01	L	90837	60	60	1
1234567	01	M	90837	60	60	1
Final claim for the day			Subtotal	675 minutes		
1234567	01	N	99213/90838	60	45	.75
Total				735 billed minutes for 1 day	720 paid minutes for 1 day	
* **Time applies towards the 12-hour limit.**						

Reminder: *The procedure codes listed above have time ranges built in, so the quantity billed should be reflected in quantities of one, versus the actual amount of time spent with the client, i.e., procedure code 90832 is for 30 minutes of time spent with the client. The provider would bill a quantity of one when submitting a claim.*

Refer to: Psychotherapy with Evaluation and Management (E/M) on the TMHP website at www.tmhp.com for an claim form example for psychotherapy services billed with an E/M procedure code and an add-on procedure code.

If a claim is adjusted and causes additional minutes to be available to the provider for that day, the system does not automatically reprocess any previously denied or cutback claims that would now be payable. It is up to the provider to request reprocessing of the denied or cutback claims.

Claims submitted for psychological evaluation or testing performed by a qualified provider at the request of the DFPS, or by a court order, are not counted against the benefit limitations. These claims must be submitted with the following information:

- The provider must submit the claim using modifier H9 with the procedure codes billed.
- If psychological services are court ordered, the claim must include a copy of the court order for outpatient treatment signed by the judge, and documentation of medical necessity.
- If psychological services are directed by DFPS, the claim must include the name and telephone number of the DFPS employee who provided the direction, the reason for the DFPS request, and documentation of medical necessity.

Texas Medicaid does not cover treatment for chronic diagnoses such as intellectual disability and organic brain syndrome. Psychiatric daycare is not a covered service.

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Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement methodologies.

Outpatient Psychotherapy/Counseling Request Form on the TMHP website at www.tmhp.com.

Section 4, "Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), and Licensed Professional Counselor (LPC)" in this handbook.

6.4 Outpatient Behavioral Health Services

Outpatient behavioral health services performed by the following providers are benefits to clients of any age who have a diagnosis as outlined below when provided in the office, home, skilled nursing or intermediate care facility, outpatient hospital, extended care facility, or in other locations:

- CNS
- LCSW
- LPC
- LMFT
- Licensed Psychologist
- Licensed LPA and PLPs under the direct supervision of a psychologist in accordance with the TSBEP
- PA
- Physicians/psychiatrist
- NP

The following procedure codes may be used for psychiatric services:

Service	Procedure Code(s)
Diagnostic	90791 (without medical services), 90792 (with medical services)
Narcosynthesis	90865
Psychological and Neuropsychological Testing	96101, 96118*
Psychotherapy	90832 (30 min), 90834 (45 min), 90837 (60 min)
Psychotherapy with evaluation and management (E/M)	E/M procedure code based on key components plus psychotherapy add-on code 90833, 90836, or 90838
Crisis psychotherapy	90839 and 90840 are noncovered procedure codes. This service is included in the appropriate therapy procedure code and is not reimbursed separately.
Family psychotherapy	90847
Group psychotherapy	90853
Pharmacologic management	E/M procedure code
Unlisted	90899
*** Procedure code 96118 is not payable for services rendered in a skilled nursing facility.**	

Interactive complexity add-on procedure code 90875 is informational only and will not be reimbursed separately from the appropriate psychotherapy procedures code.

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Family psychotherapy is defined as therapy that focuses on the dynamics of a family unit where the goal is to strengthen the family's problem solving and communication skills.

Individual psychotherapy is defined as therapy that focuses on the client but may include others in the session with the goals of treatment focused on the client versus the others in attendance.

6.4.1 Annual Encounter or Visit Limitations

Outpatient behavioral health services without prior authorization are limited to 30 encounters or visits per client, for each calendar year. An encounter or visit is defined as any outpatient behavioral health services (i.e., examination, therapy, psychological and neuropsychological testing) by any provider, in the office, outpatient hospital, nursing home, or home settings. This limitation includes outpatient encounters or visits by all practitioners, excluding pharmacological management visits.

Each individual encounter or visit and each hour of psychological or neuropsychological testing will count toward the 30-encounter or visit limitation even when services are performed by different providers on the same date of service.

Services other than pharmacological management exceeding 30 encounters or visits per calendar year, per client must be prior authorized.

6.5 Prior Authorization Requirements After the Annual Encounter or Visit Limitations Have Been Met

All outpatient behavioral health services for all provider types approved to deliver outpatient services will require prior authorization with the exception of the following:

- County Indigent Health Care Program (CIHCP) services
- FQHC and rural health clinic (RHC) services
- Laboratory and radiology services
- Mental Health Targeted Case Management and Mental Health Rehabilitation services
- Pharmacological management services (billed with the most appropriate E/M procedure code)
- SHARS behavioral health rehabilitation services
- One psychiatric diagnostic evaluation (procedure code 90791 or 90792) per year, per client, per provider (same provider)

Prior authorization requests in increments of up to 10 additional encounters or visits may be considered. Providers with established clients must request prior authorization when they determine the client is approaching 30 encounters or visits to all behavioral health providers for the calendar year. If the client changes providers during the year and the new provider is unable to obtain complete information on the client's encounters or visits, providers are encouraged to obtain prior authorization before rendering services.

All requests for prior authorization with the exception of psychological and neuropsychological testing must include a completed Outpatient Psychotherapy/Counseling Request Form dated and signed by the performing provider with the following information:

- Client name, Medicaid number, date of birth, age, and sex
- Provider name and identifier
- A current DSM diagnosis
- History of substance abuse
- Current medications
- Current living condition

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- Clinical update, including specific symptoms and responses to past treatment, treatment plan (measurable short term goals for the extension of services, specific therapeutic interventions to be used, measurable expected outcomes of therapy, anticipated length of treatment, and the planned frequency of encounters or visits)
- Number of services requested for each type of therapy and the dates based on the frequency of encounters or visits for the services to be provided
- The date on which current treatment is to begin
- An indication of court-ordered or DFPS-directed services

The Outpatient Psychotherapy/Counseling Request Form may be mailed to the TMHP Special Medical Prior Authorization Department at:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization Department
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727

The form may also be faxed to 1-512-514-4211 or submitted online on the TMHP website at www.tmhp.com.

All of the required areas on the request form must be completed. If additional space is needed for a particular section of the form, providers may state "see attached" in that section and attach the additional pages to the form. The attachment must contain the specific information required in that section of the form.

The request must be signed and received no later than the start date listed on the request form and no earlier than 30 days prior to the start date listed on the form so the most current clinical information is provided.

To avoid unnecessary denials, the provider must provide correct and complete information, including accurate documentation of medical necessity for the services requested. The provider 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 outpatient behavioral health services.

Requests for prior authorization for procedure code 90899 (psychiatric service or a procedure that is unlisted) must be submitted by the provider to the Special Medical Prior Authorization Department by mail or approved electronic method using the Special Medical Prior Authorization Request Form with documentation supporting medical necessity including:

- Client's diagnosis
- Prior treatment for this diagnosis and the medical necessity of the requested procedure
- A clear, concise description and the procedure to be performed
- The reason for recommending this particular procedure
- A procedure code that is comparable to the procedure being requested
- Documentation that this procedure is not investigational or experimental
- The physician's intended fee for this procedure

Prior authorization requests will be reviewed by a mental health professional. The number of encounters or visits authorized will be dependent upon the client's symptoms and response to past treatment. If the client requires additional extensions, the provider must submit a new request for prior authorization at the end of each extension period. The additional requests must include new documentation concerning the client's current condition.

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6.6 Court-Ordered and DFPS-Directed Services

Court-ordered services are not subject to the 12-hour system limitation per provider, per day when billed with modifier H9.

Retrospective review may occur for both the total hours of services performed per day and for the total hours of services billed per day.

6.6.1 Prior Authorization

A request for prior authorization of court-ordered or DFPS-directed services must be submitted no later than seven calendar days after the date on which the services began.

6.6.2 Documentation Requirements

If the client requires more than four hours of psychological or neuropsychological testing per day or more than eight hours of psychological or neuropsychological testing per calendar year, additional documentation is required to support the medical necessity for the additional hours. Additional psychological or neuropsychological testing hours may be considered when supported by a court-order or DFPS-direction, or as an exception on a case-by-case basis. All documentation must be maintained by the provider in the client's record.

For court-ordered admissions, a copy of the doctor's certificate and all court-ordered commitment papers signed by the judge must be submitted with the psychiatric hospital inpatient form.

Specific court-ordered services for evaluations, psychological or neuropsychological testing, or treatment may be prior authorized as mandated by the court. Prior authorization requests must be accompanied by a copy of the court document signed by the judge. If the requested services differ from or go beyond the court order, the additional services will be reviewed for medical necessity.

Specific DFPS-directed services for evaluations, psychological or neuropsychological testing, or treatment may be prior authorized as directed. Prior authorization requests must be accompanied by a copy of the directive or summary signed by the DFPS employee. If the requested services differ from the DFPS direction, the additional services will be reviewed for medical necessity. Requested services beyond those directed by DFPS are subject to medical necessity review.

6.7 Electroconvulsive Therapy (ECT)

ECT (procedure code 90870) is the induction of convulsions by the passage of an electric current through the brain. It is used in the treatment of certain psychiatric disorders. ECT treatments are limited to one per day.

ECT performed by the following providers may be provided in the office, outpatient hospital, and inpatient hospital setting:

- Physicians
- CNS
- PA
- NP

Authorization is not required for ECT services.

Psychotherapy billed in addition to ECT on the same day will be denied as part of another procedure on the same day.

Hospital subsequent care (procedure codes 99231, 99232, or 99233) billed on the same day as ECT is not a separate benefit. Hospital subsequent care for diagnoses unrelated to the ECT will be considered on appeal.

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6.8 Family Therapy or Counseling Services

Family psychotherapy is defined as therapy that focuses on the dynamics of a family unit where the goal is to strengthen the family's problem solving and communication skills. When providing family counseling services (procedure code 90847), the client and a family member must be present during the face-to-face visit.

According to the definition of family provided by the HHSC Household Determination Guidelines, only specific relatives are allowed to participate in family counseling services. The following specific relatives are included in family counseling services:

- Father
- Mother
- Grandfather
- Grandmother
- Brother
- Sister
- Uncle
- Aunt
- Nephew
- Niece
- First cousin
- First cousin once removed
- Stepfather
- Stepmother
- Stepbrother
- Stepsister
- Foster parent
- Legal guardian

6.8.1 Prior Authorization

Family psychotherapy is defined as therapy that focuses on the dynamics of a family unit where the goal is to strengthen the family's problem solving and communication skills. Family therapy or counseling services do not require prior authorization unless the limitation of 30 encounters or visits per calendar year has been met.

6.8.2 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including family therapy or counseling services.

6.8.3 Reimbursement

Regardless of the number of family members present per outpatient session, family counseling or psychotherapy (procedure code 90847) is reimbursed for only one Medicaid-eligible client per session.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied.

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Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

6.9 Pharmacological Management Services

Pharmacological management is a benefit of Texas Medicaid when provided by a physician, CNS, NP, or PA and are limited to the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)									
F0390	F0391	F04	F05	F060	F061	F062	F0630	F0631	F0632
F0633	F0634	F064	F068	F070	F09	F1010	F10120	F10121	F10129
F1014	F10150	F10159	F10180	F10181	F10182	F10188	F1019	F1020	F1021
F10220	F10221	F10229	F10230	F10232	F10239	F1024	F10250	F10259	F10280
F10281	F10282	F10288	F1029	F10920	F10921	F10929	F1094	F10950	F10959
F10980	F10981	F10982	F10988	F1099	F1110	F11120	F11121	F1114	F11150
F11151	F11159	F11181	F11182	F11188	F1119	F1120	F1121	F11220	F11221
F11222	F11229	F1123	F1124	F11250	F11251	F11259	F11281	F11282	F11288
F1129	F11920	F11921	F11922	F11929	F1193	F1194	F11950	F11951	F11959
F11981	F11982	F11988	F1199	F1210	F12120	F12121	F12122	F12129	F12150
F12151	F12159	F12180	F12188	F1219	F1220	F1221	F12220	F12221	F12222
F12229	F12250	F12251	F12259	F12280	F12288	F1229	F12920	F12921	F12922
F12929	F12950	F12951	F12959	F12980	F12988	F1299	F1310	F13120	F13121
F13129	F1314	F13150	F13151	F13159	F13180	F13181	F13182	F13188	F1320
F1321	F13220	F13221	F13229	F13230	F13231	F13232	F13239	F1324	F13250
F13251	F13259	F1326	F13280	F13281	F13282	F13288	F13920	F13921	F13929
F13930	F13931	F13932	F13939	F1394	F13950	F13951	F13959	F1396	F13980
F13981	F13982	F13988	F1399	F1410	F14120	F14121	F14122	F14129	F1414
F14150	F14151	F14159	F14180	F14181	F14182	F14188	F1419	F1420	F1421
F14220	F14221	F14222	F14229	F1423	F1424	F14250	F14251	F14259	F14280
F14281	F14282	F14288	F1429	F14920	F14921	F14922	F14929	F1494	F14950
F14951	F14959	F14980	F14981	F14982	F14988	F1499	F15120	F15121	F15122
F15129	F1514	F15150	F15151	F15159	F15180	F15181	F15182	F15188	F1519
F1520	F1521	F15220	F15221	F15222	F15229	F1523	F1524	F15250	F15251
F15259	F15280	F15281	F15282	F15288	F1529	F15920	F15921	F15922	F15929
F1593	F1594	F15950	F15951	F15959	F15980	F15981	F15982	F15988	F1599
F1610	F16120	F16121	F16122	F16129	F1614	F16150	F16151	F16159	F16180
F16183	F16188	F1619	F1620	F16220	F16221	F16229	F1624	F16250	F16251
F16259	F16280	F16283	F16288	F1629	F16920	F16921	F16929	F1694	F16950
F16951	F16959	F16980	F16983	F16988	F1699	F17208	F17209	F17218	F17219
F17228	F17229	F17298	F17299	F1810	F18120	F18121	F18129	F1814	F18150
F18151	F18159	F18180	F18188	F1819	F1820	F1821	F18220	F18221	F18229
F1824	F18250	F18251	F18259	F18280	F18288	F1829	F18920	F18921	F18929
F1894	F18950	F18951	F18959	F18980	F18988	F1899	F1910	F19120	F19121
F19122	F19129	F1914	F19150	F19151	F19159	F1916	F19180	F19181	F19182

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)									
F19188	F1919	F1920	F1921	F19220	F19221	F19222	F19229	F19230	F19231
F19232	F19239	F1924	F19250	F19251	F19259	F1926	F19280	F19281	F19282
F19288	F1929	F19920	F19921	F19922	F19930	F19931	F19932	F19939	F1994
F19950	F19951	F19959	F1996	F19980	F19981	F19982	F19988	F1999	F200
F201	F202	F205	F2081	F209	F21	F22	F23	F24	F250
F251	F258	F259	F29	F3010	F3011	F3012	F3013	F302	F303
F304	F309	F310	F3110	F3111	F3112	F3113	F312	F3130	F3131
F3132	F314	F315	F3160	F3161	F3162	F3163	F3164	F3173	F3174
F3175	F3176	F3177	F3178	F3181	F319	F320	F321	F322	F323
F324	F325	F329	F330	F331	F332	F333	F3341	F3342	F339
F340	F341	F39	F4001	F4002	F4010	F4011	F40210	F40218	F40220
F40228	F40230	F40231	F40232	F40233	F40240	F40241	F40242	F40243	F40248
F40290	F40291	F40298	F408	F410	F411	F419	F42	F430	F4310
F4311	F4312	F4320	F4321	F4322	F4323	F4324	F4325	F438	F439
F440	F441	F444	F445	F446	F447	F4481	F449	F450	F451
F4520	F4521	F4522	F4529	F4541	F4542	F458	F459	F481	F482
F489	F5000	F5001	F5002	F502	F508	F509	F5101	F5102	F5103
F5104	F5105	F5109	F5111	F5112	F5113	F5119	F513	F514	F515
F518	F519	F520	F521	F5221	F5222	F5231	F5232	F524	F525
F526	F529	F54	F551	F553	F600	F601	F602	F603	F604
F605	F606	F607	F6081	F609	F630	F631	F632	F633	F6381
F6389	F639	F641	F642	F648	F649	F650	F651	F652	F653
F654	F6551	F6552	F6581	F6589	F659	F66	F6810	F6811	F6812
F6813	F69	F70	F72	F73	F79	F800	F801	F802	F804
F810	F812	F8181	F819	F82	F840	F843	F900	F901	F902
F908	F909	F911	F912	F913	F918	F919	F930	F938	F939
F940	F941	F948	F950	F951	F952	F959	F980	F981	F9821
F9829	F983	F984	F989	G44209	G4720	G4721	G4722	G4723	G4724
G4725	G4726	G4727	G4729	R413	R41840	R41841	R41842	R41843	R41844
R4189	R45850	Z561	Z6331	Z6332	Z635	Z638	Z655	Z658	Z781
Z8651	Z9183								

The focus of a pharmacological management encounter or visit is the use of medication to treat a client's signs and symptoms of mental illness. When the client continues to experience signs and symptoms of mental illness necessitating discussion beyond minimal outpatient psychotherapy or counseling in a given day, the focus of the service is broader and would be outpatient psychotherapy or counseling rather than strictly pharmacological management.

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6.9.1 Indications for Pharmacological Management Services

Pharmacological management refers to the in-depth management of psychopharmacological agents, which are medications with potentially significant side effects, and represents a very skilled aspect of client care. It is intended for use for clients who are being managed primarily by psychotropic medications or electroconvulsive therapy (ECT). Pharmacological management can be provided in both the inpatient and outpatient settings.

Pharmacological management describes a physician service and cannot be provided by a non-physician or "incident to" a physician service, with the exception of CNS, NP, and PA providers whose scope of license in this state permits them to prescribe. Pharmacological management does not refer to the actual administration of medication or observation of the patient taking an oral medication. The administration and supply of oral medication are non-covered services.

Pharmacological management does not count against the 30 psychiatric visits annual limitation.

6.9.2 Prior Authorization

Pharmacological management does not require prior authorization.

6.9.3 Documentation Requirements

Documentation of medical necessity for pharmacological management must be dated (month/date/year) and signed by the performing provider and must address all of the following information in the client's medical record in legible format:

- A complete diagnosis utilizing diagnostic criteria in the current edition of the DSM
- Current list of medication(s)
- Current psychiatric symptoms and problems, to include 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
- Any medication modifications made during visit and the reasons for medication adjustments/changes or continuation
- Desired therapeutic drug levels, if applicable for medications requiring blood level monitoring, e.g., Lithium
- Current laboratory values, if applicable, for medications requiring monitoring for potential side effects, e.g., hyperglycemia caused by anti-psychotic medications
- Treatment goal(s)

6.9.4 Reimbursement

The treating provider must document the medical necessity for the chosen treatment in the client's medical record as well as the diagnosis code(s) that most accurately describes the client's condition that necessitated the pharmacological management visit. The medical record (outpatient hospital records, reports, or progress notes) should be clear and concise, documenting the reasons for the pharmacological management treatment and the outcome.

The treating provider should use the most appropriate E/M code for the pharmacological management visit depending on the place of service and complexity of the client's condition, along with modifier UD to designate the visit as primarily focused on pharmacological management.

Texas Medicaid does not reimburse pharmacological management for the actual administration of medication, or for observation of the client taking an oral medication.

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If the primary reason for the office encounter or visit is for outpatient psychotherapy or counseling, then the specific outpatient psychotherapy or counseling procedure code must be billed.

Pharmacological management is limited to one service per day, per client, by any provider in any setting.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied.

Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

6.10 Psychiatric Diagnostic Evaluations

6.10.1 Psychiatric Diagnostic Evaluation Without Medical Services

Procedure code 90791 is a benefit when the services are performed by LPCs, LMFTs, LCSWs, APRNs, LPAs, PLPs, psychiatrists/physician, or psychologists in the office, home, skilled nursing facility, outpatient hospital, nursing home, or other (place of service 9) settings. LPC, LMFT, and LCSW providers are expected to abide by their scopes and standards of practice.

A psychiatric diagnostic evaluation without medical services (procedure code 90791) includes a history, mental status assessment, and disposition and may include communication with family members. Documentation time and time spent on medical records are considered part of the diagnostic interview service and are not reimbursed separately.

6.10.2 Psychiatric Diagnostic Evaluation With Medical Services

A psychiatric diagnostic evaluation with medical services (procedure code 90792) may be covered to the extent that it is medically necessary. It includes a history, mental status assessment, and disposition, and may include communication with family members. Procedure code 90792 is a benefit only when services are performed by psychiatrists/physician, clinical nurse specialists, nurse practitioners, or physician assistants.

Examples of medical necessity include, but are not limited to, clients whose ability to communicate is impaired by an expressive or receptive language impairment from various causes, such as conductive or sensorineural hearing loss, deaf mutism, or aphasia.

Medical interpretation of laboratory and other medical diagnostic studies, documentation time, and time spent on medical records are considered part of the diagnostic interview service and are not reimbursed separately.

Psychiatric diagnostic evaluations (procedure code 90791 or 90792) are limited to the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
F0390	F0391	F04	F05	F060	F061	F062	F0630
F0631	F0632	F0633	F0634	F064	F068	F070	F09
F1010	F10121	F1014	F10150	F10151	F10159	F10180	F10181
F10182	F10188	F1019	F1020	F1021	F10221	F10230	F10231
F10232	F10239	F1024	F10250	F10251	F10259	F1026	F10280
F10281	F10282	F10288	F1029	F10921	F1094	F10950	F10951
F10959	F1096	F10980	F10981	F10982	F10988	F1099	F1110
F11120	F11121	F1114	F11150	F11151	F11159	F11181	F11182
F11188	F1119	F1120	F1121	F11220	F11221	F11222	F11229

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
F1123	F1124	F11250	F11251	F11259	F11281	F11282	F11288
F1129	F11920	F11921	F11922	F11929	F1193	F1194	F11950
F11951	F11959	F11981	F11982	F11988	F1199	F1210	F12120
F12121	F12122	F12129	F12150	F12151	F12159	F12180	F12188
F1219	F1220	F1221	F12220	F12221	F12222	F12229	F12250
F12251	F12259	F12280	F12288	F1229	F12920	F12921	F12922
F12929	F12950	F12951	F12959	F12980	F12988	F1299	F13120
F13121	F13129	F1314	F13150	F13151	F13159	F13180	F13181
F13182	F13188	F1320	F1321	F13220	F13221	F13229	F13230
F13231	F13232	F13239	F1324	F13250	F13251	F13259	F1326
F13280	F13281	F13282	F13288	F13920	F13921	F13929	F13930
F13931	F13932	F13939	F1394	F13950	F13951	F13959	F1396
F13980	F13981	F13982	F13988	F1399	F1410	F14120	F14121
F14122	F14129	F1414	F14150	F14151	F14159	F14180	F14181
F14182	F14188	F1419	F1420	F1421	F14220	F14221	F14222
F14229	F1423	F1424	F14250	F14251	F14259	F14280	F14281
F14282	F14288	F1429	F14920	F14921	F14922	F14929	F1494
F14950	F14951	F14959	F14980	F14981	F14982	F14988	F1499
F1510	F15120	F15121	F15122	F15129	F1514	F15150	F15151
F15159	F15180	F15181	F15182	F15188	F1519	F1520	F1521
F15220	F15221	F15222	F15229	F1523	F1524	F15250	F15251
F15259	F15280	F15281	F15282	F15288	F1529	F15920	F15921
F15922	F15929	F1593	F1594	F15950	F15951	F15959	F15980
F15981	F15982	F15988	F1599	F1610	F16120	F16121	F16122
F16129	F1614	F16150	F16151	F16159	F16180	F16183	F16188
F1619	F1620	F16220	F16221	F16229	F1624	F16250	F16251
F16259	F16280	F16283	F16288	F1629	F16920	F16921	F16929
F1694	F16950	F16951	F16959	F16980	F16983	F16988	F1699
F17208	F17209	F17218	F17219	F17228	F17229	F17298	F17299
F1810	F18120	F18121	F18129	F1814	F18150	F18151	F18159
F18180	F18188	F1819	F1820	F1821	F18220	F18221	F18229
F1824	F18250	F18251	F18259	F18280	F18288	F1829	F18920
F18921	F18929	F1894	F18950	F18951	F18959	F18980	F18988
F1899	F1910	F19120	F19121	F19122	F19129	F1914	F19150
F19151	F19159	F1916	F19180	F19181	F19182	F19188	F1919
F1920	F1921	F19220	F19221	F19222	F19229	F19230	F19231
F19232	F19239	F1924	F19250	F19251	F19259	F1926	F19280
F19281	F19282	F19288	F1929	F19920	F19921	F19922	F19930
F19931	F19932	F19939	F1994	F19950	F19951	F19959	F1996
F19980	F19981	F19982	F19988	F1999	F200	F201	F202

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
F205	F2081	F209	F21	F22	F23	F24	F250
F251	F258	F259	F29	F3010	F3011	F3012	F3013
F302	F303	F304	F309	F310	F3110	F3111	F3112
F3113	F312	F3130	F3131	F3132	F314	F315	F3160
F3161	F3162	F3163	F3164	F3173	F3174	F3175	F3176
F3177	F3178	F3181	F319	F320	F321	F322	F323
F324	F325	F329	F330	F331	F332	F333	F3341
F3342	F339	F340	F341	F39	F4001	F4002	F4010
F4011	F40210	F40218	F40220	F40228	F40230	F40231	F40232
F40233	F40240	F40241	F40242	F40243	F40248	F40290	F40291
F40298	F408	F410	F411	F419	F42	F430	F4310
F4311	F4312	F4320	F4321	F4322	F4323	F4324	F4325
F438	F439	F440	F441	F444	F445	F446	F447
F4481	F449	F450	F451	F4520	F4521	F4522	F4529
F4541	F4542	F458	F459	F481	F482	F488	F489
F5000	F5001	F5002	F502	F508	F509	F5101	F5102
F5103	F5104	F5105	F5109	F5111	F5112	F5113	F5119
F513	F514	F515	F518	F519	F520	F521	F5221
F5222	F5231	F5232	F524	F525	F526	F529	F54
F551	F553	F600	F602	F603	F604	F605	F606
F607	F6081	F609	F630	F631	F632	F633	F6381
F6389	F639	F641	F642	F648	F649	F650	F651
F652	F653	F654	F6551	F6552	F6581	F6589	F659
F66	F6810	F6811	F6812	F6813	F69	F70	F72
F73	F79	F800	F801	F802	F809	F8181	F819
F82	F840	F842	F845	F849	F900	F901	F902
F908	F909	F911	F912	F913	F918	F919	F930
F938	F939	F940	F941	F948	F950	F951	F952
F959	F980	F981	F9821	F9829	F983	F984	F989
G3184	G44209	G4720	G4721	G4722	G4723	G4724	G4725
G4726	G4727	G4729	R413	R41840	R41841	R41842	R41843
R41844	R4189	R45850	T7402XA	T7402XD	T7402XS	T7411XA	T7411XD
T7411XS	T7412XA	T7412XD	T7412XS	T7421XA	T7421XD	T7421XS	T7422XA
T7422XD	T7422XS	T7602XA	T7602XD	T7602XS	T7611XA	T7611XD	T7611XS
T7612XA	T7612XD	T7612XS	T7621XA	T7621XD	T7621XS	T7622XA	T7622XD
T7622XS	Z0389	Z561	Z600	Z608	Z609	Z6331	Z6332
Z634	Z635	Z638	Z644	Z655	Z658	Z69010	Z69020
Z69021	Z6982	Z72810	Z72811	Z736	Z781	Z8651	Z9183

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An interactive psychiatric diagnostic evaluation (procedure code 90791 or 90792) may be covered to the extent that it is medically necessary. Examples of medical necessity include, but are not limited to, clients whose ability to communicate is impaired by expressive or receptive language impairment from various causes, such as conductive or sensorineural hearing loss, deaf mutism, or aphasia.

Note: *Interactive complexity for psychotherapy services is not reimbursed separately. Interactive complexity add-on procedure code 90875 is informational only and will not be reimbursed separately from the appropriate psychotherapy procedures code.*

A psychiatric diagnostic evaluation may be incorporated into an E/M service provided the required elements of the E/M service are fulfilled. An E/M procedure code may be appropriate when the level of decision making is more complex or advanced than that commonly associated with a psychiatric diagnostic evaluation.

Due to the nature of these encounters or visits, the general time frame for such a diagnostic evaluation visit is one hour. A psychiatric diagnostic evaluation counts towards the 12-hour per day, per provider system limitation.

6.10.3 Prior Authorization

Psychiatric diagnostic evaluations performed in the inpatient setting are not limited to once per year, but must be based on medical necessity.

Psychiatric diagnostic evaluations do not require prior authorization when performed in the office, home, nursing facility, outpatient hospital, or other settings.

Additional psychiatric diagnostic evaluations may be considered for prior authorization on a case-by-case basis when submitted with supporting documentation, including but not limited to the following:

- A court order or a DFPS directive
- If a new episode of illness occurs after a hiatus

6.10.4 Documentation Requirements

In addition to the inpatient and outpatient psychotherapy or counseling documentation requirements outlined in this section, supporting documentation for psychiatric diagnostic evaluation examinations must include:

- Reason for referral or presenting problem
- Prior history, including prior treatment
- Other pertinent medical, social, and family history
- Clinical observations and mental status examinations
- A complete diagnosis utilizing diagnostic criteria in the current edition of the DSM
- Recommendations, including expected long term and short term goals

6.10.5 Domains of a Clinical Evaluation

The following domains must be included in the evaluation documentation:

- Reason for the evaluation
- History of the present illness
- Past psychiatric history
- History of alcohol and other substance use
- General medical history
- Developmental, psychosocial, and sociocultural history

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- Occupational and military history
- Legal history
- Family history of psychiatric disorder
- Mental status examination

The treating provider must document the medical necessity for the chosen treatment in the client's medical record and also include the diagnosis code that most accurately describes the client's condition that necessitated the psychiatric diagnostic evaluation (procedure code 90791 or 90792). The medical record (inpatient or outpatient hospital records, reports, or progress notes) must be signed and dated by the performing provider, and should be clear and concise, documenting the reasons for the psychiatric diagnostic evaluation, and the outcome.

6.11 Psychological and Neuropsychological Testing

Psychological testing (procedure code 96101) and neuropsychological testing (procedure code 96118) are covered services when they are provided by a psychiatrist, psychologist, PLP, or LPA and are limited to the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
A8100	A8101	A8109	A8181	A8183	B1001	B1009	B451
D8681	E7500	E7501	E7502	E7509	E7510	E7511	E7519
E7523	E7525	E7529	E754	F0390	F0391	F04	F05
F060	F061	F062	F0630	F0631	F0632	F0633	F0634
F064	F068	F070	F0781	F09	F1010	F10120	F10121
F10129	F1014	F10150	F10151	F10159	F10180	F10181	F10182
F10188	F1019	F1020	F1021	F10220	F10221	F10229	F10230
F10231	F10232	F10239 *	F1024	F10250	F10251	F10259	F1026
F10280	F10281	F10282	F10288	F1029	F10920	F10921	F10929
F1094	F10950	F10951	F10959	F1096	F10980	F10981	F10982
F10988	F1099	F1110	F11120	F11121	F1114 *	F11150	F11151
F11159	F11181	F11182	F11188	F1119	F1120	F1121	F11220
F11221	F11222	F11229	F1123	F1124	F11250	F11251	F11259
F11281	F11282	F11288	F1129	F11920	F11921	F11922	F11929
F1193	F1194	F11950	F11951	F11959	F11981	F11982	F11988
F1199	F1210	F12120	F12121	F12122	F12129	F12150	F12151
F12159	F12180	F12188	F1219	F1220	F1221	F12220	F12221
F12222	F12229	F12250	F12251	F12259	F12280	F12288	F1229
F12920	F12921	F12922	F12929	F12950	F12951	F12959	F12980
F12988	F1299	F1310	F13120	F13121	F13129	F1314	F13150
F13151	F13159	F13180	F13181	F13182	F13188	F1320	F1321
F13220	F13221	F13229	F13230	F13231	F13232	F13239	F1324
F13250	F13251	F13259	F1326	F13280	F13281	F13282	F13288
F13920	F13921	F13929	F13930	F13931	F13932	F13939	F1394
F13950	F13951	F13959	F1396	F13980	F13981	F13982	F13988
F1399	F1410	F14120	F14121	F14122	F14129	F1414	F14150

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
F14151	F14159	F14180	F14181	F14182	F14188	F1419	F1420
F1421	F14220	F14221	F14222	F14229	F1423	F1424	F14250
F14251	F14259	F14280	F14281	F14282	F14288	F1429	F14920
F14921	F14922	F14929	F1494	F14950	F14951	F14959	F14980
F14981	F14982	F14988	F1499	F1510	F15120	F15121	F15122
F15129	F1514	F15150	F15151	F15159	F15180	F15181	F15182
F15188	F1519	F1520	F1521	F15220	F15221	F15222	F15229
F1523	F1524	F15250	F15251	F15259	F15280	F15281	F15282
F15288	F1529	F15920	F15921	F15922	F15929	F1593	F1594
F15950	F15951	F15959	F15980	F15981	F15982	F15988	F1599
F1610	F16120	F16121	F16122	F16129	F1614	F16150	F16151
F16159	F16180	F16183	F16188	F1619	F1620	F16220	F16221
F16229	F1624	F16250	F16251	F16259	F16280	F16283	F16288
F1629	F16920	F16921	F16929	F1694	F16950	F16951	F16959
F16980	F16983	F16988	F1699	F17208	F17209	F17218	F17219
F17228	F17229	F17298	F17299	F1810	F18120	F18121	F18129
F1814	F18150	F18151	F18159	F18180	F18188	F1819	F1820
F1821	F18220	F18221	F18229	F1824	F18250	F18251	F18259
F18280	F18288	F1829	F1890	F18920	F18921	F18929	F1894
F18950	F18951	F18959	F18980	F18988	F1899	F1910	F19120
F19121	F19122	F19129	F1914	F19150	F19151	F19159	F1916
F19180	F19181	F19182	F19188	F1919	F1920	F1921	F19220
F19221	F19222	F19229	F19230	F19231	F19232	F19239	F1924
F19250	F19251	F19259	F1926	F19280	F19281	F19282	F19288
F1929	F19920	F19921	F19922	F19929	F19930	F19931	F19932
F19939	F1994	F19950	F19951	F19959	F1996	F19980	F19981
F19982	F19988	F1999	F200	F201	F202	F203	F205
F2081	F2089	F209	F21	F22	F23	F24	F250
F251	F258	F259	F28	F29	F3010	F3011	F3012
F3013	F302	F303	F304	F308	F309	F310	F3110
F3111	F3112	F3113	F312	F3130	F3131	F3132	F314
F315	F3160	F3161	F3162	F3163	F3164	F3173	F3174
F3175	F3176	F3177	F3178	F3181	F319	F320	F321
F322	F323	F324	F325	F328	F329	F330	F331
F332	F333	F3341	F3342	F339	F340	F341	F348
F39	F4001	F4002	F4010	F4011	F40210	F40218	F40220
F40228	F40230	F40231	F40232	F40233	F40240	F40241	F40242
F40243	F40248	F40290	F40291	F40298	F408	F409	F410
F411	F413	F418	F419	F42	F430	F4310	F4311
F4312	F4320	F4321	F4322	F4323	F4324	F4325	F4329

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
F438	F439	F440	F441	F444	F445	F446	F447
F4481	F4489	F449	F450	F451	F4520	F4521	F4522
F4529	F4541	F4542	F458	F459	F481	F482	F488
F489	F5000	F5001	F5002	F502	F508	F509	F5101
F5102	F5103	F5104	F5105	F5109	F5111	F5112	F5113
F5119	F513	F514	F515	F518	F519	F520	F521
F5221	F5222	F5231	F5232	F524	F525	F526	F529
F54	F551	F553	F600	F601	F602	F603	F604
F605	F606	F607	F6081	F6089	F609	F630	F631
F632	F633	F6381	F6389	F639	F641	F642	F648
F649	F650	F651	F652	F653	F654	F6551	F6552
F6581	F6589	F659	F66	F6810	F6811	F6812	F6813
F69	F70	F71	F72	F73	F79	F800	F801
F802	F804	F8089	F809	F8181	F819	F82	F840
F842	F843	F845	F849	F88	F900	F901	F902
F908	F909	F911	F912	F913	F918	F919	F930
F938	F939	F940	F941	F948	F950	F951	F952
F959	F980	F981	F9821	F9829	F983	F984	F989
G000	G001	G002	G003	G008	G009	G01	G02
G030	G031	G038	G039	G0400	G0401	G0402	G042
G0430	G0431	G0439	G0481	G0489	G0490	G0491	G053
G054	G060	G061	G062	G07	G210	G3101	G3181
G3182	G3184	G319	G3289	G35	G40001	G40009	G40011
G40019	G40101	G40109	G40111	G40119	G40201	G40209	G40211
G40219	G40301	G40309	G40311	G40319	G40801	G40802	G40803
G40804	G40811	G40813	G40821	G40822	G40823	G40824	G4089
G40901	G40909	G40911	G40919	G40A01	G40A09	G40A11	G40A19
G44209	G450	G451	G454	G458	G459	G468	G4720
G4721	G4722	G4723	G4724	G4725	G4726	G4727	G4729
G910	G911	G912	G92	G930	G931	G9340	G9341
G9349	G937	G9381	G9389	G939	G94	H93291	H93292
H93293	I6001	I6002	I6011	I6012	I6021	I6022	I6031
I6032	I604	I6051	I6052	I606	I608	I610	I611
I613	I614	I615	I616	I618	I6200	I6201	I6202
I6203	I621	I6300	I63011	I63012	I6302	I63031	I63032
I6309	I6310	I63111	I63112	I6312	I63131	I63132	I6319
I6320	I63211	I63212	I63231	I63232	I6329	I63311	I63312
I63321	I63322	I63331	I63332	I63341	I63342	I6339	I63411
I63412	I63421	I63422	I63431	I63432	I63441	I63442	I6349
I6350	I63511	I63512	I63519	I63521	I63522	I63529	I63531

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
I63532	I63539	I63541	I63542	I63549	I6359	I6501	I6502
I6503	I651	I6521	I6522	I6523	I658	I659	I6601
I6602	I6603	I6611	I6612	I6613	I6621	I6622	I6623
I663	I668	I669	I671	I672	I674	I675	I676
I677	I6781	I6782	I6789	I679	I680	I682	I688
I6901	I69020	I69021	I69022	I69023	I69028	I69031	I69032
I69033	I69034	I69041	I69042	I69043	I69044	I69051	I69052
I69053	I69054	I69061	I69062	I69063	I69064	I69065	I69090
I69091	I69092	I69093	I69098	I6911	I69120	I69121	I69122
I69123	I69128	I69131	I69132	I69133	I69134	I69141	I69142
I69143	I69144	I69151	I69152	I69153	I69154	I69161	I69162
I69163	I69164	I69165	I69190	I69191	I69192	I69193	I69198
I6921	I69220	I69221	I69222	I69223	I69228	I69231	I69232
I69233	I69234	I69241	I69242	I69243	I69244	I69251	I69252
I69253	I69254	I69261	I69262	I69263	I69264	I69265	I69290
I69291	I69292	I69293	I69298	I6931	I69320	I69321	I69322
I69323	I69328	I69331	I69332	I69333	I69334	I69341	I69342
I69343	I69344	I69351	I69352	I69353	I69354	I69361	I69362
I69363	I69364	I69365	I69390	I69391	I69392	I69393	I69398
I6981	I69820	I69821	I69822	I69823	I69828	I69831	I69832
I69833	I69834	I69841	I69842	I69843	I69844	I69851	I69852
I69853	I69854	I69861	I69862	I69863	I69864	I69865	I69890
I69891	I69892	I69893	I69898	I69951	I69952	I69953	I69954
I69961	I69962	I69963	I69964	I69965	P102	P103	P520
P521	P5221	P5222	P523	P525	P84	P90	R0901
R0902	R413	R41840	R41841	R41842	R41843	R41844	R4189
R450	R453	R454	R457	R45850	R45851	R4586	R4587
R4589	R5600	R5601	R569	S060X0A	S060X0D	S060X0S	S060X1A
S060X1D	S060X1S	S060X2A	S060X2D	S060X2S	S060X3A	S060X3D	S060X3S
S060X4A	S060X4D	S060X4S	S060X5A	S060X5D	S060X5S	S060X6A	S060X6D
S060X6S	S060X9A	S060X9D	S060X9S	S06306D	S06306S	S06310A	S06310D
S06310S	S06311A	S06311D	S06311S	S06312A	S06312D	S06312S	S06313A
S06313D	S06313S	S06314A	S06314D	S06314S	S06315A	S06315D	S06315S
S06316A	S06316D	S06316S	S06319A	S06319D	S06319S	S06320A	S06320D
S06320S	S06321A	S06321D	S06321S	S06322A	S06322D	S06322S	S06323A
S06323D	S06323S	S06324A	S06324D	S06324S	S06325A	S06325D	S06325S
S06326A	S06326D	S06326S	S06329A	S06329D	S06329S	S06330A	S06330D
S06330S	S06331A	S06331D	S06331S	S06332A	S06332D	S06332S	S06333A
S06333D	S06333S	S06334A	S06334D	S06334S	S06335A	S06335D	S06335S
S06336A	S06336D	S06336S	S06339A	S06339D	S06339S	S06340A	S06340D

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
S06340S	S06341A	S06341D	S06341S	S06342A	S06342D	S06342S	S06343A
S06343D	S06343S	S06344A	S06344D	S06344S	S06345A	S06345D	S06345S
S06346A	S06346D	S06346S	S06349A	S06349D	S06349S	S06350A	S06350S
S06351A	S06351D	S06351S	S06352A	S06352D	S06352S	S06353A	S06353D
S06353S	S06354A	S06354D	S06354S	S06355A	S06355D	S06355S	S06356A
S06356D	S06356S	S06359A	S06359D	S06359S	S06360A	S06360D	S06360S
S06361A	S06361D	S06361S	S06362A	S06362D	S06362S	S06363A	S06363D
S06363S	S06364A	S06364D	S06364S	S06365A	S06365D	S06365S	S06366A
S06366D	S06366S	S06369A	S06369D	S06369S	S06370A	S06370D	S06370S
S06371A	S06371D	S06371S	S06372A	S06372D	S06372S	S06373A	S06373D
S06373S	S06374A	S06374D	S06374S	S06375A	S06375D	S06375S	S06376A
S06376D	S06376S	S06379A	S06379D	S06379S	S06380A	S06380D	S06380S
S06381A	S06381D	S06381S	S06382A	S06382D	S06382S	S06383A	S06383D
S06383S	S06384A	S06384D	S06384S	S06385A	S06385D	S06385S	S06386A
S06386D	S06386S	S06389A	S06389D	S06389S	S064X0A	S064X0D	S064X0S
S064X1A	S064X1D	S064X1S	S064X2A	S064X2D	S064X2S	S064X3A	S064X3D
S064X3S	S064X4A	S064X4D	S064X4S	S064X5A	S064X5D	S064X5S	S064X6A
S064X6D	S064X6S	S064X9A	S064X9D	S064X9S	S065X0A	S065X0D	S065X0S
S065X1A	S065X1D	S065X1S	S065X2A	S065X2D	S065X2S	S065X3A	S065X3D
S065X3S	S065X4A	S065X4D	S065X4S	S065X5A	S065X5D	S065X5S	S065X6A
S065X6D	S065X6S	S065X9A	S065X9D	S065X9S	S066X0A	S066X0D	S066X0S
S066X1A	S066X1D	S066X1S	S066X2A	S066X2D	S066X2S	S066X3A	S066X3D
S066X3S	S066X4A	S066X4D	S066X4S	S066X5A	S066X5D	S066X5S	S066X6A
S066X6D	S066X6S	S066X9A	S066X9D	S066X9S	S06890A	S06890D	S06890S
S06891A	S06891D	S06891S	S06892A	S06892D	S06892S	S06893A	S06893D
S06893S	S06894A	S06894D	S06894S	S06895A	S06895D	S06895S	S06896A
S06896D	S06896S	S06897S	S06899A	S06899D	S06899S	S069X0A	S069X0D
S069X0S	S069X1A	S069X1D	S069X1S	S069X2A	S069X2D	S069X2S	S069X3A
S069X3D	S069X3S	S069X4A	S069X4D	S069X4S	S069X5A	S069X5D	S069X5S
S069X6A	S069X6D	S069X6S	S069X9A	S069X9D	S069X9S	T5801XA	T5801XD
T5801XS	T5802XA	T5802XD	T5803XA	T5803XD	T5804XA	T5804XD	T5804XS
T5811XA	T5811XD	T5811XS	T5812XA	T5812XD	T5813XA	T5813XD	T5814XA
T5814XD	T5814XS	T582X1A	T582X1D	T582X1S	T582X2A	T582X2D	T582X3A
T582X3D	T582X4A	T582X4D	T588X1A	T588X1D	T588X1S	T588X2A	T588X2D
T588X3A	T588X3D	T588X3S	T588X4A	T588X4D	T588X4S	T5891XA	T5891XD
T5891XS	T5892XA	T5892XD	T5893XA	T5893XD	T5894XA	T5894XD	T71111A
T71111D	T71111S	T71112A	T71112S	T71113A	T71113D	T71113S	T71114A
T71114D	T71114S	T71121A	T71121D	T71121S	T71122A	T71122S	T71123A
T71123D	T71123S	T71124A	T71124S	T71131A	T71131D	T71131S	T71132A
T71133A	T71133D	T71133S	T71134A	T71134D	T71134S	T71141A	T71141D

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
T71141S	T71143A	T71143D	T71143S	T71144A	T71144D	T71144S	T71151A
T71151D	T71151S	T71152A	T71152D	T71152S	T71153A	T71153D	T71153S
T71154A	T71154D	T71154S	T71161A	T71162A	T71163A	T71164A	T71191A
T71192A	T71193A	T71194A	T71194D	T71194S	T7120XA	T7121XA	T71221A
T71222A	T71223A	T71224A	T71231A	T71232A	T71233A	T71233D	T71234A
T7129XA	T7402XA	T7402XD	T7402XS	T7411XA	T7411XD	T7411XS	T7412XA
T7412XD	T7412XS	T7421XA	T7421XD	T7421XS	T7422XA	T7422XD	T7422XS
T751XXA	T751XXD	T751XXS	T7602XA	T7602XD	T7602XS	T7611XA	T7611XD
T7611XS	T7612XA	T7612XD	T7612XS	T7621XA	T7621XD	T7621XS	T7622XA
T7622XD	T7622XS	Z134	Z1389	Z561	Z600	Z608	Z609
Z634	Z644	Z658	Z69010	Z69020	Z69021	Z6982	Z72810
Z72811	Z736	Z73810	Z73811	Z73812	Z73819	Z781	Z818
Z8651	Z8659	Z87820	Z87890	Z9183			

Combination Diagnosis Codes (Must be submitted in pairs)							
S06330A, S0190XA	S06331A, S0190XA	S06332A, S0190XA	S06333A, S0190XA	S06334A, S0190XA	S06335A, S0190XA	S06336A, S0190XA	S06339A, S0190XA
S06360A, S0190XA	S06361A, S0190XA	S06362A, S0190XA	S06363A, S0190XA	S06364A, S0190XA	S06365A, S0190XA	S06366A, S0190XA	S06369A, S0190XA
S06370A, S0190XA	S06371A, S0190XA	S06372A, S0190XA	S06373A, S0190XA	S06374A, S0190XA	S06375A, S0190XA	S06376A, S0190XA	S06379A, S0190XA
S06380A, S0190XA	S06381A, S0190XA	S06382A, S0190XA	S06383A, S0190XA	S06384A, S0190XA	S06385A, S0190XA	S06386A, S0190XA	S06389A, S0190XA
S06890A, S060X0A	S064X0A, S0190XA	S064X1A, S0190XA	S064X2A, S0190XA	S064X3A, S0190XA	S064X4A, S0190XA	S064X5A, S0190XA	S064X6A, S0190XA
S064X9A, S0190XA	S065X0A, S0190XA	S065X1A, S0190XA	S065X2A, S0190XA	S065X3A, S0190XA	S065X4A, S0190XA	S065X5A, S0190XA	S065X6A, S0190XA
S065X9A, S0190XA	S066X0A, S0190XA	S066X1A, S0190XA	S066X2A, S0190XA	S066X3A, S0190XA	S066X4A, S0190XA	S066X5A, S0190XA	S066X6A, S0190XA
S066X9A, S0190XA							

Psychologists licensed by the TSBEP and enrolled as Medicaid providers are authorized to perform counseling and testing for mental illness or debility. LPAs and PLPs licensed by the TSBEP are authorized to perform counseling and testing for mental illness and debility when delegated and supervised by a licensed psychologist.

Psychological and neuropsychological testing are not covered benefits when provided by a CNS, NP, or PA. Each hour of psychological or neuropsychological testing counts toward the 12-hour per day, per provider system limitation.

6.11.1 Prior Authorization

Psychological or neuropsychological testing requires prior authorization for services rendered in any place of service except the inpatient setting under the following circumstances:

- After the 30 encounter or visit annual limitation has been met

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- If more than four hours of testing per day, or more than eight hours of testing per calendar year, are medically necessary

Prior authorization must include documentation of medical necessity, and must be submitted on a Psychological/Neuropsychological Testing Request Form.

If the client requires more than four hours of testing per day, or more than eight hours of psychological or neuropsychological testing per calendar year, additional documentation is required to support the medical necessity for the additional hours. Additional testing hours may be considered as an exception on a case-by-case basis when supported by medical necessity. The number of hours prior authorized are based on the medical necessity as supported by the documentation provided. All documentation must be maintained by the provider in the client's medical record.

6.11.2 Documentation Requirements

The treating provider must document the medical necessity for the chosen treatment in the client's medical record and also include the diagnosis code that most accurately describes the client's condition that necessitated the psychological or neuropsychological testing. The medical record (inpatient or outpatient hospital records, reports, or progress notes) must be signed and dated by the performing provider, and should be clear and concise, documenting the reasons for the psychological or neuropsychological testing and the outcome.

In addition, the following documentation must be maintained by the provider in the client's medical record:

- The Psychological/Neuropsychological Testing Request Form.
- The name of the tests that were performed (e.g., Wechsler Adult Intelligence Scale–Revised [WAIS-R], Rorschach, Minnesota Multiphasic Personality Inventory [MMPI]).
- How the tests were scored.
- The location at which the test was performed.
- The name and credentials of each of the providers who were involved in administering the test, and in the interpretation and preparation of the report.
- The interpretation of the test, which must include narrative descriptions of the findings of the tests.
- The length of time that each provider spent in face-to-face administration, interpretation, reporting the test, integrating the test interpretation, and documenting the comprehensive report based on the integrated data.
- The treatment being administered, including how the test results affect the prescribed treatment.
- Any recommendation for further testing, including an explanation that substantiates the necessity for retesting, if testing is repeated.
- Rationale or extenuating circumstances that impact the ability to complete the testing, such as, but not limited to, the client's condition requires testing over two days and client does not return, or the client's condition precludes completion of the testing.

The original testing material must be maintained by the provider and must be readily available for retrospective review by HHSC.

6.11.3 Reimbursement

Psychological (procedure code 96101) and neuropsychological (procedure code 96118) testing is limited to a total of four hours per day, and eight hours per client, per calendar year for any provider. Hours billed beyond four hours per day will be denied without prior authorization. All supporting documentation must be maintained by the provider in the client's medical record.

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Reimbursement for the psychological and neuropsychological testing (procedure codes 96101 and 96118) include both the time spent during face-to-face testing with the client and the time spent scoring and interpreting the results. If the scoring and interpretation are performed on a different date of service from the testing, then the date of service on the claim must reflect the date and time spent for each service performed. Even if scoring and interpretation are completed on a different date from the testing, providers must submit only one claim for each psychological or neuropsychological test performed. If necessary, providers can submit the claim with multiple details for each date of service.

The correct modifier AH, UC, or U9 must be appended to the procedure code to identify who rendered the service. If the LPA, PLP, and psychologist perform services on the same date, one detail must be submitted for each provider with each detail accurately representing the time spent by the psychologist or LPA. Time billed for services performed on the same client must not be billed for the same time and date of service.

Services provided by both the psychologist and LPA count toward the total four hours of testing allowed per client, per day.

Psychological and neuropsychological testing will not be reimbursed to a CNS, NP, or a PA. Behavioral health testing may be performed during an assessment by a CNS, NP, or a PA, but will not be reimbursed separately. The most appropriate office encounter or visit procedure code must be billed. Behavioral health testing performed by a CNS, NP, or a PA during an assessment will be denied as part of another service.

Psychological or neuropsychological testing may be reimbursed on the same date of service as an initial psychiatric diagnostic evaluation or interactive psychiatric diagnostic evaluation.

Psychological testing performed on the same date of service as neuropsychological testing will be denied as part of another service. All documentation must be maintained by the provider in the client's medical record.

Providers must bill the preponderance of each half hour of testing and indicate that number of units on the claim form.

6.12 Psychotherapy or Counseling

Psychotherapy or counseling is the treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the client and, through definitive therapeutic communication or therapeutic interactions, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

Assessment, treatment planning, and documentation time, including time to document test results in the client's medical record, are not reimbursed separately. Reimbursement is included in the covered procedure codes. Providers must bill the preponderance of each half hour of psychotherapy or counseling and indicate that number of 30-minute units on the claim form.

Psychotherapy or counseling is limited to the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
F0390	F0391	F04	F05	F060	F061	F062	F0630
F0631	F0632	F0633	F0634	F064	F068	F070	F09
F1010	F10121	F1014	F10150	F10151	F10159	F10180	F10181
F10182	F10188	F1019	F1020	F1021	F10221	F10230	F10231
F10232	F10239	F1024	F10250	F10251	F10259	F1026	F10280
F10281	F10282	F10288	F1029	F10921	F1094	F10950	F10951
F10959	F1096	F10980	F10981	F10982	F10988	F1099	F1110

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
F11120	F11121	F1114	F11150	F11151	F11159	F11181	F11182
F11188	F1119	F1120	F1121	F11220	F11221	F11222	F11229
F1123	F1124	F11250	F11251	F11259	F11281	F11282	F11288
F1129	F11920	F11921	F11922	F11929	F1193	F1194	F11950
F11951	F11959	F11981	F11982	F11988	F1199	F1210	F12120
F12121	F12122	F12129	F12150	F12151	F12159	F12180	F12188
F1219	F1220	F1221	F12220	F12221	F12222	F12229	F12250
F12251	F12259	F12280	F12288	F1229	F12920	F12921	F12922
F12929	F12950	F12951	F12959	F12980	F12988	F1299	F13120
F13121	F13129	F1314	F13150	F13151	F13159	F13180	F13181
F13182	F13188	F1320	F1321	F13220	F13221	F13229	F13230
F13231	F13232	F13239	F1324	F13250	F13251	F13259	F1326
F13280	F13281	F13282	F13288	F13920	F13921	F13929	F13930
F13931	F13932	F13939	F1394	F13950	F13951	F13959	F1396
F13980	F13981	F13982	F13988	F1399	F1410	F14120	F14121
F14122	F14129	F1414	F14150	F14151	F14159	F14180	F14181
F14182	F14188	F1419	F1420	F1421	F14220	F14221	F14222
F14229	F1423	F1424	F14250	F14251	F14259	F14280	F14281
F14282	F14288	F1429	F14920	F14921	F14922	F14929	F1494
F14950	F14951	F14959	F14980	F14981	F14982	F14988	F1499
F1510	F15120	F15121	F15122	F15129	F1514	F15150	F15151
F15159	F15180	F15181	F15182	F15188	F1519	F1520	F1521
F15220	F15221	F15222	F15229	F1523	F1524	F15250	F15251
F15259	F15280	F15281	F15282	F15288	F1529	F15920	F15921
F15922	F15929	F1593	F1594	F15950	F15951	F15959	F15980
F15981	F15982	F15988	F1599	F1610	F16120	F16121	F16122
F16129	F1614	F16150	F16151	F16159	F16180	F16183	F16188
F1619	F1620	F16220	F16221	F16229	F1624	F16250	F16251
F16259	F16280	F16283	F16288	F1629	F16920	F16921	F16929
F1694	F16950	F16951	F16959	F16980	F16983	F16988	F1699
F17208	F17209	F17218	F17219	F17228	F17229	F17298	F17299
F1810	F18120	F18121	F18129	F1814	F18150	F18151	F18159
F18180	F18188	F1819	F1820	F1821	F18220	F18221	F18229
F1824	F18250	F18251	F18259	F18280	F18288	F1829	F18920
F18921	F18929	F1894	F18950	F18951	F18959	F18980	F18988
F1899	F1910	F19120	F19121	F19122	F19129	F1914	F19150
F19151	F19159	F1916	F19180	F19181	F19182	F19188	F1919
F1920	F1921	F19220	F19221	F19222	F19229	F19230	F19231
F19232	F19239	F1924	F19250	F19251	F19259	F1926	F19280
F19281	F19282	F19288	F1929	F19920	F19921	F19922	F19930

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
F19931	F19932	F19939	F1994	F19950	F19951	F19959	F1996
F19980	F19981	F19982	F19988	F1999	F200	F201	F202
F205	F2081	F209	F21	F22	F23	F24	F250
F251	F258	F259	F29	F3010	F3011	F3012	F3013
F302	F303	F304	F309	F310	F3110	F3111	F3112
F3113	F312	F3130	F3131	F3132	F314	F315	F3160
F3161	F3162	F3163	F3164	F3173	F3174	F3175	F3176
F3177	F3178	F3181	F319	F320	F321	F322	F323
F324	F325	F329	F330	F331	F332	F333	F3341
F3342	F339	F340	F341	F39	F4001	F4002	F4010
F4011	F40210	F40218	F40220	F40228	F40230	F40231	F40232
F40233	F40240	F40241	F40242	F40243	F40248	F40290	F40291
F40298	F408	F410	F411	F419	F42	F430	F4310
F4311	F4312	F4320	F4321	F4322	F4323	F4324	F4325
F438	F439	F440	F441	F444	F445	F446	F447
F4481	F449	F450	F451	F4520	F4521	F4522	F4529
F4541	F4542	F458	F459	F481	F482	F488	F489
F5000	F5001	F5002	F502	F508	F509	F5101	F5102
F5103	F5104	F5105	F5109	F5111	F5112	F5113	F5119
F513	F514	F515	F518	F519	F520	F521	F5221
F5222	F5231	F5232	F524	F525	F526	F529	F54
F551	F553	F600	F602	F603	F604	F605	F606
F607	F6081	F609	F630	F631	F632	F633	F6381
F6389	F639	F641	F642	F648	F649	F650	F651
F652	F653	F654	F6551	F6552	F6581	F6589	F659
F66	F6810	F6811	F6812	F6813	F69	F70	F72
F73	F79	F800	F801	F802	F809	F8181	F819
F82	F840	F842	F845	F849	F900	F901	F902
F908	F909	F911	F912	F913	F918	F919	F930
F938	F939	F940	F941	F948	F950	F951	F952
F959	F980	F981	F9821	F9829	F983	F984	F989
G3184	G44209	G4720	G4721	G4722	G4723	G4724	G4725
G4726	G4727	G4729	R413	R41840	R41841	R41842	R41843
R41844	R4189	R45850	T7402XA	T7402XD	T7402XS	T7411XA	T7411XD
T7411XS	T7412XA	T7412XD	T7412XS	T7421XA	T7421XD	T7421XS	T7422XA
T7422XD	T7422XS	T7602XA	T7602XD	T7602XS	T7611XA	T7611XD	T7611XS
T7612XA	T7612XD	T7612XS	T7621XA	T7621XD	T7621XS	T7622XA	T7622XD
T7622XS	Z0389	Z561	Z600	Z608	Z609	Z6331	Z6332
Z634	Z635	Z638	Z644	Z655	Z658	Z69010	Z69020
Z69021	Z6982	Z72810	Z72811	Z736	Z781	Z8651	Z9183

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The appropriate service is chosen based on the type of inpatient or outpatient psychotherapy or counseling, the place of service, the face-to-face time spent with the client during inpatient or outpatient psychotherapy or counseling, and whether E/M services are furnished on the same date of service as inpatient or outpatient psychotherapy or counseling.

The treating provider must document the medical necessity for the chosen treatment in the client's medical record and also include the diagnosis code that most accurately describes the client's condition that necessitated the psychotherapy or counseling. The medical record (inpatient or outpatient hospital records, reports, or progress notes) must be signed and dated by the performing provider, and should be clear and concise, documenting the reasons for the psychotherapy or counseling and the outcome.

Inpatient and outpatient psychotherapy or counseling counts towards the 12-hour per day, per provider system limitation.

6.12.1 Prior Authorization

Prior authorization for inpatient psychotherapy or counseling is not required for 30 encounters or visits per calendar year.

After the 30 encounter or visit annual limitation has been met, prior authorization will be considered in increments of up to 10 additional encounters or visits per request. All requests for prior authorization of extensions beyond the 30 initial encounter or visit annual limit must include a completed Outpatient Psychotherapy/Counseling Request Form, including:

- Client name and Medicaid number, date of birth, age, and sex
- Provider name and identifier
- A complete diagnosis as listed in the current edition of the DSM
- History of substance abuse
- Current medications
- Current living condition
- Clinical update, including specific symptoms and response to past treatment, treatment plan (measurable short term goals, specific therapeutic interventions to be used in therapy, measurable expected outcomes of therapy, length of treatment anticipated, and planned frequency of encounters or visits)
- Number, type of services requested, and the dates based on the frequency of encounters or visits for which the services will be provided
- Date on which the current treatment is to begin
- Indication of court-ordered or DFPS-directed services

All areas of the request form must be completed with the required information. If additional space is needed for a particular section of the form, providers may state, "see attached," in that section and attach the additional pages to the form. The attachment must contain information specific to that section of the form.

A request for outpatient behavioral health services must be submitted no sooner than 30 days before the date of service being requested, so that the most current information is provided.

The number of encounters or visits authorized will be dependent upon the client's symptoms and response to past treatment. The provider must submit a new prior authorization request at the end of each extension period. The additional requests must include new documentation concerning the client's current condition.

Prior authorization requests will be reviewed by a mental health professional.

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6.12.2 Documentation Requirements

Each client for whom services are provided must have supporting documentation included in their medical record. All entries must be documented clearly, be legible to individuals other than the author, and be dated (month/date/year) and signed by the performing provider. Those services not supported by the documentation in the client's medical record are subject to recoupment. Documentation must include the following:

- Notations of the session beginning and ending times
- All pertinent information regarding the client's condition to substantiate the need for services, including, but not limited to, the following:
  - A current DSM diagnosis
  - Background, symptoms, impression
  - Narrative description of the assessment
  - Behavioral observations during the session
  - Narrative description of the counseling session
  - Treatment plan and recommendations

6.12.3 Initial Outpatient Psychotherapy or Counseling for an Individual, Group, or Family

Family psychotherapy is defined as therapy that focuses on the dynamics of a family unit where the goal is to strengthen the family's problem solving and communication skills.

Individual psychotherapy is defined as therapy that focuses on the client but may include others in the session with the goals of treatment focused on the client versus others in attendance.

Client Condition Requirements

The following documentation requirements must be submitted when requesting prior authorization for outpatient services beyond the 30-encounter or visit annual limitation:

- A description of why treatment is being sought at the present time
- A mental status examination, which validates a diagnosis as listed in the current edition of the DSM
- A description of any existing psychosocial or environmental problems
- A description of the current level of social and occupational or educational functioning

Initial Assessment Requirements

There must be pertinent documentation that contains all of the following:

- A chronological psychiatric, medical and substance use history with time frames of prior treatment and the outcomes of that treatment
- A social and family history
- An educational and occupational history

Active Treatment Plan Requirements

The treatment plan must contain the following elements:

- A description of the primary focus of the treatment
- Clearly defined discharge goals that indicate treatment can be successfully accomplished
- The expected number of sessions it will take to reach the discharge goals, and standards of practice for the client's diagnosis

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- Family therapy services are appropriately planned unless there are valid clinical contraindications

When a medication regimen is planned by a psychiatrist, PA, NP, or CNS, it must meet the following:

- Guidelines specific to the medication or medications prescribed
- Accepted standard of practice for the diagnosis for which it is prescribed
- Accepted standard of practice for the age group for which it is prescribed

Discharge Plan Requirements

Discharge planning must reflect the following:

- A plan for concluding the client's treatment based on an assessment of the client's progress in meeting the discharge goals
- Identification of the client's aftercare needs that includes a plan for transition

6.12.4 Subsequent Outpatient Psychotherapy or Counseling for an Individual, Group or Family

Client Condition Requirements

All of the requirements for the first authorized treatment sessions must be met in addition to an assessment of the client's response to treatment that indicates one of the following:

- The client has not achieved the discharge goal necessary to conclude treatment, but the description of the client's progress indicates that successful treatment can be concluded with this extension request.
- The client has not achieved the discharge goal necessary to conclude treatment and there is potential for serious regression or admission to a more intensive setting without ongoing outpatient management (requiring several months or longer of outpatient therapy).
- The client's condition is one that includes long standing, pervasive symptoms or patterns of maladaptive behavior.

6.12.4.1 Active Treatment Plan Requirements

There must be an assessment, which explains the client's inability to achieve the treatment objectives as expected. This assessment must address the following:

- Factors that interfere with the client's ability to make progress as expected
- The continued appropriateness of the treatment goals
- The continued appropriateness of the type of therapy being utilized
- The need for obtaining consultation
- The current diagnosis and the need for revisions or additional assessments

The ongoing treatment plan must reflect the initial treatment plan requirements, and the following additional information must be included:

- Changes in primary treatment focus or discharge goals have been identified and are consistent with the client's current condition
- The expected progress toward the discharge goals is described within the extended time frame
- Appropriate adjustments have been made in the medication regimen based on the client's therapeutic response
- No contraindications to the use of the prescribed medications are present

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6.12.4.2 Discharge Plan Requirements

Discharge planning must reflect the following:

- A plan for concluding the client's treatment based on an assessment of the client's progress in meeting the discharge goals
- Identification of the client's aftercare needs that includes a plan for transition

6.12.5 Reimbursement

The following procedure codes may be submitted when billing for inpatient psychotherapy or counseling services: 90832, 90834, or 90837, or an E/M procedure code with add-on procedure code 90833, 90836, or 90838.

Outpatient psychotherapy or counseling is limited to no more than four hours per client, per day.

Providers must bill with modifier 59 when performing individual psychotherapy (procedure codes 90832, 90834, or 90837) and family psychotherapy (procedure code 90847) on the same day for the same client. When billing for these services, providers must append modifier 59 to the family psychotherapy procedure code on the claim to indicate that the procedure or service was distinct or independent from other services performed on the same day for the same client. Documentation that supports the provision of distinct or independent services must be maintained in the client's medical record and made available to Texas Medicaid upon request. Services are reimbursed only for the Medicaid eligible client per session.

A CNS, NP, PA, or psychiatrist may bill an E/M visit if less than 20 minutes of outpatient psychotherapy or counseling is provided.

Only the CNS, LCSW, LMFT, LPC, NP, or PA actually performing the mental health service may bill Texas Medicaid. The CNS, LCSW, LMFT, LPC, NP, or PA must not bill for services performed by people under their supervision. A psychiatrist may bill for services performed by people under their supervision. A psychologist may bill for services performed by an LPA under their direct supervision.

The services of a psychiatric nurse or behavioral health worker are not covered by the Texas Medicaid program and cannot be billed under the provider identifier of any other outpatient behavioral health provider.

Interpretation and documentation time, including time to document test results in the client's medical record, is not reimbursed separately. Reimbursement is included in the covered procedure codes. Providers must bill the preponderance of each half hour of group counseling sessions and indicate that number of units on the claim form.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied.

Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

6.13 Treatment for Alzheimer's Disease and Dementia

Alzheimer's disease and dementia (diagnosis codes F0390, F0391, G3184, and R41841) are valid diagnoses for the following procedure codes:

Procedure Codes								
90832	90833	90834	90836	90837	90838	90847	90853	90899

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Treatment for clients with Alzheimer's disease or dementia is a benefit of Texas Medicaid for clients in the following stages:

- 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 (e.g., forgetting familiar words or the location of everyday objects) but no symptoms of dementia can be detected 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.

Documentation to support the treatment for Alzheimer's disease or dementia must be maintained in the client's medical record and may be subject to retrospective review. Psychotherapy services that are no longer beneficial to the client must not be continued.

6.14 Narcosynthesis

Narcosynthesis (procedure code 90865) is a benefit of Texas Medicaid when billed by a physician.

6.15 Noncovered Services

The following services are not benefits of Texas Medicaid:

- Administration and supply of oral medication
- Adult and individual activities
- Biofeedback for psychological, psychophysiological, behavioral health therapy, and psychosomatic conditions
- Day-care
- Family psychotherapy without client present (procedure code 90846)
- Hypnosis
- Intensive outpatient program services (excluding substance use disorder [SUD] services)
- Marriage counseling
- Multiple family group psychotherapy (procedure code 90849)
- Music or dance therapy

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- Psychiatric day treatment program services
- Psychiatric services for chronic disease, such as MR
- Psychoanalysis (procedure code 90845)
- Recreational therapy
- Services provided by a psychiatric nurse, mental health worker, psychiatric assistant, psychological assistant (excluding Master's level LPA), or licensed chemical dependency counselor (LCDC)
- Thermogenic therapy

6.16 Psychiatric Services for Hospitals

Inpatient admissions to acute care hospitals for adults and children for psychiatric conditions are a benefit of Texas Medicaid. Admissions must be medically necessary and are subject to Texas Medicaid's retrospective utilization review (UR) requirements. The UR requirements are applicable regardless of the hospital's designation of a unit as a psychiatric unit versus a medical or surgical unit.

Clients who are 20 years of age and younger may be admitted to a freestanding psychiatric facility or a state psychiatric facility. Clients who are 21 years of age and older may be admitted only to an acute care facility. Providers should use the most appropriate revenue code when billing for inpatient psychiatric services in an acute care facility. A certification of need must be completed and placed in the client's medical record within 14 days of the admission or once the client becomes Medicaid-eligible while in the facility.

Inpatient psychiatric treatment is a benefit of Texas Medicaid if all the following apply:

- The client has a psychiatric condition that requires inpatient treatment.
- The inpatient treatment is directed by a psychiatrist.
- The inpatient treatment is provided in a nationally accredited facility or hospital.
- The provider is enrolled in Texas Medicaid.

Clients of all ages may be admitted to an acute care facility. Inpatient admissions for the single diagnosis of chemical dependency or abuse (such as alcohol, opioids, barbiturates, and amphetamines) without an accompanying medical complication are not benefits of Texas Medicaid. Additionally, admissions for chronic diagnoses such as intellectual disability, organic brain syndrome, or chemical dependency or abuse are not covered benefits for acute care hospitals without an accompanying medical complication or medical condition. The UB-04 CMS-1450 paper claim form must indicate all relevant diagnoses that necessitate the inpatient stay.

Supporting documentation (certification of need) must be documented in the client's medical record. This documentation must be maintained by each facility for a minimum of five years and be readily available for review when requested by HHSC or its designee.

Additional coverage through the Comprehensive Care Program (CCP) may be allowed for Medicaid-eligible clients who are 20 years of age and younger. Providers should use revenue code 124 when billing for inpatient psychiatric services in freestanding and state psychiatric facilities.

Refer to: Section 2.15, "Inpatient Psychiatric Hospital or Facility (Freestanding) (CCP)" in the Children's Services Handbook (Vol. 2, Provider Handbooks).

6.16.1 Prior Authorization Requirements

Prior authorization is not required for fee-for-service clients who are admitted to psychiatric units in acute care hospitals. Out-of-network admissions require notification within the next business day and submission of clinical information to determine appropriateness for transfer to a contracted facility.

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For clients who are 20 years of age and younger, initial admission to a state psychiatric facility or freestanding psychiatric facility may be prior authorized through CCIP for a maximum of five days based on Medicaid eligibility and documentation of medical necessity. Court-ordered services are not subject to the five-day admission limitation.

Refer to: Section 2.16.3, "* Prior Authorization and Documentation Requirements" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about inpatient psychiatric services.

6.16.2 Documentation Requirements

Documentation of medical necessity for inpatient psychiatric care must specifically address the following issues:

- Why the ambulatory care resources in the community cannot meet the treatment needs of the client.
- Why inpatient psychiatric treatment under the care of a psychiatrist is required to treat the client's acute episode.
- How the services can reasonably be expected to improve the client's condition or prevent further regression of the client's condition in a proximate time period.

6.16.3 Psychological and Neuropsychological Testing Services

Psychological (procedure code 96101) and neuropsychological (procedure code 96118) testing, when performed in an acute care hospital or in a freestanding or state psychiatric facility, does not require prior authorization; however, these facilities must maintain documentation that supports medical necessity for the testing and the testing results of any psychological or neuropsychological testing that are performed while the client is an inpatient. Psychological and neuropsychological testing services are diagnosis restricted.

6.16.4 Inpatient Hospital Discharge

Procedure codes 99238 and 99239 must be submitted when billing for a hospital discharge.

6.17 Claims Filing and Reimbursement

Providers must bill Medicare before billing Medicaid. Medicaid's responsibility for the coinsurance or deductible is determined in accordance with Medicaid benefits and limitations. Providers must check the client's Medicare card for Part B coverage before billing Texas Medicaid. When Medicare is primary, it is inappropriate to bill Medicaid without first billing Medicare.

Note: *Texas Medicaid may reimburse the full amount of the Medicare coinsurance and deductible for services rendered by psychiatrists and psychologists.*

Claims for behavioral health services must be submitted to TMHP in an approved electronic format or on the CMS-1500 or UB-04 CMS-1450 paper claim forms. Providers may purchase CMS-1500 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 or 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 diagnosis code that supports medical necessity for the billed outpatient behavioral health service must be referenced on the claim.

The Medicaid rates for psychologists are calculated in accordance with 1 TAC §355.8081 and §355.8085. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com. An FQHC is reimbursed for psychological services according to its specific Prospective Payment System (PPS) rate per visit calculated in accordance with 1 TAC §355.8261.

A freestanding psychiatric hospital or facility is reimbursed for psychological services in accordance with 1 TAC §355.8060.

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Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 4, "Federally Qualified Health Center (FQHC)" in the *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*) for more information.

Subsection 4.11.2, "Medicare Part B Crossovers" in Section 4, "Client Eligibility" (*Vol. 1, General Information*)

Subsection 6.1, "Claims Information" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

Subsection 2.7.2, "Part B" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for information about how coinsurance and deductibles may be reimbursed by Texas Medicaid.

6.17.1 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the Texas Medicaid Provider Procedures Manual are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manual. The CMS NCCI and MUE guidelines can be found in the NCCI Policy and Medicaid Claims Processing manuals, which are available on the CMS website. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

Whenever Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

7 Screening, Brief Intervention, and Referral to Treatment (SBIRT)

SBIRT is a comprehensive, public health approach to the delivery of early intervention and treatment services for clients who have substance use disorders and those who are at risk of developing such disorders. Substance abuse includes, but is not limited to, the abuse of alcohol and the abuse of, improper use of, or dependency on illegal or legal drugs. SBIRT is used for intervention directed to individual clients and not for group intervention.

SBIRT is targeted to clients who are 14 years through 20 years of age and who present to the hospital emergency department for a traumatic injury, condition, or accident related to substance abuse. SBIRT may also be medically necessary for clients who are 10 years through 13 years of age.

The first SBIRT session, including screening and brief intervention, must be billed by the hospital using an appropriate revenue code and procedure code H0050. Brief treatment is performed during the second, third, and fourth sessions, outside of the hospital. The second, third, and fourth sessions cannot be billed if clients were not referred from the hospital.

Additional services, outside the four sessions, will not be provided as SBIRT.

Refer to: Section 8, "Substance Use Disorder (SUD) Services (Abuse and Dependence)" in this handbook for additional information on SUD treatment.

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7.1 Screening

Screening to identify clients who have problems related to substance use must be performed during the first session in the hospital emergency department or inpatient setting, but will not be separately reimbursed. Screening may be completed through interview and self-report, blood alcohol content, toxicology screen, or by using a standardized tool. Standardized tools that may be used include, but are not limited to, the following:

- Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
- Drug Abuse Screening Test (DAST)
- Alcohol Use Disorders Identification Test (AUDIT)
- Cut-down, Annoyed, Guilty, Eye-opener (CAGE) questionnaire
- Car, Relax, Alone, Forget, Family or Friends, Trouble (CRAFFT) questionnaire
- Binge drinking questionnaire

7.2 Brief Intervention

Brief intervention is performed during the first session in the ED or inpatient hospital setting following a positive screen or a finding of at least a moderate risk for substance or alcohol abuse. Brief intervention is directed to the client and involves motivational discussion that is focused on raising the client's awareness of his or her substance use and its consequences. The session is also focused on motivating the client toward behavioral change.

Successful brief intervention encompasses support of the client's empowerment to make behavioral changes. A client who is found to have a moderate risk for substance or alcohol abuse should be referred for brief treatment of up to three sessions. Upon determination that the client has a severe risk for substance or alcohol abuse, the client should also be referred for more extensive treatment to the appropriate chemical dependency treatment center or outpatient behavioral health provider. If the client is currently under the care of a behavioral health provider, the client must be referred back to that provider.

SBIRT documentation for the first session must include:

- Whether the client has an alcohol or drug-related traumatic injury or condition.
- Positive screening by a standardized screening tool.
- Laboratory results such as blood alcohol content, toxicology screen, or other measures showing at least a moderate risk for alcohol or substance abuse.
- The name, address, and telephone number of the provider to which the client is referred, if a referral is made.

The provider who performed the screening must document that a follow-up appointment was made for a subsequent session.

7.3 Brief Treatment

A client found to have a moderate-to-high risk for substance abuse should be referred for brief treatment. Brief treatment is performed during the second, third, and fourth sessions, outside of the hospital emergency department or inpatient setting.

Brief treatment, although it includes a motivational discussion and client empowerment, is a more comprehensive intervention than the first session. Brief treatment includes assessment, education, problem solving, coping mechanisms, building a supportive social environment, goal setting, and a plan of action.

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Procedure code H0050 will be eligible for reimbursement to the following provider types for the second, third, and fourth sessions:

- NP
- CNS
- PA
- LPC
- Social worker enrolled in CCP
- Physician and physician group
- Psychologist and psychologist group
- LCSW

7.4 Referral to Treatment

If the provider determines that the client is in need of more extensive treatment or has a severe risk for substance abuse, the client must be referred to an appropriate chemical dependency treatment center or outpatient behavioral health provider.

Referral to more extensive treatment is a proactive process that facilitates access to care for clients who require a more extensive level of service than SBIRT provides. Referral is an essential component of the SBIRT intervention because referral ensures that all clients who are screened have access to the appropriate level of care.

Referral to more extensive treatment must be integrated during the second, third, and fourth SBIRT sessions, if necessary, unless the client's condition changes. Referral to more extensive treatment may also occur during the first session.

Providers must refer the client to more extensive treatment as soon as the need is determined.

7.5 Reimbursement and Limitations

SBIRT is limited to clients who are 10 years through 20 years of age.

SBIRT is limited to a maximum of three dates of service following the first session, per calendar year, by any provider. If a client requires more than three dates of services per year, the client must be referred for chemical dependency treatment.

Procedure code H0050 must be submitted in 15-minute increments, with a maximum of 3 units (45 minutes) per date of service by any provider.

Procedure code H0050 will be denied if it is billed for the same date of service, by the same provider, as any of the following procedure codes:

Procedure Codes									
90791	90792	90832	90833*	90834	90836*	90837	90838*	90870	96101
96118	H0004	H0005							
***Note: Procedure codes 90833, 90836, and 90838 are add-on procedure codes and must be submitted with the most appropriate E/M procedure code.**									

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7.6 Documentation Requirements

Client record documentation must support medical necessity for the services provided and must be maintained and made readily available for review when requested by the Health and Human Services Commission (HHSC) or its designee. SBIRT documentation must include the following:

- An indication that the client has an alcohol or drug-related traumatic injury or condition
- Positive screening by a standardized substance abuse screening tool
- Laboratory results, such as blood alcohol content, toxicology screen, or other measures, that show at least a moderate risk for substance abuse
- If a referral is made, the name, address, and telephone number of the provider to whom the client was referred
- A written, client-centered plan for the delivery of medically necessary SBIRT. The plan must be completed at the time the client is admitted to the second session (referral). The plan must include the following:
  - Real-life goals expected
  - Strategies to achieve the goals
  - Support system such as family members, a legal guardian, friends, or anyone the client identifies as important to them, who can help the client achieve their goals
  - A mechanism for following up with the client to ensure that the client keeps appointments for additional sessions

The provider who performed the screening must document that a follow-up appointment was made for a subsequent session.

If inappropriate payments are identified on retrospective review for any provider, the payments will be recouped.

7.7 Claims Filing and Reimbursement

SBIRT 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: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Subsection 6.1, "Claims Information" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

Texas Medicaid rates for Hospitals are calculated according to 1 TAC §355.8061.

According to 1 TAC §355.8091, the Medicaid rate for LCSWs, LMFTs, and LPCs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085.

The Medicaid rates for psychologists are calculated in accordance with 1 TAC §355.8081 and §355.8085.

Texas Medicaid rates for physicians and certain other practitioners are calculated in accordance with TAC §355.8085.

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Texas Medicaid rates for Nurse Practitioners and Clinical Nurse Specialists are calculated in accordance with TAC §355.8281.

According to 1 TAC §355.8093, the Medicaid rate for PAs is 92 percent of the rate paid to a physician (MD or DO) for the same professional service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections. Services performed by a PA and billed under a physician's or RHC's provider identifier are reimbursed according to the Texas Medicaid Reimbursement Methodology (TMRM) for physician services.

Note: *For more information about Texas Medicaid rates for the provider types above, refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.*

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied.

Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

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

8 Substance Use Disorder (SUD) Services (Abuse and Dependence)

8.1 Overview

Treatment for SUD is a benefit of Texas Medicaid. SUD treatment services are age appropriate medical and psychotherapeutic services designed to treat a client's substance use disorder and restore function. Services and provider requirements associated with this benefit are found in Texas Department of Insurance (TDI) regulations (28 TAC, part 1 subchapter 3 subcategory HH) and TAC §448.902 and must be strictly followed. Medical necessity for substance abuse services will be determined based on the TDI regulations and nationally recognized standards such as those from the American Society of Addiction Medicine (ASAM) or the Center for Substance Abuse Treatment (CSAT).

The following SUD services are a benefit of Texas Medicaid:

- Assessment by a CDTF for admission into a SUD treatment program.
- Detoxification services when provided in a general acute care hospital, residential, or ambulatory CDTF setting.

  Note: *Crisis intervention is not a component of detoxification. Crisis intervention for a mental health condition may be provided as needed when the service is medically necessary and the clinical criteria for psychiatric care are met.*
- Residential SUD treatment services.
- Ambulatory SUD treatment services provided by a CDTF.
- Medicaid assisted therapy (MAT) in an outpatient setting.

SUD services provided by a CDTF are limited to those provided by facilities that are licensed and regulated by DSHS to provide SUD services within the scope of that facility's DSHS license.

Intensive outpatient (IOP) services are ambulatory outpatient services that are provided by CDTF providers.

IOP services are benefits of Texas Medicaid. IOP services are available to clients of all ages and include a maximum of 135 hours of group counseling and 26 hours of individual counseling per calendar year.

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The modifiers listed in the following table must be used in the appropriate combination for SUD services to identify the services performed:

Modifiers	Description
HF	Use to identify a substance abuse program in a facility
HG	Use to identify an opioid addiction treatment program
UA	Use to identify supervised administered dosing
U1	Use to identify unsupervised dosing

8.2 Enrollment

8.2.1 CDTFs

Only CDTFs licensed by DSHS are eligible to enroll and participate in Texas Medicaid. Each facility must submit a copy of its DSHS license with the enrollment packet. Facilities that are maintained or operated by the federal government or directly operated by the state of Texas are exempt from the licensing requirements.

Refer to: Subsection 1.1, "Provider Enrollment and Reenrollment" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for information on the provider enrollment process.

8.3 Assessment

Clients must be assessed by a Medicaid-enrolled CDTF for treatment services to begin. Clients who are in fee-for-service Medicaid can obtain their assessment from any Medicaid-enrolled CDTF.

CDTF assessment must be performed by a qualified credentialed counselor (QCC) (as defined by the DSHS licensure standard) to determine the severity of a client's SUD and identify their treatment needs. Assessments are limited to once per episode of care. An assessment must be billed with procedure code H0001 and modifier HF.

Documentation of the QCC assessment must be maintained in the client's medical record.

8.4 Opioid Treatment Program (OTP)

SUD services that are provided in an opioid treatment program (OTP) are a benefit of Texas Medicaid. OTP services are medication-assisted therapy services that threat patients addicted to heroin or other opiates.

OTPs are required to follow guidelines established by the following:

- Code of Federal Regulations Title 42 Part 8.
- Controlled Substances Act section 303(g), United States Code Title 21 section 823(g).
- Substance Abuse and Mental Health Services Administration (SAMHSA).

Detoxification in an OTP is the gradual tapering of methadone or buprenorphine doses, which results in the eventual cessation of these drugs. Claims for OTP-based detoxification are submitted as medication-assisted therapy using one of the following procedure codes:

- Procedure code H0020
- Procedure code H2010 with modifier HF or HG

An OTP must have current procedures to ensure that clients are admitted to detoxification treatment by qualified personnel, such as a program physician, who uses established diagnostic criteria to determine that the treatment is appropriate for each client. A client may not be admitted for more than two detox-

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ification episodes in one rolling year. Clients with two or more unsuccessful detoxification episodes with in a 12-month period must be assessed by the OTP physician for other forms of treatment. An assessment for the opioid addiction treatment program must be billed with procedure code H0001 and modifier HG.

Note: *There is no billing provider type in Texas Medicaid for an OTP or narcotic treatment clinic. OTPs must either submit claims using the physicians' provider identifier, or as a Department of State Health Services (DSHS) licensed chemical dependency treatment facility (CDTF).*

8.5 Detoxification Services

Detoxification services are a set of interventions aimed at managing acute physiological substance dependence. According to TAC §448.902 detoxification services include, but are not limited to, the following components:

- Evaluation
- Monitoring
- Medication
- Daily interactions

All clients who are admitted to a detoxification program must meet the current DSM criteria for physiological substance dependence and must meet the admission requirements based on a nationally-recognized standard.

8.5.1 Ambulatory (Outpatient) Detoxification Services

Ambulatory (outpatient) detoxification is appropriate when the client's medical needs do not require close monitoring.

Ambulatory (outpatient) detoxification is not a stand-alone service and must be provided in conjunction with ambulatory (outpatient) substance abuse treatment services.

Ambulatory (outpatient) detoxification services must be billed with procedure codes H0016, H0050, or S9445 and modifier HF.

8.5.2 Residential Detoxification Services

Residential detoxification is appropriate when the client's medical needs do not warrant an acute inpatient hospital admission, but the severity of the anticipated withdrawal requires close monitoring.

The assessment by a CDTF is required before services begin; however, if the client's condition is such that a comprehensive assessment cannot be completed, it is appropriate to conduct an abbreviated assessment on admission. The full assessment must be completed within 24 hours of admission.

Residential detoxification services must be billed with procedure codes H0012, H0031, H0047, S9445, or T1007 and modifier HF.

Medically-supervised hospital inpatient detoxification is appropriate when one of the following criteria is met:

- The client has complex medical needs or complicated comorbid conditions that necessitate hospitalization for stabilization.
- The services that are provided to a client are incidental to other medical services that are provided as a component of an acute care hospital stay.

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8.6 Treatment Services

Treatment services may be provided by a CDTF in a residential facility or as an ambulatory (outpatient) service.

Note: *MAT is recognized as a separately identifiable service in the ambulatory (outpatient) setting and may be provided during the treatment period in conjunction with other ambulatory (outpatient) treatment services.*

8.6.1 Residential Treatment Services

Residential treatment services include counseling and psycho-education and must be billed with procedure codes H0047 and H2035 and modifier HF.

8.6.2 Ambulatory (Outpatient) Treatment Services

Ambulatory (outpatient) treatment services must be billed with procedure codes H0004 or H0005 and modifier HF.

Procedure codes H0004 and H0005 are limited to the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
F1010	F10120	F10129	F10159	F10188	F1019	F1020	F1021
F10220	F10229	F10230	F10232	F10239	F10259	F10281	F10288
F1029	F10920	F10929	F10959	F10988	F1099	F1110	F11120
F11159	F11181	F11182	F11188	F1119	F1120	F1121	F11220
F11222	F11229	F1123	F11259	F11281	F11282	F11288	F1129
F11920	F11922	F11929	F1193	F11959	F11981	F11982	F11988
F1199	F1210	F12120	F12122	F12129	F12159	F12180	F12188
F1219	F1220	F1221	F12220	F12222	F12229	F12259	F12280
F12288	F1229	F12920	F12922	F12929	F12959	F12980	F12988
F1299	F13120	F13129	F13159	F13180	F13181	F13182	F13188
F1320	F1321	F13220	F13229	F13230	F13232	F13239	F13259
F13280	F13281	F13282	F13288	F13920	F13929	F13930	F13932
F13939	F13959	F13980	F13981	F13982	F13988	F1399	F1410
F14120	F14122	F14129	F14159	F14180	F14181	F14182	F14188
F1419	F1420	F1421	F14220	F14222	F14229	F1423	F14259
F14280	F14281	F14282	F14288	F1429	F14920	F14922	F14929
F14959	F14980	F14981	F14982	F14988	F1499	F1510	F15120
F15122	F15129	F15159	F15180	F15181	F15182	F15188	F1519
F1520	F1521	F15220	F15222	F15229	F1523	F15259	F15280
F15281	F15282	F15288	F1529	F15920	F15922	F15929	F1593
F15959	F15980	F15981	F15982	F15988	F1599	F1610	F16120
F16122	F16129	F16159	F16180	F16183	F16188	F1619	F1620
F16220	F16229	F16259	F16280	F16283	F16288	F1629	F16920
F16929	F16959	F16980	F16983	F16988	F1699	F17208	F17209
F17218	F17219	F17228	F17229	F17298	F17299	F1810	F18120
F18129	F18159	F18180	F18188	F1819	F1820	F1821	F18220
F18229	F18259	F18280	F18288	F1829	F18920	F18929	F18959

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
F18980	F18988	F1899	F1910	F19120	F19122	F19129	F19159
F19180	F19181	F19182	F19188	F1919	F1920	F1921	F19220
F19222	F19229	F19230	F19232	F19239	F19259	F19280	F19281
F19282	F19288	F1929	F19920	F19922	F19929	F19930	F19932
F19939	F19959	F19980	F19981	F19982	F19988	F1999	F551
F553							

8.6.3 Physician Services

Physician services may be reimbursed separately using the appropriate E/M procedure codes.

8.7 Medication Assisted Therapy (MAT)

MAT may be a benefit of Texas Medicaid when using a drug or biological recognized in the treatment of SUD and provided as a component of a comprehensive treatment program per TAC §448.902, or as a conjunctive treatment regimen for individuals addicted to abusable substances who meet the current DSM criteria for a SUD.

MAT is considered part of detoxification (residential and ambulatory outpatient) and residential treatment except for the following:

- Pregnant women with an opioid addiction
- Clients in current treatment for an opioid addiction who also have a substance addiction to another substance other than opioids

Documentation requirements supporting the medical necessity for MAT must be maintained in the client's medical record according to the requirements in Federal Regulation 42 CFR §8. MAT must be performed by a physician; however, the physician may delegate this responsibility to other licensed personnel under his supervision. Documentation must include the name and title of the physician performing or delegating other MAT services. The client's medical records are subject to retrospective review.

Clients who are 17 years of age and younger may not be admitted to a narcotic maintenance program unless a parent, legal guardian, or responsible adult designated by the relevant state authority consents in writing to such treatment. To be eligible for narcotic maintenance treatment, clients who are 17 years of age and younger must have had two documented attempts at short-term detoxification or drug-free (non-opioid) treatment within a 12-month period. A waiting period of no less than seven days is required between the first and the second short-term detoxification treatment.

Every exception to the general age requirement must be clinically justified and documented by a QCC. The facility must maintain the supporting documentation, including the QCC admission approval in the client's medical record.

MAT for the treatment of opioid addiction must comply with the requirements in Federal Regulation 42 CFR §8.

Refer to: Subsection 8.10.3, "MAT Services" in this handbook for more information on claims filing.

8.8 Prior Authorization

The following services do not require prior authorization:

- Assessment
- Ambulatory (outpatient) treatment services

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- MAT
- Inpatient hospital detoxification for fee-for-service clients in a general acute care facility

The following services require prior authorization:

- Ambulatory (outpatient) detoxification services
- Ambulatory (outpatient) treatment for clients who are 20 years of age and younger and who exceed the benefit limitation of 135 hours of group service and 26 hours of individual services per calendar year
- Residential detoxification services
- Residential treatment services

Providers must submit the appropriate prior authorization request form for the initial or continuation of ambulatory (outpatient) or residential detoxification treatment and residential treatment services. A physician (who does not need to be affiliated with the CDTF) must complete and sign the Ambulatory (Outpatient) Substance Abuse Extension Request Form. A QCC (as defined by the DSHS licensure standard) must complete and sign the other prior authorization request forms listed below.

Providers must submit one of the following forms to obtain prior authorization:

- Ambulatory (Outpatient) Detoxification Authorization Request Form
- Ambulatory (Outpatient) Substance Abuse Counseling Extension Request Form
- Residential Detoxification Authorization Request Form
- Residential Substance Abuse Treatment Authorization Request Form

Prior authorization for ambulatory and residential detoxification services will not be issued for clients who are 12 years of age or younger unless the request is accompanied by a waiver from DSHS Regulatory and Licensing Division.

Prior authorization will be considered for the least restrictive environment appropriate to the client's medical need as determined in the client's plan of care (POC), based on national standards.

Prior authorization requests for clients who are 20 years of age and younger for services beyond the limitations outlined in this section, may be considered with documentation from a physician (who does not need to be affiliated with the CDTF) supporting the medical necessity for continuation of the treatment.

8.8.1 Prior Authorization for Fee-for-Service Clients

Prior authorization requests for fee-for-service clients may be submitted to the TMHP Prior Authorization Unit online at www.tmhp.com, by fax at 1-512-514-4211, or by mail to:

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

Providers may contact the TMHP Prior Authorization Unit by telephone at 1-800-213-8877, Option 2, to obtain information about substance use disorder benefits, the prior authorization process, or the status of a prior authorization request. Prior authorization for substance use disorder services cannot be obtained through this line.

Prior authorization for ambulatory (outpatient) detoxification, residential treatment, or residential detoxification services may be considered when requested within three business days after the date of admission.

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8.8.2 Prior Authorization for Ambulatory (Outpatient) Detoxification Treatment Services

Ambulatory (outpatient) detoxification services may be prior authorized for up to 21 days. The level of service and number of days that are prior authorized will be based on the substances that are abused, level of intoxication and withdrawal potential, and the client's medical needs.

8.8.2.1 Admission Criteria for Ambulatory (Outpatient) Detoxification Treatment Services

To be considered eligible for treatment for ambulatory detoxification services, the client must meet the following conditions:

Chemical Substance Withdrawal

The client must meet all of the following criteria with regard to chemical substance withdrawal:

- The client is expected to have a stable withdrawal from alcohol or drugs.
- The diagnosis must meet the criteria for the definition of substance (chemical) dependence, as detailed in the most current revision of the ICD-10-CM, or the most current revision of the *Diagnostic and Statistical Manual for Professional Practitioners*, accompanied by evidence that some of the symptoms have persisted for at least one month or have occurred repeatedly over a longer period of time.

Medical Functioning

The client must meet all of the following criteria with regard to medical functioning:

- No history of recent seizures or past history of seizures during withdrawal.
- No clinical evidence of altered mental state as manifested by disorientation to self, alcoholic hallucinations, toxic psychosis, or altered level of consciousness (clinically significant obtundation, stupor, or coma).
- The symptoms are due to withdrawal and not due to a general medical condition. Absence of any presumed new asymmetric or focal findings (i.e., limb weakness, clonus, spasticity, unequal pupils, facial asymmetry, eye ocular movement paresis, papilledema, or localized cerebellar dysfunction, as reflected in asymmetrical limb coordination).
- Stable vital signs as interpreted by a physician. The client must also be without a previous history of complications from acute chemical substance withdrawal and judged to be free of a health risk as determined by a physician.
- No evidence of a coexisting serious injury or systemic illness either newly discovered or progressive in nature.
- Absence of serious disulfiram-alcohol (Antabuse) reaction with hypothermia, chest pains, arrhythmia, or hypotension.
- Clinical condition that allows for a comprehensive and satisfactory assessment.

Family, Social, or Academic Dysfunction

The client must meet at least one of the following criteria with regard to family, social, or academic dysfunction:

- The client's social system and significant others are supportive of recovery to the extent that the client can adhere to a treatment plan and treatment service schedules without substantial risk of reactivating the client's addiction.
- The client's family or significant others are willing to participate in the ambulatory (outpatient) detoxification treatment program.

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- The client may or may not have a primary or social support system to assist with immediate recovery, but the client has the social skills to obtain such a support system or to become involved in a self-help fellowship.
- The client does not live in an environment where licit or illicit mood altering substances are being used. A client living in an environment where licit or illicit mood altering substances are being used may not be a candidate for this level of care.

Emotional and Behavioral Status

The client must meet all of the following criteria with regard to emotional and behavioral status:

- Client is coherent, rational, and oriented for treatment.
- The mental state of the client does not preclude the client's ability to comprehend and understand the materials presented, and the client is able to participate in the ambulatory (outpatient) detoxification treatment process.
- Documentation exists in the medical record that the client expresses an interest to work toward ambulatory (outpatient) detoxification treatment goals.
- Client has no neuropsychiatric condition that places the client at imminent risk of harming self or others (e.g. pathological intoxication or alcohol idiosyncratic intoxication).
- Client has no neurological, psychological, or uncontrolled behavior that places the client at imminent risk of harming self or others (depression, anguish, mood fluctuations, overreactions to stress, lower stress tolerance, impaired ability to concentrate, limited attention span, high level of distractibility, negative emotions, or anxiety).
- Client has no documented DSM condition or disorder that, in combination with alcohol or drug use, compounds a pre-existing or concurrent emotional or behavioral disorder and presents a major risk to the client.
- The client has no mental confusion or fluctuating orientation.

Chemical Substance Use

The client must meet the criteria in at least one of the following conditions with regard to recent chemical substance use:

- The client's chemical substance use is excessive, and the client has attempted to reduce or control it but has been unable to do so (as long as chemical substances are available).
- The client is motivated to stop using alcohol or drugs and is in need of a supportive, structured treatment program to facilitate withdrawal from chemical substances.

8.8.2.2 * Continued Stay Criteria for Ambulatory (Outpatient) Detoxification Treatment Services

A client is considered eligible for continued stay in the ambulatory (outpatient) detoxification treatment service when the client meets at least one of the conditions for either chemical substance withdrawal or psychiatric or medical complications. Requests for continuation of services must be received on or before the last date authorized or denied. The prior authorization unit will notify the provider by fax or electronic portal. If the date of the prior authorization unit determination letter is on or after the last date authorized or denied, the request for continuation of services is due by 5 p.m. of the next business day. Documentation in the client's medical record must support either Chemical Substance Withdrawal or Psychiatric or Medical Complications as outlined below.

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Chemical Substance Withdrawal

The client must meet at least one of the following conditions with regard to chemical substance withdrawal complications:

- The client, while physically abstinent from chemical substance use, is exhibiting incomplete stable withdrawal from alcohol or drugs, as evidenced by psychological and physical cravings.
- The client, while physically abstinent from chemical substance use, is exhibiting incomplete stable withdrawal from alcohol or drugs, as evidenced by significant drug levels.

Psychiatric or Medical Complications

The client must meet both of the following psychiatric or medical complication conditions:

- The intervening medical or psychiatric event was serious enough to interrupt the ambulatory (outpatient) detoxification treatment.
- Evidence that the client is progressing in treatment again.

8.8.3 Prior Authorization for Residential Detoxification Treatment Services

Detoxification services may be prior authorized for up to 21 days. The level of service and number of prior authorized days will be based on the substances that are abused, level of intoxication and withdrawal potential, and the client's medical needs.

Requests for detoxification services for clients who are 20 years of age and younger and who need more than 21 days of residential detoxification require Medical Director review with documentation of medical necessity from a physician who is familiar with the client.

8.8.3.1 Admission Criteria for Residential Detoxification Treatment Services

Clients are eligible for admission to a residential detoxification service when they have failed two previous individual treatment episodes of ambulatory (outpatient) detoxifications or when they have a diagnosis that meets the criteria for the definition of chemical dependence, as detailed in either the most current revision of the ICD-10-CM, or the most current revision of the *Diagnostic and Statistical Manual for Professional Practitioners*.

In addition, the client must meet at least one of the following criteria for chemical substance withdrawal, major medical complication, or major psychiatric illness for admission to residential treatment for detoxification:

Chemical Substance Withdrawal

Impaired neurological functions as evidenced by:

- Extreme depression (e.g., suicidal).
- Altered mental state with or without delirium as manifested by disorientation to self; alcoholic hallucinosis, toxic psychosis, altered level of consciousness, as manifested by clinically significant obtundation, stupor, or coma.
- History of recent seizures or past history of seizures on withdrawal.
- The presence of any presumed new asymmetric or focal findings (i.e., limb weakness, clonus, spasticity, unequal pupils, facial asymmetry, eye ocular movement paresis, papilledema, or localized cerebellar dysfunction, as reflected in asymmetrical limb incoordination).
- Unstable vital signs combined with a history of past acute withdrawal syndromes that are interpreted by a physician to be indication of acute alcohol or drug withdrawal.
- Evidence of coexisting serious injury or systemic illness, newly discovered or progressive.

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- Clinical condition (e.g., agitation, intoxication, or confusion) that prevents satisfactory assessment of the above conditions and indicates placement in residential detoxification service may be justified.
- Neuropsychiatric changes of such severity and nature that they put the client at imminent risk of harming self or others (e.g., pathological intoxication or alcohol idiosyncratic intoxication, etc.).
- Serious disulfiram-alcohol (Antabuse) reaction with hypothermia, chest pains, arrhythmia, or hypotension.

Major Medical Complications

For major medical complications, the client must present a documented condition or disorder that, in combination with alcohol or drug use, presents a determined health risk (e.g., gastrointestinal bleeding, gastritis, severe anemia, uncontrolled diabetes mellitus, hepatitis, malnutrition, cardiac disease, hypertension).

Major Psychiatric Illness

The client must meet at least one of the following conditions with regard to major psychiatric illness:

- Documented DSM condition or disorder that, in combination with alcohol or drug use, compounds a pre-existing or concurrent emotional or behavioral disorder and presents a major risk to the individual.
- Severe neurological and psychological symptoms: (e.g., anguish, mood fluctuations, overreactions to stress, lowered stress tolerance, impaired ability to concentrate, limited attention span, high level of distractibility, extreme negative emotions, or extreme anxiety).
- Danger to others or homicidal.
- Uncontrolled behavior that endangers self or others, or documented neuropsychiatric changes of a severity and nature that place the individual at imminent risk of harming self or others.
- Mental confusion or fluctuating orientation.

8.8.3.2 Continued Stay Criteria for Residential Detoxification Treatment Services

Eligibility for continued stay for residential detoxification services is based on the client meeting at least one of the criteria for chemical substance withdrawal, major medical complications, or major psychiatric complications.

Chemical Substance Withdrawal

The client must exhibit one of the following conditions with regard to chemical substance withdrawal complications:

- Incomplete medically stable withdrawal from alcohol or drugs, as evidenced by documentation of at least one of the following conditions:
  - Unstable vital signs
  - Continued disorientation
  - Abnormal laboratory findings related to chemical dependency
  - Continued cognitive deficit related to withdrawal so that the client is unable to recognize alcohol or drug use as a problem
  - Laboratory finding that, in the judgment of a physician, indicates that a drug has not sufficiently cleared the client's system

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Major Medical Complications

For major medical complications, the client must have documentation in the medical record that indicates that a medical condition or disorder (e.g., uncontrolled diabetes mellitus) continues to present a health risk and is being actively treated.

Major Psychiatric Complications

The client must meet at least one of the following with regard to major psychiatric complications:

- Documentation in the medical record that a DSM psychiatric condition or disorder that, in combination with alcohol or drug use, continues to present a major health risk, is actively being treated.
- Documentation in the medical record that severe neurological or psychological symptoms have not been satisfactorily reduced but are actively being treated.

8.8.4 Prior Authorization for Residential Treatment Services

Residential treatment may be prior authorized for up to 35 days per episode of care, with a maximum of two episodes of care per rolling six-month period, and four episodes of care per rolling year.

8.8.4.1 Admission Criteria for Residential Treatment Services

The diagnosis must meet the criteria for the definition of chemical dependence, as detailed in the most current revision of the ICD-10-CM, or the most current revision of the *Diagnostic and Statistical Manual for Professional Practitioners*, accompanied by evidence that some of the symptoms have persisted for at least one month or have occurred repeatedly over a longer period of time.

Clients must meet the following conditions in order to receive treatment in a residential treatment service program:

Medical Functioning

The following must be present with regard to medical functioning:

- Documented medical assessment following admission (except in instances where the client is being referred from an inpatient service) indicates that the client is medically stable and not in acute withdrawal.
- The client is not bed-confined and has no medical complications that would hamper participation in the residential service.

Family, Social, or Academic Dysfunction and Logistic Impairments

At least one of the following must be present with regard to family, social, or academic dysfunction and logistic impairments:

- The client manifests severe social isolation or withdrawal from social contacts.
- The client lives in an environment (social and interpersonal network) in which treatment is unlikely to succeed (e.g., a chaotic family dominated by interpersonal conflict, which undermines client's efforts to change).
- Client's family or significant others are opposed to the client's treatment efforts and are not willing to participate in the treatment process.
- Family members or significant others living with the client manifest current chemical dependence disorders and are likely to undermine treatment.
- Logistic impairments (e.g., distance from treatment facility or mobility limitations) preclude participation in a partial hospitalization or ambulatory (outpatient) treatment service.

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Emotional and Behavioral Status

The client must meet all three of the following criteria with regard to emotional and behavioral status:

- Client is coherent, rational, and oriented for treatment.
- Mental state of the client does not preclude the client's ability to comprehend and understand the materials presented and participate in rehabilitation or the treatment process.
- The medical record contains documentation that with continued treatment the client will be able to improve or internalize the client's motivation toward recovery within the recommended length of stay time frames (e.g., becoming less defensive, verbalizing, and working on alcohol or drug related issues). Interventions, treatment goals, or contracts are in place to help the client deal with or confront the blocks to treatment (e.g., family intervention or employee counseling confrontation).

Chemical Substance Use

The client must meet at least one of the following criteria with regard to chemical substance use:

- The client's chemical substance use is excessive, and the client has attempted to reduce or control it but has been unable to do so (as long as chemical substances are available).
- Virtually all of the client's daily activities revolve around obtaining, using, or recuperating from the effects of chemical substances, and the client requires a secured environment to control the client's access to chemical substances.

8.8.4.2 Residential Treatment Services for Adolescents

Clients who are 13 through 17 years of age must meet all above conditions and the following conditions in order to receive treatment in an adolescent residential treatment service program:

- At the maturation level, the adolescent client must meet both of the following criteria:
  - The client is assessed as manifesting physical maturation at least in middle adolescent range (i.e., post-pubescent; not growth-retarded).
  - The history of the adolescent reflects cognitive development of at least 11 years of age.
- The adolescent client must display at least one of the following with regard to developmental status:
  - Documented history of inability to function within the expected age norms despite normal cognitive and physical maturation (e.g., refusal to interact with family members, overt prostitution, felony, or other criminal charges).
  - A recent history of moderate to severe conduct disorder, as defined in the *Diagnostic and Statistical Manual for Professional Practitioners*, or impulsive disregard for social norms and rights of others.
  - Documented difficulty in meeting developmental expectations in a major area of functioning (e.g., social, academic, or psychosexual) to an extent that interferes with the capacity to remain behaviorally stable.

8.8.4.3 Continued Stay Criteria for Residential Treatment Services

At least one of the following conditions must be present for continued stay in a residential treatment program:

- Chemical Dependency Rehabilitation or Treatment Complications
  - The client recognizes or identifies with the severity of the alcohol or drug problem but demonstrates minimal insight into the client's defeating the use of alcohol or drugs. However, documentation in the medical record indicates that the client is progressing in treatment; *or*

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- The client identifies with the severity of the alcohol or drug problem and manifests insight into the client's personal relationship with mood-altering chemicals, yet does not demonstrate behaviors that indicate the development of problem-solving skills that are necessary to cope with the problem; *and*
- The client would predictably relapse if moved to a lesser level of care.

- Psychiatric or Medical Complications:
  - Documentation in the medical record indicates an intervening medical or psychiatric event that was serious enough to interrupt rehabilitation or treatment, but the client is again progressing in treatment.
  - Documentation in the medical record indicates that the client is being held pending an immediate transfer to a psychiatric, acute medical service, or inpatient detoxification alcohol or drug service.

8.8.5 Prior Authorization for Ambulatory (Outpatient) Treatment Services for Clients Who Are 20 Years of Age and Younger

Prior authorization for ambulatory (outpatient) treatment services beyond the annual limitation of 135 hours of group services and 26 hours of individual services per calendar year, may be considered for clients who are 20 years of age and younger with documentation from a physician (who does not need to be affiliated with the CDTF) of the supporting medical necessity for continued treatment services.

Requests must be submitted before providing the extended services. The documentation must include the following information:

- The client is meeting treatment goals.
- The client demonstrates insight and understanding into relationship with mood altering chemicals, but continues to present with issues addressing the life functions of work, social, or primary relationships without the use of mood-altering chemicals.
- And one of the following:
  - Although physically abstinent from chemical substance use, the client remains mentally preoccupied with such use to the extent that the client is unable adequately to address primary relationships or social or work tasks. Nevertheless, there are indications that, with continued treatment, the client will effectively address these issues.
  - Although other psychiatric or medical complications exist that affect the client's treatment, documentation exists that the client continues to show treatment progress and that there is evidence to support the benefits of continued treatment.

8.9 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including SUD services.

All SUD services are subject to retrospective review. All documentation must be maintained in the client's medical record and be made available upon request.

8.10 Reimbursement and Limitations

8.10.1 Detoxification Services

Inpatient detoxification is reimbursed by the reimbursement methodology specific to the inpatient hospital. Separate reimbursement may be provided for physician services performed during an inpatient stay.

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Residential detoxification and treatment services are considered outpatient services for the purposes of reimbursement and should be billed accordingly.

Residential detoxification (procedure codes H0012, H0031, S9445, and T1007) are limited to once per day.

Residential detoxification (procedure codes H0031, H0047, S9445, or T1007) will be denied if billed without procedure code H0012.

Room and board for residential detoxification and treatment (procedure code H0047) is limited to once per date of service. Procedure code H0047 is reimbursed for clients who are 21 years of age and older as an access-based fee, and as an informational detail for clients who are 20 years of age and younger.

Ambulatory (outpatient) detoxification (procedure codes H0016, H0050, and S9445) are limited to once per day and may be reimbursed on the same date of service as ambulatory (outpatient) SUD treatment by the same or different provider when medically necessary and identified in the client's treatment plan. For services rendered in the CDTF setting, providers must use the HF modifier.

Ambulatory (outpatient) detoxification (procedure codes H0050 and S9445) will be denied if billed without procedure code H0016.

Separate reimbursement may be provided for physician services during a residential stay.

8.10.2 Treatment Services

Ambulatory (outpatient) treatment (procedure codes H0004 and H0005) is reimbursed at a time-based rate.

Ambulatory (outpatient) treatment services are limited to 135 hours of group counseling and 26 hours of individual counseling per calendar year when provided by a CDTF.

Residential treatment services (procedure code H2035) are limited to one per day and are allowed up to a maximum of 35 days.

Ambulatory (outpatient) treatment (procedure codes H0004 and H0005) will be denied if billed on the same date of service as residential detoxification (procedure codes H0012, H0031, H0047, and T1007) or residential treatment (procedure code H2035).

Procedure code H0047 will be denied if billed without procedure code H2035.

8.10.3 MAT Services

MAT may be considered for reimbursement on appeal on the same date of service as residential detoxification, ambulatory (outpatient) detoxification, or residential treatment services. For the claim to be considered, providers must:

- Submit supporting documentation that indicates one of the following:
  - The client is a pregnant woman with an opioid addiction.
  - The client is in current MAT treatment for an opioid addiction and is also receiving residential services for a substance other than opioids.
- Submit one of the following opioid diagnosis codes on the claim:

Diagnosis Codes	Description
F1120, F1121, F11220, F11221, F11222, F11229, F1123, F1124, F11259, F11281, F11282, F11288, F1129	Opioid type dependence
F1821, F1920, F1921	Combination of opioid type drug
F1110	Opioid abuse

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- Submit one of each of the following non-opioid and pregnancy diagnosis codes on the claim:

Diagnosis Codes	Description
F1020, F1021	Other and unspecified alcohol dependence
F1320, F1321	Sedative, hypnotic or anxiolytic dependence
F1420, F1421	Cocaine dependence
F1520, F1521	Amphetamine and other psychostimulant dependence
F1620, F1621	Hallucinogen dependence
F1620, F1820, F1821, F1920, F1921	Other or unspecified drug dependence
F15120, F15129, F15220, F15229, F15920, F15929, F1610, F1810, F1890, F1910, F551, F553	Other, mixed, or unspecified drug abuse
O99320, O99321, O99322, O99323, O99325	Pregnancy-related diagnoses

Claims billed for MAT must include the client's substance use disorder diagnosis.

Procedure codes H0020 or H2010 will be denied if a claim is submitted for the same date of service as procedure codes H0012, H0016, H0031, H0047, H0050, H2035, S9445, or T1007.

Methadone administration (procedure code H0020) for opioid addiction must be submitted with the following modifiers:

- When methadone is administered with supervision in a facility the provider must submit claims using the UA modifier to indicate the facility administered doses
- When methadone is dispensed without supervision as a take home dose the provider must submit claims using the U1 modifier to indicate take home doses

Methadone administration (procedure code H0020) with modifier U1 for unsupervised take home doses must be submitted on the same claim and with the same date of service as methadone administration (procedure code H0020) with modifier UA for supervised facility doses or the take home doses will be denied.

MAT provided in an ambulatory (outpatient) setting (procedure code H0020) is limited to once per date of service, except for unsupervised take home doses (U1 modifier), by any provider and is reimbursed at a fixed daily rate.

Methadone administration (procedure code H0020) submitted without a modifier will be denied.

Non-methadone (e.g., buprenorphine) administration (procedure code H2010) for opioid addiction must be submitted with the following modifiers:

- When non-methadone is administered with supervision in a facility the provider must submit claims using the modifier combination of HG and UA to indicate opioid addiction treatment facility doses or claims will be denied
- When non-methadone is dispensed without supervision as a take home dose the provider must submit claims using the modifier combination of HG and U1 to indicate opioid addiction take home doses or claims will be denied

MAT provided in an ambulatory (outpatient) setting (procedure code H2010 with modifier HG and procedure code H2010 with modifier HF), is limited to once per date of service, except for unsupervised take home doses (U1 modifier), by any provider.

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Non-methadone administration (procedure code H2010-HG) with modifier U1 for unsupervised take home doses must be submitted on the same claim and with the same date of service as non-methadone administration (procedure code H2010-HG) with modifier UA for supervised facility doses or the take home doses will be denied.

When non-methadone is administered in a facility for a non-opioid treatment, providers must use procedure code H2010 with the HF modifier to indicate non-opioid treatment in a facility.

Non-methadone administration (procedure code H2010) submitted without a modifier will be denied. Physician services may be reimbursed separately using the appropriate evaluation and management procedure codes.

Injectable administration is considered part of MAT and is not reimbursed separately. Procedure code 96372 will be denied when billed for the same date of service by any provider as procedure code H0020 or H2010.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied.

Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

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

8.11 Noncovered Services

The following SUD services are not a benefit of Texas Medicaid:

- Aftercare
- Occupational therapy as part of a residential detoxification or treatment program
- Services for which the client fails to meet the treatment eligibility or authorization criteria, or which are not clinically appropriate in the setting requested based on the client's medical condition
- Services for tobacco and caffeine addiction
- Detoxification services and MAT for hashish or marijuana addiction
- Detoxification with an opioid when the client has had two or more unsuccessful opioid detoxification episodes (has left the program against medical advice) within a 12-month period (see 42 CFR Section 8)
- Detoxification or substance abuse counseling services provided by electronic means such as telemedicine, email, or telephone

8.12 Claims Filing

Claims for SUD 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.

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Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Subsection 6.1, "Claims Information" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

9 Claims Resources

Refer to the following sections or forms when filing claims:

Resource	Location
Appendix A: State, Federal, and TMHP Contact Information	Appendix A (*Vol. 1, General Information*)
Appendix D: Acronym Dictionary	Appendix D (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	TMHP Telephone and Fax Communication (*Vol. 1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5 (*Vol. 1, General Information*)
Section 3: TMHP Electronic Data Interchange (EDI)	Section 3 (*Vol. 1, General Information*)
TMHP Electronic Claims Submission	Subsection 6.2 (*Vol. 1, General Information*)

10 Contact TMHP

Providers can call the TMHP Contact Center at 1-800-925-9126 from Monday through Friday, 7 a.m. to 7 p.m., Central Time.

11 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Ambulatory (Outpatient) Detoxification Authorization Request Form
Ambulatory (Outpatient) Substance Abuse Counseling Extension Request Form
Outpatient Psychotherapy/Counseling Request Form
Psychological/Neuropsychological Testing Request Form
Residential Detoxification Authorization Request Form
Residential Substance Use Disorder Treatment Request Form

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12 Claim Form Examples

The following linked claim form examples can also be found on the Claim Form Examples page of the Provider section of the TMHP website at www.tmhp.com:

Claim Form Examples
Blind Children's Vocational Discovery and Development Program (BCVDDP)
Case Management for Children and Pregnant Women
Licensed Clinical Social Worker (LCSW)
Licensed Marriage and Family Therapist (LMFT)
Licensed Professional Counselor (LPC)
Mental Health Case Management
Psychologist
Psychotherapy with Evaluation and Management (E/M)

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Children's Services Handbook

Texas Medicaid Provider Procedures Manual: Vol. 2

April 2016

TEXAS
Health and Human
Services Commission

CHILDREN'S SERVICES HANDBOOK

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1 General Information

The information in this handbook is intended for dentists, school districts, physicians, physician assistants (PAs), rural health clinics (RHCs), federally qualified health centers (FQHCs), advanced practice registered nurses (APRNs), home health agencies (HHAs), durable medical equipment (DME) suppliers, hospitals, and clinics. The handbook provides information about Texas Medicaid's benefits, policies, and procedures applicable to these providers.

Important: *All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

All providers are required to report suspected child abuse or neglect as outlined in Subsection 1.6, "Provider Responsibilities" in Section 1, "Provider Enrollment and Responsibilities" (*Vol 1, General Information*).

1.1 Medical Transportation Program

The Medical Transportation Program (MTP) is funded with federal and state dollars to arrange nonemergency transportation to medical or dental appointments for eligible clients and their attendants.

The Health and Human Services Commission (HHSC) administrative rules govern parental accompaniment of children who receive Medicaid screenings, treatments, and MTP services.

Titles 1 Texas Administrative Code (TAC), Part 15, §380.207 allows parents or guardians to authorize one adult and one alternate adult to accompany their children on MTP rides when the parent or guardian is unable to do so. The parent or guardian is required to designate the other adult on a form prescribed by HHSC in accordance with section §380.207(4).

An adult who is authorized by a parent or guardian may not be a provider or an employee or affiliate of a provider that submits claims for services.

Refer to: *Medical Transportation Program Handbook* (*Vol. 2, Provider Handbooks*) for more information.

1.2 Rates Reduction

Texas Medicaid implemented mandated rate reductions for certain services. The Online Fee Lookup (OFL) and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the Texas Medicaid & Healthcare Partnership (TMHP) website at www.tmhp.com/pages/topics/rates.aspx.

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1.3 NP, CNS, PA, and CNM Claims Submitted by a Physician

Physicians will be reimbursed 92 percent of the established reimbursement rate for services provided by an NP, CNS, PA, or CNM 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. Physicians who submit a claim using the physician's own provider identifier for the services that were provided by the NP, CNS, PA, or CNM must submit one of the following modifiers on each claim detail:

- SA—Services were provided by an NP or CNS
- U7—Services were provided by a PA
- SB—Services were provided by a CNM

Exception: *The 92 percent reimbursement rate does not apply to laboratory services, radiology services, or injections provided by an NP, CNS, PA, or CNM.*

1.4 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 time frame 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:

- Services are rendered at a federally qualified health center (FQHC) or rural health clinic (RHC).
- Services are for a THSteps medical checkup.
- 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.

These reimbursement guidelines do not apply for FQHC, RHC, THSteps, and professional services that are rendered in the inpatient hospital setting.

Refer to: Subsection 3.7.3.8, "Payment Window Reimbursement Guidelines" of the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about the payment window reimbursement guidelines.

2 Medicaid Children's Services Comprehensive Care Program (CCP)

2.1 CCP Overview

CCP is an expansion of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) service as mandated by the Omnibus Budget Reconciliation Act (OBRA) of 1989, which requires all states to provide all medically necessary treatment for correction of physical or mental problems to Texas Health Steps (THSteps)-eligible clients when federal financial participation (FFP) is available, even if the services are not covered under the state's Medicaid plan.

The following CCP provider sections describe the specific requirements of each area of responsibility:

- Subsection 2.4, "Clinician-Directed Care Coordination Services (CCP)" in this handbook.

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- Subsection 2.5, "Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Outpatient Rehabilitation Facilities (ORFs)" in this handbook.
- Subsection 2.6, "Durable Medical Equipment (DME) Supplier (CCP)" in this handbook.
- Subsection 2.7, "Early Childhood Intervention (ECI) Services" in this handbook.
- Subsection 2.9, "Medical Nutrition Counseling Services (CCP)" in this handbook.
- Subsection 2.10, "Orthotic and Prosthetic Services (CCP)" in this handbook.
- Subsection 2.11, "Personal Care Services (PCS) (CCP)" in this handbook.
- Subsection 2.13, "Private Duty Nursing (PDN)(CCP)" in this handbook.
- Subsection 2.14, "Therapy Services (CCP)" in this handbook.
- Subsection 2.15, "Inpatient Psychiatric Hospital or Facility (Freestanding) (CCP)" in this handbook.
- Subsection 2.16, "Inpatient Rehabilitation Facility (Freestanding) (CCP)" in this handbook.

2.1.1 Client Eligibility

The client must be birth through 20 years of age and eligible for THSteps on the date of service. If the client's Your Texas Benefits card states "Emergency Care," "PE," or "QMB," the client is not eligible for CCP benefits.

Clients are ineligible for CCP services beginning the day of their 21st birthday.

2.1.2 Enrollment

CCP providers must meet Medicaid and Health and Human Services Commission (HHSC) participation standards to enroll in the program. All CCP providers must be enrolled in Texas Medicaid to be reimbursed for services. Provider enrollment inquiries and application requests must be sent to the TMHP Provider Enrollment department at:

Provider Enrollment
Texas Medicaid & Healthcare Partnership
PO Box 200555
Austin, TX 78720-0555

Home and community support services agencies (HCSSAs) that want to provide CCP private-duty nursing (PDN), home telemonitoring, occupational therapist, physical therapist, or speech therapist services under the licensed-only home health (LHH) category must first enroll with TMHP. To enroll with TMHP in the LHH category, an HCSSA must:

- Complete a provider enrollment form, which can be found on the TMHP website at www.tmhp.com, provide its license information, and check the "Only CCP services" box on the form.
- Obtain a Texas Provider Identifier (TPI) for CCP services.
- Provide PDN, occupational therapy (OT), physical therapy (PT), or speech therapy (ST) services only to eligible CCP clients and use the TPI number assigned for CCP services. Texas Medicaid home health services must be delivered under the licensed and certified home health (LCHH) category.

2.1.3 Services, Benefits, and Limitations

Payment is considered for any health-care service that is medically necessary and for which FFP is available. CCP benefits are allowable services not currently covered under Texas Medicaid (e.g., speech-language pathology [SLP] services for nonacute conditions, PDN, prosthetics, orthotics, apnea monitors and some DME, some specific medical nutritional products, medical nutrition services, inpatient

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rehabilitation, travel strollers, and special needs car seats). CCP benefits also include expanded coverage of current Texas Medicaid services where services are subject to limitations (e.g., diagnosis restrictions for total parenteral nutrition [TPN] or diagnosis restrictions for attendant care services).

Requests for services that require a prior authorization must be submitted to TMHP. Prior authorization is a condition for reimbursement, not a guarantee of payment. For information about specific benefits, providers can refer to provider-specific sections of this manual.

Payment cannot be made for any service, supply, or equipment for which FFP is not available. The following are some examples:

- Vehicle modification, mechanical, or structural (such as wheelchair lifts).
- Structural changes to homes, domiciles, or other living arrangements.
- Environmental equipment, supplies, or services, such as room dehumidifiers, air conditioners, filters, space heaters, fans, water purification systems, vacuum cleaners, and treatments for dust mites, rodents, and insects.
- Ancillary power sources and other types of standby equipment (except for technology-dependent clients such as those who are ventilator-dependent for more than six hours per day).
- Educational programs, supplies, or equipment (such as a personal computer or software).
- Equine or hippotherapy.
- Exercise equipment, home spas or gyms, toys, therapeutic balls, or tricycles.
- Tennis shoes.
- Respite care (relief to caregivers).
- Aids for daily living (toothbrushes, spoons, reachers, and foot stools).
- Take-home drugs from hospitals (Eligible hospitals may enroll in and bill Vendor Drug Program (VDP). Pharmacies that want to enroll should call 1-512-491-1429.
- Therapy involving any breed of animal.

2.1.4 * Prior Authorization and Documentation Requirements

Prior authorization is a condition for reimbursement; it is not a guarantee of payment. A prior authorization number (PAN) is a TMHP-assigned number establishing that a service or supply has been determined to be medically necessary and for which FFP is available. It is each provider's responsibility to verify the client's eligibility at the time each service is provided. Any service provided while the client is not eligible cannot be reimbursed by TMHP. The responsibility for payment of services is determined by private arrangements made between the provider and client.

Prior authorization of CCP services may be requested in writing by completing the appropriate request form, attaching any necessary supportive documentation, and submitting them by mail, fax, or the electronic portal to the TMHP-CCP department. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

Providers who fax new prior authorization requests, resubmitted requests, or additional information to complete a request must include:

- A working fax number on the prior authorization form, so that they can receive faxed responses and correspondence from TMHP.
- The last four digits of the client's Medicaid identification number on the fax coversheet.

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Prior authorization may also be requested through the TMHP website. (Providers can refer to subsection 5.5.1, "Prior Authorization Requests Through the TMHP Website" in Section 5, *"Prior Authorization"* (*Vol. 1, General Information)* for additional information to include mandatory documentation and retention requirements). All requested information on the form must be completed, or the request is returned to the provider. Incomplete forms are *not* accepted. If prior authorization is granted, the potential service provider (such as the DME supplier, pharmacy, registered nurse (RN), or physical therapist) receives a letter that includes the PAN, the procedures prior authorized, and the length of the authorization. Providers are notified in writing when additional information is needed to process the request for services.

Providers must submit a CCP Prior Authorization Request Form and documentation to support medical necessity to the CCP department *before* providing services. Providers must submit the CCP Prior Authorization Request Form when requesting a medically necessary service if the service is not addressed in the *Texas Medicaid Provider Procedures Manual* and the client is 20 years of age or younger.

Important: *Documentation to support medical necessity of the service, equipment, or supply (such as a prescription, letter, or medical records) must be current, signed, and dated by a physician (M.D. or D.O.) before services are performed. Providers must keep the information on file.*

Refer to: CCP provider-specific sections for prior authorization requirements of specific services, including the appropriate prior authorization request forms.

2.1.4.1 Incomplete Prior Authorization Requests

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

Prior to denying an incomplete request, TMHP's Prior Authorization department will attempt to get the the correct information from the requesting provider. The Prior Authorization department will make a minimum of three attempts to contact the requesting provider before sending a letter to the client about the status of the request and the need for additional information.

If the necessary information to make a prior authorization determination is not received within 14 business days of 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.

For fee-for-service (FFS) Medicaid requests that require a physician review before a final determination can be made, TMHP's Physician Reviewer will complete the review within three business days of receipt of the completed prior authorization request. An additional three business days will be allowed for requests that require a peer-to-peer review with the client's prescribing physician.

2.1.4.2 Diagnosis Coding

All providers must obtain the client's medical diagnosis from the physician. This information must be reflected on each claim submitted to TMHP.

2.1.4.3 Drug and Medical Device Approval

Manufacturers may request to have drug or medical device products added as a CCP benefit by sending the information in writing to the following address:

HHSC
1100 West 49th Street
Austin, TX 78756-3179

HHSC reviews the information. Requests for consideration must *not* be sent to TMHP.

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2.1.4.4 Physician Signature

The dated signature of the physician (M.D. or D.O.) on a prescription or CCP Authorization Request Form must be current to the service date(s) of the request, i.e., the signature must always be on or before the service start date and no older than three months before the current date(s) of service requested. Physician signatures dated after the service start date on initial requests cannot be accepted as documentation supporting medical necessity for dates of service prior to the signature date. A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply. If services begin as a result of a verbal order before the physician's dated signature, proof of the verbal order must be submitted with the request.

Stamped signatures and dates are not accepted on CCP Authorization Request Forms or prescriptions for CCP prior authorized services, supplies, or equipment. Verbal orders must be cosigned and dated by a physician (M.D. or D.O.) within two weeks, per provider policy. Signatures of chiropractors or doctors of philosophy (PhDs) are not accepted on CCP Authorization Request Forms or prescriptions for CCP prior authorized services.

Certified nurse midwife (CNM), clinical nurse specialist (CNS), nurse practitioner (NP), and PA providers may sign on behalf of the physician for private duty nursing, physical, occupational and speech therapy services when the physician delegates this authority.

Physician prescriptions must be specific to the type of service requested. For example, if the provider is requesting PT, the prescription must request physical therapy, not just therapy.

2.2 Managed Care Organization (MCO) Clients Who Transition to Medicaid Fee-For-Service (FFS)

When clients transition from an MCO to FFS, providers can request that previously approved authorizations for Comprehensive Care Program (CCP) services, occupational therapy (OT), physical therapy (PT), private duty nursing (PDN), and speech therapy (ST) be transferred from the MCO to FFS.

2.2.1 Submission Guidelines

To consider the reimbursement of claims for services that were rendered on or after the MCO disenrollment date, TMHP must receive the request to transition the authorization from the MCO to FFS within the following time frames:

- Providers have three business days from the client's MCO disenrollment date to submit a request to TMHP to transfer the authorization for PDN and Skilled Nursing/Aide visit services from the MCO to FFS.
- Providers have five business days from the client's MCO disenrollment date to submit a request to TMHP to transfer the authorizations of all therapy services from the MCO to FFS.

2.2.2 Documentation Requirements

All of the requests to transfer the authorizations from the MCO to FFS must include:

- A copy of the authorization letter.
- All of the documentation that was sent in the original authorization request, including any physician orders that were used to determine the start of care. TMHP will accept the physician orders as the required documentation for the requested services.
- The completed CCP prior authorization form, Special Medical Prior Authorization (SMPA) form or Home Health Plan of Care, whichever is applicable for the requested service. The form must include the dates of service and quantities that are being requested from TMHP, and they must match the dates of service and quantities that were approved in the original MCO authorization. It

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is not necessary to obtain signatures or dates on the forms if they are submitted to TMHP for the purpose of transferring an authorization from an MCO to FFS Medicaid. Authorizations for services transferred from an MCO to FFS Medicaid are subject to retrospective review.

When the required documentation has been received, TMHP will verify the client's eligibility, the dates of service, and the quantities requested. If the information matches the original MCO authorization, TMHP will generate a new FFS Medicaid.

If a request to transfer an authorization is submitted after the deadline, TMHP will process reimbursement claims as follows:

- Claims for services that were rendered before the date on which the transfer request was received will be denied as a late submission, and the provider will be notified of their administrative appeal rights through the Health and Human Services Commission (HHSC).
- Claims for services that were rendered on or after the date of receipt use the required information from the transferred authorization and will be processed as if the request was received in a timely manner.

If a client transfers from an MCO to FFS and the provider does not have an authorization letter from the MCO, TMHP will process the request to transfer the authorization based on established TMHP authorization submission guidelines for OT, PT, PDN, and ST services.

All new requests for rendered services must meet the documentation requirements.

For therapy services, the prescribing physician's signature is required unless one of the following from the prescribing physician is attached to the request: a signed and dated prescription, a dated written order, or a dated documented verbal order.

2.2.3 New Services and Extension of Services

For new services that occur after the client's MCO disenrollment change date, the provider is responsible for submitting all TMHP required paperwork and meeting all established submission guidelines for prior authorization.

Requests for the extension of services that occur after the MCO disenrollment change date must include all of the paperwork that is required by TMHP. The requests must be submitted within the following time frames:

- Within seven calendar days of the extension start of care for CCP-PDN
- No more than 30 days before the current authorization expires for all therapy services

2.2.4 Loss of Eligibility

If an MCO disenrolled a client and the client also loses Medicaid eligibility, providers must anticipate, if and when Medicaid eligibility is restored, that the client will initially be considered a Medicaid FFS client and will have a retroactive eligibility period.

All requests for services that require prior authorization and that occur during the client's retroactive eligibility period, must be submitted to TMHP following the process that is outlined in Subsection 5.1.1, "Prior Authorization Requests for Clients with Retroactive Eligibility" in "Fee-for-Service Prior Authorizations" (Vol.1, *Provider Handbooks*).

If a client is retroactively disenrolled by an MCO, all of the services that are rendered by the provider during this retroactive disenrollment period (specifically from the date on which the client was eligible for FFS to the date of the client's MCO eligibility change) will be denied by TMHP, and the provider will be notified of their administrative appeal rights.

TMHP may consider services for the MCO transition beginning on the date of the client's MCO eligibility change date and going forward. TMHP uses the MCO transition process for the submission of paperwork and the processing of provider requests.

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2.3 Certified Respiratory Care Practitioner Services (CCP)

2.3.1 Services, Benefits, and Limitations

In-home certified respiratory care practitioner (CRCP) services are a benefit of the CCP for non-ventilator-dependent clients who are 20 years of age and younger.

Refer to: Section 2, "Certified Respiratory Care Practitioner (CRCP) Services" in the *Nursing and Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for information about respiratory care practitioner services for ventilator-dependent clients.

In-home respiratory services are a benefit when provided to clients who have a chronic, underlying respiratory illness or a newly diagnosed long-term respiratory condition that currently results in a suboptimal respiratory status. These services are designed to maximize the client's or caregiver's ability to manage the client's disease when the physician deems the client or caregiver will benefit from the expertise of a respiratory care practitioner for the provision of respiratory care or education.

A CRCP must hold a certificate or temporary permit in compliance with the Texas Occupations Code, Chapter 604, Subchapter A. CRCPs must be enrolled with Texas Medicaid as an independent practitioner or be employed by a physician, physician group, or home health agency.

The CRCP's services allow for the performance of pulmonary care, when required, and the education of the client or caregiver in the following:

- Disease management
- Prevention of infections and complications
- Proper use of medications and respiratory equipment that the client is using

Respiratory therapy care services that do not require the specialty of a CRCP are not a benefit.

In-home respiratory services must be billed using procedure codes 98960, 99503, and S9441.

Procedure codes 98960, 99503, and S9441 are limited to twice per lifetime. Services that exceed the twice-per-lifetime limitation must meet additional criteria for prior authorization.

Only one procedure code (98960, 99503, 99504, or S9441) may be reimbursed per day, to any provider.

2.3.2 * Prior Authorization and Documentation Requirements

Prior authorization is required for in-home respiratory services (procedure codes 98960, 99503, and S9441). Prior authorization requests must be submitted on the CRCP Prior Authorization Request Form.

Refer to: CRCP Prior Authorization Request Form on the TMHP website at www.tmhp.com.

Providers must submit the following documentation to the CCP Prior Authorization Unit:

- A physician's order
- Client's primary diagnosis with details of current suboptimal respiratory status and history of more than one emergency room or acute care clinic visit within the last three months
- The services that the CRCP will provide
- Reason this service/education needs to be provided in the home setting and not in the office or facility setting. Reasons may include, but are not limited to, the following:
  - Testing of home equipment
  - Evaluation of the patient/caregiver's technique with home respiratory care equipment
  - Evaluation of caregiver's ability to assess the client's respiratory status and intervene appropriately if necessary

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  - Assessment of the home environment
- The goals of the services to be provided in the home and the estimated length of time to attain these goals

Procedure code S9441 must be performed by a CRCP who has been certified by the National Asthma Educator Certification Board (NAECB) as a certified asthma educator. Certification documentation must be provided with the CRCP Prior Authorization Request Form in order to be considered for prior authorization. Asthma conditions may include, but are not limited to, the following:

- Extrinsic asthma
- Intrinsic asthma
- Chronic obstructive asthma
- Exercise-induced asthma

For procedure codes 98960 and 99503, covered respiratory conditions may include, but are not limited to, the following:

- Cystic fibrosis
- Obstructive sleep apnea (use of continuous positive airway pressure [CPAP] or bi-level positive airway pressure [BiPAP])
- Chronic respiratory insufficiency

Prior authorization requests for conditions or quantities beyond two per lifetime will be considered on a case-by-case basis upon review by the TMHP Medical Director. Providers must submit the following additional information when requesting prior authorization beyond the two-per-lifetime limit:

- Documentation that the objectives of prior visits were not yet achieved
- Reason the additional services need to be provided in the home setting
- The goals of these services and the estimated length of time to attain these goals
- The frequency and number of home visits requested by the CRCP

To avoid unnecessary denials, the provider must submit correct and complete information, including documentation for medical necessity of the service requested. The provider ordering the service and the provider performing the service 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 service.

A completed CRCP Prior Authorization Request Form requesting these services must be signed and dated by the treating physician familiar with the client before requesting prior authorization. A copy of the completed, signed, and dated CRCP Prior Authorization Request Form must be maintained by the provider in the client's medical record. The completed CRCP Prior Authorization Request Form with the original dated signature must be maintained by the physician in the client's medical record.

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

To complete the prior authorization process by paper, the provider must fax or mail the completed CRCP Prior Authorization Request Form to the CCP Prior Authorization Unit and retain a copy of the signed and dated CRCP Prior Authorization Request Form in the client's medical record at the provider's place of business.

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2.4 Clinician-Directed Care Coordination Services (CCP)

2.4.1 Services, Benefits, and Limitations

Clinician-directed (physician, NP, CNS, and PA) care coordination services are a benefit of CCP for eligible clients who are birth through 20 years of age and have special health needs. These services are payable only to the clinician (primary care, specialist, or sub-specialist) who provides the medical home for the client.

To provide a medical home for the client, the primary care clinician directs care coordination together with the client and family. Care coordination consists of managing services and resources for clients with special health needs and their families to maximize the clients' potential and provide them with optimal health care.

Clinician-directed care coordination services (face-to-face and non-face-to-face) must include the following components:

- A written care plan (either a formal document or documentation contained in the client's progress notes) developed and revised by the medical home clinician, in partnership with the client, family, and other agreed-upon contributors. This plan is shared with other providers, agencies, and organizations involved with the care of the client, including educational and other community organizations with permission of the client or family. The care plan must be maintained by the medical home clinician and reviewed every six months or more frequently as necessary for the client's needs.
- Care among multiple providers that are coordinated through the clinician.
- A central record or database maintained by the medical home clinician containing all pertinent medical information, including hospitalizations and specialty care.
- Assistance for the client or family in communicating clinical issues when a client is referred for a consultation or additional care, such as evaluation, interpretation, implementation, and management of the consultant recommendations for the client or family in partnership and collaboration with other providers, the client, or family.

Clinician-directed care coordination services must also include the supervision of the development and revision of the client's emergency medical plan in partnership with the client, the family, and other providers for use by emergency medical services (EMS) personnel, utility service companies, schools, other community agencies, and caregivers.

Face-to-face care coordination services are encompassed within the various levels of evaluation and management (E/M) encounters and prolonged services.

Non-face-to-face clinician-directed care coordination services include:

- Prolonged services (procedure codes 99358 and 99359).
- Medical team conference (procedure code 99367).
- Care plan oversight and supervision, including telephone consultations with a specialist or subspecialist (procedure codes 99339, 99340, 99374, 99375, 99377, 99378, 99379, and 99380).
- Specialist or subspecialist telephone consultations (procedure code 99499 with modifier U9).

Non-face-to-face clinician-directed care coordination services are not considered case management by Texas Medicaid.

Specifically, non-face-to-face medical home clinician oversight and supervision of the development or revision of a client's care plan may include the following activities, which do not have to be contiguous:

- Review of charts, reports, treatment plans, and 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.

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- Telephone calls with other Medicaid-enrolled health-care professionals (*not* employed in the same practice) 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.
- Documenting the services provided, which includes writing a note in the client's chart describing the services provided, decision-making performed, and the amount of time spent performing the countable services, including the start and stop times and time spent by the physician working on the care plan after the nurse has conveyed pertinent information from agencies and facilities to the physician.

The following activities are *not* covered as non-face-to-face clinician supervision of the development or revision of the client's care plan (care plan oversight services):

- Time that the staff spends getting or filing charts, calling home health agencies or clients, and similar administrative actions.
- Clinician telephone calls to client or family, except when necessary to discuss changes in client's care plan.
- Clinician time spent telephoning prescriptions to a pharmacist (does not require clinician work and does not require a clinician to perform).
- Clinician time getting or filing the chart, dialing the telephone, or time on hold (does not require clinician work and does not 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 services.
- Consultations with health professionals not involved in the client's case.

2.4.1.1 Non-Face-to-Face Services

2.4.1.1.1 Non-Face-to-Face Medical Conferences

Procedure code 99367 must be used when billing for medical team conferences.

2.4.1.1.2 Non-Face-to-Face Clinician Supervision of a Home Health Client

Procedure code 99374 or 99375 must be used when billing for services requiring interaction with a home health agency.

2.4.1.1.3 Non-Face-to-Face Clinician Supervision of a Hospice Client

Procedure code 99377 or 99378 must be used when billing for services requiring interaction with a hospice.

2.4.1.1.4 Non-Face-to-Face Clinician Supervision of a Nursing Facility Client

Procedure code 99379 or 99380 must be used when billing for services requiring interaction with a nursing facility.

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2.4.1.1.5 Other Non-Face-to-Face Supervision

Procedure code 99339 or 99340 must be used when billing for services requiring interaction with an independently-enrolled nurse or other provider (e.g., not a home health agency, nursing facility, or hospice provider).

2.4.1.1.6 Non-Face-to-Face Prolonged Services

Procedure code 99358 or 99359 must be used when billing for prolonged services without face-to-face contact. This service is to be reported in addition to other clinician services, including E/M services at any level, or health-care professionals outside of a home health agency, hospice, or nursing facility.

Non-face-to-face prolonged services are limited to a maximum of 90 minutes once per client by the same provider unless one of the following significant changes in the client's clinical condition occurs:

- The client will soon be, or has recently been, discharged from a prolonged and complicated hospitalization that required coordination of complex care with multiple providers in order for the client to be adequately cared for in the home.
- The client has experienced 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.

Procedure code 99359 must be billed on the same date of service as procedure code 99358. Additional prolonged non-face-to-face services may be authorized if the provider submits supporting documentation for authorization.

Procedure code 99358 must be used to report the first hour of prolonged services and must be billed with the appropriate physician E/M procedure code listed in the table below. Prolonged services of less than 30 minutes are considered part of the physician's E/M service being provided.

Procedure Codes									
99201	99202	99203	99204	99205	99211	99212	99213	99214	99215
99221	99222	99223	99231	99232	99233	99241	99242	99243	99244
99245	99251	99252	99253	99254	99255	99304	99305	99306	99307
99308	99309	99310	99318	99324	99325	99326	99327	99328	99334
99335	99336	99337	99341	99342	99343	99344	99345	99347	99348
99349	99350								

Procedure code 99359 is used to report an additional 15 to 30 minutes of prolonged non-face-to-face services beyond the first hour. Prolonged services of less than 15 minutes beyond the first hour are considered part of the first hour.

2.4.1.1.7 Non-Face-to-Face Specialist or Subspecialist Telephone Consultation

Telephone consultations are limited to two every six months to the same provider and will not be reimbursed to the clinician providing the medical home.

The clinician providing the medical home must have an authorization on file for one of the following procedure codes before the specialist or subspecialist can be reimbursed:

Procedure Codes								
99339	99340	99358	99374	99375	99377	99378	99379	99380

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Because the specialist or sub-specialists cannot be reimbursed without the medical home clinician's current prior authorization information, the clinician providing the medical home should provide their information to the specialist or subspecialist.

The specialist or subspecialist will not be separately reimbursed for the telephone consultation if he or she is the medical home clinician because care plan oversight by the medical home provider includes telephone consultations. The referring provider identifier and prior authorization number must be submitted on the claim.

2.4.1.1.8 General Requirements for Non-Face-to-Face Clinician-Directed Care Coordination Services

These services may be reimbursed for the medical home 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. Care coordination provided during post-surgical care is a benefit if the care is unrelated to the surgery.

2.4.1.1.9 Non-Face-to-Face Care Plan Oversight

The medical home clinician who bills for the care plan oversight must be the clinician who signed the plan of care (POC) in the home or domiciliary (procedure codes 99339 and 99340), home health agency (procedure codes 99374 and 99375), hospice (procedure codes 99377 and 99378), or nursing facility (procedure codes 99379 and 99380).

Procedure code 99339 is denied when billed on the same date of service by the same provider as procedure code 99340.

Procedure code 99374 is denied when billed on the same date of service by the same provider as procedure code 99375.

Procedure code 99377 is denied when billed on the same date of service by the same provider as procedure code 99378.

Procedure code 99379 is denied when billed on the same date of service by the same provider as procedure code 99380.

Care plan oversight 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.

Only one clinician-directed care plan oversight service (procedure codes 99339, 99340, 99374, 99375, 99377, 99378, 99379 or 99380) is reimbursed every six months.

Payment is made only to one clinician per client, per calendar month for procedure code 99374 or 99375.

The medical home 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 medical home clinician may not be the medical director or employee of the hospice and may not furnish services under arrangements with the hospice, including volunteering.

2.4.1.1.10 Medical Team Conference

One medical team conference (procedure code 99367) may be reimbursed once every six months when the medical home coordinating clinician attests that they are providing the medical home for the client. The coordinating clinician may be the client's primary care provider or a specialist.

Additional medical team conferences may be considered with documentation of a change in the client's medical home.

The medical team conference time must be documented in the client's record.

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2.4.1.2 Face-to-Face Services

2.4.1.2.1 General Requirements for Face-to-Face Clinician-Directed Care Coordination Services

Providers must 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/unit time in the hospital), then time may be considered the key or controlling factor to qualifying for a particular level of E/M service.
- Counseling is a 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.

Modifiers must be used as appropriate for billing.

Any face-to-face inpatient or outpatient E/M procedure code that is a benefit of Texas Medicaid may be billed on the same day as the following non-face-to-face clinician-directed care coordination procedure codes when the procedure requires significant, separately-identifiable E/M services by the same physician on the same day.

Procedure Codes									
99339	99340	99358	99359	99367	99374	99375	99377	99378	99379
99380									

2.4.2 Prior Authorization and Documentation Requirements

Non-face-to-face clinician-directed care coordination services provided by the medical home require prior authorization. Providers must submit a request for prior authorization within seven business days of the date of service. Prior authorization is limited to a maximum of six months. Prior authorization is required to recertify the client for additional six-month periods and requires submission of a new request with documentation supporting medical necessity for ongoing services.

Prior authorization for initial non-face-to-face clinician-directed care coordination requires documentation of at least one covered face-to-face inpatient or outpatient E/M visit by the medical home clinician directing the care coordination during the six months preceding the provision of the first non-face-to-face care coordination service.

Prior authorization for subsequent non-face-to-face clinician-directed care coordination services requires at least one covered face-to-face inpatient or outpatient E/M visit by the medical home clinician directing the care coordination during the previous 12 months or more frequently as indicated by the client's condition.

Prior authorization of CCP services may be requested in writing by completing a CCP Prior Authorization Request Form, attaching the necessary supportive documentation as detailed below, and mailing or faxing it to the TMHP-CCP department:

Texas Medicaid & Healthcare Partnership
Comprehensive Care Program
PO Box 200735
Austin, TX 78720-0735
Fax: 1-512-514-4212

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For prior authorization to be considered, clients 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:

- ***Medically complex***. The health care needed by a Medicaid client achieves the designation of medically complex when the approved POC necessitates a clinical professional practicing within the scope of his or her license and in the context of a medical home to coordinate ongoing treatment to ensure its safe and effective delivery. The diagnosis must be covered under Texas Medicaid and be characterized by one of the following:
  - Significant and interrelated disease processes that involve more than one organ system (including behavioral health diagnoses) and require the services of two or more licensed clinical professionals, specialists, or subspecialists.
  - Significant physical or functional limitations that require the services of two or more therapeutic or ancillary disciplines, including, but not limited to, nursing, nutrition, OT, PT, ST, orthotics, and prosthetics.
  - Significant physical, developmental, or behavioral impairment that requires the integration of two or more medical or community-based providers, including, but not limited to, educational, social, and developmental professionals, that impact the care of the client.
- ***Multidisciplinary Care***. Care is multidisciplinary when the medically necessary covered services of an approved POC include the need to coordinate the assessment, treatment, or services of a Medicaid-enrolled clinical provider with two or more additional medical, educational, social, developmental, or other professionals impacting the health care of the client.

Prior authorization is effective for care coordination services provided over a period of six months. Medical home clinicians must submit a revised care plan for subsequent periods of prior authorization.

Documentation of the following components must be submitted with the prior authorization form to obtain an initial authorization or renewal:

- A current medical summary, encompassing all disciplines and all aspects of the client's care, and containing key information about the client's health, including conditions, complexity, medications, allergies, past surgical procedures, and so on.
- A current list of the main concerns, issues, and problems as well as key strengths and assets and the related current clinical information including a list of all diagnosis codes.
- Planned action steps and interventions to address the concerns and to sustain and build strengths, with the expected outcomes.
- Disciplines involved with the client's care and how the multiple disciplines will work or are working together to meet the client's need. Providers must explain how the multidisciplinary approach will or do benefit the client's needs.
- Short-term and long-term goals with timeframes.

The supporting documentation can be any of the following:

- A formal written care plan
- Progress note detailing the care coordination planning
- A letter of medical necessity detailing the care plan oversight and care coordination

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 medical home clinician's time spent performing specific care coordination activities, including start and stop times.

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The documentation must also include a formal care plan and an emergency services plan. The supporting documentation maintained in the client's medical records must be dated and include the following components and requirements:

- Problem list
- Interventions
- Short-term and long-term goals
- Responsible parties

Client medical records are subject to retrospective review.

Documentation for care coordination provided during post-surgical care must clearly indicate the care coordination is unrelated to the surgery.

2.4.2.1 Documentation Requirements for the Medical Home Clinician for a Telephone Consult with a Specialist

The clinician providing the medical home must maintain the following documentation in the client's medical record:

- Start and stop times showing that the consultation was 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 specialist or subspecialist

2.4.2.2 Documentation Requirements for the Specialist or Subspecialist for a Telephone Consult with the Medical Home Clinician

Specialists or subspecialists must complete and retain the Specialist or Subspecialist Telephone Consultation Form for Non-Face-to-Face Clinician Directed Care Coordination Services-CCP. 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 Medicaid identification number
- Start and stop times indicating the consultation lasted at least15 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 clinician providing the medical home
- Provider information for the specialist's or subspecialist's and the clinician providing the medical home

2.4.3 Claims Information

Claims for clinician-care coordination services must be submitted to TMHP in an approved electronic claims 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.

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Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in Section 6, Claims Filing (*Vol. 1, General Information*) for instructions on completing paper claims.

2.4.4 Reimbursement

Clinician-directed care coordination services are reimbursed in accordance with 1 TAC §355.8441.

2.5 Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Outpatient Rehabilitation Facilities (ORFs)

2.5.1 Enrollment

CORFs and ORFs must be certified by Medicare, have a valid provider agreement with HHSC, and have documentation that the TMHP enrollment process has been completed.

For questions about enrollment or billing, call the TMHP Contact Center at 1-800-925-9126.

Refer to: Subsection 1.1, "Provider Enrollment and Reenrollment" in Section 1, "Provider Enrollment and Responsibilities" *(Vol. 1, General Information)* for information about enrollment procedures.

2.5.2 Services, Benefits, and Limitations

OT, PT, and ST services are a benefit for clients who are 20 years of age or younger and who are CCP eligible when:

- Therapy is prescribed by a licensed physician.
- Documentation of medical necessity supports a condition that requires ongoing therapy or rehabilitation in the usual course, treatment, and management of the client's condition.
- Therapy services are provided by a licensed therapist in an outpatient rehabilitation facility.

Therapy goals for an acute or chronic medical condition include, but are not limited to, improving, maintaining, and slowing the deterioration of function.

Therapy is considered acute for 180 days from the first date (onset) of therapy for a specific condition. If the client's condition persists for more than 180 days from the start of therapy services, the condition is considered chronic.

Providers must maintain a comprehensive treatment plan that includes documentation that supports medical necessity for therapy services and confirms that the client meets the criteria for acute services. The treatment plan must include all of the following:

- The specific procedures and disciplines to be used
- The amount, duration, and frequency of therapy
- The therapist who participated in developing the comprehensive treatment plan
- Rehabilitation potential of the client
- Functional limitations of the client
- Date the client was last seen by the physician

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Therapy may be performed by a licensed occupational therapist, physical therapist, speech therapist, or one of the following under the supervision of a licensed therapist: licensed therapy assistant or licensed speech-language pathology intern.

Services performed by an occupational therapist aide, occupational therapist orderly, occupational therapist student, occupational therapist technician, physical therapist aide, physical therapist orderly, physical therapist student, physical therapist technician, SLP aide, SLP orderly, SLP student, or SLP technician are not a benefit of Texas Medicaid.

Therapy services performed by an unlicensed provider are subject to retrospective review and recoupment.

CORF and ORF services provided at schools, homes, daycare facilities, or any other non-Medicare-approved ORF or CORF facility is not a covered CCP benefit.

Services That Are Not a Benefit

The following services are not a benefit of CCP:

- Procedure code 97010 (application of a modality to one or more areas; hot or cold packs).
- Services that are not medically necessary. Examples include, but are not limited to:
  - Massage therapy that is the sole therapy or is not part of a therapeutic comprehensive treatment plan to address an acute condition.
  - Hippotherapy.
  - Separate reimbursement for VitalStim® therapy for dysphagia.
  - Treatment solely for the instruction of other agency or professional personnel in the client's PT, OT, or ST program.
  - Training in nonessential tasks (e.g., homemaking, gardening, recreational activities, cooking, driving, assistance with finances, scheduling).
  - Emotional support, adjustment to extended hospitalization or disability, and behavioral readjustment.
  - Therapy prescribed primarily as an adjunct to psychotherapy.

2.5.3 Occupational Therapy

2.5.3.1 Services, Benefits, and Limitations

A procedural modifier is required when submitting claims for occupational therapist services. Providers must use modifier GO for occupational therapist services. Procedural modifiers are not required for evaluations and re-evaluations.

Evaluations (procedure code 97003) are limited to once every 180 rolling days, any provider. Re-evaluations (procedure code 97004) may be reimbursed when documentation supports a change in the client's status, a request for extension of services, or a change of provider.

An evaluation or re-evaluation performed on the same day as therapy from a different therapy type must be performed at distinctly separate times to be considered for reimbursement.

If a therapy evaluation or re-evaluation procedure code and like therapy procedure codes are billed for the same date of service by any provider, the like therapy evaluation or re-evaluation will be denied.

OT evaluation (procedure code 97003) or re-evaluation (procedure code 97004) will be denied as part of the following OT procedure codes billed with Modifier GO.

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Additional OT evaluations or reevaluations and swallowing function evaluations or re-evaluations exceeding the limits outlined in this section may be considered for reimbursement with documentation of one of the following:

- A change in the client's medical condition
- A change of provider letter signed and dated by the client or responsible adult documenting all of the following:
  - The date the client ended therapy (effective date of change) with the previous provider
  - The names of the previous and new providers
  - An explanation why providers were changed

The following procedure codes are billed in 15-minute increments:

Procedure Codes									
97012	97014	97016	97018	97022	97024	97026	97028	97032	97033
97034	97035	97036	97039	97110	97112	97113	97116	97124	97139
97140	97150	97530	97535	97537	97542	97750	97760	97761	97762
97799	S8990								

OT procedure codes that are billed in 15-minute units are limited to a combined maximum of 4 units (1 hour) per day per therapy type. Additional services may be considered with prior authorization. If the claims for therapy services exceed four units a day, the claim will be denied, but providers may appeal with all of the following information:

- Provider must identify the authorization week period that includes the date of service being appealed.
- Provider must attest that claims for all therapy services provided for the week in question have been submitted.

All 15-minute increment 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 must be rounded up or down to the nearest quarter hour.

The documentation retained in the client's file must include the billable start time, billable stop time, total billable minutes, and activity that was performed.

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 evenly divisible by 15, minutes greater than 7 are converted to 1 unit and 7 or fewer minutes are converted to 0 unit.

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 1 unit. Consequently, 68 total billable minutes = 5 units of service. The following table indicates the time intervals for 0 through 8 units:

Units	Number of Minutes
0 units	0 minutes through 7 minutes
1 units	8 minutes through 22 minutes
2 units	23 minutes through 37 minutes
3 units	38 minutes through 52 minutes
4 units	53 minutes through 67 minutes
5 units	68 minutes through 82 minutes

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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

Electrical stimulation therapy (procedure code 97032) may be considered with documentation of medical necessity.

2.5.3.2 Prior Authorization and Documentation Requirements

Prior authorization is required for OT except evaluations and re-evaluations.

Prior authorization for individual therapy services will be considered when all of the following criteria are met:

- The client has an acute or chronic medical condition resulting in a significant decrease in functional ability that will benefit from therapy services.
- Documentation supports treatment goals and outcomes for the specific therapy disciplines requested.
- Services do not duplicate those that are provided concurrently by any other therapy.
- Services are 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 per event for acute care services. Subsequent prior authorization requests may be requested for up to 180 days when submitted with documentation of a chronic condition.

Coverage periods do not necessarily coincide with calendar weeks or months, but instead cover a number of services to be scheduled between a start date and end date that is assigned during the prior authorization period. Prior authorization requests for OT services may be requested with either a weekly frequency or monthly frequency, not both. A week includes the day of the week on which the prior authorization period begins and continues for total of seven days. The number of therapy services authorized for a week must be provided in that prior authorization week. A month includes the day of the month on which the prior authorization period begins and continues for 30 days. The number of therapy services authorized for a month must be provided in that prior authorization month. Claims for services that exceed those authorized for the prior authorization week or month are subject to recoupment.

All documentation that is related to the therapy services that are prior authorized and provided, including medical necessity and the comprehensive treatment plan, must be maintained in the client's medical record and made available upon request. For each therapy discipline that is provided, the documentation that is maintained in the client's medical record must identify the therapy provider's name and include all of the following:

- Date of service
- Start time of therapy
- Stop time of therapy
- Total minutes of therapy
- Specific therapy performed
- Client's response to therapy

To complete the prior authorization process by paper, the provider must submit the required 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.

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To complete the prior authorization process electronically, the provider must submit the required documentation through any approved electronic 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 must submit correct and complete information including documentation of medical necessity for the service requested. The physician 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.

2.5.3.2.1 Initial Prior Authorization Requests

Therapy services may be initiated upon the receipt of the physician's order. Therapy services initiated before the date of the physician order will not be approved.

The initial request for prior authorization must be received no later than five business days from the date therapy treatments are initiated. Requests that are received after the five business-day period will be denied for dates of service that occurred before the date that the request was received.

The following supporting documentation must be submitted for an initial prior authorization request:

- A completed Request for CCP Outpatient Therapy prior authorization form. The request form must be signed and dated by the ordering physician.
    - If the prior authorization form is not signed and dated by the physician, the form must be accompanied by a written order or prescription that is signed and dated by the physician, or a documented verbal order from the physician that includes the date that the verbal order was received.

      Note: *A verbal order is considered current when the date received is on or no more than 60 days before the start of therapy. A written order or prescription is considered current when it is signed and dated on or no more than 60 days before the start of therapy.*
    - A request received without a physician's signature, documented verbal order, or written prescription will not be processed and will be returned to the provider.
- A current therapy evaluation for each therapy discipline that documents the client's age at the time of the evaluation.

  Note: *A therapy evaluation is current when it is performed within 60 days before the initiation of therapy services.*
- A client-specific comprehensive treatment plan that is established by the ordering physician or therapist to be followed during treatment and includes all of the following:
    - Date and signature of the licensed therapist
    - Diagnosis(es)
    - Treatment goals that are related to the client's individual needs for the therapy discipline and associated disciplines requested
    - A description of the specific therapy disciplines being prescribed
    - Duration and frequency of therapy
    - Date of onset of the illness, injury, or exacerbation that requires the therapy services
    - Requested dates of service

A CNM, CNS, NP, or PA may sign all documentation related to the provision of therapy services on behalf of the client's physician when the physician delegates this authority.

The GO modifier is required on all prior authorization requests for OT.

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2.5.3.2.2 Subsequent Prior Authorization Requests

A prior authorization request for subsequent services must be received no more than 30 days before the current authorization expires. Prior authorization requests for subsequent services that are received after the current authorization expires will be denied for dates of service that occurred before the date that the submitted request was received.

Prior authorization requests for subsequent services may be considered with documentation that supports medical necessity and includes all of the following:

- A completed Request for CCP Outpatient Therapy prior authorization form that has been signed and dated by the ordering physician
  - If the prior authorization form is not signed and dated by the physician, the form must be accompanied by a written order or prescription that is signed and dated by the physician, or a documented verbal order from the physician that includes the date the verbal order was received.

    Note: *A verbal order is considered current when the date received is on or no more than 60 days before the start of therapy. A written order or prescription is considered current when it is signed and dated on or no more than 60 days before the start of therapy.*
  - A request received without a physician's signature, documented verbal order, or written prescription will not be processed and will be returned to the provider.
- A current therapy evaluation or re-evaluation for each therapy discipline that documents the client's age at the time of the evaluation or re-evaluation.
  - A therapy evaluation or re-evaluation for subsequent services is current when performed within 30 days before the prior authorization request is received. For example:
    - If an authorization period ends on July 31, 2014, TMHP must receive the prior authorization request for subsequent services between July 1, 2014, and July 31, 2014.
    - The therapy evaluation or re-evaluation for subsequent services can be performed up to 30 days before the date that TMHP receives the prior authorization request.
    - If TMHP receives the prior authorization request for subsequent services on July 1, 2014, the evaluation or re-evaluation can be performed June 1, 2014, through July 1, 2014.
    - If TMHP receives the prior authorization request for subsequent services on July 31, 2014, the evaluation or re-evaluation can be performed July 1, 2014, through July 31, 2014.

An updated, client-specific comprehensive treatment plan that was established by the ordering physician or therapist to be followed during treatment must include all of the following:

- Date and signature of the licensed therapist
- Diagnosis(es)
- Updated treatment goals that are related to the client's individual needs for the therapy discipline and associated disciplines requested
- A description of the specific therapy disciplines that are being prescribed
- Duration and frequency of therapy
- Date of onset of the illness, injury, or exacerbation that requires the therapy services
- A brief summary of the outcomes of the previous treatment as it relates to the client's debilitating condition
- Requested dates of service

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2.5.3.2.3 Revisions to Existing Prior Authorization Requests

A prior authorization request for revisions to services may be considered up to the end of the current approved prior authorization.

Requests for revisions to an existing authorization must be received no later than five business days from the date that the revised therapy treatments are initiated. Requests that are received after the five business-day period will be denied for dates of service that occurred before the date that the request was received.

If a provider or client discontinues therapy during an existing prior authorized period and the client requests services through a new provider, the new provider must submit all of the following:

- A new therapy request form
- A new evaluation with required documentation
- A change-of-provider letter that has been signed and dated by the client or responsible adult and that 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 in this section.

2.5.3.2.4 Frequency Levels

OT services may be provided at one of the following levels commensurate with the client''s medical condition, developmental needs, life stage, and therapy needs that are identified in the documentation submitted:

- High Frequency: Therapy provided three or more times a week may be considered when documentation shows all of the following:
  - Client has a medical condition that is rapidly changing.
  - Client has a potential for rapid progress or rapid decline or loss of functional skill.
  - The client's therapy plan and home program require frequent modification by the licensed therapist.
  - The client requires a high frequency of intervention for a limited duration (60 days or fewer) to achieve an identified new skill or recover function lost due to surgery, illness, or trauma.
- Moderate Frequency: Therapy provided two times a week may be considered when documentation shows one or more of the following:
  - The client is making functional progress toward goals.
  - The client is in a critical period to restore function or is at risk of regression.
  - The licensed therapist needs to adjust the client's therapy plan and home program weekly or more often than weekly based on the client's progress and medical needs.
  - The client has complex needs requiring on-going education of the responsible adult.
- Low Frequency: Therapy provided one time per week or every other week may be considered when the documentation shows one or more of the following:
  - The client is making progress toward the client's goals, but the progress has slowed, or the client may be at risk of deterioration due to the client's development or medical condition.
  - The licensed therapist is required to adjust the client's therapy plan and home program weekly based on the client's progress.

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- Every other week therapy is supported for clients whose medical condition is stable, they are making progress, and it is anticipated the client will not regress with every other week therapy. Because the therapy plan changes very slowly, the home program can be managed by the client and the responsible adult and does not require frequent changes by the licensed therapist.

- Maintenance Level/Prevent Deterioration: every other week to monthly or less often visits/sessions may be considered when the client meets one of the following criteria:
  - Progress has slowed or stopped, but documentation supports that ongoing therapy is required to maintain the progress made or prevent deterioration
  - The documentation submitted shows the client may be making limited progress toward goals, or goal attainment is extremely slow
  - Factors are identified that inhibit the client's ability to achieve established goals (e.g., the client cannot participate in therapy sessions due to behavior issues or issues with anxiety)
  - Documentation shows the client and the responsible adult have a continuing need for education, a periodic adjustment of the home program, or regular modification of equipment to meet the client's needs

As a client's condition improves and goals are met, it is anticipated the therapist will decrease to a lesser frequency level.

2.5.4 Physical Therapy

2.5.4.1 Services, Benefits, and Limitations

A procedural modifier is required when submitting claims for physical therapist services. Providers must use modifier GP for physical therapist services. Procedural modifiers are not required for evaluations and re-evaluations.

Evaluations (procedure code 97001) are limited to once every 180 rolling days, any provider. Re-evaluations (procedure code 97002) may be reimbursed when documentation supports a change in the client's status, a request for extension of services, or a change of provider.

An evaluation or re-evaluation performed on the same day as therapy from a different therapy type must be performed at distinctly separate times to be considered for reimbursement.

If a therapy evaluation or re-evaluation procedure code and like therapy procedure codes are billed for the same date of service by any provider, the like therapy evaluation or re-evaluation will be denied.

PT evaluation (procedure code 97001) or re-evaluation (procedure code 97002) will be denied as part of the following PT procedure codes billed with Modifier GP.

Additional PT evaluations or re-evaluations and swallowing function evaluations or re-evaluations exceeding the limits outlined in this section may be considered for reimbursement with documentation of one of the following:

- A change in the client's medical condition
- A change of provider letter signed and dated by the client or responsible adult documenting all of the following:
  - The date the client ended therapy (effective date of change) with the previous provider
  - The names of the previous and new providers
  - An explanation why providers were changed

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The following procedure codes are billed in 15-minute increments:

Procedure Codes									
97012	97014	97016	97018	97022	97024	97026	97028	97032	97033
97034	97035	97036	97039	97110	97112	97113	97116	97124	97139
97140	97150	97530	97535	97537	97542	97750	97760	97761	97762
97799	S8990								

PT procedure codes that are billed in 15-minute units are limited to a combined maximum of 4 units (1 hour) per day per therapy type. Additional services may be considered with prior authorization. If the claims for therapy services exceed four units a day, the claim will be denied, but providers may appeal with all of the following information:

- Provider must identify the authorization week period that includes the date of service being appealed.
- Provider must attest that claims for all therapy services provided for the week in question have been submitted.

All 15-minute increment 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 must be rounded up or down to the nearest quarter hour.

The documentation retained in the client's file must include the billable start time, billable stop time, total billable minutes, and activity that was performed.

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 evenly divisible by 15, minutes greater than 7 are converted to 1 unit, and 7 or fewer minutes are converted to 0 unit.

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 1 unit. Consequently, 68 total billable minutes = 5 units of service.

Refer to: Section 2.5.3, "Occupational Therapy" in this handbook for the 15-minute conversion table.

Electrical stimulation therapy (procedure code 97032) may be considered with documentation of medical necessity.

2.5.4.2 Prior Authorization and Documentation Requirements

Prior authorization is required for PT except evaluations and re-evaluations.

Prior authorization for individual therapy services will be considered when all of the following criteria are met:

- The client has an acute or chronic medical condition resulting in a significant decrease in functional ability that will benefit from therapy services.
- Documentation supports treatment goals and outcomes for the specific therapy disciplines requested.
- Services do not duplicate those that are provided concurrently by any other therapy.
- Services are 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 per event for acute care services. Subsequent prior authorization requests may be requested for up to 180 days when submitted with documentation of a chronic condition.

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Coverage periods do not necessarily coincide with calendar weeks or months, but instead cover a number of services to be scheduled between a start date and end date that is assigned during the prior authorization period. Prior authorization requests for PT services may be requested with either a weekly frequency or monthly frequency, but not both. A week includes the day of the week on which the prior authorization period begins and continues for total of seven days. The number of therapy services authorized for a week must be provided in that prior authorization week. A month includes the day of the month on which the prior authorization period begins and continues for 30 days. The number of therapy services authorized for a month must be provided in that prior authorization month. Claims for services that exceed those authorized for the prior authorization week or month are subject to recoupment.

All documentation that is related to the therapy services that are prior authorized and provided, including medical necessity and the comprehensive treatment plan, must be maintained in the client's medical record and made available upon request. For each therapy discipline that is provided, the documentation that is maintained in the client's medical record must identify the therapy provider's name and include all of the following:

- Date of service
- Start time of therapy
- Stop time of therapy
- Total minutes of therapy
- Specific therapy performed
- Client's response to therapy

To complete the prior authorization process by paper, the provider must submit the required 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 required documentation through any approved electronic 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 must submit correct and complete information including documentation of medical necessity for the service requested. The physician 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.

2.5.4.2.1 Initial Prior Authorization Requests

Therapy services may be initiated upon the receipt of the physician's order. Therapy services initiated before the date of the physician order will not be approved.

The initial request for prior authorization must be received no later than five business days from the date therapy treatments are initiated. Requests that are received after the five business-day period will be denied for dates of service that occurred before the date that the request was received.

The following supporting documentation must be submitted for an initial prior authorization request:

- A completed Request for CCP Outpatient Therapy prior authorization form. The request form must be signed and dated by the ordering physician.

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- If the prior authorization form is not signed and dated by the physician, the form must be accompanied by a written order or prescription that is signed and dated by the physician, or a documented verbal order from the physician that includes the date that the verbal order was received.

  Note: *A verbal order is considered current when the date received is on or no more than 60 days before the start of therapy. A written order or prescription is considered current when it is signed and dated on or no more than 60 days before the start of therapy.*

- A request received without a physician's signature, documented verbal order, or written prescription will not be processed and will be returned to the provider.

- A current therapy evaluation for each therapy discipline that documents the client's age at the time of the evaluation.

  Note: *A therapy evaluation is current when it is performed within 60 days before the initiation of therapy services.*

- A client-specific comprehensive treatment plan that is established by the ordering physician or therapist to be followed during treatment and includes all of the following:
  - Date and signature of the licensed therapist
  - Diagnosis(es)
  - Treatment goals that are related to the client's individual needs for the therapy discipline and associated disciplines requested
  - A description of the specific therapy disciplines being prescribed
  - Duration and frequency of therapy
  - Date of onset of the illness, injury, or exacerbation that requires the therapy services
  - Requested dates of service

A CNM, CNS, NP, or PA may sign all documentation related to the provision of therapy services on behalf of the client's physician when the physician delegates this authority.

The GP modifier is required on all prior authorization requests for PT.

2.5.4.2.2 Subsequent Prior Authorization Requests

A prior authorization request for subsequent services must be received no more than 30 days before the current authorization expires. Prior authorization requests for subsequent services that are received after the current authorization expires will be denied for dates of service that occurred before the date that the submitted request was received.

Prior authorization requests for subsequent services may be considered with documentation that supports medical necessity and includes all of the following:

- A completed Request for CCP Outpatient Therapy prior authorization form that has been signed and dated by the ordering physician
  - If the prior authorization form is not signed and dated by the physician, the form must be accompanied by a written order or prescription that is signed and dated by the physician, or a documented verbal order from the physician that includes the date the verbal order was received.

    Note: *A verbal order is considered current when the date received is on or no more than 60 days before the start of therapy. A written order or prescription is considered current when it is signed and dated on or no more than 60 days before the start of therapy.*

  - A request received without a physician's signature, documented verbal order, or written prescription will not be processed and will be returned to the provider.

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- A current therapy evaluation or re-evaluation for each therapy discipline that documents the client's age at the time of the evaluation or re-evaluation.
    - A therapy evaluation or re-evaluation for subsequent services is current when performed within 30 days before the prior authorization request is received. For example:
        - If an authorization period ends on July 31, 2014, TMHP must receive the prior authorization request for subsequent services between July 1, 2014, and July 31, 2014.
        - The therapy evaluation or re-evaluation for subsequent services can be performed up to 30 days before the date that TMHP receives the prior authorization request.
        - If TMHP receives the prior authorization request for subsequent services on July 1, 2014, the evaluation or re-evaluation can be performed June 1, 2014, through July 1, 2014.
        - If TMHP receives the prior authorization request for subsequent services on July 31, 2014, the evaluation or re-evaluation can be performed July 1, 2014, through July 31, 2014.

An updated, client-specific comprehensive treatment plan that was established by the ordering physician or therapist to be followed during treatment must include all of the following:

- Date and signature of the licensed therapist
- Diagnosis(es)
- Updated treatment goals that are related to the client's individual needs for the therapy discipline and associated disciplines requested
- A description of the specific therapy disciplines that are being prescribed
- Duration and frequency of therapy
- Date of onset of the illness, injury, or exacerbation that requires the therapy services
- A brief summary of the outcomes of the previous treatment as it relates to the client's debilitating condition
- Requested dates of service

2.5.4.2.3 Revisions to Existing Prior Authorization Requests

A prior authorization request for revisions to services may be considered up to the end of the current approved prior authorization.

Requests for revisions to an existing authorization must be received no later than five business days from the date that the revised therapy treatments are initiated. Requests that are received after the five business-day period will be denied for dates of service that occurred before the date that the request was received.

If a provider or client discontinues therapy during an existing prior authorized period and the client requests services through a new provider, the new provider must submit all of the following:

- A new therapy request form
- A new evaluation with required documentation
- A change-of-provider letter that has been signed and dated by the client or responsible adult and that 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 in this section.

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2.5.4.2.4 Frequency Levels

PT services may be provided at one of the following levels commensurate with the client's medical condition, developmental needs, life stage, and therapy needs that are identified in the documentation submitted:

- High Frequency: Therapy provided three or more times a week may be considered when documentation shows all of the following:
  - Client has a medical condition that is rapidly changing.
  - Client has a potential for rapid progress or rapid decline or loss of functional skill.
  - The client's therapy plan and home program require frequent modification by the licensed therapist.
  - The client requires a high frequency of intervention for a limited duration (60 days or fewer) to achieve an identified new skill or recover function lost due to surgery, illness, or trauma.
- Moderate Frequency: Therapy provided two times a week may be considered when documentation shows one or more of the following:
  - The client is making functional progress toward goals.
  - The client is in a critical period to restore function or is at risk of regression.
  - The licensed therapist needs to adjust the client's therapy plan and home program weekly or more often than weekly based on the client's progress and medical needs.
  - The client has complex needs requiring on-going education of the responsible adult.
- Low Frequency: Therapy provided one time per week or every other week may be considered when the documentation shows one or more of the following:
  - The client is making progress toward the client's goals, but the progress has slowed, or the client may be at risk of deterioration due to the client's development or medical condition.
  - The licensed therapist is required to adjust the client's therapy plan and home program weekly based on the client's progress.
  - Every other week therapy is supported for clients whose medical condition is stable, they are making progress, and it is anticipated the client will not regress with every other week therapy. Because the therapy plan changes very slowly, the home program can be managed by the client and the responsible adult and does not require frequent changes by the licensed therapist.
- Maintenance Level/Prevent Deterioration: every other week to monthly or less often visits/sessions may be considered when the client meets one of the following criteria:
  - Progress has slowed or stopped, but documentation supports that ongoing therapy is required to maintain the progress made or prevent deterioration
  - The documentation submitted shows the client may be making limited progress toward goals, or goal attainment is extremely slow
  - Factors are identified that inhibit the client's ability to achieve established goals (e.g., the client cannot participate in therapy sessions due to behavior issues or issues with anxiety)
  - Documentation shows the client and the responsible adult have a continuing need for education, a periodic adjustment of the home program, or regular modification of equipment to meet the client's needs

As a client's condition improves and goals are met, it is anticipated the therapist will decrease to a lesser frequency level.

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2.5.5 Speech Therapy (ST)

2.5.5.1 Services, Benefits, and Limitations

A procedural modifier is required when submitting claims for ST services. Providers must use modifier GN for ST services. Procedural modifiers are not required for evaluations and re-evaluations.

ST evaluations (procedure codes 92521, 92522, 92523, and 92524) are limited to once every 180 rolling days, any provider. If ST reassessment is necessary within the 180-day period, (procedure code S9152) may be reimbursed when documentation supports a change in the client's status, or a request for extension of services, or a change of provider.

Additional ST evaluations or re-evaluations and swallowing function evaluations or re-evaluations exceeding the limits outlined in this section may be considered for reimbursement with documentation of one of the following:

- A change in the client's medical condition
- A change of provider letter signed and dated by the client or responsible adult documenting all of the following:
  - The date the client ended therapy (effective date of change) with the previous provider
  - The names of the previous and new providers
  - An explanation why providers were changed

ST treatment codes 92507, 92508, and 92526 are payable in 15-minute increments at a maximum of 4 units (1 hour) per day.

ST procedure codes that are billed in 15-minute units are limited to a combined maximum of 4 units (1 hour) per day per therapy type. Additional services may be considered with prior authorization. If the claims for therapy services exceed four units a day, the claim will be denied, but providers may appeal with all of the following information:

- Provider must identify the authorization week period that includes the date of service being appealed.
- Provider must attest that claims for all therapy services provided for the week in question have been submitted.

All 15-minute increment 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 must be rounded up or down to the nearest quarter hour.

The documentation retained in the client's file must include the billable start time, billable stop time, total billable minutes, and activity that was performed.

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 evenly divisible by 15, minutes greater than 7 are converted to 1 unit and 7 or fewer minutes are converted to 0 unit.

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 1 unit. Consequently, 68 total billable minutes = 5 units of service.

Refer to: Section 2.5.3, "Occupational Therapy" in this handbook for the 15-minute conversion table.

ST evaluation and re-evaluations will be denied when billed on the same date of service, any provider as procedure code 92507 and 92508 with modifier GN.

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Procedure codes 92526 and 92610 may be considered for treatment and evaluation of swallowing dysfunctions and oral functions for feeding.

Procedure code 97535 is used for ST services for training for augmentative communication devices.

2.5.5.2 Prior Authorization and Documentation Requirements

Prior authorization is required for ST except evaluations and re-evaluations.

Prior authorization for individual therapy services will be considered when all of the following criteria are met:

- The client has an acute or chronic medical condition resulting in a significant decrease in functional ability that will benefit from therapy services.
- Documentation supports treatment goals and outcomes for the specific therapy disciplines requested.
- Services do not duplicate those that are provided concurrently by any other therapy.
- Services are 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 per event for acute care services. Subsequent prior authorization requests may be requested for up to 180 days when submitted with documentation of a chronic condition.

Coverage periods do not necessarily coincide with calendar weeks or months, but instead cover a number of services to be scheduled between a start date and end date that is assigned during the prior authorization period. Prior authorization requests for ST services may be requested with either a weekly frequency or monthly frequency, but not both. A week includes the day of the week on which the prior authorization period begins and continues for total of seven days. The number of therapy services authorized for a week must be provided in that prior authorization week. A month includes the day of the month on which the prior authorization period begins and continues for 30 days. The number of therapy services authorized for a month must be provided in that prior authorization month. Claims for services that exceed those authorized for the prior authorization week or month are subject to recoupment.

All documentation that is related to the therapy services that are prior authorized and provided, including medical necessity and the comprehensive treatment plan, must be maintained in the client's medical record and made available upon request. For each therapy discipline that is provided, the documentation that is maintained in the client's medical record must identify the therapy provider's name and include all of the following:

- Date of service
- Start time of therapy
- Stop time of therapy
- Total minutes of therapy
- Specific therapy performed
- Client's response to therapy

To complete the prior authorization process by paper, the provider must submit the required 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 required documentation through any approved electronic 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.

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To avoid unnecessary denials, the physician must submit correct and complete information including documentation of medical necessity for the service requested. The physician 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.

2.5.5.2.1 Initial Prior Authorization Requests

Therapy services may be initiated upon the receipt of the physician's order. Therapy services initiated before the date of the physician order will not be approved.

The initial request for prior authorization must be received no later than five business days from the date therapy treatments are initiated. Requests that are received after the five business-day period will be denied for dates of service that occurred before the date that the request was received.

The following supporting documentation must be submitted for an initial prior authorization request:

- A completed Request for CCP Outpatient Therapy prior authorization form. The request form must be signed and dated by the ordering physician.
    - If the prior authorization form is not signed and dated by the physician, the form must be accompanied by a written order or prescription that is signed and dated by the physician, or a documented verbal order from the physician that includes the date that the verbal order was received.

      Note: *A verbal order is considered current when the date received is on or no more than 60 days before the start of therapy. A written order or prescription is considered current when it is signed and dated on or no more than 60 days before the start of therapy.*
    - A request received without a physician's signature, documented verbal order, or written prescription will not be processed and will be returned to the provider.
- A current therapy evaluation for each therapy discipline that documents the client's age at the time of the evaluation.

  Note: *A therapy evaluation is current when it is performed within 60 days before the initiation of therapy services.*
- A client-specific comprehensive treatment plan that is established by the ordering physician or therapist to be followed during treatment and includes all of the following:
    - Date and signature of the licensed therapist
    - Diagnosis(es)
    - Treatment goals that are related to the client's individual needs for the therapy discipline and associated disciplines requested
    - A description of the specific therapy disciplines being prescribed
    - Duration and frequency of therapy
    - Date of onset of the illness, injury, or exacerbation that requires the therapy services
    - Requested dates of service

A CNM, CNS, NP, or PA may sign all documentation related to the provision of therapy services on behalf of the client's physician when the physician delegates this authority.

The GN modifier is required on all prior authorization requests for ST.

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2.5.5.2.2 Subsequent Prior Authorization Requests

A prior authorization request for subsequent services must be received no more than 30 days before the current authorization expires. Prior authorization requests for subsequent services that are received after the current prior authorization expires will be denied for dates of service that occurred before the date that the submitted request was received.

Prior authorization requests for subsequent services may be considered with documentation that supports medical necessity and includes all of the following:

- A completed Request for CCP Outpatient Therapy prior authorization form that has been signed and dated by the ordering physician
  - If the prior authorization form is not signed and dated by the physician, the form must be accompanied by a written order or prescription that is signed and dated by the physician, or a documented verbal order from the physician that includes the date the verbal order was received.

    Note: *A verbal order is considered current when the date received is on or no more than 60 days before the start of therapy. A written order or prescription is considered current when it is signed and dated on or no more than 60 days before the start of therapy.*
  - A request received without a physician's signature, documented verbal order, or written prescription will not be processed and will be returned to the provider.
- A current therapy evaluation or re-evaluation for each therapy discipline that documents the client's age at the time of the evaluation or re-evaluation.
  - A therapy evaluation or re-evaluation for subsequent services is current when performed within 30 days before the prior authorization request is received. For example:
    - If an authorization period ends on July 31, 2014, TMHP must receive the prior authorization request for subsequent services between July 1, 2014, and July 31, 2014.
    - The therapy evaluation or re-evaluation for subsequent services can be performed up to 30 days before the date that TMHP receives the prior authorization request.
    - If TMHP receives the prior authorization request for subsequent services on July 1, 2014, the evaluation or re-evaluation can be performed June 1, 2014, through July 1, 2014.
    - If TMHP receives the prior authorization request for subsequent services on July 31, 2014, the evaluation or re-evaluation can be performed July 1, 2014, through July 31, 2014.
- An updated, client-specific comprehensive treatment plan that was established by the ordering physician or therapist to be followed during treatment must include all of the following:
  - Date and signature of the licensed therapist
  - Diagnosis(es)
  - Updated treatment goals that are related to the client's individual needs for the therapy discipline and associated disciplines requested
  - A description of the specific therapy disciplines that are being prescribed
  - Duration and frequency of therapy
  - Date of onset of the illness, injury, or exacerbation that requires the therapy services
  - A brief summary of the outcomes of the previous treatment as it relates to the client's debilitating condition
  - Requested dates of service

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2.5.5.2.3 Revisions to Existing Prior Authorization Requests

A prior authorization request for revisions to services may be considered up to the end of the current approved prior authorization.

Requests for revisions to an existing authorization must be received no later than five business days from the date that the revised therapy treatments are initiated. Requests that are received after the five business-day period will be denied for dates of service that occurred before the date that the request was received.

If a provider or client discontinues therapy during an existing prior authorized period and the client requests services through a new provider, the new provider must submit all of the following:

- A new therapy request form
- A new evaluation with required documentation
- A change-of-provider letter that has been signed and dated by the client or responsible adult and that 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 in this section.

2.5.5.2.4 Frequency Levels

ST services may be provided at one of the following levels commensurate with the client's medical condition, developmental needs, life stage, and therapy needs that are identified in the documentation submitted:

- High Frequency: Therapy provided three or more times a week may be considered when documentation shows all of the following:
  - Client has a medical condition that is rapidly changing.
  - Client has a potential for rapid progress or rapid decline or loss of functional skill.
  - The client's therapy plan and home program require frequent modification by the licensed therapist.
  - The client requires a high frequency of intervention for a limited duration (60 days or fewer) to achieve an identified new skill or recover function lost due to surgery, illness, or trauma.
- Moderate Frequency: Therapy provided two times a week may be considered when documentation shows one or more of the following:
  - The client is making functional progress toward goals.
  - The client is in a critical period to restore function or is at risk of regression.
  - The licensed therapist needs to adjust the client's therapy plan and home program weekly or more often than weekly based on the client's progress and medical needs.
  - The client has complex needs requiring on-going education of the responsible adult.
- Low Frequency: Therapy provided one time per week or every other week may be considered when the documentation shows one or more of the following:
  - The client is making progress toward the client's goals, but the progress has slowed, or the client may be at risk of deterioration due to the client's development or medical condition.
  - The licensed therapist is required to adjust the client's therapy plan and home program weekly based on the client's progress.

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  - Every other week therapy is supported for clients whose medical condition is stable, they are making progress, and it is anticipated the client will not regress with every other week therapy. Because the therapy plan changes very slowly, the home program can be managed by the client and the responsible adult and does not require frequent changes by the licensed therapist.
- Maintenance Level/Prevent Deterioration: every other week to monthly or less often visits/sessions may be considered when the client meets one of the following criteria:
  - Progress has slowed or stopped, but documentation supports that ongoing therapy is required to maintain the progress made or prevent deterioration
  - The documentation submitted shows the client may be making limited progress toward goals, or goal attainment is extremely slow
  - Factors are identified that inhibit the client's ability to achieve established goals (e.g., the client cannot participate in therapy sessions due to behavior issues or issues with anxiety)
  - Documentation shows the client and the responsible adult have a continuing need for education, a periodic adjustment of the home program, or regular modification of equipment to meet the client's needs

As a client's condition improves and goals are met, it is anticipated the therapist will decrease to a lesser frequency level.

2.5.6 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.

2.5.6.1 Group Therapy Guidelines

In order to meet Texas Medicaid 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 and short- and long-term goals and measurable outcomes.

  Note: *Texas Medicaid 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.*

2.5.6.2 Group Therapy Documentation Requirements

The following documentation must be maintained in the client's medical record:

- Physician prescription for group therapy, exception for Early Childhood Intervention (ECI) providers.
- 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

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- 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.

Note: *There is an exception to these requirements for ECI services. Group therapy guidelines for ECI services are in this handbook subsection 2.7.2, "Services, Benefits, Limitations, and Prior Authorization"*

2.5.7 Claims Information

Providers must submit services provided by CORFs and ORFs in an approved electronic claims format or on the UB-04 CMS-1450 paper claim form from the vendor of their choice. TMHP does not supply the forms.

Revenue and Current Procedural Terminology (CPT) procedure codes are used when submitting claims for CORF and ORF services. The only POS is outpatient facility (POS 5).

Refer to: Comprehensive Outpatient Rehabilitation Facility (CORF) (CCP Only) on the TMHP website at www.tmhp.com for a claim form example.

Section 3: TMHP Electronic Data Interchange (EDI) *(Vol. 1, General Information)* for information on electronic claims submissions.

Section 6: Claims Filing *(Vol. 1, General Information)* for general information about claims filing.

Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in Section 6, *"Claims Filing" (Vol. 1, General Information)* for paper claims completion instructions.

2.5.8 Reimbursement

CORFs and ORFs are reimbursed in accordance with 1 TAC §355.8441.

See the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com for reimbursement rates.

2.6 Durable Medical Equipment (DME) Supplier (CCP)

2.6.1 Enrollment

To be eligible to participate in CCP, providers of DME (including customized or non-basic medical equipment) and expendable medical supplies must be enrolled in Medicare.

Home health agencies that provide DME and supplies should refer to subsection 2.1, "Enrollment" in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*).

2.6.1.1 Pharmacies (CCP)

Pharmacy providers are eligible to participate in CCP. To be enrolled in CCP, the pharmacy must also be enrolled in VDP.

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This enrollment allows pharmacy providers to bill for those medications and supplies payable by Medicaid for clients who are birth through 20 years of age but *not* covered by VDP (e.g., some over-the-counter drugs, some nutritional products, diapers, and disposable or expendable medical supplies). Pharmacy providers must continue to bill HHSC for drugs covered under VDP.

To locate a pharmacy CCP provider, use the Online Provider Lookup (OPL) at http://opl.tmhp.com/ProviderManager/AdvSearch.aspx.

Refer to: Subsection 2.1.2, "Enrollment" in this handbook for more information about CCP enrollment procedures.

"Appendix B: Vendor Drug Program" (*Vol. 1, General Information*)

Section 2, "Texas Medicaid (Title XIX) Home Health Services" in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*) for details about coverage through Texas Medicaid (Title XIX) Home Health Services.

2.6.2 Services, Benefits, and Limitations

Medicaid clients who are birth through 20 years of age are entitled to all medically necessary DME and expendable medical supplies. DME or supplies are medically necessary when required to correct or ameliorate disabilities or physical or mental illnesses or conditions. Any numerical limit on the amount of a particular item of DME or expendable medical supply can be exceeded if medically necessary for Medicaid clients who are birth through 20 years of age. Likewise, time periods for replacement of DME and expendable medical supplies do not apply to Medicaid clients who are birth through 20 years of age if the replacement is medically necessary.

DME is defined as medical equipment that is manufactured to withstand repeated use, ordered by a physician for use in the home, and required to correct or ameliorate the client's disability, condition, or illness.

Because there is no single authority (such as a federal agency) that confers the official status of "DME" on any device or product, HHSC retains the right to make such determinations with regard to DME covered by Texas Medicaid. DME covered by Texas Medicaid must either have a well-established history of efficacy or, in the case of novel or unique equipment, valid peer-reviewed evidence that the equipment corrects or ameliorates a covered medical condition or functional disability.

Requested DME may be a benefit of Texas Medicaid when it meets the Medicaid definition of DME.

The majority of DME and expendable medical supplies are covered through Texas Medicaid (Title XIX) Home Health Services.

If a service cannot be provided through Texas Medicaid (Title XIX) Home Health Services, the service may be covered through CCP if it is determined to be medically necessary for the client and if FFP is available.

If a DME provider is unable to deliver a piece of equipment, the provider must allow the client the option of obtaining the DME or expendable medical supplies from another provider.

Periodic rental payments are made only for the lesser of the following:

- The period of time the equipment is medically necessary
- The total monthly rental payments equal the reasonable purchase cost for the DME

DME will be purchased when a purchase is determined to be medically necessary and more cost effective than leasing the device with supplies. Only new, unused equipment will be purchased. When a provider is replacing a piece of rental DME with purchased DME, the provider must supply a new piece of DME to the client.

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Purchase is justified when the estimated duration of need multiplied by the rental payments would exceed the reasonable purchase cost of the equipment or it is otherwise more practical to purchase the equipment.

DME repair will be considered based on the age of the item and cost to repair it. A request for repair of DME must include:

- A statement or medical information that is provided by the attending physician and that substantiates the medical appliance or equipment continues to serve a specific medical purpose.
- An itemized estimated cost list from the vendor or DME provider who will make the repairs.

Rental equipment may be provided to replace purchased medical equipment for the period of time it will take to make necessary repairs to purchased medical equipment.

All adjustments and modifications that are made within the first six months after delivery are considered part of the purchase price. However, DME that has been delivered to the client's home and then found to be inappropriate for the client's condition will not be eligible for an upgrade within the first six months following purchase unless there had been a significant change in the client's condition, as documented by the physician familiar with the client.

Rental reimbursement to the same provider cannot exceed the purchase price, except as addressed in specific policies.

All DME purchased for a client becomes the Medicaid client's property upon receipt of the item. Delivered equipment will become the Medicaid client's property in the following instances even though it will not be prior authorized or reimbursed:

- Equipment delivered to the client before the physician signature date on the CCP Prior Authorization Form or prescription.
- Equipment delivered more than three business days before obtaining prior authorization from TMHP that meets the criteria for purchase.

As long as the client is eligible for CCP services on the date the custom equipment is ordered from the manufacturer, the provider must use the order date as the date of service since custom equipment is client specific and cannot be used for another client.

To establish medical necessity of the equipment for the client, the provider must have on file in the client's records current documentation that is signed by a physician (e.g., a signed and dated prescription) showing the following:

- A diagnosis relative to each item requested.
- The specific type of supply needed.
- The length of time needed.

2.6.2.1 Purchase Versus Equipment Rental

When providing equipment not prior authorized under Texas Medicaid (Title XIX) Home Health Services for CCP clients with long-term or chronic conditions, it is more cost-effective, in many cases, to purchase the equipment rather than rent it. The client's condition and length of time the equipment will be used must be carefully assessed before prior authorization for rental or purchase is requested. CCP nurses determine whether the equipment will be rented, purchased, repaired, or modified based on the client's needs, the duration of use, and the age of the equipment.

CCP does not pay for the purchase of certain types of equipment; consequently, long-term rental may be considered. Most other equipment is rented for only four months initially. During this time, the provider must assess whether the equipment should be purchased before the rental lapses. Rentals and purchases must be prior authorized.

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After prior authorization is obtained for purchase, new equipment must be provided and the rental discontinued. CCP does not purchase used equipment.

Providers of customized or nonbasic medical equipment also must be enrolled as Medicare DME providers.

2.6.3 * Prior Authorization and Documentation Requirements

Providers can request prior authorization for most DME through the TMHP website. Providers that make written requests for prior authorization must complete the CCP Prior Authorization Request Form on the TMHP website at www.tmhp.com, and they must attach the documentation necessary to support the request. The documentation must include a current prescription that has been signed and dated by a physician (M.D. or D.O.), and it must be mailed or faxed to TMHP with the prior authorization request. For specific policy information not contained in this manual related to the purchase of DME, providers can call TMHP-CCP Customer Service at 1-800-846-7470.

A completed CCP Prior Authorization Request Form prescribing the DME or medical supplies must be signed and dated by the prescribing physician familiar with the client before requesting prior authorization. The completed CCP Prior Authorization Request Form must be maintained by the requesting provider and the prescribing physician. The original signature copy must be kept in the physician's medical record for the client.

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

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

To avoid unnecessary denials, the physician must provide correct and complete information, including accurate documentation of the medical necessity for the equipment and services 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 mobility aid.

A determination is made by the CCP nurses as to whether the equipment will be rented, purchased, repaired, or modified based on the client's needs, duration of use, and age of equipment.

A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or expendable medical supply. Physician prescriptions must be specific to the item requested. For example, if the provider is requesting a customized wheelchair, the prescription must request a customized wheelchair, not just a wheelchair. Providers must submit a CCP Prior Authorization Request Form and documentation to support medical necessity to the CCP department *before* providing services. Providers must obtain prior authorization within three business days of the requested date of service.

Refer to: Subsection 2.2.25, "Procedure Codes That Do Not Require Prior Authorization" in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (Vol. 2, Provider Handbooks) for details about specific procedure codes that do not require prior authorization through Texas Medicaid (Title XIX) Home Health Services.

2.6.3.1 Equipment Accessories

CCP may consider prior authorization of equipment accessories, such as ventilator and oxygen trays and positioning inserts, when supporting documentation takes into account all the client's needs, capabilities, and physical or mental status.

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2.6.3.2 Equipment Modifications

A modification is the replacement of a component due to changes in the client's condition, not the replacement of a component that is no longer functioning.

DME that has been delivered to the client's home and then found to be inappropriate for the client's condition will not be eligible for an upgrade within the first six months following purchase. All modifications that are made within the first six months after delivery are considered part of the purchase price.

However, CCP may consider prior authorization of modifications to custom equipment if a change occurs in the client's needs, capabilities, or physical or mental status that cannot be anticipated. Documentation must include:

- All projected changes in the client's needs.
- The age of the current equipment, and the cost of purchasing new equipment versus modifying current equipment.

2.6.3.3 Equipment Adjustments

Adjustments do not require supplies.

Labor for adjustments within the first six months after delivery are not prior authorized because these are considered part of the purchase price.

Up to one hour of labor for adjustments may be considered for reimbursement with prior authorization through CCP as needed after the first six months. Providers must use procedure code K0739 for adjustments.

2.6.3.4 Equipment Repairs

Repairs require replacement of components that are no longer functional. Repairs to client-owned equipment may be considered for reimbursement with prior authorization through CCP.

Technician fees are considered part of the cost of the repair. Providers must use procedure code K0739.

Repairs for non-warranty DME may be billed using procedure code K0739. Non-warranty DME repairs will require prior authorization. Providers are responsible for maintaining documentation in the client's medical record that specifies the repairs and supporting medical necessity.

Rentals may be considered for reimbursement during the repair period of the client's owned equipment.

Routine maintenance of rental equipment is the provider's responsibility.

2.6.3.5 DME Certification and Receipt Form

The DME Certification and 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 DME provider must maintain the signed and dated form in the client's medical record.

DME claims and appeals that meet or exceed a billed amount of $2,500 for the same date of service will suspend for verification of client receipt of the DME item(s). The DME Certification and Receipt Form must be faxed to 1-512-506-6615. If the claim is submitted without the form or if receipt of the DME item(s) cannot be verified, the DME item(s) on the claim will be denied. TMHP may contact the client that received the product for verification of services rendered.

Refer to: DME Certification and Receipt Form on the TMHP website at www.tmhp.com.

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2.6.3.6 Documentation of Supply Delivery

Providers must retain individual delivery slips or corresponding invoices for each date of service to document the date of delivery for all supplies provided to a client. Providers must disclose this documentation to HHSC or its designee upon request. These records and claims must be retained for a minimum of five years from the date of service (DOS) or until all audit questions, appeals, hearings, investigations, or court cases are resolved. The DOS is the date on which supplies are delivered to the client or shipped by a carrier to the client as evidenced by the dated tracking document attached to the corresponding invoice for that date.

Documentation of delivery must include one of the following:

- Delivery slip or invoice signed and dated by the client or caregiver.
- A dated carrier tracking document that includes the shipping date and delivery date must be printed from the carrier's website as confirmation that the supplies were shipped and delivered. The dated carrier tracking document must be attached to the delivery slip or corresponding invoice.

The dated delivery slip or invoice must include the client's full name and address to where supplies were delivered, and an itemized list of goods that includes the descriptions and numerical quantities of the supplies delivered to the client, and the corresponding tracking number from the carrier. This document could also include prices, shipping weights, shipping charges, and any other description.

All claims submitted for DME supplies must include the same quantities or units that are documented on the delivery slip or corresponding invoice and on the CCP Prior Authorization Request form. They must reflect the number of units by which each product is measured. For example, diapers are measured as individual units. If one package of 300 diapers is delivered, the delivery slip or invoice and the claim must reflect that 300 diapers were delivered and not that one package was delivered. Diaper wipes are measured as boxes or packages. If one box of 200 wipes is delivered, the delivery slip or invoice and the claim must reflect that one box was delivered and not that 200 individual wipes were delivered. There must be one dated delivery slip or invoice for each claim submitted for each patient. All claims submitted for DME supplies must reflect the same date as the delivery slip or corresponding invoice and the same timeframe covered by the CCP Prior Authorization Request form. The DME Certification and Receipt Form is still required for all equipment delivered.

2.6.3.7 Specific CCP Policies

Most DME and expendable medical supplies are available under Texas Medicaid (Title XIX) Home Health Services. If the service is not available under Texas Medicaid (Title XIX) Home Health Services, CCP may cover the requested service, if the client is CCP-eligible and the service is medically necessary, requested by a physician, and for which FFP is available.

Refer to: DME Certification and Receipt Form on the TMHP website at www.tmhp.com.

Section 2, "Texas Medicaid (Title XIX) Home Health Services" in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*) for specific policies.

2.6.4 Blood Pressure Devices

2.6.4.1 Services, Benefits, and Limitations

The following blood pressure devices and their components are benefits of CCP in the home setting for self-monitoring when the equipment is prescribed by a physician:

- *Manual blood pressure device.* A device that requires manual cuff inflation with real-time visualization of the results displayed on the manometer.

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- *Automated blood pressure device.* A device that inflates the cuff manually or automatically and displays the blood pressure results on a small screen.

  Note: *Finger cuff automated blood pressure devices for diagnostic purposes are not a benefit of Texas Medicaid.*

- *Hospital-grade blood pressure device.* A device that 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.

Documentation that supports medical necessity of the requested equipment, including the diagnosis, must be maintained in the client's medical record and is subject to retrospective review.

Refer to: Subsection 9.2.26.1, "Ambulatory Blood Pressure Monitoring" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about ambulatory blood pressure devices.

2.6.4.1.1 Manual and Automated Blood Pressure Devices

Providers must use procedure code A4660 or A4670 when billing for manual or automated blood pressure devices.

Manual and automated blood pressure devices that have been purchased are anticipated to last a minimum of one year and may be considered for replacement when one year has passed or when the equipment is not functional and not repairable.

Manual and automated blood pressure devices may be reimbursed when billed with one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
I10	I110	I119	I120	I129	I130	I1310	I1311
I132	I150	I151	I152	I158	I159	I2601	I2602
I2609	I2690	I2692	I2699	I270	I271	I2781	I2782
I2789	I279	I340	I341	I342	I348	I349	I350
I351	I352	I358	I359	I360	I361	I362	I368
I369	I370	I371	I372	I378	I379	I421	I422
I424	I425	I428	I429	I43	I440	I441	I442
I4430	I4439	I444	I445	I4460	I4469	I447	I450
I4510	I4519	I452	I453	I454	I455	I456	I4581
I4589	I459	I471	I472	I479	I480	I481	I482
I483	I484	I4891	I4892	I495	I501	I5020	I5021
I5022	I5023	I5030	I5031	I5032	I5033	I5040	I5041
I5042	I5043	I509	I950	I951	I952	I953	I9581
I9589	I959	N010	N011	N012	N013	N014	N015
N016	N017	N018	N050	N051	N052	N053	N054
N055	N056	N057	N058	N059	N08	N1330	N1339
N13721	N13722	N13729	N13731	N13732	N13739	N170	N171
N172	N178	N179	N181	N182	N183	N184	N185
N186	N189	N250	N2589	Q200	Q201	Q202	Q203
Q204	Q205	Q208	Q210	Q211	Q212	Q213	R001

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Combination Diagnosis Codes (Must be submitted in pairs)							
T800XXA, I2690	T800XXA, I2699	T81718A, I2690	T81718A, I2699	T8172XA, I2690	T8172XA, I2699	T82817A, I2690	T82817A, I2699
T82818A, I2690	T82818A, I2699						

2.6.4.1.2 Hospital-Grade Blood Pressure Devices

Providers must use procedure code A9279 with modifier U1 when billing for hospital-grade blood pressure devices.

Hospital-grade blood pressure devices that have been purchased are anticipated to last a minimum of three years and may be considered for replacement when three 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 and 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.

The following indications are recognized by Texas Medicaid for hospital-grade blood pressure devices:

- Hypotension
- Essential hypertension
- Hypertensive heart disease
- Hypertensive renal disease
- Acute pulmonary heart disease
- Chronic pulmonary heart disease
- Cardiomyopathy
- Conduction disorders
- Cardiac dysrhythmias
- Heart failure
- Acute kidney failure
- Chronic kidney disease
- Hydronephrosis
- Vesicoureteral reflux with neuropathy
- Bulbus cordis anomalies and anomalies of cardiac septal closure

All rental costs of the hospital-grade blood pressure device apply toward the purchase price.

2.6.4.1.3 Blood Pressure Device Components, Replacements, and Repairs

The following may be considered for reimbursement of blood pressure device:

- Replacement of blood pressure cuffs (procedure code A4663)
- Replacement of other components (procedure code A4660)
- Repairs of the equipment (procedure code A4660)

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2.6.4.2 Prior Authorization and Documentation Requirements

A CCP Prior Authorization Request Form, signed and dated by the physician, must be submitted with the documentation supporting medical necessity for the device. Supporting documentation of medical necessity must include the diagnosis.

2.6.4.2.1 Manual and Automated Blood Pressure Devices

Prior authorization is not required for manual and automated blood pressure devices except when the following situations apply:

- *Another blood pressure device is medically necessary within the same year*. Replacement of equipment within the same year as the purchase requires prior authorization. When equipment needs to be replaced sooner than the anticipated lifespan, the provider must submit a copy of the police or fire report, when appropriate, and the measures to be taken to prevent reoccurrence.
- *The client has a diagnosis code other than those in the diagnosis table listed above*. If the client has a diagnosis code other than those listed in the above table, a request for prior authorization for an initial or replacement device with all necessary documentation supporting medical necessity of the blood pressure device.

2.6.4.2.2 Hospital-Grade Blood Pressure Devices

Prior authorization is required for the rental or purchase of a hospital-grade blood pressure device. A determination will be made by HHSC or its designee as to whether the equipment will be rented, purchased, repaired, or modified based on the client's needs, duration of use, and age of the equipment. Repairs and modifications can only be performed on purchased equipment.

Documentation of medical necessity for the hospital-grade blood pressure device must support the client's need for self-monitoring and address why an automated blood pressure device will not meet the client's needs. The documentation must include:

- All pertinent diagnoses.
- Initial evaluation.
- Symptoms.
- Duration of symptoms.
- Any recent hospitalizations (within past 12 months).
- Comorbid conditions.
- How frequent or continuous self-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 and object permanence and who has agreed to accept the responsibility to be trained to use the hospital-grade monitor.

Prior authorization may be granted for a six-month rental period when the request is submitted with documentation of medical necessity supporting the client's need for self-monitoring and addressing why an automated blood pressure device will not meet the client's needs.

Recertification for an additional six-month period may be considered when the physician provides current documentation that supports the ongoing medical necessity for self-monitoring and confirms the client or family is compliant with its use.

A hospital-grade blood pressure device will not be considered for prior authorization of purchase until the client has completed a six-month trial period.

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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.

2.6.4.2.3 Blood Pressure Device Components, Replacements, and Repairs

Replacement of blood pressure cuffs and other components may be considered for purchase with prior authorization and documentation of medical necessity that explains the need for the replacement.

Repair of equipment must be prior authorized when irreparable damage has occurred and documentation exists that supports the need for repair. Repair of equipment will be considered after the factory warranty has expired.

2.6.5 Cardiorespiratory (Apnea) Monitor

2.6.5.1 Services, Benefits, and Limitations

Apnea monitors are a benefit of CCP for clients who are birth through 20 years of age. The purchase of an apnea monitor (procedure code E0618 or E0619) is limited to once every five years. The rental of an apnea monitor (procedure code E0619) is limited to once per month.

The rental of an apnea monitor with recording feature may be considered for two months without prior authorization for infants birth through 4 months of age with one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
G9009	I440	I441	I442	I4430	I4439	I471	I479
I498	K219	P228	P270	P271	P278	P282	P283
P284	P285	P2889	P2911	P2912	Q246	R000	R0681
Z8489							

Diagnosis code I498 includes atrial tachycardia (supraventricular tachycardia [SVT], atrioventricular [AV] nodal re-entry, nodal, and sinoauricular) and bradycardia (nodal, sinoatrial).

Other diagnoses may be considered for prior authorization based on medical necessity. Use of diagnosis code Z8489 requires submission of additional documentation to support medical necessity.

Procedure code 94774 may be used by the physician to bill for the interpretation of the apnea monitor recordings.

Electrodes and lead wires (procedure codes A4556 and A4557) for the apnea monitor are a benefit only if the apnea monitor is owned by the client. Additional documentation such as the purchase date, the serial number, and purchasing entity may be requested. Procedure code A4556 may be considered for purchase for a maximum of 15 pairs per month. Procedure code A4557 may be considered for purchase for a maximum of two pairs per month. Additional lead wires may be requested on appeal with documentation of medical necessity. The physician must provide medical necessity for the electrodes, lead wires, and a statement that the client owns the monitor. If the apnea monitor is rented, the electrodes and lead wires are considered part of the rental fee.

The apnea monitor and pulse oximeter combination device is not a benefit of Texas Medicaid.

2.6.5.2 Prior Authorization and Documentation Requirements

Prior authorization for the purchase of an apnea monitor with or without recording features may be considered for use in the home with one of the diagnosis codes listed in the table above.

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Prior authorization is required for rental of an apnea monitor, and may be considered for clients who are birth through 20 years of age that are CCP-eligible when documentation submitted clearly shows that the equipment is medically necessary and will correct or ameliorate the client's disability or physical or mental illness or condition. Documentation must include one of the following:

- The client is five months of age or older.
- A documented cardiorespiratory episode occurred during the initial two-month rental period requiring continued monitoring.

Clients who are five months of age and older must have demonstrated an apparent life-threatening event, tracheostomy, anatomic abnormality of the airway, chronic lung disease requiring oxygen or ventilatory support, or other diagnoses based on documented medical necessity.

Prior authorization must be obtained in writing and must include all of the following:

- A completed CCP Prior Authorization Request Form signed and dated by the physician
- Documentation to support medical necessity and appropriateness of the apnea monitor
- A physician interpretation, signed and dated by the physician, of the most recent two month's apnea monitor downloads if the client has used an apnea monitor

Apnea monitors are not prior authorized if the documentation does not support medical necessity.

2.6.6 Pulse Oximeter

2.6.6.1 Services, Benefits, and Limitations

A pulse oximeter (procedure code E0445) is a benefit of Texas Medicaid through CCP. A higher-level pulse oximeter (procedure code E0445 with modifier TG) may be reimbursed based on documentation of medical necessity. Modifier TG must be submitted in addition to procedure code E0445. Modifier TG is used for complex or high level of care.

A pulse oximeter rental is limited to once per month for a maximum of six months. For those clients who require long-term monitoring, recertification may be considered for up to a maximum of six additional months. Purchase may be considered when it is determined to be medically necessary and more cost-effective than leasing the device with supplies. Before purchase, the provider must supply a new pulse oximeter to the client.

A pulse oximeter may be reimbursed for purchase once every five years.

The provider is responsible for retaining a current prescription.

The rental of equipment includes all necessary supplies, adjustments, repairs, and replacement parts. Pulse oximeter sensor probes (procedure code A4606) for client-owned equipment are limited to four per month without prior authorization.

2.6.6.2 Prior Authorization and Documentation Requirements

A pulse oximeter requires prior authorization.

A pulse oximeter may be considered for prior authorization for clients who are birth through 20 years of age who are CCP-eligible when documentation submitted clearly shows that the equipment is medically necessary and will correct or ameliorate the client's disability or physical or mental illness or condition. Documentation must include the following for the level requested:

- *Level One*. Basic level monitoring capable of spot checks and heart rate or capable of continuous monitoring, alarm, memory, and correction of motion artifact. Applicable if there is a caregiver or medical provider identified and present who has been trained in use of the oximeter and how to respond to readings in a medically safe way and the client meets at least one of the following criteria:
  - Client is oxygen- or ventilator-dependent (up to 16 hours per day).

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- Client is clinically stable and able to wean from oxygen or ventilator.
- Client has other medically necessary condition(s) requiring monitoring of oxygen saturation or needs continuous monitoring of oxygen saturation during sleep or to maintain optimal levels.

- *Level Three.* Providers must use modifier TG if the oximeter device is for a serious condition and there is critical need for continuous monitoring. Applicable if the client meets all the following criteria:
  - Client has frequent need for changes in oxygen and ventilator settings.
  - Client is oxygen- or ventilator-dependent (e.g., 16 to 24 hours per day).
  - Client is in the weaning process from oxygen or ventilator and experiencing respiratory complications.
  - Client requires equipment that is motion-sensitive or that has more complex readouts or monitoring capabilities.
  - There is a caregiver or medical provider identified and present who has been trained in use of the oximeter and how to respond to readings in a medically safe way.

For all requests providers must:

- Submit the completed Pulse Oximeter Form and CCP Prior Authorization Request Form, which are available on the TMHP website at www.tmhp.com.
- Clearly indicate medical necessity using the TG modifier on the Pulse Oximeter Form.
- Continue to use the current code for lease (E0445 with modifier RR) and purchase (E0445 with modifier NU).

A pulse oximeter rental includes the system, the sensor probes, and all necessary supplies.

Pulse oximeter sensor probes (procedure code A4606) for client-owned equipment are limited to four per month without prior authorization. Providers may obtain additional probes for clients who are birth through 20 years of age with documentation of medical necessity. Additional probes require prior authorization through CCP.

2.6.7 Diabetic Equipment and Supplies

Note: *This section is only for tubeless external insulin infusion pumps.*

Refer to: Subsection 2.2.11, "* Diabetic Equipment and Supplies" in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2 Provider Handbooks)* for all other diabetic equipment and supplies, including the external insulin pump.

2.6.7.1 Services, Benefits, and Limitations

The tubeless external insulin infusion pump and supplies are a benefit of Texas Medicaid through CCP.

The tubeless external insulin pump must be ordered by, and the client's follow-up care must be managed by, a prescribing provider who has experience managing clients with insulin infusion pumps and who is knowledgeable in the use of insulin infusion pumps.

Providers must use procedure code E0784 and modifier U1 for the rental or purchase of the tubeless external insulin pump and procedure code A9274 for the tubeless external insulin pump supplies. Procedure code A9274 is limited to 15 per month.

A tubeless external insulin pump that has been purchased is expected to last a minimum of three years and may be considered for replacement when three years have passed or the equipment is no longer repairable. The replacement of the equipment may also be considered when it has been lost or irrepa-

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rably damaged. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent a reoccurrence must be submitted. Additional services may be considered based on documentation of medical necessity.

Routine maintenance of rental equipment is the provider's responsibility.

2.6.7.2 Prior Authorization and Documentation Requirements

Prior authorization is required for the tubeless external insulin pump with carrying cases and related supplies and repairs. The tubeless external insulin pump supplies may be considered separately when a tubeless external insulin pump is rented.

The tubeless external insulin pump and supplies may be obtained through one of the following methods:

- *CCP Prior Authorization Request Form.* The completed CCP Prior Authorization Request Form must be maintained by the dispensing provider and the prescribing physician in the client's medical record. The physician must maintain the original signed and dated copy of the CCP Prior Authorization Request Form. The completed CCP Prior Authorization Request Form is valid for a period up to six months from the physician's signature date.
- *Verbal or detailed written order.* The verbal or detailed written order must be provided by a physician, PA, NP, CNS, or a CNM.

If the dispensing provider does not have a detailed written order, a verbal order is required to be on file until the written order is received from the prescribing provider and before providing diabetic equipment and supplies. The prescribing provider's order may be a written, fax, electronic, or verbal order and must include:

- A description of the item(s).
- The client's name.
- The name of the physician or authorized prescribing provider.
- The date of the order.

A detailed written order must be received by the DME supplier within 90 days from the date of the prescribing provider's signature. For initial orders, the detailed written order for diabetic equipment and supplies is valid for six months from the date of the order or the date of the prescribing provider's signature, whichever is earlier. For renewal orders the detailed written order is valid for six months from the start date, or in absence of a start date, the date of the authorized prescribing signature.

2.6.7.2.1 Tubeless External Insulin Pump Rentals

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

- The client has a diagnosis of type 1 or type 2 diabetes and meets at least two of the following criteria while on multiple daily injections of insulin:
  - Elevated glycosylated hemoglobin level (HbA1c) > 7.0 percent.
  - A history of dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl.
  - A history of severe glycemic excursions with wide fluctuations in blood glucose.
  - A history of recurring hypoglycemia (less than 60 mg/dL) with or without hypoglycemic unawareness.
  - Expectation of becoming pregnant within three months.
- The client has a diagnosis of gestational diabetes and meets at least one of the following criteria:
  - Erratic blood sugars in spite of maximal compliance and split dosing.

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- Other evidence that adequate control is not being achieved by current methods.

In addition to the clinical documentation, the provider must submit an External Insulin Pump form that indicates:

- The client or caregiver possesses:
  - 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 prescribing provider has attested that:
  - A training and 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 the necessary proficiency to integrate insulin pump therapy with their current treatment regimen for ambient glucose control.

2.6.7.2.2 Purchase of Tubeless External Insulin Pump

The purchase of a tubeless external insulin pump may be considered for prior authorization after it has been rented for a three-month trial and all of the following documentation has been provided:

- The training or 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.

2.6.8 Donor Human Milk

2.6.8.1 Services, Benefits, and Limitations

Donor human milk is a benefit of CCP for clients who are birth through 11 months of age who are CCP-eligible when documentation submitted clearly shows that it is medically necessary and will correct or ameliorate the client's disability or physical or mental illness or condition. Documentation must include all of the following:

- The requesting physician has documented medical necessity and appropriateness.
- The parent or guardian has signed and dated an informed consent form indicating that the risks and benefits of using banked donor human milk have been discussed with them.
- The donor human milk bank adheres to quality guidelines consistent with the Human Milk Bank Association of North America or such other standards as may be adopted by HHSC.

Additional donor human milk benefits beyond the limitations listed above may be available to clients who are birth through 20 years of age with documentation of medical necessity.

Procedure code B9998 must be used when requesting or billing for donor human milk.

Donor human milk is reimbursed at a maximum fee determined by HHSC or manual pricing.

Donor human milk is only reimbursed to a Texas Medicaid-enrolled donor milk bank and only for children who are in the home setting.

The physician must address the benefits and risks of using donor human milk, such as HIV, freshness, effects of pasteurization, nutrients, and growth factors to the parent. The physician also must address donor screening, pasteurization, milk storage, and transport of the donor milk. The physician may obtain this information from the donor milk bank.

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2.6.8.2 Prior Authorization and Documentation Requirements

Donor human milk may be considered for a maximum of six months per authorization. The authorization may be extended with documentation of medical necessity.

Prior authorization is required for donor human milk provided through Texas Medicaid CCP Services. To obtain prior authorization, providers must complete the CCP Prior Authorization Request Form and a Donor Human Milk Request Form every 180 days. Both the ordering physician and the providing milk bank must maintain copies of the form in the client's medical records.

The physician ordering the donor human milk must complete all of the fields in Part A of the original form, including the documentation of medical necessity. This information must be substantiated by written documentation in the clinical report. The physician must specify the quantity and the time frame in the Quantity Requested field (e.g., cubic centimeters per day or ounces per month). All of the fields in Part B of the form must be completed by the donor milk bank providing the donor human milk.

The prior authorization request and all completed documentation must be submitted to the TMHP CCP Prior Authorization Unit at:

Texas Medicaid & Healthcare Partnership
Comprehensive Care Program (CCP)
PO Box 200735
Austin, TX 78720-0735
Fax: 1-512-514-4212

The documentation of medical necessity and appropriateness and the signed and dated written informed consent form must be maintained in the client's clinical records. The documentation of medical necessity must be completed by the physician ordering the donor human milk. The clinical records are subject to retrospective review. The documentation must address all of the following:

- Medical necessity, including why the particular client cannot survive and gain weight on any appropriate formula (e.g., elemental, special, or routine formula or food), or any enteral nutritional product other than donor human milk.
- A clinical feeding trial of an appropriate nutritional product has been considered with each authorization.
- The informed consent provided to the parent or guardian details the risks and benefits of using banked donor human milk.
- A copy of the CCP Prior Authorization Request Form and the Donor Human Milk Request Form.

Refer to: Donor Human Milk Request Form on the TMHP website at www.tmhp.com.

CCP Prior Authorization Request Form on the TMHP website at www.tmhp.com.

2.6.9 Incontinence Supplies

2.6.9.1 Services, Benefits, and Limitations

Incontinence supplies, such as diapers, briefs, pull-ons, liners, wipes, and underpads, may be considered for reimbursement through CCP for those clients who are birth through 3 years of age with a medical condition resulting in an increased urine or stool output beyond the typical output for this age group, such as celiac disease, short bowel syndrome, Crohn's disease, thymic hypoplasia, Acquired Immunodeficiency Syndrome (AIDS), congenital adrenal hyperplasia, diabetes insipidus, Hirschsprung's disease, or radiation enteritis.

For clients who are 4 years of age and older, incontinence supplies may be considered through Title XIX Home Health Services when their medical condition results in an impairment of urination and/or stool. For clients who do not meet criteria through Title XIX Home Health Services, incontinence supplies may be considered through CCP with documentation of medical necessity.

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Lack of bladder or bowel control is considered normal development for clients who are 4 years of age or younger.

Reusable diapers, briefs, pull-ons, liners, wipes, and underpads are not a benefit of CCP. Gloves used to change diapers, briefs, and pull-ons are not considered medically necessary unless the client has skin breakdown or a documented disease that may be transmitted through the urine.

2.6.9.1.1 Skin Sealants, Protectants, Moisturizers, Ointments

Skin sealants, protectants, moisturizers, and ointments may be considered for clients with documented incontinence associated dermatitis.

> ***Note:*** *Skin sealants, protectants, moisturizers, and ointments for diagnoses other than incontinence-associated dermatitis (e.g., wounds, decubitus ulcers, periwound skin complications, peristomal skin complications) may be considered for prior authorization through home health services wound care supplies and systems.*

Incontinence-associated dermatitis is classified using the following categories:

- *Category 1*. A small area of skin breakdown (less than 20 cm2) with mild redness (blotchy and non-uniform) and mild erosion involving the epidermis only.
- *Category 2.* A moderate area of skin breakdown (20 cm2 through 50 cm2) with moderate redness (severe in spots, but not uniform in appearance) and moderate erosion involving epidermis and dermis with no or little exudate.
- *Category 3.* A large area of skin breakdown (greater than 50 cm2) with severe redness (uniformly severe in appearance) and severe erosion of epidermis with moderate involvement of the dermis and no or small volume of exudate.
- *Category 4.* A large area of skin breakdown (greater than 50 cm2) with severe redness (uniformly severe in appearance) and extreme erosion of epidermis and dermis with moderate volume of persistent exudate.

The category of incontinence-based dermatitis determines the benefit limitation and whether to use a modifier when submitting a claim for procedure code A6250, as shown in the following table:

Dermatitis Category	Procedure Code	Modifier	Benefit Limitation
Category 1 or 2	A6250	UA	Up to 2 containers (no less than 4 ounces per container) of skin sealants, protectants, moisturizers, and ointments per month.
Category 3 or 4	A6250	None	Skin sealants, protectants, moisturizers, and ointments may be considered.

2.6.9.1.2 Diapers, Briefs, and Liners

The following procedure codes must be used when billing for diapers, briefs, and liners and are limited to a combined total of 240 per month:

Procedure Codes									
T4521	T4522	T4523	T4524	T4525	T4526	T4527	T4528	T4529	T4530
T4531	T4532	T4533	T4534	T4535	T4543	T4544			

2.6.9.1.3 Diaper Wipes

Diaper wipes may be considered for clients who are receiving diapers, briefs, or pull-ons through CCP.

Providers must use procedure code A4335 and modifier U9 when billing for diaper wipes. Procedure code A4335 is limited to 2 boxes per month.

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2.6.9.1.4 Underpads

Underpads may be considered for clients who are receiving diapers, briefs, or pull-ons through CCP.

Providers must use procedure code A4554 when billing for underpads. Procedure code A4554 is limited to 120 per month.

2.6.9.1.5 External Urinary Collection Devices

External urinary collection devices, including, but not limited to, male external catheters, female collection devices, and related supplies may be considered with a documented medical condition resulting in an increased urine or stool output beyond the typical output.

The following procedure codes must be used when billing for external urinary collection devices:

Procedure Code	Maximum Limitation
A4326	31 per month
A4327	4 per month
A4328	4 per month
A4349	31 per month

2.6.9.2 Prior Authorization and Documentation Requirements

Prior authorization is required for incontinence supplies through CCP.

A determination is made by HHSC or its designee as to the number of incontinence supplies prior authorized based on the client's medical needs.

Additional quantities may be considered with documentation of medical necessity.

The quantity of incontinence supplies billed for a one-month period must be consistent with the number of times per day the physician has ordered the supply be used on the CCP Prior Authorization Request Form.

To request prior authorization for incontinence supplies, the following documentation must be provided for the items requested:

- Accurate diagnostic information pertaining to the underlying diagnosis or condition as well as any other medical diagnoses or conditions, to include the client's overall health status
- Diagnosis or condition causing increased urination or stooling
- Client's height, weight, and waist size
- Number of times per day the physician has ordered the supply be used
- Quantity of disposable supplies requested per month

Additional information may be requested to clarify or complete a request for the supplies and equipment.

2.6.10 Mobility Aids

2.6.10.1 Services, Benefits, and Limitations

Mobility aids and related supplies, including, but not limited to, strollers, special-needs car seats, and travel safety restraints are a benefit to assist clients to move about in their environment when medically necessary and Federal Financial Participation is available.

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Mobility aids and related supplies may be considered for reimbursement through CCP for clients who are birth through 20 years of age who are CCP-eligible when documentation submitted clearly shows that the equipment is medically necessary and will correct or ameliorate the client's disability or physical or mental illness or condition. Documentation must include the following:

- The client's mobility status would be compromised without the requested equipment.
- The requested equipment or supplies are safe for use in the home.

Mobility aids may be considered through CCP if the requested equipment is not available through Texas Medicaid (Title XIX) Home Health Services or the client does not meet criteria through Texas Medicaid (Title XIX) Home Health Services.

Mobility aid lifts for vehicles and vehicle modifications are not reimbursed through Texas Medicaid in accordance with federal regulations.

Note: *Permanent ramps, vehicle ramps, and home modifications are not a benefit of Texas Medicaid.*

2.6.10.1.1 Portable Client Lifts for Outside the Home Setting

Providers must use procedure code E0635 with modifier TG for the purchase of the portable client lift and is limited to once per lifetime, any provider. Portable electric lifts are a benefit of Texas Medicaid if they can fold-up for transport and can be used outside the home setting if the client must attend health-related services that require an overnight stay in a noninstitutional setting.

2.6.10.1.2 Wheeled Mobility Systems

A wheeled mobility system is a manual or power wheelchair, or scooter that is a customized power or manual mobility device, or a feature or component of the mobility device, including, but not limited to, the following:

- Seated positioning components
- Manual seating options
- Adjustable frame
- Other complex or specialized components

A stroller (a multipositional client transfer system with integrated seat, operated by caregiver) for medical needs may be considered for clients who are CCP-eligible when documentation submitted clearly shows that the equipment is medically necessary and will correct or ameliorate the client's disability or physical or mental illness or condition. Documentation must include the following:

- The client does not own another seating system, including, but not limited to, a wheelchair.
- The client's condition does not require another type of seating system, including, but not limited to, a wheelchair.

If the client does not meet criteria for a stroller, a wheelchair may be considered through Texas Medicaid (Title XIX) Home Health Services.

Scooters may be considered for reimbursement through Texas Medicaid (Title XIX) Home Health Services.

Definitions and Responsibilities

The following definitions and responsibilities apply to the provision of wheeled mobility systems:

Adjustments. The adjustment of a component or feature of a wheeled mobility system. Adjustments require labor only and do not include the addition, modification, or replacement of components or supplies needed to complete the adjustment.

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Texas Medicaid will consider adjustments only to client-owned equipment that is considered a benefit of Texas Medicaid.

Major Modification. The addition of a custom or specialized feature or component of a wheeled mobility system that did not previously exist on the system due to changes in the client's needs, including but not limited to, the items listed in this paragraph. This definition also includes the modification of a custom or specialized feature or component due to a change in the client's needs, including but not limited to, the following:

- Seated positioning components including, but not limited to, specialized seating or positioning components
- Powered or manual seating options including, but not limited to, power tilt or recline seating systems and seat elevation systems
- Specialty driving controls including, but not limited to, nonstandard alternative power drive control systems
- Adjustable frame including, but not limited to, nonstandard seat frame dimensions
- Other complex or specialized components including, but not limited to, power elevating leg rests and specialized electronic interfaces

The replacement of a previously existing custom or specialized feature or component with an identical or comparable component is considered a repair and not a major modification.

Texas Medicaid will consider major modifications only to client-owned equipment that is considered a benefit of Texas Medicaid.

Minor Modification. The addition or modification of non-custom or non-specialized features or components due to changes in the client's needs, including but not limited to, the following:

- Armpads/armrests
- Legrests/Leg extensions
- Modification of seating and positioning components to accommodate for a change in the client's size.

The replacement of a previously existing noncustom or nonspecialized feature or component with an identical or comparable component is considered a repair and not a minor modification.

Texas Medicaid will consider minor modifications only to client-owned equipment that is considered a benefit of Texas Medicaid.

Mobility Related Activity to Daily Living (MRADL). An activity of daily living that requires the use of mobility aids (i.e., toileting, feeding, dressing, grooming, and bathing).

Occupational Therapist. A person who is currently licensed by the Executive Council of Physical Therapy & Occupational Therapy Examiners to practice OT.

Physical Therapist. A person who is currently licensed by the Executive Council of Physical Therapy & Occupational Therapy Examiners to practice PT.

> ***Note:*** *An occupational or physical therapist is responsible for completing the required seating assessment for a client to obtain a wheeled mobility system.*

Qualified Rehabilitation Professional (QRP). A QRP is a person who meets one or more of the following criteria:

- Holds a certification as an Assistive Technology Professional (ATP) or a Rehabilitation Engineering Technologist (RET) issued by, and in good standing with, the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).

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- Holds a certification as a Seating and Mobility Specialist (SMS) issued by, and in good standing with, RESNA.
- Holds a certification as a Certified Rehabilitation Technology Supplier (CRTS) issued by, and in good standing with, the National Registry of Rehabilitation Technology Suppliers (NRRTS).
- The QRP is responsible for:
  - Being present at and involved in the seating assessment of the client for the rental or purchase of a wheeled mobility system.
  - Being present at the time of delivery of the wheeled mobility system to direct the fitting of the system to ensure that the system functions correctly relative to the client.

Repairs. The replacement of a component or feature of a wheeled mobility system with an identical or comparable component that does not change the size or function of the system due to the component no longer functioning as designed.

Texas Medicaid will consider repairs only to client-owned equipment that is considered a benefit of Texas Medicaid.

2.6.10.1.3 Seating Assessment

A seating assessment is required for the rental or purchase of any device meeting the definition of a wheeled mobility system or purchase of any device meeting the definition of a wheelchair for a client with a congenital or neurological condition, myopathy, or skeletal deformity that requires the use of a wheelchair as defined under subsection 2.6.10.1.2, "Wheeled Mobility Systems" in this handbook.

A seating assessment with measurements, including specifications for exact mobility and seating equipment and all necessary accessories, must be completed by a physician, licensed occupational therapist, or licensed physical therapist.

A QRP directly employed or contracted by the DME provider must be present at, and participate in all seating assessments, including those provided by a physician.

Upon completion of the seating assessment, the QRP must attest to his or her participation in the assessment by signing the Wheelchair/Scooter/Stroller Seating Assessment Form. This form must be submitted with all requests for wheeled mobility systems.

When the practitioner completing the seating assessment is an occupational therapist or physical therapist, the occupational therapist or physical therapist may perform the seating assessment as the therapist, or as the QRP, but may not perform in both roles at the same time. If the occupational therapist or physical therapist is attending the seating assessment as the QRP, the occupational therapist or physical therapist must meet the credentialing requirements and be enrolled in Texas Medicaid as a QRP.

If the seating assessment is completed by a physician, reimbursement is considered part of the physicians office visit and will not be reimbursed separately.

The practitioner (occupational therapist or physical therapist) completing the assessment must submit procedure code 97001 or 97003 with modifier U1, to bill for the seating assessment.

Services for the QRP's participation in the seating assessment must be submitted for reimbursement by the DME provider billing for the wheeled mobility system using procedure code 97542 with modifier U1. The DME provider must include the QRP specialty as the performing provider on the claim for all components of the wheeled mobility system, including the QRP's participation in the seating assessment.

Note: *Seating assessment services performed by a QRP are limited to four units (one hour).*

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2.6.10.1.4 Fitting of Custom Wheeled Mobility Systems

The fitting of a wheeled mobility system is defined as the time the QRP spends with the client fitting the various systems and components of the system to the client. It may also include time spent training the client or caregiver in the use of the wheeled mobility system. Time spent setting up the system, or travel time without the client present, is not included.

A fitting is required for any device meeting the definition of a wheeled mobility system as defined under subsection 2.6.10.1.2, "Wheeled Mobility Systems" in this handbook.

The fitting of a wheeled mobility system must be:

- Performed by the same QRP that was present for, and participated in, the seating assessment of the client.
- Completed prior to submitting a claim for reimbursement of a wheeled mobility system.

The QRP performing the fitting will:

- Verify the wheeled mobility system has been properly fitted to the client.
- Verify that the wheeled mobility system will meet the client's functional needs for seating, positioning, and mobility.
- Verify that the client, parent, guardian of the client, and/or caregiver of the client has received training and instruction regarding the wheeled mobility system's proper use and maintenance.

The QRP must complete and sign the DME Certification and Receipt form after the wheeled mobility system has been delivered and fitted to the client. Completion of this form by the QRP signifies that all components of the fitting as outlined above have been satisfied. The form must be completed prior to submission of a claim for a wheeled mobility system, and submitted to HHSC's designee according to instructions on the form to allow for proper claims processing.

Services for fitting of a wheeled mobility system by the QRP must be submitted for reimbursement by the DME provider of the wheeled mobility system using procedure code 97542 with modifier U2. The DME provider must list the QRP who participated in the seating assessment as the performing provider on the claim for all components of the wheeled mobility system, including the fitting performed by the QRP.

Procedure code 97542 with modifier U2 must be billed on the same claim as the procedure code(s) for the wheeled mobility system in order for both services to be reimbursed.

2.6.10.1.5 Modifications, Adjustments, and Repairs

Major and minor modifications, adjustments, and repairs to standard mobility aid equipment within the first six months after delivery are considered part of the purchase price.

Modifications, adjustments, and repairs, as well as the associated services by the QRP for the seating assessment and fitting, within the first six months after delivery are considered part of the purchase price.

Major modifications to a wheeled mobility system requires the completion of a new seating assessment by a qualified practitioner (physician, physical therapist, or occupational therapist), with the participation of a QRP.

Minor modifications, adjustments, or repair to a wheeled mobility system does not require the completion of a new seating assessment.

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A wheeled mobility system that has been fitted and delivered to the client's home by a QRP and then found to be inappropriate for the client's condition will not be eligible for an upgrade, replacement, or major modification within the first six months following purchase unless there has been a significant change in the client's condition. The significant change in the client's condition must be documented by a physician familiar with the client.

Claims submitted for equipment provided as a minor modification or repair to a wheeled mobility system must be submitted with modifier RB.

2.6.10.1.6 Stroller Ramps—Portable and Threshold

A portable ramp is defined as a ramp that is able to be carried as needed to access a home and weighing no more than 90 pounds and measuring no more than 10 feet in length. A threshold ramp is defined as a ramp that provides access over elevated thresholds.

Portable ramps exceeding the above criteria may be considered on a case-by-case basis with documentation of medical necessity and a statement that the requested equipment is safe for use.

Ramps may be considered for rental for short-term disabilities. Ramps may be considered for purchase for long-term disabilities.

Providers must use procedure code E1399 for the purchase of portable and threshold stroller ramps.

2.6.10.1.7 Feeder Seats, Floor Sitters, Corner Chairs, and Travel Chairs

Feeder seats, floor sitters, corner chairs, and travel chairs are not considered medically necessary and are not a benefit of CCP. If a client requires seating support and meets the criteria for a seating system, a stroller may be considered for reimbursement with prior authorization through CCP, or a wheelchair may be considered through Texas Medicaid (Title XIX) Home Health Services.

2.6.10.1.8 Special-Needs Car Seats

A special-needs car seat may be considered for a client who has outgrown an infant car seat and is unable to travel safely in a booster seat or seat belt.

A special-needs car seat for a client who does not meet the criteria may be considered on a case-by-case basis with documentation of medical necessity upon review by the state or its designee.

Providers must use procedure code E1399 for the purchase of a special-need car seat.

2.6.10.1.9 Travel Safety Restraints

A travel safety restraint and ankle or wrist belts may be considered for clients with a medical condition requiring transportation in either a prone or supine position. The DME provider and the prescribing physician familiar with the client must maintain documentation in the client's medical record supporting the medical necessity of the travel safety restraint.

Providers must use procedure code E0700 for the purchase of travel safety restraints, including ankle and wrist belts.

2.6.10.2 Prior Authorization and Documentation Requirements

Prior authorization is required for all mobility aids and related services, except travel safety restraints for clients with a medical condition requiring them to be transported in either a prone or supine position.

Mobility aid equipment that has been purchased is anticipated to last a minimum of five years and may be considered for replacement with prior authorization when five years have passed or the equipment is no longer repairable. Prior authorization for replacement of mobility aid equipment may also be considered when loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent recurrence must be submitted.

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When prior authorization of a mobility aid replacement is requested before five years have passed, the following information must be submitted with the request:

- A statement from the prescribing physician or licensed occupational therapist or physical therapist stating that the equipment no longer meets the client's needs
- Documentation supporting why the equipment no longer meets the client's needs

HHSC or its designee determines whether the equipment is rented, purchased, repaired, or modified based on the client's needs, duration of use, and age of equipment.

Rental of equipment includes all necessary accessories, supplies, adjustments, repairs, and replacement parts.

2.6.10.2.1 Portable Client Lifts for Outside the Home Setting

Prior authorization is required and will be considered on a case-by-case basis for portable client electric lifts that can fold-up for transport and that are necessary for use outside the home setting.

The provider must submit a prior authorization request with the following documentation for consideration of medical necessity:

- An explanation of why a home-based portable lift will not meet the client's needs.
- A description of the circumstances, including duration of need, when the client is required to attend health-related services requiring an overnight stay in a non-institutional setting.
- The family member or caregiver(s) supporting the client in the use of the portable client lift when required to travel outside the home setting for health related visits.

2.6.10.2.2 Wheeled Mobility System

A medical stroller does not have the capacity to accommodate the client's growth. Strollers for medical use may be considered for prior authorization when all of the following criteria are met:

- The client weighs 30 pounds or more.
- The client does not already own another seating system, including, but not limited to, a standard or custom wheelchair.
- The stroller must have a firm back and seat, or insert.
- The client is expected to be ambulatory within one year of the request date or is not expected to need a wheelchair within two years of the request date.

To request prior authorization for the purchase of procedure code E1035, the criteria must be met for the level of stroller requested:

- *Level One, Basic Stroller.* The client meets the criteria for a stroller. Providers must use procedure code E1035.
- *Level Two, Stroller with Tray for Oxygen or Ventilator.* The client meets the criteria for a level-one stroller and is oxygen- or ventilator-dependent. Providers must use procedure code E1035 with modifier TF.
- *Level Three, Stroller with Positioning Inserts.* The client meets the criteria for a level-one or level-two stroller and requires additional positioning support. Providers must use procedure code E1035 with modifier TG.

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The following supporting documentation must be submitted:

- A completed Wheelchair/Stroller Seating Assessment Form that includes documentation supporting medical necessity. This documentation must address why the client is unable to ambulate a minimum of 10 feet due to his or her condition (including, but not limited to, AIDS, sickle cell anemia, fractures, a chronic diagnosis, or chemotherapy), or if able to ambulate further, why a stroller is required to meet the client's needs.
- If the client is three years of age or older, documentation must support that the client's condition, stature, weight, and positioning needs allow adequate support from a stroller.

Note: *A stroller may be considered on a case-by-case basis with documentation of medical necessity for a client who does not meet the criteria listed above.*

2.6.10.2.3 Modifications

Modifications to custom equipment after the first six months from fitting and delivery may be considered for prior authorization should a change occur in the client's needs, capabilities, or physical and mental capability, which cannot be anticipated.

Documentation supporting the medical necessity of the requested modification must include the following:

- Description of the change in the client's condition that requires accommodation by different seating, drive controls, electronics, or other mobility base components.
- All projected changes in the client's mobility needs.
- The date of purchase, the serial number of the current equipment, and the cost of purchasing new equipment versus modifying current equipment.

Major modifications to a wheeled mobility system also require that a new seating assessment be completed and submitted with the prior authorization request. A request for authorization of the QRP's participation in the seating assessment for the major modification must be included with the prior authorization request for the major modification.

Minor modifications to a wheeled mobility system do not require the completion of a new seating assessment.

Requests for equipment submitted as a minor modification to a wheeled mobility system must be submitted with modifier RB.

2.6.10.2.4 Adjustments

Adjustments within the first six months after delivery, including adjustments to a wheeled mobility system within the first six months after fitting and delivery by a QRP will not be prior authorized.

A seating or positioning component alteration to accommodate a change in the client's size (height or weight) that does not require replacement components is considered an adjustment and not a major modification.

A maximum of one hour of labor for adjustments may be prior authorized as needed after the first six months from delivery.

Documentation must include the date of purchase, the serial number of the current equipment, and the reason for adjustments.

2.6.10.2.5 Repairs

Repairs to client owned equipment may be considered for prior authorization, as needed, with documentation of medical necessity. Technician fees are considered part of the cost of the repair.

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HHSC 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. Requests for repairs when there is documented proof of abuse or neglect will not be authorized.

Requests for equipment submitted as a repair to a wheeled mobility system must be submitted with modifier RB.

Providers are responsible for maintaining documentation in the client's medical record specifying the repairs and supporting medical necessity.

Documentation must include the date of purchase and serial number of the current equipment, the cause of the damage or need for repairs, the steps the client or caregiver will take to prevent further damage if repairs are due to an accident and, when requested the cost of purchasing new equipment as opposed to repairing current equipment.

2.6.10.2.6 Seating Assessments

A seating assessment performed by an occupational therapist, physical therapist, or a physician, with the participation of a QRP, does not require prior authorization. A seating assessment performed by a physician is considered part of the physician E/M service.

A seating assessment must be completed by a physician or licensed occupational therapist or physical therapist, who is not employed by the equipment supplier, before requesting prior authorization.

The seating assessment must clearly show that the equipment is medically necessary and will correct or ameliorate the client's disability or physical or mental illness or condition.

The QRP's participation in the seating assessment requires authorization before the service can be reimbursed. Authorization must be requested at the same time and on the same prior authorization request form as the prior authorization request for the QRP fitting and the wheeled mobility system or major modification to the wheeled mobility system.

- Prior authorization requests for the QRP's participation in the seating assessment will be returned to the provider if the seating assessment is requested separately from the prior authorization for the QRP fitting and the wheeled mobility system or major modification to the wheeled mobility system.
- The QRP participating in the seating assessment must be directly employed by, or contracted with, the DME provider requesting the wheeled mobility system or major modification to a wheeled mobility system.
- An authorization for the QRP's participation in the seating assessment for a wheeled mobility system or major modification to a wheeled mobility system may be issued to the QRP in 15-minute increments, for a time period of up to one hour (4 units).

Documentation must include the following:

- Explain how the 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 anticipated width of the medical stroller to allow client growth with use of lateral and thigh supports.
- 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, any recent changes in the client's physical or functional status, and any expected or potential surgeries that will improve or further limit mobility.
- Include information on the client's current mobility and seating equipment, how long the client has been in the current equipment, and why it no longer meets the client's needs.

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- Include the client's height, weight, and a description of where the equipment is to be used.

Seating measurements are required.

- Include information on the accessibility of the client's residence.
- Include manufacturer's information, including the description of the specific base, any attached seating system components, and any attached accessories.

2.6.10.2.7 Stroller Ramps—Portable and Threshold

One portable and one threshold ramp for stroller access may be considered for prior authorization when documentation supports medical necessity and includes the following:

- Diagnosis with duration of expected need
- A diagram of the house showing the access points with the ground-to-floor elevation and any obstacles

A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

Ramps may be considered for rental for short-term disabilities. Ramps may be considered for purchase for long-term disabilities.

Mobility aid lifts for vehicles and vehicle modifications are not reimbursed through Texas Medicaid according to federal regulations.

> ***Note:*** *Permanent ramps, vehicle ramps, and home modifications are not a benefit of Texas Medicaid.*

2.6.10.2.8 Special-Needs Car Seats

A special-needs car seat may be considered for prior authorization for a client who has outgrown an infant car seat and is unable to travel safely in a booster seat or seat belt. Consideration should be given to the manufacturer's weight and height limitations, and must reflect allowances for at least 12 months of growth.

Car seat accessories available from the manufacturer may be considered for prior authorization when medically necessary for correct positioning.

A special-needs car seat must have a top tether installed. The top tether is essential for proper use of the car seat. The installer is reimbursed for the installation by the manufacturer. The provider must maintain a statement that has been signed and dated by the client's parent or legal guardian in the client's medical record that states the following:

- A top tether has been installed in the vehicle in which the client will be transported by a manufacturer-trained vendor.
- Training in the correct use of the car seat has been provided by a manufacturer-trained vendor.
- The client's parent or guardian has received instruction and has demonstrated the correct use of the car seat to a manufacturer-trained vendor.

To request prior authorization for a special-needs car seat or accessories, all of the following criteria must be met:

- The client must weigh at least 40 pounds or be at least 40 inches in height.
- The supporting documentation must include the following:
  - Accurate diagnostic information pertaining to the underlying diagnosis or condition as well as any other medical diagnoses or conditions, including the client's overall health status.

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- A description of the client's postural condition specifically including head and trunk control (or lack of control) and why a booster chair or seatbelt will not meet the client's needs. The car seat must be able to support the head if head control is poor.
- The expected long term need for the special needs car seat.
- A copy of the manufacturer's certification for the installer's training to insert the specified car seat, such as Columbia Medical Manufacturing Corporation for Columbia products.

2.6.11 Nutritional Products

2.6.11.1 Services, Benefits, and Limitations

Medical nutritional products including enteral formulas and food thickener, may be approved for clients who are CCP-eligible, birth through 20 years of age, and have specialized nutritional requirements. Medical nutritional products must be prescribed by a physician and be medically necessary.

Nutritional products may be reimbursed with the following procedure codes:

Procedure Codes									
B4100	B4103	B4104	B4149	B4150	B4152	B4153	B4154	B4155	B4157
B4158	B4159	B4160	B4161	B4162					

Enteral nutrition supplies and equipment may be reimbursed with the following procedure codes and limitations:

Procedure Codes	Limitations
A4322	4 per month
A5200	2 per month
B4034	Up to 31 per month
B4035	Up to 31 per month
B4036	Up to 31 per month
B4081	As needed
B4082	As needed
B4083	As needed
B4087	2 per rolling year
B4088	2 per rolling year
B9000	1 purchase every 5 years; 1 per month rental
B9002	1 purchase every 5 years; 1 per month rental
B9998*	As needed*
B9998 with modifier U1	4 per month
B9998 with modifier U2	2 per rolling year
B9998 with modifier U3	4 per month
B9998 with modifier U4	2 per rolling year
B9998 with modifier U5	4 per month
***Appropriate limitations for miscellaneous procedure codes B9998 and T1999 are determined on a case-by-case basis through prior authorization. Specific items may be requested using procedure code B9998 and the modifiers outlined in the table above.**	

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Procedure Codes	Limitations
T1999*	As needed* If procedure code T1999 is used for a needleless syringe, the allowed amount is eight per month.
***Appropriate limitations for miscellaneous procedure codes B9998 and T1999 are determined on a case-by-case basis through prior authorization. Specific items may be requested using procedure code B9998 and the modifiers outlined in the table above.**	

The purchase of a backpack or carrying case for a portable enteral feeding pump may be a benefit of CCP, using procedure code B9998, if it is medically necessary and prior-authorized.

Clients for whom nutritional products are being requested may benefit from nutritional counseling. Nutritional counseling is a benefit of CCP if it is provided to treat, prevent, or minimize the effects of illness, injury, or other impairment.

Refer to: Subsection 2.9, "Medical Nutrition Counseling Services (CCP)" in this handbook for information about nutritional counseling.

2.6.11.2 Women, Infants, and Children Program (WIC)

Generic nutritional products that have been approved by the United States Department of Agriculture (USDA) for use in the Women, Infants, and Children Program (WIC) may be approved for use by CCP clients.

While CCP does not require that a client access WIC, it is only recommended as another source of services for clients who are 4 years of age and younger, or clients who are pregnant or breast feeding. Nutritional products are not provided to infants who are 11 months of age and younger unless medical necessity is documented.

2.6.11.3 Noncovered Services

CCP will not cover the following:

- Nutritional products that are traditionally used for infant feeding.
- Nutritional products for the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth. The underlying cause of failure to thrive, gain weight, and lack of growth is required.
- Nutritional bars.
- Nutritional products for clients who could be sustained on an age-appropriate diet.

2.6.11.4 * Prior Authorization and Documentation Requirements

Prior authorization for nutritional products is not required for a client who meets at least one of the following criteria:

- Client receives all or part of their nutritional intake through a tube.
- Client has a metabolic disorder that has been documented with one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
C880	C965	C966	D472	D800	D801	D802	D803
D804	D805	D806	D807	D808	D809	D810	D811
D812	D814	D816	D817	D8189	D819	D820	D821
D822	D823	D824	D828	D829	D830	D831	D832
D838	D839	D840	D841	D848	D849	D890	D891
D893	D8982	D8989	D899	E201	E670	E671	E672
E673	E678	E68	E700	E701	E7020	E7021	E7029

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
E7030	E70310	E70311	E70318	E70319	E70320	E70321	E70328
E70329	E70330	E70331	E70338	E70339	E7039	E7040	E7041
E7049	E705	E708	E709	E710	E71110	E71111	E71118
E71120	E71121	E71128	E7119	E712	E7130	E71310	E71311
E71312	E71313	E71314	E71318	E7132	E7139	E7140	E7141
E7142	E7143	E71440	E71448	E7150	E71510	E71511	E71518
E71520	E71521	E71522	E71528	E71529	E7153	E71540	E71541
E71542	E71548	E7200	E7201	E7202	E7203	E7204	E7209
E7210	E7211	E7212	E7219	E7220	E7221	E7222	E7223
E7229	E723	E724	E7250	E7251	E7252	E7253	E7259
E728	E729	E730	E738	E739	E7400	E7401	E7402
E7403	E7404	E7409	E7410	E7411	E7412	E7419	E7420
E7421	E7429	E7431	E7439	E744	E748	E749	E7500
E7509	E7510	E7511	E7519	E7521	E7522	E7523	E75240
E75241	E75242	E75243	E75248	E75249	E7529	E753	E754
E755	E756	E7601	E7602	E7603	E761	E76210	E76211
E76219	E7622	E7629	E763	E768	E769	E770	E771
E778	E779	E780	E781	E782	E783	E784	E785
E786	E7870	E7879	E7881	E7889	E789	E791	E792
E798	E799	E800	E801	E8020	E8021	E8029	E803
E804	E805	E806	E807	E8300	E8301	E8309	E8310
E8319	E8330	E8331	E8332	E8339	E8340	E8341	E8342
E8349	E8350	E8351	E8352	E8359	E8381	E8389	E839
E840	E8411	E8419	E848	E849	E850	E851	E852
E853	E854	E858	E859	E860	E861	E869	E870
E871	E872	E873	E874	E875	E876	E8770	E8779
E878	E8801	E8809	E881	E882	E8840	E8841	E8842
E8849	E8881	E8889	E889	H49811	H49812	H49813	M1000
M10011	M10012	M10019	M10021	M10022	M10029	M10031	M10032
M10039	M10041	M10042	M10049	M10051	M10052	M10059	M10061
M10062	M10069	M10071	M10072	M10079	M1008	M1009	M10111
M10112	M10121	M10122	M10131	M10132	M10141	M10142	M10151
M10152	M10161	M10162	M10171	M10172	M10211	M10212	M10221
M10222	M10231	M10232	M10241	M10242	M10251	M10252	M10261
M10262	M10271	M10272	M1030	M10311	M10312	M10319	M10321
M10322	M10329	M10331	M10332	M10339	M10341	M10342	M10349
M10351	M10352	M10359	M10361	M10362	M10369	M10371	M10372
M10379	M1038	M1039	M1040	M10411	M10412	M10419	M10421
M10422	M10429	M10431	M10432	M10439	M10441	M10442	M10449
M10451	M10452	M10459	M10461	M10462	M10469	M10471	M10472

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
M10479	M1048	M1049	M109	M1A00X0	M1A00X1	M1A0110	M1A0111
M1A0120	M1A0121	M1A0190	M1A0191	M1A0210	M1A0211	M1A0220	M1A0221
M1A0290	M1A0291	M1A0310	M1A0311	M1A0320	M1A0321	M1A0390	M1A0391
M1A0410	M1A0411	M1A0420	M1A0421	M1A0490	M1A0491	M1A0510	M1A0511
M1A0520	M1A0521	M1A0590	M1A0591	M1A0610	M1A0611	M1A0620	M1A0621
M1A0690	M1A0691	M1A0710	M1A0711	M1A0720	M1A0721	M1A0790	M1A0791
M1A08X0	M1A08X1	M1A09X0	M1A09X1	M1A20X0	M1A20X1	M1A2110	M1A2111
M1A2120	M1A2121	M1A2190	M1A2191	M1A2210	M1A2211	M1A2220	M1A2221
M1A2290	M1A2291	M1A2310	M1A2311	M1A2320	M1A2321	M1A2390	M1A2391
M1A2410	M1A2411	M1A2420	M1A2421	M1A2490	M1A2491	M1A2510	M1A2511
M1A2520	M1A2521	M1A2590	M1A2591	M1A2610	M1A2620	M1A2621	M1A2690
M1A2691	M1A2710	M1A2711	M1A2720	M1A2721	M1A2790	M1A2791	M1A28X0
M1A28X1	M1A29X0	M1A29X1	M1A30X0	M1A30X1	M1A3110	M1A3111	M1A3120
M1A3121	M1A3190	M1A3191	M1A3210	M1A3211	M1A3220	M1A3221	M1A3290
M1A3291	M1A3310	M1A3311	M1A3320	M1A3321	M1A3390	M1A3391	M1A3410
M1A3411	M1A3420	M1A3421	M1A3490	M1A3491	M1A3510	M1A3511	M1A3520
M1A3521	M1A3590	M1A3591	M1A3610	M1A3611	M1A3620	M1A3621	M1A3690
M1A3691	M1A3710	M1A3711	M1A3720	M1A3721	M1A3790	M1A3791	M1A38X0
M1A38X1	M1A39X0	M1A39X1	M1A40X0	M1A40X1	M1A4110	M1A4111	M1A4120
M1A4121	M1A4190	M1A4191	M1A4210	M1A4211	M1A4220	M1A4221	M1A4290
M1A4291	M1A4310	M1A4311	M1A4320	M1A4321	M1A4390	M1A4391	M1A4410
M1A4411	M1A4420	M1A4421	M1A4490	M1A4491	M1A4510	M1A4511	M1A4520
M1A4521	M1A4590	M1A4591	M1A4610	M1A4611	M1A4620	M1A4621	M1A4690
M1A4691	M1A4710	M1A4711	M1A4720	M1A4721	M1A4790	M1A4791	M1A48X0
M1A48X1	M1A49X0	M1A49X1	M1A9XX0	M1A9XX1	M359	N200	Z431
Z87738	Z931	Z934					

Prior authorization is required for nutritional products that are provided through CCP to clients who do not meet the criteria above and for all related supplies and equipment.

A completed CCP Prior Authorization Request Form that prescribes the nutritional product and/or related services must be signed and dated by a prescribing physician who was familiar with the client before requesting prior authorization. The completed CCP Prior Authorization Request Form must include the procedure codes and numerical quantities for the services requested. A copy of the completed, signed, and dated CCP Prior Authorization Form must be maintained by the provider in the client's medical record. The completed CCP Prior Authorization Request Form with the original dated signature must be maintained by the prescribing physician in the client's medical record.

Requests for prior authorization must include the following documentation:

- Accurate diagnostic information pertaining to the underlying diagnosis or condition that resulted in the requirement for a nutritional product, as well as any other medical diagnoses or conditions, including:
  - The client's overall health status.
  - Height and weight.

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  - Growth history and growth charts.
  - Why the client cannot be maintained on an age-appropriate diet.
  - Other formulas tried and why they did not meet the client's needs.
- Diagnosis or condition.
- The goals and timelines on the medical plan of care.
- Total caloric intake prescribed by the physician.
- Acknowledgement that the client has a feeding tube in place.

Related supplies and equipment for clients who require nutritional products may be considered for prior authorization when the criteria for nutritional products are met and medical necessity is included for each item requested.

Prior authorization may be given for up to 12 months. Prior authorization may be recertified with documentation that supports the ongoing medical necessity of the requested nutritional products.

A retrospective review may be performed to ensure that the documentation included in the client's medical record supports the medical necessity of the requested service.

2.6.11.4.1 Nutritional Products

Requests for prior authorization, when required, must include the necessary product information.

Enteral formulas consisting of semi-synthetic intact protein or protein isolates (procedure codes B4150 and B4152) are appropriate for the majority of clients who require enteral nutrition.

Special enteral formula or additives (procedure code B4104) may be considered for prior authorization with supporting documentation submitted by the client's physician indicating the client's medical needs for these special enteral formulas. Special enteral formula may be reimbursed with the following procedure codes:

Procedure Codes						
B4149	B4153	B4154	B4155	B4157	B4161	B4162

Food thickener may be considered for clients with a swallowing disorder.

Prior authorization of nutritional pudding products may be considered for children who have a documented oropharyngeal motor dysfunction and receive greater than 50 percent of their daily caloric intake from a nutritional pudding product.

Requests for electrolyte replacement products, such as Pedialyte or Oralyte, require documentation of medical necessity, including:

- The underlying acute or chronic medical diagnoses or conditions that indicate the need to replace fluid and electrolyte losses.
- The presence of mild to moderate dehydration due to the persistent mild to moderate diarrhea or vomiting.

Electrolyte replacement products are not indicated for clients with:

- Intractable vomiting
- Adynamic ileus
- Intestinal obstruction or perforated bowel
- Anuria, oliguria, or impaired homeostatic mechanism
- Severe, continuing diarrhea, when intended for use as the sole therapy

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Nasogastric, Gastrostomy, or Jejunostomy Feeding Tube

Feeding tubes require prior authorization. Additional feeding tubes may be prior authorized if the submitted documentation supports medical necessity, such as documentation of an infection at the gastrostomy site, leakage, or occlusion.

Enteral Feeding Pumps

The prior authorization of the lease or purchase of enteral feeding pumps may be considered with documentation of medical necessity that indicates that the client meets the following criteria:

- Gravity or syringe feedings are not medically indicated.
- The client requires an administration rate of less than 100 ml. per hr.
- The client requires night-time feedings.
- The client has one of the following medical conditions (this list is not all-inclusive):
  - Reflux and/or aspiration
  - Severe diarrhea
  - Dumping syndrome
  - Blood glucose fluctuations
  - Circulatory overload

Enteral Supplies

Enteral supplies require prior authorization, with the exception of irrigation syringes (procedure code A4322) and percutaneous catheter/tube anchoring devices (procedure code A5200) within the allowable limits.

Additional enteral feeding supply kits beyond the stated benefit limitation may be considered for prior authorization on a case-by-case basis with documentation of medical necessity.

Procedure code B4034 will not be prior authorized for use in place of procedure code A4322 for irrigation syringes when they are not part of a bolus administration kit. Gravity bags and pump nutritional containers are included in the feeding supply kits and will not be prior authorized separately.

Specific items may be considered for prior authorization using miscellaneous procedure code B9998 and modifier U1, U2, U3, U4, or U5.

Requests for a backpack or carrying case for a portable enteral feeding pump will be considered for prior authorization for clients who meet all of the following medical necessity criteria:

- The client requires enteral feedings that last more than eight continuous hours, or feeding intervals that are greater than the time that the client must be away from home to:
  - Attend school or work.
  - Participate in extensive, physician-ordered outpatient therapies.
  - Attend frequent, multiple medical appointments.
- The client is ambulatory or uses a wheelchair that will not support the use of a portable pump by other means, such as an intravenous (IV) pole.
- The portable enteral feeding pump is client-owned.

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2.6.11.5 Managed Care Clients

Nutritional products that are provided to WIC clients are carved-out of the Medicaid Managed Care Program and must be billed to TMHP for payment consideration. Carved-out services are those that are rendered to Medicaid Managed Care clients but are administered by TMHP and not the client's managed care organization (MCO).

Nutrition products that are provided to other Medicaid Managed Care Program clients (other than WIC clients) are not carved out and must be submitted to the managed care organization that administers the client's Medicaid managed care benefits.

2.6.12 Hospital Beds, Cribs, and Equipment

2.6.12.1 Services, Benefits, and Limitations

The following items may be considered under CCP:

- Pediatric hospital cribs and beds
- Enclosure frame, canopy, or bubble tops
- Positioning pillows or cushions
- Reflux wedges
- Reflux slings

Non-pediatric hospital cribs or enclosed beds can be considered through Texas Medicaid (Title XIX) Home Health Services.

The items listed above may be a benefit for clients who are CCP-eligible when documentation submitted clearly shows that the equipment is medically necessary and will correct or ameliorate the client's disability or physical or mental illness or condition. Hospital beds, cribs, and equipment are a benefit when all the following criteria are met:

- FFP must be available.
- The requested equipment or supplies must be safe for use in the home.

A pediatric hospital bed or pediatric crib is defined as a fully enclosed bed with all of the following features:

- A bed that allows adjustment of the head and foot of the bed.
    - A manual pediatric hospital bed (procedure code E0328) or pediatric crib (procedure code E0300) allows manual adjustment to the head and leg elevation.
    - A semi-electric or fully electric hospital bed (procedure code E0329) allows manual or electric adjustments to height and electric adjustments to head and leg elevation.
- A headboard
- A footboard
- A mattress
- Side rails of any type (A side rail is defined as a hinged or removable rail, board, or panel.)

Pediatric hospital beds and pediatric cribs that do not have all of these features will not be considered for prior authorization.

A bed that has side rails that extend 24 inches or less above the mattress is considered a pediatric hospital bed (procedure code E0328 or E0329). A pediatric hospital bed may be fixed or variable height. Variable height beds may be adjusted manually or electrically as required for the client's medical condition.

Procedure codes E0328 and E0329 are restricted to clients who are 20 years of age and younger.

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A bed that has side rails that extend more than 24 inches above the mattress is considered a pediatric crib (procedure code E0300).

A pediatric hospital bed or pediatric crib of any width that has all of the features defined above may be considered for prior authorization using only procedure code E0300, E0328, or E0329.

Hospital beds that are not fully enclosed can be considered through Texas Medicaid home health services.

Note: *Texas Medicaid defines fully enclosed as having 360-degree side enclosures.*

The following procedure codes are used when billing for the rental or purchase of pediatric hospital beds, cribs, and equipment:

Procedure Codes						
E0190*	E0300	E0316	E0328	E0329	E1399	K0739*
*** Purchase only**						

Note: *Procedure code E1399 may be used for reflux slings only.*

The purchase of a safety enclosure frame, canopy, or bubble top (procedure code E0316) may be a benefit when the protective crib top or bubble top is for safety use. It is not considered a benefit when it is used as a restraint or for the convenience of family or caregivers.

Procedure code E0316 may be used in conjunction with procedure codes E0300, E0328, or E0329 to request a pediatric fully-enclosed bed with a canopy.

Enclosed bed systems that are not approved by the Food and Drug Administration (FDA) are not a covered benefit.

Reflux slings or wedges may be considered for clients who are birth through 11 months of age. Reflux slings or wedges may be used as positioning devices for infants who require elevation after feedings when prescribed by a physician as medically necessary and appropriate.

Procedure code E0190 with modifier UD must be used to bill the purchase of reflex wedges and positional devices (positioning pillows and cushions). This code and modifier will require manual pricing. Procedure code E0190 is limited to once per three years, per client, any provider.

Procedure code K0739 may be reimbursed for the repair of equipment.

2.6.12.2 Prior Authorization and Documentation Requirements

Prior authorization is required for all DME and services provided through CCP, including any accessories, modifications, adjustments, replacements, and repairs to the equipment.

To be considered for prior authorization, the provider must include all of the following to support medical necessity:

- The diagnosis, medical needs, treatments, developmental level, and functional skills of the child. A diagnosis alone is insufficient information to consider prior authorization of the requested equipment.
- The age, length, and weight of the child.
- A description of any other devices that have been used, the length of time used, and why they were ineffective.
- How the requested equipment will correct or ameliorate the client's condition beyond that of a standard child's crib, regular bed, or standard hospital bed.
- The name of the manufacturer and the manufacturer's suggested retail price (MSRP).

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A determination will be made by HHSC or its designee whether the equipment will be rented, purchased, repaired, or modified based on the client's needs, duration of use, and age of equipment. All modifications, adjustments, and repairs within the first six months after delivery are considered to be part of the purchase price.

2.6.12.2.1 Hospital Beds and Safety Enclosure

Pediatric hospital beds and pediatric cribs (procedure codes E0300, E0316, E0328, and E0329) may be considered for prior authorization when the documentation submitted clearly shows that the requested bed or crib will correct or ameliorate the client's condition. The documentation must meet at least one of the following criteria:

- The client's medical condition requires positioning of the body in ways that are not feasible in an ordinary bed, including, but not limited to, the need for positioning to alleviate pain.
- The head of the bed must be elevated 30 or more degrees most of the time due to, but not limited to, congestive heart failure, chronic pulmonary disease, or problems with aspiration, and alternative measures, such as wedges or pillows, have been attempted but have failed to manage the client's medical condition.

  Note: *Texas Medicaid defines a failed measure as having no clinically significant improvement after being introduced.*

- The client requires traction equipment that can only be attached to a hospital bed.

A semi-electric or fully electric hospital bed (procedure code E0329) may be considered for prior authorization when the submitted documentation shows that the client has a medical condition that requires frequent changes in body position or might require an immediate change in body position to avert a life-threatening situation.

The safety enclosure frame, canopy, or bubble top may be considered for prior authorization with documentation that the protective canopy top or bubble will provide for the client's safety. Prior authorization will not be considered when it will be used as a restraint or for the convenience of family or caregivers.

2.6.12.2.2 Positioning Devices

Reflux slings or wedges may be considered for prior authorization for clients who are 11 months of age and younger. These may be used as positioning devices for infants who require the head of the bed or crib to be elevated greater than 30 degrees after feedings when prescribed by a physician as medically necessary and appropriate.

Positioning pillows and cushions may be considered for prior authorization with documentation of medical necessity that indicates the item will provide for or assist in the positioning needs of the client to maintain proper body alignment and skin integrity. Documentation must include what other devices have been used previously and why they proved to be ineffective.

Items used for PT or rehabilitation in the home are provided by the therapist. Requests for authorization for these purposes will not be considered.

2.6.12.2.3 Repair or Replacement

Repairs require replacement of components that are no longer functional. Technician fees are considered to be part of the cost of the repair.

Repairs to client-owned equipment may be considered with documentation of medical necessity.

Providers are responsible for maintaining documentation in the client's medical record specifying the repairs and supporting medical necessity.

Rental equipment may be considered during the period of repair. Routine maintenance of rented equipment is the provider's responsibility.

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Pediatric hospital cribs and beds, enclosed beds, and safety enclosure frames, canopies, or bubble tops that have been purchased are anticipated to last a minimum of five years.

Prior authorization for replacement may be considered within five years of purchase if one of the following occurs:

- There has been a significant change in the client's condition such that the current equipment no longer meets the client's needs.
- The equipment is no longer functional and cannot be repaired or it is not cost effective to repair.

Replacement equipment may also be considered if loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent reoccurrence must be submitted.

2.6.13 Phototherapy Devices

2.6.13.1 Services, Benefits, and Limitations

The rental of phototherapy devices (procedure code E0202) for use in the home are a benefit of Texas Medicaid for low-risk infants.

Low-risk infants are 35 or more weeks gestation at birth, without comorbidity, and with a total serum bilirubin (TSB) level within the following ranges:

Infant's Gestation at Birth	TSB for infant 0-24 hours of age*	TSB for infant 25-48 hours of age*	TSB for infant 49-72 hours of age*	TSB for infant older than 72 hours of age*
35–37 weeks	3–7	7–13	10–15	13–18
38 weeks or greater	6–11	12–15	15–18	18–21

*** Infant age when TSB level is drawn.**
TSB levels are expressed in milligrams per deciliter (mg/dl).

The DME provider must perform routine maintenance and provide instructions to the parent or guardian on the safe use of the phototherapy device. Rental of a phototherapy device is reimbursed as a daily global fee and is limited to one per day, per client, any provider.

Providers may not bill for those days the phototherapy device is at the client's home and is not in use.

Skilled nursing (SN) visits for clients requiring phototherapy services may be reimbursed separately through Title XIX Home Health Services for nonroutine clinical teaching and assessment. Routine laboratory specimens are obtained during the SN visit, and may only be considered when the alternative to obtaining the specimen is to transport the client by ambulance.

If a client who is receiving PDN services requires phototherapy, instructions in the use of the equipment must be part of the existing PDN authorized hours. SN visits will not be allowed on the same day as PDN services.

In accordance with American Academy of Pediatrics (AAP) guidelines, providers must conduct ongoing assessments for risk of severe hyperbilirubinemia for all infants who receive home phototherapy.

Initiation of home phototherapy for medium- and high-risk infants is not a benefit of Texas Medicaid. As defined by the AAP, medium- and high-risk infants should be considered for more extensive initial treatment in an inpatient setting. Medium- and high-risk infants include, but are not limited to, those who have one of the following known risk factors:

- Acidosis
- Albumin less than 3.0 g/dl

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- Asphyxia
- Glucose-6-phosphate dehydrogenase (G6PD) deficiency
- Isoimmune hemolytic disease (blood group incompatibility)
- Jaundice within the first 24 hours
- Sepsis
- Significant lethargy
- Temperature instability

2.6.13.2 Prior Authorization and Documentation Requirements

Home phototherapy devices require prior authorization and are provided only for the days that are medically necessary.

For low-risk infants, prior authorization will be considered for phototherapy services that begin in the home.

For stabilized infants who began phototherapy treatment during their hospitalization and have been discharged from the hospital, prior authorization will be considered for the continuation of phototherapy services in the home. Initial prior authorization may be given for a maximum of seven days of home phototherapy. A new "CCP Prior Authorization Request Form" must be submitted to request more than seven days of home phototherapy.

The following documentation is required to support medical necessity when requesting home phototherapy services:

- A diagnostic evaluation, which must include, but is not limited to, a normal history and physical exam, and normal laboratory values for the following, as medically indicated:
  - Complete blood count with differential
  - Platelets
  - Blood smear for red blood cell morphology
  - Reticulocyte count
  - Urinalysis
  - Maternal and infant blood typing
  - Coombs test
- TSB level (in mg/dl)
- Gestational age
- Documentation of adequate infant hydration, as demonstrated by 4-6 wet diapers per day and 3-4 stools per day
- Documentation stating that infant weight loss does not exceed 10 percent of the infant's birth weight
- Physician's plan of care
- Anticipated number of days the client will need the phototherapy treatment
- Documentation of parental education regarding the importance of monitoring and follow-up

When requesting prior authorization for a hospitalized infant that requires continued home phototherapy, providers must submit documentation that indicates all pre-existing medium- or high-risk factors have resolved or stabilized.

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Providers must submit the following additional documentation for prior authorization requests for previously hospitalized infants that require continued home phototherapy or for more than seven days of home phototherapy:

- TSB level greater than 13 mg/dl and trending downward. TSB levels less than 13 will require medical review to determine medical necessity.

  Note: *According to AAP guidelines, phototherapy may be discontinued when the TSB level falls below 13–14 mg/dl; however, exceptions to the guidelines may be considered. As a result, documentation must include the rationale for not discontinuing phototherapy when the TSB level drops below 13 mg/dl.*

- Birth weight and current weight demonstrating weight gain.

  Note: *According to AAP guidelines, breast-fed infants are expected to gain 15-30 grams per day (1/2-1 ounce per day) through the first 2-3 months of life.*

2.6.13.2.1 Retroactive Eligibility

Newborn babies may not have a Medicaid number at the time that services are ordered by the physician and provided by the supplier. In these cases, prior authorization may be given retroactively for services rendered between the start date and the date that the client's Medicaid number becomes available.

- The provider is responsible for finding out the effective dates of client eligibility.
- The provider has 95 days from the date on which the client's Medicaid number becomes available (add date) to obtain prior authorization for services that were already rendered.

2.6.14 Special Needs Car Seats and Travel Restraints

2.6.14.1 Services, Benefits, and Limitations

2.6.14.1.1 Special Needs Car Seats

A special needs car seat must have a top tether installed. The top tether is essential for proper use of the car seat. The installer is reimbursed for the installation by the manufacturer.

Providers must use procedure code E1399 for a special needs car seat.

Car seat accessories available from the manufacturer may be considered for reimbursement with prior authorization when medically necessary for correct positioning.

A stroller base for a special needs car seat is not a benefit of Texas Medicaid.

2.6.14.1.2 Travel Safety Restraints

Providers must use procedure code E0700 for the purchase of travel safety restraints, such as ankle and wrist belts.

2.6.14.2 Prior Authorization and Documentation Requirements

2.6.14.2.1 Special Needs Car Seats

A special needs car seat may be considered for reimbursement with prior authorization for a client who has outgrown an infant car seat and is unable to travel safely in a booster seat or seat belt. Consideration must be given to the manufacturer's weight and height limitations and must reflect allowances for at least 12 months of growth.

The provider must maintain a statement that has been signed and dated by the client's parent or legal guardian in the client's medical record that states the following:

- A top tether has been installed in the vehicle in which the client will be transported, by a manufacturer-trained vendor.
- Training in the correct use of the car seat has been provided by a manufacturer-trained vendor.

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- The client's parent or legal guardian has received instruction and has demonstrated the correct use of the car seat to a manufacturer-trained vendor.

To request prior authorization for a special needs car seat or accessories, the following documentation must be provided:

- The client's weight must be at least 40 pounds, or the client's height must be at least 40 inches.
- Supporting documentation must include the following and must be submitted for prior authorization:
  - Accurate diagnostic information pertaining to the underlying diagnosis or condition as well as any other medical diagnoses or conditions, to include the client's overall health status.
  - A description of the client's postural condition specifically including head and trunk control (or lack of control) and why a booster chair or seatbelt will not meet the client's needs (the car seat must be able to support the head if head control is poor).
  - The expected long-term need for the special needs car seat.
  - A copy of the manufacturer's certification for the installer's training to insert the specified car seat.

A request for a client who does not meet the criteria may be considered on a case-by-case basis on review by HHSC or its designee.

2.6.14.2.2 Travel Safety Restraints

A travel safety restraint and ankle or wrist belts may be considered for reimbursement through CCP without prior authorization for clients with a medical condition requiring them to be transported in either a prone or supine position. The DME provider and the prescribing physician familiar with the client must maintain documentation in the client's medical record supporting the medical necessity of the travel safety restraint.

2.6.15 Total Parenteral Nutrition (TPN)

2.6.15.1 Services, Benefits, and Limitations

In-home TPN is a benefit of CCP for clients who require short-term or long-term nutritional support. Covered services must be medically necessary and prescribed by the physician.

Parenteral nutrition solution, supplies, and infusion pumps services may be reimbursed with the following procedure codes:

Procedure Codes									
Solution Procedure Codes									
B4164	B4168	B4172	B4176	B4178	B4180	B4185	B4189	B4193	B4197
B4199	B4216	B5000	B5100	B5200					
Supply Procedure Codes									
B4220	B4222	B4224	B9999						
Infusion Pump Procedure Codes									
B9004	B9006								

If the solutions and additives are shipped and not used because of the client's loss of eligibility, change in treatment, or inpatient hospitalization, then no more than a one-week supply of solutions and additives will be reimbursed. Any days on which the client is an inpatient of a hospital or other medical

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facility or institution will be excluded from the daily billing. Payment for partial months will be prorated based upon the actual days of administration. The administration of intravenous fluids and electrolytes cannot be billed as in-home TPN.

A backpack or carrying case for a portable infusion pump may be a benefit when it is medically necessary and must be billed using procedure code B9999.

The infusion pump may be rented once a month or purchased once every five years.

2.6.15.2 Prior Authorization and Documentation Requirements

Prior authorization is required for TPN solutions, lipids, supply kits, and infusion pumps that are provided through CCP. Renewal of the prior authorization will be considered on the basis of medical necessity.

TPN solutions, lipids, supply kits, and infusion pumps will be considered for the prior authorization of short-term or long-term nutritional therapy for clients who are CCP-eligible when documentation submitted clearly shows that it is medically necessary and will correct or ameliorate the client's disability or physical or mental illness or condition. Documentation must include the following:

- Conditions that result in a loss of function of the gastrointestinal (GI) tract and the inability to obtain adequate nutrition by the enteral route, such as:
  - Infections of the pancreas, intestines, or other body organs that result in a loss of GI function
  - Inflammatory bowel disease
  - Necrotizing enterocolitis
  - Malnutrition
  - Trauma
  - Overwhelming systemic infections
  - Serious burns
- Conditions that result in an inability of the bowel to absorb nutrition, such as:
  - Extensive bowel resection
  - Severe, advanced bowel disease. Examples include short bowel syndrome (SBS), chronic intestinal pseudo-obstruction (CIPS), Hirshprungs disease (HD), Crohn's disease, and ulcerative colitis
- Prematurity
- Leukemias
- Congenital gastrointestinal anomalies
- Acquired immunodeficiency syndrome

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 and supplies requested. The physician must also maintain documentation of medical necessity in the client's medical record.

Prior authorization requests for TPN must include the following information:

- Medical condition for which TPN is necessary
- Documentation of any trials with oral and enteral feedings
- Percent of daily nutritional needs from TPN

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- A copy of the TPN formula or prescription that includes amino acids and lipids and is signed and dated by the physician
- A copy of the most recent laboratory results that includes potassium, calcium, liver function studies, and albumin

Note: *Conditions or durations of need that are not listed above may be considered by HHSC or its designee with documentation of medical necessity.*

Prior authorization requests for a portable parenteral nutrition infusion pump (procedure code B9004) must also include documentation of medical necessity that demonstrates at least one of the following:

- The client requires continuous feedings.
- Feeding intervals exceed the time that the client must be away from home to:
  - Attend school or work
  - Participate in extensive, physician-ordered outpatient therapies
  - Attend frequent, multiple, medical appointments

Prior authorization for parenteral nutrition infusion pumps are limited to one portable pump (procedure code B9004) or one stationary pump (procedure code B9006) at any one time, unless medical necessity for two infusion pumps is established. Supporting documentation for the additional pump must be included with the prior authorization request.

Prior authorization requests for miscellaneous procedure code B9999 must include the following:

- A detailed description of the requested item or supply
- Documentation that supports the medical necessity of the requested item or supply

Requests for a backpack or carrying case for the portable infusion pump will be considered for prior authorization under miscellaneous code B9999, if the clients meet the medical necessity criteria for the portable pump that are outlined above. The following criteria also apply:

- The client is ambulatory or uses a wheelchair that will not support the use of a portable pump by other means, such as an intravenous (IV) pole.
- The portable enteral feeding pump is client-owned.

The requesting provider may be asked for additional information to clarify or complete a request for TPN services.

Retrospective review may be performed to ensure that the documentation supports the medical necessity of the TPN services.

2.6.16 Vitamin and Mineral Products

2.6.16.1 Services, Benefits, and Limitations

Vitamin and mineral products prescribed or ordered by a physician to treat various conditions are a benefit of Texas Medicaid through CCP for clients who are 20 years of age and younger.

Vitamin and mineral products must be submitted with procedure code A9152 or A9153, the appropriate modifier, and the corresponding National Drug Code. Units must be based on the quantity dispensed, for up to a 30-day supply.

Note: *It is acceptable for providers to bill in excess of a 30-day supply when billing for liquid formulations due to variances in container size.*

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.

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Providers must dispense the most cost-effective product prescribed in accordance with a prescription from a licensed physician. Organic products will not be reimbursed unless medical documentation is provided to substantiate the need for that formulation.

The following vitamin and mineral products may be a benefit when submitted with the corresponding procedure code and state-identified modifier:

Vitamin or Mineral	Procedure Code	State-Identified Modifier
Beta-carotene	A9152	U1
Vitamin A (retinol)	A9152	U1
Biotin	A9152	U2
Boric acid	A9152	U3
Copper	A9152	U3
Iodine	A9152	U3
Phosphorus	A9152	U3
Zinc	A9152	U3
Calcium	A9152	U4
Chloride	A9152	U5
Iron	A9152	U6
Magnesium	A9152	U7
Vitamin B1 (thiamin)	A9152	U8
Vitamin B2 (riboflavin)	A9152	U8
Vitamin B3 (niacin)	A9152	U8
Vitamin B5 (pantothenic acid)	A9152	U8
Vitamin B6 (pyridoxine, pyridoxal 5-phosphate)	A9152	U8
Vitamin B9 (folic acid)	A9152	U8
Vitamin B12 (cyanocobalamin)	A9152	U8
Vitamin C (ascorbic acid)	A9152	U9
Vitamin D (ergocalciferol)	A9152	UA
Vitamin E (tocopherols)	A9152	UB
Vitamin K (phytonadione)	A9152	UC
Multiminerals	A9153	U1
Multivitamins	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.*

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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
Boric acid	Recalcitrant vulva vaginitis
Calcium	Calcium deficiency
	Disorders of calcium metabolism
	Chronic renal disease
	Pituitary dwarfism, isolated growth hormone deficiency
	Hypocalcemia and hypomagnesaemia of the newborn
	Intestinal disaccharidase deficiencies and disaccharide malabsorption
	Allergic gastroenteritis and colitis
	Hypocalcemia due to use of Depo-Provera contraceptive injection
Chloride	Hypochloremia
	Hypercapnia with mixed acid-base disorder
	Bronchopulmonary dysplasia
Copper	Disorders of copper metabolism
Iodine	Iodine deficiency
	Simple and unspecified goiter and nontoxic nodular goiter
Iron	Disorders of iron metabolism
	Iron deficiency anemia
	Sideroachrestic anemia
Magnesium	Magnesium deficiency
	Hypoparathyroidism
Phosphorus	Disorders of phosphorus metabolism
Vitamin A (retinol)	Vitamin A deficiency
	Intestinal malabsorption
	Disorders of the biliary tract
	Cystic fibrosis
Vitamin B1 (thiamin)	Vitamin B1 deficiency
	Disturbances of branched-chain amino-acid metabolism (e.g., maple syrup urine disease)
	Disorders of mitochondrial metabolism
	Wernicke-Korsakoff syndrome

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Vitamin or Mineral	Condition
Vitamin B2 (riboflavin)	Vitamin B2 deficiency
	Disorders of fatty acid oxidation
	Riboflavin deficiency, ariboflavinosis
	Disorders of mitochondrial metabolism
Vitamin B3 (niacin)	Vitamin B3 deficiency
	Disorders of lipid metabolism, (e.g., pure hypercholesterolemia)
Vitamin B5 (pantothenic acid)	Vitamin B5 deficiency
Vitamin B6 (pyridoxine, pyridoxal 5-phosphate)	Vitamin B6 deficiency
	Sideroblastic anemia
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
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
Vitamin C (ascorbic acid)	Vitamin C deficiency
	Anemia due to disorders of glutathione metabolism
	Disorders of mitochondrial metabolism
Vitamin D (ergocalciferol)	Vitamin D deficiency
	Galactosemia
	Glycogenosis
	Disorders of magnesium metabolism
	Intestinal malabsorption
	Chronic renal disease
	Cystic fibrosis
	Disorders of phosphorus metabolism
	Hypocalcemia
	Disorders of the biliary tract
	Hypoparathyroidism
	Intestinal disaccharidase deficiencies and disaccharide malabsorption
	Allergic gastroenteritis and colitis

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Vitamin or Mineral	Condition
Vitamin E (tocopherols)	Vitamin E deficiency
	Inflammatory bowel disease (e.g., Crohn's, granulomatous enteritis, 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
	Hypoprothrombinemia of the newborn
	Hemorrhagic disease of the newborn
	Intestinal malabsorption
	Acquired coagulation factor deficiency
	Cystic fibrosis
	Disorders of the biliary tract
	Chronic liver disease
Zinc	Zinc deficiency
	Wilson's disease
	Acrodermatitis enteropathica
Multi-minerals	Other and unspecified protein-calorie malnutrition
Multi-vitamins	Cystic fibrosis
	Other and unspecified protein-calorie malnutrition
Trace elements	Mineral deficiency

2.6.16.2 Prior Authorization and Documentation Requirements

Prior authorization for vitamin and mineral products must be requested using the CCP Prior Authorization Request Form. Requests for prior authorizations must be submitted and approved before the date of dispensing the vitamin or mineral products. Prior authorization requests for vitamin and mineral products that are initiated before the date of the physician's order will not be approved.

The following documentation must be submitted with the prior authorization request:

- A physician's prescription with the name of the vitamin or mineral product, dosage, frequency, duration, and route of administration
- The MSRP or average wholesale price (AWP), whichever is applicable, or the provider's documented invoice price
- The calculated price per dose
- Documentation that supports the medical necessity of the requested vitamin or mineral

The following sample tables, taken from the CCP 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

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HCPCS Code	Brief Description of Requested Services	Retail Price
A9152 UA	Vitamin D (ergocalciferol) 10 ml bottle (8000 units/ml)	$40.00/bottle
	Dose: 400 units (0.05 ml)	$0.20/dose
	Route: PO	
	Frequency: QD	
Note: *HCPCS codes and descriptions must be provided.*		

- Example 2: Multivitamin Tablets

HCPCS Code	Brief Description of Requested Services	Retail Price
A9153 U2	Centrum Kids (80 tablets/bottle)	$8.99/bottle
	Dose: 1 tablet	$0.11/dose
	Route: PO	
	Frequency: QD	
Note: *HCPCS codes and descriptions must be provided.*		

Prior authorization requests for products, conditions, or quantities other than those described in the "Benefits" section of this handbook will be considered on a case-by-case basis after review by the medical director. Providers must submit documentation that the prescribed products are for a medically accepted indication. Documentation must include one of the following:

- FDA approval
- The use is supported by one or more citations that are included or approved for inclusion in the following compendia:
  - The American Hospital Formulary Service Drug Information
  - The United States Pharmacopoeia-Drug Information (or its successor publications)
  - The DRUGDEX Information System
  - Two articles from major medical peer-reviewed literature that demonstrate validated, uncontested data for the use of the agent in a specific medical condition that is safe and effective

Prior authorization of vitamin and mineral products may be granted for up to six months, and for a quantity up to a 30-day supply.

Note: *Quantities in excess of these limitations may be considered when requesting liquid formulations due to variances in container size.*

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.

2.6.17 Claims Information

Claims for DME must be submitted to TMHP in an approved electronic claims 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.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in Section 6, Claims Filing (*Vol. 1, General Information*) for instructions on completing paper claims.

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2.6.18 Reimbursement

DME and expendable medical supplies are reimbursed in accordance with 1 TAC §355.8441. See the applicable fee schedule on the TMHP website at www.tmhp.com.

Providers may be reimbursed for DME either by the lesser of the provider's billed charges or the published fee determined by HHSC or through manual pricing. If manual pricing is used, the provider must request prior authorization and submit documentation of either of the following:

- The MSRP or AWP, whichever is applicable.
- The provider's documented invoice cost.

Manually priced items are reimbursed as follows as is appropriate:

- MSRP less 18 percent or AWP less 10.5 percent, whichever is applicable.
- The provider's documented invoice cost.

2.7 Early Childhood Intervention (ECI) Services

The Texas ECI Program is available statewide to all children who have been determined to be eligible for ECI services by ECI Program providers. To be eligible for ECI services, children must be 35 months of age and younger (i.e., before their third birthday) and have disabilities or developmental delays as defined by ECI criteria. Texas Medicaid covers the ECI claims for children who are Medicaid clients.

All health-care professionals are required by federal and state regulations to refer children who are 35 months of age and younger (i.e., before their third birthday) to the Texas ECI Program as soon as possible, but no longer than 7 days after identifying a disability or suspected delay in development. Referrals can be based on professional judgment or a family's concern. A medical diagnosis or a confirmed developmental delay is not required for referrals.

To refer families for services, providers can call their local ECI program, or they can call the Department of Assistive and Rehabilitative Services (DARS) Inquiry Line at 1-800-628-5115. For additional ECI information, providers can visit the DARS website at www.dars.state.tx.us/ecis. Persons who are hearing-impaired can call the TDD/TTY line at 1-866-581-9328.

2.7.1 Enrollment

DARS contracts with local ECI providers to take referrals, determine clients' eligibility for the Texas ECI Program, and provide services to ECI-eligible children and their families. ECI providers must be contracted with the Texas ECI Program and must comply with all of the applicable federal and state laws and regulations that govern the Texas ECI Program.

ECI providers are eligible to enroll as Texas Medicaid ECI providers to render services to eligible Medicaid clients. After providers meet the criteria of the Texas ECI Program, they must complete a Medicaid application.

To participate in Texas Medicaid, an ECI provider must be certified by the Texas ECI Program and must submit a copy of the current contract award from the Texas ECI Program.

Refer to: Subsection 1.1, "Provider Enrollment and Reenrollment" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about the procedures for enrolling as a Medicaid provider.

2.7.2 Services, Benefits, Limitations, and Prior Authorization

ECI services are usually provided in the client's natural environments, which are defined as settings that individual families identify as natural or normal for their family, including the home, neighborhood, and community settings in which children without disabilities participate. ECI services may be provided in the following places of service (POS): office/facility (POS 1), home (POS 2), and other locations (POS 9).

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The Texas ECI Program uses evaluations and assessments to determine eligibility. Clients are eligible for ECI if they are 35 months of age and younger and have a developmental delay, a medically diagnosed condition that has a high probability of resulting in developmental delay, or an auditory or visual impairment as defined by the Texas Education Agency.

Under the Texas ECI Program, families and professionals work together to develop an Individualized Family Service Plan (IFSP) which is based on the unique needs of the client and the client's family. The IFSP serves as the authorization for the services and documents the medical necessity for the services.

A single identified need and treatment goal (outcome on the (IFSP)) may be addressed by more than one discipline. Documentation of service provision must demonstrate the application of discipline specific knowledge (i.e., OT, PT, ST, SST) for each of the services provided.

ECI services must be provided as stated in 40 TAC, Part 2, Chapter 108.

Refer to: Texas Administrative Code, Title 40 (40 TAC), Part 2, Chapter 108, Subchapter H.

2.7.2.1 Therapy

Providers may submit claims for therapy services that are included in the client's IFSP.

A client may receive a combination of PT, OT, ST, or specialized skills training (SST) in the home or community setting when the IFSP indicates necessity for two services to be provided at the same time and the parent(s) have agreed on the two services being provided at the same time.

PT, OT, and ST equipment and supplies used during therapy visits are included in the therapy visit and are not reimbursed separately.

2.7.2.1.1 Occupational Therapy (OT)

OT procedure codes must be submitted with modifier GO.

The following procedure codes must be submitted in 15-minute increments:

OT Procedure Codes									
97032	97033	97034	97035	97036	97110	97112	97113	97116	97124
97140	97530	97535	97542	97750	97760	97761	97762		

The following procedure codes are limited to once per date of service, for each therapy type (PT and OT):

OT Procedure Codes								
97012	97014	97016	97018	97022	97024	97026	97028	97150

OT includes services that address the functional needs of a client that are related to adaptive development, adaptive behavior and play, and sensory, motor, and postural development. These services are designed to improve the client's functional ability to perform tasks in the home and community settings.

- All services must be delivered according to §454.213 of the Texas Occupations Code.
- Occupational therapist services must be identified on the IFSP and prescribed by a physician.
- Occupational therapist services may be performed in an individual or group setting.
- Occupational therapist services may be provided in an outpatient, home, or other natural environment setting.

Occupational therapist services are provided by an ECI provider. The ECI provider ensures that occupational therapist services are performed by one of the following:

- A licensed occupational therapist who meets the requirements of 42 CFR §440.110(b).

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- A certified occupational therapist assistant (COTA) when the assistant is acting under the direction of a licensed occupational therapist in accordance with 42 CFR §440.110 and all other applicable state and federal laws.

2.7.2.1.2 Physical Therapy (PT)

PT procedure codes must be submitted with modifier GP.

The following PT procedure codes may be reimbursed for therapy services and must be submitted in 15-minute increments:

PT Procedure Codes									
97032	97033	97034	97035	97036	97110	97112	97113	97116	97124
97140	97530	97535	97542	97750	97760	97761	97762		

The following procedure codes are limited to once per date of service, for each therapy type (PT and OT):

PT Procedure Codes								
97012	97014	97016	97018	97022	97024	97026	97028	97150

PT includes services that address the promotion of sensory and motor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation.

- All services must be delivered according to 22 TAC Part 16, Chapter 322, §322.1(a)(2)(A).
- Physical therapist services must be identified on the IFSP and prescribed by a physician.
- Physical therapist services may be performed in an individual or group setting.
- Physical therapist services may be provided in an outpatient, home, or other natural environment setting.

Physical therapist services are provided by an ECI provider. The ECI provider ensures that physical therapist services are performed by one of the following:

- A licensed physical therapist who meets the requirements of 42 CFR §440.110(a).
- A licensed PT assistant (LPTA) when the assistant is acting under the direction of a licensed physical therapist in accordance with 42 CFR §440.110 and all other applicable state and federal laws.

2.7.2.1.3 Speech Therapy (ST)

ST procedure codes must be submitted with modifier GN.

The following ST procedure codes may be reimbursed for therapy services and must be submitted in 15-minute increments:

ST Procedure Codes		
92507	92508	92526

Speech and language therapy includes services designed to promote rehabilitation and remediation of delays or disabilities in language-related symbolic behaviors, communication, language, speech, emergent literacy, or feeding and swallowing behavior.

- All services must be delivered according to §401.001(6) of the Texas Occupations Code.
- ST services must be identified on the IFSP.
- ST services may be performed on an individual or group setting.

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- ST services may be provided in an outpatient setting, home, or other natural environment setting.

ST services are provided by an ECI provider. The ECI provider ensures that ST services are performed by one of the following:

- A licensed SLP who meets the requirements of 42 CFR §440.110(c) and all other applicable state and federal law.
- A licensed assistant in speech language pathology when the assistant is acting under the direction of a licensed SLP in accordance with 42 CFR §440.110.
- A licensed intern when the intern is acting under the direction of a licensed SLP in accordance with 42 CFR §440.110 and all other applicable state and federal law.

2.7.2.2 Specialized Skills Training (SST)

SST is a rehabilitative service that promotes age-appropriate development by providing skills training to correct deficits and teach compensatory skills for deficits that directly result from medical, developmental, or other health-related conditions.

- SST services must be provided as stated in 40 TAC, Part 2, Chapter 108, Subchapter E. Documentation of each SST visit must comply with 40 TAC, Part 2, Chapter 108, Subchapter E, §108.501.
- SST services must be identified on the IFSP and have been recommended by a licensed practitioner of the healing arts (as defined in 40 TAC, Part 2, Chapter 108, Subchapter A, §108.103).
- SST services may be performed in an individual or group setting.
- Services must include all the following:
  - Be designed to create learning environments and activities that promote the client's acquisition of skills in one or more of the following developmental areas: physical or motor, communication, adaptive, cognitive, and social or emotional.
  - Include skills training and anticipatory guidance for family members, or other significant caregivers, to ensure effective treatment and to enhance the client's development.
  - Be provided in the client's natural environment, as defined in 34 CFR Part 303, unless the criteria listed at 34 CFR §303.167 are met and documented in the client's record.
  - In addition to the criteria noted above, services performed in a group must include all the following:
    - Recommended by the interdisciplinary team and documented on the IFSP, only when participation in the group will assist the client reach the outcomes in the IFSP.
    - Planned as part of an IFSP that also contains individual services.
    - Be limited to no more than four clients and their parent(s) or other significant caregiver(s).

Documentation of each specialized skilled training contact must include the following:

- Name of the client
- Name of the ECI contractor and Early Intervention Specialist
- Date, start time, length of time, and place of service (POS)
- Method (individual or group)
- A description of the contact including a summary of activities and the family or primary caregiver's level of involvement
- The IFSP outcome(s) that was the focus of the intervention
- The client's progress toward the identified IFSP outcome(s)

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- Relevant new information about the client provided by the family or other routine caregiver
- The early intervention specialist's signature

Providers must submit procedure code T1027 for SST services, which are billed in 15-minute increments. Providers must submit procedure code T1027 when services are performed in a group setting or T1027 with modifier U1 when performed in an individual setting.

SST services are provided by an ECI provider. The ECI provider ensures that SST services are provided by an early intervention specialist who meets the criteria established in 40 TAC Part 2, Chapter 108, Subchapter C, §108.313.

2.7.2.3 Targeted Case Management (TCM)

Targeted Case Management (TCM) services are provided to help eligible clients gain access to needed medical, social, educational, developmental, and other appropriate services.

Providers may perform and submit claims for TCM services after the client's ECI eligibility has been established. The IFSP does not have to be completed before providers may perform TCM services and submit claims to Texas Medicaid.

DARS provides additional guidance to ECI contractors about requirements for including ongoing case management services on the IFSP.

Providers must use procedure code T1017 when billing for TCM services, which are billed in 15-minute increments.

TCM services may be delivered face-to-face or by telephone. Providers must use procedure code T1017 for telephone interaction and T1017 with modifier U1 for face-to-face interaction. The POS is determined by the service coordinator's location at the time the service is rendered.

Claims may be submitted to Texas Medicaid when the interaction is with the client or the client's parent(s) (as defined in 10 United States Code (U.S.C.) §1401) or other routine caregiver(s), or occurs in the presence of the client or the client's parent(s) or other routine caregiver.

Providers may contact other individuals to help eligible clients gain access to needed medical, social, educational, developmental, and other appropriate services, to help identify the eligible client's needs, to assist the eligible client in obtaining services and to receive useful feedback and alert the service coordinator to changes in the eligible client's needs. These contacts must be documented in the client's record, but claims may not be submitted to Texas Medicaid for reimbursement unless the contacts occur in the presence of the client and the client's parent(s) or other routine caregiver.

TCM must be provided as stated in 40 TAC, Part 2, Chapter 108, Subchapter D.

All documentation must be retained in the client's record and available upon request. The documentation must be in compliance with 40 TAC, Part 2, Chapter 108, Subchapter D, §108.415.

TCM services are provided by an ECI provider. The ECI provider ensures that TCM services are provided by a service coordinator who meets the criteria established in 40 TAC Part 2, Chapter 108, Subchapter C, §108.315.

2.7.3 Documentation Requirements

All ECI services require documentation to support the medical necessity of the services rendered. ECI services are subject to retrospective review and recoupment if documentation does not support the service that was submitted.

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2.7.4 Claims Filing and Reimbursement

2.7.4.1 Claims Information

Claims for ECI therapy, SST, and TCM services that have been rendered by an ECI provider must be submitted to TMHP in an approved electronic format or on 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. 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.

Claims for ECI services must include the ECI provider identifier and EC1 benefit code.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Subsection 6.1, "Claims Information" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*) to find the instructions for completing paper claims.

Subsection 2.2, "Fee-for-Service Reimbursement Methodology"in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

2.7.4.1.1 Billing Units Based on 15 Minutes

All claims for reimbursement 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 to the nearest quarter hour.

The following table shows the time intervals for 1 through 8 units:

Units	Number of Minutes
0 units	0 minutes through 7 minutes
1 unit	8 minutes through 22 minutes
2 units	23 minutes through 37 minutes
3 units	38 minutes through 52 minutes
4 units	53 minutes through 67 minutes
5 units	68 minutes through 82 minutes
6 units	83 minutes through 97 minutes
7 units	98 minutes through 112 minutes
8 units	113 minutes through 127 minutes

2.7.4.1.2 Managed Care Clients

ECI case management and specialized skills training are carved-out of Medicaid managed care and must be billed to TMHP for payment consideration. TCM services funded by a criminal justice agency (submitted with modifier HZ) are carved-out of Medicaid managed care. Carved-out services are those that are rendered to Medicaid managed care clients but are administered by TMHP and not the client's MCO.

ECI therapies (PT/OT/ST) are not carved out and must be submitted to the managed care organization (MCO) that administers the client's managed care benefits.

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2.7.4.2 Reimbursement

ECI therapy, SST, and TCM services are reimbursed according to a maximum allowable fee established by HHSC. See the applicable fee schedule on the TMHP website at www.tmhp.com.

- ECI therapy services are reimbursed in accordance with 1 TAC §355.8441.
- SST services are reimbursed in accordance with 1 TAC §355.8422.
- TCM services are reimbursed in accordance with 1 TAC §355.8421.

2.8 Health and Behavior Assessment and Intervention

2.8.1 Services, Benefits, and Limitations

Health and Behavior Assessment and Intervention (HBAI) services are a benefit of Texas Medicaid for clients who are 20 years of age and younger when the services are provided by a licensed practitioner of the healing arts (LPHA) who is co-located in the same office or building complex as the client's primary care provider. These services are designed to identify the psychological, behavioral, emotional, cognitive and social factors important to prevention, treatment or management of physical health symptoms.

HBAI services are a benefit when the client meets all of the following criteria:

- The client has an underlying physical illness or injury.
- There are indications that biopsychosocial factors may be significantly affecting the treatment or medical management of an illness or an injury.
- The client is alert, oriented, and, depending on the client's age, has the capacity to understand and to respond meaningfully during the in-person evaluation.
- The client has a documented need for psychological evaluation or intervention to successfully manage his or her physical illness, and activities of daily living.
- The assessment is not duplicative of other provider assessments.

HBAI services that include the client's family are a benefit when the family member directly participates in the overall care of the client.

Family is defined as a responsible adult. This adult individual has agreed to accept the responsibility for providing food, shelter, clothing, education, nurturing, and supervision for the client. Responsible adults include, but are not limited to, biological parents, adoptive parents, foster parents, guardians, court-appointed managing conservators, and other family members by birth or marriage.

HBAI services may be reimbursed when billed with the following procedure codes:

Procedure Codes					
96150	96151	96152	96153	96154	96155

These services may be rendered by physician, nurse practitioner (NP), clinical nurse specialist (CNS), physician assistant (PA), licensed professional counselor (LPC), licensed clinical social worker (LCSW), licensed marriage family therapist (LMFT), Comprehensive Care Program (CCP) social worker, or psychologist provider in the office or outpatient setting.

LMFTs must bill with state defined modifier U8 to identify services billed.

For services that are rendered by physician, NP, CNS, or PA providers, claims must be submitted with the appropriate evaluation and management (E/M) procedure codes (99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, or 99215). A primary care provider may bill the HBAI procedure codes for an LPHA that is in the PCP's practice.

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HBAI services are limited to four 15-minute units (one hour) per day, any procedure, any provider. A unit is defined as 15 minutes of in-person evaluation time. An in-person evaluation is defined as a patient evaluation conducted by a provider who is at the same physical location as the client. These services are considered acute per rolling 180 days from the initiation of services and are limited as shown in the following table:

Procedure Codes	Limitations
96150	Limited to a maximum of four 15-minute units (one hour) per client, per rolling 180 days, any provider
96151	Limited to a maximum of four 15-minute units (one hour) per client, per rolling 180 days, any provider
96152, 96153, 96154, 96155	Limited to a maximum of sixteen 15-minute units (four hours), per client, per rolling 180 days, any provider

Rural Health Clinics and Federally Qualified Health Centers may be reimbursed for client in-person evaluation visits based on encounter rates.

For re-assessment (procedure code 96151), providers must maintain documentation in the client's medical record that details the change in the mental or medical status warranting reassessment of the client's capacity to understand and cooperate with the medical interventions that are necessary to the client's health and well-being.

Clients must be referred for psychiatric or psychological counseling as soon as the need is identified. Providers cannot use all 16 units if the need for psychiatric or psychological intervention is identified earlier.

After the initial assessment (procedure code 96150), if the client's PCP learns that the client is receiving psychiatric or psychological services from another health-care provider, the PCP should contact the health-care provider to determine whether the client is already receiving any HBAI services. If HBAI services are not being provided, the PCP may consider referring the client for a more appropriate level of psychiatric or psychological treatment.

Refer to: Subsection 6.4, "Outpatient Behavioral Health Services"in the Behavioral Health, Rehabilitation, and Case Management Services Handbook (Vol. 2, Provider Handbooks) for more information about psychological counseling services beyond the acute care limitations outlined in this section.

The initial clinical interview, reassessment, psychophysiological monitoring, observation, and intervention do not include the following:

- Conversations about educating the family or caregivers outside of the in-person evaluation sessions
- Psychotherapy

After the initial 180 days of HBAI services, the client may receive another episode of HBAI with the same medical diagnosis if there is a newly identified behavioral health issue. The client may have two episodes of HBAI per rolling year.

HBAI services are adjunct to other services and are to be used as a non-intensive means to identify specific needs. As appropriate, the client should be referred for those additional services that would meet the client's biopsychosocial needs.

2.8.2 Prior Authorization and Documentation Requirements

Prior authorization is not required for HBAI services.

Documentation is required for HBAI services to support the medical necessity of the initial assessment, reassessment, and intervention.

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For the initial assessment, documentation must support the medical necessity of the assessment and must include the following information:

- The date of initial diagnosis of physical illness
- A clear rationale for assessment
- Outcome of assessment, which includes mental status and the client's or caregiver's ability to understand and respond meaningfully
- Goals and expected duration of specifically recommended psychological intervention(s).

For reassessment, documentation must support the reassessment is necessary and include the following information:

- The date of change in mental or physical status
- Rationale for re-assessment with a clear indication of precipitating events.

For the intervention, documentation must support the necessity of the intervention and include the following information:

- Evidence that the client or caregiver has the capacity to understand and respond meaningfully,
- Clear outline of planned psychological intervention
- Goals of the psychological intervention identifying expected improvement in compliance with the medical treatment plan
- The client's response to the intervention
- Rationale for frequency and duration of acute care services

All documentation must include the amount of time spent in the HBAI assessment or intervention and must be documented in the client's medical record.

All services are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the services provided.

2.8.3 HBAI Services Provided by Psychologists

HBAI services (procedure codes 96150, 96151, 96152, 96153, 96154, and 96155) are a benefit when rendered by psychologist, provisionally licensed psychologist (PLP), or licensed psychological assistant (LPA) providers who are practicing under the direct supervision of a psychologist.

The appropriate modifier in the table below must be used to identify whether the psychologist, PLP or LPA rendered the service.

Modifier	Description
AH	Clinical psychologist
U9 (state defined)	PLP
UC (state defined)	LPA

Refer to: Section 6, "Physician, Psychologist, and Licensed Psychological Associate (LPA) Providers" in the Behavioral Health, Rehabilitation, and Case Management Services Handbook (Vol. 2, Provider Handbooks) for more information about psychologist providers.

2.8.4 Claims Information

Claims for HBAI services must be submitted to TMHP in an approved electronic claims 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.

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Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, *General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (Vol. 1, *General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in Section 6, Claims Filing (Vol. 1, *General Information*) for instructions on completing paper claims.

2.8.5 Reimbursement

Providers may refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com for reimbursement rates.

2.9 Medical Nutrition Counseling Services (CCP)

2.9.1 Enrollment

Independently practicing licensed dietitians may enroll in Texas Medicaid to provide services to CCP-eligible clients. Dieticians who provide nutrition assessments and counseling must be currently licensed by the Texas State Board of Examiners of Dietitians in accordance with the Licensed Dietitians Act, Chapter 701, Texas Occupations Code.

Refer to: Subsection 2.1.2, "Enrollment" in this handbook for more information about CCP enrollment procedures.

2.9.2 Services, Benefits, and Limitations

Medical nutrition therapy (assessment, re-assessment, and intervention) and medical nutrition counseling may be beneficial for treating, preventing, or minimizing the effects of illness, injuries, or other impairments. A case manager, school counselor, or school nurse may refer a client for medical nutrition counseling services.

Medical nutrition counseling services are a benefit when all of the following criteria are met:

- The client is 20 years of age or younger
- The client is eligible for CCP
- The services are prescribed by a physician
- The services are performed by a Medicaid-enrolled licensed dietitian
- Clinical documentation supports medical necessity and medical appropriateness
- FFP is available

Medical nutrition therapy and nutrition counseling may be considered beneficial for disease states for which dietary adjustment has a therapeutic role. Such disease states include, but are not limited to, the following conditions:

- Abnormal weight gain
- Cardiovascular disease
- Diabetes or alterations in blood glucose
- Eating disorders
- Gastrointestinal disorders
- Gastrostomy or other artificial opening of gastrointestinal tract
- Hypertension
- Inherited metabolic disorders

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- Kidney disease
- Lack of normal weight gain
- Multiple food allergies
- Nutritional deficiencies

Nutrition intervention for the following conditions is considered experimental and investigational and is not a benefit:

- Attention-deficit hyperactivity disorder
- Chemical sensitivities
- Chronic fatigue syndrome
- Idiopathic environmental intolerance

Medical nutrition counseling services for the diagnosis of obesity without a comorbid condition is not a benefit.

Medical nutrition therapy (procedure code 97802) is a more comprehensive service than medical nutrition counseling and is provided to individual clients for assessment and intervention. Procedure code 97802 is limited to one session per day and four units per rolling year.

Medical nutrition therapy (procedure code 97803) is provided to individual clients for a reassessment and intervention, after the initial assessment and intervention. Procedure code 97803 may be used for direct therapy sessions with clients. These sessions are limited to 1 session per day and 12 units per rolling year.

Nutrition assessments and re-assessments are in-depth evaluations of both objective and subjective data related to an individual's food and nutrient intake, lifestyle, and medical history. Nutrition assessments and re-assessments are performed as part of medical nutrition therapy. Nutrition assessments and re-assessments may be required as a result of a medical diagnosis and may be performed in conjunction with other therapies for treatment or as a goal to help clients make and maintain dietary changes. Documentation must include the following:

- Objective and subjective date obtained
- Height, weight, body mass index (BMI), and correlating percentiles on the growth curves
- Estimated caloric needs
- Nutritional diagnosis
- Intervention and plan
- Evaluation

Medical nutrition counseling (procedure code S9470) is provided to individual clients after an initial assessment and is less comprehensive than medical nutrition therapy. Nutritional counseling may be used to discuss the plan of care or intervention and to determine whether modifications are needed. Procedure code S9470 is limited to one visit per day and four visits per rolling year.

Medical nutrition group therapy (procedure code 97804) is not a benefit in the home setting, and does not include an individual nutrition assessment. Medical nutrition group therapy is limited to eight units per rolling year.

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Medical nutrition group therapy may be provided to a group of clients with the same condition. While medical nutrition group therapy must be led by a Medicaid-enrolled dietitian licensed by the Texas State Board of Examiners of Dietitians, other health-care providers may participate in the group sessions. The focus of the therapy is on nutrition and health for chronic conditions such as the following:

- Acquired acanthosis nigricans
- Diabetes
- Dysmetabolic syndrome X
- Eating disorder
- Hyperlipidemia
- Other specified hypoglycemia
- Pure hypercholesterolemia
- Pure hyperglyceridemia

Medical nutrition group therapy sessions must last at least 30 minutes, have a minimum of two clients and a maximum of ten clients, and must include the following:

- An age-appropriate presentation on nutrition issues related to the chronic condition. (The presentation may include information about prevention of disease exacerbation or complications and living with chronic illness. The presentation may also offer suggestions for making healthy food choices or changing ideas about food.)
- A question-and-answer period.

Client participation in medical nutrition group therapy is optional. Providers must obtain an informed consent from a client's parent or guardian before rendering services. The medical documentation maintained in a client's medical record must include the following:

- Physician prescription
- Referral, if applicable
- Location where the services were provided
- Services that were provided during medical nutrition group therapy
- Goals or objectives for the group therapy
- Client participation
- Beginning and ending time of the group therapy session

In the following table, the procedure codes in Column A will be denied as part of another service if they are submitted by any provider for the same date of service as the corresponding procedure codes in Column B:

Column A: Procedure Codes Denied When Submitted With…	Column B: Procedure Codes
S9470	97802, 97803, or 97804

Claims for medical nutrition therapy and counseling services should be submitted as follows:

Procedure Code	Time Unit	Limitation
97802 Initial assessment	15 minutes	4 units per rolling year

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Procedure Code	Time Unit	Limitation
97803 Reassessment	15 minutes	12 units per rolling year
97804 Group	30 minutes	8 units per rolling year
S9470 Dietitian visit	Per visit	1 visit per day/ 4 visits per rolling year

2.9.3 Prior Authorization and Documentation Requirements

Prior authorization is required for services that exceed the limitations for medical nutrition therapy (assessment, re-assessment, and intervention), medical nutrition group therapy, and nutrition counseling visits.

Prior authorization is also required for consideration of other health conditions that are not addressed.

The following documentation must be submitted to the CCP Prior Authorization Unit for prior authorization:

- Completed CCP Prior Authorization Request Form
- Treatment plan
- Diagnosis of a condition for which there is medical necessity for the service
- Obstacles for not meeting goals
- Interventions planned to meet goals

The prescribing physician and provider must maintain documentation of medical necessity, including the completed CCP Prior Authorization Request Form, in a client's medical record. The physician must maintain the original signed copy of the CCP Prior Authorization Request Form. The completed CCP Prior Authorization Request Form is valid for a period of up to six months from the date of the physician's signature.

2.9.4 Claims Information

Providers must submit services provided by licensed dietitians in an approved electronic claims format or on a CMS-1500 paper claim form from the vendor of their choice. TMHP does not supply the forms.

Claims for services that have been prior authorized must reflect the PAN in Block 23 of the CMS-1500 paper claim form or its equivalent.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in Section 6, Claims Filing (*Vol. 1, General Information*) for instructions on completing paper claims.

Medical Nutrition Counseling (CCP Only) on the TMHP website at www.tmhp.com for a claim form example.

2.9.5 Reimbursement

Dietitian services are reimbursed in accordance with 1 TAC §355.8441.

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2.10 Orthotic and Prosthetic Services (CCP)

2.10.1 Enrollment

To be eligible to participate in CCP, providers of orthotics and prosthetics services must be enrolled in Medicare.

Texas Medicaid enrolls and reimburses orthotic and prosthetic suppliers only for CCP services and Medicare crossovers. The information in this section is applicable to CCP services only.

Refer to: Subsection 2.1.2, "Enrollment" in this handbook for more information about CCP enrollment procedures.

2.10.2 Orthotics Services

2.10.2.1 Services, Benefits, and Limitations

Orthoses, including orthopedic shoes, wedges, and lifts, are a benefit of Texas Medicaid when provided by a licensed orthotist or a licensed prosthetist/orthotist through CCP for clients who are birth through 20 years of age.

The following orthoses and related services may be reimbursed when medical necessity criteria are met:

- Spinal orthoses and additions to spinal orthoses, including those for scoliosis
- Lower-limb orthoses and additions to lower-limb orthoses, including fracture orthoses
- Foot orthoses, including inserts, orthopedic shoes, surgical boots, heel lifts, and wedges
- Upper-limb orthoses and additions to upper-limb orthoses, including fracture orthoses
- Other orthopedic devices, including protective helmets and dynamic splints
- Repairs, replacements, and modifications
- Orthotic device training

Note: *Training in the use of an orthotic device for a client who has not worn one previously, has not worn one for a prolonged period, or is receiving a different type is a benefit when the training is provided by a physical or occupational therapist.*

Refer to: Subsection 2.14, "Therapy Services (CCP)" in this handbook for more information on physical and occupational therapy services.

As defined by the Texas State Board of Orthotics and Prosthetics the following definitions are used by Texas Medicaid:

- An orthosis is defined as: A custom-fabricated or custom-fitted medical device designed to provide for the support, alignment, prevention or correction of neuromuscular or musculoskeletal disease, injury, or deformity. The term does not include a fabric or elastic support, corset, arch support, low-temperature plastic splint, a truss, elastic hose, cane, crutch, soft cervical collar, orthosis for diagnostic or evaluation purposes, dental appliance, or other similar device carried in stock and sold by a drugstore, department store or corset shop.
- A brace is defined as: An orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body, and that allows for motion of that part. It must be a rigid or semirigid device used for the purpose of supporting a weak or deformed body part or restricting or eliminating motion in a diseased or injured body part.

To be considered for reimbursement, orthoses must be dispensed, fabricated, or modified by a licensed orthotist or licensed prosthetist/orthotist enrolled with Medicare and CCP. The following applies:

- Upper extremity customized splints made with low-temperature materials and inhibitive casting may be provided by occupational or physical therapists.

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- Other orthopedic devices addressed in the orthotic section may be provided by a Medicaid-enrolled DME vendor.
- Orthopedic shoes must be provided by a shoe vendor enrolled as a DME provider.

The date of service for a custom-made or custom-fitted orthosis is the date the supplier places an order for the equipment and incurs liability for the equipment. The custom-made or custom-fitted orthosis will be eligible for reimbursement as long as the service is provided during a month the client is eligible for Medicaid.

The following items and services are included in the reimbursement for an orthotic device and not reimbursed separately:

- Client evaluation, measurement, casting, or fitting of the orthosis.
- Repairs due to normal wear and tear during the 90 days following delivery.
- Adjustments or modifications of the orthotic device made when fitting the orthosis and for 90 days from the date of delivery (adjustments and modifications during the first 90 days are considered part of the purchase of the initial device).

Orthopedic shoes that are attached to a brace must be billed by the vendor that bills for the brace.

Reimbursement for lifts and wedges may include the cost of the prescription shoe.

2.10.2.1.1 Noncovered Orthotic Services

The following circumstances are not a benefit of Texas Medicaid:

- Orthoses whose sole purpose is for restraint
- Orthoses provided solely for use during sports-related activities in the absence of an acute injury or other indicated medical condition
- Orthotic devices prescribed by a chiropractor

Diagnoses that are not considered medically necessary include, but are not limited to, the following:

- Tired feet
- Fatigued feet
- Nonsevere bow legs
- Valgus deformity of the foot, except as outlined in the orthotic section
- Pes planus (flat feet), except when there is a coexisting medical condition as outlined in the orthotic section

Orthopedic shoes with deluxe features, such as special colors, special leathers, and special styles, are not considered medically necessary, and the features do not contribute to the accommodative or therapeutic function of the shoe.

A foot-drop splint and recumbent positioning device and replacement interface are not considered medically necessary in a client with foot drop who is nonambulatory, because there are other more appropriate treatment modalities.

A static ankle-foot orthosis (AFO) or AFO component is not medically necessary if:

- The contracture is fixed.
- The client has foot drop without an ankle flexion contracture.
- The component is used to address knee or hip positioning, because the effectiveness of this type of component is not established.

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A pneumatic thoracic-lumbar-sacral orthosis is considered experimental and investigational and is not a benefit of Texas Medicaid.

2.10.2.2 * Prior Authorization and Documentation Requirements

Prior authorization is required for all orthoses and related services.

Before submitting a request for prior authorization for orthosis, the orthosis provider must have a completed CCP Prior Authorization Form requesting the orthosis or related services that has been signed and dated by a physician who is familiar with the client. The completed CCP Prior Authorization Form must include the procedure codes and quantities for requested services. A copy of the completed, signed, and dated form must be maintained by the orthosis provider in the client's medical record. The completed CCP Prior Authorization Form with the original dated signature must be maintained by the prescribing physician in the client's medical record.

- To complete the prior authorization process electronically, the orthosis provider must complete the prior authorization requirements through any approved electronic method and retain a copy of the signed and dated CCP Prior Authorization Request form in the client's medical record at the provider's place of business.
- To complete the prior authorization process by paper, the orthosis provider must fax or mail the completed CCP Prior Authorization Request Form to the CCP prior authorization unit and retain a copy of the signed and dated CCP form in the client's medical record at the provider's place of business.

To facilitate determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation for medical necessity of the equipment and supplies requested. The physician must maintain documentation of medical necessity in the client's medical record. The provider may be asked for additional information to clarify or complete a request for the service or device.

All requests for prior authorization must include documentation of medical necessity including, but not limited to, documentation that the device is needed for one of the following *general 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 or a deformity of the affected body part.

Prior authorization requests for some types of orthosis require additional documentation. See the appropriate sections for additional documentation needed for each service.

The provider must keep the following written documentation in the client's medical record:

- The prescription for the device.
  - Orthotic devices must be prescribed by a physician (M.D. or D.O.) or a podiatrist. A podiatrist prescription is valid for conditions of the ankle and foot.
  - The prescription must be dated on or before the initial date of the requested dates of service, which can be no longer than 90 days from the signature date on the prescription.
- Accurate diagnostic information that supports the medical necessity for the requested device. A retrospective review may be performed to ensure that the documentation included in the client's medical record supports the medical necessity of the requested service or device.

A 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.

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The actual date of service is the date the supplier has placed an order for the equipment and has incurred liability for the equipment.

2.10.2.2.1 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.

2.10.2.2.2 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:

Ankle-Foot Orthoses

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.

Knee-Ankle-Foot Orthoses

KAFOs used during ambulation will be considered for prior authorization for clients with documentation that supports medical necessity for additional knee stabilization.

KAFOs that are custom-fabricated (molded-to-patient model) for ambulation will be considered for prior authorization when at least one of the following criteria is met:

- The client cannot be fit with a prefabricated AFO/KAFO.
- The condition that necessitates the orthosis is expected to be permanent or of long-standing duration (more than six months).

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- There is a need to control the knee, ankle, or foot in more than one plane.
- The client has a documented neurological, circulatory, or orthopedic status that requires custom fabrication to prevent tissue injury.
- The client has a healing fracture that lacks normal anatomical integrity or anthropometric proportions.

Reciprocating Gait Orthoses

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 PT treatment plan, and documentation that the client and family are willing to comply with the treatment plan.

2.10.2.2.3 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 of 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 PT, 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:

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.

Removable foot inserts may be covered independently of orthopedic shoes with documentation that the client has appropriate footwear into which the insert can be placed.

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A University of California at 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 with pain.
- A structural problem that results in significant pes planus, such as Down syndrome.
- Acute plantar fasciitis.

Orthopedic Shoes

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 necessary to hold a surgical correction, postoperative casting, or serial or clubfoot casting.

An orthopedic shoe may be prior authorized up to one year from the date of the surgical procedure.

Only one pair of orthopedic 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 another six months.

Requests for orthopedic shoes that do not meet the criteria listed above may be considered for prior authorization with documentation of medical necessity.

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.

2.10.2.2.4 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 the following criteria for specific orthotic devices.

2.10.2.2.5 Other Orthopedic Devices

Protective Helmets

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

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Requests for all conditions other than those listed above require submission of additional documentation that supports the medical necessity of the requested device.

Dynamic Splints

Static and dynamic mechanical stretching devices will be considered for prior authorization for a four-month rental period when the request is submitted with the following documentation:

- 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

After completion of the four-month rental period, the provider may submit a request for purchase of the static or dynamic mechanical stretching device. Requests for purchase of the static or dynamic mechanical stretching device must include documentation that the four-month rental period was successful and showed improvement in the client's condition as measured by the following:

- Demonstrated increase in range of motion
- Demonstrated improvement in the ability to complete ADLs or perform activities outside the home

2.10.2.2.6 Related Services

Repairs, Replacements, and Modifications to Orthoses

Within the guarantee of the manufacturer, providers are responsible, without charge to the client or to Texas Medicaid, for replacement or repair of equipment or any part thereof that is found to be nonfunctional because of faulty material or workmanship.

Service and repairs must be handled under any warranty coverage an item may have. If there is no warranty, providers may request prior authorization for the necessary service and repairs.

A repair because of normal wear or a modification because of growth or change in medical status will be considered for prior authorization if it proves to be more cost effective than replacing the device.

The request for repairs must include a breakdown of charges for parts and the number of hours of labor required to complete the repairs. No charge is allowed for pickup or delivery of the item or for the assembly of Medicaid-reimbursed parts. The following information must be submitted with the request:

- The description and procedure code of the item being serviced or repaired.
- The age of the item.
- The number of times the item has been previously repaired.
- The replacement cost for the item.

The anticipated life expectancy of an orthotic device is six months. Requests for prior authorization for the replacement of a device before its usual life expectancy has ended must include documentation that explains the need for the replacement.

Replacement of orthotic equipment will be considered when the item is out of warranty and repairing the item is no longer cost-effective or when loss or irreparable damage has occurred. 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.

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2.10.3 Cranial Molding Orthosis

2.10.3.1 Services, Benefits, and Limitations

Cranial molding orthosis (procedure code S1040) may be a benefit when all of the following criteria are met:

- The client is CCP eligible.
- The client is 3 through 18 months of age.
- The client requires a cranial molding orthosis as part of the treatment plan for a documented diagnosis of synostotic plagiocephaly.

The limitation for procedure code S1040 is one device per lifetime.

The definition for cosmetic, as it applies to cranial molding orthosis, includes surgery or other services used primarily to improve appearance and not to restore or correct significant deformity resulting from disease, trauma, congenital or developmental anomalies, or previous therapeutic process.

2.10.3.2 Noncovered Services

A cranial molding orthosis that is used for the treatment of positional plagiocephaly is considered cosmetic, and therefore is not a benefit of Texas Medicaid.

The effective use of a 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 Texas Medicaid.

2.10.3.3 * Prior Authorization and Documentation Requirements

Cranial molding orthoses do not require prior authorization for clients with a diagnosis of synostotic plagiocephaly. Documentation of medical necessity must be maintained in the client's medical record.

Prior authorization requests for a cranial molding orthosis for congenital conditions that are not outlined in this section may be considered by the Medical Director on a case-by-case basis with documentation of medical necessity. Additional devices beyond the once-per-lifetime benefit may be considered for prior authorization with documentation of all of the following:

- The initial device was obtained to treat synostotic plagiocephaly.
- Treatment with the device has been effective.
- The new device is needed due to growth.

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 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 an additional cranial molding orthosis.

The completed CCP Prior Authorization Form, which includes the DME must be signed and dated by the prescribing physician familiar with the client's condition. The completed CCP Prior Authorization Form must be maintained by the requesting provider and the prescribing physician. The original signature copy must be kept by the physician in the client's medical record.

2.10.4 Thoracic-Hip-Knee-Ankle Orthoses (THKAO) (Vertical or Dynamic Standers, Standing Frames, Braces, and Parapodiums)

2.10.4.1 Services, Benefits, and Limitations

THKAO (vertical or dynamic standers, standing frames or braces, and parapodiums), including all accessories, require prior authorization. A THKAO may be considered if the client requires assistance to stand and remain standing.

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2.10.4.1.1 Parapodium

A parapodium is used to help clients with neuromuscular diseases or conditions resulting in a lack of sufficient muscle power in the trunk and lower extremities to stand with their hands free. It helps develop a sense of balance and aids in learning functional movements such as standing with the hands free. A parapodium acts as an exoskeleton, providing side struts and chest, hip, knee, and foot bracing.

A parapodium may be considered for reimbursement for one of the following levels:

- *Level One:* Small Parapodium. The client has a maximum axillary height of 35 inches and a maximum weight of 55 pounds (normal age range is 1 through 10 years of age).
- *Level Two:* Medium parapodium. The client has a maximum axillary height of 41 inches and a maximum weight of 77 pounds (normal age range is 5 through 12 years of age).
- *Level Three:* Large parapodium. The client has a maximum axillary height of 45 inches and a maximum weight of 115 pounds (normal age range is 10 through 16 years of age). Labor for parapodium assembly may be prior authorized.

Procedure code E0638 must be submitted with one of the following modifiers:

- UA—Standing frame/table system, one position (e.g., upright, supine, or prone stander), any size, including pediatric, with or without wheels. Medicaid level of care 10, as defined by each state

  Note: *Use modifier UA to identify an upright or prone system stander.*

- UB—Standing frame/table system, one position (e.g., upright, supine, or prone stander), any size, including pediatric, with or without wheels. Medicaid level of care 11, as defined by each state

  Note: *Use modifier UB to identify a supine stander.*

2.10.4.1.2 Standing Frame or Brace

A standing frame or brace is used to help very young clients, who are 12 months of age and older, who have good head control in the upright position and who have a neuromuscular disease or condition resulting in a lack of sufficient muscle power in the trunk and lower extremities to stand with their hands free.

Providers must use procedure code E0638 for a standing frame or brace.

2.10.4.1.3 Vertical or Dynamic Stander

A vertical stander or dynamic stander is used to initiate standing for clients who cannot maintain a good standing posture or may never be able to stand independently. A vertical stander is used to develop weight bearing through the legs in order to decrease demineralization and to promote better body awareness. Documentation for these standers must address medical necessity for the standers to be mobile.

Providers must use procedure code E0642 for the purchase of a dynamic stander.

2.10.4.2 Prior Authorization and Documentation Requirements

THKAO (vertical or dynamic standers, standing frames or braces, and parapodiums), including all accessories, requires prior authorization.

THKAO may be considered for clients who are CCP-eligible and who require assistance to stand and remain standing when documentation submitted clearly shows that it is medically necessary and will correct or ameliorate the client's disability or physical or mental illness or condition.

Prior authorization may be considered for the THKAOs with the following documentation:

- Diagnoses relevant to the requested equipment, including functioning level and ambulatory status
- Anticipated benefits of the equipment

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- Frequency and amount of time of a standing program
- Anticipated length of time the client will require this equipment
- Client's height, weight, and age
- Anticipated changes in the client's needs, anticipated modifications, or accessory needs, as well as the growth potential of the stander

2.10.5 Prosthetic Services

2.10.5.1 Services, Benefits, and Limitations

External prostheses are a benefit of Texas Medicaid when provided by a licensed prosthetist or licensed prosthetist/orthotist through CCP for clients who are birth through 20 years of age.

The following prostheses and related services may be reimbursed when medical necessity criteria are met:

- Lower limb
- Upper limb
- Craniofacial
- External breast
- Repair, replacements, and modifications
- Prosthetic training
- Accessories to prostheses

Prosthetic training by a physical or occupational therapist for a lower limb prosthesis or an upper extremity prosthesis is a benefit for clients who have not worn one previously or for a prolonged period or who are receiving a different type.

Refer to: Subsection 2.14, "Therapy Services (CCP)" in this handbook for more information on physical and occupational therapy services.

To be considered for reimbursement, prostheses must be dispensed, fabricated, or modified by a licensed prosthetist or licensed prosthetist/orthotist enrolled with Medicare and CCP.

The date of service for a custom-made or custom-fitted prosthesis is the date the supplier places an order for the equipment and incurs a liability for the equipment. The custom-made or custom-fitted prosthesis will be eligible for reimbursement as long as the service is provided during a month the client is eligible for Medicaid.

The following items and services are included in the reimbursement for a prosthetic device and not reimbursed separately:

- Evaluation of the residual limb and gait
- Measurement, casting, or fitting of the prosthesis
- Cost of base component parts and labor contained in the base procedure code description
- Repairs due to normal wear and tear during the 90 days following delivery
- Adjustments or modifications of the prosthesis or the prosthetic component made when fitting the prosthesis or component and for 90 days from the date of delivery when the adjustments are not necessitated by changes in the residual limb or the client's functional ability

In general, base codes do not represent a complete device. To include the additional components necessary for a complete device, providers may bill additional components with a code that is used in addition to a base code. Addition codes may also be used to indicate modifications to a device. The

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values assigned to the additional codes do not represent the actual value of the component or modification, but only the difference between the total value and the value of the base code. As a result, reimbursement of an addition does not involve subtraction of any amounts from the base code allowance.

2.10.5.1.1 Noncovered Prosthetic Services

Prosthetic devices prescribed by a chiropractor are not a benefit of Texas Medicaid.

A vacuum-assisted socket system (procedure code L5781 or L5782), which is a specialized vacuum pump, is considered experimental and investigational, and is not a benefit of Texas Medicaid.

Myoelectric hand prostheses for conditions other than the absence of forearm(s) and hand(s) are considered experimental and investigational and are not a benefit of Texas Medicaid.

A prosthetic device customized with enhanced features is not considered medically necessary if ADLs can be met with a standard prosthetic device.

Accessories that are not required for the effective use of a prosthetic device are not considered medically necessary.

2.10.5.2 * Prior Authorization and Documentation Requirements

Prior authorization is required for all prosthetic devices.

A completed CCP Prior Authorization Form requesting the prosthesis must be signed and dated by a physician familiar with the client before requesting prior authorization for all prostheses. The completed CCP Prior Authorization Form must include the procedure codes and numerical quantities for services requested. A copy of the completed, signed, and dated form must be maintained by the prosthesis provider in the client's medical record. The completed CCP Prior Authorization Form with the original dated signature must be maintained by the prescribing physician in the client's medical record.

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

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

To facilitate determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation for medical necessity of the equipment or supplies requested. The physician must maintain documentation of medical necessity in the client's medical record. The provider may be asked for additional information to clarify or complete a request for the service or device.

All requests for prior authorization must include documentation of medical necessity including, but not limited to, documentation that the client meets the following general indications for the requested device:

- The prosthesis replaces all or part of the function of a permanently inoperative, absent, or malfunctioning part of the limb, and identification of the specific limb that is being replaced by the prosthesis.
- The prosthesis is required for ADLs or for rehabilitation purposes, and identification of the ADLs or rehabilitation purpose for which the prosthesis is required.

The provider must keep the following written documentation in the client's medical record:

- The prescription for the device.

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    - Prosthetic devices must be prescribed by a physician (M.D. or D.O.).
    - The prescription must be dated prior to or on the initial date of the requested dates of service, which can be no longer than 90 days from the signature date on the prescription.
- Accurate diagnostic information that supports the medical necessity for the requested device. (A retrospective review may be performed to ensure that the documentation included in the client's medical record supports the medical necessity of the requested service or device.)
- The specific make, model, and serial number of the prosthetic components.
- The treatment plan outlining the therapy program prescribed by the treating physician, including expected goals with the use of the prosthesis.
- A statement submitted by the physician that indicates that the client or client's family or caregiver demonstrates willingness to comply with the therapy program.

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.

The actual date of service is the date the supplier has placed an order for the equipment and has incurred liability for the equipment.

2.10.5.2.1 Lower-Limb Prostheses

Lower limb prostheses include, but are not limited to, the following:

- Partial foot, ankle, and knee disarticulation sockets
- Above-knee short prostheses
- Hip and knee disarticulation prostheses
- Postsurgical prostheses
- Preparatory prostheses
- Additions to lower extremity prostheses
- Replacement sockets

A basic lower limb prosthesis consists of the following:

- A socket or connection between the residual limb and the prosthesis
- A suspension mechanism attaching the socket to the prosthesis
- A knee joint that provides support during stance, smooth control during the swing phase, and unrestricted motion for sitting and kneeling
- An exoskeleton or endoskeleton pylon (tube or shell) that attaches the socket to the terminal device
- A terminal device (foot)

In addition to the general indication requirements, the following additional documentation is also 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 the 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 includes, but is not limited to, the following:
    - The client's history, including prior use of a prosthesis if applicable

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- The client's current condition, including the status of the residual limb and any coexisting medical conditions
- The client's motivation to ambulate and ability to achieve independent transfers or ambulation with the use of a lower limb prosthesis

The following functional modifiers and levels have been defined by the Centers for Medicare & Medicaid Services (CMS):

Functional Level	Functional Modifier	Description
Level 0	K0	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.
Level 1	K1	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
Level 2	K2	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.
Level 3	K3	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.
Level 4	K4	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 (0) is not a candidate for a prosthetic device; the device is not considered medically necessary.

Advanced knee, ankle, and foot prostheses procedure codes must be submitted with the appropriate functional modifier in the table above.

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, and who meet the following criteria:

- The individual has adequate cardiovascular reserve and cognitive learning ability to master the higher level of technology and to allow for faster than normal walking speed.
- The individual demonstrates the ability to ambulate at a faster than baseline rate using a standard prosthetic application with a swing and stance control knee.
- The individual has a demonstrated need for long-distance ambulation at variable rates (greater than 400 yards) on a daily basis. Use of the limb in the home or for basic community ambulation is not sufficient to justify provision of the computerized limb instead of standard limb applications.
- The individual has a demonstrated need for regular ambulation on uneven terrain or for regular use on stairs. Use of the limb for limited stair climbing in the home or employment environment is not sufficient evidence for prescription of this device over standard prosthetic application.

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The licensed prosthetist or licensed prosthetist/orthotist providing the device must be trained in the fitting and programming of the microprocessor-controlled prosthetic device.

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, multiaxial 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.

Ankle Prosthesis

An axial rotation unit will be considered for prior authorization for clients whose documented functional level is 2 or above.

Knee Prosthesis

A single-axis, constant-friction knee and 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.

Prosthetic Substitutions or Additions for Below-Knee Prostheses

Prosthetic substitutions or additions (procedure codes L5629, L5638, L5639, L5646, L5647, L5704, L5785, L5962, and L5980) are not considered medically necessary when an initial below-knee prosthesis (procedure code L5500) or a preparatory below-knee prosthesis (procedure codes L5510, L5520, L5530, or L5540) is provided.

Prosthetic substitutions or additions (procedure codes L5620, L5629, L5645, L5646, L5670, L5676, L5704, and L5962) are not considered medically necessary when a below-knee preparatory, prefabricated prosthesis (procedure code L5535) is provided.

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.

2.10.5.2.2 Upper-Limb Prostheses

Upper limb prostheses include, but are not limited to, the following:

- Partial hand prostheses
- Wrist and elbow disarticulation prostheses
- Shoulder and interscapular thoracic prostheses
- Immediate postsurgical or early fitting prostheses

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- Preparatory prostheses
- Terminal devices
- Replacement sockets
- Inner sockets-externally powered
- Electric hand, wrist, and elbow prostheses

Upper limb prostheses will be considered for prior authorization with documentation of all of the general indication requirements. The additional criteria in the following sections apply for specific prosthetic devices.

Myoelectric Upper Limb Prostheses

A myoelectric upper limb prosthetic device is considered medically necessary when all of the following criteria have been met:

- The client has sufficient neurological, myocutaneous, and cognitive function to operate the prosthesis effectively.
- The client has an amputation or missing limb at the wrist or above (e.g., forearm, elbow, and so on).
- The client is free of comorbidities that could interfere with maintaining function of the prostheses (e.g., neuromuscular disease).
- The client retains sufficient microvolt threshold in the residual limb to allow proper function of the prostheses.
- Standard body-powered prosthetic devices cannot be used or are insufficient to meet the functional needs of the patient in performing ADLs.
- The client does not function in an environment that would inhibit function of the prosthesis (e.g., a wet environment or a situation involving electrical discharges that would affect the prosthesis).

2.10.5.2.3 External Breast Prostheses

External breast prostheses will be considered for prior authorization for clients who have congenital absence of a breast or who have had a mastectomy.

2.10.5.2.4 Craniofacial Prostheses

Craniofacial prostheses include, but are not limited to, external nasal, ear, and facial prostheses.

Craniofacial prostheses will be considered for prior authorization with documentation that the device is necessary to correct an absence or deformity of the affected body part.

2.10.5.2.5 Related Services

Accessories to Prostheses

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 prosthetic device.

Repairs, Replacements, and Modifications to Prostheses

Repairs due to normal wear and tear will be considered for prior authorization after 90 days from the date of delivery of the initial prosthesis, when the repair is:

- Necessary to make the equipment functional.
- More cost-effective than the replacement of the prosthetic device.

Providers must include documentation that supports medical necessity when they request prior authorization. Additional information from the provider may be requested to determine cost-effectiveness.

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Replacement of prosthetic equipment will be considered for coverage when loss or irreparable damage has occurred. A copy of the police or fire report when appropriate and the measures to be taken to prevent re-occurrence must be submitted with the prior authorization request.

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.

Children typically require new prosthetic devices every 12 to 18 months, although the actual lifespan of a device depends on the child's rate of skeletal growth. Prosthetic devices for children must accommodate growth and other physiological changes.

Components and systems that allow for growth or increase the lifespan of the prosthesis may include the following:

- Growth-oriented suspension systems and modifications
- Use of modular systems
- Use of flexible sockets
- Use of removable sockets (slip or triple-wall sockets)
- Use of distal pads
- Modification of socket liners
- Increasing or decreasing sock thickness

Modifications due to growth or change in medical status will be considered for prior authorization with documentation of medical necessity.

Medical necessity for requested components or additions to the prosthesis is based on the client's current functional ability and the expected functional potential as defined by the prosthetist and the ordering physician.

2.10.6 Claims Information

Submit services provided by orthotic and prosthetic suppliers in an approved electronic format or on a CMS-1500 paper claim form. Providers must purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

Important: *Attach the invoice to the claim for any specialized equipment.*

Include the name of the referring physician in Block 17 of the CMS-1500 paper claim form or its electronic equivalent. Orthotics or prosthetics may be billed in the office, home, or outpatient setting. Claims for services that have been prior authorized must reflect the PAN in Block 23 of the CMS-1500 paper claim form or its electronic equivalent.

Refer to: Orthotic and Prosthetic Services (CCP Only) on the TMHP website at www.tmhp.com for a claim form example.

2.10.7 Reimbursement

Orthotic and prosthetic services are reimbursed in accordance with 1 TAC §355.8441. Outpatient hospitals are reimbursed for THSteps DME and expendable supplies in accordance with 1 TAC §355.8061.

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2.11 Personal Care Services (PCS) (CCP)

2.11.1 Enrollment

CCP providers that want to participate in the delivery of PCS to Medicaid clients must be enrolled with TMHP and have the appropriate Texas Department of Aging and Disability Services (DADS) licensure or certification.

All PCS providers must have a TPI and a National Provider Identifier (NPI).

Providers that are *currently* contracted with DADS to administer consumer-directed services (CDS) or provide PCS through the service responsibility option (SRO), including providers currently enrolled in Texas Medicaid, are required to enroll or re-enroll separately as a CDS or SRO provider. Texas Medicaid enrolls only new providers that are *currently* contracted with DADS to provide PCS through CDS and SRO.

Providers (other than those discussed above) that want to provide PCS to Medicaid clients must enroll through TMHP. Texas Medicaid enrollment rules for PCS participation require providers to have one of the following categories of DADS licensure prior to enrollment:

- Personal Assistance Services (PAS)
- Licensed Home Health Services (LHHS)
- Licensed and Certified Home Health Services (LCHHS)

LCHH and LHH agencies that are currently enrolled through TMHP do not need to enroll as CCP-PCS providers to provide PCS. Providers must have a TPI in one of the following enrollment categories: LHHS agency, LCHHS agency, or PCS provider.

Providers that are enrolled as any entity other than an LHHS agency or LCHHS agency are required to meet the provider enrollment rules in order to participate in the delivery of PCS through Texas Medicaid.

Refer to: Subsection 2.1.2, "Enrollment" in this handbook for more information about CCP enrollment procedures.

2.11.2 Services, Benefits, and Limitations

PCS is a benefit of CCP for Texas Medicaid clients who are birth through 20 years of age. PCS may not be authorized in hospitals, nursing facilities, or intermediate care facilities for individuals with intellectual or developmental disabilities (ICF-IID). PCS will be denied when billed on the same date of service as an inpatient stay service. The provider may appeal the denied claim with documentation supporting that PCS was performed while the client was not in a hospital setting. PCS are support services provided to clients who meet the definition of medical necessity and require assistance with the performance of ADLs, instrumental activities of daily living (IADLs), and health maintenance activities (HMAs) due to a physical, cognitive, or behavioral limitation related to a client's disability or chronic health condition. PCS are provided by someone other than the responsible adult of the client who is a minor child or the legal spouse of the client.

A responsible adult is an individual, 18 years of age or older, who has agreed to accept the responsibility for providing food, shelter, clothing, education, nurturing, and supervision for the client. Responsible adults include, but are not limited to, biological parents, adoptive parents, step parents, foster parents, legal guardians, court-appointed managing conservators, and the primary adult who is acting in the role of parent.

PCS are those services that assist eligible clients in performing ADLs, IADLs, and HMAs. The scope of ADLs, IADLs, and HMAs includes a range of activities that healthy, nondisabled adults can perform for themselves. Typically, developing children gradually and sequentially acquire the ability to perform these ADLs, IADLs, and HMAs for themselves. If a typically developing child of the same chronological

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age could not safely and independently perform an ADL, IADL, or HMAs without adult supervision, then the client's responsible adult ensures that the client's needs for the ADLs, IADLs, and HMAs are met.

PCS include direct intervention (assisting the client in performing a task) or indirect intervention (cueing or redirecting the client to perform a task). ADLs, IADLs, and HMAs include, but are not limited to, the following:

ADLs	IADLs
Bathing	Escort or Assistance with Transportation Services
Dressing	Grocery or Household Shopping
Eating	Laundry
Locomotion or Mobility	Light housework
Personal Hygiene	Meal preparation
Positioning	Medication Assistance
Toileting	Money management
Transferring	Telephone Use or Other Communication
*** Escort or Assistance with Transportation Services includes the coordination of transportation to medical appointments and accompaniment to appointments to assist with needed ADLs. PCS does not include the payment for transportation or transportation vehicles since these services are available through MTP.**	

Note: *Health maintenance activities (HMAs) and nurse-delegated tasks that fall within the scope of the task listed above are allowable in PCS.*

Note: *Exercise and range of motion are not available through PCS, but are services that could be provided through PT, PDN, or home health SN.*

PCS does not include the following:

- ADLs, IADLs, or HMAs that a typically developing child of the same chronological age could not safely and independently perform without adult supervision
- Services that provide direct intervention when the client has the physical, behavioral, and cognitive abilities to perform an ADL, IADL, or health-related function without adult supervision
- Services used for or intended to provide respite care, child care, or restraint of a client
- Stand-by supervision related to safety
- Potty training
- Grocery shopping for members of the client's family or household
- Cleaning for members of the client's family or household (exception: light housework is approved if the client shares a room with a person)
- Cleaning the entire house (exception: a need for clean environment is approved if related to the client's diagnosis or condition [e.g., asthma, allergies, or autoimmune deficiencies])

  Note: *Cleaning an area or equipment that is used to complete a task may be included in the light housework IADL, as appropriate.*

- Laundry services for members of the client's family or household (exception: laundry is approved when related to the client's diagnosis or condition that results in soiled bedding or clothing for the client beyond the norm [e.g., incontinence, feeding tube, trachea, an ostomy, diapers, or skin condition])

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- Waiting time for the laundry machine to complete a cycle in the home setting (exception: the time an attendant is at a laundromat completing the laundry task for the client is covered for PCS)
- Meal preparation for members of the client's family or household
- Time of a PCS attendant while acting as the responsible adult for the receipt of medical care or providing medical transportation

An escort is approved if it is related to the client's diagnosis or condition, such as using the toilet at the appointment or assistance carrying equipment (e.g., feeding pump, oxygen tank).

An escort is approved if it is related to the client's diagnosis or condition and the responsible adult is occupied during the transport. For example, a child's condition might include behaviors that create an unsafe situation for the child during transport, such as removing a seatbelt, attempting to open the car door while the car is in motion, or elopement.

PCS does cover the entire time that an attendant is away from the home performing this task.

PCS is considered for reimbursement when providers use procedure code T1019 in conjunction with the appropriate modifier listed in the table below. PCS provided by a home health agency or PCS-only provider, including PCS being provided under the SRO defined in 40 TAC Part 1, Chapter 41, must be billed in 15-minute increments. PCS provided by a financial management services agency (FMSA) under the CDS option defined in 40 TAC Part 1, Chapter 41, must submit the attendant fee in 15-minute increments. FMSAs must bill the administration fee once per calendar month per client for any month in which the client receives PCS under the CDS option and regardless of the number of PCS units of service the client receives under the CDS option during the month. PCS claims are considered for reimbursement only when TMHP has issued a valid PAN to a PCS provider.

PCS Procedure Codes	
All PCS Providers* (except FMSA)	
Procedure Code	T1019
Modifier	U6 (PCS each 15 minutes)
	UA (Behavioral health condition, each 15 minutes)
FMSA Under CDS Option*	
Procedure Code	T1019
Modifier	U7 (Attendant fee each 15 minutes)
	U8 (Administration fee once a month)
	UB (Behavior health condition, each 15 minutes)
*** 40 TAC Part 1, Chapter 41**	

Home health agencies and Personal Care Services (PCS) providers that provide PCS and Community First Choice (CFC) Services in the home setting may be reimbursed for nurse evaluation and supervision using procedure code G0162.

The following limitations apply for procedure code G0162:

- For a registered nurse (RN) assessment, procedure code G0162 (without modifier) is limited to three hours per day (12 to 15 minute increments) and two occurrences per rolling year for any provider.
- For training and supervision of the attendant, procedure code G0162 must be billed with modifier U1 and is limited to three hours (12 to 15 minute increments) per 30 days for any provider.

Note: *Training and supervision and an RN assessment may be billed on the same day.*

Prior authorization is not required for procedure code G0162.

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2.11.2.1 Place of Services

PCS may be provided in the following settings if medically necessary:

- The client's home
- The client's school
- The client's daycare facility
- Other community setting in which the client is located

Note: *For claims filing purposes, the PCS provider must bill POS 2 (home) when submitting claims to TMHP.*

Texas Medicaid does not reimburse providers for PCS that duplicate services that are the legal responsibility of school districts. The school district, through the School Health and Related Services (SHARS) program, is required to meet the client's personal care needs while the client is at school. If those needs cannot be met by SHARS or the school district, the school district must submit documentation to the Texas Department of State Health Services (DSHS) case manager indicating the school district is unable to provide all medically necessary services. When clients are receiving both PCS and PDN services from an individual person over the same span of time, the combined total number of hours for PCS and PDN are reimbursed according to the maximum allowable rate.

2.11.2.2 Client Eligibility

The PCS benefit is available to Texas Medicaid clients who:

- Are birth through 20 years of age.
- Are enrolled with Texas Medicaid.
- Are eligible for CCP.
- Have physical, cognitive, or behavioral limitations related to a disability or chronic health condition that inhibits the client's ability to accomplish ADLs, IADLs, or HMAs.

Whether the client has a physical, cognitive, or behavioral limitation related to a disability or chronic health condition that inhibits the client's ability to accomplish ADLs, IADLs, or HMAs, the following needs and conditions of the responsible adult will be considered:

- The responsible adult's need to sleep, work, attend school, and meet their own medical obligations
- The responsible adult's legal obligation to care for, support, and meet the medical, educational, and psychosocial needs of other dependents
- Whether requiring the responsible adult to perform the PCS will put the client's health or safety in jeopardy
- The time periods during which the PCS tasks are required by the client, as they occur over the course of a 24-hour day and a seven-day week.
- Whether or not the need to help the family perform PCS on behalf of the client is related to a medical, cognitive, or behavioral condition that results in a level of functional ability that is below that expected of a typically developing child of the same chronological age
- Whether services are needed based on:
  - The Practitioner Statement of Need (PSON)
  - The client's personal care assessment form (PCAF)

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Clients who are enrolled in a DADS waiver program may also receive PCS if they are eligible for it, as long as the services that are provided through the waiver program and PCS are not duplicated. Clients who are enrolled in the following DADS waiver programs may access the PCS benefits if they meet the PCS eligibility requirements:

- Community Living Assistance and Support Services (CLASS)
- Deaf/Blind Multiple Disabilities (DBMD)
- Community-Based Alternatives (CBA)
- Consolidated Waiver Program (CWP)
- Medically Dependent Children Program (MDCP)
- Texas Home Living Waiver (TxHmL)
- Home and Community Services (HCS)

Note: *Clients who receive HCS Residential Support Services, Supervised Living Services, or Foster/Companion Care Services are not eligible to receive attendant care services through PCS.*

Clients must choose the program through which they receive attendant care, if they meet the eligibility requirements of both programs. Clients will be given the following options for the delivery of attendant care services:

- A client can receive all attendant care services through PCS.
- A client can decline PCS and receive all attendant care service through a waiver program, if the waiver program offers attendant care.

Clients who participate in the CDS option for PCS and for a waiver program are required to choose one FMSA to provide services through both programs. FMSAs will only be permitted to file the financial management services (FMS) fee, also known as the monthly administrative fee, through one program. The FMSA must file the FMS claim through the program that provides the highest reimbursement rate.

2.11.2.2.1 Accessing the PCS Benefit

Clients must be referred to DSHS before receiving the PCS benefit. A referral can be made by any person who recognizes a client may have a need for PCS, including, but not limited to, the following:

- The client, a parent, a guardian, or a responsible adult
- A primary practitioner, primary care provider, or medical home
- A licensed health professional who has a therapeutic relationship with the client and ongoing clinical knowledge of the client
- A family member
- Home health, personal assistance, or FMSA providers

Referrals to DSHS can be made to the appropriate DSHS Health Service Region, based on the client's place of residence in the state. Clients, parents, or guardians may also call the TMHP PCS Client Line at 1-888-276-0702 for more information on PCS. PCS providers must provide contact information for the client or responsible adult to DSHS or the TMHP PCS Client Contact Line when making a referral.

Upon receiving a referral, DSHS assigns the client a case manager, who then conducts an assessment in the client's home with the input and assistance of the client or responsible adult. Based on the assessment, the case manager identifies whether the client has a need for PCS. If the case manager identifies a need for PCS, the client or responsible adult is asked to select a Medicaid-enrolled PCS provider in their area.

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Once a provider is selected, the DSHS case manager prior authorizes a quantity of PCS based on the assessment and requests TMHP to issue a PAN to the selected PCS provider. The PCS provider uses the PAN to submit claims to TMHP for the services provided.

2.11.2.2.2 The Primary Practitioner's Role in the PCS Benefit

A client who is assessed for the PCS benefit must have a primary practitioner (a licensed physician, APRN, or PA) or a primary care provider who has personally examined the client within the last 12 months and reviewed all of the appropriate medical records. The primary practitioner or primary care provider must have established a diagnosis for the client and must provide continuing care and medical supervision of the client. Prior to authorizing PCS, HHSC requires the completion of an HHSC-approved Practitioner Statement of Need (PSON) by a primary practitioner. The PSON must be on file with HHSC prior to the initiation of PCS and will only accept the PSON from an individual who is a physician, APRN, or PA.

The PSON certifies that the client is 20 years of age or younger and has a physical, cognitive, or behavioral limitation related to a disability or chronic health condition. The primary practitioner or primary care provider must mail or fax the completed PSON to the appropriate DSHS Health Services Region. DSHS keeps the signed and dated PSON and the client's PCAF in the client's case management record for the duration of the client's participation in the benefit.

When a behavioral health condition exists, the primary practitioner may be a behavioral health provider.

If the client's medical record does not include the primary practitioner's documentation and a PSON that certifies that the client has a physical, cognitive or behavioral health condition that impacts the client's ability to perform an ADL or IADL, then PCS payments may be recouped.

Note: *If a client is entering or is already in the conservatorship of the state, PCS may be provisionally initiated for up to 60 days once eligibility has been established through the assessment.*

HHSC requires the reassessment of the client's need for PCS every 12 months or when requested due to a change in the client's health or living condition. A new PSON will be required at each annual reassessment and when there is a change in the client's medical condition that may increase the need for services.

2.11.2.3 PCS Provided in Group Settings

PCS may be provided in a provider to client ratio other than one-to-one. Settings in which providers can provide PCS in a provider to client ratio other than one-to-one include homes with more than one client needing PCS, foster homes, and independent living arrangements.

A PCS provider may provide PCS to more than one client over the span of the day as long as:

- Each client's care is based on an individualized service plan.
- Each client's needs and service plan do not overlap with another client's needs and service plan.

Example: *If the prior authorized PCS hours for Client A is four hours, Client B is six hours, and the actual time spent with both clients is eight hours, the provider must bill for the actual one-on-one time spent with each client, not to exceed the client's prior authorized hours or total hours worked. It would be acceptable to bill four hours for Client A and four hours for Client B, or three hours for Client A and five hours for Client B. It would not be acceptable to bill five hours for Client A and three hours for Client B. It would be acceptable to bill ten hours if the individual person actually spent ten hours onsite providing prior authorized PCS split as four hours for Client A and six hours for Client B. A total of ten hours cannot be billed if the individual person worked only eight hours.*

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- PCS may be delivered in a client-to-provider ratio other than one-on-one as long as each client's care is based on an individualized POC and each client's needs are being met. Only the time spent on authorized PCS tasks for each client is eligible for reimbursement. Total PCS billed for all clients cannot exceed an individual attendant's total number of hours at the place of service.

When there is more than one client within the same household receiving PCS, the DSHS case manager will synchronize authorizations within the households for all eligible clients. The DSHS case manager will assess all eligible clients in the home and submit authorizations for all eligible clients in the household for the same authorization period. DSHS case managers will communicate with the provider the actions that are being taken using the existing Communication Tool.

Note: *There should be no lapse in services to the client.*

2.11.3 Prior Authorization and Documentation Requirements

Prior authorization is required before services are provided. All PCS must be prior authorized by a DSHS case manager based upon client need, as determined by the client assessment. DSHS prior authorizes PCS for eligible clients. The DSHS case manager notifies TMHP of the authorized quantity of PCS. TMHP sends a notification letter with the PAN to the client or responsible adult and the selected PCS provider if PCS is approved or modified. Only the client or responsible adult receives a notification letter with an explanation of denied services. PCS is prior authorized for periods of up to twelve months. PCS providers must provide services from the start of care date agreed to by the client or responsible adult, the case manager, and the PCS provider.

A PCS provider may obtain prior authorization to provide enhanced PCS to clients with a behavioral health condition when the following criteria are met:

- The DSHS case manager completes the Personal Care Assessment Form (PCAF) and identifies the behavioral health condition.
- The PCAF indicates that the identified behavioral health condition impacts the client's ability to perform an ADL or IADL.
- The PCAF indicates which ADL(s) or IADL(s) cannot be performed by the client without assistance.
- The DSHS case manager submits the appropriate modifier on the authorization request.

When a client experiences a change in condition, the client or responsible adult must notify the DSHS Health Service Office in the client's region. A DSHS case manager must perform a new assessment and prior authorize any revisions in the quantity of PCS based on the new assessment. TMHP issues a revised authorization and notifications are sent to the client or responsible adult and the selected PCS provider. If the change is made during a current prior authorization period, the new prior authorization will maintain the same end date as the original prior authorization period. The revised authorization period will begin on the SOC date stated in the new assessment.

For continuing and ongoing PCS needs beyond the initial prior authorization period of up to twelve months, a DSHS case manager must conduct a new assessment and submit a new authorization request to TMHP. TMHP sends a notification letter updating the prior authorization to the client, responsible adults, and the selected PCS provider.

HHSC or its designee may suspend an authorization for PCS when either:

- The client or the client's family creates an unsafe environment for the attendant's health and safety.
- The provider requests suspension for the reasons outlined in 40 TAC Part 1, Chapter 41.

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Providers can call a toll-free PCS Provider Inquiry Line at 1-888-648-1517 for assistance with inquiries about the status of a PCS prior authorization. Providers should direct inquiries about other Medicaid services to the TMHP Contact Center at 1-800-925-9126. PCS providers should encourage the client or responsible adult to contact the appropriate DSHS Health Service Region with inquiries or concerns about the PCS assessment.

Note: *Any organization that employs attendants who provide PCS, and any organization serving as an FMSA, must comply with all documentation requirements as specified by the PCS program.*

2.11.3.1 PCS Provider Responsibilities

PCS providers must comply with all applicable federal, state, and local laws and regulations.

All PCS providers must maintain written policies and procedures for obtaining consent for medical treatment in the absence of the responsible adult. The procedure and policy must meet the standards of the Texas Family Code, Chapter 32.

Providers must accept clients only when there is a reasonable expectation and evidence that the client's needs can be adequately met in the POS. The POS must be able to support the client's health and safety needs and adequately support the use, maintenance, and cleaning of all required medical devices, equipment, and supplies. Necessary primary and backup utility, communication, and fire safety systems must be available in the POS.

The PCS provider is responsible for the supervision of the PCS attendant as required by the PCS provider's licensure requirements.

2.11.3.2 Documentation of Services Provided and Retrospective Review

Documentation elements are routinely assessed for compliance in retrospective review of client records, including the following:

- All entries are legible to people other than the author, dated (month, day, year, time), and signed by the author.
- Each page of the record documents the client's name and Medicaid identification number.
- All attendants' arrival and departure times are documented with signature and time.
- Documentation of services correlates with, and reflects medical necessity for, the services provided on any given day.
- Client's arrival or departure from the home setting is documented with the time of arrival, departure, mode of transportation, and who accompanied the client.

2.11.4 Claims Information

TMHP processes PCS claims. PCS providers must submit claims for services in an approved electronic claims format or on the appropriate claim form based on their provider type. PCS providers, other than home health agencies, that are enrolled as PAS-only providers, FMSAs, or SRO providers must file PCS claims using a CMS-1500 paper claim form. Home health agencies, including those enrolled as an FMSA, or an SRO provider, must file PCS claims using the UB-04 CMS-1450 paper claim form. TMHP does not supply the forms.

Home health agencies and consumer-directed agencies that bill for PCS using procedure code T1019 must include the prior authorization number on claims submitted for reimbursement. Additionally, providers utilizing paper, TexMedConnect, or billing through EDI must include the prior authorization number with all claims submissions.

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2.11.4.1 Managed Care Clients

PCS services are carved-out of the Medicaid Managed Care Program for State of Texas Access Reform (STAR) clients and must be billed to TMHP for payment consideration. Carved-out services are those that are rendered to Medicaid Managed Care clients but are administered by TMHP and not the client's MCO. Claims for STAR Health and STAR+PLUS are not carved out and must be submitted to the client's MCO for payment consideration.

2.11.4.2 PCS for STAR Health Clients

PCS for eligible STAR Health clients are authorized and processed by Superior HealthPlan.

Medicaid providers that want to provide PCS services to clients in the STAR Health program should contact Superior HealthPlan for information regarding the contracting and credentialing process at:

Superior HealthPlan - Network Development
Telephone: 1-866-615-9399 Ext. 22534
Email: shp-networkdevelopment@centene.com

2.11.5 Reimbursement

Providers of PCS are reimbursed in accordance with 1 TAC §355.8441.

2.12 Community First Choice (CFC) Services

2.12.1 Enrollment

CFC providers, including providers offering the Service Responsibility Option (SRO), must be licensed and enrolled in Texas Medicaid and comply with all applicable federal, state, and local laws and regulations. When CFC is provided through the Consumer Directed Services (CDS) option by a Financial Management Services Agency (FMSA), the FMSA must be certified and enrolled in Texas Medicaid as a FMSA and must comply with all applicable federal, state, and local laws and regulations.

Note: *CDS, FMSA, and SRO are defined in the Title 40 Texas Administrative Code (TAC), Part 1, Chapter 41. Licensure requirements for FMSA and SRO providers are defined in the Title 40 TAC, Part 1, Chapter 49.*

Note: *Any organization that employs attendants who provide CFC, and any organization serving as an FMSA, must comply with all documentation requirements as specified in CFC program policy.*

All CFC providers must maintain written policies and procedures for obtaining consent for medical treatment for clients in the absence of a responsible adult that meet the standards of the Texas Family Code, Chapter 32.

Providers must only accept clients when there is a reasonable expectation and evidence that the client's CFC needs can be adequately met in the place of service.

The CFC provider is responsible for supervising the CFC attendant in accordance with the provider's licensure requirements.

Note: *For CFC services delivered through a Department of Aging and Disability Services (DADS) 1915(c) waiver or through a managed care organization (MCO), providers must refer to DADS or the MCO for information about benefits, limitations, prior authorization, reimbursement, and specific claim processing procedures.*

2.12.2 Services, Benefits, and Limitations

CFC services may be rendered by a Home Health Agency, PCS-only provider, Financial Management Services Agency (FMSA) under the CDS option, or by a Service Responsibility Option (SRO) Provider.

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CFC is a benefit for Texas Medicaid fee-for-service clients who are birth through 20 years of age and who are:

- Eligible for medical assistance under the state plan
- Need help with activities of daily living; and
- Need an institutional level of care (to include hospital, nursing facility, intermediate care facility for clients with intellectual disabilities or institution of mental disease)

Services included are CFC personal assistance services, CFC habilitation, and CFC support management. CFC personal assistance services is the assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) through hands-on assistance, supervision, and/or cueing. CFC habilitation services are the acquisition, maintenance, and enhancement of skills necessary for the client to accomplish ADLs, IADLs, and health maintenance activities (HMAs). CFC support management is voluntary training on how to select, manage, and dismiss attendants.

CFC includes assistance with ADLs, IADLs and HMAs through hands-on assistance, supervision, or cueing. CFC also includes training on the acquisition, maintenance, and enhancement of skills necessary for the client to accomplish ADLs, IADLs, and HMAs listed below.

ADLs are activities that include:

- Bathing—Assisting the client with any or all parts of bathing; selecting appropriate water temperature and flow speed, turning water on and off; laying out and putting away supplies; transferring in and out of bathtub or shower; washing and drying hair and body; clean up after task is completed.
- Dressing—Assisting the client with any or all parts of getting dressed; putting on, fastening, and taking off all items of clothing; donning and removing shoes or prostheses; choosing and laying out weather-appropriate clothing.
- Eating—Assisting the client with some or all parts of eating and drinking; feeding the client; assistance with utensils or special or adaptive eating devices; clean up after task is completed.
- Personal hygiene: Assisting the client with some or all parts of personal hygiene; routine hair care; oral care; ear care; shaving; applying makeup; managing feminine hygiene; washing and drying face, hands, perineum; basic nail care; applying deodorant; routine skin care; clean up after task is completed.
- Toileting—Assisting the client with some or all parts of toileting; using commode, bedpan, urinal, toilet chair; transferring on and off; cleansing; changing diapers, pad, incontinence supplies; adjusting clothing; clean up after task is completed.
- Locomotion or mobility—Assisting the client with moving between locations; assisting the client with walking or using wheelchair, walker, or other mobility equipment.
- Positioning—Assisting the client with positioning their body while in a chair, bed, or other piece of furniture or equipment; changing and adjusting positions; moving to or from a sitting position; turning side-to-side; assisting the client to sit upright.
- Transferring—Assisting the client with moving from one surface to another with or without a sliding board; moving from bed, chair, wheelchair, or vehicle to a new surface; moving to or from a standing or sitting position; moving the client with lift devices.

IADLs are activities that include:

- Telephone use or other communication—Assisting the client in making or receiving telephone calls; managing and setting up communication devices; making and receiving the call for the client.
- Grocery or household shopping—Shopping for or assisting clients in shopping for grocery and household items; preparing a shopping list; putting food and household items away; picking up medication and supplies.

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- Light housework—Performing or assisting the client in performing light housework such as: Cleaning and putting away dishes; wiping countertops; dusting; sweeping, vacuuming or mopping; changing linens and making bed; cleaning bathroom; taking out trash.
- Laundry—Assisting the client with doing laundry; gathering, sorting, washing, drying, folding, and putting away personal laundry, bedding, and towels; removing bedding to be washed and remaking the bed; using a laundry facility.
- Meal preparation—Assisting clients in preparing meals and snacks; cooking; assembling ingredients; cutting, chopping, grinding, or pureeing food; setting out food and utensils; serving food; preparing and pouring a predetermined amount of liquid nutrition; cleaning the feeding tube; cleaning area after meal; washing dishes.
- Money management—Assisting the client with managing their day-to-day finances; paying bills; balancing checkbook; making deposits or withdrawals; assisting in preparing and adhering to a budget.
- Medication assistance or administration—Assisting the client with oral medications that are normally self-administered, including administration through a permanently placed feeding tube with irrigation.
- Escort or assistance with transportation services—Assisting the client in making transportation arrangements for medical and other appointments; accompanying the client to a health care appointment to assist with needed ADLs.

HMAs include tasks that may be exempt from delegation based on the Registered Nurse (RN) assessment that enables the client to remain in an independent living environment and go beyond ADLs because of the higher skill level in which they are required to perform. HMAs will be limited to those within the scope of CFC that include:

- Administering oral medications that are normally self-administered, including administration through a permanently placed feeding tube with irrigation.
- Topically applied medications.
- Insulin or other injectable medications prescribed in the treatment of diabetes mellitus administered subcutaneously, nasally, or via an insulin pump.
- Unit dose medication administration by way of metered dose inhaler (MDIs) including medications administered as nebulizer treatments for prophylaxis or maintenance.
- Routine administration of a prescribed dose of oxygen.
- Noninvasive ventilation (NIV) such as continuous positive airway pressure (CPAP) and bi-level positive airway pressure (BiPAP) therapy.
- The administering of a bowel and bladder program, including suppositories, enemas, manual evacuation, intermittent catheterization, digital stimulation associated with a bowel program, tasks related to external stoma care including but not limited to pouch changes, measuring intake and output, and skin care surrounding the stoma area.
- Routine preventive skin care and care of Stage 1 pressure ulcers.
- Feeding and irrigation through a permanently placed feeding tube inserted in a surgically created orifice or stoma.
- Those tasks that an RN may reasonably conclude as safe to exempt from delegation based on an assessment consistent with 22 Texas Administrative Code (TAC) §225.6 of this title (relating to the RN Assessment of the client).
- Reporting as to the client's condition, including changes to the client's condition or needs and completing appropriate record.

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- Skin care: Maintenance of the hygienic state of the client's skin under optimal conditions of cleanliness and comfort.
- Use of durable medical equipment (DME).
- Such other tasks as the Board of Nursing may designate.

Whether the client has a physical, cognitive, or behavioral limitation related to a disability or chronic health condition that inhibits the client's ability to accomplish ADLs, IADLs, or HMAs, the following needs and conditions of the responsible adult will be considered in the determination of hours for CFC personal assistance services:

- The responsible adult's need to sleep, work, attend school, and meet their own medical obligations
- The responsible adult's legal obligation to care for, support, and meet the medical, educational, and psychosocial needs of other dependents
- Whether requiring the responsible adult to perform the CFC personal assistance services will put the client's health or safety in jeopardy
- The time periods during which the CFC personal assistance services tasks are required by the client, as they occur over the course of a 24-hour day and a seven-day week.
- Whether or not the need to help the family perform CFC personal assistance services on behalf of the client is related to a medical, cognitive, or behavioral condition that results in a level of functional ability that is below that expected of a typically developing child of the same chronological age

CFC also includes training on the acquisition, maintenance, and enhancement of the additional habilitation needs listed below:

- Community integration—Client may need assistance finding, participating in and accessing community activities or community services such as free meal programs, churches, parks or self-advocacy training or events.
- Use of adaptive equipment—Client may need assistance operating, learning to use, or accessing adaptive equipment.
- Personal decision-making—Client may need assistance making decisions for him or herself, including assistance in assessing what is important to that client, pros and cons, as well as consequences.
- Reduce challenging behaviors to allow clients to accomplish ADLs, IADLs, and HMAs—Client may need assistance in increasing positive social encounters and engagement in preferred activities. Client may have challenging behaviors that can be reduced through behavior support plans, prompting, rewards, or redirection among others.
- Socialization/relationship development—Client may need assistance with development and maintenance of relationships or appropriate social behaviors.
- Accessing leisure and recreational activities—Client may need assistance identifying, finding, or accessing activities they would like to participate in during leisure time.

CFC does not include the following:

- Direct intervention to perform a task the client has the physical, behavioral, and cognitive abilities to perform;
- Skilled nursing services, or the supervision of delegated nursing tasks as described in the Texas Nurse Practice Act, the Act's implementing regulations, the Texas Medicaid Provider Procedures Manual sections for Private Duty Nursing (PDN) Services - THSteps - Comprehensive Care Program (CCP) and Home Health Skilled Nursing and Home Health Aide Services;

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- Costs associated with purchasing products for ADLs or IADLs;
- Services used for or intended to provide respite care, child care, or restraint of a client;
- Duplication of services provided by another program;
- Tasks that a typically developing child of the same chronological age could not safely and independently perform without adult supervision;
- Services provided in an institutional setting including hospitals, nursing facilities, psychiatric hospitals, or intermediate care facilities for clients with intellectual or developmental disabilities.

CFC is considered for reimbursement when billed with procedure code T1019 in conjunction with the appropriate modifier listed in the table below. CFC provided by a home health agency or PCS-only provider, including CFC being provided under the SRO defined in 40 TAC Part 1, Chapter 41, must be billed in 15-minute increments. CFC provided by a FMSA under the CDS option defined in 40 TAC Part 1, Chapter 41, must submit the attendant fee in 15-minute increments.

CFC Procedure Codes	
All CFC Providers (except FMSA)	
Procedure Code	T1019
Modifier	UD (CFC —client needs attendant care only, each 15 minutes)
	U9 (CFC—client needs habilitation only, or attendant and habilitation, each 15 minutes)
Procedure Code	T1019
Modifier	U3 (CFC attendant care for PCS - CDS Option, each 15 minutes) ***Note:*** *This modifier will be used for individuals receiving attendant care only.*
	U4 (CFC Habilitation for PCS - CDS Option, each 15 minutes) ***Note:*** *This modifier will be used for individuals receiving attendant care and habilitation.*
	U5 (CFC CDS, per month) ***Note:*** *This modifier is used for the administrative fee for CFC provider under the CDS option.*

FMSAs must bill the administration fee once per calendar month per client for any month in which the client receives CFC under the CDS option and regardless of the number of CFC units of service the client receives under the CDS option during the month. CFC claims are considered for reimbursement only when TMHP has issued a valid PAN to a CFC provider.

Home health agencies and Personal Care Services (PCS) providers that provide PCS and Community First Choice (CFC) Services in the home setting may be reimbursed for nurse evaluation and supervision using procedure code G0162.

The following limitations apply for procedure code G0162:

- For a registered nurse (RN) assessment, procedure code G0162 (without modifier) is limited to three hours per day (12 to 15 minute increments) and two occurrences per rolling year for any provider.

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- For training and supervision of the attendant, procedure code G0162 must be billed with modifier U1 and is limited to three hours (12 to 15 minute increments) per 30 days for any provider.

Note: *Training and supervision and an RN assessment may be billed on the same day.*

Prior authorization is not required for procedure code G0162.

2.12.2.1 Place of Service

CFC may be provided in the following settings:

- Client's home;
- Client's school;
- Client's daycare facility; or
- Other community setting in which the client is located.

Note: *For claims filing purposes, the CFC provider must bill POS 2 (home) when submitting claims to TMHP.*

Texas Medicaid does not reimburse providers for CFC services that duplicate services that are the legal responsibility of school districts. The school district, through the School Health and Related Services (SHARS) program, is required to meet the client's personal care needs while the client is at school. If those needs cannot be met by SHARS or the school district, the school district must submit documentation to the DSHS case manager indicating the school district is unable to provide all medically necessary services.

2.12.3 CFC Attendant and Habilitation Services in Group Settings

CFC may be provided in a provider to client ratio other than one-to-one. Settings in which providers can provide CFC in a provider to client ratio other than one-to-one include homes with more than one client needing CFC, foster homes, and independent living arrangements. A CFC provider may provide CFC to more than one client over the span of the day as long as:

- Each client's care is based on an individualized service plan.
- Each client's needs and service plan do not overlap with another client's needs and service plan.
- Only the time spent on authorized CFC tasks for each client is eligible for reimbursement. Total CFC billed for all clients cannot exceed an individual attendant's total number of hours at the place of service.

When there is more than one client within the same household receiving CFC, the Department of State Health Services (DSHS) case manager will synchronize authorizations within the households for all eligible clients. The DSHS case manager will assess all eligible clients in the home and submit authorizations for all eligible clients in the household for the same authorization period. DSHS case managers will communicate with the provider the actions that are being taken using the existing Communication Tool.

2.12.4 Prior Authorization

Prior authorization is required before services are provided. All CFC must be prior authorized by a DSHS case manager based upon client need, as determined by the client assessment. DSHS prior authorizes CFC for eligible clients. The DSHS case manager notifies TMHP of the authorized quantity of CFC. TMHP sends a notification letter with the prior authorization number (PAN) to the client or responsible adult and the selected CFC provider if CFC is approved or modified. Only the client or responsible adult receives a notification letter with an explanation of denied services. CFC is prior authorized for periods of up to twelve months. CFC providers must provide services from the start of care date agreed to by the client or responsible adult, the case manager, and the CFC provider.

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When DSHS has approved CFC services, DSHS will send the client's selected CFC provider: A CFC Communication tool, specifying the approved hours and CFC tasks and a copy of the Personal Care Assessment Form (PCAF) CFC Addendum, which documents that client's goals and preferences for the delivery of CFC services. The CFC provider may receive a Practitioner's Statement of Need (PSON) for the client, but this form is not required documentation for CFC and is intended merely for informational purposes.

When a client experiences a change in condition, the client or responsible adult must notify the DSHS Health Service Office in the client's region. A DSHS case manager must perform a new assessment and prior authorize any revisions in the quantity of CFC based on the new assessment. TMHP issues a revised authorization and notifications are sent to the client or responsible adult and the selected CFC provider. If the change is made during a current prior authorization period, the new prior authorization will maintain the same end date as the original prior authorization period. The revised authorization period will begin on the start of care date stated in the new assessment.

For ongoing CFC needs beyond the initial prior authorization period of up to twelve months, a DSHS case manager must conduct a new assessment and submit a new authorization request to TMHP. A new in-home assessment must be conducted every twelve months with the client. TMHP will send a notification letter updating the prior authorization to the client, responsible adults, and the selected CFC provider. HHSC or its designee may suspend an authorization for CFC when either:

- The client or the client's family creates an unsafe environment for the attendant's health and safety; or
- The provider requests suspension for the reasons outlined in 40 TAC Part 1, Chapter 41.

Providers can call a toll-free Provider Inquiry Line at 1-888-648-1517 for assistance with inquiries about the status of a CFC prior authorization. Providers should direct inquiries about other Medicaid services to the TMHP Contact Center at 1-800-925-9126. CFC providers should encourage the client or responsible adult to contact the appropriate DSHS Health Service Region with inquiries or concerns about the CFC assessment.

2.12.4.1 CFC Provider Responsibilities

CFC providers must comply with all applicable federal, state, and local laws and regulations. All CFC providers must maintain written policies and procedures for obtaining consent for medical treatment in the absence of the responsible adult. The procedure and policy must meet the standards of the Texas Family Code, Chapter 32. Providers must accept clients only when there is a reasonable expectation and evidence that the client's needs may be adequately met in the place of service (POS). The POS must be able to support the client's health and safety needs and adequately support the use, maintenance, and cleaning of all required medical devices, equipment, and supplies. Necessary primary and backup utility, communication, and fire safety systems must be available in the POS. The CFC provider is responsible for the supervision of the CFC attendant as required by the CFC provider's licensure requirements.

2.12.4.2 Documentation Requirements

Documentation elements are routinely assessed for compliance in retrospective review of client records, including the following:

- All entries are legible to people other than the author, dated (month, day, year, time), and signed by the author.
- Each page of the record documents the client's name and Medicaid identification number.
- All attendants' arrival and departure times are documented with signature and time.
- Documentation of services correlates with, and reflects medical necessity for, the services provided on any given day.

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- Client's arrival or departure from the home setting is documented with the time of arrival, departure, mode of transportation, and who accompanied the client.

2.12.5 Claims Information

TMHP processes CFC claims. CFC providers must submit claims for services in an approved electronic claims format or on the appropriate claim form based on their provider type. CFC providers, other than home health agencies, that are enrolled as PAS-only providers, FMSAs, or SRO providers must file CFC claims using a CMS-1500 paper claim form. Home health agencies, including those enrolled as an FMSA, or an SRO provider, must file PCS claims using the UB-04 CMS-1450 paper claim form.

TMHP does not supply the forms. Home health agencies and consumer-directed agencies that bill for CFC using procedure code T1019 must include the prior authorization number on claims submitted for reimbursement. Additionally, providers utilizing paper, TexMedConnect, or billing through EDI must include the prior authorization number with all claims submissions.

2.12.5.1 Managed Care Clients

CFC services are carved-out of the Medicaid Managed Care Program for State of Texas Access Reform (STAR) clients and must be billed to TMHP for payment consideration. Carved-out services are those that are rendered to Medicaid Managed Care clients but are administered by TMHP and not the client's MCO. Claims for STAR Health and STAR+PLUS are not carved out and must be submitted to the client's MCO for payment consideration.

2.13 Private Duty Nursing (PDN)(CCP)

2.13.1 Enrollment

Home health agencies may enroll to provide PDN under CCP. RNs and licensed vocational nurses (LVNs) may enroll independently to provide PDN under CCP.

Home health agencies must do all of the following:

- Comply with provider participation requirements for home health agencies that participate in Texas Medicaid
- Comply with mandatory reporting of suspected abuse and neglect of children or adults
- Maintain written policies and procedures for obtaining consent for medical treatment for clients in the absence of the parent or guardian
- Comply with all requirements in this manual

Independently-enrolled RNs and LVNs must be enrolled as providers in CCP and comply with all of the following:

- The terms of the Texas Medicaid Provider Agreement
- All state and federal regulations and rules relating to Texas Medicaid
- The requirements of this manual, all handbooks, standards, and guidelines published by HHSC

Independently enrolled RNs and LVNs must also:

- Provide at least 30 days' written notice to clients of their intent voluntarily to terminate services except in situations of potential threat to the nurse's personal safety.
- Comply with mandatory reporting of suspected abuse and neglect of children.
- Maintain written policies and procedures for obtaining consent for medical treatment for clients in the absence of the parent or guardian.

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Independently enrolled RNs must:

- Hold a current license from the Texas Board of Nursing (BON) or another compact state to practice as an RN.
- Agree to provide services in compliance with all applicable federal, state, and local laws and regulations, including the Texas Nursing Practice Act.
- Comply with accepted professional standards and principles of nursing practice.

Independently enrolled LVNs must:

- Hold a current license from the Texas BON to practice as an LVN.
- Agree to provide services in compliance with all applicable federal, state, and local laws and regulations, including the Texas Nursing Practice Act.
- Comply with accepted standards and principles of vocational nursing practice.
- Be supervised by an RN once per month. The supervision must occur when the LVN is present and be documented in the client's medical record.

Refer to: Subsection 2.1.2, "Enrollment" in this handbook for more information about CCP enrollment procedures.

2.13.2 Services, Benefits, and Limitations

Medicaid clients who are birth through 20 years of age are entitled to all medically necessary PDN services and home health SN services.

PDN is nursing services, as described by the Texas Nursing Practice Act and its implementing regulations, for clients who meet medical necessity criteria listed below and who require individualized, continuous, skilled care beyond the level of SN visits provided under Texas Medicaid (Title XIX) Home Health Services SN.

Nursing services are medically necessary under the following conditions:

- The requested services are nursing services as defined by the Texas Nursing Practice Act and its implementing regulations.
- The requested services correct or ameliorate the client's disability, physical or mental illness, or condition. Nursing services correct or ameliorate the client's disability, physical or mental illness, or condition when the services improve, maintain, or slow the deterioration of the client's heath status.
- There is no third party resource (TPR) financially responsible for the services.

Medically necessary nursing services may be either PDN services or home health SN services, depending on whether the client's nursing needs can be met on a per-visit basis.

When documentation does not support medical necessity for PDN services, services may be available on an intermittent or part-time basis through home health SN.

Intermittent visits may be delivered in interval visits of up to 2.5 hours per visit and must not exceed a combined total of three visits per day. A part-time basis is an SN visit that is provided for less than eight hours per day for any number of days per week. Part-time visits may be continuous up to 7.5 hours per day and must not exceed a combined total of three 2.5 hour visits. SN visits may be provided on consecutive days.

PDN must be ordered or prescribed by a physician and provided by an RN, LVN, or a licensed practical nurse (LPN).

Professional nursing provided by an RN, as defined in the Texas Nursing Practice Act, means the performance of an act that requires substantial specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science,

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as acquired by a completed course in an approved school of professional nursing. The term *does not* include acts of medical diagnosis or the prescription of therapeutic or corrective measures. Professional nursing involves:

- The observation, assessment, intervention, evaluation, rehabilitation, care and counsel, or health teachings of a person who is ill, injured, infirm, or experiencing a change in normal health processes.
- The maintenance of health or prevention of illness.
- The administration of a medication or treatment as ordered by a physician, podiatrist, or dentist.
- The supervision of delegated nursing tasks or teaching of nursing.
- The administration, supervision, and evaluation of nursing practices, policies, and procedures.
- The performance of an act delegated by a physician.
- Development of the nursing care plan.

Vocational nursing, as defined in the Texas Nursing Practice Act, means a directed scope of nursing practice, including the performance of an act that requires specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of vocational nursing. The term *does not* include acts of medical diagnosis or the prescription of therapeutic or corrective measures. Vocational nursing involves:

- Collecting data and performing focused nursing assessments of the health status of an individual.
- Participating in the planning of the nursing care needs of an individual.
- Participating in the development and modification of the nursing care plan.
- Participating in health teaching and counseling to promote, attain, and maintain the optimum health level of an individual.
- Assisting in the evaluation of an individual's response to a nursing intervention and the identification of an individual's needs.
- Engaging in other acts that require education and training, as prescribed by board rules and policies, commensurate with the nurse's experience, continuing education, and demonstrated competency.

Professional and vocational nursing care consists of those services that must, under state law, be performed by an RN or LVN as defined by the Texas Nursing Practice Act §301.002. These services include observation, assessment, intervention, evaluation, rehabilitation, care and counseling, and health teaching, and which are further defined as nursing services in 42 CFR §§409.32, 409.33, and 409.44.

- In determining whether a service requires the skill of a licensed nurse, consideration must be given to the inherent complexity of the service, the condition of the client, and the accepted standards of medical and nursing practice.
- The fact that the nursing care can be, or is, taught to the client or to the client's family or friends does not negate the skilled aspect of the service when the service is performed by a nurse.
- If the service could be performed by the average nonmedical person, the absence of a competent person to perform it does not cause it to be a nursing service.
- If the nature of a service is such that it can safely and effectively be performed by the average nonmedical person without direct supervision of a licensed nurse, the services cannot be regarded as nursing care.

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- Some services are classified as nursing care on the basis of complexity alone (e.g., intravenous and intramuscular injections or insertion of catheters), and if reasonable and necessary to the treatment of the client's illness or injury, would be covered on that basis. In some cases, however, the client's condition may cause a service that would ordinarily be considered unskilled to be considered nursing care. This would occur when the client's condition is such that the service can be safely and effectively provided only by a nurse.
- A service that, by its nature, requires the skills of a nurse in order for it to be provided safely and effectively, continues to be a skilled service even if it is taught to the client, the client's family, or other caregivers.

PDN should prevent prolonged and frequent hospitalizations or institutionalization and provide cost-effective and quality care in the most appropriate, least restrictive environment. PDN provides direct nursing care and caregiver training and education. The training and education is intended to optimize client health status and outcomes, and to promote family-centered, community-based care as a component of an array of service options.

A request must include documentation from the provider to support the medical necessity of the service, equipment, or supply. CCP is obligated to authorize all medically necessary PDN to promote independence and support the client living at home.

PDN cannot be considered for the primary purpose of providing respite care, childcare, or ADLs for the client, housekeeping services, or comprehensive case management beyond the service coordination required by the Texas Nursing Practice Act.

Claims for PDN services must be submitted to TMHP as follows:

Procedure Code	Maximum Fee
Independently Enrolled RNs/LVNs	
T1000 with modifier TD or TE	15 minutes
Home Health Agencies	
T1000 with modifier TD or TE	15 minutes
T1002	15 minutes
T1003	15 minutes

Note: *Independently-enrolled LVNs must use the TE modifier, and independently-enrolled RNs must use the TD modifier.*

Home health agencies that provide PDN services for clients with a tracheostomy or clients who are ventilator-dependent receive additional reimbursement. Providers must bill using procedure codes T1000, T1002, or T1003 with the UA modifier and one of the following diagnosis codes:

Diagnosis Codes							
J9500	J9501	J9502	J9503	J9504	J9509	Z930	Z990
Z9911	Z9912	J95850	Z9989	Z430			

Because of the nature of the service being provided, some billing situations are unique to PDN. These billing requirements are as follows:

- All hours worked on one day must be billed together, on one detail, even if they involve two shifts. For example, if Nurse A works 7 a.m. to 11 a.m. and then returns and works 7 p.m. to 11 p.m., services must be billed for 8 hours (32 15-minute units) on one detail for that date of service.
- An individually-enrolled nurse will not be reimbursed for more than 16 hours of PDN services in one day.

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PDN may be delivered in a provider to client ratio other than one-on-one. An RN or LVN may provide PDN services to more than one client over the span of the day as long as each client's care is based on an individualized POC, and each client's needs and POC do not overlap with another client's needs and POC. Only the time spent on direct PDN for each client is reimbursed. Total PDN billed for all clients cannot exceed an individual provider's total number of hours at the POS.

A single nurse may be reimbursed for services to more than one client in a single setting when the following conditions are met:

- The hours for PDN for each client have been authorized through CCP.
- Only the actual "hands-on" time spent with each client is billed for that client.
- The hours billed for each client do not exceed the total hours approved for that client and do not exceed the actual number of hours for which services were provided.

  Example: *If the prior authorized PDN hours for Client A is four hours, Client B is six hours, and the actual time spent with both clients is eight hours, the provider must bill for the actual one-on-one time spent with each client, not to exceed the client's prior authorized hours or total hours worked. It would be acceptable to bill four hours for Client A and four hours for Client B, or three hours for Client A and five hours for Client B. It would not be acceptable to bill five hours for Client A and three hours for Client B. It would be acceptable to bill ten hours if the nurse actually spent ten hours onsite providing prior authorized PDN services split as four hours for Client A and six hours for Client B. A total of ten hours cannot be billed if the nurse worked only eight hours.*

For reimbursement purposes, PDN must always be submitted with POS 2 (home) regardless of the setting in which services are actually provided. PDN may be provided in any of the following settings:

- Client's home
- Client's school
- Client's daycare facility

PDN that duplicates services that are the legal responsibility of the school districts are not reimbursed. The school district, through the SHARS program, is required to meet the client's SN needs while the client is at school; however, if those needs cannot be met by SHARS or the school district, documentation supporting medical necessity may be submitted to the CCP with documentation that nursing services are not provided in the school.

"Responsible adult" means an individual who is an adult, as defined by the Texas Family Code, and who has agreed to accept the responsibility for providing food, shelter, clothing, education, nurturing, and supervision for the client. Responsible adults include, but are not limited to: biological parents, adoptive parents, foster parents, guardians, court-appointed managing conservators, and other family members by birth or marriage.

A responsible adult of a minor client or a client's spouse may not be reimbursed for PDN even if the responsible adult is an enrolled provider or employed by an enrolled provider.

PDN is subject to retrospective review and possible recoupment when the medical record does not document that the provision of PDN is medically necessary based on the client's situation and needs. The PDN provider's record must explain all discrepancies between the service hours approved and the service hours provided. For example, the parents released the provider from all responsibility for the service hours or the agency was not able to staff the service hours. The release of provider responsibility does not indicate the client does not have a medical need for the services during those time periods.

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2.13.2.1 PDN Provided During a Skill Nursing Visit for TPN Administration Education

For clients who receive PDN services and who also require TPN administration education, the intermittent SN visits may be reimbursed separately when the SN services are for client and caregiver training in TPN administration and the PDN provider is not an RN appropriately trained in the administration of TPN, and the PDN provider is not able to perform the function.

PDN and SN must not be routinely performed on the same date during the same time period.

PDN and SN will not be considered for reimbursement when the services are performed on the same date during the same time period without prior authorization approval.

If the SN visit for TPN education occurs during a time period when the PDN provider is caring for the client, both the PDN provider and the nurse educator must document in the client's medical record the skilled services individually provided including, but not limited to:

- The start and stop time of each nursing providers specialized task(s)
- The client condition that requires the performance of skilled PDN tasks during the SN visit for TPN education
- The skilled services that each provided during that time period

Both the intermittent skilled nurse visit and the PDN services provided during the same time period may be recouped if the documentation does not support the medical necessity of each service provided.

2.13.2.2 Criteria

2.13.2.2.1 Client Eligibility Criteria

To be eligible for PDN services, a client must meet all the following criteria:

- Be birth through 20 years of age and eligible for Medicaid and THSteps
- Meet medical necessity criteria for PDN
- Have a primary physician who must:
  - Provide a prescription for PDN.
  - Establish a POC.
  - Provide documentation to support the medical necessity of PDN services.
  - Provide continuing medical care and supervision of the client, including, but not limited to, examination or treatment within 30 calendar days prior to the start of PDN services, or examination or treatment that complies with the THSteps periodicity schedule, or is within six months of the PDN extension SOC date, whichever is more frequent (for extensions of PDN services). This requirement may be waived based on review of the client's specific circumstances.

    Note: *The physician visit may be waived when a diagnosis has already been established by the physician, and the client is under the continuing care and medical supervision of the physician. A waiver is valid for no more than 365 days, and the client must be seen by his/her physician at least once every 365 days. The waiver must be based on the physician's written statement that an additional evaluation visit is not medically necessary. This documentation must be maintained by the physician and the provider in the client's medical record.*
- Provide specific written, dated orders for the client who is receiving continuing or ongoing PDN services.
- Require care beyond the level of services provided under Texas Medicaid (Title XIX) Home Health Services

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Clients who are birth through 17 years of age must reside with a responsible adult who is either trained to provide nursing care or is capable of initiating an identified contingency plan when the scheduled private duty nurse is unexpectedly unavailable.

2.13.2.2.2 Medical Necessity

PDN is considered medically necessary when a client has a disability, physical, or mental illness, or chronic condition and requires continuous, skillful observations, judgments, and interventions to correct or ameliorate his or her health status.

Documentation submitted for a request for PDN must address the following questions:

- Is the client dependent on technology to sustain life?
- Does the client require ongoing and frequent skilled interventions to maintain or improve health status?
- Will delaying skilled intervention impact the health status of the client? If so, how will the health status be affected?
    - Deterioration of a chronic condition
    - Risk of death
    - Loss of function
    - Imminent risk to health status due to medical fragility

2.13.2.2.3 Place of Service (POS)

PDN is based on the need for skilled care in the client's home; however, these services may follow the client and may be provided in accordance with 42 CFR §440.80.

The POS must be able to support the client's health and safety needs. It must be adequate to accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies required by the client. Necessary primary and backup utilities, communication, fire, and safety systems must be available at all times.

2.13.2.2.4 Amount and Duration of PDN

The amount and duration of PDN must always be commensurate with the client's medical needs. Requests for services must reflect changes in the client's condition that affect the amount and duration of PDN.

2.13.3 * Prior Authorization and Documentation Requirements

A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

A CNM, CNS, NP, or PA may sign all documentation related to the provision of private duty nursing services on behalf of the client's physician when the physician delegates this authority.

All documentation must be maintained by the requesting PDN provider. The PDN provider may be asked to submit additional documentation to support medical necessity.

Requests for nursing services must be submitted on the required Medicaid authorization forms and include supporting documentation. The supporting documentation must:

- Clearly and consistently describe the client's current diagnosis, functional status, and condition.
- Consistently describe the treatment throughout the documentation.
- Provide a sufficient explanation as to how the requested nursing services correct or ameliorate the client's disability, physical or mental illness, or condition.

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When a provider receives a referral for PDN, the provider must have an RN perform a nursing assessment of the client within the client's home environment. This assessment must be performed before seeking prior authorization for PDN, with any request for PDN recertification, or any request to modify PDN hours.

The assessment must demonstrate the following:

- Medical necessity for PDN.
- Safety of providing care in the proposed setting.
- If birth through 17 years of age, the client resides with a responsible adult who is either trained to provide nursing care or is capable of initiating an identified contingency plan when the scheduled private duty nurse is unexpectedly unavailable.
    - "Responsible adult" means an individual who is an adult, as defined by the Texas Family Code, and who has agreed to accept the responsibility for providing food, shelter, clothing, education, nurturing, and supervision for the client. Responsible adults include, but are not limited to: biological parents, adoptive parents, foster parents, guardians, court-appointed managing conservators, and other family members by birth or marriage.
    - An identified contingency plan is a structured process designed by the responsible adult and the PDN provider, by which a client will receive care when a scheduled private duty nurse is unexpectedly unavailable, and the responsible adult is unavailable, or is not trained to provide the nursing care. The identified responsible adult must be able to initiate the contingency plan.
- The existing level of care and any additional health-care services including the following: SHARS, MDCP, OT, PT, ST, primary home care (PHC), and case management services.

    Note: *Services provided under these programs do not prevent a client from obtaining all medically necessary services. Certain school services are provided to meet education needs, not medical needs. Records related to a client's Individuals with Disabilities Education Act (IDEA) services are confidential records that clients do not have to release or provide access to.*

When an RN completes a client assessment and identifies a medical necessity for ADLs or health-related functions to be provided by a nurse, the scope of PDN services may include these ADLs or health-related functions.

Note: *CCP does not review or authorize PDN based on partial or incomplete documentation.*

PDN must be prior authorized, and requests for PDN must be based on the current medical needs of the client.

The following criteria are considered for PDN prior authorization:

- The documentation submitted with the request is complete.
- The requested services are nursing services as defined by the Texas Nursing Practice Act and its implementing regulations.
- The explanation of the client's medical needs is sufficient to support a determination that the requested services correct or ameliorate the client's disability, physical or mental illness, or chronic condition.
- The client's nursing needs cannot be met on an intermittent or part-time basis through Texas Medicaid (Title XIX) Home Health Services skilled nursing services.
- There is no TPR financially responsible for the services.

Only those services that CCP determines to meet the medical necessity criteria for PDN are reimbursed. Before CCP determines the requested nursing services do not meet the criteria, the TMHP Medical Director contacts the treating physician to determine whether additional information or clarification can be provided that would allow for the prior authorization of the requested PDN. If the TMHP

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Medical Director is not successful in contacting the treating physician or cannot obtain additional information or clarification, the TMHP Medical Director makes a decision based on the available information.

Providers must obtain prior authorization within three calendar days of the SOC for services that have not been prior authorized. During the prior authorization process, providers are required to deliver the requested services from the SOC date. The SOC date is the date agreed to by the physician, the PDN provider, and the client or responsible adult and is indicated on the submitted POC as the SOC date.

Note: *CCP does not prior authorize an SOC date earlier than seven calendar days before contact with TMHP.*

Prior authorizations for more than 16 hours per day are not issued to a single, independently-enrolled nurse. Requests for prior authorizations of PDN must always be commensurate with the client's medical needs. Requests for services must reflect changes in the client's condition that affect the amount and duration of PDN.

The length of the prior authorization is determined on an individual basis and is based on the goals and timelines identified by the physician, provider, and client or responsible adult. PDN is not prior authorized for more than six months at a time.

PDN is not prior authorized under any of the following conditions:

- The client does not meet medical necessity criteria.
- The client does not have a primary physician.
- The client is 21 years of age or older.
- The client's needs are within the scope of services available through Texas Medicaid (Title XIX) Home Health Services SN or home health agency services because the needs can be met on a part-time or intermittent basis.

Intermittent SN visits for clients who receive PDN and who require TPN administration education may be considered for separate prior authorization if:

- The PDN provider is not an RN who has been appropriately trained in the administration of TPN, and the PDN provider is not able to perform the function.
- There is documentation that supports the medical need for an additional skilled nurse to perform TPN.

The SN services may be prior authorized only for the client and caregiver who will be trained in TPN administration.

Clients whose only SN need is the provision of education for self-administration of prescribed subcutaneous (SQ), intramuscular (IM), or intravenous (IV) injections will not qualify for PDN services. Nursing hours for the sole purpose of providing education to the client and caregiver may be considered through intermittent home health SN visits.

2.13.3.1 Retroactive Client Eligibility

Retroactive eligibility occurs when the effective date of a client's Medicaid coverage is before the date that the client's Medicaid eligibility is added to TMHP's eligibility file, which is called the "add date."

For clients with retroactive eligibility, prior authorization requests must be submitted after the client's add date and before a claim is submitted to TMHP.

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For services provided to Medicaid clients during the client's retroactive eligibility period (i.e., the period from the effective date to the add date, prior authorization must be obtained within 95 days from the client's add date and before a claim for those services is submitted to TMHP). For services provided on or after the client's add date, the provider must obtain prior authorization within three business days of the date of service.

The provider is responsible for verifying eligibility. The provider is strongly encouraged to access the Automated Inquiry System (AIS) or TexMedConnect to verify eligibility frequently while providing services to the client. If services are discontinued before the client's add date, the provider must still obtain prior authorization within 95 days of the add date to be able to submit claims.

2.13.3.2 Start of Care (SOC)

The SOC is the date that care is to begin, as agreed on by the family, the client's physician, and the provider, and as listed on the POC and the CCP Prior Authorization Request Form. Providers are responsible for determining whether they can accept the client for services.

Once the provider accepts a client for service and accepts responsibility for providing PDN, the provider is required to deliver those services beginning with the SOC date. Providers are responsible for a safe transition of services when the authorization decision is a denial or a reduction of services. Providers are required to notify the physician and the client's family on receipt of an authorization, a denial, or a change in PDN.

Providers must submit complete documentation no later than three business days from an SOC date to obtain initial coverage for the SOC date.

> ***Note:*** *Texas Medicaid (Title XIX) Home Health Services does not authorize an SOC date earlier than three business days before contact with TMHP.*

For PDN recertification, CCP must receive complete documentation no later than three business days before the SOC date. It is recommended that recertification requests be submitted up to 30 days before the current authorization ends.

During the prior authorization process for initial and recertification requests, providers are required to deliver the requested services from the SOC date.

2.13.3.3 Prior Authorization of Initial Requests

Completed initial requests must be received and dated by CCP within three business days of the SOC. The request must be received by CCP no later than 5 p.m., Central Time, on the third day to be considered received within three business days. If a request is received more than three business days after the SOC, or after 5 p.m., Central Time, on the third day, authorization is given for dates of service beginning three business days before receipt of the completed request.

An initial PDN prior authorization request requires all of the following:

- CCP Prior Authorization Request form
- Home Health Plan of Care (POC) form
- CCP Nursing Addendum to Plan of Care form

All forms must be completed, signed, and dated by the primary physician within 30 calendar days prior to the SOC. The RN who completes the assessment and the client, or responsible adult, must also sign the CCP Nursing Addendum to Plan of Care form.

The CCP Nursing Addendum to Plan of Care form must include all of the following:

- Updated problem list
- Updated rationale/summary page
- Contingency plan

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- 24-hour daily care flowsheet
- Signed acknowledgement

Initial requests for PDN may be prior authorized for up to 90 days.

Refer to: Nursing Addendum to Plan of Care (CCP) on the TMHP website at www.tmhp.com.

CRCP Prior Authorization Request Form on the TMHP website at www.tmhp.com.

Home Health Plan of Care (POC) on the TMHP website at www.tmhp.com.

2.13.3.4 Authorization for Revision of Current Services

The provider may request a revision at any time during the authorization period if medically necessary. The provider must notify TMHP at any time during an authorization period if the client's condition changes and the authorized services are not commensurate with the client's medical needs.

Completed requests for revision of PDN hours during the current authorization period must be received by CCP within three business days of the revised SOC. The request must be received by CCP no later than 5 p.m., Central Time, on the seventh day to be considered received within three business days. If a request is received more than three business days after the revised SOC or after 5 p.m., Central Time, on the third day, authorization is given for dates of service beginning three business days before receipt of the completed request.

The revised PDN prior authorization request must include all of the following:

- CCP Prior Authorization Request form
- Home Health Plan of Care (POC) form
- CCP Nursing Addendum to Plan of Care form

The provider is responsible for ensuring that the physician reviews and signs the POC within 30 calendar days of the start date of the revised authorization period or more often if required by the client's condition or agency licensure. The provider must maintain the physician-signed POC in the client's medical record. PDN providers should not submit a revised POC unless they are requesting a revision.

Revision requests for PDN may be prior authorized up to six months.

If all necessary documentation is not submitted for a six-month authorization, an authorization for a period up to three months may be approved.

Revisions to a current certification must fall within the certification period. If the revision extends beyond the current certification period, new authorization documentation must be submitted to CCP.

Refer to: Nursing Addendum to Plan of Care (CCP) on the TMHP website at www.tmhp.com.

CRCP Prior Authorization Request Form on the TMHP website at www.tmhp.com.

Home Health Plan of Care (POC) on the TMHP website at www.tmhp.com.

2.13.3.5 Recertifications of Authorizations

Completed extension requests must be received and dated by CCP at least seven calendar days before, but no more than 30 days before, the current authorization expiration date. The request must be received by CCP no later than 5 p.m., Central Time, on the seventh day, to be considered received within seven calendar days. If a request is received less than seven calendar days before the current authorization expiration date, or after 5 p.m., Central Time, on the seventh day, authorization is given for dates of service beginning no sooner than seven calendar days after the receipt of the completed request by CCP.

Recertifications may be prior authorized for up to six months. The following criteria are required for recertification authorization:

- The client has received PDN services for at least three months.

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- No significant changes in the client's condition have occurred for at least three months.
- No significant changes in the client's condition are anticipated.
- The client's responsible adult, physician, and provider agree that a recertification authorization is appropriate.

The recertification process includes the following:

- All required documentation for PDN services (including the Physician POC, the Nursing Addendum to POC, and the CCP Prior Authorization Request Form)
- CCP Private Duty Nursing six-Month Authorization form, which must be signed and dated by the primary physician, nurse provider, and client, or responsible adult

The nursing care provider is responsible for ensuring that a new Physician POC is obtained within 30 calendar days of the authorization period ending and maintained in the client's record. Providers should not submit interim POCs to CCP unless requesting a revision.

The nursing care provider must notify CCP at any time during the authorization period if the client's condition and need for SN care significantly changes.

The nursing care provider may request a revision from TMHP at any time during the authorization period if the client's condition requires it.

All authorization timelines apply to recertifications also.

Refer to: Nursing Addendum to Plan of Care (CCP) on the TMHP website at www.tmhp.com.

CRCP Prior Authorization Request Form on the TMHP website at www.tmhp.com.

Home Health Plan of Care (POC) on the TMHP website at www.tmhp.com.

2.13.3.6 Termination of Authorization

An authorization may be terminated when the:

- Client is no longer eligible for CCP or Medicaid.
- Client no longer meets the medical necessity criteria for PDN.
- POS can no longer accommodate the client's health and safety.
- Client or responsible adult refuses to comply with the service plan and compliance is necessary to ensure the client's health and safety.

2.13.3.7 Client and Provider Notification

When PDN is approved as requested, the provider receives written notification. The provider is responsible for notifying the client/family and the physician of the authorized services.

CCP notifies the client and provider in writing when the following instances occur:

- PDN is denied.
- PDN hours authorized are less than the hours requested on the POC.
- PDN hours are modified (e.g., hours are requested by the week but are authorized by the day).
- CCP receives incomplete information from the provider.
- Dates of service authorized are different from those requested.
- The provider is responsible for notification and coordination with the physician and family.

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2.13.3.8 Authorization Appeals

Providers may appeal denials or modifications of requested PDN with documentation to support the medical necessity of the requested PDN. A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply. Appeals must be submitted to CCP with complete documentation and any additional information within two weeks of the date on the decision letter. If changes are made to the authorization based on this documentation, CCP goes back no more than three business days for initial or revision requests and no more than seven calendar days for recertification requests when additional documentation is submitted.

The client or responsible adult is notified of any denial or modification of requested services and is given information about how to appeal CCP's decision.

Documentation forms have been designed to improve communication between providers and CCP. The forms are available in English and Spanish.

All documentation must be submitted together, and requests are not reviewed until all documentation is received. If complete documentation is received at CCP by 3 p.m., Central Time, a response is returned to the provider within one business day. Complete documentation for initial, revision, recertification, and extension requests for PDN authorizations include all of the following:

- CCP Prior Authorization Request Form on the TMHP website at www.tmhp.com.
- Home Health Plan of Care (POC) on the TMHP website at www.tmhp.com.
- Nursing Addendum to Plan of Care (CCP) on the TMHP website at www.tmhp.com.

2.13.3.9 CCP Prior Authorization Request Form

The CCP Prior Authorization Request Form must be completed, signed, and dated by the physician. When PDN services are ordered, by signing the form the physician attests and certifies the client's medical condition is sufficiently stable to permit safe delivery of PDN as described in the plan of care. All requested dates of service must be included.

2.13.3.10 Home Health Plan of Care (POC)

The POC must be recommended, signed, and dated by the client's primary physician. A POC must meet the standards outlined in the 42 CFR §484.18 related to the written POC. The primary physician must review and revise the POC, in consultation with the provider and the responsible adult, for each prior authorization, or more frequently as the physician deems necessary or the client's situation changes.

Pursuant to 42 CFR §484.18, the POC must include the following elements:

- All pertinent diagnoses
- Client's mental status
- Types of services requested including amount, duration, and frequency
- Medical equipment needed
- Prognosis
- Rehabilitation potential
- Functional limitations
- Activities permitted
- Nutritional requirements
- Medications, including dose, route, and frequency
- Treatments, including amount, duration, and frequency
- Safety measures needed

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- Instructions for a timely discharge from service, if appropriate
- Date the client was last seen by the physician
- Other medical orders
- Start- and end-of-care dates
- Responsible adult or identified contingency plan

Note: *Coverage periods do not coincide necessarily with calendar weeks or months but, instead, cover a number of services to be scheduled between a start and end date that is assigned during the prior authorization period. A week includes the day of the week on which the prior authorization period begins and continues for seven days. For example, if the prior authorization starts on a Thursday, the prior authorization week runs Thursday through Wednesday. The number of nursing hours authorized for a week must be contained in that prior authorization week. Hours billed in excess of those authorized for the PAN week are subject to recoupment.*

2.13.3.11 Nursing Addendum to Plan of Care (CCP) Form

The Nursing Addendum to Plan of Care (CCP) Form addresses PDN eligibility criteria, nursing care plan summary, health history summary, 24-hour schedule, and the rationale for the hours of PDN requested.

The following is a description of the nursing care plan summary:

- The nursing care summary is not a complete nursing care plan.
- Information must be client-focused and detailed.
- The problem list must reflect the reasons that nursing services are needed. The problem list is not the nursing care plan. Providers must identify two-to-four current priority problems from their nursing care plan. The problem does not need to be stated as a nursing diagnosis. The problems listed must focus on the primary reasons that a licensed nurse is required to care for the client. Other attached documents *are not* accepted in lieu of this section.
- The Goals must relate directly to the problems listed and be client-specific and measurable. Goals may be short- or long-term; however, for many clients who receive PDN, the goals generally are long-term.
- The Outcomes are the effects of the provider's nursing interventions and must be measurable. Generally, these are more short-term than goals. For initial requests, list expected outcomes. Extension requests should note the results of nursing interventions.
- The Progress must be viewed as a "yardstick" or continuum on which progress toward goals is marked. Initial requests must state expected progress for the authorization period. Extension requests must list the progress noted during the previous authorization period. It is recognized that all progress may not be positive.
- The addendum must summarize the client's health problems relating to the medical necessity for PDN.
- The addendum must clearly communicate a picture of the client's overall condition and nursing care needs.
- The summary of recent health history is imperative in determining whether the client's condition is stable or if new nursing care needs have been identified. This section gives the PDN provider an opportunity to describe the client's recent health problems, including acute episodes of illness, hospitalizations, injuries, and so on. The summary should create a complete picture of the client's condition and nursing care needs. The summary may cover the previous 90 days, even though the authorization period is 60 days; however, the objective of the summary is to capture the client's

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recent health problems and current health priorities. This section should not be merely a list of events. This section is the place to indicate the frequency of nursing interventions if they are different from the physician's order on the POC, such as, the order may be for a procedure to be PRN (Pro Re Nata "As Needed"), but it is actually being performed every two hours.

- The addendum must include the rationale for increasing, decreasing, or maintaining the level of PDN and must relate to the client's health problems and goals.
- The addendum must include the provider's plan to decrease hours or discharge from service (if appropriate).

2.13.3.11.1 The client's 24-Hour Daily Schedule

All direct-care services must be identified. It is understood that the schedule may change, as the client's needs change. CCP does not have to be notified of changes in the schedule except as they occur when a PDN recertification is requested.

2.13.3.12 Responsible Adult or Identified Contingency Plan Requirement

For clients who are birth through 17 years of age, the client must reside with an identified responsible adult who is either trained to provide nursing care or is capable of initiating an identified contingency plan when the scheduled private duty nurse is unexpectedly unavailable.

- "Responsible adult" means an individual who is an adult, as defined by the Texas Family Code, and who has agreed to accept the responsibility for providing food, shelter, clothing, education, nurturing, and supervision for the client. Responsible adults include, but are not limited to: biological parents, adoptive parents, foster parents, guardians, court-appointed managing conservators, and other family members by birth or marriage.
- An identified contingency plan is a structured process, designed by the responsible adult and the PDN provider, by which a client will receive care when a scheduled private duty nurse is unexpectedly unavailable, and the responsible adult is unavailable, or is not trained, to provide the nursing care. The responsible adult must be able to initiate the identified contingency plan.

The responsible adult's signature must be on the form acknowledging:

- Information about CCP PDN has been discussed and received.
- PDN may change or end based on a client's need for nursing care.
- PDN is not authorized for the primary purpose of providing respite, childcare, ADLs, or housekeeping.
- All requirements have been met before seeking prior authorization for PDN.
- The responsible adult has participated in the development of the POC and the nursing care plan for the client.
- Emergency plans have been made and are part of the client's care plan.
- The client or responsible adult agrees to follow the physician's POC.

2.13.3.13 Special Circumstances

Prior authorization may be considered for PDN services provided in a school or day care facility, at the request of the family, provided the client requires the requested amount of PDN services in the home.

Prior authorization may be considered for PDN services provided in a hospital, SN facility, or intermediate care facility for the mentally retarded, or special care facility with documentation from the facility showing it is unable to meet the SN needs of the client and the services are medically necessary. These facilities are required by licensure to meet all the medical needs of the client.

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2.13.3.14 Documentation of Services Provided and Retrospective Review

Documentation elements that are routinely assessed for compliance in retrospective review of client records include, but are not limited to, the required documentation noted previously, as well as the following:

- All entries are legible to people other than the author, dated (month, day, year, time), and signed by the author.
- Each page of the record documents the client's name and Medicaid identification number.
- Client assessment time is documented at the beginning of each shift.
- All nurses' arrival and departure times are documented with signature and time in the narrative section of the nurses' notes.
- Entries in the nursing flowsheet or narrative notes must be dated and timed every 1 to 2 hours and must include the following:
  - The client's condition.
  - The name of the medication, dose, route, time given, client response, and other pertinent information is recorded when medication is administered.
  - The name of treatment, time given, route or method used, client response, and other pertinent information is provided when treatments are administered.
  - The amount, type, times given, route or method used, client response, and other pertinent information is provided when feedings are administered.
- The POC and documentation of services correlate with and reflect medical necessity for the services provided on any given day.
- A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.
- Client's arrival or departure from the home setting is documented with the time of arrival, departure, mode of transportation, and who accompanied the client.
- Documentation of teaching the client or the client's responsible adult includes the length of time, the subject of the teaching, the understanding of the subject matter by the person receiving the teaching, and other pertinent information.
- Supervisory visits include specifics of the visit.
- If a client is receiving SN services through another program or service in addition to CCP, such as MDCP, each provider's shift notes designate specifically which type of service they are providing during that shift.

2.13.4 Claims Information

PDN providers must submit claims for services in an approved electronic claims format or on the appropriate claim form based on their provider type. Home health agencies must submit claims on the UB-04 CMS-1450 paper claim form. Independently enrolled nurses must submit claims on the CMS-1500 paper claim form. TMHP does not supply the forms.

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Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims.

Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for paper claims completion instructions.

2.13.5 Reimbursement

PDN services are reimbursed in accordance with 1 TAC §355.8441.

2.14 Therapy Services (CCP)

Occupational therapist, physical therapist, and speech therapist services beyond the limitations of Texas Medicaid and Title XIX Home Health Services are benefits of the CCP for clients who are birth through 20 years of age and who are CCP eligible when:

- Therapy is prescribed by a licensed physician.
- Documentation of medical necessity supports a condition that requires ongoing therapy or rehabilitation in the usual course, treatment, and management of the client's condition.
- Therapy services are provided by a licensed therapist.
- Therapy is provided in one of the following places of service:
  - CORF and ORF
  - Inpatient rehabilitation facility (freestanding)
  - Home
  - Licensed hospital
  - Medicaid-enrolled private therapist office
  - Physician office

This section does not apply to CORFs and ORFs.

Refer to: Subsection 2.5, "Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Outpatient Rehabilitation Facilities (ORFs)" in this handbook.

Subsection 2.16, "Inpatient Rehabilitation Facility (Freestanding) (CCP)" in this handbook.

Therapy goals for an acute or chronic medical condition include, but are not limited to, improving, maintaining, and slowing the deterioration of function.

Therapy is considered acute for 180 days from the first date (onset) of therapy for a specific condition. If the client's condition persists for more than 180 days from the start of therapy services, the condition is considered chronic.

Providers must maintain a comprehensive treatment plan that includes documentation that supports medical necessity for therapy services and confirms that the client meets the criteria for acute services. The treatment plan must include all of the following:

- The specific procedures and disciplines to be used
- The amount, duration, and frequency of therapy
- The therapist who participated in developing the comprehensive treatment plan

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- Rehabilitation potential of the client
- Functional limitations of the client
- Date the client was last seen by the physician

Therapy may be performed by a licensed occupational therapist, physical therapist, speech therapist, or one of the following under the supervision of a licensed therapist: licensed therapy assistant or licensed speech-language pathology intern.

Services performed by an OT aide, OT orderly, OT student, OT technician, PT aide, PT orderly, PT student, PT technician, SLP aide, SLP orderly, SLP student, or SLP technician are not a benefit of Texas Medicaid.

Therapy services performed by an unlicensed provider are subject to retrospective review and recoupment.

OT, PT, and ST may be performed in the office or home setting and may be authorized to be provided in the following locations: home of the client, home of the caregiver or guardian, client's daycare facility, or the client's school.

Services provided to a client on school premises are only permitted when delivered before or after school hours. The only CCP therapy services that can be delivered in the client's school during regular school hours are those delivered by school districts as SHARS in POS 9.

Refer to: Section 3, "School Health and Related Services (SHARS)" in this handbook for more information about SHARS.

PT provided in the nursing home setting is limited to the nursing facility because it must be available to nursing home residents on an "as needed" basis and must be provided directly by the staff of the facility or furnished by the facility through arrangements with outside-qualified resources. Nursing home facilities must refrain from admitting clients who need goal directed therapy if the facility is unable to provide these services.

Home health agencies that perform therapy services under CCP are allowed one visit per day, per therapy type, and may be reimbursed at the statewide visit rate.

Services That Are Not a Benefit

The following services are not a benefit of CCP:

- Procedure code 97010 (application of a modality to one or more areas; hot or cold packs).
- Services that are not medically necessary. Examples include, but are not limited to:
  - Massage therapy that is the sole therapy or is not part of a therapeutic comprehensive treatment plan to address an acute condition.
  - Hippotherapy.
  - Separate reimbursement for VitalStim® therapy for dysphagia.
  - Treatment solely for the instruction of other agency or professional personnel in the client's PT, OT, or ST program.
  - Training in nonessential tasks (e.g., homemaking, gardening, recreational activities, cooking, driving, assistance with finances, scheduling).
  - Emotional support, adjustment to extended hospitalization or disability, and behavioral readjustment.
  - Therapy prescribed primarily as an adjunct to psychotherapy.

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2.14.1 Occupational Therapy (OT)

2.14.1.1 Enrollment

HHSC allows enrollment of independently-practicing licensed occupational therapist under CCP. The information in this section applies to CCP services only.

2.14.1.2 Services, Benefits, and Limitations

A procedural modifier is required when submitting claims for occupational therapist services. Providers must use modifier GO for occupational therapist services. Procedural modifiers are not required for evaluations and re-evaluations.

Evaluations (procedure code 97003) are limited to once every 180 rolling days any provider. Re-evaluations (procedure code 97004) may be reimbursed when documentation supports a change in the client's status, or a request for extension of services, or a change of provider.

An evaluation or re-evaluation performed on the same day as therapy from a different therapy type must be performed at distinctly separate times to be considered for reimbursement.

Additional OT evaluations or re-evaluations and swallowing function evaluations or re-evaluations exceeding the limits outlined in this section may be considered for reimbursement with documentation of one of the following:

- A change in the client's medical condition
- A change of provider letter signed and dated by the client or responsible adult documenting all of the following:
  - The date the client ended therapy (effective date of change) with the previous provider
  - The names of the previous and new providers
  - An explanation why providers were changed

If a therapy evaluation or re-evaluation procedure code and like therapy procedure codes are billed for the same date of service by any provider, the like therapy evaluation or re-evaluation will be denied. OT evaluation (procedure code 97003) or re-evaluation (procedure code 97004) will be denied as part of the following OT procedure codes billed with Modifier GO.

Procedure Codes									
97012	97014	97016	97018	97022	97024	97026	97028	97032	97033
97034	97035	97036	97039	97110	97112	97113	97116	97124	97139
97140	97150	97530	97535	97537	97542	97750	97760	97761	97762
97799	S8990								

The following procedure codes are billed in 15-minute increments:

Procedure Codes									
97032	97033	97034	97035	97036	97039	97110	97112	97113	97116
97124	97139	97140	97530	97535	97537	97542	97750	97760	97761
97762	97799	S8990							

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OT procedure codes that are billed in 15-minute units are limited to a combined maximum of 4 units (1 hour) per day per therapy type. Additional services may be considered with prior authorization. If the claims for therapy services exceed four units a day, the claim will be denied, but providers may appeal with all of the following information:

- Provider must identify the authorization week period that includes the date of service being appealed.
- Provider must attest that claims for all therapy services provided for the week in question have been submitted.

All 15-minute increment 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 must be rounded up or down to the nearest quarter hour.

The documentation retained in the client's file must include the billable start time, billable stop time, total billable minutes, and activity that was performed.

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 evenly divisible by 15, minutes greater than 7 are converted to 1 unit and 7 or fewer minutes are converted to 0 unit.

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 1 unit. Consequently, 68 total billable minutes = 5 units of service. The following table indicates the time intervals for 0 through 8 units:

Units	Number of Minutes
0 units	0 minutes through 7 minutes
1 unit	8 minutes through 22 minutes
2 units	23 minutes through 37 minutes
3 units	38 minutes through 52 minutes
4 units	53 minutes through 67 minutes
5 units	68 minutes through 82 minutes
6 units	83 minutes through 97 minutes
7 units	98 minutes through 112 minutes
8 units	113 minutes through 127 minutes

The following procedure codes are limited to once per day, for each therapy type (OT and PT):

Procedure Codes								
97012	97014	97016	97018	97022	97024	97026	97028	97150

Electrical stimulation therapy (procedure code 97032) may be considered with documentation of medical necessity.

2.14.1.3 Prior Authorization and Documentation Requirements

Prior authorization is required for OT except for therapy provided in the acute care inpatient setting, evaluations or re-evaluations, services provided through the SHARS or Early Childhood Intervention (ECI) programs.

Refer to: Section 3, "School Health and Related Services (SHARS)" in this handbook for more information about SHARS.

Subsection 2.7, "Early Childhood Intervention (ECI) Services" in this handbook for more information about ECI.

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Prior authorization for individual therapy services will be considered when all of the following criteria are met:

- The client has an acute or chronic medical condition resulting in a significant decrease in functional ability that will benefit from therapy services.
- Documentation supports treatment goals and outcomes for the specific therapy disciplines requested.
- Services do not duplicate those that are provided concurrently by any other therapy.
- Services are 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 per event for acute care services. Subsequent prior authorization requests may be requested for up to 180 days when submitted with documentation of a chronic condition.

Coverage periods do not necessarily coincide with calendar weeks or months, but instead cover a number of services to be scheduled between a start date and end date that is assigned during the prior authorization period. Prior authorization requests for OT services may be requested with either a weekly frequency or monthly frequency, but not both. A week includes the day of the week on which the prior authorization period begins and continues for total of seven days. The number of therapy services authorized for a week must be provided in that prior authorization week. A month includes the day of the month on which the prior authorization period begins and continues for 30 days. The number of therapy services authorized for a month must be provided in that prior authorization month. Claims for services that exceed those authorized for the prior authorization week or month are subject to recoupment.

All documentation that is related to the therapy services that are prior authorized and provided, including medical necessity and the comprehensive treatment plan, must be maintained in the client's medical record and made available upon request. For each therapy discipline that is provided, the documentation that is maintained in the client's medical record must identify the therapy provider's name and include all of the following:

- Date of service
- Start time of therapy
- Stop time of therapy
- Total minutes of therapy
- Specific therapy performed
- Client's response to therapy

To complete the prior authorization process by paper, the provider must submit the required 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 required documentation through any approved electronic 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 must submit correct and complete information including documentation of medical necessity for the service requested. The physician 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.

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2.14.1.3.1 Initial Prior Authorization Requests

Therapy services may be initiated upon the receipt of the physician's order. Therapy services initiated before the date of the physician order will not be approved.

The initial request for prior authorization must be received no later than five business days from the date therapy treatments are initiated. Requests that are received after the five business-day period will be denied for dates of service that occurred before the date that the request was received.

The following supporting documentation must be submitted for an initial prior authorization request:

- A completed Request for CCP Outpatient Therapy prior authorization form. The request form must be signed and dated by the ordering physician.
  - If the prior authorization form is not signed and dated by the physician, the form must be accompanied by a written order or prescription that is signed and dated by the physician, or a documented verbal order from the physician that includes the date that the verbal order was received.

    Note: *A verbal order is considered current when the date received is on or no more than 60 days before the start of therapy. A written order or prescription is considered current when it is signed and dated on or no more than 60 days before the start of therapy.*
  - A request received without a physician's signature, documented verbal order, or written prescription will not be processed and will be returned to the provider.
- A current therapy evaluation for each therapy discipline that documents the client's age at the time of the evaluation.

  Note: *A therapy evaluation is current when it is performed within 60 days before the initiation of therapy services.*
- A client-specific comprehensive treatment plan that is established by the ordering physician or therapist to be followed during treatment and includes all of the following:
  - Date and signature of the licensed therapist
  - Diagnosis(es)
  - Treatment goals that are related to the client's individual needs for the therapy discipline and associated disciplines requested
  - A description of the specific therapy disciplines being prescribed
  - Duration and frequency of therapy
  - Date of onset of the illness, injury, or exacerbation that requires the therapy services
  - Requested dates of service

A CNM, CNS, NP, or PA may sign all documentation related to the provision of therapy services on behalf of the client's physician when the physician delegates this authority.

The GO modifier is required on all prior authorization requests for OT.

2.14.1.3.2 Subsequent Prior Authorization Requests

A prior authorization request for subsequent services must be received no more than 30 days before the current authorization expires. Prior authorization requests for subsequent services that are received after the current authorization expires will be denied for dates of service that occurred before the date that the submitted request was received.

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Prior authorization requests for subsequent services may be considered with documentation that supports medical necessity and includes all of the following:

- A completed Request for CCP Outpatient Therapy prior authorization form that has been signed and dated by the ordering physician
  - If the prior authorization form is not signed and dated by the physician, the form must be accompanied by a written order or prescription that is signed and dated by the physician, or a documented verbal order from the physician that includes the date the verbal order was received.

    Note: *A verbal order is considered current when the date received is on or no more than 60 days before the start of therapy. A written order or prescription is considered current when it is signed and dated on or no more than 60 days before the start of therapy.*
  - A request received without a physician's signature, documented verbal order, or written prescription will not be processed and will be returned to the provider.
- A current therapy evaluation or re-evaluation for each therapy discipline that documents the client's age at the time of the evaluation or re-evaluation.
  - A therapy evaluation or re-evaluation for subsequent services is current when performed within 30 days before the prior authorization request is received. For example:
    - If an authorization period ends on July 31, 2014, TMHP must receive the prior authorization request for subsequent services between July 1, 2014, and July 31, 2014.
    - The therapy evaluation or re-evaluation for subsequent services can be performed up to 30 days before the date that TMHP receives the prior authorization request.
    - If TMHP receives the prior authorization request for subsequent services on July 1, 2014, the evaluation or re-evaluation can be performed June 1, 2014, through July 1, 2014.
    - If TMHP receives the prior authorization request for subsequent services on July 31, 2014, the evaluation or re-evaluation can be performed July 1, 2014, through July 31, 2014.

An updated, client-specific comprehensive treatment plan that was established by the ordering physician or therapist to be followed during treatment must include all of the following:

- Date and signature of the licensed therapist
- Diagnosis(es)
- Updated treatment goals that are related to the client's individual needs for the therapy discipline and associated disciplines requested
- A description of the specific therapy disciplines that are being prescribed
- Duration and frequency of therapy
- Date of onset of the illness, injury, or exacerbation that requires the therapy services
- A brief summary of the outcomes of the previous treatment as it relates to the client's debilitating condition
- Requested dates of service

2.14.1.3.3 Revisions to Existing Prior Authorization Requests

A prior authorization request for revisions to services may be considered up to the end of the current approved prior authorization.

Requests for revisions to an existing authorization must be received no later than five business days from the date that the revised therapy treatments are initiated. Requests that are received after the five business-day period will be denied for dates of service that occurred before the date that the request was received.

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If a provider or client discontinues therapy during an existing prior authorized period and the client requests services through a new provider, the new provider must submit all of the following:

- A new therapy request form
- A new evaluation with required documentation
- A change-of-provider letter that has been signed and dated by the client or responsible adult and that 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 in this section.

2.14.1.3.4 Frequency Levels

OT services may be provided at one of the following levels commensurate with the client's medical condition, developmental needs, life stage, and therapy needs that are identified in the documentation submitted:

- High Frequency: Therapy provided three or more times a week may be considered when documentation shows all of the following:
  - Client has a medical condition that is rapidly changing.
  - Client has a potential for rapid progress or rapid decline or loss of functional skill.
  - The client's therapy plan and home program require frequent modification by the licensed therapist.
  - The client requires a high frequency of intervention for a limited duration (60 days or fewer) to achieve an identified new skill or recover function lost due to surgery, illness, or trauma.
- Moderate Frequency: Therapy provided two times a week may be considered when documentation shows one or more of the following:
  - The client is making functional progress toward goals.
  - The client is in a critical period to restore function or is at risk of regression.
  - The licensed therapist needs to adjust the client's therapy plan and home program weekly or more often than weekly based on the client's progress and medical needs.
  - The client has complex needs requiring on-going education of the responsible adult.
- Low Frequency: Therapy provided one time per week or every other week may be considered when the documentation shows one or more of the following:
  - The client is making progress toward the client's goals, but the progress has slowed, or the client may be at risk of deterioration due to the client's development or medical condition.
  - The licensed therapist is required to adjust the client's therapy plan and home program weekly based on the client's progress.
  - Every other week therapy is supported for clients whose medical condition is stable, they are making progress, and it is anticipated the client will not regress with every other week therapy. Because the therapy plan changes very slowly, the home program can be managed by the client and the responsible adult and does not require frequent changes by the licensed therapist.
- Maintenance Level/Prevent Deterioration: every other week to monthly or less often visits/sessions may be considered when the client meets one of the following criteria:

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- Progress has slowed or stopped, but documentation supports that ongoing therapy is required to maintain the progress made or prevent deterioration
- The documentation submitted shows the client may be making limited progress toward goals, or goal attainment is extremely slow
- Factors are identified that inhibit the client's ability to achieve established goals (e.g., the client cannot participate in therapy sessions due to behavior issues or issues with anxiety)
- Documentation shows the client and the responsible adult have a continuing need for education, a periodic adjustment of the home program, or regular modification of equipment to meet the client's needs

As a client's condition improves and goals are met, it is anticipated the therapist will decrease to a lesser frequency level.

2.14.1.4 Claims Information

Providers must submit claims for therapy services in an approved electronic claims format, a CMS-1500, or UB-04 CMS-1450 paper claim form from the vendor of their choice. TMHP does not supply the forms.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Refer to: Section 6: Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in Section 6, Claims Filing (*Vol. 1, General Information*).

Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for paper claims completion instructions.

2.14.1.5 Reimbursement

Occupational therapist services are reimbursed in accordance with 1 TAC §355.8441.

See the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com for reimbursement rates.

2.14.2 Physical Therapy (PT)

2.14.2.1 Enrollment

HHSC allows enrollment of independently-practicing licensed physical therapist under CCP. The information in this section applies to CCP services only.

2.14.2.2 Services, Benefits, and Limitations

A procedural modifier is required when submitting claims for physical therapist services. Providers must use modifier GP for physical therapist services. Procedural modifiers are not required for evaluations and re-evaluations.

Evaluations (procedure code 97001) are limited to once every 180 rolling days any provider. Re-evaluations (procedure code 97002) may be reimbursed when documentation supports a change in the client's status, or a request for extension of services, or a change of provider.

An evaluation or re-evaluation performed on the same day as therapy from a different therapy type must be performed at distinctly separate times to be considered for reimbursement.

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Additional PT evaluations or re-evaluations and swallowing function evaluations or re-evaluations exceeding the limits outlined in this section may be considered for reimbursement with documentation of one of the following:

- A change in the client's medical condition
- A change of provider letter signed and dated by the client or responsible adult documenting all of the following:
  - The date the client ended therapy (effective date of change) with the previous provider
  - The names of the previous and new providers
  - An explanation why providers were changed

If a therapy evaluation or re-evaluation procedure code and like therapy procedure codes are billed for the same date of service by any provider, the like therapy evaluation or re-evaluation will be denied. PT evaluation (procedure code 97001) or re-evaluation (procedure code 97002) will be denied as part of the following PT procedure codes billed with Modifier GP.

Procedure Codes									
97012	97014	97016	97018	97022	97024	97026	97028	97032	97033
97034	97035	97036	97039	97110	97112	97113	97116	97124	97139
97140	97150	97530	97535	97537	97542	97750	97760	97761	97762
97799	S8990								

The following procedure codes are billed in 15-minute increments:

Procedure Codes									
97032	97033	97034	97035	97036	97039	97110	97112	97113	97116
97124	97139	97140	97530	97535	97537	97542	97750	97760	97761
97762	97799	S8990							

PT procedure codes that are billed in 15-minute units are limited to a combined maximum of 4 units (1 hour) per day per therapy type. Additional services may be considered with prior authorization. If the claims for therapy services exceed four units a day, the claim will be denied, but providers may appeal with all of the following information:

- Provider must identify the authorization week period that includes the date of service being appealed.
- Provider must attest that claims for all therapy services provided for the week in question have been submitted.

All 15-minute increment 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 must be rounded up or down to the nearest quarter hour.

The documentation retained in the client's file must include the billable start time, billable stop time, total billable minutes, and activity that was performed.

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 evenly divisible by 15, minutes greater than 7 are converted to 1 unit and 7 or fewer minutes are converted to 0 unit.

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 1 unit. Consequently, 68 total billable minutes = 5 units of service.

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Refer to: Subsection 2.14.1, "Occupational Therapy (OT)" in this handbook for 15-minute conversion table.

The following procedure codes are limited to once per day, for each therapy type (OT and PT):

Procedure Codes								
97012	97014	97016	97018	97022	97024	97026	97028	97150

Electrical stimulation therapy (procedure code 97032) may be considered with documentation of medical necessity.

2.14.2.3 Prior Authorization and Documentation Requirements

Prior authorization is required for PT except for therapy provided in the acute care inpatient setting, evaluations or re-evaluations, services provided through the SHARS or Early Childhood Intervention (ECI) programs.

Refer to: Section 3, "School Health and Related Services (SHARS)" in this handbook for more information about SHARS.

Subsection 2.7, "Early Childhood Intervention (ECI) Services" in this handbook for more information about ECI.

Prior authorization for individual therapy services will be considered when all of the following criteria are met:

- The client has an acute or chronic medical condition resulting in a significant decrease in functional ability that will benefit from therapy services.
- Documentation supports treatment goals and outcomes for the specific therapy disciplines requested.
- Services do not duplicate those that are provided concurrently by any other therapy.
- Services are 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 per event for acute care services. Subsequent prior authorization requests may be requested for up to 180 days when submitted with documentation of a chronic condition.

Coverage periods do not necessarily coincide with calendar weeks or months, but instead cover a number of services to be scheduled between a start date and end date that is assigned during the prior authorization period. Prior authorization requests for PT services may be requested with either a weekly frequency or monthly frequency, but not both. A week includes the day of the week on which the prior authorization period begins and continues for total of seven days. The number of therapy services authorized for a week must be provided in that prior authorization week. A month includes the day of the month on which the prior authorization period begins and continues for 30 days. The number of therapy services authorized for a month must be provided in that prior authorization month. Claims for services that exceed those authorized for the prior authorization week or month are subject to recoupment.

All documentation that is related to the therapy services that are prior authorized and provided, including medical necessity and the comprehensive treatment plan, must be maintained in the client's medical record and made available upon request. For each therapy discipline that is provided, the documentation that is maintained in the client's medical record must identify the therapy provider's name and include all of the following:

- Date of service
- Start time of therapy
- Stop time of therapy

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- Total minutes of therapy
- Specific therapy performed
- Client's response to therapy

To complete the prior authorization process by paper, the provider must submit the required 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 required documentation through any approved electronic 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 must submit correct and complete information including documentation of medical necessity for the service requested. The physician 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.

2.14.2.3.1 Initial Prior Authorization Requests

Therapy services may be initiated upon the receipt of the physician's order. Therapy services initiated before the date of the physician order will not be approved.

The initial request for prior authorization must be received no later than five business days from the date therapy treatments are initiated. Requests that are received after the five business-day period will be denied for dates of service that occurred before the date that the request was received.

The following supporting documentation must be submitted for an initial prior authorization request:

- A completed Request for CCP Outpatient Therapy prior authorization form. The request form must be signed and dated by the ordering physician.
  - If the prior authorization form is not signed and dated by the physician, the form must be accompanied by a written order or prescription that is signed and dated by the physician, or a documented verbal order from the physician that includes the date that the verbal order was received.

    Note: *A verbal order is considered current when the date received is on or no more than 60 days before the start of therapy. A written order or prescription is considered current when it is signed and dated on or no more than 60 days before the start of therapy.*
  - A request received without a physician's signature, documented verbal order, or written prescription will not be processed and will be returned to the provider.
- A current therapy evaluation for each therapy discipline that documents the client's age at the time of the evaluation.

  Note: *A therapy evaluation is current when it is performed within 60 days before the initiation of therapy services.*
- A client-specific comprehensive treatment plan that is established by the ordering physician or therapist to be followed during treatment and includes all of the following:
  - Date and signature of the licensed therapist
  - Diagnosis(es)
  - Treatment goals that are related to the client's individual needs for the therapy discipline and associated disciplines requested
  - A description of the specific therapy disciplines being prescribed

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- Duration and frequency of therapy
- Date of onset of the illness, injury, or exacerbation that requires the therapy services
- Requested dates of service

A CNM, CNS, NP, or PA may sign all documentation related to the provision of therapy services on behalf of the client's physician when the physician delegates this authority.

The GP modifier is required on all prior authorization requests for PT.

2.14.2.3.2 Subsequent Prior Authorization Requests

A prior authorization request for subsequent services must be received no more than 30 days before the current authorization expires. Prior authorization requests for subsequent services that are received after the current authorization expires will be denied for dates of service that occurred before the date that the submitted request was received.

Prior authorization requests for subsequent services may be considered with documentation that supports medical necessity and includes all of the following:

- A completed Request for CCP Outpatient Therapy prior authorization form that has been signed and dated by the ordering physician
  - If the prior authorization form is not signed and dated by the physician, the form must be accompanied by a written order or prescription that is signed and dated by the physician, or a documented verbal order from the physician that includes the date the verbal order was received.

    Note: *A verbal order is considered current when the date received is on or no more than 60 days before the start of therapy. A written order or prescription is considered current when it is signed and dated on or no more than 60 days before the start of therapy.*
  - A request received without a physician's signature, documented verbal order, or written prescription will not be processed and will be returned to the provider.
- A current therapy evaluation or re-evaluation for each therapy discipline that documents the client's age at the time of the evaluation or re-evaluation.
  - A therapy evaluation or re-evaluation for subsequent services is current when performed within 30 days before the prior authorization request is received. For example:
    - If an authorization period ends on July 31, 2014, TMHP must receive the prior authorization request for subsequent services between July 1, 2014, and July 31, 2014.
    - The therapy evaluation or re-evaluation for subsequent services can be performed up to 30 days before the date that TMHP receives the prior authorization request.
    - If TMHP receives the prior authorization request for subsequent services on July 1, 2014, the evaluation or re-evaluation can be performed June 1, 2014, through July 1, 2014.
    - If TMHP receives the prior authorization request for subsequent services on July 31, 2014, the evaluation or re-evaluation can be performed July 1, 2014, through July 31, 2014.

An updated, client-specific comprehensive treatment plan that was established by the ordering physician or therapist to be followed during treatment must include all of the following:

- Date and signature of the licensed therapist
- Diagnosis(es)
- Updated treatment goals that are related to the client's individual needs for the therapy discipline and associated disciplines requested
- A description of the specific therapy disciplines that are being prescribed

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- Duration and frequency of therapy
- Date of onset of the illness, injury, or exacerbation that requires the therapy services
- A brief summary of the outcomes of the previous treatment as it relates to the client's debilitating condition
- Requested dates of service

2.14.2.3.3 Revisions to Existing Prior Authorization Requests

A prior authorization request for revisions to services may be considered up to the end of the current approved prior authorization.

Requests for revisions to an existing authorization must be received no later than five business days from the date that the revised therapy treatments are initiated. Requests that are received after the five business-day period will be denied for dates of service that occurred before the date that the request was received.

If a provider or client discontinues therapy during an existing prior authorized period and the client requests services through a new provider, the new provider must submit all of the following:

- A new therapy request form
- A new evaluation with required documentation
- A change-of-provider letter that has been signed and dated by the client or responsible adult and that 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 in this section.

2.14.2.3.4 Frequency Levels

PT services may be provided at one of the following levels commensurate with the client's medical condition, developmental needs, life stage, and therapy needs that are identified in the documentation submitted:

- High Frequency: Therapy provided three or more times a week may be considered when documentation shows all of the following:
  - Client has a medical condition that is rapidly changing.
  - Client has a potential for rapid progress or rapid decline or loss of functional skill.
  - The client's therapy plan and home program require frequent modification by the licensed therapist.
  - The client requires a high frequency of intervention for a limited duration (60 days or fewer) to achieve an identified new skill or recover function lost due to surgery, illness, or trauma.
- Moderate Frequency: Therapy provided two times a week may be considered when documentation shows one or more of the following:
  - The client is making functional progress toward goals.
  - The client is in a critical period to restore function or is at risk of regression.
  - The licensed therapist needs to adjust the client's therapy plan and home program weekly or more often than weekly based on the client's progress and medical needs.
  - The client has complex needs requiring on-going education of the responsible adult.

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- Low Frequency: Therapy provided one time per week or every other week may be considered when the documentation shows one or more of the following:
  - The client is making progress toward the client's goals, but the progress has slowed, or the client may be at risk of deterioration due to the client's development or medical condition.
  - The licensed therapist is required to adjust the client's therapy plan and home program weekly based on the client's progress.
  - Every other week therapy is supported for clients whose medical condition is stable, they are making progress, and it is anticipated the client will not regress with every other week therapy. Because the therapy plan changes very slowly, the home program can be managed by the client and the responsible adult and does not require frequent changes by the licensed therapist.
- Maintenance Level/Prevent Deterioration: every other week to monthly or less often visits/sessions may be considered when the client meets one of the following criteria:
  - Progress has slowed or stopped, but documentation supports that ongoing therapy is required to maintain the progress made or prevent deterioration
  - The documentation submitted shows the client may be making limited progress toward goals, or goal attainment is extremely slow
  - Factors are identified that inhibit the client's ability to achieve established goals (e.g., the client cannot participate in therapy sessions due to behavior issues or issues with anxiety)
  - Documentation shows the client and the responsible adult have a continuing need for education, a periodic adjustment of the home program, or regular modification of equipment to meet the client's needs

As a client's condition improves and goals are met, it is anticipated the therapist will decrease to a lesser frequency level.

2.14.2.4 Claims Information

Providers must submit claims for therapy services in an approved electronic claims format, a CMS-1500, or UB-04 CMS-1450 paper claim form from the vendor of their choice. TMHP does not supply the forms.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in Section 6, Claims Filing (*Vol. 1, General Information*).

Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in Section 6, Claims Filing (*Vol. 1, General Information*) for paper claims completion instructions.

2.14.2.5 Reimbursement

Physical therapist services are reimbursed in accordance with 1 TAC §355.8441.

See the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com for reimbursement rates.

2.14.3 Speech Therapy (ST)

2.14.3.1 Enrollment

HHSC allows enrollment of independently-practicing licensed SLPs under CCP. The information in this section applies to CCP services only.

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2.14.3.2 Services, Benefits, and Limitations

A procedural modifier is required when submitting claims for ST services. Providers must use modifier GN for ST services. Procedural modifiers are not required for evaluations and re-evaluations.

ST evaluations (procedure codes 92521, 92522, 92523, and 92524) are limited to once every 180 rolling days, any provider. If ST reassessment is necessary within the 180 day period, (procedure code S9152) may be reimbursed when documentation supports a change in the client's status, or a request for extension of services, or a change of provider.

Additional ST evaluations or re-evaluations and swallowing function evaluations or re-evaluations exceeding the limits outlined in this section may be considered for reimbursement with documentation of one of the following:

- A change in the client's medical condition
- A change of provider letter signed and dated by the client or responsible adult documenting all of the following:
  - The date the client ended therapy (effective date of change) with the previous provider
  - The names of the previous and new providers
  - An explanation why providers were changed

ST treatment codes 92507, 92508, and 92526 are payable in 15-minute increments at a maximum of four units (one hour) per day.

ST procedure codes that are billed in 15-minute units are limited to a combined maximum of 4 units (1 hour) per day per therapy type. Additional services may be considered with prior authorization. If the claims for therapy services exceed four units a day, the claim will be denied, but providers may appeal with all of the following information:

- Provider must identify the authorization week period that includes the date of service being appealed.
- Provider must attest that claims for all therapy services provided for the week in question have been submitted.

All 15-minute increment 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 must be rounded up or down to the nearest quarter hour.

The documentation retained in the client's file must include the billable start time, billable stop time, total billable minutes, and activity that was performed.

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 evenly divisible by 15, minutes greater than 7 are converted to 1 unit and 7 or fewer minutes are converted to 0 unit.

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 1 unit. Consequently, 68 total billable minutes = 5 units of service.

Refer to: Subsection 2.14.1, "Occupational Therapy (OT)" in this handbook for the 15-minute conversion table.

ST evaluation and re-evaluations will be denied when billed on the same date of service, any provider, as procedure codes 92507 and 92508 with modifier GN.

Procedure codes 92526 and 92610 may be considered for reimbursement for treatment and evaluation of swallowing dysfunctions and oral functions for feeding.

Procedure code 97535 is used for ST services for training for augmentative communication devices.

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2.14.3.3 Prior Authorization and Documentation Requirements

Prior authorization is required for ST except for therapy provided in the acute care inpatient setting, evaluations or re-evaluations, services provided through the SHARS or Early Childhood Intervention (ECI) programs.

Refer to: Section 3, "School Health and Related Services (SHARS)" in this handbook for more information about SHARS.

Subsection 2.7, "Early Childhood Intervention (ECI) Services" in this handbook for more information about ECI.

Prior authorization for individual therapy services will be considered when all of the following criteria are met:

- The client has an acute or chronic medical condition resulting in a significant decrease in functional ability that will benefit from therapy services.
- Documentation supports treatment goals and outcomes for the specific therapy disciplines requested.
- Services do not duplicate those that are provided concurrently by any other therapy.
- Services are 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 per event for acute care services. Subsequent prior authorization requests may be requested for up to 180 days when submitted with documentation of a chronic condition.

Coverage periods do not necessarily coincide with calendar weeks or months, but instead cover a number of services to be scheduled between a start date and end date that is assigned during the prior authorization period. Prior authorization requests for ST services may be requested with either a weekly frequency or monthly frequency, but not both. A week includes the day of the week on which the prior authorization period begins and continues for total of seven days. The number of therapy services authorized for a week must be provided in that prior authorization week. A month includes the day of the month on which the prior authorization period begins and continues for 30 days. The number of therapy services authorized for a month must be provided in that prior authorization month. Claims for services that exceed those authorized for the prior authorization week or month are subject to recoupment.

All documentation that is related to the therapy services that are prior authorized and provided, including medical necessity and the comprehensive treatment plan, must be maintained in the client's medical record and made available upon request. For each therapy discipline that is provided, the documentation that is maintained in the client's medical record must identify the therapy provider's name and include all of the following:

- Date of service
- Start time of therapy
- Stop time of therapy
- Total minutes of therapy
- Specific therapy performed
- Client's response to therapy

To complete the prior authorization process by paper, the provider must submit the required 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.

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To complete the prior authorization process electronically, the provider must submit the required documentation through any approved electronic 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 must submit correct and complete information including documentation of medical necessity for the service requested. The physician 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.

2.14.3.3.1 Initial Prior Authorization Requests

Therapy services may be initiated upon the receipt of the physician's order. Therapy services initiated before the date of the physician order will not be approved.

The initial request for prior authorization must be received no later than five business days from the date therapy treatments are initiated. Requests that are received after the five business-day period will be denied for dates of service that occurred before the date that the request was received.

The following supporting documentation must be submitted for an initial prior authorization request:

- A completed Request for CCP Outpatient Therapy prior authorization form. The request form must be signed and dated by the ordering physician.
    - If the prior authorization form is not signed and dated by the physician, the form must be accompanied by a written order or prescription that is signed and dated by the physician, or a documented verbal order from the physician that includes the date that the verbal order was received.

      Note: *A verbal order is considered current when the date received is on or no more than 60 days before the start of therapy. A written order or prescription is considered current when it is signed and dated on or no more than 60 days before the start of therapy.*
    - A request received without a physician's signature, documented verbal order, or written prescription will not be processed and will be returned to the provider.
- A current therapy evaluation for each therapy discipline that documents the client's age at the time of the evaluation.

  Note: *A therapy evaluation is current when it is performed within 60 days before the initiation of therapy services.*
- A client-specific comprehensive treatment plan that is established by the ordering physician or therapist to be followed during treatment and includes all of the following:
    - Date and signature of the licensed therapist
    - Diagnosis(es)
    - Treatment goals that are related to the client's individual needs for the therapy discipline and associated disciplines requested
    - A description of the specific therapy disciplines being prescribed
    - Duration and frequency of therapy
    - Date of onset of the illness, injury, or exacerbation that requires the therapy services
    - Requested dates of service

A CNM, CNS, NP, or PA may sign all documentation related to the provision of therapy services on behalf of the client's physician when the physician delegates this authority.

The GN modifier is required on all prior authorization requests for ST.

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2.14.3.3.2 Subsequent Prior Authorization Requests

A prior authorization request for subsequent services must be received no more than 30 days before the current authorization expires. Prior authorization requests for subsequent services that are received after the current authorization expires will be denied for dates of service that occurred before the date that the submitted request was received.

Prior authorization requests for subsequent services may be considered with documentation that supports medical necessity and includes all of the following:

- A completed Request for CCP Outpatient Therapy prior authorization form that has been signed and dated by the ordering physician
  - If the prior authorization form is not signed and dated by the physician, the form must be accompanied by a written order or prescription that is signed and dated by the physician, or a documented verbal order from the physician that includes the date the verbal order was received.

    Note: *A verbal order is considered current when the date received is on or no more than 60 days before the start of therapy. A written order or prescription is considered current when it is signed and dated on or no more than 60 days before the start of therapy.*
  - A request received without a physician's signature, documented verbal order, or written prescription will not be processed and will be returned to the provider.
- A current therapy evaluation or re-evaluation for each therapy discipline that documents the client's age at the time of the evaluation or re-evaluation.
  - A therapy evaluation or re-evaluation for subsequent services is current when performed within 30 days before the prior authorization request is received. For example:
    - If an authorization period ends on July 31, 2014, TMHP must receive the prior authorization request for subsequent services between July 1, 2014, and July 31, 2014.
    - The therapy evaluation or re-evaluation for subsequent services can be performed up to 30 days before the date that TMHP receives the prior authorization request.
    - If TMHP receives the prior authorization request for subsequent services on July 1, 2014, the evaluation or re-evaluation can be performed June 1, 2014, through July 1, 2014.
    - If TMHP receives the prior authorization request for subsequent services on July 31, 2014, the evaluation or re-evaluation can be performed July 1, 2014, through July 31, 2014.

An updated, client-specific comprehensive treatment plan that was established by the ordering physician or therapist to be followed during treatment must include all of the following:

- Date and signature of the licensed therapist
- Diagnosis(es)
- Updated treatment goals that are related to the client's individual needs for the therapy discipline and associated disciplines requested
- A description of the specific therapy disciplines that are being prescribed
- Duration and frequency of therapy
- Date of onset of the illness, injury, or exacerbation that requires the therapy services
- A brief summary of the outcomes of the previous treatment as it relates to the client's debilitating condition
- Requested dates of service

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2.14.3.3.3 Revisions to Existing Prior Authorization Requests

A prior authorization request for revisions to services may be considered up to the end of the current approved prior authorization.

Requests for revisions to an existing authorization must be received no later than five business days from the date that the revised therapy treatments are initiated. Requests that are received after the five business-day period will be denied for dates of service that occurred before the date that the request was received.

If a provider or client discontinues therapy during an existing prior authorized period and the client requests services through a new provider, the new provider must submit all of the following:

- A new therapy request form
- A new evaluation with required documentation
- A change-of-provider letter that has been signed and dated by the client or responsible adult and that 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 in this section.

2.14.3.3.4 Frequency Levels

ST services may be provided at one of the following levels commensurate with the client's medical condition, developmental needs, life stage, and therapy needs that are identified in the documentation submitted:

- High Frequency: Therapy provided three or more times a week may be considered when documentation shows all of the following:
  - Client has a medical condition that is rapidly changing.
  - Client has a potential for rapid progress or rapid decline or loss of functional skill.
  - The client's therapy plan and home program require frequent modification by the licensed therapist.
  - The client requires a high frequency of intervention for a limited duration (60 days or fewer) to achieve an identified new skill or recover function lost due to surgery, illness, or trauma.
- Moderate Frequency: Therapy provided two times a week may be considered when documentation shows one or more of the following:
  - The client is making functional progress toward goals.
  - The client is in a critical period to restore function or is at risk of regression.
  - The licensed therapist needs to adjust the client's therapy plan and home program weekly or more often than weekly based on the client's progress and medical needs.
  - The client has complex needs requiring on-going education of the responsible adult.
- Low Frequency: Therapy provided one time per week or every other week may be considered when the documentation shows one or more of the following:
  - The client is making progress toward the client's goals, but the progress has slowed, or the client may be at risk of deterioration due to the client's development or medical condition.
  - The licensed therapist is required to adjust the client's therapy plan and home program weekly based on the client's progress.

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- Every other week therapy is supported for clients whose medical condition is stable, they are making progress, and it is anticipated the client will not regress with every other week therapy. Because the therapy plan changes very slowly, the home program can be managed by the client and the responsible adult and does not require frequent changes by the licensed therapist.

- Maintenance Level/Prevent Deterioration: every other week to monthly or less often visits/sessions may be considered when the client meets one of the following criteria:
  - Progress has slowed or stopped, but documentation supports that ongoing therapy is required to maintain the progress made or prevent deterioration
  - The documentation submitted shows the client may be making limited progress toward goals, or goal attainment is extremely slow
  - Factors are identified that inhibit the client's ability to achieve established goals (e.g., the client cannot participate in therapy sessions due to behavior issues or issues with anxiety)
  - Documentation shows the client and the responsible adult have a continuing need for education, a periodic adjustment of the home program, or regular modification of equipment to meet the client's needs

As a client's condition improves and goals are met, it is anticipated the therapist will decrease to a lesser frequency level.

2.14.4 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.

2.14.4.1 Group Therapy Guidelines

In order to meet Texas Medicaid 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 and short- and long-term goals and measurable outcomes.

Note: *Texas Medicaid 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.*

2.14.4.1.1 Group Therapy Documentation Requirements

The following documentation must be maintained in the client's medical record:

- Physician prescription for group therapy, exception for Early Childhood Intervention (ECI) providers.
- 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

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- 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.

Note: *There is an exception to these requirements for ECI services. Group therapy guidelines for ECI services are in subsection 2.7.2, "Services, Benefits, Limitations, and Prior Authorization" in this handbook*

2.14.4.2 Claims Information

Providers must submit claims for therapy services in an approved electronic claims format, a CMS-1500, or UB-04 CMS-1450 paper claim form from the vendor of their choice. TMHP does not supply the forms.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in Section 6, Claims Filing (*Vol. 1, General Information*).

Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in Section 6, Claims Filing (*Vol. 1, General Information*) for paper claims completion instructions.

2.14.4.3 Reimbursement

ST services are reimbursed in accordance with 1 TAC §355.8441.

See the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com for reimbursement rates.

2.15 Inpatient Psychiatric Hospital or Facility (Freestanding) (CCP)

Inpatient psychiatric treatment in a nationally accredited freestanding psychiatric facility or a nationally accredited state psychiatric hospital is a benefit of Texas Medicaid for clients who are birth through 20 years of age at the time of the service request and service delivery, if the client meets certain conditions.

Refer to: Subsection 3.4, "Services, Benefits, Limitations, and Prior Authorization - Inpatient Psychiatric Services" in the *Inpatient and Outpatient Services Handbook (Vol.2, Provider Handbooks)*.

2.16 Inpatient Rehabilitation Facility (Freestanding) (CCP)

2.16.1 Enrollment

Note: *Rehabilitation provided at an acute care facility is covered through Texas Medicaid fee-for-service.*

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To be eligible to participate in CCP, a freestanding inpatient rehabilitation facility must be certified by Medicare, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process. Texas Medicaid enrolls and reimburses freestanding inpatient rehabilitation facilities for CCP services and Medicare deductibles or coinsurance according to current payment guidelines. The information in this section is applicable to CCP services only.

Refer to: Subsection 2.1.2, "Enrollment" in this handbook for more information about CCP enrollment procedures.

2.16.1.1 Continuity of Hospital Eligibility Through Change of Ownership

Under procedures set forth by the CMS and HHSC, a change in ownership of a hospital does not terminate Medicare eligibility; therefore, Medicaid participation may be continued subject to the following requirements:

- The provider must obtain recertification as a Title XVIII (Medicare) hospital.
- The hospital under new ownership must submit a new signed and dated HHSC Medicaid Provider Agreement between the hospital and HHSC.

Providers can download the HHSC Medicaid Provider Agreement from the TMHP website at www.tmhp.com.

2.16.2 Services, Benefits, and Limitations

Inpatient rehabilitation services include medically necessary items and services ordinarily furnished by a Medicaid hospital or by an approved out-of-state hospital under the direction of a physician for the care and treatment of inpatient clients. Inpatient rehabilitation services will be considered for an acute problem or an acute exacerbation of a chronic problem resulting in a significant decrease in functional ability that will benefit from inpatient rehabilitation services. A condition is considered to be acute or an acute exacerbation of a chronic condition only during the six months from the onset date of the acute condition or the acute exacerbation of the chronic condition.

When a client is admitted to an inpatient facility for acute care physical, occupational, or speech therapy services, the therapy services are reimbursed as part of the inpatient hospital reimbursement methodology (Diagnosis- Related Group [DRG] or Tax Equity and Fiscal Responsibility Act [TEFRA]) and not reimbursed separately to the individual therapist. The hospital must include the physician's written treatment plan that supports the medical necessity of the hospitalization and services.

2.16.2.1 Comprehensive Treatment

The intensity of necessary rehabilitative service cannot be provided in the outpatient setting.

Comprehensive rehabilitation treatment must be under the leadership of a physician. Comprehensive rehabilitation treatment must be an active interdisciplinary team, defined as at least two types of therapies.

Comprehensive treatment must consist of at least two appropriate physical modalities designed to resolve or improve the client's condition (OT, PT, and ST), and must be provided for a minimum of three hours per day for five days per week.

2.16.3 * Prior Authorization and Documentation Requirements

All inpatient rehabilitation services provided to clients who are birth through 20 years of age in a freestanding inpatient rehabilitation facility require prior authorization.

Prior authorization will be considered when the client has met all of the following criteria:

- The client has an acute problem or an acute exacerbation of a chronic problem resulting in a significant decrease in functional ability that will benefit from inpatient rehabilitation services.
- The intensity of necessary rehabilitative service cannot be provided in the outpatient setting.

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- The client requires and will receive multidisciplinary team care defined as at least two therapies (OT, PT, or ST).
- This therapy will be provided for a minimum of three hours per day, five days per week.

The physician and the provider must maintain all documentation in the client's medical record.

Inpatient rehabilitation may be prior authorized for up to two months when the attending physician submits documentation of medical necessity. The treatment plan must indicate that the client is expected to improve within a 60-day period and be restored to a more functional lifestyle for an acute condition or the previous level of function for an acute exacerbation of a chronic condition.

Requests for subsequent services for increments up to 60 days may be prior authorized based on medical necessity. Requests for prior authorization of subsequent services must be received before the end-date of the preceding prior authorization.

A prior authorization request for an additional 60 days of therapy will be considered with documentation supporting medical necessity.

Supporting documentation for an initial request must include the following:

- The request for inpatient rehabilitation and the treatment plan must be signed and dated by the physician. The physician's signature is valid for no more than 60 days prior to the requested start of care date.
- A CCP Prior Authorization Form signed and dated by the physician.
- A current therapy evaluation with the documented age of the client at the time of evaluation.
- Therapy goals related to the client's individual needs; goals may include improving or maintaining function, or slowing of deterioration of function.
- An updated written comprehensive treatment plan established by the attending physician or by the therapist to be followed during the inpatient rehabilitation admission that:
    - Is under the leadership of a physician and includes a description of the specific therapy being prescribed, diagnosis, treatment goals related to the client's individual needs, and duration and frequency of therapy.
    - Includes the date of onset of the illness or injury requiring the freestanding inpatient rehabilitation facility admission.
    - Includes the requested dates of service.
    - Incorporates an active interdisciplinary team.
    - Consists of at least two appropriate physical modalities (OT, PT, and ST) designed to resolve or improve the client's condition.
    - Includes a minimum of three hours of team interaction with the client every day, five days per week.
- In addition to the documentation for an initial request, supporting documentation for a request for subsequent services must include the following:
    - A brief synopsis of the outcomes of the previous treatment relative to the debilitating condition.
    - The expected results to be achieved by an extension of the active treatment plan, and the time interval at which this extension outcome should be achieved.
    - Discussion why the initial two months of inpatient rehabilitation has not met the client's needs and why the client cannot be treated in an outpatient setting.

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After receiving the documentation establishing the medical necessity and plan of medical care by the treating physician, prior authorization is considered by CCP for the initial service and an extension of service as applicable. A request for prior authorization must include documentation from the provider to support the medical necessity of the service.

2.16.4 Claims Information

Providers must submit inpatient rehabilitation services to TMHP in an approved electronic claims format or on a UB-04 CMS-1450 paper claim form. Providers must purchase the UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

For OT, PT, and ST services, freestanding inpatient rehabilitation facilities and acute care hospitals can use revenue codes 128, 420, 424, 430, 434, 440, and 444.

TMHP must receive claims for payment consideration according to filing deadlines for inpatient claims. Claims for services that have been prior authorized must reflect the PAN in Block 63 of the UB-04 CMS-1450 paper claim form or its electronic equivalent.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for paper claims completion instructions.

Inpatient Rehabilitation Facility (Freestanding) (CCP Only) on the TMHP website at www.tmhp.com for a claim form example.

2.16.5 Reimbursement

Reimbursement for care provided in the freestanding inpatient rehabilitation facility is made under the Texas Diagnosis-Related Group (DRG) Payment System.

A new provider is given a reimbursement interim rate of 50 percent until a cost audit has been performed. Payment is calculated by multiplying the standard dollar amount (SDA) for the hospital's payment division indicator times the relative weight associated with the DRG assigned by Grouper.

Important: *Outpatient services are not reimbursed.*

The DRG payment may be enhanced by an adjusted day or cost outlier payment, if applicable. For example, the limit per spell-of-illness under Texas Medicaid guidelines is waived for clients who are birth through 20 years of age. An outlier payment may be made to compensate for unusual resource utilization or a lengthy stay.

The following criteria must be met to qualify for a day outlier payment. Inpatient days must exceed the DRG day threshold for the specific DRG. Additional payment is based on inpatient days that exceed the DRG day threshold multiplied by 70 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.

To establish a cost outlier, TMHP determines the outlier threshold by using the greater of the full DRG payment amount multiplied by 1.5 or an amount determined by selecting the lesser of the universe mean of the current base year data multiplied by 11.14 or the hospital's SDA multiplied by 11.14.

The calculation that yields the greater amount is used in calculating the actual cost outlier payment. The outlier threshold is subtracted from the amount of reimbursement for the admission established under the TEFRA principles and the remainder multiplied by 70 percent to determine the actual amount of the cost outlier payment.

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If an admission qualifies for both a day and a cost outlier, the outlier resulting in the highest payment to the hospital is paid.

The Remittance and Status (R&S) Report reflects the outlier reimbursement payment and defines the type of outlier paid, day or cost.

Providers should call the TMHP provider relations representative for their area with questions about the outlier payment.

2.16.5.1 Client Transfers

When more than one hospital provides care for the same case, the hospital furnishing the most significant amount of care receives consideration for a full DRG payment.

The other hospital(s) is/are paid a per diem rate based on the lesser of the mean length of stay for the DRG or eligible days in the facility. The DRG modifier PT on the R&S Report indicates per diem pricing related to a client transfer.

Client transfers within the same facility are considered one continuous stay and receive only one DRG payment. The facility must bill only one claim.

After all hospital claims have been submitted, HHSC performs a post-payment review to determine whether the hospital furnishing the most significant amount of care received the full DRG. If the review reveals that the hospital furnishing the most significant amount of care did not receive the full DRG, an adjustment is initiated.

3 School Health and Related Services (SHARS)

3.1 Overview

Medicaid services provided by school districts in Texas to Medicaid-eligible students are known as SHARS. The oversight of SHARS is a cooperative effort between the Texas Education Agency (TEA) and HHSC. SHARS allows local school districts, including public charter schools, to obtain Medicaid reimbursement for certain health-related services provided to students in special education under IDEA that are documented in a student's Individualized Education Program (IEP).

Important: *CMS requires school districts to be enrolled as a SHARS Medicaid provider, participate in the Random Moment Time Study (RMTS), claim on an interim basis, and submit an annual SHARS Cost Report.*

SHARS reimbursement is provided for students who meet all of the following requirements:

- Are 20 years of age and younger and eligible for Medicaid
- Meet eligibility requirements for special education described in IDEA
- Have IEPs that prescribe the needed services

Services covered by SHARS includes:

- Audiology services
- Counseling
- Nursing services
- Occupational therapy (OT)
- Personal care services (PCS)
- Physical therapy (PT)

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- Physician services
- Psychological services, including assessments
- Speech therapy (ST)
- Transportation in a school setting

These services must be provided by qualified personnel who are under contract with or employed by the school district.

3.1.1 Random Moment Time Study (RMTS)

CMS requires SHARS providers to participate in the RMTS to be eligible to submit claims and receive reimbursement for SHARS services. SHARS providers must comply with the *Texas Time Study Guide*, which includes, but is not limited to, Mandatory Annual RMTS Contact training certification of RMTS participants for all three annual RMTS quarters, and compliance with participation requirements for selected sampled moments. The three annual RMTS quarters are October through December, January through March, and April through June. A July through September RMTS is not conducted.

An existing school district can only become a SHARS provider effective October 1, each year and they must participate in all three RMTS quarters for that annual period. SHARS providers that do not participate in all three required RMTS quarters, or are RMTS non-compliant, cannot be a SHARS provider for that entire annual period (October 1 through September 30) and will be required to return any Medicaid payments received for SHARS services delivered during that annual cost report period. The school district can return to participating in the SHARS program the following federal fiscal year beginning on October 1.

A new school district (i.e., a newly formed district that began operations after October 1) can become a SHARS provider effective with the first day of the federal quarter in which it participates in the RMTS. New SHARS providers may not submit claims or be reimbursed for SHARS services provided prior to the RMTS quarter in which they begin to participate and they must participate in all remaining RMTS quarters for that annual period.

School districts can access the Texas Time Study Guide, on the HHSC website at www.hhsc.state.tx.us/rad/time-study/ts-isd.shtml and refer to the link titled Guides/Manuals.

SHARS providers can contact the HHSC Time Study Unit by email at TimeStudy@hhsc.state.tx.us or by telephone at 1-512-491-1715.

3.1.2 Eligibility Verification

The following are means to verify Medicaid eligibility of students:

- Verify electronically through third party software or TexMedConnect.
- School districts may inquire about the eligibility of a student by submitting the student's Medicaid number or two of the following: name, date of birth, or Social Security number (SSN). A search can be narrowed further by entering the county code or sex of the student. Verifications may be submitted in batches without limitations on the number of students.
- Contact AIS at 1-800-925-9126.

3.2 Enrollment

3.2.1 SHARS Enrollment

To enroll in Texas Medicaid as a SHARS provider, school districts, including public charter schools, must employ or contract with individuals or entities that meet certification and licensing requirements in accordance with the Texas Medicaid State Plan for SHARS to provide program services. Since public school districts are government entities, they should select "public entity" on the enrollment application.

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SHARS providers are required to notify parents or guardians of their rights to a "freedom of choice of providers" (42 CFR §431.51) under Texas Medicaid. Most SHARS providers currently provide this notification during the initial Admission, Review, and Dismissal (ARD) process. If a parent requests that someone other than the employees or currently contracted staff of the SHARS provider (school district) provide a required service listed in the student's IEP, the SHARS provider must make a good faith effort to comply with the parent's request. The SHARS provider can negotiate with the requested provider to provide the services under contract. The requested provider must meet, comply with, and provide all of the employment criteria and documentation that the SHARS provider normally requires of its employees and currently contracted staff. The SHARS provider can negotiate the contracted fee with the requested provider and is not required to pay the same fee that the requested provider might receive from Medicaid for similar services.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information.

3.2.2 Private School Enrollment

A private school may not participate in the SHARS program as a SHARS provider.

3.3 Services, Benefits, Limitations, and Prior Authorization

All of the SHARS procedures listed in the following sections require a valid diagnosis code. SHARS includes audiology services, counseling, physician services, nursing services, psychological services, OT, PT, or ST services, personal care services, and transportation.

Reminder: *SHARS are the services determined by the ARD committee to be medically necessary and reasonable to ensure that children with disabilities who are eligible for Medicaid and who are 20 years of age and younger receive the benefits accorded to them by federal and state law in order to participate in the educational program.*

3.3.1 Audiology

Audiology evaluation services include:

- Identification of children with hearing loss
- Determination of the range, nature, and degree of hearing loss, including the referral for medical or other professional attention for the habilitation of hearing
- Determination of the child's need for group and individual amplification

Audiology therapy services include the provision of habilitation activities, such as language habilitation, auditory training, audiological maintenance, speech reading (lip reading), and speech conversation.

Audiology services must be provided by a professional who holds a valid state license as an audiologist or by an audiology assistant who is licensed by the state when the assistant is acting under the supervision of a qualified audiologist. State licensure requirements are equal to American Speech-Language-Hearing Association (ASHA) certification requirements.

Audiology evaluation is billable on an individual (procedure code 92620) basis only. Audiology evaluation (procedure code 92620) is limited to a combined maximum total of twelve units in a 30-day period.

Audiology therapy is billable on an individual (procedure code 92507) and group (procedure code 92508) basis.

Only the time spent with the student present is billable; time spent without the student present is not billable.

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Session notes for evaluations are not required; however, documentation must include the billable start time, billable stop time, and total billable minutes with a notation of the activity performed (e.g., audiology evaluation).

Session notes are required for therapy. Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

3.3.1.1 Audiology Billing Table

POS*	Procedure Code	Individual or Group	Therapist or Assistant
1, 2, or 9	92507 with modifier U9	Individual	Licensed audiologist
1, 2, or 9	92507 with modifier U1	Individual	Licensed/certified assistant
1, 2, or 9	92508 with modifier U9	Group	Licensed audiologist
1, 2, or 9	92508 with modifier U1	Group	Licensed/certified assistant
1, 2, or 9	92620	Individual	Licensed audiologist
***Place of Service: 1=office; 2=home; 9=other locations**			

Providers must use a 15-minute unit of service for billing.

Refer to: Subsection 3.5.1.2, "Billing Units Based on 15 Minutes" in this handbook.

The recommended maximum billable time for audiology evaluation is three hours, which may be billed over several days. The recommended maximum billable time for direct audiology therapy (individual or group) is one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

3.3.2 Counseling Services

Counseling services are provided to help a child with a disability benefit from special education and must be listed in the IEP. Counseling services include, but are not limited to, the following:

- Assisting the child or parents in understanding the nature of the child's disability
- Assisting the child or parents in understanding the special needs of the child
- Assisting the child or parents in understanding the child's development
- Health and behavior interventions to identify the psychological, behavioral, emotional, cognitive, and social factors that are important to the prevention, treatment, or management of physical health problems
- Assessing the need for specific counseling services

Counseling services must be provided by a professional who has one of the following certifications or licensures: a licensed professional counselor (LPC), a licensed clinical social worker (LCSW), or a licensed marriage and family therapist (LMFT).

Counseling services are billable on an individual (procedure code 96152) or group (procedure code 96153) basis. Session notes are required and documentation must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

School districts may receive reimbursement for emergency counseling services as long as the student's IEP includes a behavior improvement plan that documents the need for emergency services.

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3.3.2.1 Counseling Services Billing Table

POS*	Procedure Code	Individual or Group
1, 2, or 9	96152 with modifier UB	Individual
1, 2, or 9	96153 with modifier UB	Group
***Place of Service: 1 = Office; 2 = Home; 9 = Other Locations**		

Providers must use a 15-minute unit of service for billing.

Refer to: Subsection 3.5.1.2, "Billing Units Based on 15 Minutes" in this handbook.

The recommended maximum billable time (individual or group) is one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

3.3.3 Psychological Testing and Services

3.3.3.1 Psychological Testing

Evaluations or assessments include activities related to the evaluation of the functioning of a student for the purpose of determining eligibility, the needs for specific SHARS services, and the development or revision of IEP goals and objectives. An evaluation or assessment is billable if it leads to the creation of an IEP for a student with disabilities who is eligible for Medicaid and who is 20 years of age or younger, whether or not the IEP includes SHARS.

Evaluations or assessments (procedure code 96101) must be provided by a professional who is a licensed specialist in school psychology (LSSP), a licensed psychologist, or a licensed psychiatrist in accordance with 19 TAC §89.1040(b)(1) and 34 CFR §300.136(a)(1).

Evaluation or assessment billable time includes the following:

- Psychological, educational, or intellectual testing time spent with the student present
- Necessary observation of the student associated with testing
- A parent/teacher consultation with the student present that is required during the assessment because a student is unable to communicate or perform certain activities
- Time spent without the student present for the interpretation of testing results
- Report writing

Time spent gathering information without the student present or observing a student is not billable evaluation or assessment time.

Session notes are not required; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note which assessment activity was performed (e.g., testing, interpretation, or report writing).

3.3.3.1.1 Evaluation or Assessment Billing Table

POS*	Procedure Code	Individual/Group	Unit of Service
1, 2, or 9	96101	Individual	1 hour
***Place of Service: 1=office; 2=home; 9=other locations**			

Important: *One unit (1.0) is equivalent to one hour or 60 minutes. Providers may bill in partial hours, expressed as 1/10th of an hour (six-minute segments). For example, express 30 minutes as a billed quantity of 0.5.*

Refer to: Subsection 3.5.1.2, "Billing Units Based on 15 Minutes" in this handbook.

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When billing, minutes of Evaluations or Assessments are not accumulated over multiple days. Minutes of Evaluations or Assessments can only be billed per calendar day.

The recommended maximum billable time for psychological testing is eight hours (8.0 units) over a 30-day period. Time spent for the interpretation of testing results without the student present is billable time. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

3.3.3.2 Psychological Services

Psychological services are counseling services provided to help a child with a disability benefit from special education and must be listed in the IEP.

Psychological services must be provided by a licensed psychiatrist, a licensed psychologist, or an LSSP. Nothing in this rule prohibits public schools from contracting with licensed psychologists, licensed psychological associates, and provisionally licensed psychologists who are not LSSPs to provide psychological services, other than school psychology, in their areas of competency. School districts may contract for specific types of psychological services, such as clinical psychology, counseling psychology, neuropsychology, and family therapy, that are not readily available from the LSSP who is employed by the school district. Such contracting must be on a short-term or part-time basis and cannot involve the broad range of school psychological services listed in 22 TAC §465.38(1)(B).

All psychological services are billable on an individual (procedure code 96152) or group (procedure code 96153) basis.

Session notes are required. Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

School districts may receive reimbursement for emergency psychological services as long as the student's IEP includes a behavior improvement plan that documents the need for the emergency services.

3.3.3.2.1 Psychological Services Billing Table

POS*	Procedure Code	Individual or Group
1, 2, or 9	96152 with modifier AH	Individual
1, 2, or 9	96153 with modifier AH	Group
***Place of Service: 1=office; 2=home; 9=other locations**		

Providers must use a 15-minute unit of service for billing.

Refer to: Subsection 3.5.1.2, "Billing Units Based on 15 Minutes" in this handbook.

The recommended maximum billable time for direct psychological therapy (individual or group) is a total of one hour per day for nonemergency situations. Providers must maintain documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

3.3.4 Nursing Services

Nursing services are SN tasks, as defined by the Texas BON, that are included in the student's IEP. Nursing services may be direct nursing care or medication administration. Examples of reimbursable nursing services include, but are not limited to, the following:

- Inhalation therapy
- Ventilator monitoring
- Nonroutine medication administration
- Tracheostomy care

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- Gastrostomy care
- Ileostomy care
- Catheterization
- Tube feeding
- Suctioning
- Client training
- Assessment of a student's nursing and personal care services needs

Direct nursing care services are billed in 15-minute increments and medication administration is reimbursed on a per-visit increment. The RN or APRN determines whether these services must be billed as direct nursing care or medication administration.

Nursing services must be provided by an RN, an APRN (including NPs and CNSs), LVN, LPN, or a school health aide or other trained, unlicensed assistive person delegated by an RN or APRN.

Nursing services are billable on an individual or group basis. Only the time spent with the student present is billable. Time spent without the student present is not billable. Session notes are not required for nursing services; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the type of nursing service that was performed.

3.3.4.1 Nursing Services Billing Table

POS*	Procedure Code	Individual or Group	Unit of Service
1, 2, or 9	T1002 with modifier TD	Individual	15 minutes
1, 2, or 9	T1002 with modifier TD and UD	Group	15 minutes
1, 2, or 9	T1502 with modifier TD		Medication administration, per visit
1, 2, or 9	T1002 with modifier U7	Delegation, Individual	15 minutes
1, 2, or 9	T1002 with modifier U7 and UD	Delegation, group	15 minutes
1, 2, or 9	T1502 with modifier U7		Delegation, medication administration, per visit
1, 2, or 9	T1003 with modifier TE	Individual	15 minutes
1, 2, or 9	T1003 with modifier TE and UD	Group	15 minutes
1, 2, or 9	T1502 with modifier TE		Medication, administration per visit

***Place of Service: 1=office; 2=home; 9=other locations**
Modifier TD = nursing services provided by an RN or APRN
Modifier U7 = nursing services delivered through delegation
Modifier TE = nursing services delivered by an LVN/LPN
Modifier UD = nursing services delivered on a group basis

The Medicaid-allowable fee is determined based on 15-minute increments. Providers must use a 15-minute unit of service for billing.

All of the nursing services minutes that are delivered to a student during a calendar day must be added together before they are converted to units of service. Do not convert minutes of nursing services separately for each nursing task that was performed.

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Minutes of nursing services cannot be accumulated over multiple days. Minutes of nursing services can only be billed per calendar day. If the total number of minutes of nursing services is less than eight minutes for a calendar day, then no unit of service can be billed for that day, and that day's minutes cannot be added to minutes of nursing services from any previous or subsequent days for billing purposes.

Refer to: Subsection 3.5.1.2, "Billing Units Based on 15 Minutes" in this handbook.

The recommended maximum billable time for direct nursing services is four hours per day. The recommended maximum billable units for procedure code T1502 with modifier TD, T1502 with modifier U7, or T1502 with modifier TE is a total of four medication administration visits per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

3.3.5 Occupational Therapy (OT)

3.3.5.1 Referral

In order for a student to receive OT through SHARS, the name and complete address or the provider identifier of the licensed physician who prescribed the OT must be provided.

3.3.5.2 Description of Services

OT evaluation services include determining what services, assistive technology, and environmental modifications a student requires for participation in the special education program.

OT includes:

- Improving, developing, maintaining, or restoring functions impaired or lost through illness, injury, or deprivation.
- Improving the ability to perform tasks for independent functioning when functions are impaired or lost.
- Preventing, through early intervention, initial or further impairment or loss of function.

OT must be provided by a professional who is licensed by the Texas Board of Occupational Therapy Examiners or a COTA acting under the supervision of a qualified occupational therapist.

OT evaluation is billable on an individual (procedure code 97003) basis only. OT is billable on an individual (procedure code 97530) or group (procedure code 97150) basis.

The occupational therapist or COTA can only bill for time spent with the student present, including time spent assisting the student with learning to use adaptive equipment and assistive technology.

Time spent without the student present, such as training teachers or aides to work with the student (unless the student is present during the training time), report writing, and time spent manipulating or modifying the adaptive equipment is not billable.

Session notes are not required for procedure code 97003; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the activity that was performed (e.g., OT evaluation).

Session notes are required for procedure codes 97530 and 97150. Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

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3.3.5.3 Occupational Therapy Billing Table

POS*	Procedure Code	Individual or Group	Therapist or Licensed/Certified Assistant
1, 2, or 9	97003	Individual	Licensed therapist
1, 2, or 9	97150 with modifier GO	Group	Licensed therapist
1, 2, or 9	97150 with modifier GO and U1	Group	Licensed/certified assistant
1, 2, or 9	97530 with modifier GO	Individual	Licensed therapist
1, 2, or 9	97530 with modifier GO and U1	Individual	Licensed/certified assistant
***Place of Service: 1=office; 2=home; 9=other locations**			

Providers must use a 15-minute unit of service for billing.

Refer to: Subsection 3.5.1.2, "Billing Units Based on 15 Minutes" in this handbook.

The recommended maximum billable time for OT evaluation is three hours, which may be billed over several days. The recommended maximum billable time for direct therapy (individual or group) is a total of one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

3.3.6 Personal Care Services

Personal care services are provided to help a child with a disability or chronic condition benefit from special education. Personal care services include a range of human assistance provided to persons with disabilities or chronic conditions which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. An individual may be physically capable of performing ADLs and IADLs but may have limitations in performing these activities because of a functional, cognitive, or behavioral impairment.

Refer to: Subsection 2.11, "Personal Care Services (PCS) (CCP)" in this handbook for a list of ADLs and IADLs.

For personal care services to be billable, they must be listed in the student's IEP. Personal care services are billable on an individual (procedure code T1019 with modifier U5 or U6) or group (procedure code T1019 with modifier U5 and UD or U6 and UD) basis.

Session notes are not required for procedure codes T1019 with modifier U5 or T1019 with modifier U5 and UD; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the type of personal care service that was performed.

Procedure codes T1019 with modifier U6 and T1019 with modifier U6 and UD are billed using a one-way trip unit of service.

3.3.6.1 Personal Care Services Billing Table

POS*	Procedure Code	Individual or Group	Unit of Service
1, 2, or 9	T1019 with modifier U5	Individual, school	15 minutes
1, 2, or 9	T1019 with modifier U5 and UD	Group, school	15 minutes
1, 2, or 9	T1019 with modifier U6	Individual, bus	Per one-way trip
1, 2, or 9	T1019 with modifier U6 and UD	Group, bus	Per one-way trip
***Place of Service: 1=office; 2=home; 9=other locations**			

Refer to: Subsection 3.5.1.2, "Billing Units Based on 15 Minutes" in this handbook.

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The recommended maximum billable units for T1019 with modifier U6 or T1019 with modifier U6 and UD is a total of four one-way trips per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended units of service are billed.

3.3.7 Physical Therapy (PT)

3.3.7.1 Referral

In order for a student to receive PT through SHARS, the name and complete address or the provider identifier of the licensed physician who prescribes the PT must be provided.

3.3.7.2 Description of Services

PT evaluation includes evaluating the student's ability to move throughout the school and to participate in classroom activities and the identification of movement dysfunction and related functional problems.

PT is provided for the purpose of preventing or alleviating movement dysfunction and related functional problems.

PT must be provided by a professional who is licensed by the Texas Board of Physical Therapy Examiners or a licensed physical therapist assistant (LPTA) acting under the supervision of a qualified physical therapist.

PT evaluation is billable on an individual (procedure code 97001) basis only. PT is billable on an individual (procedure code 97110) or group (procedure code 97150) basis.

The physical therapist can only bill time spent with the student present, including time spent helping the student to use adaptive equipment and assistive technology.

Time spent without the student present, such as training teachers or aides to work with the student (unless the student is present during the training time) and report writing, is not billable.

Session notes are not required for procedure code 97001; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the activity that was performed (e.g., PT evaluation). Session notes are required for procedure codes 97110 and 97150.

Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

3.3.7.3 Physical Therapy Billing Table

POS*	Procedure Code	Individual or Group	Therapist or Licensed/Certified Assistant
1, 2, or 9	97001	Individual	Licensed therapist
1, 2, or 9	97110 with modifier GP	Individual	Licensed therapist
1, 2, or 9	97110 with modifier GP and U1	Individual	Licensed or certified assistant
1, 2, or 9	97150 with modifier GP	Group	Licensed therapist
1, 2, or 9	97150 with modifier GP and U1	Group	Licensed or certified assistant
***Place of Service: 1=office; 2=home; 9=other locations**			

Providers must use a 15-minute unit of service for billing.

Refer to: Subsection 3.5.1.2, "Billing Units Based on 15 Minutes" in this handbook.

The recommended maximum billable time for PT evaluation is three hours, which may be billed within a 30 day period. The recommended maximum billable time for direct therapy (individual or group) is a total of one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

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3.3.8 Physician Services

Diagnostic and evaluation services are reimbursable under SHARS physician services. Physician services must be provided by a licensed physician (M.D. or D.O.). A physician prescription is required before PT or OT services may be reimbursed under SHARS. ST services require either a physician prescription or a referral from a licensed SLP before the ST services may be reimbursed under the SHARS program. The school district must maintain the prescription or referral. The prescription or referral must relate directly to specific services listed in the IEP. If a change is made to a service on the IEP that requires a prescription or referral, the prescription or referral must be revised accordingly.

The expiration date for the physician prescription is the earlier of either the physician's designated expiration date on the prescription or three years, in accordance with the IDEA three-year re-evaluation requirement.

SHARS physician services are billable only when they are provided on an individual basis. The determination as to whether or not the provider needs to see the student while reviewing the student's records is left up to the professional judgment of the provider. Therefore, billable time includes the following:

- The diagnosis or evaluation time spent with the student present
- The time spent without the student present reviewing the student's records for the purpose of writing a prescription or referral for specific SHARS services
- The diagnosis or evaluation time spent with the student present, or the time spent without the student present reviewing the student's records for the evaluation of the sufficiency of an ongoing SHARS service to see whether any changes are needed in the current prescription or referral for that service

Session notes are not required for procedure code 99499; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the medical activity that was performed.

3.3.8.1 Physician Services Billing Table

POS*	Procedure Code
1, 2, or 9	99499
***Place of Service: 1 = Office; 2 = Home; 9 = Other Locations**	

Providers must use a 15-minute unit of service for billing.

Refer to: Subsection 3.5.1.2, "Billing Units Based on 15 Minutes" in this handbook.

The recommended maximum billable time is one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

3.3.9 Speech Therapy (ST)

3.3.9.1 Referral

The name and complete address or the provider identifier or license number of the referring licensed physician or licensed SLP is required before ST services can be billed under SHARS. A licensed SLP's evaluation and recommendation for the frequency, location, and duration of ST serves as the speech referral.

3.3.9.2 Description of Services

ST evaluation services include the identification of children with speech or language disorders and the diagnosis and appraisal of specific speech and language disorders. ST services include the provision of speech and language services for the habilitation or prevention of communicative disorders.

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ST evaluation is billable on an individual (procedure codes 92521, 92522, 92523, and 92524) basis only. ST is billable on an individual (procedure code 92507) or group (procedure code 92508) basis.

Procedure codes 92521, 92522, 92523, and 92524 are limited to a total of 12 units and may be reimbursed for each client per provider in a 30-day period.

Procedure code 92522 will be denied if it is submitted with the same date of service as procedure code 92523.

Procedure code 92523 will be denied if it is submitted with the same date of service as procedure code 92522.

Providers can only bill time spent with the student present, including assisting the student with learning to use adaptive equipment and assistive technology.

Time spent without the student present, such as report writing and training teachers or aides to work with the student (unless the student is present during training), is not billable. Session notes are not required for procedure codes 92521, 92522, 92523, and 92524; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the activity that was performed (e.g., speech evaluation).

Session notes are required for procedure codes 92507 and 92508. Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

3.3.9.3 Provider and Supervision Requirements

ST services are eligible for reimbursement when they are provided by a qualified SLP, who holds a Texas license or an ASHA-equivalent SLP (has a master's degree in the field of speech-language pathology and a Texas license). ST services are also eligible for reimbursement when provided by an SLP with a state education agency certification, a licensed SLP intern, or a grandfathered SLP when acting under the supervision or direction of an SLP.

The supervision must meet the following provisions:

- The supervising SLP must provide supervision that is sufficient to ensure the appropriate completion of the responsibilities that were assigned.
- The direct involvement of the supervising SLP in overseeing the services that were provided must be documented.
- The SLP who provides the direction must ensure that the personnel who carry out the directives meet the minimum qualifications set forth in the rules of the State Board of Examiners for Speech-Language Pathology and Audiology which relate to Licensed Interns or Assistants in Speech-Language Pathology.

CMS interprets "under the direction of a speech-language pathologist," as an SLP who:

- Is directly involved with the individual under his direction.
- Accepts professional responsibility for the actions of the personnel he agrees to direct.
- Sees each student at least once.
- Has input about the type of care provided.
- Reviews the student's speech records after the therapy begins.
- Assumes professional responsibility for the services provided.

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3.3.9.4 Speech Therapy Billing Table

POS*	Procedure Code	Individual or Group	Therapist or Licensed/Certified Assistant
1, 2, or 9	92521, 92522, 92523, or 92524 with modifier GN	Individual	Licensed therapist
1, 2, or 9	92507 with modifier GN and U8	Individual	Licensed therapist
1, 2, or 9	92507 with modifier GN and U1	Individual	Licensed/certified assistant acting under the supervision or direction of an SLP
1, 2, or 9	92508 with modifier GN and U8	Group	Licensed therapist
1, 2, or 9	92508 with modifier GN and U1	Group	Licensed/certified assistant acting under the supervision or direction of an SLP
***Place of Service: 1=office; 2=home; 9=other locations**			

Providers must use a 15-minute unit of service for billing.

Refer to: Subsection 3.5.1.2, "Billing Units Based on 15 Minutes" in this handbook.

The recommended maximum billable time for evaluation is three hours, which may be billed over several days. The recommended maximum billable time for direct therapy (individual or group) is a total of one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

3.3.10 Transportation Services in a School Setting

Transportation services in a school setting may be reimbursed when they are provided on a specially adapted vehicle and if the following criteria are met:

- Provided to or from a Medicaid-covered service on the day for which the claim is made
- A child requires transportation in a specially adapted vehicle to serve the needs of the disabled
- A child resides in an area that does not have school bus transportation, such as those in close proximity to a school
- The Medicaid services covered by SHARS are included in the student's IEP
- The special transportation service is included in the student's IEP

A specially adapted vehicle is one that has been physically modified (e.g., addition of a wheelchair lift, addition of seatbelts or harnesses, addition of child protective seating, or addition of air conditioning). A bus monitor or other personnel accompanying children on the bus is not considered an allowable special adaptive enhancement for Medicaid reimbursement under SHARS specialized transportation. Specialized transportation services reimbursable under SHARS requires the Medicaid-eligible special education student has the following documented in his or her IEP:

- The student requires a specific physical adaptation or adaptations of a vehicle in order to be transported
- The reason the student needs the specialized transportation

Children with special education needs who ride the regular school bus to school with other nondisabled children are not required to have the transportation services in a school setting listed in their IEP. Also, the cost of the regular school bus ride cannot be billed to SHARS. Therefore, the fact that a child may receive a service through SHARS does not necessarily mean that the transportation services in a school setting may be reimbursed for them.

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Reimbursement for covered transportation services is on a student one-way trip basis. If the student receives a billable SHARS service (including personal care services on the bus) and is transported on the school's specially adapted vehicle, the following one-way trips may be billed:

- From the student's residence to school
- From the school to the student's residence
- From the student's residence to a provider's office that is contracted with the district
- From a provider's office that is contracted with the district to the student's residence
- From the school to a provider's office that is contracted with the district
- From a provider's office that is contracted with the district to the student's school
- From the school to another campus to receive a billable SHARS service
- From the campus where the student received a billable SHARS service back to the student's school

Covered transportation services from a child's residence to school and return are not reimbursable if, on the day the child is transported, the child does not receive Medicaid services covered by SHARS (other than transportation). Documentation of each one-way trip provided must be maintained by the school district (e.g., trip log). This service must not be billed by default simply because the student is transported on a specially adapted bus.

3.3.10.1 Transportation Services in a School Setting Billing Table

POS*	Procedure Code	Unit of Service
1, 2, or 9	T2003	Per one-way trip
***Place of Service: 1=office; 2=home; 9=other locations**		

The recommended maximum billable units for procedure code T2003 is a total of four one-way trips per day.

3.3.11 Prior Authorization

Prior authorization is not required for SHARS services.

3.4 Documentation Requirements

3.4.1 Record Retention

Student-specific records that are required for SHARS become part of the student's educational records and must be maintained for seven years. All records that are pertinent to SHARS billings must be maintained by the school district until all audit questions, appeal hearings, investigations, or court cases are resolved. Records must be stored in a readily accessible location and format and must be available for state or federal audits.

The following is a checklist of the minimum documents to collect and maintain:

- IEP
- Current provider qualifications (licenses)
- Attendance records
- Prescriptions and referrals
- Medical necessity documentation (e.g., diagnoses and history of chronic conditions or disability)
- Session notes or service logs, including provider signatures
- Supervision logs

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- Special transportation logs
- Claims submittal and payment histories

All services require documentation to support the medical necessity of the service rendered, including SHARS services. SHARS services are subject to retrospective review and recoupment if documentation does not support the service billed.

3.5 Claims Filing and Reimbursement

During the cost report period, school districts participating in SHARS are reimbursed on an interim claiming basis using district-specific interim rates. It is important that SHARS providers understand that SHARS interim payments are provisional in nature. The total allowable costs for providing services for SHARS must be documented by submitting the required annual cost report.

3.5.1 Claims Information

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

Claims must be submitted within 365 days from the date of service, or no later than 95 days after the end of the Federal Fiscal Year (i.e., January 3), whichever comes first.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims.

3.5.1.1 Appealing Denied SHARS Claims

SHARS providers that appeal claims denied for exceeding benefit limitations must submit documentation of medical necessity with the appeal. Documentation submitted with an appeal must include the pages from the IEP and ARD documents that show the authorization of the services, including the specified frequency and duration and the details of the need for additional time or the reasons for exceeding the benefit limitations.

Each page of the documentation must have the client's name and Medicaid number.

3.5.1.2 Billing Units Based on 15 Minutes

All claims for reimbursement are based on the actual amount of billable time associated with the SHARS service. For those services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units must be rounded up or down to the nearest quarter hour.

Reminder: *Enter the number of billing units in Block 24G of the CMS-1500 paper claim form. Claims without this information may be reimbursed as a unit of 1.*

To calculate billing units, count the total number of billable minutes for the calendar day for the SHARS student, 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.

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Examples:

Minutes	Units
0 min–7 mins	0 units
8 mins–22 mins	1 unit
23 mins–37 mins	2 units
38 mins–52 mins	3 units
53 mins–67 mins	4 units
68 mins–82 mins	5 units

3.5.1.3 Billing Units Based on an Hour

All claims for reimbursement are based on the actual amount of billable time associated with the SHARS service. For those services for which the unit of service is an hour (1 unit = 60 minutes = one hour), partial units must be billed in tenths of an hour and rounded up or down to the nearest six-minute increment.

Enter the number of billing units in Block 24G of the CMS-1500 paper claim form. Claims without this information may be reimbursed as a unit of 1.

To calculate billing units, count the total number of billable minutes for the calendar day for the SHARS student and divide by 60 to convert to billable units of service. If the total billable minutes are not divisible by 60, the minutes are converted to partial units of service as follows:

Minutes	Units
0 mins–3 mins	0 units
4 mins–9 mins	0.1 unit
10 mins–15 mins	0.2 unit
16 mins–21 mins	0.3 unit
22 mins–27 mins	0.4 unit
28 mins–33 mins	0.5 unit
34 mins–39 mins	0.6 unit
40 mins–45 mins	0.7 unit
46 mins–51 mins	0.8 unit
52 mins–57 mins	0.9 unit

Other examples:

Minutes	Units
58 mins–63 mins	1 unit
64 mins–69 mins	1.1 units
70 mins–75 mins	1.2 units
76 mins–81 mins	1.3 units
82 mins–87 mins	1.4 units
88 mins–93 mins	1.5 units

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3.5.2 Managed Care Clients

SHARS services are carved-out of the Medicaid Managed Care Program and must be billed to TMHP for payment consideration. Carved-out services are those that are rendered to Medicaid Managed Care clients, but are administered by TMHP and not the client's MCO.

3.5.3 Reimbursement

Providers are reimbursed for medical and transportation services provided under the SHARS Program on a cost basis using federally mandated allocation methodologies in accordance with 1 TAC §355.8443.

In order to accommodate participating SHARS districts that require interim cash flow to offset the financial burden of providing for students, an interim fee-for-service claiming system still exists for SHARS. The interim claims are based on district-specific interim rates but are provisional in nature.

The provider's final reimbursement amount is arrived at by a cost report, cost reconciliation, and cost settlement process. The provider's total costs for both direct medical and transportation services as reported in the cost report are adjusted using the federally mandated allocation methodologies.

- If a provider's interim payments exceed the provider's federal portion of the total certified Medicaid allowable costs, HHSC will recoup the federal share of the overpayment.
- If the provider's federal portion of the total certified Medicaid allowable costs exceeds the interim Medicaid payments, HHSC will pay the federal share of the difference to the provider in accordance with the final actual certification agreement.

Submittal of a SHARS cost report is mandatory for each provider that requests and receives interim payments. Failure to file a SHARS cost report will result in sanctions, which includes recoupment of all interim payments for the cost report period in which the default occurs.

School districts can access district-specific interim rates and published cost report guidance documents, on the HHSC website at www.hhsc.state.tx.us/rad/acute-care/shars/index.shtml.

For additional information SHARS providers can contact a SHARS Rate Analyst by email at ra_shars@hhsc.state.tx.us or by telephone at 1-512-491-1361.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information.

Subsection 2.8, "Federal Medical Assistance Percentage (FMAP)" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

3.5.3.1 Quarterly Certification of Funds

SHARS providers are required to certify on a quarterly basis the amount reimbursed during the previous federal fiscal quarter. TMHP Provider Enrollment mails the quarterly Certification of Funds statement to SHARS providers after the end of each quarter of the federal fiscal year (October 1 through September 30). The purpose of the statement is to verify that the school district incurred costs on the dates of service that were funded from state or local funds in an amount equal to, or greater than, the combined total of its interim rates times the paid units of service. While the payments were received the previous federal fiscal quarter, the actual dates of service could have been many months prior. Therefore, the certification of public expenditures is for the date of service and not the date of payment.

In order to balance amounts in the Certification of Funds, providers will receive, or have access to, the Certification of Funds Claims Information Report. For help balancing the amounts in the statement, providers can contact the TMHP Contact Center at 1-800-925-9126.

Refer to: "Preliminary Information" in (*Vol 1, General Information*) for more information about provider relations representatives.

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The Certification of Funds statement *must* be:

- Signed by the business officer or other financial representative who is responsible for signing other documents that are subject to audit.
- Notarized.
- Returned to TMHP within 25 calendar days of the date printed on the letter.

Failure to do so may result in recoupment of funds or the placement of a vendor hold on the provider's payments until the signed Certification of Funds statement is received by TMHP. Providers must contact the TMHP Contact Center at 1-800-925-9126 if they do not receive their Certification of Funds statement.

On an annual basis, SHARS providers are required to certify through their cost reports their total, actual, incurred costs, including the federal share and the nonfederal share. Refer to the section below for additional information about cost reporting.

3.6 Cost Reporting, Cost Reconciliation, and Cost Settlement

CMS requires annual cost reporting, cost reconciliation, and cost settlement processes for all Medicaid SHARS services delivered by school districts. CMS requires that school districts, as public entities, not be paid in excess of their Medicaid-allowable costs and that any overpayments be recouped through the cost reconciliation and cost settlement processes. In an effort to minimize any potential recoupments, HHSC has assigned district-specific interim rates that are as close as possible to each district's Medicaid-allowable costs for providing each SHARS service.

3.6.1 Cost Reporting

Each SHARS provider is required to complete an annual cost report for all SHARS that were delivered during the previous federal fiscal year (October 1 through September 30). The cost report is due on or before April 1 of the year following the reporting period.

School districts can access published cost report guidance documents, on the HHSC website at www.hhsc.state.tx.us/rad/acute-care/shars/index.shtml.

The following certification forms must be submitted and received by HHSC for the cost report. The annual cost report includes two certification forms which must be completed to certify the provider's incurred actual costs:

- Cost report certification
- Claimed expenditures

The certification forms received by HHSC for the cost report must be:

- The original certification pages.
- Signed by the business officer or other financial representative who is responsible for legally binding the district.
- Notarized.

The primary purpose of the cost report is to document the provider's costs for delivering SHARS, including direct costs and indirect costs, and to reconcile the provider's interim payments for SHARS with its actual total Medicaid-allowable costs. All annual SHARS cost reports that are filed are subject to desk review by HHSC or its designee.

For additional information, SHARS providers can contact a SHARS Rate Analyst by email at ra_shars@hhsc.state.tx.us or by telephone at 1-512-730-7400.

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3.6.2 Cost Reconciliation and Cost Settlement

The cost reconciliation process must be completed within 24 months of the end of the reporting period covered by the annual SHARS cost report. The total Medicaid-allowable costs are compared to the provider's interim payments for SHARS delivered during the reporting period, which results in a cost reconciliation.

If a provider has not complied with all cost report requirements or a provider's interim payments exceed the actual certified Medicaid-allowable costs of the provider for SHARS to Medicaid clients, HHSC will recoup the federal share of the overpayment by one of the following methods:

- Offset all future claims payments to the provider until the amount of the federal share of the overpayment is recovered
- Recoup an agreed-upon percentage from future claims payments to the provider to ensure recovery of the overpayments within one year
- Recoup an agreed-upon dollar amount from future claims payments to ensure recovery of the overpayment within one year

If the actual certified Medicaid-allowable costs of a provider for SHARS exceed the provider's interim payments, HHSC will pay the federal share of the difference to the provider in accordance with the final, actual certification agreement and submit claims to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

HHSC issues a notice of settlement that denotes the amount due to or from the provider.

3.6.3 Informal Review of Cost Reports Settlement

An ISD or the Superintendent, Chief Financial Officer, Business Officer, or other ISD Official with legal authority who disagrees with the adjustments made during the cost reconciliation process has the right to request an informal review of the adjustments. Requests for informal reviews must be sent by certified mail and received by HHSC within the time frame designated on the settlement notice. Furthermore, the request for informal review must include a concise statement of the specific actions or determinations the district disputes, the ISD's recommended resolution, and any supporting documentation deemed relevant to the dispute. Failure to follow these instructions will result in the denial of the request for an informal review.

School districts can access published cost report guidance documents, on the HHSC website at www.hhsc.state.tx.us/rad/acute-care/shars/index.shtml. For additional information, SHARS providers can contact a SHARS Rate Analyst by email at ra_shars@hhsc.state.tx.us or by telephone at (512) 730-7400.

4 Texas Health Steps (THSteps) Dental

Medicaid dental services rules are described under Title 25 Texas Administrative Code (TAC) Part 1, Chapter 33. The online version of TAC is available at the Secretary of State's website at www.sos.state.tx.us/tac/index.shtml. All dental providers must comply with the rules and regulations of the Texas State Board of Dental Examiners (TSBDE), including standards for documentation and record maintenance as stated in 22 TAC §108.7, *Minimum Standard of Care*, General, and §108.8, *Records of the Dentist*.

> ***Note:*** *THSteps dental benefits are administered as Children's Medicaid Dental Services by dental managed care organizations for most Medicaid fee-for-service and managed care clients who are 20 years of age and younger.*

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Refer to: The *Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks)* or to the HHSC website at www.hhsc.state.tx.us/medicaid/managed-care/mmc.shtml, for additional information about children's Medicaid dental Services.

4.1 Enrollment

To become a provider of THSteps or intermediate care facility for persons with intellectual disability (ICF-IID) dental services, a dentist must:

- Practice within the scope of the provider's professional licensure.
- Complete the Dental Provider Enrollment Application and return it to TMHP.

Dental providers are required to maintain an active license status with the TSBDE. TMHP receives a monthly automated board feed from TSBDE to update licensure information. If licensure cannot be verified with the automated board feed, it is the providers' responsibility to provide a copy of the active TSBDE license to TMHP. If TSBDE has a delay in processing license applications and renewals, the provider must request a letter from TSBDE for their individual provider information and send the letter of verification of current licensure to TMHP. The letter must contain the provider's specific identification information, license number, and licensure period.

If TMHP cannot verify a valid license at the time of enrollment, it is the providers' responsibility to provide a copy of the active TSBDE license to TMHP.

A dental provider cannot be enrolled if his or her dental license is due to expire within 30 days; a current license must be submitted. Dental licensure for owners of a dental practice is a requirement of the Occupations Code, Vernon's Texas Codes Annotated (VTCA), Subtitle D, Chapters 251-267 (the Texas Dental Practice Act).

Providers can download and print dental provider enrollment application forms from the TMHP website at www.tmhp.com or call the TMHP Contact Center at 1-800-925-9126 to request them.

All owners of a dental practice must maintain an active license status with the TSBDE to receive reimbursement from Texas Medicaid. Any change in ownership or licensure status for any enrolled dentist must be immediately reported in writing to TMHP Provider Enrollment and will affect reimbursement by Texas Medicaid.

A dentist must complete the Dental Provider Enrollment Application for each separate practice location and will receive a unique provider identifier for each practice location if the application is approved.

The application form includes a written agreement with HHSC.

Dental providers may enroll in the THSteps Dental program and ICF-IID Dental Programs or as a Doctor of Dentistry Practicing as a Limited Physician, or both. The enrollment requirements are different with respect to the category of enrollment.

- All dental providers must declare one or more of the following categories:
- General practice
- Pediatric dentist
- Periodontist
- Endodontist
- Oral and maxillofacial surgeon
- Orthodontist
- Other (prosthodontist, public health, and others)

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Dentists (D.D.S., D.M.D.) who want to provide orthodontic services must be enrolled as a dentist or orthodontist provider for THSteps and must have at least one of the qualifications listed below.

THSteps dental providers may perform and be reimbursed for orthodontic services if they have attested to at least one of the following requirements:

- Completion of a dental pediatric specialty residency
- Completion of a minimum of 200 hours of continuing education in orthodontics within the last 10 years (8 hours can be online or self instruction) (Proof of the completion of continuing education hours is not required to be submitted with a request for prior authorization of orthodontic services; however, documentation must be produced by the dentist during retrospective review.)

Orthodontist providers are eligible to provide orthodontic services. In order to comply with the TSBDE rules and regulations, this designation can only be associated with dentists who are board-eligible or board-certified by an American Dental Association (ADA) recognized orthodontic specialty board.

Refer to: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*)

Dental residents may provide dental services in a teaching facility under the guidance of the attending staff/faculty member(s) as long as the facility's dental staff by-laws and standards by the Commission on Dental Accreditation (CODA) are met, and the attending dentist/faculty member has determined the resident to be competent to perform the dental services. THSteps does not require the supervising dentist to examine the client as long as these conditions are met.

In a clinic, an attending dentist/faculty member must be present in the dental clinic for consultation, supervision, and active teaching when residents are treating patients in scheduled clinic sessions. This does not preclude occasional situations where a faculty member cannot be available. A dentist must assume responsibility for the clinic's operation.

4.1.1 THSteps Dental Eligibility

The client must be Medicaid- and THSteps-eligible (birth through 20 years of age) at the time of the service request and service delivery. However, Medicaid-approved orthodontic services already in progress may be continued even after the client loses Medicaid eligibility if the orthodontic treatment:

- Began before the loss of Medicaid eligibility.
- Began before the day of the client's 21st birthday.
- Was completed within 36 months of the beginning date.

The client is not eligible for a THSteps medical checkup or THSteps dental benefits if the client's Your Texas Benefits card or Medicaid Eligibility Verification Form (Forms H1027 and H1027-A-C) states any of the following:

- Emergency care only
- Presumptive eligibility (PE)
- Qualified Medicare beneficiary (QMB)
- Texas Women's Health Program

4.1.2 THSteps Dental and ICF-IID Dental Services

A provider may enroll as an individual dentist, a group practice, or both. Regardless of the category of practice designation under THSteps Dental, providers can only submit claims for THSteps and ICF-IID Dental Services.

Refer to: Subsection 4.2, "Services, Benefits, Limitations, and Prior Authorization" in this handbook.

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4.1.3 THSteps Dental Checkup and Treatment Facilities

All THSteps dental checkup and treatment policies apply to examinations and treatment completed in a dentist's office, a health department, clinic setting, hospital operating room, or in a mobile/satellite unit. Enrollment of a mobile/satellite unit must be under a dentist or clinic name. Mobile units can be a van or any temporary site away from the primary office and are considered extensions of that office and are not separate entities. The physical setting must be appropriate so that all elements of the checkup or treatment can be completed. The checkup must meet the requirements detailed in subsection D.5, "Parental Accompaniment" in Appendix D, "Texas Health Steps Statutory State Requirements," of this handbook. The provider with a mobile unit or who uses portable dental equipment must obtain a permit for the mobile unit from the TSBDE.

4.1.4 Doctor of Dentistry Practicing as a Limited Physician

Dentists who serve clients and submit claims using medical (CPT) procedure codes, such as oral-maxillofacial surgeons, may enroll as a doctor of dentistry practicing as a limited physician. Providers may enroll as an individual dentist or as a dental group. To enroll as a doctor of dentistry practicing as a limited physician, a dentist must:

- Be currently licensed by the TSBDE or currently licensed in the state where the service was performed.
- Have a Medicare provider identification number before applying for a Medicaid provider identifier.
- Enroll as a Medicaid provider with a limited physician provider identifier.

4.1.5 Client Rights

Dental providers enrolled in Texas Medicaid enter into a written contract with HHSC to uphold the following rights of the Medicaid client:

- To receive dental services that meet or exceed the standards of care established by the laws relating to the practice of dentistry and the rules and regulations of the TSBDE.
- To receive information following a dental examination about the dental diagnosis; scope of proposed treatment, including alternatives and risks; anticipated results; and the need and risks for administration of sedation or anesthesia.
- To have full participation in the development of the treatment plan and the process of giving informed consent.
- To have freedom from physical, mental, emotional, sexual, or verbal abuse, or harm from the provider or staff.
- To have freedom from overly aggressive treatment in excess of that required to address documented medical necessity.

A provider's failure to ensure any of the client rights may result in termination of the provider agreement or contract and other civil or criminal remedies.

4.1.6 Complaints and Resolution

Complaints about dental services are typically received through the TMHP Contact Center, although a complaint is accepted from any source. A complaint is researched by TMHP and resolved or escalated as appropriate. Examples of complaints from clients about providers include:

- The provider did not consult with the client, explain what services were necessary, or obtain parent or guardian informed consent.
- The treating provider refused to make the child's record available to the new provider.
- The provider did not give the child the appropriate local anesthesia or pain medication.

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- The provider did not use sterile procedures; the facility or equipment were not clean.
- The provider or his staff were verbally abusive.
- The client did not receive a service, but the provider submitted a claim to Texas Medicaid.
- The provider charged a Medicaid client for benefits covered by Medicaid.

4.2 Services, Benefits, Limitations, and Prior Authorization

4.2.1 THSteps Dental Services

THSteps is the Texas version of the Medicaid program known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

THSteps dental services are mandated by Medicaid to provide for the early detection and treatment of dental health problems for Medicaid-eligible clients who are birth through 20 years of age. THSteps dental service standards are designed to meet federal regulations and incorporate the recommendations of representatives of national and state dental professional organizations.

THSteps' designated staff (DSHS, DADS, or contractor), through outreach and informing, encourage eligible children to use THSteps dental checkups and services when children first become eligible for Medicaid, and each time children are periodically due for their next dental checkup.

Children within Medicaid have free choice of Medicaid-enrolled providers and are given names of enrolled providers. A list of THSteps dental providers in a specific area can be obtained using the Online Provider Lookup on the TMHP website at www.tmhp.com, or by calling 1-877-847-8377.

Upon a provider's request, DSHS (or its contractor) will assist eligible children with the scheduling of free transportation to their dental appointment or clients can call the Medical Transportation Program at 1-877-633-8747.

Refer to: The *Medical Transportation Program Handbook (Vol. 2, Provider Handbooks)* for information about transportation arrangements.

4.2.1.1 Eligibility for THSteps Dental Services

A client is eligible for THSteps dental services from birth through 20 years of age. The eligibility period is determined by the client's age on the first of the month. If a client's birthday is not on the first of a month, the new eligibility period begins on the first day of the following month. When the client turns 21 years of age during a month, the client is eligible for THSteps dental non-CCP services through the end of that month.

A client is eligible for Comprehensive Care Program (CCP) dental services until their 21st birthday. The eligibility period ends on their 21st birthday and does not continue through the end of the month in which the birthday falls.

4.2.1.2 Parental Accompaniment

Children who are 14 years of age and younger must be accompanied to THSteps dental appointments by a parent, legal guardian, or another adult who is authorized by the parent or guardian unless the services are provided by an exempt entity as defined by the Human Resources Code. For additional information and exceptions, see subsection D.5, "Parental Accompaniment" in Appendix D, "Texas Health Steps Statutory State Requirements," in this handbook.

4.2.2 Comprehensive Care Program (CCP)

The Omnibus Budget Reconciliation Act (OBRA) of 1989 mandated the expansion of the federal EPSDT program to include any service that is medically necessary and for which federal financial participation (FFP) is available, regardless of the limitations of Texas Medicaid. This expansion is referred to as the Comprehensive Care Program (CCP).

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CCP services are provided only for those clients who are birth through 20 years of age who are eligible to receive THSteps services. When the client becomes 21 years of age, all CCP benefits stop. Dental services that are a benefit through CCP are designated in the Limitations column of the tables beginning in subsection 4.2.13, "Diagnostic Services" of this handbook, with the notation "CCP."

4.2.3 Children's Medicaid Dental Plan Choices

Children's Medicaid dental services benefits are administered by two dental managed care organizations (i.e., dental plans) across the state of Texas.

Medicaid Managed Care Dental Plan	Dental Plan Provider Services
DentaQuest	1-800-685-9971
MCNA Dental	1-855-776-6262

Note: *Services provided to Medicaid managed care clients must be provided by their main dentist.*

4.2.4 Authorization Transfers for Medicaid Managed Care Dental Orthodontic Services

If a client transitions to a managed care dental plan after their orthodontic services were initially authorized by TMHP, the claims for the orthodontic services will be processed and reimbursed by the managed care dental plan. Providers should check client eligibility to identify the managed care dental plan to which the client transitions.

Claims for orthodontic services remain the responsibility of the dental managed care plan until the authorized services are completed, even if the client loses dental managed care or Medicaid eligibility.

4.2.5 ICF-IID Dental Services

ICF-IID dental services are mandated by Medicaid. Reimbursement is provided for treatment of dental problems for Medicaid-eligible residents of ICF-IID facilities who are 21 years of age and older. Residents of ICF-IID facilities who are 20 years of age and younger receive services through the regular THSteps Program. Eligibility for ICF-IID services is determined by DADS.

Procedure codes that do not have a CCP designation in the *Limitations* column of the dental fee schedule may be submitted in a routine manner for ICF-IID clients. These procedures must be documented as medically necessary and appropriate. ICF-IID clients are not subject to periodicity for preventive care. For procedure codes that have a CCP designation, a provider may request authorization with documentation or provide documentation on the submitted claim.

Refer to: Subsection 4.2.12, "Medicaid Dental Benefits, Limitations, and Fee Schedule" of this handbook.

4.2.5.1 THSteps and ICF-IID Provision of Dental Services

All THSteps and ICF-IID dental services must be performed by the Medicaid-enrolled dental provider except for permissible work that is delegated to a licensed dental hygienist, dental assistant, or dental technician in a dental laboratory on the premises where the dentist practices, or in a commercial laboratory registered with the TSBDE. The Texas Dental Practice Act and the rules and regulations of the TSBDE (22 TAC, Part 5) define the scope of work that dental auxiliary personnel may perform. Any deviations from these practice limitations shall be reported to the TSBDE and HHSC, and could result in sanctions or other actions imposed against the provider.

THSteps and ICF-IID clients must receive:

- Dental services specified in the treatment plan that meet the standards of care established by the laws relating to the practice of dentistry and the rules and regulations of the TSBDE.
- Dental services free from abuse or harm from the provider or the provider's staff.

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- Only the treatment required to address documented medical necessity that meets professionally recognized standards of health care.

4.2.5.2 Children in Foster Care

Clients in foster care receive services from Superior HealthPlan's dental contractor. Providers may contact DentaQuest at 1-888-308-9345 for more information.

Paper claims and requests for prior authorization must be mailed to:

DentaQuest
12121 North Corporate Parkway
Mequon, WI 53092
Fax: (262) 241-7150 or 1-888-313-2883

4.2.6 Written Informed Consent and Standards of Care

As outlined in 22 TAC §108.7, the dental provider must maintain written informed consent signed by the patient, or a parent or legal guardian of the patient if the patient is a minor, or a legal guardian of the patient if the patient has been adjudicated incompetent to manage the patient's personal affairs.

Additionally, as required in 25 TAC §33.6 and §33.20, THSteps providers must obtain legally effective, written informed consent before providing THSteps dental checkups and treatment services. Such consent is required for all oral evaluations; dental diagnostic, preventative, and therapeutic services; and treatment plans. The written informed consent must identify the tooth and surface IDs associated with the proposed treatment and should disclose risks or hazards that could influence a reasonable person in making a decision to give or withhold consent.

THSteps clients or their parents or legal guardians who can give written informed consent must receive information following a dental examination about the dental diagnosis, scope of proposed treatment, including alternatives and risks, anticipated results, and need for and risks of the administration of sedation or anesthesia. Additionally, they must receive a full explanation of the treatment plan and give written informed consent before treatment is initiated. The parent or guardian being present at the time of the dental visit facilitates the provider obtaining written informed consent. Dentists must comply with TSBDE Rule 22 TAC §108.2, "Fair Dealing."

4.2.7 First Dental Home

Based on the American Academy of Pediatric Dentistry's (AAPD) definition, Texas Medicaid 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. Establishment of a client's dental home begins no later than 6 months of age and includes referrals to dental specialists when appropriate.

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

Clients who are from 6 through 35 months of age may be seen for dental checkups by a certified First Dental Home provider.

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First Dental Home services are submitted using procedure code D0145. The dental home provider must retain supporting documentation for procedure code D0145 in the client's 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
- Caries risk assessment
- Dental prophylaxis, which may include a toothbrush prophylaxis
- Oral hygiene instruction with parent or caregiver
- Fluoride varnish application
- An appropriate preventive oral health regimen (recall schedule)
- 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/other family members
  - Development of mouth and teeth
  - Oral habits
  - Diet, nutrition, and food choices
  - Fluoride needs
  - Injury prevention
  - Medications and oral health
  - Any referrals, including dental specialist's name

Procedure code D0145 is limited to individual dentists certified by the DSHS Oral Health Program to perform this service. Training for certification as a First Dental Home provider is available as a free continuing education course on the THSteps website at www.txhealthsteps.com.

Procedure codes D0120, D0150, D0160, D0170, D0180, D1120, D1206, D1208, and D8660 are denied if procedure code D0145 is submitted for the same DOS by any provider. A First Dental Home examination is limited to ten services per client lifetime with at least 60 days between visits by any provider to prevent denials of the service.

4.2.8 Dental Referrals by THSteps Primary Care Providers

Dental providers may receive referrals for clients who are 6 months of age and older from THSteps primary care providers. The primary care provider must provide information about the initiation of routine dental services with the recommendation to the client's parent or guardian that an appointment be scheduled with a dental provider in order to establish a dental home. If a THSteps dental checkup reveals a dental health condition that requires follow-up diagnosis or treatment, the provider performing the dental checkup should assist the client in planning follow-up care within their practice or in making a referral to another qualified dental provider.

Note: *For clients who are 20 years of age and younger, the client's guardian may refer the client for dental services or a client of legal age may refer themselves for dental services.*

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4.2.9 Change of Provider

A provider may refer a client to another dental provider for treatment for any of the following reasons:

- Treatment by a dental specialist such as a pediatric dentist, periodontist, oral surgeon, endodontist, or orthodontist is indicated and is in the best interests of the THSteps client.
- The services needed are outside the skills or scope of practice of the initial provider.

A provider may discontinue treatment if there is documented failure to keep appointments by the client, noncompliance with the treatment plan, or conflicts with the client or other family members. In any such action to discontinue treatment, providers must comply with 22 TAC §108.5, "Patient Abandonment."

The client also may select another provider, if desired. HHSC may refer the client to another provider as a result of adverse information obtained during a utilization review or resolution of a complaint from either provider or client.

4.2.9.1 Interrupted or Incomplete Orthodontic Treatment Plans

Authorizations for orthodontic or extensive restorative treatment plans that have been prior authorized for a provider are not transferable to another provider. If a client's treatment plan is interrupted and the services are not completed, the original or new provider must request a new prior authorization to complete the interrupted, incomplete, and prior authorized treatment plan.

To complete the treatment plan, the client must be eligible for Medicaid. It is the provider's responsibility to verify the client's eligibility through www.YourTexasBenefitsCard.com, TexMedConnect, or the TMHP Contact Center.

If the client does not return for the completion of services and there is a documented failure to keep appointments by the client, the dental provider who initiated the services may submit a claim for reimbursement in compliance with the 95-day filing deadline.

Refer to: Subsection 4.2.27.4, "Premature Termination of Comprehensive Orthodontic Treatment" in this handbook.

4.2.10 Periodicity for THSteps Dental Services

For clients who are 6 months through 20 years of age, dental checkups may occur at 6-month (181-day) intervals. Texas Medicaid has adopted the AAPD's "Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Children" to serve as a guide and reference for dentists when scheduling and providing services to THSteps clients.

In November 2004, the ADA, in conjunction with the FDA, established "Guidelines for Prescribing Dental Radiographs." The guidelines include type of encounters relevant to the client's age and dental developmental stage. Texas Medicaid has adopted the ADA guidelines to serve as a guide and reference for dentists who treat THSteps clients.

Refer to: Appendix G. American Academy of Pediatric Dentistry Periodicity Guidelines in this handbook.

THSteps dental providers may provide any medically necessary dental services such as emergency, diagnostic, preventive, therapeutic, and orthodontic services that are within the Texas Medicaid guidelines and limitations specified for each area as long as the client's Medicaid eligibility is current for the date that dental services are being provided.

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4.2.10.1 Exceptions to Periodicity

If a periodic dental checkup has been conducted within the last six months, the client still may be able to receive another periodic dental checkup in the same six-month period by any provider. For THSteps clients, exceptions to the six-month periodicity schedule for dental checkup services may be approved for one of the following reasons:

- Medically necessary service, based on risk factors and health needs (includes clients who are birth through 6 months of age).
- Required to meet federal or state exam requirements for Head Start, daycare, foster care, preadoption, or to provide a checkup prior to the next periodically-due checkup if the client will not be available when due. This includes clients whose parents are migrant or seasonal workers.
- Clients' choice to request a second opinion or change service providers (not applicable to referrals).
- Subsequent therapeutic services necessary to complete a case for clients who are 5 months of age and younger when initiated as emergency services, for trauma, or early childhood caries.
- Medical checkup prior to a dental procedure requiring general anesthesia.
- A First Dental Home client can be seen up to ten times within the age of 6 through 35 months.

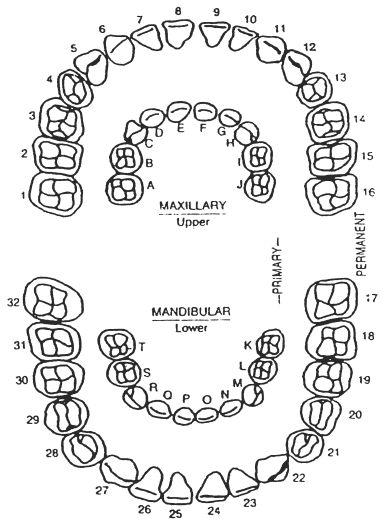
It is the provider's responsibility to verify that the client is eligible for the date that dental services are to be provided. Eligibility may be verified through www.YourTexasBenefitsCard.com, TexMedConnect, or the TMHP Contact Center.

When the need for an exception to periodicity is established, a narrative explaining the reason for the exception to periodicity limitations must be documented in the client's file and on the claim submission. For claims filed electronically, check "yes" when prompted. For claims filed on paper, place comments in Block 35.

For ICF-IID clients who are 21 years of age and older, the periodicity schedule for preventive dental procedures (exams, prophylaxis, fluoride, and radiographs) does not apply.

4.2.11 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. For SID designation on anterior teeth, use facial (F) and incisal (I). For SID purposes, use buccal (B) and occlusal (O) designations for posterior teeth.



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	

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4.2.11.1 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 Current Dental Terminology (CDT) published by the ADA.

The TID for each identified supernumerary tooth will be used for paper and electronic claims and can only be submitted for payment with the following procedure codes:

- For primary teeth only: D7111.
- For both primary and permanent teeth the following codes can be submitted: 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

4.2.12 Medicaid Dental Benefits, Limitations, and Fee Schedule

For THSteps clients, dental procedure limitations may be waived when *all* the following have been met. The dental procedure is:

- Medically necessary and FFP is available for it.
- Prior authorized by the TMHP Dental Director.
- Properly documented in the client's record.

Refer to: Subsection 4.3, "Documentation Requirements" in this handbook.

For ICF-IID clients, services designated as CCP-type are available. In the *Limitations* column of the fee schedule, abbreviations indicate the age range limitations and documentation requirements. The following abbreviations also appear in a table at the bottom of each page of the fee schedule:

Acronym	Description
A	Age range limitations
CCP	Payable under CCP for clients who are 20 years of age and younger when THSteps benefits or limits are exceeded
DOS	Date of service
FMX	Intraoral radiographs—complete series
MTID	Missing tooth ID(s)

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Acronym	Description
N	Narrative of medical necessity for the procedure must be retained in the client's record
NC	Not reimbursed by Medicaid. Services may not be charged to the client.
PATH	Pathology report must accompany the claim and must be retained in the client's record
PC	Periodontal charting must be retained in the client's record
PHO	Preoperative and postoperative photographs required and must be maintained in the client's medical record
PPXR	Preoperative and postoperative radiographs are required when the procedure is performed and must be retained in the client's record; do not send with initial claims
PXR	Preoperative radiographs are required when the procedure is performed and must be retained in the client's record; do not send with initial claims

4.2.13 Diagnostic Services

Diagnostic services should be performed for all clients, starting within the first six months of the eruption of the first primary tooth, but no later than one year of age.

Procedure Code	Limitations
Clinical Oral Evaluations	
Procedure codes D0140, D0160, D0170, and D0180 are limited dental codes and may be paid in addition to a comprehensive oral exam (procedure code D0150) or periodic oral exam (procedure code D0120), when submitted within a six-month period. When submitting a claim for procedure code D0140, D0160, D0170, or D0180, the provider must indicate documentation of medical necessity on the claim. These claims are subject to retrospective review. If no comments are indicated on the claim form, the payment may be recouped.	
D0120*	A Birth–20. Limited to one every six months by the same provider. Denied when submitted for the same DOS as D0145 by any provider.
D0140*	Used for problem-focused examination of a specific tooth or area of the mouth. Limited to one service per day by the same provider or to two services per day by different providers. Denied when submitted for the same DOS as D0160 by the same provider. A Birth–20, N
D0145*	Limited to one service per day and ten times a lifetime, with a minimum of 60 days between dates of service. Providers must be certified by DSHS Oral Health Program staff to perform this procedure. Procedure codes D0120, D0150, D0160, D0170, D0180, D1120, D1206, D1208, or D8660 will be denied when submitted by any provider for the same DOS. A 6–35 months
D0150*	Used for a comprehensive oral evaluation. Limited to one service every three years by the same provider. Denied when submitted for the same DOS as D0145 by any provider. A Birth–20
D0160*	Used for a problem focused, detailed and extensive oral evaluation. Limited to one service per day by the same provider. Not payable for routine postoperative follow-up. Denied when submitted for the same DOS as D0145 by any provider. A 1–20, N, CCP
D0170*	Limited to one service per day by the same provider. When used for emergency claims, refer to General Information. Denied when submitted for the same DOS as procedure code D0140 or D0160 for the same provider. Denied when submitted for the same DOS as D0145 by any provider. A Birth–20
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter	

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Procedure Code	Limitations
D0180*	Used for periodontal evaluation. Denied when submitted for the same DOS as D0120, D0140, D0145, D0150, D0160 or D0170 by the same provider. A 13–20
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter	

The provider must document medical necessity and the specific tooth or area of the mouth on the claim for procedure codes D0140, D0160, and D0170.

Documentation supporting medical necessity for procedure codes D0140, D0160, and D0170 must also be maintained by the provider in the client's medical record and must include the following:

- The client's complaint supporting medical necessity for the examination
- The specific area of the mouth that was examined or the tooth involved
- A description of what was done during the visit
- Supporting documentation of medical necessity which may include, but is not limited to, radiographs or photographs

Documentation supporting medical necessity for procedure code D0180 must be maintained by the provider in the client's medical record and must include the following:

- The client's complaint supporting medical necessity for the examination
- A description of what was done during the treatment
- Supporting documentation of medical necessity which may include, but is not limited to, radiographs or photographs

A caries risk assessment procedure code (D0601, D0602, or D0603) is required on the same claim when dental examination procedure code D0120, D0145, or D0150 is submitted for reimbursement. Procedure codes D0601, D0602, and D0603 are informational only, and are not payable. Information-only procedure codes must be billed in the amount of at least $0.01 in the cost column on the claim form.

The client's dental condition(s) that justifies the risk assessment classification submitted with the claim must be maintained by the provider in the client's medical record, and it must be clearly documented using a caries risk assessment tool or in narrative charting. The client's medical record is subject to retrospective review.

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

Procedure Code	Limitations
Radiographs/Diagnostic Imaging (Including Interpretation)	
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter	

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Procedure Code	Limitations
Number of films required is dependent on the age of the client. A minimum of eight films is required to be considered a full-mouth series. Adults and children who are 12 years of age and older require 12–20 films, as is appropriate. The Panorex radiographic image (D0330) with four bitewing radiographic images (D0274) may be considered equivalent to the complete or full-mouth series of radiographic images (D0210), and the submitted amount for either combination is equivalent to the maximum fee.	
D0210	Limited to one service every three years by the same provider. Not allowed as an emergency service. A 2–20
D0220	Limited to one service per day by the same provider. A 1–20
D0230	The total cost of periapicals and other radiographs cannot exceed the payment for a complete intraoral series. A 1–20
D0240	Limited to two services per day by the same provider. Periapical films taken at an occlusal angle must be submitted as periapical radiograph, procedure code D0230. May be submitted as an emergency service. A Birth–20
D0250	Limited to one service per day by the same provider. A 1–20, N, CCP
D0270	Limited to one service per day by the same provider. A 1–20
D0272	Limited to one service per day by the same provider. A 1–20
D0273	Limited to one service per day by the same provider. A 1–20
D0274	Limited to one service per day by the same provider. A 2–20
D0277	Limited to one service per day by the same provider. Not to be submitted within 36 months of D0210 or D0330. A 2–20
D0290	A 1–20, N, CCP
D0310	A 1–20, N, CCP
D0320	A 1–20, N, CCP
D0321	A 1–20, N, CCP
D0322	A 1–20, N, CCP
D0330*	Limited to one service per day, any provider, and to one service every three years by the same provider. Not allowed on emergency claims unless third molars or a traumatic condition is involved. For clients who are 2 years of age and younger, must document the necessity of a panoramic film. The Panorex radiographic image (D0330) with four bitewing radiographic images (D0274) may be considered equivalent to the complete or full-mouth series of radiographic images (D0210), and the submitted amount for either combination is equivalent to the maximum fee. A 3–20
D0340*	Limited to one service per day by the same provider. Not reimbursable separately when a comprehensive orthodontic or crossbite therapy workup is performed. A 1–20, N, CCP
D0350*	Limited to one service per day by the same provider. Not reimbursable separately when a comprehensive orthodontic or crossbite therapy workup is performed. A Birth–20
D0367	Prior authorization is required. Limited to a combined maximum of three services per year, any provider. Additional services may be considered with documentation of medical necessity. A Birth-20
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter	

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Procedure Code	Limitations
	Note: *Radiograph codes do not include the exam. If an exam is also performed, providers must submit the appropriate ADA procedure code.*
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter	

Procedure code D0350 must be used to submit claims for photographs, and will be accepted only when diagnostic-quality radiographs cannot be taken. Supporting documentation and photographs must be maintained in the client's medical record when medical necessity is not evident on radiographs for dental caries or the following procedure codes. Medical necessity must be documented on the electronic or paper claim.

Procedure Codes									
D4210	D4211	D4240	D4241	D4245	D4266	D4267	D4270	D4273	D4275
D4276	D4277	D4278	D4283	D4285	D4355	D4910			

Procedure Code	Limitations
Tests and Examinations	
D0415	A 1–20, N, CCP
D0425	Not reimbursable separately. Considered part of another dental procedure.
D0460	Limited to one service per day by the same provider. Not payable for primary teeth. Will deny when submitted for the same DOS as any endodontic procedure. A 1-20, N, CCP
Tests and Examinations continued	
D0470*	Not reimbursable separately when crown, fixed prosthodontics, diagnostic workup, or crossbite therapy workup is performed. A 1-20, N, CCP
Oral Pathology Laboratory	
D0472	By pathology laboratories only. (refer to CPT codes)
D0473	By pathology laboratories only. (refer to CPT codes)
D0474	By pathology laboratories only. (refer to CPT codes)
D0480	By pathology laboratories only. (refer to CPT codes)
D0502	A 1–20, N, CCP
D0999	A 1–20, N, CCP
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter	

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4.2.14 Preventive Services

Procedure Code	Limitations
Dental Prophylaxis	
D1110*	Limited to one prophylaxis per client, same provider, per six-month period (includes oral health instructions). If submitted on emergency claim, procedure code will be denied. Denied when submitted for the same DOS as any D4000 series periodontal procedure code. A 13–20
D1120*	Limited to one prophylaxis per client, same provider, per six-month period (includes oral health instructions). If submitted on emergency claim, procedure code will be denied. Denied when submitted for the same DOS as any D4000 series periodontal procedure code, or with procedure code D0145. A 6 months–12 years
Topical Fluoride Treatment (Office Procedure)	
D1206	Includes oral health instructions. Denied when submitted for the same DOS as any D4000 series periodontal procedure code or with procedure code D0145. A 6 months–20 years, N, CCP
D1208	Includes oral health instructions. Denied when submitted for the same DOS as any D4000 series periodontal procedure code or with procedure code D0145. A 6 months–20 years, N, CCP
Other Preventive Services	
D1310	Denied as part of all preventative, therapeutic and diagnostic dental procedures. A client requiring more involved nutrition counseling may be referred to a THSteps primary care physician.
D1320	A client requiring tobacco counseling may be referred to a THSteps primary care provider.
D1330	Requires documentation of the type of instructions, number of appointments, and content of instructions. This procedure refers to services above and beyond routine brushing and flossing instruction and requires that additional time and expertise have been directed toward the client's care. Denied when billed for the same DOS as dental prophylaxis (D1110 or D1120) or topical fluoride treatments (D1206 or D1208) by the same provider. Limited to once per client, per year, by any provider. A 1–20, N, CCP
D1351*	Sealants may be applied to the occlusal, buccal, and lingual pits and fissures of any tooth that is at risk for dental decay and is free of proximal caries and free of restorations on the surface to be sealed. Sealants are a benefit when applied to deciduous (baby or primary) teeth or permanent teeth. Indicate the tooth numbers and surfaces on the claim form. Reimbursement will be considered on a per-tooth basis, regardless of the number of surfaces sealed. Denied when billed for the same DOS as any D4000 series periodontal procedure code. Sealants and replacement sealants are limited to one every 3 years per tooth by the same provider or provider group. Dental sealants performed more frequently than once every three years by a different provider are also a benefit if the different provider is not associated with the provider or provider group that initially placed the sealant on the tooth. A Birth–20
D1352	A 1–20

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	Limitations
Space Maintenance (Passive Appliances)	
Space maintainers are a benefit of Texas Medicaid after premature loss of primary or secondary molars (TID A, B, I, J, K, L, S, and T for clients who are 1 through 12 years of age, and after loss of permanent molars (TID 3, 14, 19, and 30) for clients who are 3 through 20 years of age. Limited to 1 space maintainer per TID per client. When procedure code D1510 or D1515 have been previously reimbursed, the recementation of space maintainers (procedure code D1550) may be considered for reimbursement to either the same or different THSteps dental provider. Replacement space maintainers may be considered upon appeal with documentation supporting medical necessity. Removal of a fixed space maintainer is not payable to the provider or dental group practice that originally placed the device.	
D1510*	A 1–20 (TIDs #A, B, I, J, K, L, S, T), MTID A 1–20 (TIDs #3, 14, 19, 30), MTID
Space Maintenance (Passive Appliances) continued	
D1515*	A 1–20 (TIDs #A, B, I, J, K, L, S, T), MTID A 1–20 (TIDs #3, 14, 19, 30), MTID
D1520*	A 1–20 (TIDs #A, B, I, J, K, L, S, T), MTID A 1–20 (TIDs #3, 14, 19, 30), MTID
D1525*	A 1–20 (TIDs #A, B, I, J, K, L, S, T), MTID A 1–20 (TIDs #3, 14, 19, 30), MTID
D1550	A 1–20 (TIDs #A, B, I, J, K, L, S, T), MTID A 1–20 (TIDs #3, 14, 19, 30), MTID
D1555*	A 1–20 (TIDs #A, B, I, J, K, L, S, T), MTID A 1–20 (TIDs #3, 14, 19, 30), MTID
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter	

4.2.15 Therapeutic Services

Medicaid reimbursement is contingent on compliance with the following limitations:

- Documentation requirements

  Refer to: Subsection 4.3, "Documentation Requirements" in this handbook.

- The total reimbursement for restorative services of a primary tooth over a 6-month period cannot exceed the fee for a stainless steel crown (with the exception of D2335 and D2933), when provided by the same dentists within a dental group. An exception will be considered when pre-treatment X-ray images, intra-oral photos, and narrative documentation clearly support the medical necessity of the retreatment dental services during pre-payment review.
- Restoration of a primary tooth through the use of a stainless steel crown is considered to be a once-in-a-lifetime restoration. An exception will be considered when pre-treatment X-ray images, intra-oral photos, and narrative documentation clearly support the medical necessity of the replacement of the stainless steel crown during pre-payment review.
- All fees for tooth restorations include local anesthesia and pulp protective media, where indicated, without additional charges. These services are considered part of the restoration.
- More than one restoration on a single surface is considered a single restoration.
- Multiple surface restorations must show definite crossing of the plane of each surface listed for each primary and permanent tooth completed.

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- A multiple surface restoration cannot be submitted as two or more separate one-surface restorations.
- Restorations and therapeutic care are provided as a Medicaid service based on medical necessity and reimbursed only for therapeutic reasons and not preventive purposes (refer to CDT).

All dental restorations and prosthetic appliances that require lab fabrication may be submitted for reimbursement using the date the final impression was made as the DOS. If the client did not return for final seating of the restoration or appliance, a narrative must be included on the claim form and in the client's chart in lieu of a postoperative radiograph. The 95-day filing deadline is in effect from the date of the final impression. If the client returns to the office after the claim has been filed, the dentist is obligated to attempt to seat the restoration or appliance at no cost to the client or Texas Medicaid. For records retention requirements, refer to subsection 4.3, "Documentation Requirements" in this handbook.

Direct pulp caps may be reimbursed separately from any final tooth restoration performed on the same tooth (as noted by the TID) on the same DOS by the same provider.

4.2.16 Restorative Services

Procedure Code	Limitations
Amalgam Restorations (Including Polishing)	
D2140*	A Birth–20, PXR
D2150*	A Birth–20, PXR
D2160*	A 1–20, PXR
D2161*	A 1–20, PXR
Resin-Based Composite Restorations—Direct	
Resin restoration includes composites or glass ionomer.	
D2330*	TID #C–H, M–R, 6–11, 22–27. A Birth–20, PXR
D2331*	TID #C–H, M–R, 6–11, 22–27. A Birth–20, PXR
D2332*	TID #C–H, M–R, 6–11, 22–27. A 1–20, PXR
D2335*	TID #C–H, M–R, 6–11, 22–27. A 1–20, PXR
D2390*	A Birth–20, PXR
D2391*	A Birth–20, PXR
D2392*	A Birth–20, PXR
D2393*	A 1–20, PXR
D2394*	A 1–20, PXR
Inlay/Onlay Restorations (Permanent Teeth only)	
For procedure codes D2510 through D2664, inlay/onlay (permanent teeth only), porcelain is allowed on all teeth. Prior authorization is required for all inlays/onlays or permanent crowns. Procedure codes D2543, D2544, D2650 through DD2652 and D2662 through D2664 are payable once per client, per tooth every ten years.	
D2510	A 13–20, N, PPXR, CCP
D2520	A 13–20, N, PPXR, CCP
D2530	A 13–20, N, PPXR, CCP
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter	

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Procedure Code	Limitations
D2542	Same as D2520. A 13–20, N, PPXR, CCP
D2543	All materials accepted. A 13–20, N, PPXR, CCP
D2544	All materials accepted. A 13–20, N, PPXR, CCP
D2650	All materials accepted. A 13–20, N, PPXR, CCP
D2651	All materials accepted. A 13–20, N, PPXR, CCP
D2652	All materials accepted. A 13–20, N, PPXR, CCP
D2662	All materials accepted. A 13–20, N, PPXR, CCP
D2663	All materials accepted. A 13–20, N, PPXR, CCP
D2664	All materials accepted. A 13–20, N, PPXR, CCP
Crowns—Single Restorations Only	
For procedure codes D2710 through D2794, single crown restorations (permanent teeth only), the following limitations apply: • Prior authorization is required for codes D2710 through D2794. • Reimbursement for crowns and onlay restorations require submission of post-operative bitewing radiograph(s) (for posterior teeth); post-operative periapical radiograph(s) (for anterior teeth) will need to be submitted with the claim to verify that the restoration meets the standard of care. • Radiographs are reviewed to verify that the restoration meets both medical necessity and standard of care to approve reimbursement. • Reimbursement for crowns and onlay restorations are payable once per client, per tooth every ten years. Stainless steel crowns and permanent all-metal cast crowns are not reimbursed on anterior permanent teeth (6–11, 22–27).	
D2710	All materials accepted. A 13–20, N, PPXR, CCP
D2720	All materials accepted. A 13–20, N, PPXR, CCP
D2721	All materials accepted. A 13–20, N, PPXR, CCP
D2722	All materials accepted. A 13–20, N, PPXR, CCP
D2740	All materials accepted. A 13–20, N, PPXR, CCP Limited to TID #4–13 and 20–29 only.
D2750*	All materials accepted. A 13–20, N, PPXR, CCP Limited to TID #4–13 and 20–29 only.
D2751*	All materials accepted. A 13–20, N, PPXR, CCP Limited to TID #4–13 and 20–29 only.
D2752	All materials accepted. A 13–20, N, PPXR, CCP Limited to TID #4–13 and 20–29 only.
D2780	A 13–20, N, PPXR, CCP
D2781	A 13–20, N, PPXR, CCP
D2782	A 13–20, N, PPXR, CCP
D2783	Anterior teeth only (#6–11 and 22–27). A 13–20, N, PPXR, CCP

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	Limitations
D2790	Posterior teeth only (#1–5, 12–21, and 28–32). All materials accepted. A 13–20, N, PPXR, CCP
D2791*	Posterior teeth only (#1–5, 12–21, and 28–32). All materials accepted. A 13–20, N, PPXR
D2792*	Posterior teeth only (#1–5, 12–21, and 28–32). All materials accepted. A 13–20, N, PPXR, CCP
D2794	A 13–20, N, PPXR, CCP
Other Restorative Services	
D2910	A 13–20, PXR
D2915	A 4–20
D2920	A 1–20, PXR
D2930*	A Birth–20, PXR
D2931*	A 1–20, PXR
D2932*	A 1–20, PXR (primary tooth)
D2933*	Limited to anterior primary teeth only (TID #C–H, M–R). A Birth–20, N, CCP, PXR
D2934*	Limited to anterior primary teeth only (TID #C–H, M–R). A Birth–20, N, CCP, PXR
D2940*	Not allowed on the same date as permanent restoration. A Birth–20, PXR
D2950*	Provider payments received in excess of $45.00 for restorative work performed within six months of a crown procedure on the same tooth will be deducted from the subsequent crown procedure reimbursement. Not allowed on primary teeth. A 4–20, N, CCP, PXR
D2951	Not allowed on primary teeth. A 4–20, PXR
D2952	Not payable with D2950. Not allowed on primary teeth. A 13–20, CCP, PXR
D2953	Must be used with D2952. Not allowed on primary teeth. A 13–20
D2954*	Not payable with D2952 or D3950 on the same TID by the same provider. Not allowed on primary teeth. A 13–20, N, CCP, PXR
D2955	For removal of posts (for example, fractured posts) not to be used in conjunction with endodontic retreatment (D3346, D3347, D3348). Not allowed on primary teeth. A 4–20, CCP, PXR
D2957	Must be used with D2954. Not allowed on primary teeth. A 13–20, PXR, CCP
D2960	A 13–20, N, PPXR, CCP
D2961	A 13–20, N, PPXR, CCP
D2962	A 13–20, N, PPXR, CCP

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	Limitations
D2971*	May be reimbursed up to four services per lifetime for each tooth. Payable to any THSteps dental provider who performed the original cementation of the crown. A 13–20
D2980	A 1–20, PXR (permanent teeth only)
D2999	A 1–20, N, CCP, PXR

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

4.2.17 Endodontics Services

Therapeutic pulpotomy (procedure code D3220) and apexification and recalcification procedures (procedure codes D3351, D3352, and D3353) are considered part of the root canal (procedure codes D3310, D3320, and D3330) or retreatment of a previous root canal (procedure codes D3346, D3347, and D3348). When therapeutic pulpotomy or apexification and recalcification procedures are submitted with root canal codes, the reimbursement rate is adjusted to ensure that the total amount reimbursed does not exceed the total dollar amount allowed for the root canal procedure.

Reimbursement for a root canal includes all appointments necessary to complete the treatment. Pulpotomy and radiographs performed pre, intra, and postoperatively are included in the root canal reimbursement.

Root canal therapy that has only been initiated, or taken to some degree of completion, but not carried to completion with a final filling, may not be submitted as a root canal therapy code. It must be submitted using code D3999 with a narrative description of what procedures were completed in the root canal therapy.

Documentation supporting medical necessity must be kept in the client's record and include the following: the medical necessity as documented through periapical radiographs of tooth treated showing pre-treatment, during treatment, and post-treatment status; 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 record.

If the client is pregnant and does not want radiographs, use alternative treatment (temporary) until after delivery.

Procedure Code	Limitations
Pulp Capping	
Procedure codes D3110 and D3120 will not be reimbursed when submitted with the following procedure codes for the same tooth, for the same DOS, by the same provider: D2952, D2953, D2954, D2955, D2957, D2980, D2999, D3220, D3230, D3240, D3310, D3320, or D3330.	
D3110	A 1–20, N, PXR, CCP
D3120	A 1–20, N, PXR, CCP

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	Limitations
Pulpotomy	
D3220*	Denied when performed within six months of D3230, D3240, D3310, D3320, or D3330 for the same primary TID, same provider. Denied when performed within six months of D3310, D3320, or D3330 on the same permanent TID, same provider. A Birth–20, PXR
Endodontic Therapy on Primary Teeth	
D3230*	Anterior primary incisors and cuspids. TIDs #C–H, M–R. A 1–20, PXR
D3240*	Posterior first and second molars. TIDs #A, B, I, J, K, L, S, T. A 1–20, PXR
Endodontic Therapy (including Treatment Plan, Clinical Procedures, and Follow-up Care)	
D3310*	A 6–20, PPXR
D3320*	A 6–20, PPXR
D3330*	A 6–20, PPXR
Endodontic Retreatment	
D3346*	A 6–20, PPXR
D3347*	A 6–20, PPXR
D3348*	A 6–20, PPXR
Apexification/Recalcification Procedures	
D3351*	A 6–20, N, PXR, CCP
D3352*	A 6–20, N, PXR, CCP
D3353*	A 6–20, PPXR, CCP
Apicoectomy/Periradicular Services	
D3410	A 6–20, N, PPXR, CCP
D3421	A 6–20, N, PPXR, CCP
D3425	A 6–20, N, PPXR, CCP
D3426	A 6–20, N, PPXR, CCP
D3430	A 6–20, N, PPXR, CCP
D3450	A 6–20, N, PXR, CCP
D3460	Prior authorization required. Submit request with periapical radiographs, for each tooth involved. A 16–20, N, PPXR, CCP
D3470	A 6–20, N, PXR, CCP
Other Endodontic Procedures	
D3910	A 1–20, N, CCP
D3920	A 6–20, N, PXR, CCP
D3950	A 6–20, N, PXR, CCP
D3999	A 1–20, N, PXR, CCP

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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4.2.18 Periodontal Services

Procedure codes D4210 and D4211, when submitted for clients who are 12 years of age and younger, will be initially denied, but may be appealed with documentation of medical necessity. Preoperative and postoperative photographs are required for the following procedure codes: D4210, D4211, D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285, D4355, and D4910.

Procedure codes D4283 and D4285 are limited to three teeth per site, same day same provider. Procedure code D4283 must be billed along with procedure code D4273 and procedure code D4285 must be billed along with procedure code D4275.

Preoperative and postoperative photographs are required when medical necessity is not evident on radiographs for the following procedure codes: D4240, D4241, D4245, D4266, and D4267. Documentation is required when medical necessity is not evident on radiographs for the following procedure codes: D4210, D4211, D4240, D4241, D4245, D4266, D4267, D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285, D4355, and D4910.

Procedure code D4278 must be billed on the same date of service as procedure code D4277 or the service will be denied.

Claims for preventive dental procedure codes D1110, D1120, D1206, D1208, and D1351 will be denied when submitted for the same DOS as any D4000 series periodontal procedure codes.

Procedure codes D4266 and D4267 may be appealed with documentation of medical necessity. Medical necessity for third molar sites are:

- Medical or dental history documenting need due to inadequate healing of bone following third molar extraction, including the date of third molar extraction.
- Secondary procedure several months postextraction.
- Position of the third molar preoperatively.
- Postextraction probing depth 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 are:

- Medical or dental history documenting comorbid condition (e.g., juvenile diabetes, cleft palate, avulsed tooth or teeth, traumatic oral injuries).
- Intra- or extra-oral radiographs of treatment site(s).
- If not radiographically evident, intraoral photographs are optional unless requested preoperatively by HHSC or its agent.
- Periodontal probing depths.
- Number of intact walls associated with an angular bony defect.
- Bone graft and barrier material used.

Procedure Code	Limitations
Surgical Services (Including Usual Postoperative Care)	
D4210	A 13–20, N, PPXR, PHO, CCP
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC= No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter	

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Procedure Code	Limitations
D4211	A 13–20, N, PHO, CCP
D4230	A 13–20, N, PHO, PXR, CCP
D4231	A 13–20, N, PHO, PXR, CCP
D4240	A 13–20, N, FMX, PXR, PHO when medical necessity is not evident on radiographs, PC, CCP
D4241	Limited to once per year. A 13–20, N, FMX, PXR, PHO when medical necessity is not evident on radiographs, PC
D4245	Per quadrant. A 13–20, N, PXR, PHO when medical necessity is not evident on radiographs, CCP
D4249	A six- to eight-week healing period following crown lengthening before final tooth preparation, impression making, and fabrication of a final restoration is required for claims submission of this code. A 13–20, N, PPXR, CCP
D4260	A 13–20, N, FMX, PXR, PC, CCP
D4261	Limited to once per year. A 13–20, N, FMX, PXR, PC
D4266	A 13–20, N, PXR, PHO when medical necessity is not evident on radiographs, CCP
D4267	A 13–20, N, PXR, PHO when medical necessity is not evident on radiographs, CCP
D4270	A 13–20, N, PXR, PHO, CCP
D4273	This procedure is performed to create or augment gingiva, to obtain root coverage or to eliminate frenum pull, or to extend the vestibular fornix. A 13–20, N, PXR, PHO, CCP
D4274	This procedure is performed in an edentulous area adjacent to a periodontally involved tooth. Gingival incisions are used to allow removal of a tissue wedge to gain access and correct the underlying osseous defect and to permit close flap adaptation. A 13–20, N, PXR, CCP
D4275	Limited to once per day. A 13–20, PXR, PHO
D4276	Prior authorization is required. Not payable in addition to D4273 or D4275 for the same DOS. A 13–20, PXR, PHO
D4277	A 13-20, N, PXR, PHO, CCP
D4278	A 13-20, N, PXR, PHO, CCP
D4283	A 13-20, N, PHO
D4285	A 13-20, N, PHO
Nonsurgical Periodontal Services	
D4320	A 1–20, PXR
D4321	A 1–20, PXR
D4341*	D4341 is denied if provided within 21 days of D4355. Denied when submitted for the same DOS as other D4000 series codes or with D1110, D1120, D1206, D1208, D1351, D1510, D1515, D1520, or D1525. A 13–20, FMX, PC, PXR, CCP

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC= No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	Limitations
D4342	Denied when submitted for the same DOS as other D4000 series codes or with D1110, D1120, D1206, D1208, D1351, D1510, D1515, D1520, or D1525. A 13–20, PC, FMX
D4355*	D4355 is not payable if provided within 21 days of D4341. Denied when submitted for the same DOS as other D4000 series codes or with D1110, D1120, D1206, D1208, D1351, D1510, D1515, D1520, or D1525. A 13–20, N, PXR, PHO, CCP
D4381	This procedure does not replace conventional or surgical therapy required for debridement, respective procedures, or regenerative therapy. The use of controlled-release chemotherapeutic agents is an adjunctive therapy or for cases in which systemic disease or other factors preclude conventional or surgical therapy. A 13–20, N, PXR, CCP
Other Periodontal Services	
D4910	Payable only following active periodontal therapy by any provider as evidenced either by a submitted claim for procedure code D4240, D4241, D4260, or D4261 or by evidence through client records of periodontal therapy while not Medicaid-eligible. Not payable within 90 days after D4355, not payable for the same DOS as any other evaluation procedure. Limited to once per 12 calendar months by the same provider. A 13–20, N, PXR, PHO, CCP
D4920	A 13–20, N, PXR, CCP
D4999	A 13–20, N, PXR, CCP
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC= No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter	

4.2.19 Prosthodontic (Removable) Services

Procedure Code	Limitations
Complete Dentures (Including Routine Post Delivery Care)	
D5110	A 3–20, PXR
D5120	A 3–20, PXR
D5130	A 13–20, N, PXR, CCP
D5140	A 13–20, N, PXR, CCP
Partial Dentures (Including Routine Post Delivery Care)	
D5211*	A 6–20, PXR, MTID
D5212*	A 6–20, PXR, MTID
D5213	A 9–20, N, PXR, MTID, CCP
D5214	A 9–20, N, PXR, MTID, CCP
D5281*	A 9–20, N, PXR, MTID, CCP
Adjustments to Dentures	
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC= No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter	

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Procedure Code	Limitations
D5410	A 3–20, PXR
D5411	A 3–20, PXR
D5421	A 6–20, PXR
D5422	A 6–20, PXR
Repairs to Complete Dentures	
D5510	Cost of repairs cannot exceed replacement costs. A 3–20, PXR
D5520	Cost of repairs cannot exceed replacement costs. A 3–20, PXR
Repairs to Partial Dentures	
Cost of repairs cannot exceed replacement costs. The laboratory portion of the claim, not to exceed $137.50, must be submitted.	
D5610*	A 3–20, PXR
D5620	A 6–20, PXR
D5630*	A 6–20, PXR
D5640*	A 6–20, PXR
D5650*	A 6–20, PXR
D5660*	A 6–20, PXR
D5670*	Will be denied as part of procedure codes D5211, D5213, D5281, and D5640. A 6–20
D5671*	Will be denied as part of procedure codes D5212, D5214, D5281, and D5640. A 6–20
Denture Rebase Procedures	
D5710	A 4–20, PXR
D5711	A 4–20, PXR
D5720*	A 7–20, PXR
D5721*	A 7–20, PXR
Denture Reline Procedures	
Allowed whether or not the denture was obtained through THSteps or ICF-IID dental services if the reline makes the denture serviceable.	
D5730	A 4–20, N, PXR, CCP
D5731	A 4–20, N, PXR, CCP
D5740*	A 7–20, N, PXR, CCP
D5741*	A 7–20, N, PXR, CCP
D5750	A 4–20, PXR
D5751	A 4–20, PXR
D5760*	A 7–20, PXR
D5761*	A 7–20, PXR
Interim Prosthesis	
D5810	A 3–20, N, PXR, CCP

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC= No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	Limitations
D5811	A 3–20, N, PXR, CCP
D5820	A 3–20, N, PXR, CCP
D5821	A 3–20, N, PXR, CCP
Other Removable Prosthetic Services	
D5850	A 3–20, N, PXR, CCP
D5851	A 3–20, N, PXR, CCP
D5862	A 4–20, N, PXR, CCP
D5863	A 4-20, N, PXR, CCP
D5864	A 4-20, N, PXR, CCP
D5865	A 4-20, N, PXR, CCP
D5866	A 4-20, N, PXR, CCP
D5899	A 1–20, N, PXR, CCP
Maxillofacial Prosthetics	
D5911	A 1–20, N, PXR, CCP
D5912	A 1–20, N, PXR, CCP
D5913	A 1–20, N, PXR, CCP
D5914	A 1–20, N, PXR, CCP
D5915	A 1–20, N, PXR, CCP
D5916	A 1–20, N, PXR, CCP
D5919	A 1–20, N, PXR, CCP
D5922	A 1–20, N, PXR, CCP
D5923	A 1–20, N, PXR, CCP
D5924	A 1–20, N, PXR, CCP
D5925	A 1–20, N, PXR, CCP
D5926	A 1–20, N, PXR, CCP
D5927	A 1–20, N, PXR, CCP
D5928	A 1–20, N, PXR, CCP
D5929	A 1–20, N, PXR, CCP
D5931	A 1–20, N, PXR, CCP
D5932	A 1–20, N, PXR, CCP
D5933	A 1–20, N, PXR, CCP
D5934	A 1–20, N, PXR, CCP
D5935	A 1–20, N, PXR, CCP
D5936	A 1–20, N, PXR, CCP
D5937	Not for temporo-mandibular dysfunction (TMD) treatment. A 1–20, N, PXR, CCP
D5951	Prior authorization. A Birth–20, N, PXR

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC= No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	Limitations
D5952	Prior authorization. A Birth–20, N, PXR
D5953	Prior authorization. A 13–20, N, PXR
D5954	Prior authorization. A Birth–20, N, PXR
D5955	Prior authorization. A Birth–20, N, PXR
D5958	Prior authorization. A Birth–20, N, PXR
D5959	Prior authorization. A Birth–20, N, PXR
D5960	Prior authorization. A Birth–20, N, PXR
D5982	A 1–20, N, PXR, CCP
D5983	A 1–20, N, PXR, CCP
D5984	A 1–20, N, PXR, CCP
D5985	A 1–20, N, PXR, CCP
D5986	A 1–20, N, PXR, CCP
D5987	A 1–20, N, PXR, CCP
D5988	A 1–20, N, PXR
D5992*	
D5993*	
D5999	A 1–20, N, PXR, CCP
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC= No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter	

4.2.20 Implant Services

Implant services require prior authorization.

Refer to: Subsection 4.2.32, "Mandatory Prior Authorization" in this handbook for documentation requirements.

Periapical radiographs are required for each tooth involved in the authorization request. The criteria used by the TMHP Dental Director are:

- At least one abutment tooth requires a crown (based on traditional requirements of medical necessity and dental disease).
- Space cannot be filled with removable partial denture.
- The purpose is to prevent the drifting of teeth in all dimensions (anterior, posterior, lateral, and the opposing arch).

4.2.21 Prosthodontic (Fixed) Services

Prosthodontic procedure codes require prior authorization.

Refer to: Subsection 4.2.32, "Mandatory Prior Authorization" in this handbook for documentation requirements.

Periapical radiographs are required for each tooth involved in the authorization request. The criteria used by the TMHP Dental Director are:

- At least one abutment tooth requires a crown (based on traditional requirements of medical necessity and dental disease).

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- The space cannot be filled with a removable partial denture.
- The purpose is to prevent the drifting of teeth in all dimensions (anterior, posterior, lateral, and the opposing arch).
- Each abutment or each pontic constitutes a unit in a bridge.
- Porcelain is allowed on all teeth.

Procedure Code	Limitations
Fixed Partial Dental Pontics	
D6210	A 16–20, PPXR, MTID, CCP
D6211	A 16–20, PPXR, MTID, CCP
D6212	A 16–20, PPXR, MTID, CCP
D6240	A 16–20, PPXR, MTID, CCP
D6241	A 16–20, PPXR, MTID, CCP
D6242	A 16–20, PPXR, MTID, CCP
D6245	A 16–20, PPXR, MTID, CCP
D6250	A 16–20, PPXR, MTID, CCP
D6251	A 16–20, PPXR, MTID, CCP
D6252	A 16–20, PPXR, MTID, CCP
Fixed Partial Dental Retainers—Inlays/Onlays	
D6545	A 16–20, PPXR, CCP
D6548	A 16–20, PPXR, CCP
D6549	A 16-20, PPXR, CCP
Fixed Partial Dental Retainers—Crowns	
D6720	A 16–20, PPXR, CCP
D6721	A 16–20, PPXR, CCP
D6722	A 16–20, PPXR, CCP
D6740	A 16–20, PPXR, CCP
D6750	A 16–20, PPXR, CCP
D6751	A 16–20, PPXR, CCP
D6752	A 16–20, PPXR, CCP
D6780	A 16–20, PPXR, CCP
D6781	A 16–20, PPXR, CCP
D6782	A 16–20, PPXR, CCP
D6783	A 16–20, PPXR, CCP
D6790	Permanent posterior teeth only. A 16–20, PPXR, CCP
D6791	Permanent posterior teeth only. A 16–20, PPXR, CCP
D6792	Permanent posterior teeth only. A 16–20, PPXR, CCP

A=Age range limitations, N=Narrative required, FMX=Full–mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	Limitations
Other Fixed Partial Dental	
D6920	A 16–20, PXR, CCP
D6930	A 16–20, PXR, CCP
D6940	A 16–20, N, PXR, CCP
D6950	A 16–20, N, PXR, CCP
D6980	A 16–20, N, PXR, CCP
D6999	A 16–20, N, PXR, CCP

A=Age range limitations, N=Narrative required, FMX=Full–mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

4.2.22 Oral and Maxillofacial Surgery Services

All oral surgery procedures include local anesthesia, suturing, if needed, and visits for routine postoperative care.

Procedure Code	Limitations
D7111	TIDs #A–T and AS–TS. A Birth–20
D7140*	Replaces procedure codes D7110, D7120, and D7130. A Birth–20, PXR
Surgical Extractions	
D7210*	Includes removal of the roots of a previously erupted tooth missing its clinical crown. A 1–20, PXR
D7220*	A 1–20, PXR
D7230*	A 1–20, PXR
D7240	A 1–20, PXR
D7241	Document unusual circumstance. A 1–20, N, PXR
D7250*	Involves tissue incision and removal of bone to remove a permanent or primary tooth root left in the bone from a previous extraction, caries, or trauma. Usually some degree of soft or hard tissue healing has occurred. A 1–20, N, PXR
Other Surgical Procedures	
D7260	Requires prior authorization. A 1–20, N, PXR; TIDs #1–16 only.
D7261	May not be paid for the same DOS as D7260; TIDs #1–16 only. A 1–20
D7270*	A 1–20, N, PXR, CCP
D7272	Requires prior authorization. A 1–20, N, PXR, CCP
D7280	A 1–20, N, PXR
D7282	Permanent TIDs #1–32 only; may not be paid for the same DOS as D7280. A 4–20
D7283	A 1–20

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	Limitations
D7285	A 1–20, PXR, PATH, CCP
D7286*	A 1–20, PXR, PATH, CCP
D7290	A 1–20, N, PXR, CCP
D7291	A 4–20, N, PXR, CCP
Alveoloplasty—Surgical Preparation of Ridge for Dentures	
D7310	A 1–20, N, PXR, CCP
D7320	A 1–20, N, PXR, CCP
Vestibuloplasty	
D7340	A 1–20, N, PXR, CCP
D7350	A 1–20, N, PXR, CCP
Surgical Excision of Soft Tissue Lesions	
D7410	A 1–20, PXR, PATH
D7411	A 1–20, PXR, PATH
D7413	The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A 1–20, N, PXR, PATH, CCP
D7414	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1–20, N, PXR, PATH, CCP
Surgical Excision of Intraosseous Lesions	
D7440	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1–20, N, PXR, PATH, CCP
D7441	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1–20, N, PXR, PATH, CCP
D7450	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1–20, N, PXR, PATH, CCP
D7451	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1–20, N, PXR, PATH, CCP
D7460	The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A Birth–20, N, PXR, PATH, CCP
D7461	The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A Birth–20, N, PXR, PATH, CCP
D7465	The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A 1–20, N, PXR, PATH, CCP
Excision of Bone Tissue	

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	Limitations
D7472	Prior authorization is required. A 1–20
Surgical Incision	
D7510*	TID required. A 1–20, PXR
D7520	A 1–20, N, PXR, CCP
D7530	A 1–20, N, PXR
D7540	A 1–20, N, PXR
D7550*	A 1–20, N, PXR
D7560	A 1–20, N, PXR, CCP
D7670	A 1–20, N, PXR, CCP
Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions	
D7820	A 1–20, N, PXR
D7880	A 1–20, N, PXR, CCP
D7899	A 1–20, N, PXR, CCP
Repair of Traumatic Wounds	
D7910*	A 1–20, N, PXR, CCP
Complicated Suturing	
D7911	A 1–20, N, PXR, CCP
D7912	A 1–20, N, PXR, CCP
Other Repair Procedures	
D7955	A 1–20
D7960	A 1–20, N, PXR, CCP
D7970*	A 1–20, N, PXR, CCP
D7971*	A 1–20, N, PXR, CCP
D7972	TIDs #1, 16, 17, and 32 only; may not be paid in addition to D7971 for the same DOS. A 13–20
D7980	A 1–20, N, PXR, CCP
D7983	A 1–20, N, PXR, CCP
D7997*	Per arch, appliance removal (not by the dentist who placed the appliance). Includes removal of arch bar. Prior authorization is required. A 1–20, N, PXR, CCP
D7999*	A 1–20, N, PXR, CCP

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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4.2.23 Adjunctive General Services

Procedure Code	Limitations
Unclassified Treatment	
D9110*	Emergency service only. The type of treatment rendered and TID must be indicated. It must be a service other than a prescription or topical medication. The reason for emergency and a narrative of the procedure actually performed must be documented and the appropriate block for emergency must be checked. Refer to subsection 4.2.30, "Emergency or Trauma Related Services for All THSteps Clients and Clients Who Are 5 Months of Age and Younger" in this handbook
D9120	
Anesthesia	
Refer to:	Criteria for Dental Therapy Under General Anesthesia on the TMHP website at www.tmhp.com for general anesthesia criteria and additional information.
D9210	Claim form narrative must describe the situation if used as a diagnostic tool. Denied if submitted with D9248. A 1–20, N, CCP
D9211*	Denied if submitted with D9248. A 1–20, N, CCP
D9212*	Denied if submitted with D9248. A 1–20, N, CCP
D9223	Limited to three hours per day. Prior authorization is required. Denied if submitted with D9248. Dental anesthesiologists are reimbursed at an enhanced rate if the provider has a level 4 permit, TSBDE portability permit, and proof of an anesthesiology residency recognized by the American Dental Board of Anesthesiology on file with TMHP. Providers who do not have the TSBDE portability permit and proof of anesthesiology residency on file with TMHP will still be eligible for reimbursement. A 1–20
D9230*	May not be submitted more than one per client, per day. Denied if submitted with D9248. A 1–20.
D9243	May be considered for reimbursement for conscious sedation services. Limited to one and one-half hours per day. Denied if submitted with D9248. A 1–20
D9248*	May be submitted twice within a 12-month period. Must comply with all TSBDE rules and AAPD guidelines, including maintaining a current permit to provide non-intravenous (IV) conscious sedation. A 1–20
Professional Consultation	
D9310	An oral evaluation by a specialist of any type who is also providing restorative or surgical services must be submitted as D0160. A 1–20, N, CCP
Professional Visits	
D9410	Narrative required on claim form. A 1–20, N
D9420	One charge per hospital or Ambulatory Surgery Center (ASC) case; one case per client in a 12-month period. Documentation supporting the reason that dental services could not be performed in the office setting must be retained in the client's record and may be subject to retrospective review and recoupment. A 1–20, N
D9430	During regularly scheduled hours, no other services performed. Visits for routine postoperative care are included in all therapeutic and oral surgery fees. A 1–20, N

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	Limitations
D9440	Visits for routine postoperative care are included in all therapeutic and oral surgery fees. A 1–20, N
Drugs	
Procedure code D9630 is not payable for take home fluorides or drugs. Prescriptions should be given to clients to be filled by the pharmacy for these medications as the pharmacy is reimbursed by the Medicaid Vendor Drug Program. Procedure code D9630 is payable for medications (antibiotics, analgesics, etc.) administered to a client in the provider's office. Documentation of dosage and route of administration must be provided in the Remarks section of the claim. ***Refer to:*** "Appendix B: Vendor Drug Program" (*Vol. 1, General Information*).	
D9610	May not be submitted with code D9248. A 1–20, N
D9612	
D9630	Includes, but is not limited to, oral antibiotics, oral analgesic, and oral sedatives administered in the office. May not be submitted with codes D9230, D9241, D9248, D9610, and D9920. A 1–20, N
Miscellaneous Services	
D9910	Per whole mouth application, does not include fluoride. Not to be used for bases, liners, or adhesives under or with restorations. Limited to once per year. A 18–20, N, CCP
D9920	The provider must indicate the client's medical diagnosis of intellectual disability described as mild, moderate, severe, profound, or unspecified by using the most appropriate diagnosis code in the diagnosis code field of the claim form, or the provider must indicate that the client is ICF-IID eligible in the Remarks field of the claim form. Documentation supporting the medical necessity and appropriateness of dental behavior management must be retained in the client's chart and available to state agencies upon request, and is subject to retrospective review. Documentation of medical necessity must include: • A current physician statement detailing the client's the intellectual disability. The statement must be signed and dated within one year prior to the dental behavior management. • A description of the service performed (including the specific problem and the behavior management technique applied). • Personnel and supplies required to provide the behavioral management. • The duration of the behavior management (including session start and end times). Dental behavior management is not reimbursed with an evaluation, prophylactic treatment, or radiographic procedure. Denied if submitted with D9248. A 1–20
D9930*	Prior authorization is required. A 1–20, N
D9940	A 13–20, N, CCP
D9950	A 13–20, N, CCP
D9951	Full mouth procedure. Limited to once per year, per client, any provider. A 13–20, N, CCP

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	Limitations
D9952	Full mouth procedure. Payable once per lifetime, any provider. A 13–20, N, CCP
D9970	One service per day, any provider. A 13–20
D9974*	Claim must include documentation of medical necessity. A 13–20, CCP
D9999*	A 1–20, N, CCP, PPXR

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

4.2.24 Dental Anesthesia

Dental providers must have the following information on file with TMHP to be eligible for reimbursement for dental anesthesia:

- A current anesthesia permit level issued by the TSBDE.
- A portability permit from the TSBDE (required to be reimbursed for anesthesia provided in a location other than the provider's office or satellite office). If the provider does not have a permit, the services will be denied.
- Providers must have a level 4 permit, a TSBDE portability permit, and an anesthesiology residency recognized by the American Dental Board of Anesthesiology to bill the enhanced rate for procedure code D9223.

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.

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 table indicates the anesthesia procedure codes and the minimum anesthesia permit level to be reimbursed for the procedure codes:

Procedure Codes	Minimum Anesthesia Permit Level
D9211	Level 3
D9212	Level 3
D9223	Level 4

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Procedure Codes	Minimum Anesthesia Permit Level
D9230	Stand-alone permit for nitrous oxide/oxygen inhalation conscious sedation or Level 1
D9243	Level 3
D9248	Level 2

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.

4.2.25 Dental Therapy Under General Anesthesia

Providers must comply with TSBDE Rules and Regulations, Chapter 8, Subsection C and 22 TAC §§108.30–108.35. Any anesthesia type services are paid only to the provider. The dental provider is responsible for determining whether a client meets the minimum criteria necessary for receiving general anesthesia. A local anesthesia fee is *not* paid in addition to other restorative, operative, or surgical procedure fees.

Prior authorization is required for the use of general anesthesia while rendering treatment (to include the anesthesia fee and the facility fee), regardless of place of service, for a client who does not meet the requirements of the "Criteria for Dental Therapy Under General Anesthesia" (22 point threshold) and the "Criteria for Dental Therapy Under General Anesthesia, Attachment 1" forms. Supporting documentation, including the appropriate narrative, must be submitted to TMHP for prior authorization. Prior authorization is required for medically necessary dental general anesthesia that exceeds once per six months, per client, per provider. The dental provider is responsible for obtaining prior authorization for the services performed under general anesthesia. Hospitals, ASCs, and anesthesiologists must obtain the prior authorization number from the dental provider.

Refer to: Criteria for Dental Therapy Under General Anesthesia on the TMHP website at www.tmhp.com. Dental rehabilitation or restoration services requiring general anesthesia are performed in an outpatient facility.

Surgical services related to THSteps dental services requiring general anesthesia must be coded as follows:

- Procedure code 00170 with modifier EP is for the anesthesiologist or certified registered nurse anesthetist (CRNA) to use on the claim form.
- Procedure code 41899 with modifier EP is for the facility to use on the claim form. Procedure code 41899 does not require prior authorization for ASCs and Hospital-based Ambulatory Surgical Centers (HASCs).
- An appropriate diagnosis code must be used on the claim form.
- Modifier EP identifies that the service is associated with THSteps.

The claim forms used are the CMS-1500 or the UB-04 CMS-1450 paper claim forms. The examining physician, anesthesiologist, hospital, ASC, or HASC must submit claims to TMHP separately for the medical and facility components of their services.

Refer to: THSteps Dental Mandatory Prior Authorization Request Form on the TMHP website at www.tmhp.com.

4.2.26 Hospitalization and ASC/HASC

Dental services performed in an ASC, HASC, or a hospital (either as an inpatient or an outpatient) may be benefits of THSteps based on the medical or behavioral justification provided, or if one of the following conditions exist:

- The procedures cannot be performed in the dental office.

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- The client is severely disabled.

To satisfy the preadmission history and physical examination requirements of the hospital, ASC, or HASC, a THSteps medical checkup for dental rehabilitation or restoration may be performed by the child's primary care provider. Physicians who are not enrolled as THSteps medical providers must submit claims for the examination of a client before the procedure with the appropriate evaluation and management procedure code from the following table:

Procedure Code	Place of Service (POS)
99202	POS 1 (office)
99222	POS 3 (inpatient hospital)
99282	POS 5 (outpatient hospital)

Refer to: Subsection 4.2.10.1, "Exceptions to Periodicity" in this handbook.

Note: *The dental provider must submit claims to TMHP using the ADA Dental Claim Form to be considered for reimbursement through THSteps Dental Services.*

The dental provider is responsible for obtaining prior authorization for the services performed under general anesthesia. Hospitals, ASC's, and anesthesiologists must obtain the prior authorization number from the dental provider.

Contact the individual HMO for precertification requirements related to the hospital procedure. If services are precertified, the provider receives a precertification number effective for 90 days.

In those areas of the state with Medicaid managed care, the provider should contact the managed care plan for specific requirements or limitations. It is the dental provider's responsibility to obtain precertification from the client's HMO or managed care plan for facility and general anesthesia services if precertification is required.

To be reimbursed by the HMO, the provider must use the HMO's contracted facility and anesthesia provider. These services are included in the capitation rates paid to HMOs, and the facility or anesthesiologist risk nonpayment from the HMO without such approval. Coordination of all specialty care is the responsibility of the client's primary care provider. The primary care provider must be notified by the dentist or the HMO of the planned services.

Dentists providing sedation or anesthesia services must have the appropriate current permit from the TSBDE for the level of sedation or anesthesia provided.

The dental provider must be in compliance with the guidelines detailed in General Information.

Note: *Post-treatment authorization will not be approved for codes that require mandatory prior authorization.*

4.2.27 Orthodontic Services (THSteps)

Orthodontic services are a benefit for THSteps clients who are 13 years of age and older who have either permanent dentition and a severe handicapping malocclusion or one of the following special medical conditions:

- Cleft palate
- Head-trauma injury involving the oral cavity
- Skeletal anomalies involving the oral cavity

A severe handicapping malocclusion is defined by Texas Medicaid as dysfunctional masticatory (chewing) capacity as a result of the existing relationship between the maxillary (upper) and mandibular (lower) dental arches or teeth that without correction will result in damage to the temporomandibular joint (s) (TMJ) or other supporting oral structures (e.g., bone, tissues, intra- or extra-oral muscles, etc.).

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Exception to the age restriction may be considered for clients who are 12 years of age and younger if medical necessity has been verified by the dental director for one of the following:

- Interceptive orthodontic treatment services
- Crossbite therapy
- Limited orthodontic treatment and minor treatment to control harmful habits
- Special medical conditions

Dental services that are not covered by THSteps Dental Services but are medically necessary and allowable may be a benefit under CCP according to federal Medicaid guidelines and TAC.

As required by the Texas Human Resources Code, if the client is 14 years of age and younger and services are not provided by an exempt entity, THSteps dental providers shall require the client to be accompanied to THSteps dental appointments by a parent, guardian, or other adult who is authorized by the parent or guardian.

Exempt entities (school health clinics, Head Start program, or childcare facilities) that provide services must as a condition of reimbursement:

- Obtain written, unrevoked consent for the services from the client's parent or legal guardian within a one-year period before the date of service.
- Encourage parental involvement in and management of the health care of the clients who receive services from the clinic, program, or facility.

The following definitions of dentition established by the ADA's Current Dental Terminology (CDT) manual are recognized by Texas Medicaid:

- Primary Dentition: Teeth developed and erupted first in order of time.
- Transitional Dentition: The final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.
- Adolescent Dentition: The dentition that is present after the normal loss of primary teeth and prior to cessation of growth that would affect orthodontic treatment.
- Adult Dentition: The dentition that is present after the cessation of growth that would affect orthodontic treatment.

The American Association of Orthodontists classification of occlusion or malocclusion is as follows:

- *Class I:* A Class I occlusion exists with the teeth in a normal relationship when the mesialbuccal cusp of the maxillary first permanent molar coincides with the buccal groove of the mandibular first molar.
- *Class II:* A Class II malocclusion occurs when the mandibular teeth are distal or behind the normal relationship with the maxillary teeth. This can be due to a deficiency of the lower jaw or an excess of the upper jaw and therefore, presents two types:
    - Division I is when the mandibular arch is behind the upper jaw with a consequential protrusion of the upper front teeth.
    - Division II exists when the mandibular teeth are behind the upper teeth, with a retrusion of the maxillary front teeth. Both of these malocclusions have a tendency toward a deep bite because of the uncontrolled migration of the lower front teeth upwards.

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- *Class III:* A Class III malocclusion occurs when the lower dental arch is in front of (mesial to) the upper dental arch. People with this type of occlusion usually have a strong or protrusive chin, which can be due to either horizontal mandibular excess or horizontal maxillary deficiency. Commonly referred to as an underbite.

4.2.27.1 Benefits and Limitations for Orthodontic Services

Comprehensive orthodontic services must be provided by a board-eligible or board-certified orthodontist.

Note: *Exceptions to a board-eligible or board-certified orthodontist may be considered for clients in a rural or frontier area or where access to care is an issue.*

The diagnostic workup is considered part of the pre-orthodontic treatment visit (procedure code D8660). The following procedure codes are used to submit claims for the diagnostic workup:

Diagnostic Workup Procedure Codes			
D0330	D0340	D0350	D0470

Comprehensive orthodontic services include all of the following:

- Diagnostic workups
- Banding
- Initial brackets
- Replacement brackets
- Monthly visits
- Initial retainers
- Special orthodontic treatment appliance(s)

The following procedure codes are used to submit claims for orthodontic services:

Orthodontic Services Procedure Codes			
D8080	D8660	D8670	D8690

Full banding is allowed on permanent dentition only, and treatment should be accomplished in one stage and is limited to once per lifetime.

Exception: Cases of mixed dentition may be considered when the treatment plan includes extractions of remaining primary teeth or in the case of cleft palate.

4.2.27.2 Crossbite Therapy

Crossbites (anterior and posterior) are defined by the American Academy of Pediatric Dentistry (AAPD) as malocclusions involving one or more teeth in which the maxillary teeth occlude lingually with the mandibular antagonistic (opposing) teeth. A crossbite can be of a dental or skeletal origin or a combination of both.

The intent of crossbite therapy is to prevent the need for comprehensive orthodontic treatment. This treatment may lessen the severity or future effects of a malformation, eliminate its cause, or may include localized tooth movement.

Crossbite therapy (limited orthodontics) is allowed for primary or transitional dentition. Crossbite therapy will not be considered for transitional dentition when there is a need for full banding of the adult teeth.

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Crossbite therapy must be submitted with procedure code D8050 or D8060. Clients with special medical conditions may be considered for interceptive orthodontic services of the primary dentition if the services are medically necessary and submitted with procedure code D8050.

Crossbite therapy is an inclusive charge for treating the crossbite to completion. Adjustments, maintenance, diagnostic models, and diagnostic workup procedures are not reimbursed separately.

4.2.27.3 Minor Treatment to Control Harmful Habits

Special orthodontic appliances are a benefit for minor treatment to control harmful habits.

Orthodontic appliances for minor treatment to control harmful habits must be submitted with procedure codes D8210, D8220, and D8670.

Monthly adjustments (procedure code D8670) for minor treatment to control harmful habits are limited up to 10 visits.

Claims for panoramic films (procedure code D0330), cephalometric films (procedure code D0340), oral/facial photographic images obtained intraorally or extraorally (procedure code D0350) and diagnostic models (procedure code D0470) will be denied when they are submitted with procedure code D8210 or D8220.

Each orthodontic appliance (procedure code D8210 and D8220) are limited to once per arch, per lifetime.

4.2.27.4 Premature Termination of Comprehensive Orthodontic Treatment

Premature termination of comprehensive orthodontic treatment includes the following:

- Removal of the brackets and arch wires
- Removal of appliances with the fabrication of retainers
- Delivery of orthodontic retainers

Documentation of one of the following must be retained for premature termination of comprehensive orthodontic treatment:

- Documentation of a lack of cooperation from the client.
- Documentation that the client requested premature removal and a release of liability form has been signed by the parent, guardian, or client if he or she is at least 18 years of age.

Premature termination of comprehensive orthodontic treatment must be submitted with procedure code D8680.

Removal of the appliance (procedure code D8680) will be denied if the claim is submitted by any provider on the same date of service as orthodontic treatment (procedure codes D8050, D8060, and D8080).

Providers must keep a copy of the release of liability form on file and are responsible for this documentation during a review process.

If premature removal of the appliances is requested before completion of treatment, future orthodontic services may not be considered. The provider must document why the premature removal was necessary.

4.2.27.5 Other Orthodontic Services

Replacement brackets (procedure code D8690) are a benefit when the client transfers from one provider to another or when trauma is involved.

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Providers are responsible for any replacement brackets that are required as part of the comprehensive orthodontic treatment. Additional reimbursement for replacement brackets (procedure code D8690) is limited to a combined total amount of $100.00, same provider.

Rebonding or recementing of fixed orthodontic appliances (procedure code D8693) may be reimbursed once per lifetime per orthodontic appliance.

Only one retainer per arch per lifetime (procedure code D8680) is allowed; however, each retainer may be replaced with prior authorization once per lifetime due to loss or breakage. Retainer adjustments are not reimbursed separately.

Appliances required as part of the cleft palate treatment plan may be reimbursed separately.

Special orthodontic appliances may be used with full banding and crossbite therapy when approved by the TMHP Dental Director or Associate Dental Director.

4.2.27.6 Non-covered Services

Single arch comprehensive orthodontic treatment is not a benefit of Texas Medicaid.

Orthodontic services that are performed solely for cosmetic purposes are not a benefit of Texas Medicaid. Although aesthetics is an important part of self-esteem, services primarily for self-worth are not within the scope of this Texas Medicaid benefit.

Orthodontic services for a client who initiated orthodontic treatment through a private arrangement while Medicaid-eligible are not a benefit of Texas Medicaid.

An initial orthodontic or pre-orthodontic treatment visit (procedure code D8660) is considered part of the exam in an oral evaluation (procedure codes D0120 or D0150).

4.2.27.7 Comprehensive Orthodontic Treatment

Comprehensive orthodontic services (procedure code D8080) are restricted to clients who are 13 years of age and older or clients who have exfoliated all primary dentition.

National procedure codes do not allow for any work-in-progress or partial submission of a claim by separating the three orthodontic components: diagnostic workup, orthodontic appliance (upper), or orthodontic appliance (lower).

When submitting claims for comprehensive orthodontic treatment procedure code D8080, three local codes must be submitted as remarks codes along with procedure code D8080. Local codes (procedure codes Z2009, Diagnostic workup approved; Z2011, Orthodontic appliance, upper; or Z2012, Orthodontic appliance, lower) must be placed in the Remarks Code field on electronic claims or Block 35 on paper claims.

Note: *If the remarks code and procedure code D8080 are not submitted, the claim will be denied.*

Each remarks code pays the correct reimbursement rate which, when combined, totals the maximum payment of $775. Procedure code D8080 must be submitted on three separate details, with the appropriate remarks code, even if the claim submission is for the workup and full banding. Submission of only one detail for a total of $775 will not be accepted.

Example 1: A client is approved for full banding, but after the initial workup, the client discontinues treatment. This provider would submit the national procedure code D8080 and place the local code Z2009, Diagnostic workup approved, in the Remarks/comment field. The claim would pay $175.

Example 2: A client is approved for full banding. The provider continues treatment and places the maxillary bands. The provider would submit the national procedure code D8080 and place the local procedure code Z2009, Diagnostic workup approved, and Z2011, Maxillary bands, in the Remarks/comment field. The claim would pay $475.

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All electronic claims for procedure code D8080 must have the appropriate remarks code associated with the procedure code.

Providers must adhere to the following guidelines for electronic claim submission so TMHP can accurately apply the correct remarks code to the appropriate claim detail.

A Diagnostic Procedure Code (DPC) remarks code must be submitted, only once, in the first three bytes of the NTE02 at the 2400 loop.

Example 1: For a claim with one detail, submitted with procedure code D8080 and remarks code Z2009, enter the information as follows: DPCZ2009. The total submitted would be $175.

Example 2: For a claim with two details, where details one and two are procedure code D8080 and the remarks codes are Z2009 and Z2011, enter the information as follows: DPCZ2009Z2011. The total submitted would be $475.

Example 3: For a claim with three details, where all three details are submitted separately with procedure code D8080, enter the remarks code based on the order of the claim detail as follows: DPCZ2009Z2011Z2012. The total submitted would be $775.

This method ensures accurate and appropriate payment for services rendered and addresses the need for submission of a partial claim.

4.2.27.8 Orthodontic Procedure Codes and Fee Schedule

When submitting claims for orthodontic procedures, use the following procedure codes:

Procedure Code	Limitations
Orthodontic Services	
D0330*, D0340*, D0350*, and D0470*	
D7280	A 1-20
D7997*	Replaces Z2016. Not payable to the dentist who placed the appliance. Includes removal of arch bar and premature removal of braces. A 1-20
Interceptive Orthodontic Treatment	
D8050*	Replaces Z2018 and 8110D. Limited to one per lifetime.
D8060*	Replaces Z2018 and 8120D. Limited to one per lifetime.
Comprehensive Orthodontic Treatment	
D8080*	Replaces Z2009, Z2011, and Z2012. Limited to one per lifetime.
Minor Treatment to Control Harmful Habits	
D8210*	Refer to subsection 4.2.28, "Special Orthodontic Appliances" in this handbook for associated remarks field code.
D8220*	Refer to subsection 4.2.28, "Special Orthodontic Appliances" in this handbook for associated remarks field code.
Other Orthodontic Services	
D8660*	Replaces Z2008. Denied when submitted for the same DOS as D0145 by any provider. Denied when submitted for the same DOS as D0120 or D0150 by the same provider.
D8670*	Replaces Z2013.
D8680*	Replaces Z2014 and Z2015; one retainer per arch per lifetime; may be replaced once because of loss or breakage (prior authorization is required).
*** = Services payable to an FQHC for a client encounter.**	

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Procedure Code	Limitations
D8690*	Bracket replacement.
D8691	Not considered medically necessary.
D8692	Although procedure code D8692 is not a benefit of Texas Medicaid, providers can use procedure code D8680 to submit a claim for retainer(s). Providers must include local code Z2014 or Z2015 on the claim form to indicate upper or lower, as appropriate.
D8693	Limited to once per lifetime per orthodontic appliance.
D8999	
*** = Services payable to an FQHC for a client encounter.**	

4.2.28 Special Orthodontic Appliances

All removable or fixed special orthodontic appliances must be prior authorized. The prior authorization request must include both the national code and remarks code. However, prior authorization requests may omit the DPC prefix to the eight-digit remarks code.

All removable or fixed special orthodontic appliances must be submitted with national procedure code D8210 or D8220. To ensure appropriate claims processing, the DPC remarks code (local procedure code) reflecting the specific service is also required. The appropriate remarks codes must be entered on the prior authorization request form. Failure to follow the following steps will cause the claims to deny. Failure to enter the DPC remarks code and the appropriate procedure code will not result in claim denial; however, manual intervention is required to process the claim, which may result in a delay of payment.

For paper claim submissions, providers must enter the local procedure code in Block 35 (Remarks) of the 2012 ADA claim form.

For electronic submissions, providers enter the DPC remarks code in the Comments field to ensure correct authorization, accurate records, and reimbursement.

For electronic submissions other than TexMedConnect submissions, providers must follow the instructions below to ensure TMHP accurately applies the correct local procedure code to the appropriate claim detail:

- The DPC prefix must be submitted, only once, in the first three bytes of the NTE02 at the 2400 loop.
- In bytes 4–8, providers must submit the remark code (local procedure code) based on the order of the claim detail. Do not enter any spaces or punctuation between remark codes, unless to designate the detail is not submitted with D8210 or D8220.

  Example: *For a claim with three details, where details one and three are submitted with procedure code D8210 and detail two is not, enter the following information in the NTE02 at the 2400 loop: DPC1014D 1046D. (The space shows that detail two needs no local code.) If all details require a local code, enter DPC, no spaces, and the appropriate local codes.*

To submit using TexMedConnect, providers must enter the local code into the Remarks Code field, located under the details header. The Remarks Code field is the field directly after the Procedure Code field. TexMedConnect submitters are not required to manually enter the DPC prefix as it is placed in the appropriate field on the TexMedConnect electronic claim.

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The following table identifies the appropriate DPC remarks codes to use when requesting prior authorization or submitting a claim for procedure code D8210 or D8220:

Procedure Code	Remarks Code	Remarks Code Description
Special Orthodontic Appliances		
D8220*	DPC1000D	Appliance with horizontal projections
D8220*	DPC1001D	Appliance with recurved springs
D8220*	DPC1002D	Arch wires for crossbite correction (for total treatment)
D8220*	DPC1003D	Banded maxillary expansion appliance
D8210*	DPC1004D	Bite plate/bite plane
D8210*	DPC1005D	Bionator
D8210*	DPC1006D	Bite block
D8210*	DPC1007D	Bite-plate with push springs
D8220*	DPC1008D	Bonded expansion device
D8210*	DPC1010D	Chateau appliance (face mask, palatal exp and hawley)
D8210*	DPC1011D	Coffin spring appliance
D8220*	DPC1012D	Crib
D8210*	DPC1013D	Dental obturator, definitive (obturator)
D8210*	DPC1014D	Dental obturator, surgical (obturator, surgical stayplate, immediate temporary obturator)
D8220*	DPC1015D	Distalizing appliance with springs
D8220*	DPC1016D	Expansion device
D8210*	DPC1017D	Face mask (protraction mask)
D8220*	DPC1018D	Fixed expansion appliance
D8220*	DPC1019D	Fixed lingual arch
D8220*	DPC1020D	Fixed mandibular holding arch
D8220*	DPC1021D	Fixed rapid palatal expander
D8210*	DPC1022D	Frankel appliance
D8210*	DPC1023D	Functional appliance for reduction of anterior openbite and crossbite
D8210*	DPC1024D	Headgear (face bow)
D8220*	DPC1025D	Herbst appliance (fixed or removable)
D8220*	DPC1026D	Inter-occlusal cast cap surgical splints
D8210*	DPC1027D	Intrusion arch
D8220*	DPC1028D	Jasper jumpers
D8220*	DPC1029D	Lingual appliance with hooks
D8220*	DPC1030D	Mandibular anterior bridge
D8220*	DPC1031D	Mandibular bihelix (similar to a quad helix for mandibular expansion to attempt nonextraction treatment)
D8210*	DPC1032D	Mandibular lip bumper
D8220*	DPC1036D	Mandibular lingual 6x6 arch wire
D8210*	DPC1037D	Mandibular removable expander with bite plane (crozat)
*** = Services payable to an FQHC for a client encounter.**		

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Procedure Code	Remarks Code	Remarks Code Description
D8210*	DPC1038D	Mandibular ricketts rest position splint
D8210*	DPC1039D	Mandibular splint
D8210*	DPC1040D	Maxillary anterior bridge
D8210*	DPC1041D	Maxillary bite-opening appliance with anterior springs
D8220*	DPC1042D	Maxillary lingual arch with spurs
D8220*	DPC1043D	Maxillary and mandibular distalizing appliance
D8220*	DPC1044D	Maxillary quad helix with finger springs
D8220*	DPC1045D	Maxillary and mandibular retainer with pontics
D8210*	DPC1046D	Maxillary Schwarz
D8210*	DPC1047D	Maxillary splint
D8210*	DPC1048D	Mobile intraoral Arch-Mia (similar to a Bihelix for nonextraction treatment)
D8220*	DPC1049D	Modified quad helix appliance
D8220*	DPC1050D	Modified quad helix appliance (with appliance)
D8220*	DPC1051D	Nance appliance
D8220*	DPC1052D	Nasal stent
D8210*	DPC1053D	Occlusal orthotic device
D8210*	DPC1054D	Orthopedic appliance
D8210*	DPC1055D	Other mandibular utilities
D8210*	DPC1056D	Other maxillary utilities
D8220*	DPC1057D	Palatal bar
D8210*	DPC1058D	Post-surgical retainer
D8220*	DPC1059D	Quad helix appliance held with transpalatal arch horizontal projections
D8220*	DPC1060D	Quad helix maintainer
D8220*	DPC1061D	Rapid palatal expander (RPE), such as quad Helix, Haas, or Menne
D8210*	DPC1062D	Removable bite plate
D8210*	DPC1063D	Removable mandibular retainer
D8210*	DPC1064D	Removable maxillary retainer
D8210*	DPC1065D	Removable prosthesis
D8210*	DPC1066D	Sagittal appliance 2 way
D8210*	DPC1067D	Sagittal appliance 3 way
D8220*	DPC1068D	Stapled palatal expansion appliance
D8210*	DPC1069D	Surgical arch wires
D8210*	DPC1070D	Surgical splints (surgical stent/wafer)
D8210*	DPC1071D	Surgical stabilizing appliance
D8220*	DPC1072D	Thumbsucking appliance, requires submission of models
D8210*	DPC1073D	Tongue thrust appliance, requires submission of models
D8210*	DPC1074D	Tooth positioner (full maxillary and mandibular)
*** = Services payable to an FQHC for a client encounter.**		

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Procedure Code	Remarks Code	Remarks Code Description
D8210*	DPC1075D	Tooth positioner with arch
D8220*	DPC1076D	Transpalatal arch
D8220*	DPC1077D	Two bands with transpalatal arch and horizontal projections forward
D8220*	DPC1078D	Appliance
*** = Services payable to an FQHC for a client encounter.**		

4.2.29 Handicapping Labio-lingual Deviation (HLD) Index

The orthodontic provider must complete and sign the HLD Index (Angle classification).

The HLD index requires the use of an HLD score sheet and a Boley gauge for measuring.

Providers should be conservative in scoring. The client must be considered severe handicapping malocclusion with dysfunctional masticatory (chewing) capacity as a result of the existing relationship between the maxillary (upper) and mandibular (lower) dental arches and/or teeth that, without correction, will result in damage to the temporomandibular joint(s) (TMJ) and/or other supporting oral structures (e.g., bone, tissues, intra and/or extra oral muscles, etc.) and have a minimum of 26 points on the HLD index to be considered for any orthodontic care other than crossbite correction. "Half-mouth" treatment cannot be approved.

With the client or models in the centric position, the HLD index is to be scored as follows. Record all measurements rounded-off to the nearest millimeter (mm). Enter a score of "0" if the condition is absent.

Cleft Palate

A cleft palate case request for mixed dentition will be considered only if narrative justification supports treatment before the client reaches full dentition.

Note: *Intermittent treatment requests may exceed the allowable 26 reimbursable treatment visits.*

Severe Traumatic Deviations

Refers to facial accidents only. Points cannot be awarded for congenital deformity. Severe traumatic deviations do not include traumatic occlusions for crossbites.

Overjet in Millimeters

Score the case exactly as measured. The measurement must be recorded from the most protrusive incisor, then subtract 2 mm (considered the norm), and enter the difference as the score.

Overbite in Millimeters

Score the case exactly as measured. The measurement must be recorded from the labio-incisal edge of the overlapped anterior tooth or teeth to the point of maximum coverage, then subtract 3 mm (considered the norm), and enter the difference as the score.

Mandibular Protrusion in Millimeters

Score the client exactly as measured. The measurement must be recorded from the "line of occlusion" of the permanent teeth, not from the ectopically erupted teeth in the anterior segment.

Open Bite in Millimeters

Score the case exactly as measured. Measurement must be recorded from the "line of occlusion" of the permanent teeth, not from the ectopically erupted teeth in the anterior segment. *Caution is advised in undertaking treatment of open bites in older teenagers, because of the frequency of relapse.*

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Ectopic Eruption

An unusual pattern of eruption, such as high labial cuspids or teeth that are grossly out of the long axis of the alveolar ridge.

Ectopic eruption does not include teeth that are rotated or teeth that are leaning or slanted especially when the enamel-gingival junction is within the long axis of the alveolar ridge.

Note: *Record the more serious condition. Do not include (score) teeth from an arch if that arch is to be counted in the category of Anterior Crowding. For each arch, either the ectopic eruption or anterior crowding may be scored, but not both.*

Anterior Crowding

Arch length insufficiency must exceed 3.5 mm to be considered as crowding in either arch. Mild rotations that may react favorably to stripping or moderate expansion procedures are not to be scored as crowded.

Excessive Anterior Spacing in Millimeters

The score for this category must be the total, in millimeters, of the anterior spaces.

Providers should be conservative in scoring. Liberal scoring will not be helpful in the evaluation and approval of the case. The case must be considered dysfunctional and have a minimum of 26 points on the HLD index to qualify for any orthodontic care other than crossbite correction. Half-mouth cases cannot be approved.

The intent of the program is to provide orthodontic care to clients with handicapping malocclusion to improve function. Although aesthetics is an important part of self-esteem, services that are primarily for aesthetics are not within the scope of benefits of this program.

The proposals for treatment services should incorporate only the minimal number of appliances required to properly treat the case. Requests for multiple appliances to treat an individual arch will be reviewed for duplication of purpose.

If attaining a qualifying score of 26 points is uncertain, providers must include a brief narrative when submitting the case. The narrative may reduce the time necessary to gain final approval and reduce shipping costs incurred to resubmit records.

Providers must properly label and protect all records (especially plaster diagnostic models) when shipping. If plaster diagnostic models are requested by and shipped to TMHP, the provider should assure that the models are adequately protected from breakage during shipping. TMHP will return intact models to the provider.

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4.2.29.1 HLD Score Sheet

This sheet and a Boley Gauge are required to score.

Procedure:

- Occlude client or models in centric position.
- Record all measurements rounded-off to the nearest millimeter.
- Enter a score of 0 if the condition is absent.

PLEASE PRINT CLEARLY:

Client Name:	Date of birth:		Medicaid ID:	
Address: (*Street/City/County/State/ZIP Code*)				
CONDITIONS OBSERVED				HLD SCORE
Cleft Palate			Score 15	
Severe Traumatic Deviations Trauma/Accident related only			Score 15	
Overjet in mm. *Minus 2 mm.* *Example: 8 mm. – 2 mm. = 6 points*				=
Overbite in mm. *Minus 3 mm.* Example: 5 mm. – 3 mm. = 2 points				=
Mandibular Protrusion in mm. See definitions/instructions to score (previous page)			x5	=
Open Bite in mm. See definitions/instructions to score (previous page)			x4	=
Ectopic Eruption (Anteriors Only) *Reminder: Points cannot be awarded on the same arch for Ectopic Eruption and Crowding*			Each tooth x3	=
Anterior Crowding *10 point maximum total for both arches combined*	Max.	Mand.	= 5 pts. each arch	=
Labio-lingual Spread in mm.				=
TOTAL				=
Diagnosis		For TMHP use only Authorization Number		
Examiner:		Recorder:		
Provider's Signature Please submit this score sheet with records				

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4.2.30 Emergency or Trauma Related Services for All THSteps Clients and Clients Who Are 5 Months of Age and Younger

THSteps clients who are birth through 5 months of age are not eligible for routine dental checkups; however:

- They can be seen for emergency dental services by the dentist at any time for trauma, early childhood caries, or other oral health problems.
- They may be referred to a dentist by their primary care provider when a medical checkup identifies the medical necessity for dental services.

Prior authorization is not required for emergency or trauma-related dental services. Claims for these dental services must be filed separately from nonemergency dental services. Only one emergency or trauma-related dental claim per client, per day, may be considered for reimbursement. Routine therapeutic procedures are not considered emergency or trauma-related procedures.

When submitting a claim for emergency or trauma-related dental services, the provider must:

- Enter the word "Emergency" or "Trauma" in the description field (Block 30) of the claim form (also enter a brief description of the CDT procedure code used). Claims are subject to retrospective review. If no comments are indicated on the claim form, the payment may be recouped.
- If checking the Other Accident box, briefly describe in the Remarks field, Block 35 of the claim form, what caused the emergency or trauma.
- Check the appropriate box in Block 45, Treatment Resulting From, of the claim form (the options to check are Occupational Illness/Injury, Auto Accident, or Other Accident).

Documentation to support the diagnosis and treatment of trauma must be retained in the client's record.

Note: *Indicating Trauma in the description field allows the provider to be reimbursed for treatment on an emergency, continuing, and long-term basis without regard to periodicity, subject to the client's eligibility and program limitations. An exception to periodicity for THSteps dental services is granted automatically for immediate treatment and any future follow-up treatment, as long as each claim submitted for payment is marked "Trauma" in the Description field, Block 30, and the original date of treatment or incident is referenced in the Remarks field, Block 35.*

Refer to: Subsection 6.7, "2012 American Dental Association (ADA) Dental Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

Subsection 4.1, "General Medicaid Eligibility" in Section 4, "Client Eligibility" (*Vol. 1, General Information*).

Subsection 9.3, "Doctor of Dentistry Practicing as a Limited Physician" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 4.2.12, "Medicaid Dental Benefits, Limitations, and Fee Schedule" of this handbook.

4.2.31 Emergency Services for Medicaid Clients Who Are 21 Years of Age and Older

Limited dental services are available for clients who are 21 years of age and older (not residing in an ICF-IID facility) whose dental diagnosis is secondary to and causally related to a life-threatening medical condition.

Refer to: Subsection 9.3, "Doctor of Dentistry Practicing as a Limited Physician" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for complete description and details.

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4.2.31.1 Long Term Care (LTC) Emergency Dental Services

DADS provides a limited range of dental services for Medicaid-eligible residents of LTC facilities. All claims for dental services provided to LTC residents are submitted to DADS. For information, providers should contact the appropriate LTC facility or DADS at 1-512-438-2633.

4.2.31.2 Laboratory Requirements

Dental laboratories must be registered with TSBDE laboratories, and technicians must not be under restrictions imposed by TSBDE or a court.

4.2.32 Mandatory Prior Authorization

Mandatory prior authorization is required for consideration of reimbursement to dental providers who render the following services:

- Orthodontia
- Implants
- Fixed prosthetic services
- Removable prosthodontics
- Dental general anesthesia
- All inlays/onlays or permanent crowns
- Procedure code D4276
- Procedure code D7272
- Procedure code D7472
- Limited dental services for clients who are 21 years of age and older (not residing in an ICF-IID facility) whose dental diagnosis is secondary to and causally related to a life-threatening medical condition
- Cone beam imaging

Approved orthodontic treatment plans must be initiated before the client's loss of Medicaid eligibility and before the 21st birthday, and must be completed within 36 months of the authorization date. Authorization for other procedures is valid for up to 90 days.

To obtain prior authorization for crowns, onlays, implants, and fixed prosthodontics, a prior authorization form together with documentation supporting medical necessity and appropriateness must be submitted. Required documentation includes, but is not limited to:

- The THSteps Dental Mandatory Prior Authorization Request Form.
- Current, dated, pre-operative periapical radiographs completely showing the apex of the tooth to be treated.
- Current, dated, pre-operative full arch radiographs are required for fixed prosthodontics.
- Documentation supporting that the mouth is free of disease; no untreated periodontal or endodontic disease, or rampant caries.
- Documentation supporting only one virgin abutment tooth; at least one tooth must require a crown unless a Maryland Bridge is being considered.
- Provider documentation supporting the medical necessity and appropriateness of the recommended treatment.
- Tooth Identification (TID) System noting only permanent teeth.

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- Documentation supporting that a removable partial is not a viable option to fill the space between the teeth.

Prior authorization will not be given when films show two abutment teeth (virgin teeth do not require a crown, except for Maryland Bridge) or there is untreated periodontal or endodontic disease, or rampant caries which would contraindicate the treatment.

Refer to: Subsection 9.3, "Doctor of Dentistry Practicing as a Limited Physician" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Removable prosthodontics (procedure codes D5951, D5952, D5953, D5954, D5955, D5958, D5959, and D5960) for clients with cleft lip or cleft palate requires prior authorization with a completed THSteps Dental Mandatory Prior Authorization Request Form and narrative documenting the medical need for these appliances. Additional information may be requested by the TMHP Dental Director if necessary before making a determination.

The prior authorization number is required on claims for processing. If the client is not eligible for Medicaid on the DOS or the claim is incomplete, it will affect reimbursement. Prior authorization is a condition for reimbursement; it is not a guarantee of payment.

Note: *Post-treatment authorization will not be approved for codes that require mandatory prior authorization.*

Refer to: THSteps Dental Mandatory Prior Authorization Request Form on the TMHP website at www.tmhp.com.

4.2.32.1 Cone Beam Imaging

Prior authorization is required for procedure code D0367.

Cone beam imaging is used to determine the best course of treatment for cleft palate repair, skeletal anomalies, post-trauma care, implanted or fixed prosthodontics, and orthodontic or orthognathic procedures. Cone beam imaging is limited to initial treatment planning, surgery, and postsurgical follow up.

To obtain prior authorization, a THSteps Dental Mandatory Prior Authorization Request Form must be submitted with documentation supporting medical necessity and appropriateness. Required documentation includes, but is not limited to, the following:

- Presenting conditions
- Medical necessity
- Status of the client's treatment

4.2.32.2 General Anesthesia for Dental Treatment

Prior authorization is required for the use of general anesthesia while rendering treatment (to include the dental service fee, the anesthesia fee, and facility fee) regardless of place of service. A client must meet the minimum requirement of 22 total points on the Criteria for Dental Therapy Under General Anesthesia form.

Refer to: Criteria for Dental Therapy Under General Anesthesia on the TMHP website at www.tmhp.com.

In those areas of the state with Medicaid Managed Care, precertification or approval is required from the client's health maintenance organization (HMO) for anesthesia and facility charges. It is the dental provider's responsibility to obtain precertification from the client's HMO or managed care plan for facility and general anesthesia services. A medical checkup prior to a dental procedure requiring general anesthesia is considered an exception to THSteps periodicity. A referral to the client's primary care

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physician is not required. Prior authorization is available for exceptions to periodicity. Providers must include all appropriate supporting documentation with the submittal. The criteria for general anesthesia applies only to treatment of clients who are 20 years of age and younger or ICF-IID program clients.

4.2.32.3 * Orthodontic Services

Prior authorization is required for all orthodontic services except for rebonding or recementing of fixed retainers (procedure code D8693). Providers must maintain documentation of medical necessity in the client's dental record for rebonding or recementing of fixed retainers.

Orthodontic services do not include any related services outside those listed in this section (e.g., extractions or surgeries); however, all services must be included in the orthodontic treatment plan.

Approved orthodontic treatment plans must be initiated before clients lose Medicaid eligibility or reach 21 years of age, and all active orthodontic treatments must be completed within 36 months of the authorization date. Services cannot be added or approved after eligibility has expired.

> ***Note:*** *If a client reaches 21 years of age or loses Medicaid eligibility before the authorized orthodontic services are completed, reimbursement is provided to complete the orthodontic treatment plan that was authorized and initiated while the client was 20 years of age or younger and eligible for Texas Medicaid as long as the orthodontic treatment plan is completed within the appropriate time frames.*

Any non-orthodontic service that is included as part of the treatment plan (extractions or surgeries) must be completed before the client loses eligibility or reaches 21 years of age in order to be reimbursed through Texas Medicaid. Services cannot be added or approved after Texas Medicaid eligibility has expired.

Once prior authorization is obtained, the provider is obligated to advise the client that he or she is able to receive the approved orthodontic service (including monthly orthodontic adjustment visits and retainers) even if the client loses eligibility or reaches his or her 21st birthday.

All requests must be reviewed by the TMHP Dental Director or other state dental contractor's board-eligible or board-certified orthodontist employee or consultant who is licensed in Texas.

To avoid unnecessary denials, providers must submit correct and complete information, including documentation for medical necessity for the services requested. Providers must maintain documentation of medical necessity in the client's medical record. Requesting providers may be asked for additional information to clarify or complete a request.

A completed Texas Health Steps (THSteps) Dental Mandatory Prior Authorization Request Form must be signed and dated by the performing dental provider. The completed authorization form must include the procedure codes for all services requested along with a written statement of medical necessity for the proposed orthodontic treatment.

All prior authorization requests for orthodontic services must be accompanied by an attestation from the requesting provider that the provider is either a pediatric dentist or orthodontist.

General dentists who are requesting prior authorization for orthodontic services must attest and maintain documentation of a minimum of 200 hours of continuing dental education specifically in orthodontics within the last 10 years; 8 hours can be online or self-instruction.

Proof of the completion of continuing education hours is not required to be submitted with a request for prior authorization of orthodontic services; however, documentation must be produced by the dentist during retrospective review. All attestations are subject to compliance review and orthodontic services may be subject to recoupment.

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4.2.32.3.1 Initial Orthodontic Services Request

The prior authorization form must include all of the procedures that are required to complete the requested treatment including, but not limited to, the following:

- Diagnostic workup
- Medically necessary extractions (Tooth ID must be included)
- Orthognathic surgery
- Upper and lower appliance
- Monthly adjustments
- Special orthodontic treatment appliances
- Placement of banding and brackets
- Replacement of brackets
- Removal of the brackets and arch wires
- Other special orthodontic appliances
- Fabrication of special orthodontic appliances
- Delivery of orthodontic retainers
- Appliance removal (if indicated)

A completed and scored Handicapping Labio-Lingual Deviations (HLD) Index with a diagnosis of Angle class (a minimum of 26 points are required for approval of non-cleft palate cases). If attaining a qualifying score of 26 points is uncertain, a brief narrative should be provided.

Note: *A score of a minimum 26 points on the HLD index does not indicate an automatic approval for comprehensive orthodontics. Approval will be based on the diagnostic workup supporting the HLD index. Documentation provided must be reviewed by a qualified board eligible or board certified orthodontist.*

When requesting prior authorization, providers must include diagnostic models, radiographs (X-rays), cephalometic X-ray with tracings, photographs, and other supporting documentation with the THSteps Dental Mandatory Prior Authorization Request Form.

All required documents must be submitted together in one package per prior authorization request. Prior authorization requests that are not submitted in one package per request will be considered incomplete.

Note: *All documentation submitted with an incomplete request will be sent back to the provider with a letter that indicates the prior authorization request was incomplete. Providers must resubmit prior authorization requests with all the required documentation within 14 business days of the request receipt date, or the request will be denied as "incomplete."*

4.2.32.3.2 Diagnostic Tools

Prior authorization requests must include the date of service the diagnostic tools were obtained (the date of service the dental records were produced). All diagnostic tools must be properly labeled and protected when shipped by the provider. If any diagnostic tool is damaged during shipment, the provider may be required to reproduce the documentation for consideration of the case for prior authorization.

Note: *If medical necessity cannot be determined from the diagnostic tools that are submitted with the request, the prior authorization request may be denied.*

TMHP will be responsible for retaining an image of each diagnostic tool that is submitted for every complete orthodontic prior authorization request.

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Copies of diagnostic models, X-rays, and any other paper diagnostic tools will be accepted and are preferred. Copies will not be returned, but providers will be required to maintain the dental records for retrospective review. Originals will be returned to the submitting provider only when the document is clearly marked "original."

Diagnostic models in the form of plaster casts are preferred; however, providers may choose the positions in which the casts are made. E-models must be in the centric occlusion position.

Radiographs that are submitted must include, but are not limited to, the following:

- Panoramic or a full mouth series
- Cephalometric with tracings

Photographic images must be submitted with the request and must be in a 1:1 ratio format (actual size), including, but not limited to, the following:

- Full face, smiling
- Left and right profiles
- Full maxillary arch (open mouth view)
- Full mandibular arch (open mouth view)
- Right side occluded in centric occlusion
- Left side occluded in centric occlusion
- Anterior occluded in centric occlusion

X-rays must be of diagnostic quality and do not have to be submitted on photographic quality paper.

Submitting providers must attest that radiographs, photographs, and other documentation are unaltered.

4.2.32.3.3 Authorization Extensions

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. Providers must submit the following:

- Diagnostic workup.

  Note: *Photographs may be substituted for models.*

- The reason the treatment was not completed in the original time frame.
- An explanation of the treatment plan status.

4.2.32.3.4 Crossbite Therapy

Requests for crossbite therapy (procedure codes D8050 or D8060) require the submission of diagnostic models to receive authorization. An HLD score sheet is not required for crossbite therapy.

Providers that submit requests for crossbite therapy must maintain documentation in the client's record that demonstrates the following criteria:

- Posterior teeth—Are not end-to-end, but the buccal cusp of the upper teeth is lingual to the buccal cusp of the lower teeth.
- Anterior teeth—The incisal edge of the upper teeth are lingual to the incisal edge of the opposing arch.

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4.2.32.3.5 Minor Treatment to Control Harmful Habits

A THSteps Dental Mandatory Prior Authorization Form must be completed when requesting prior authorization for orthodontic appliances for minor treatment to control harmful habits. Documentation must support medical necessity of any appliance requested.

Providers must submit diagnostic models when requesting prior authorization for a removable appliance or fixed appliance.

Procedure codes D8210 or D8220 may only be approved for control of harmful habits including, but not limited to, thumb sucking or tongue thrusting and may not be prior authorized for services that are related to comprehensive orthodontic services.

4.2.32.3.6 Premature Termination of Orthodontic Services

Prior authorization for the premature termination of orthodontic services (procedure code D8680) is required.

Premature termination of orthodontic services includes all of the following:

- Removal of the brackets and arch wires.
- Other special orthodontic appliances.
- Fabrication of special orthodontic appliances.
- Delivery of orthodontic retainers.

The prior authorization must include all of the following for consideration:

- Panoramic radiograph (copies are preferred).
- Cephalometric radiograph with tracing (copies are preferred).
- Six intra-oral photographs (copies are preferred).
- Three extra-oral photographs (copies are preferred).
- A narrative documenting why the provider is terminating the orthodontic services early.
- Documentation that the parent, legal guardian, or the client, if he or she is 18 years of age or older or an emancipated minor, understands that the provider is terminating the orthodontic services, and the client is no longer eligible for orthodontic services by Texas Medicaid/THSteps.

In addition to the final record, the provider requesting premature termination of orthodontic services must submit a copy of the signed release form that includes the following:

A signature by one of the following:

  - The parent
  - Legal guardian
  - The client, if he or she is 18 years of age or older or an emancipated minor

- One of the following statements:
  - The client is uncooperative or non-compliant with the treating dentist's directions and does not intend to complete orthodontic treatment.
  - The client requested the premature removal of orthodontic appliances and does not intend to complete orthodontic treatment.

Note: *A client for whom removal of an appliance has occurred due to the client's request, or is uncooperative or non-compliant will not be eligible for any additional Medicaid orthodontic services.*

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- The client has requested the premature removal of orthodontic appliances due to extenuating circumstances including, but not limited to, the following:
  - Incarceration.
  - Mental health complications with a recommendation from the treating physician.
  - Foster care placement.
  - Child of a migrant farm worker. With the intent to complete orthodontic treatment at a later date if Medicaid eligibility for orthodontic services continues.
  - Special medical conditions.

Note: *If comprehensive orthodontic services are terminated due to extenuating circumstances, clients will be eligible for completion of their Medicaid orthodontic services if the services are re-initiated while the client is eligible for Medicaid.*

The requesting provider will be responsible for removal of the orthodontic appliances, final records, and fabrication and delivery of orthodontic retainers at the time of premature removal or at any future time should the client present to the treating provider's office.

4.2.32.3.7 Transfer of Services

Prior authorization that is issued to a provider for orthodontic services is not transferable to another provider. The new provider must request a new prior authorization to complete the orthodontic treatment that was initiated by the original provider. The original prior authorization will be end-dated when services are transferred to another provider.

The new provider must obtain his or her own records, and the new request for orthodontic services must include the date of service on which the documentation was obtained (the date of service on which the records were produced) and the following supporting documentation:

- All of the documentation that is required for the original request

  Note: *Photographs may be substituted for models.*
- The reason the client left the previous provider
- An explanation of the treatment status

The authorization request for clients who are undergoing orthodontic treatment services and subsequently become eligible for Medicaid are subject to the same requirements.

4.2.32.3.8 Orthodontic Cases Initiated Through a Private Arrangement

Authorization may be given for continuation of orthodontic cases for clients who initiated orthodontic treatment through a private arrangement before becoming eligible for Medicaid.

Authorization will not be given for continuation of orthodontic cases for clients who initiated orthodontic treatment through a private arrangement and were eligible for Medicaid at the start of service.

4.2.33 THSteps and ICF-IID Dental Prior Authorization

Submit claims, dental correspondence, and THSteps and ICF-IID prior authorization requests to the appropriate address listed in the table below:

Correspondence	Address
ADA dental claim forms	Texas Medicaid & Healthcare Partnership PO Box 200555 Austin, TX 78720-0555

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Correspondence	Address
All dental correspondence Prior authorization requests	Texas Medicaid & Healthcare Partnership Fee-for-Service and ICF-IID Dental Authorizations PO Box 204206 Austin, TX 78720-4206

4.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including dental services. Dental services are subject to retrospective review and recoupment if documentation does not support the service submitted for payment.

The provider must educate all staff members, including dentists, about the following documentation requirements and charting procedures:

- For THSteps and ICF-IID dental claims, providers are not required to submit preoperative and postoperative radiographs unless these are specifically requested by HHSC, the TMHP Dental Director, or are needed for prior authorization or pre-payment review.
- Documentation of all restorative, operative, crown and bridge, and fixed and removable prosthodontics procedures must support the services that were performed and must demonstrate medical necessity that meets the professional standards of health care that are recognized by TSBDE. Documentation must include appropriate pretreatment, precementation and postcementation radiographs, study models and working casts, laboratory prescriptions, and invoices. Documentation must include the correct DOS. A panoramic radiograph without additional bitewing radiographs is considered inadequate as a diagnostic tool for caries detection. OIG may retrospectively recoup payment if the documentation does not support the services submitted for payment.
- All documentation must be maintained in the client's record for a period of five years to support the medical necessity at the time of any post-payment utilization review. All documentation, including radiographs, must be of diagnostic and appropriate quality.
- In any situation where radiographs are required but cannot be obtained, intraoral photographs must be in the chart.
- Any complications, unusual circumstances encountered, morbidity, and mortality must be entered as a complete narrative in the client's record.
- A provider must maintain a minimum standard of care through appropriate and adequate records, including a current history, limited physical examination, diagnosis, treatment plan, and written informed consent as a reasonable and prudent dentist would maintain. These records, as well as the actual treatment, must be in compliance with all state statutes, the Dental Practice Act, and the TSBDE Rules.
- Documentation for endodontic therapy must include the following: the medical necessity, pretreatment, 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 entered in the chart. Endodontic therapy must be in compliance with the American Association of Endodontists quality assurance guidelines.
- Documentation for most periodontal services requires a six-point per tooth depth of pocket charting, a complete mouth series of periapical and bitewing radiographs, and any other narratives or supporting documentation consistent with the nationally accepted standards of care of the specialty of periodontics, and which conform to the minimum standard of care for periodontal treatment required of Texas dentists. A panoramic radiograph without additional bitewing or periapical radiographs is considered inadequate for diagnosis of periodontal problems.

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- Documentation for surgical procedures requiring a definitive diagnosis for submitting a claim for a specific CDT code necessitates that a pathology report and a written record of clinical observations be present in the chart, together with any appropriate radiographs, operative reports, and appropriate supporting documentation. All impactions, surgical extractions, and residual tooth root extractions require appropriate preoperative periapical or panoramic radiographs (subject to limitations) be present in the chart.
- Any documentation requirements or limitations not mentioned in this manual that are present in the CDT are applicable. The written documentation requirements or limitations in this manual supercede those in the CDT.

4.3.1 General Anesthesia

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 narratives justifying the need for general anesthesia
- client's demographics, including date of birth
- Relevant dental and medical history
- Dental radiographs, intraoral/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 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 they understand and agree with the dentist's assessment of their child's behavior
- Dentist's attestation statement and signature, which may be put on the bottom of the Criteria for Dental Therapy Under General Anesthesia form or included in the record as a stand alone form

4.3.2 Orthodontic Services

Requests for orthodontic services must be accompanied by all of the following documentation:

- An orthodontic treatment plan. The treatment plan must include all procedures required to complete full treatment (e.g., extractions, orthognathic surgery, upper and lower appliance, monthly adjustments, anticipated bracket replacements, appliance removal if indicated, special orthodontic appliances). The treatment plan should incorporate only the minimal number of appliances required to properly treat the case. Requests for multiple appliances to treat an individual arch are reviewed for duplication of purpose.
- Diagnostic models.
- Cephalometric radiograph with tracings.
- Completed and scored HLD sheet with diagnosis of Angle class (a minimum of 26 points is required for consideration of approval of non cleft palate cases).
- Facial photographs.
- Full series of radiographs or a panoramic radiograph; diagnostic-quality films are required (copies are preferred and will not be returned to the provider).

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- Any additional pertinent information as determined by the dentist or requested by TMHP's Dental Director. Requests for crossbite therapy require the submission of diagnostic models to receive authorization. Providers must maintain documentation in the client's record that demonstrates the following criteria:
  - Posterior teeth. Not end-to-end, but buccal cusp of upper teeth should be lingual to buccal cusp of lower teeth.
  - Anterior teeth. The incisal edge of upper should be lingual to the incisal of the opposing arch.

The dentist should be certain that radiographs, photographs, and other information are properly packaged to avoid damage. TMHP is not responsible for lost or damaged materials.

Refer to: THSteps Dental Mandatory Prior Authorization Request Form on the TMHP website at www.tmhp.com.

4.4 Utilization Review

HHSC or a designated entity may conduct utilization reviews through automated analysis of a provider's pattern(s) of practice, including peer group analysis. Such analysis may result in a subsequent on-site utilization review. HHSC or its claims processing contractor may conduct utilization reviews at the direction of the Office of Inspector General (OIG), according to HHSC rules.

DSHS may also conduct dental utilization reviews of randomly selected THSteps dental providers. These reviews compare Medicaid dental services that have been reimbursed to a dental provider to the results of an oral examination of the client as conducted by DSHS regional dentists.

Refer to: 25 TAC, §33.72 for more information about utilization review.

4.5 Claims Filing and Reimbursement

4.5.1 Reimbursement

The Medicaid rates for dentists are calculated as access-based fees in accordance with 1 TAC §§355.455(b), 355.8081, 355.8085, and 355.8441(11). Providers can refer to the online fee lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

4.5.2 Third Party Resources (TPR)

For THSteps and ICF-IID dental claims, TMHP is responsible for determining if a TPR exists and for recouping payment from the TPR.

THSteps providers are not required to bill other insurance before billing Medicaid. If the provider is aware of other insurance, however, the provider must choose whether or not to bill the other insurance.

The provider has the following options:

- If the provider chooses to bill the other insurance, the provider must submit the claim to the client's other insurance before submitting the claim to Medicaid.
- If the provider chooses to bill Medicaid and not the client's other insurance, the provider is indicating that he or she accepts the Medicaid payment as payment in full. Medicaid then has the right to recovery from the other insurance. The provider does not have the right to recovery and cannot seek reimbursement from the other insurance after Medicaid has made payment.

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- If the provider learns that a client has other insurance coverage after Medicaid has paid a claim, the provider must refund the payment to Medicaid before billing the other insurance.

Refer to: Section 6: Claims Filing (*Vol. 1, General Information*).

4.5.3 Claim Submission After Loss of Eligibility

The Texas Medicaid 95-day filing deadline applies to all THSteps and ICF-IID dental services. If a client has lost Medicaid eligibility or turned 21 years of age, continue to file claims for services provided on the DOS the client was eligible. Indicate the actual DOS on the claim form, and enter the authorization number in the appropriate block on each claim filed.

Refer to: Subsection 6.1.4, "Claims Filing Deadlines" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

4.5.4 Claims Information

Dental services must be submitted to TMHP in an approved electronic format or on the ADA Dental Claim Form. Providers may purchase ADA Dental claim forms from the vendor of their choice. TMHP does not supply the forms. A sample of the ADA Dental Claim form can be found on the ADA website at www.ada.org.

When completing an ADA Dental claim form, all required information must be included on the claim, as TMHP does not key information from attachments. Superbills or itemized statements are not accepted as claim supplements.

All THSteps and ICF-IID claims must be received by TMHP within 95 days from each DOS and submitted to the following address:

Texas Medicaid & Healthcare Partnership
PO Box 200555
Austin, TX 78720-0555

Claims for emergency, orthodontic, or routine dental services must each be filed on separate forms. A claim submitted for either emergency or orthodontic services must be identified as such in Block 35 (Remarks) of the claim form.

A THSteps and ICF-IID dental provider cannot submit claims to Texas Medicaid under his individual performing provider identifier for the services provided by one or more associate dentists practicing in his office as employees or independent contractors with specific employer-employee or contractual relationships. All dentists providing services to Medicaid clients must enroll as THSteps dental providers regardless of employer relationships. The individual provider submitting claims may be reimbursed into a single accounting office to maintain these described relationships.

Claims submitted by newly-enrolled providers must be received within 95 days of the date the new provider identifier is issued, and within 365 days of the DOS.

Providers should submit claims to Texas Medicaid for their usual and customary fees.

Claims for dental services provided to children in foster care must be filed with DentaQuest, the dental claims processor for Superior HealthPlan.

Refer to: Subsection 4.2.5.2, "Children in Foster Care" in this handbook.

Claims must not be submitted to Texas Medicaid for appointments missed by clients. A client with Medicaid cannot be billed for failure to keep an appointment. Only claims for actual services rendered are considered for payment.

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Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (*Vol. 1*, *General Information*).

Subsection 1.6.9, "Billing Clients" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1*, *General Information*).

4.5.5 Claim Appeals

A claim denied because of age restrictions or other limitations listed in the Medicaid dental fee schedule may be considered for reimbursement on appeal when client medical necessity is provided to the TMHP Dental Director.

All denied claim appeals (see Section 7: Appeals [*Vol. 1, General Information*]) must be submitted to TMHP with the exception of a request to waive late filing deadlines. TMHP does not have the authority to waive state or federal mandates regarding claim filing deadlines.

If, after all appeal processes at TMHP have been exhausted, the provider remains dissatisfied with TMHP's decision concerning the appeal, the provider may file a complaint with the HHSC Claims Administrator Operations Management Unit.

Refer to: Subsection 7.3.1, "* Administrative Claim Appeals" in Section 7, "Appeals" (*Vol. 1, General Information*).

Note: *Providers must exhaust the appeals process with TMHP before filing a complaint to the HHSC Claims Administrator Operations Management Unit.*

Refer to: Subsection 7.1.4, "Paper Appeals" in Section 7, "Appeals" (*Vol. 1, General Information*).

Providers may use one of three methods to appeal Medicaid claims to TMHP: telephone (AIS), paper, or electronic.

All appeals of denied claims or requests for adjustments on paid claims must be received by TMHP within 120 days of the date of disposition of the R&S Report on which the claim appears. If the 120-day appeal deadline falls on a weekend or TMHP-recognized holiday, the deadline will be extended to the next business day.

Certain claims must be appealed on paper; they cannot be appealed either electronically or by telephone.

Refer to: Subsection 7.1.4, "Paper Appeals" in Section 7, "Appeals" (*Vol. 1, General Information*) for information about appeals that may not be appealed electronically and claims that may not be appealed through AIS.

To appeal in writing:

If a claim cannot be appealed electronically or by telephone, appeal the claim on paper by completing the following steps:

1) Provide a copy of the R&S Report page where the claim is reported.
2) Circle one claim per R&S Report page.
3) Identify the information that was incorrectly provided and note the correct information that should be used to appeal the claim. If necessary, specify the reason for appealing the claim.
4) Attach radiographs or other necessary supporting documentation.
5) If available, attach a copy of the original claim. Claim copies are helpful when the appeal involves dental policy or procedure coding issues.
6) Do not copy supporting documentation on the opposite side of the R&S Report.
7) It is strongly recommended that providers submitting paper appeals retain a copy of the documentation being sent. It is also recommended that paper documentation be sent by certified mail with a return receipt requested to establish TMHP's receipt of the claim and the date the claim was

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received. The provider is urged to retain copies of multiple claim submissions if the Medicaid provider identifier is pending.

Note: *Claims submitted by newly-enrolled providers must be received within 95 days of the date the new provider identifier is issued, and within 365 days of the DOS.*

8) Submit the paper appeal with supporting documentation and any radiographs and adjustment requests to the following address:

Texas Medicaid & Healthcare Partnership
Inquiry Control Unit
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727

To appeal by telephone:

1) Contact the Dental Line at 1-800-568-2460.
2) For each claim in question, have the R&S Report listing the claim and any supporting documents readily available.
3) Identify the claim submitted for appeal. The internal control number (ICN) will be requested.
4) Supply the information necessary to correct the claim, such as the missing tooth number or letter, the corrected procedure code, surface ID, or Medicaid number.

The appeal will appear as finalized or pending on the following week's R&S Report.

Providers may also appeal electronically.

Electronic appeal submission is a method of submitting Texas Medicaid appeals using a personal computer. The electronic appeals feature can be accessed directly through the TMHP EDl Gateway or by using TexMedConnect. For additional information, contact the TMHP EDI Help Desk at 1-888-863-3638.

Electronic appeals can increase accuracy of claims processing, resulting in a more efficient case flow to the provider:

- Download and printout capabilities help maintain audit trails for the provider.
- Appeal submission windows can be automatically filled in with electronic R&S Report information, thereby reducing data entry time.

4.5.6 Frequently Asked Questions About Dental Claims

Q *Why is routine dental treatment not a benefit when performed at the same visit as an emergency visit?*

A The following are reasons routine dental treatment is not a benefit when performed at the same visit as an emergency visit:

- The purpose of an emergency claim is to allow the provider to treat a true emergency without the concern that routine dental procedures may be denied.
- Medicaid program policy guidelines do not allow payment for both emergency and routine services to the same provider at the same visit. True emergency claims process through the audit system correctly when "emergency" is checked on either the paper or electronic claim and the Remarks or Narrative section of the claim form describes the nature of the emergency.

Q *Why are some claims for oral exams and emergency exams on the same date for the same client denied?*

A Medicaid program policy does not allow claims for an initial oral exam and an emergency exam to be submitted for the same DOS for the same client. An emergency exam performed by the same provider in the same six-month time period as an initial exam may be considered for

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reimbursement only when the claim for the emergency exam indicates it is an emerg*ency and the emergency block is marked and the Remarks or Narrative section is completed. If t*he claim is not marked as an emergency, the claim will be denied.

Q *How are orthodontic bracket replacements reimbursed? Can the client be charged for bracket replacements?*

A The provider must use *orthodontic procedure code D8690 to claim reimbursement for bracket replacement. M*edical necessity must be documented in the client record. Payment is subject to retrospective review. The client with current Medicaid eligibility must not be charged for bracket replacement. If the provider charges the client erroneously, the provider must refund any amount paid by the client.

Q *Why could an appeal of a denied claim take a long time?*

A An appeal can take a long time if TMHP is required to research the denied claim and determine the reason the claim did not go through the system. For faster results, providers should submit appeals as soon as possible and not use the entire 120 days allowed to submit the appeal.
The following are guidelines on filing claims efficiently:

- Use R&S Report dates to track filed claims.
- File claims electronically through TMHP EDI. Electronic claims submission does not allow a claim with an incorrect date to be accepted and processed, which saves time for the provider submitting claims and TMHP in processing claims. Call 1-888-863-3638, for more information about TMHP EDI.
- File claims with the correct information included. Most denied claims result from the omission of dates, signature, or narrative, or incorrect ID numbers such as client Medicaid numbers or provider identifiers.

Q *Why are only ten appeals allowed per call?*

A There is a limit on appeals per call to allow all providers equal access.

Q *Why do reimbursement checks sometimes take a long time to arrive?*

A Reimbursement may be delayed if a provider fails to submit claims in a timely manner.

Q *Does electronic claims submission result in delayed payment?*

A No. Providers who submit claims electronically report faster results than when submitting claims on paper. Providers are encouraged to use TMHP EDI for claims submission.

The following are helpful hints to a more efficiently processed claim:

- Ensure the provider identifier is on all claims.
- Include the performing provider's signature on all paper claims.
- Verify client eligibility for procedures.
- Verify if the procedure code requires a narrative on the claim; the narrative is for medical necessity.
- Include the required client information, including name, birth date, and client number.
- Dental auxiliary staff (i.e., the hygienist or the chairside assistant) cannot enroll in Texas Medicaid; therefore, they cannot submit claims to Texas Medicaid. Any procedure performed by the auxiliary must be submitted by the supervising dentist, using the dentist's provider identifier.

Claim Submission Reminders:

- Procedure code D8660 is allowed at different age levels, per provider. If a claim for procedure code D8660 is submitted within six months of procedure code D8080, procedure code D8080 will be reduced by the amount that was paid for procedure code D8660.

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- Prior authorization is required with documentation of medical necessity when replacing lost or broken orthodontic retainers (procedure code D8680). Clients may not be billed for covered services.
- Prior authorization of orthodontic services is nontransferable. If a client changes an orthodontic provider for any reason, or a provider ceases to be a Medicaid provider, the new orthodontic services provider must submit a separate request for prior authorization. The provider requesting and receiving authorization for the service also must perform the service and submit the claim. Codes listed on the authorization letters are the only codes considered for payment. All other codes submitted for payment are denied. Providing the authorization number on the submitted claim results in more efficient claims processing.
- General anesthesia (provided in the dentist office, ambulatory service clinic, and inpatient/outpatient hospital settings) does not require prior authorization, unless the client does not meet the minimum required points for general anesthesia in Criteria for Dental Therapy Under General Anesthesia on the TMHP website at www.tmhp.com. All THSteps dental charts for dental general anesthesia are subject to retrospective, random review for compliance with the Criteria for Dental Therapy Under General Anesthesia and requirements for chart documentation.
- Providers must not bill a client unless a formal denial for the requested item or service has been issued by TMHP stating the service is not a benefit of Texas Medicaid and the client has signed the Client Acknowledgment Statement in advance of the service being provided for that specific item or service. A provider must not bill Medicaid clients if the provided service is a benefit of Texas Medicaid.

Refer to: Subsection 1.6.9.1, "Client Acknowledgment Statement" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

THSteps clients must receive:

- Dental services specified in the treatment plan that meet the standards of care established by the laws relating to the practice of dentistry and the rules and regulations of the TSBDE.
- Dental services that are free from abuse or harm from the provider or the provider's staff.
- Only the treatment required to address documented medical necessity that meets professionally recognized standards of health care.

5 THSteps Medical

5.1 THSteps Medical and Dental Administrative Information

5.1.1 Overview

This section describes the administrative requirements for THSteps, including provider requirements, client eligibility requirements, and billing and claims processing information. Providers that need additional information may call 1-800-757-5691 or refer to Appendix F. Texas Health Steps Quick Reference Guide in this handbook for a more specific list of resources and telephone numbers. Providers may also contact the Texas Department of State Health Services (DSHS) THSteps Provider Relations staff located in DSHS regional offices by calling the appropriate regional office as listed in"Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*). THSteps Provider Relations contact information is also available on the DSHS website at www.dshs.state.tx.us/thsteps/regions.shtm.

In addition, THSteps has developed online educational modules to provide additional information about the program, components of the medical checkup, and other information. These modules provide free continuing education hours for a variety of providers. Providers do not have to be enrolled in THSteps. These courses may be accessed at www.txhealthsteps.com.

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The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service is Medicaid's comprehensive preventive child health service for clients who are birth through 20 years of age. In Texas, EPSDT is known as THSteps and includes periodic screening, vision, hearing, and dental preventive and treatment services. EPSDT was created by the 1967 amendments to the federal Social Security Act and defined by the Omnibus Budget Reconciliation Act (OBRA) of 1989. The periodic screening for a checkup consists of five federally required components as noted on the THSteps Periodicity Schedule. In addition, Section 1905(r)(5) of the Social Security Act (SSA) requires that any medically necessary health-care service listed in the Act be provided to EPSDT clients even if the service is not available under the state's Medicaid plan to the rest of the Medicaid population. A service is medically necessary when it corrects or ameliorates the client's disability, physical or mental illness, or chronic condition. These additional services are available through CCP. For questions about coverage, providers can call CCP at 1-800-846-7470.

5.1.2 Statutory Requirements

Several specific legislative requirements affect THSteps and the providers participating in the program. These include, but are not limited to, the following:

- Newborn Screening, Health and Safety Code, Chapter 33, Section §33.011 Newborn Screening Test Requirement.
- Subsection D.5, "Parental Accompaniment" in Appendix D, "Texas Health Steps Statutory State Requirements," of this handbook.
- Requirements for Reporting Abuse or Neglect, as outlined in subsection 1.6.1, "Compliance with Texas Family Code" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).
- Early Childhood Intervention (ECI), 34 Code of Federal Regulations (CFR) Part 303; Chapter 73, Texas Human Resources Code, and Title 40 TAC, Chapter 108.
- Newborn Hearing Screening, Health and Safety Code, Chapter 47.
- Teen Confidentiality Issues. There are many state statutes that may affect consent to medical care for a minor, depending on the facts of the situation. Among the relevant statutes are Chapters 32, 33, 153, and 266 of the Texas Family Code. Providers may want to consult an attorney, their licensing board, or professional organization if guidance is needed or questions arise on matters of medical consent.

Refer to: Appendix D. Texas Health Steps Statutory State Requirements of this handbook for more information.

5.1.3 Texas Vaccines for Children (TVFC) Program

The TVFC program provides vaccines at no cost to the provider. The vaccines are recommended according to the *Recommended Childhood and Adolescent Immunization Schedule* (Advisory Committee on Immunization Practices [ACIP], AAP, and the American Academy of Family Physicians [AAFP]). Medicaid does not reimburse for vaccines/toxoids that are available from TVFC. THSteps providers are strongly encouraged to enroll in TVFC at DSHS and must do so in order to obtain free vaccines for clients who are birth through 18 years of age. Providers may not charge Texas Medicaid for the cost of the vaccines obtained from TVFC; however the administration fee, not to exceed $14.85, is considered for reimbursement.

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When single antigen vaccine(s)/toxoid(s) or comparable antigen vaccine(s)/toxoid(s) are available for distribution through TVFC, but the provider chooses to use an ACIP-recommended product that is not distributed through TVFC, the vaccine/toxoid will not be covered; however, the administration fee will be considered.

Note: *Administered vaccines/toxoids must be reported to DSHS. DSHS submits all vaccines/toxoids reported with parental consent to a centralized repository of immunization histories for clients younger than 18 years of age. This repository is known in Texas as ImmTrac.*

For additional information about immunizations, providers can refer to the THSteps online educational module "Immunization" at www.txhealthsteps.com.

Refer to: Appendix B. Immunizations in this handbook.

5.1.4 Vaccine Adverse Event Reporting System (VAERS)

The National Childhood Vaccine Injury Act (NCVIA) of 1986 requires health-care providers to report:

- Any reaction listed by the vaccine manufacturer as a contraindication to subsequent doses of the vaccine.
- Any reaction listed in the Reportable Events Table that occurs within the specified time period after vaccination.

NCVIA requires health-care providers to report certain adverse events that occur following vaccination. As a result, VAERS was established by CDC and FDA in 1990. VAERS provides a mechanism for the collection and analysis of adverse events (side effects) associated with vaccines currently licensed in the United States. Adverse events are defined as health effects that occur after immunization that may or may not be related to the vaccine. VAERS data are monitored continually to detect unknown adverse events or increases in known side effects.

A copy of the Reportable Events Table can be obtained by calling VAERS at 1-800-822-7967 or by downloading it from www.dshs.state.tx.us/immunize/forms/vaers_table.pdf.

Clinically significant adverse events should be reported even if it is unclear whether a vaccine caused the event. For additional information about NCVIA, providers can refer to www.dshs.state.tx.us/immunize/forms/11-11246.

5.1.5 Referrals for Medicaid-Covered Services

When a provider performing a checkup determines that a referral for diagnosis or treatment is necessary for a condition found during the medical checkup, that information must be discussed with the parents or guardians. A referral must be made to a provider who is qualified to perform the necessary diagnosis or treatment services. If the performing provider is competent to treat the condition found, a referral elsewhere is not necessary, unless it is to the primary care provider to assure continuity of care.

Providers that need assistance finding a specialist who accepts clients with Medicaid coverage can call the THSteps toll-free helpline at 1-877-847-8377, or they can find one using the Online Provider Lookup on the TMHP website at www.tmhp.com.

Continuity of care is an important aspect of providing services and follow-up. Efforts should be made to determine that the appointment was kept and that the provider who received the referral has provided a diagnosis and recommendations for further care to the referring provider.

In addition to referrals for conditions discovered during a checkup or for specialized care, the following referrals may be used:

- *Case Management for Children and Pregnant Women*. Case Management for Children and Pregnant Women provides health-related case management services to eligible children and pregnant women. Case Management for Children and Pregnant Women services include assessing the needs of eligible clients, formulating a service plan, making referrals, problem-solving, advocacy, and

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follow-up regarding family and client needs. For more information about eligibility and client referral, see Subsection 3.1.1, "Eligibility" or subsection 3.1.2, "Referral Process" in the *Behavioral Health, Rehabilitation, and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*).

- *Hearing Services referrals*. If the hearing screening returns abnormal results, clients who are birth through 20 years of age must be referred to a Texas Medicaid provider who is an audiologist or physician who is experienced with the pediatric population and who offers auditory services.
- *Routine Dental Referrals.* 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 6-month medical checkup, the provider must confirm if a dental home has been established and is ongoing; if not, additional referrals must be made at subsequent medical checkups until the parent or caregiver confirms that a dental home has been established for the client. Clients who are birth through 5 months of age are not eligible for routine dental checkups but should be referred to a dentist if any dental issues are identified during a THSteps medical checkup or acute care visit. When possible, clients should be referred to a provider who has completed the required benefit education and is certified by the DSHS Oral Health Program to perform First Dental Home services. The First Dental Home provider may be located through the advanced search function in the Online Provider Look Up or by calling 1-877-847-8377.
- *Referrals for Dental Treatment*. If a THSteps medical provider identifies the medical necessity of dental services, the provider must refer the client to a THSteps dental provider. The THSteps medical provider can accomplish this by providing the parent or guardian a listing of THSteps dentists from the Online Provider Lookup. The parent or guardian can receive assistance in locating a THSteps dentist and assistance with scheduling of dental appointments by contacting the THSteps toll-free helpline at 1-877-847-8377. Clients who are birth through 5 months of age also can be seen for emergency dental services by the dentist at any time for trauma, early childhood caries, or other oral health problems. Clients who are birth through 20 years of age may self-refer for dental care.
- *Emergency Dental Referrals.* If a medical checkup provider identifies an emergency need for dental services, such as bleeding, infection, or excessive pain, the client may be referred directly to a participating dental provider. Emergency dental services are covered at any time for all Medicaid clients who are birth through 20 years of age.

  Note: *Assistance in coordinating dental referrals can be obtained from the THSteps toll-free helpline at 1-877-847-8377 or the DSHS Regional THSteps Coordinator for the respective region (lists are provided in* Appendix A: State, Federal, and TMHP Contact Information (Vol. 1, General Information). *In cases of both emergency and nonemergency dental services, clients are able to make a choice when selecting a dental provider who is participating in the THSteps Dental Program.*
- *Family Planning and Genetic Services Referrals.* For clients eligible for Medicaid who need genetic services or family planning services, a referral should be made. Information about Medicaid-covered genetic services is available in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) and information about family planning services is available in Section 2, "Medicaid Title XIX Family Planning Services" in the Gynecological and Reproductive Health and Family Planning Services Handbook (*Vol. 2, Provider Handbooks*). If a THSteps medical provider also provides family planning, the provider may inform clients that these services are available.
- *ECI Referrals*. Federal and state law requires providers to refer children as soon as possible, but no longer than 7 days after identification of a suspected developmental delay or disability to the local ECI program for children who are birth through 35 months of age regardless if a referral was made to another qualified provider. The provider may call the local ECI Program or the DARS Inquiries Line at 1-800-628-5115 to make referrals. Children who are 3 years of age and older with a suspected developmental delay or disability should be referred to the local school district.

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- *WIC Referrals.* Clients who are birth through 5 years of age or who are pregnant are eligible for WIC and should be referred to WIC for nutrition education and counseling, and food benefits.

Refer to: Section 1, "General Information" in the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*) for more information about referrals.

5.1.6 THSteps Medical Checkup Facilities

All THSteps medical checkup policies apply to checkups completed in a physician's office, a health department, clinic setting, or in a mobile/satellite unit. Enrollment of a mobile/satellite unit must be under a physician or clinic name. Mobile units can be a van or any area away from the primary office and are considered extensions of that office and are not separate entities.

The physical setting must be appropriate so that all elements of the checkup can be completed.

Refer to: Subsection 5.3.10, "THSteps Medical Checkups Periodicity Schedule" in Section 5 of this handbook for information on the THSteps Periodicity Schedule.

Subsection 5.3.11, "Mandated Components" in Section 5 of this handbook for additional information on checkup components.

5.1.7 THSteps Dental Services

Access to THSteps dental services is mandated by Texas Medicaid and provides reimbursement for the early detection and treatment of dental health problems, including oral health preventive services, for Medicaid clients who are birth through 20 years of age. THSteps dental service standards are designed to meet federal regulations and to incorporate the recommendations of representatives of national and state dental professional groups.

OBRA 1989 mandated the expansion of the federal EPSDT program to include any service that is medically necessary and for which FFP is available, regardless of the limitations of Texas Medicaid. This expansion is referred to as CCP.

Refer to: Section 2, "Medicaid Children's Services Comprehensive Care Program (CCP)" in this handbook for more information.

THSteps-designated staff (HHSC, DSHS, or its designee), through outreach and education, encourage the parents or caregivers of eligible clients to use THSteps dental checkups and preventive care when clients first become eligible for Medicaid and each time clients are due for their next periodic dental checkup.

Upon request, THSteps-designated staff (HHSC, DSHS, or its designee) assist the parents or caregivers of eligible clients with scheduling appointments and transportation. Medicaid clients have freedom of choice of providers and are given names of enrolled providers. Call the THSteps toll-free helpline at 1-877-847-8377 for a list of THSteps dental providers in a specific area.

For additional information about dental health, providers can refer to the THSteps online educational modules "Oral Health For Primary Care Providers" and "Oral Health Examinations for Dental Professionals" at www.txhealthsteps.com.

5.2 Enrollment

5.2.1 THSteps Medical Provider Enrollment

Providers cannot be enrolled if their professional license is due to expire within 30 days of application. Facility providers must submit a current copy of the supervising practitioner's license. To provide Medicaid services, each NP or CNS must be licensed as an RN and be recognized as an APRN by Texas BON.

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Refer to: Subsection 1.1, "Provider Enrollment and Reenrollment" in Section 1, *"Provider Enrollment and Responsibilities" (Vol. 1, General Information)* for information about enrollment procedures.

The following provider types may provide THSteps preventive services within his or her scope of practice and must also be enrolled in Texas Medicaid and as a THSteps provider:

- A physician (doctor of medicine [M.D.] or doctor of osteopathy [D.O.]) or physician group
- A physician assistant (PA)
- A clinical nurse specialist (CNS)
- A nurse practitioner (NP)
- A certified nurse midwife (CNM)
- A federal qualified health center (FQHC)
- A rural health clinic (RHC)
- A health-care provider or facility with physician supervision including, but not limited to:
  - Community-based hospital and clinic
  - Family planning clinic
  - Home health agency
  - Local or regional health department
  - Maternity clinic
  - Migrant health center
  - School-based health center

Medical Residents – Medical residents may provide medical checkups in a teaching facility under the guidance of the attending staff as long as the facility's medical staff by-laws and requirements of the Graduate Medical Education (GME) Program are met, and the attending physician has determined the intern or resident to be competent to perform checkups. THSteps does not require the supervising physician to examine the client as long as these conditions are met.

Clinics – In a clinic, a physician is not required to be present at all times during the hours of operation unless otherwise required by federal regulations. A physician must assume responsibility for the clinic's operation.

5.2.1.1 Requirements for Registered Nurses Who Provide Medical Checkups

RNs without a CNS, NP, or CNM recognition as an APRN by the Texas BON may provide medical checkups only under direct physician supervision, meaning the physician is either on site during the checkup or immediately available to furnish assistance and direction to the RN during the checkup.

Required online education modules developed by THSteps must be completed prior to providing checkup services. All modules are approved for continuing education units (CEUs) for RNS as well as other medical disciplines. Required THSteps online education modules may be accessed at www.txhealthsteps.com. The RN or the RN's employer must maintain documentation that the required modules were completed. Required modules include:

- Adolescent Health Screening
- Behavioral Health: Screening and Intervention
- Case Management Services in Texas
- Cultural Competence

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- Developmental Surveillance and Screening
- Hearing and Vision Screening
- Immunization
- Introduction to the Medical Home
- Management of Overweight and Obesity in Children and Adolescents
- Newborn Hearing Screening
- Newborn Screening
- Nutrition
- Oral Health for Primary Care Providers
- Texas Health Steps: Overview
- Texas Medicaid Services for Children
- Using Developmental Screening Tools

Online modules are updated regularly to include new content. RNs that have completed the required modules previously are encouraged, but not required to retake online modules.

Before a physician delegates a THSteps checkup to an RN, the physician must establish the RN's competency to perform the service as required by the physician's scope of practice. The delegating physician is responsible for supervising the RN who performs the services. The delegating physician remains responsible for any service provided to a client.

Refer to: Subsection 5.2.1, "THSteps Medical Provider Enrollment" in this handbook for more information about enrollment procedures.

5.3 Services, Benefits, Limitations, and Prior Authorization

5.3.1 Eligibility for THSteps Services and Checkup Due Dates

Through outreach, THSteps staff (DSHS, HHSC, or contractors) encourage clients to use THSteps preventive medical checkup services when they first become eligible for Medicaid and each time thereafter when they are periodically due for their next medical checkup. THSteps will send clients a letter when they are due for a medical checkup.

A client is eligible for THSteps services, including medical checkups, from birth through 20 years of age. The following applies:

- If the client turns 21 on the first day of the month, the client is no longer eligible for THSteps services.
- If the client turns 21 on the second day of the month or later, the client is eligible for THSteps services through the end of the month.

Although the Medicaid Eligibility Verification Letter (Form H1027) identifies eligible clients when the client's Your Texas Benefits Medicaid card is lost or has not yet been issued, Form H1027 does not indicate whether the client is due for medical checkup services. Providers can verify the client's eligibility through www.YourTexasBenefitsCard.com, TexMedConnect, or the TMHP Contact Center.

A client is due for a THSteps medical checkup based on his or her date of birth and the ages indicated on the periodicity schedule. Children younger than three years of age are due at frequent intervals. Children and youth three years of age and older are considered due for a checkup on their birthday and are encouraged to have a yearly checkup as soon as practical. In addition, for children enrolled in

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Medicaid managed care, a new member is due for a THSteps medical checkup as soon as practicable, but in no case later than 14 days of enrollment for newborns, and no later than 90 days of enrollment for all other eligible child members.

Managed care organizations are also required to assure existing members of their health plan eligibility requirements to receive timely medical checkups. A checkup for an existing member from birth through 35 months of age is timely if received within 60 days beyond the periodic due date based on the client's birth date. For existing members 36 months of age and older, a checkup is due beginning on the child's birthday and is considered timely if it occurs within 364 calendar days after the child's birthday in a non-leap year or 365 days after the child's birthday in a leap year. Checkups received before the periodic due date are not reportable as timely medical checkups. Providers should contact the appropriate MCO for further details.

Providers should schedule checkups based on the ages in the periodicity schedule, but circumstances may support the need for a checkup prior to the client's birthday (for example, a 4-year checkup could be performed prior to the child's 4th birthday if the child is a member of a migrant family that is leaving the area). THSteps fee-for-service policy creates this flexibility by allowing a total number of checkups at each age range.

Refer to: "Subsection 5.3.6, "THSteps Medical Checkups" in this handbook for additional details.

Providers are encouraged to notify the client when they are due for the next checkup according to the THSteps periodicity schedule.

A checkup that is necessary more frequently than indicated on the periodicity schedule is considered an exception-to-periodicity.

Refer to: Subsection 5.3.7, "Exception-to-Periodicity Checkups" in this handbook for additional details about billing for a checkup performed as an exception-to-periodicity checkup.

5.3.2 Prior Authorization

Prior authorization is not required for preventive care medical checkups.

5.3.3 Additional Consent Requirements

Additional parental or guardian consent may be required if online or web-based screening tools are used that 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 THSteps screening. The provider should seek legal advice regarding the need for this consent.

5.3.4 Verification of Medical Checkups

The first source of verification that a THSteps medical checkup has occurred is a paid claim or encounter. THSteps encourages providers to file a claim either electronically or on a CMS-1500 paper claim form as soon as possible after the date of service, as the paid claim updates client information. The provider may contact TMHP through the TMHP website at www.tmhp.com or AIS at 1-800-925-9126 to verify that the client is due for a checkup.

A second source of acceptable verification is a physician's written statement that the checkup occurred. If the provider chooses to give the client written verification, it must include the client's name, Medicaid ID number, date of the medical checkup, and a notation that a complete THSteps medical checkup was performed.

Note: *Verification of medical checkups must not be sent to THSteps but must be maintained by the client to be provided as needed by an HHSC eligibility caseworker.*

If neither the first nor the secondary source of verification is available, a THSteps outreach worker may contact the provider's office for verification.

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5.3.5 Medical Home

HHSC and DSHS encourage the provision of the THSteps medical checkup as part of a medical home. Texas Medicaid defines a medical home as a model of delivering care that is accessible, continuous, comprehensive, family-centered, and coordinated. In providing a medical home for the client, the primary care clinician directs care coordination together with the client or youth and/or family.

Medical checkup providers with mobile units should encourage the families to establish a medical home for their child(ren) and obtain future checkups from their primary care provider.

When a checkup is provided in the home setting, mobile unit, or clinic other than the medical home, it should be in coordination with the medical home and the results must be provided to the medical home as soon as possible.

A mobile unit is an extension of the provider's office and must be able to provide a complete checkup.

For additional information on the medical home, providers can refer to the "Introduction to the Medical Home" module provided by THSteps at www.txhealthsteps.com.

5.3.6 THSteps Medical Checkups

THSteps medical checkups reflect the federal and state requirements for a preventive checkup. Preventive care medical checkups are a benefit of the THSteps program if they are provided by enrolled THSteps providers and all of the required components are completed. An incomplete preventive medical checkup is not a benefit. The THSteps periodicity schedule specifies screening procedures required at each stage of the client's life to ensure that health screenings occur at age-appropriate points in a client's life.

Components of a medical checkup that have an available CPT code are not reimbursed separately on the same day as a medical checkup, with the exception of initial point-of-care blood lead testing, once per lifetime mental health screening for adolescents, a tuberculin skin test (TST), developmental and autism screening, vaccine administration, and OEFV.

Note: *Initial blood lead testing, other than point-of-care, must be sent to the DSHS Laboratory for testing.*

Reminder: *Incomplete medical checkups are subject to recoupment unless there is documentation supporting why a component was not completed.*

Refer to: Subsection 5.3.11.1.3, "Mental Health Screening" in this handbook for more information about required mental health screenings.

Sports physical examinations are not a benefit of Texas Medicaid. If the client is due for a THSteps medical checkup and a comprehensive medical checkup is completed, a THSteps medical checkup may be reimbursed and the provider may complete the documentation for the sports physical.

THSteps preventive medical checkups are not a benefit under telemedicine or telehealth.

Refer to: The THSteps Medical Checkups Periodicity Schedule which may be found at www.dshs.state.tx.us/thsteps/providers.shtm.

Checkups should be scheduled, to the extent possible, based on the ages on the periodicity schedule to accommodate the need for flexibility when scheduling checkup appointments.

The following table lists the number of visits allowed at each age range:

Age Range	Number of Visits
Birth through 11 months (does not include 12 month checkup)	6
1 through 4 years	7
5 through 11 years	7

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Age Range	Number of Visits
12 through 17 years	6
18 through 20 years	3

All of the checkups listed on the periodicity schedule were developed according to the recommendations of the AAP and in consultation with recognized authorities in pediatric preventive health. In Texas, the THSteps periodicity schedule may differ from the AAP periodicity schedule based on the scheduling of laboratory or other tests in federal EPSDT or state regulations.

For more information about conducting a THSteps checkup, providers can refer to the THSteps online educational modules at www.txhealthsteps.com.

The following table includes the procedure codes for checkups and the referral and condition indicators. Condition indicators must be used to describe the results of a checkup. A condition indicator must be submitted on the claim with the periodic medical checkup procedure code. Indicators are required whether a referral was made or not. If a referral is made, then providers must use the Y referral indicator. If no referral is made, then providers must use the N referral indicator.

Procedure Codes	Referral Indicator	Condition Indication
99381, 99382, 99383, 99384, and 99385 (new client preventive visit) -or- 99391, 99392, 99393, 99394, and 99395 (Established client preventive visit)	N (no referral given)	NU (not used)
99381, 99382, 99383, 99384, and 99385 (new client preventive visit) -or- 99391, 99392, 99393, 99394, and 99395 (established client preventive visit)	Y (yes THSteps or EPSDT referral was given to the client)	S2 (under treatment) or ST* (new services requested)
*** The ST condition indicator should only be used when a referral is made to another provider or the client must be rescheduled for another appointment with the same provider. It does not include treatment initiated at the time of the checkup.**		

THSteps preventive care medical checkups for clients who are 18 through 20 years of age must be submitted with procedure codes 99385 or 99395 and diagnosis code Z0000 or Z0001.

Claims for procedure codes 99381, 99382, 99383, 99384, 99391, 99392, 99393, and 99394 must be submitted with the appropriate age related diagnosis code listed in the table below:

Client Age	Diagnosis Code
Birth through 7 days	Z00110
8 through 28 days	Z00111
29 days through 17 years	Z00121, Z00129
18 through 20 years	Z0000, Z0001

The age-appropriate diagnosis code for a preventive care medical checkup must be submitted on the claim. If an immunization is administered as part of the preventive care medical checkup, diagnosis code Z23 may also be included on the claim, in addition to the age-appropriate diagnosis.

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If an immunization is the only service provided during an office visit, providers may submit only diagnosis code Z23 on the claim.

Note: *Note: A THSteps preventive care medical checkup will not be reimbursed if the office visit is only for immunization.*

Modifier AM, SA, TD, or U7 must be submitted with the THSteps medical checkups procedure code to indicate the practitioner who performed the unclothed physical examination during the medical checkup.

Modifier	Practitioner
AM	Physician, team member service
SA	Nurse practitioner rendering service in collaboration with a physician
TD	Registered nurse
U7	Physician assistant

THSteps medical checkups performed in an FQHC or RHC setting are paid an all-inclusive rate per encounter, which includes immunizations, developmental screening, autism screening, once per lifetime mental health screening for adolescents, TST, blood lead test, and oral evaluation and fluoride varnish. When submitting claims for THSteps checkups and services, RHC providers must use the national POS code 72, and FQHC providers must use modifier EP in addition to the modifiers used to identify who performed the medical checkup. In accordance with the federal rules for RHCs and FQHCs, an RN in an RHC or FQHC may not perform THSteps checkups independently of a physician's interactions with the client.

Refer to: Section 4, "Federally Qualified Health Center (FQHC)" in the *Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks)* for information related to billing

Section 7, "Rural Health Clinic" in the *Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks)* for information related to billing.

Checkups, exception-to-periodicity checkups, and follow-up visits are limited to once per day any provider.

A checkup and the associated follow-up visit may not be reimbursed on the same date of service. The follow-up visit will be denied.

An incomplete checkup is subject to recoupment unless there is documentation to support why the component was not completed as part of the checkup.

A new patient is one who has not received any professional services within the preceding three years from the provider or from another provider of the same specialty who belongs to the same group practice. As an exception, a new preventive care medical checkup (procedure code 99381, 99382, 99383, 99384, or 99385) may be billed when no prior checkups have been billed by the same provider or provider group, even if an acute care new patient E/M service was previously performed by the same provider.

An additional new checkup is allowed only when the client has not received any professional services in the preceding three years from the same provider or another provider who belongs to the same group practice, because subsequent acute care visits to the new patient THSteps checkup continues the established relationship with the provider.

If the provider that performs the medical checkup provides treatment for an identified condition on the same day, the provider may submit a separate claim for an acute care established-client office visit. The separate claim must include the established-client procedure code that is appropriate for the diagnosis

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and treatment of the identified problem. Treatment of minor illnesses or conditions (e.g., follow-up of a mild upper respiratory infection) during the THSteps medical checkup may not warrant additional billing.

Acute Care Visits

When a new patient checkup is billed for the same date of service as a new patient acute care visit, both new patient services may be reimbursed when billed by the same provider or provider group if no other acute care visits or preventive care medical checkups have been billed in the past three years.

Providers must use modifier 25 to describe circumstances in which an acute care E/M visit was provided at the same time as a checkup. Providers must submit modifier 25 with the E/M procedure code when the rendered services are distinct and provided for a different diagnosis. Providers must bill an appropriate level E/M procedure code with the diagnosis that supports the acute care visit. The medical record must contain documentation that supports the medical necessity and the level of service of the E/M procedure code that is submitted for reimbursement.

An acute care E/M visit for an insignificant or trivial problem or abnormality billed on the same date of service as a checkup or exception-to-periodicity checkup is subject to recoupment.

Providers must bill an acute care visit with their provider identifier on a separate claim without benefit code EP1.

Refer to: Acute Care Visit on the Same Day as a THSteps Preventive Visit Checkup on the TMHP website at www.tmhp.com.

THSteps Preventive Visit Checkup with Immunization and Vaccine Administration on the TMHP website at www.tmhp.com for a claim form example.

5.3.7 Exception-to-Periodicity Checkups

Exception-to-periodicity checkups are complete medical checkups completed outside the timeframes listed in the THSteps Periodicity Schedule due to extenuating circumstances.

Exception-to-periodicity checkups are complete medical checkups, which are medically necessary and might cause the total number of checkups to exceed the number allowed for the client's age range if the client were to have all regular scheduled checkups. An exception-to-periodicity checkup is allowed when:

- Medically necessary, for example, for a client with developmental delay, suspected abuse, or other medical concerns or a client in a high-risk environment, such as living with a sibling with elevated blood lead.
- Required to meet state or federal exam requirements for Head Start, day care, foster care, or preadoption.
- When needed before a dental procedure requiring general anesthesia.

As noted in the Periodic Checkup Age Range table, the number of checkups is set for each age range. This may avoid an exception-to-periodicity checkup and allow flexibility for the provider and family to schedule a checkup including before the child's birthday.

If a client is due for a medical checkup, a checkup outside of the regular THSteps schedule must be billed as a regular checkup rather than an exception to periodicity.

The checkup is considered complete when all the required components are documented in the client's medical record or supporting documentation, which details the reason a component(s) was not completed. A plan to complete the component(s) if not due to reasons of conscious or parental concerns must be included in the documentation.

Note: *A sports physical is not a reason for an exception-to-periodicity checkup.*

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When billing for an exception-to-periodicity visit, provider must also include the most appropriate exception-to-periodicity modifiers. Claims for periodic THSteps medical checkups exceeding periodicity that do not include one for these modifiers will be denied as exceeding periodicity.

Modifier	Description
SC	Medically necessary service or supply
23	Unusual Anesthesia: Occasionally, a procedure that usually requires either no anesthesia or local anesthesia must be done under general anesthesia because of unusual circumstances. This circumstance may be reported by adding the modifier "23" to the procedure code of the basic service.
32	Mandated Services: Services related to mandated consultation or related services (e.g., PRO, third party payer, governmental, legislative, or regulatory requirement) may be identified by adding the modifier "32" to the basic procedure.

THSteps medical exception-to-periodicity services must be billed with the same procedure codes, provider type, modifier, and condition indicators as a medical checkup. Additionally, providers must use modifiers 23, 32, and SC to indicate the exception.

5.3.8 Medical Checkup Follow-up Visit

Use procedure code 99211 with the provider identifier and THSteps benefit code when billing for a follow-up visit.

Note: *Reimbursement for the follow-up visit includes all elements of the visit. Reimbursement may not be allowed for the follow-up visit when submitted with certain procedure codes. For example: In accordance with CMS NCCI requirements, modifier 25 guidelines do not apply for procedure code 99211 when billed with other procedure codes that are included in the visit as related elements, including, but not limited to, administration of immunizations.*

Refer to: Subsection 6.4.1, "National Correct Coding Initiative (NCCI) Guidelines" in Section 6: Claims Filing (*Vol. 1, General Information*) for additional information.

Medical Checkup Follow-up Visit with Immunization Administration on the TMHP website at www.tmhp.com for a claim form example.

Medical Checkup Follow-up Visit with TB Skin Test on the TMHP website at www.tmhp.com for a claim form example.

A follow-up visit may be required to complete necessary procedures related to a checkup or exception-to-periodicity checkup, such as:

- Reading the TST.
- Administering immunizations in cases where the client's immunizations were not up-to-date, medically contraindicated, or unable to be given during the checkup.
- Collection of specimens for laboratory testing that were not obtained during the checkup or the original specimen could not be processed.
- Completion of sensory or developmental screening that was not completed at the time of the checkup due to the client's condition.

A return visit to follow up on treatment initiated during a checkup or to make a referral is not a follow-up visit, but is considered an acute care visit under an appropriate E/M procedure code for an established client.

If the parent or guardian did not give consent for a component during the initial checkup, and supporting documentation is provided, no follow-up visit is necessary.

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5.3.9 Newborn Examination

Providers do not have to be enrolled as THSteps providers to bill newborn examination procedure codes 99460, 99461, or 99463.

Newborn examinations that are billed with procedure code 99460, 99461, or 99463 may qualify as a THSteps medical checkup when all required components are completed according to the THSteps Periodicity Schedule and documented in the medical record.

Providers must use their provider identifier without benefit code EP1 when billing newborn examination services.

Note: *In Texas, the mandated newborn hearing screening and newborn screening test is included as part of the in-hospital newborn exam.*

State-mandated newborn screening for critical congenital heart disease (CCHD) is offered by and performed in the birth facility in accordance with Health and Safety Code (HSC) § 33.011 and 25 TAC §§37.75–37.79.

Providers billing these newborn codes are not required to be THSteps providers, but they must be enrolled as Medicaid providers. TMHP encourages THSteps enrollment for all providers that offer a medical home for clients and provide them with medical checkups and immunizations. Physicians and hospital staff are encouraged to inform parents eligible for Medicaid that the next THSteps checkup on the periodicity schedule should be scheduled from discharge to five days of age and that regular checkups should be scheduled during the first year and after.

Refer to: Subsection 9.2.45, "Newborn Services" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)* for additional information on inpatient newborn services.

The THSteps online education module "Newborn Hearing Screening" on the THSteps website at www.txhealthsteps.com for additional information about conducting a newborn hearing screen.

5.3.10 THSteps Medical Checkups Periodicity Schedule

The client is periodically eligible for medical checkup services based on the THSteps Medical Checkups Periodicity Schedule. All the checkups listed on the periodicity schedule have been developed based on recommendations of the AAP and recognized authorities in pediatric preventive health. In Texas, THSteps has modified the AAP periodicity schedule based on the scheduling of a laboratory or other test in federal EPSDT or state regulations.

The THSteps Medical Checkups Periodicity Schedule is available on the DSHS website at www.dshs.state.tx.us/thsteps/providers.shtm.

5.3.11 Mandated Components

THSteps medical checkups must include regularly scheduled examinations and screenings of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth.

The following federal and state mandated components must be documented in the client's medical record for the checkup to be considered complete:

- Comprehensive health and developmental history, including physical and mental health development
- Comprehensive unclothed physical examination
- Immunizations appropriate for age and health history
- Laboratory test appropriate to age and risk, including lead toxicity at specific federally-mandated ages

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- Health education including anticipatory guidance
- Dental referral

The client's medical record must include documentation to support the rationale a component was not completed, and a plan to complete the component(s) if not due to parent or caregiver concern or reasons of conscience, including religious beliefs. THSteps provides optional clinical records to assist the provider in the documentation of the required components.These forms may be found at www.dshs.state.tx.us/thsteps/forms.shtm.

If the client has a condition that has been previously diagnosed and is currently receiving treatment, the associated standardized screening may be omitted with proper documentation.

Documented test or screening results obtained within the preceding 30 days for clients who are two years of age and younger, and the preceding 90 days for clients who are three years of age and older may be used to meet the testing or screening requirements. Results must include the dates of service and one of the following:

- A clear reference to the previous visit by the same provider
- Results obtained from another provider

5.3.11.1 Comprehensive Health and Developmental History

5.3.11.1.1 Nutritional Screening

Dietary practices must be evaluated at each checkup to identify and address nutritional issues or concerns.

5.3.11.1.2 Developmental Surveillance or Screening

Developmental surveillance or screening is a required component of every checkup for clients who are birth through 6 years of age. Autism screening is required at 18 months of age and again at 24 months of age. If not completed at 24 months of age, or if there is a particular concern it should be completed at 30 months of age.

As a THSteps medical service, developmental screening (procedure code 96110) or autism screening (procedure code 96110 with modifier U6) is limited to once per day, per client, by the same provider or provider group. This service will be denied unless a checkup, exception-to-periodicity checkup, or follow-up visit was reimbursed for the same date of service by the same provider.

Standardized developmental screening is required at the ages listed in the table below. Providers must use one of the validated, standardized tools listed below when performing a developmental or autism screening. A standardized screen is not required at other checkups up to and including the 6-year checkup; however, developmental surveillance is required at these checkups and includes a review of milestones (gross and fine motor skills, communication skills, speech-language development, self-help/care skills, and social, emotional, and cognitive development) and mental health and is not considered a separate service.

Providers may be reimbursed separately when using one of the required screening tools listed in the table below in addition to the checkup visit at specific age visits. THSteps requires one of the following required standardized tools at the following ages for a checkup to be considered complete:

Required Screening Ages and Recommended Tools		
Screening Ages	Developmental Screening Tools	Autism Screening Tools
9 months	Ages and Stages Questionnaire (ASQ) or Parents' Evaluation of Development Status (PEDS)	N/A

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Required Screening Ages and Recommended Tools		
Screening Ages	Developmental Screening Tools	Autism Screening Tools
18 months	ASQ or PEDS	Modified Checklist for Autism in Toddlers (M-CHAT) or M-CHAT Revised with Follow-Up (M-CHAT R/F)
24 months	ASQ or PEDS	M-CHAT or M-CHAT R/F
3 years	ASQ, Ages and Stages Questionnaire: Social-Emotional (ASQ:SE) or PEDS	N/A
4 years	ASQ, ASQ:SE or PEDS	N/A

If a developmental or autism screening that is required in the Required Screening Ages and Recommended Tools table is not completed during a checkup or if the client is being seen for the first time, standardized developmental screening must be completed through 6 years of age.

If a provider administers a standardized and validated developmental screening at additional checkups other than those listed in the Required Screening Ages and Recommended Tools table, the provider must document the rationale for the additional screening, which may be due to provider or parental concerns.

Developmental screening that is completed without the use of one of the required standardized screening tools is not a separately payable benefit, and the checkup will be considered incomplete.

Standardized developmental screening as part of a medical checkup and for ages other than required on the periodicity schedule is not covered when completed for the sole purpose of meeting day care, Head Start, or school program requirements.

Standardized developmental screening may be performed outside a THSteps medical checkup as part of development and neurological assessment testing.

Refer to: Subsection 9.2.25, "Developmental and Neurological Assessment and Testing" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2 Provider Handbooks)* for information related to developmental screening testing outside a THSteps medical checkup.

Referral for an in-depth developmental evaluation is determined by the criteria of the specific tool or at the provider's discretion. Referral for in-depth evaluation of development should be provided when parents express concern about their child's development, regardless of scoring on a standardized development screening tool. A medical diagnosis or a confirmed developmental delay is not required for referrals.

The ECI program serves clients who are birth through 35 months of age with disabilities or developmental delays. Under federal and state regulations, all health-care professionals are required to refer children to the Texas ECI program as soon as possible, but no longer than 7 days after identifying a disability or a suspected delay in development, even if referred to an appropriate provider for further testing. If the client is 3 years of age or older, referral should be made to the local school district's special education program.

5.3.11.1.3 Mental Health Screening

Mental health screening for behavioral, social, and emotional development is required at each THSteps checkup.

Mental health screening using one of the following validated, standardized mental health screening tools recognized by THSteps is required once for all clients who are 12 through 18 years of age:

- Pediatric Symptom Checklist (PSC-35)

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- Pediatric Symptom Checklist for Youth (Y-PSC)
- Patient Health Questionnaire (PHQ-9)
- Car, Relax, Alone, Forget, Family, and Trouble Checklist (CRAFFT)

A mental health screening must be submitted with procedure code 99420. When claims with procedure code 99420 are submitted for mental health screenings, one of the validated, standardized mental health screening tools recognized by THSteps must be used.

Mental health screening at other checkups does not require the use of a validated, standardized mental health screening tool.

Procedure code 99420 must be submitted on the same date of service by the same provider as procedure code 99384, 99385, 99394, or 99395, and reimbursement is limited to once per lifetime.

The client's medical record must include documentation identifying the tool that was used, the screening results, and any referrals that are made.

When the clinician conducting the mental health screen has the appropriate training and credentials to conduct the mental health evaluation and provide treatment, the clinician may choose to provide the mental health services or refer the client to an appropriate clinician. Clinicians who do not have these qualifications must refer clients to a qualified Medicaid-enrolled mental health specialist for such care.

For additional information about conducting a mental health screen, providers can refer to the THSteps online educational module "Mental Health Screening" at www.txhealthsteps.com.

5.3.11.1.4 Tuberculosis (TB) Screening

Administer the TB risk screening tool annually beginning at 12 months of age and thereafter at other medical checkups.

The TB risk screening tool is available on the DSHS website at www.dshs.state.tx.us/thsteps/forms.shtm.

A TST is to be administered when the screening tool indicates a risk for possible exposure. Providers must use procedure code 86580 when a TST is administered.

A TST may be reimbursed separately when performed as part of a THSteps medical checkup. TB screenings are part of the encounter rates for FQHCs and RHCs and are not reimbursed separately.

A follow-up visit (procedure code 99211) is required to read all TSTs. The provider may bill the follow-up visit with a provider identifier and THSteps benefit code.

If further evaluation is required to diagnose either latent TB infection or active TB disease, the provider may bill the appropriate E/M office visit code. Diagnosis and treatment are provided as a medical office visit. Providers can also call the TB program at 1-512-533-3000 for additional clinical information.

Refer to: "TB Policies and Procedures" at www.dshs.state.tx.us/idcu/disease/tb/ for guidance on skin testing children in various settings. Click TB Control Standards, and then look under "Texas TB Policies and Procedures."

5.3.11.2 Comprehensive Unclothed Physical Examination

An age-appropriate unclothed physical examination is required at each checkup.

Recording of measurements and percentiles as appropriate to age to document growth and development including:

- Length or height and weight
- The World Health Organization (WHO) growth charts are recommended for clients from birth to 2 years of age.

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- The Centers for Disease Control and Prevention (CDC) growth charts are recommended for clients from 2 years of age and older.
- Fronto-occipital circumference (FOC) through the first 24 months of age
- Body mass index (BMI) calculated beginning at 2 years of age
- Blood pressure beginning at 3 years of age

5.3.11.2.1 Oral Health Screening

Oral health screening is a part of the medical checkup physical examination.

5.3.11.2.2 Sensory Screening

Documentation of test results from a school vision or hearing screening program may replace the required audiometric or visual acuity screening if conducted within 12 months prior to the checkup.

Clients who are birth through 35 months of age with suspected or confirmed hearing or visual impairment must be referred to ECI as soon as possible, but no longer than 7 days after identification.

5.3.11.2.3 Hearing Screening

State-mandated newborn hearing screening is offered by and performed in the birth facility in accordance with Health and Safety Code (HSC), Chapter 47, §§ 47.001–47.009 and 25 TAC §§ 37.501–37.512.

The provider must review the results with the parent or caregiver at the first checkup and determine if any additional follow-up is necessary.

Hearing screening must be performed at each checkup. Audiometric screening must be performed at specific ages indicated on the periodicity schedule. Subjective screening through provider observation or informant report is done at the other checkups.

Clients at high risk or with abnormal screening results must be referred to an appropriate Medicaid-enrolled provider who specializes in pediatric audiology services. Clients who are birth through 20 years of age enrolled with Texas Medicaid for the date(s) of service are eligible for Texas Medicaid hearing services benefits.

5.3.11.2.4 Vision Screening

Vision screening must be performed at each checkup. A visual acuity test must be performed at ages indicated on the periodicity schedule. Subjective screening through provider observation or informant report is done at the other checkups.

All clients must be screened for eye abnormalities by history, observation, and physical exam and referred to a Medicaid-enrolled optometrist or ophthalmologist experienced with the pediatric population if at high risk.

Clients with abnormal visual acuity screening results must be referred to a Medicaid-enrolled optometrist or ophthalmologist experienced with the pediatric population.

5.3.11.3 Immunizations

Providers must assess the immunization status at every medical checkup to ensure all age requirements have been met. The necessary vaccines and toxoids must be administered at the time of the checkup unless medically contraindicated or because of parent's or caregiver's reasons of conscience including religious beliefs. If an indicated vaccine or toxoid was not administered, the reason must be documented in the client's medical record.

Vaccines and toxoids must be administered according to the current ACIP "Recommended Childhood and Adolescent Immunization Schedule - United States." Providers must not refer clients to the local health department or other entity for immunization administration.

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THSteps providers are strongly encouraged to obtain vaccines from TVFC for clients who are birth through 18 years of age. Vaccines that are identified as being distributed through TVFC are not reimbursed separately.

Vaccines and toxoids may be reimbursed through Texas Medicaid at a fee determined by HHSC when the vaccine is medically necessary for THSteps clients who are 19 through 20 years of age.

The specific diagnosis necessitating the vaccine and toxoid is required when billing with the following administration procedure codes in combination with an appropriate vaccine/toxoid procedure code:

Procedure Codes					
90460	90461	90471	90472	90473	90474

The age-appropriate diagnosis code for a preventive care medical checkup must be submitted on the claim. If an immunization is administered as part of a preventive care medical checkup, diagnosis code Z23 may also be included on the claim, in addition to the age-appropriate diagnosis.

Providers may only submit diagnosis code Z23 on the claim if an immunization is the only service provided during an office visit.

Vaccine and toxoid administration must be billed with the following age appropriate diagnosis codes:

Client Age	Diagnosis Code
Birth through 7 days	Z00110
Eight through 28 days	Z00111
29 days through 17 years	Z00121, Z00129
18 years or older	Z0000, Z0001

Procedure codes 90460 and 90461 are benefits for services rendered to clients who are birth through 18 years of age when counseling is provided for the immunization administered.

Procedure codes 90471 and 90472 are benefits for services rendered to clients of any age when counseling is not provided for the immunization administered.

Procedure codes 90473 and 90474 are benefits for services rendered to clients who are birth through 20 years of age when counseling is not provided for the immunization administered.

The following vaccines and toxoids are a benefit of Texas Medicaid:

Procedure Code	Number of Components**	Procedure Code	Number of Components**	Procedure Code	Number of Components**
90620	1	90621	1	90630	1
90632	1	90633*	1	90636	2
90644	2	90647*	1	90648*	1
90649*	1	90650*	1	90654	1
90651*	1	90655*	1	90656*	1
90657*	1	90658*	1	90660*	1
90661	1	90670*	1	90672*	1
90673	1	90680*	1	90681*	1
90685*	1	90686*	1	90687*	1
90688*	1	90696*	4	90698*	5
90700*	3	90702*	2	90707*	3

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Procedure Code	Number of Components**	Procedure Code	Number of Components**	Procedure Code	Number of Components**
90710*	4	90713*	1	90714*	2
90715*	3	90716*	1	90723*	5
90732*	1	90733	1	90734*	1
90743	1	90744*	1	90746	1
90748*	2	90749	1		

*** TVFC-distributed vaccine/toxoid**

**** The number of components applies if counseling is provided and procedure code 90460 and 90461 are submitted.**

Providers may use the state-defined modifier U1 in addition to the associated administered vaccine procedure code for clients who are birth through 18 years of age and the vaccine was unavailable through TVFC.

Modifier	Description
U1	State-defined modifier: Vaccine(s)/toxoid(s) privately purchased by provider when TVFC vaccine/toxoid is unavailable

Note: *"Unavailable" is defined as a new vaccine approved by ACIP that has not been negotiated or added to a TVFC contract, funding for new vaccine that has not been established by TVFC, or national supply or distribution issues. Providers will be informed if a vaccine meets the definition of 'not available' from TVFC and when the provider's privately purchased vaccine may be billed with modifier U1.*

Modifier U1 may not be used for failure to enroll in TVFC, maintain sufficient TVFC vaccine/toxoid inventory, or clients who are 19 through 20 years of age.

Each vaccine or toxoid and its administration must be submitted on the claim in the following sequence: the vaccine procedure code immediately followed by the applicable immunization administration procedure code(s). All of the immunization administration procedure codes that correspond to a single vaccine or toxoid procedure code must be submitted on the same claim as the vaccine or toxoid procedure code.

Each vaccine or toxoid procedure code must be submitted with the appropriate "administration with counseling" procedure code(s) (procedure codes 90460 and 90461) or the most appropriate "administration without counseling" procedure code (procedure code 90471, 90472, 90473, or 90474). If an "administration with counseling" procedure code is submitted with an "administration without counseling" procedure code for the same vaccine or toxoid, the administration of the vaccine or toxoid will be denied.

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.

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The necessary counseling that is conducted by a physician or other qualified health-care professional must be documented in the client's medical record.

The following is an example of how to submit claims for immunization administration procedure codes when counseling is provided:

Procedure Code	Quantity Billed
Vaccine or toxoid procedure code with 1 component	1
90460 (1st component)	1
Vaccine or toxoid procedure code with 3 components	1
90460 (1st component)	1
90461 (2nd and 3rd components)	2

Note: *The term "components" refers to the number of antigens that prevent disease(s) caused by one organism. Combination vaccines are those that contain multiple vaccine components.*

Administration Without Counseling

Procedure codes 90471, 90472, 90473, and 90474 may be reimbursed per vaccine based on the 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

Vaccine Administration and Preventive E/M Visits

For claims that are submitted with an immunization administration procedure code and a preventive E/M visit, providers may append modifier 25 to the preventive E/M visit procedure code to identify a significant, separately identifiable E/M service that was rendered by the same provider on the same day as the immunization administration. 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 Texas Medicaid upon request.

Refer to: Acute Care Visit on the Same Day as a THSteps Preventive Visit Checkup on the TMHP website at www.tmhp.com.

THSteps Preventive Visit Checkup with Immunization and Vaccine Administration on the TMHP website at www.tmhp.com for a claim form example.

5.3.11.3.1 Vaccine Information Statement (VIS)

A VIS is required by federal mandate to inform parents and vaccine recipients of the risks and benefits of the vaccine they are about to receive. Not only is it important to explain the risks and benefits before a vaccine is administered, it is also important that providers use the most current forms available. For more about immunizations, vaccine-preventable diseases, or literature and forms, providers can call the DSHS Immunization Branch at 1-800-252-9152 or review information at www.dshs.state.tx.us/immunize.

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Refer to: Appendix B. Immunizations in this handbook.

The DSHS website for TVFC provider enrollment information at www.dshs.state.tx.us/immunize/tvfc/default.shtm.

The THSteps online education module "Immunizations," located on the THSteps website at www.txhealthsteps.com, for more information about immunizations.

5.3.11.4 Health Education and Anticipatory Guidance

Anticipatory guidance is a federally mandated component of the THSteps medical checkup and includes health education and counseling. Health education and counseling with parents or guardians and clients are required to assist parents in understanding what to expect in terms of the client's development and to provide information about the benefits of healthy lifestyles and practices, as well as accident and disease prevention. Written material may also be given but does not replace counseling. The optional THSteps clinical records include age-appropriate topics on the back of each form. These forms can be found at www.dshs.state.tx.us/thsteps/forms.shtm.

5.3.11.5 Dental Referral

Based on the AAPD definition of a dental home, Texas Medicaid 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 should begin at 6 months of age but no later than 12 months of age and includes referral to dental specialists when appropriate.

The physician 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, the provider must confirm if a dental home has been established and is on-going; if not, additional referrals must be made at subsequent medical checkup visits until the parent or caregiver confirms that a dental home has been established for the client. The parent or caregiver of the client may self-refer for dental care at any age, including 12 months of age or younger.

5.3.11.6 Laboratory Test

Age-appropriate and risk-based laboratory testing as noted on the periodicity schedule is considered part of the medical checkup. The DSHS Laboratory provides supplies for specimen collection and mailing and shipping; and reporting of test results to enrolled THSteps medical providers that submit specimens to the DSHS Laboratory. These services and supplies are limited to THSteps medical checkup laboratory services provided in the course of a medical checkup to THSteps clients. Unauthorized use of services and supplies is a violation of federal regulations.

DSHS Laboratory services are available at no cost to all enrolled THSteps medical providers for THSteps medical checkups only.

Example: *If a provider needs immediate results for the anemia screening, the specimen may be processed in the office/clinic, but will not be separately reimbursed. The test results must be documented in the client's medical record.*

Exception: *For tests related to screening for type 2 diabetes, dyslipidemia, HIV, and syphilis, the client or specimen may be sent to the laboratory of the provider's choice. Point-of-care testing that is performed in the provider's office to obtain the initial blood lead specimen may be reimbursed separately.*

The date of service for the laboratory testing is to be the date the specimen was obtained as part of the medical checkup, follow-up, or exception-to-periodicity checkup.

The procedure codes for any laboratory testing services other than screening for type 2 diabetes, dyslipidemia, HIV, and syphilis are informational when obtained on the same day a checkup is completed, even if an acute care visit is performed on the same date of service.

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If the laboratory testing as identified on the THSteps Medical Checkup Periodicity Schedule is obtained as part of an E/M visit on a different date of service than a checkup, the services may be considered as separate services and may be sent to the laboratory of the provider's choice.

Laboratory specimens obtained for diagnostic evaluation, rather than for screening purposes and performed on the same day as a checkup, may be considered as separate services unless the test is required as part of a checkup. If the test is required as part of the checkup, the laboratory specimens, with the exception of screening tests for dyslipidemia, type 2 diabetes, HIV, and syphilis must be submitted to the DSHS Laboratory for testing. Diagnostic specimens that are not part of the checkup can be sent to the laboratory of the provider's choice.

Laboratory services that are related to a THSteps medical checkup are available from the DSHS Laboratory and may not be billed separately with an office visit or consultation on the same day as a THSteps medical checkup.

All of the laboratory tests that are listed on the THSteps Periodicity Schedule may be submitted to the DSHS Laboratory if the specimen submission requirements can be met. Tests that are listed in the "Laboratory Test Procedure Codes" table below must be submitted to the DSHS Laboratory. Tests that must be sent to the DSHS laboratory but that are processed elsewhere are not reimbursed; however, the documentation results may be used to meet the requirements for a checkup.

The following procedure codes may not be billed separately with an office visit or consultation on the same day as a THSteps medical checkup either by a provider or laboratory. Claims for procedure codes listed below submitted by a provider or a commercial laboratory for the same DOS as a THSteps medical checkup are denied and are subject to retrospective review:

Laboratory Test Procedure Codes			
83655*	85018	87491	87591
*** Unless performed using point-of-care testing, the initial lead specimen must be sent to the DSHS Laboratory**			

For specimens sent to the DSHS Laboratory, the complete medical checkup includes the specimen collection and supplies, mailing and shipping supplies, and the review of the test results from the DSHS Laboratory.

For specimens sent to a laboratory of the provider's choice, the checkup includes the specimen collection or ordering of the test and the review of the test results from the laboratory.

5.3.11.6.1 Laboratory Supplies

The DSHS Laboratory verifies enrollment of THSteps medical providers before sending laboratory supplies and the informational packet to the medical providers. Newly enrolled providers should contact the DSHS Laboratory to request laboratory supplies. Upon request, the DSHS Laboratory provides THSteps medical providers with laboratory supplies associated with specimen collection, submission, and mailing and shipping of required laboratory tests related to medical checkups. Requests for specimen submission forms are routed to the DSHS Laboratory reporting staff and mailed separately to the providers. The Child Health Laboratory Supplies Order Form lists the laboratory supplies that the DSHS Laboratory provides to THSteps medical providers.

To obtain a THSteps Child Health Laboratory Supplies Order Form, providers can call 1-512-776-7661 or 1-888-963-7111, ext. 7661, or download the form online at www.dshs.state.tx.us/lab/MRS_forms.shtm.

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5.3.11.6.2 Newborn Screening Supplies

Providers that perform newborn screening (NBS) can order supplies by submitting a Newborn Screening Supplies Order Form to the DSHS Laboratory. The Newborn Screening Supplies Order Form lists the NBS supplies that the DSHS Laboratory provides to medical providers.

> ***Note:*** *For newborn screening, only the specimen collection form (NBS 3), mailing envelope and provider address labels are provided. Lancets, mailing, and shipping costs are the responsibility of the submitter.*

To obtain a Newborn Screening Supplies Order Form, medical providers can call 1-512-776-7661 or 1-888-963-7111, ext. 7661, or download the form online at www.dshs.state.tx.us/lab/MRS_forms.shtm.

Contact information for requesting laboratory supplies:

Container Preparation
Laboratory Services Section, MC 1947
Department of State Health Services
PO Box 149347
Austin, TX 78714-93471
1-512-776-7661 or 1-888-963-7111, Ext. 7661
Fax: 1-512-776-7672

5.3.11.6.3 Laboratory Submission

All required laboratory testing for THSteps clients must be performed by the Department of State Health Services (DSHS) Laboratory in Austin, TX, with the following exceptions:

- Specimens collected for type 2 diabetes, dyslipidemia, HIV, and syphilis screening may be sent to the laboratory of a provider's choice or to the DSHS Laboratory in Austin if submission requirements can be met.
- Initial blood lead testing using point-of-care testing.

THSteps medical checkup laboratory specimens submitted to the DSHS Laboratory must be accompanied with the DSHS Laboratory Specimen Submission Form (Newborn Screening NBS 3 or G-THSTEPS as appropriate) for test(s) requested. All forms must include the client's name and Medicaid number as they appear on the Your Texas Benefits card. If a number is not currently available but is pending (i.e., a newborn or a newly certified client verified by a Medicaid Eligibility Verification [Form H1027] as eligible for Medicaid), providers must write "pending" in the Medicaid number space, which is located in the payor source section of the laboratory specimen submission form.

Laboratory specimens received at the DSHS Laboratory without a Medicaid number or the word "pending" written on the accompanying specimen submission form will be analyzed, and the provider will be billed.

Specimens submitted to the laboratory must also meet specific acceptance criteria. For additional information on specimen submission, providers can refer to the DSHS Laboratory web page at: www.dshs.state.tx.us/lab/MRS_specimens.shtm.

> ***Note:*** *If an extreme health problem exists and telephone results are needed quickly, providers should make a request on the laboratory form. With the exception of weekends and holidays, routine specimens are analyzed and reported within three business days after receipt by the DSHS Laboratory. Critical abnormal test results (e.g., hemoglobin equal to or below 7g/dL or blood lead levels greater than or equal to 40 mcg/dL) are identified in the laboratory within 36 hours after receipt of specimens and are reported to the submitter by telephone within one hour of confirmation.*

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The THSteps laboratory specimens that can be mailed at ambient temperature can be sent to the DSHS Laboratory Services Section through the U.S. Postal Service at no cost using the provided business reply labels:

DSHS Laboratory Services Section
Walter Douglass
PO Box 149163
Austin, TX 78714-9803
1-512-776-7318 or 1-888-963-7111 Ext. 7318

THSteps laboratory specimens that require overnight shipping on cold packs through a courier service must be sent to the DSHS Laboratory Services Section at:

DSHS Laboratory Services Section, MC-1947
1100 West 49th Street
Austin, TX 78756-3199

Newborn Screening specimens can be sent through the U.S. Postal Service to:

Texas Department of State Health Services
Laboratory Services Section
PO Box 149341
Austin, TX 78714-9341

Gonorrhea and Chlamydia specimens for regular delivery are sent to:

Department of State Health Services
Laboratory - MC 1947
Walter Douglass, 1-512-776-7569
PO Box 149163
Austin, TX 78714-9803

Gonorrhea and Chlamydia specimens that are shipped cold overnight by courier are sent to:

Department of State Health Services
Laboratory - MC 1947
Walter Douglass, 1-512-776-7569
1100 W. 49th Street
Austin, TX 78756-3199

Collectors are available from the DSHS Austin Laboratory. To order collectors, providers must complete the Order Form for Gonorrhea/Chlamydia (GC/CT) Laboratory Supplies (G-6C) that is posted on the DSHS website at www.dshs.state.tx.us/lab/mrs_forms.shtm and fax the completed form to (512) 776-7672.

Providers can call 1-512-776-6030 or toll-free 1-888-963-7111, ext. 6030, for questions about submission requirements such as collection, supplies, and mailing of specimens for THSteps gonorrhea and chlamydia adolescent screening.

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5.3.11.6.4 Send Comments

Providers with comments or feedback about THSteps specimen collection supplies should contact the DSHS Laboratory. Supplies are evaluated continually, and feedback from supply users is useful. Documented comments may support, justify, or initiate a change in a provided item. Providers can send a brief letter or fax to the following address:

Quality Assurance Unit
Laboratory Services Section, MC 1947
Department of State Health Services
PO Box 149347
Austin, TX 78714-9347
Fax: 1-512-776-7294

5.3.11.6.5 Laboratory Reporting

A computer-generated result report is mailed or faxed to the submitting THSteps medical checkup provider. A monthly statistical report card is only available online for providers documenting their total number of Total Hemoglobin and Blood Lead submissions by diagnosis and adequacy. The DSHS Laboratory has web-based services (remote order or result reporting) available for THSteps and Newborn Screening laboratory services. For more information, providers can visit the DSHS website at www.dshs.state.tx.us/lab/remoteData.shtm or call 1-888-963-7111, Ext. 6030.

5.3.11.6.6 Required Laboratory Tests Related to Medical Checkups

The following laboratory screening procedures are required components of the THSteps medical checkup and are to be performed in accordance with the age and frequency specified on the THSteps medical checkup periodicity schedule. Due to changes in specimen collection, handling, and submission criteria, providers should contact the DSHS Laboratory for the most current specimen requirements by calling 1-888-963-7111, Ext. 6236, 6237, or 2628, email ClinicalChemistry@dshs.state.tx.us, or visiting the DSHS website at www.dshs.state.tx.us/lab/MRS_labtests_toc.shtm.

Anemia Screening

Anemia screening by hemoglobin or hematocrit levels is required at ages as noted on the THSteps Periodicity Schedule and the specimen must be sent to the DSHS Laboratory. If there is an urgent need for test results, these tests may be completed in a provider's office or clinic, but they will not be reimbursed separately. These test results must be documented in the client's medical record.

Lead Screening and Testing

In accordance with current federal regulations, THSteps requires blood lead screening at ages notated on the THSteps Periodicity Schedule and must be performed during the medical checkup.

Environmental lead risk assessments, as part of anticipatory guidance, should be completed at all checkups through age 6 when testing is not mandated, and may be performed using the Lead Risk Questionnaire, Form Pb-110, which is provided in both English and Spanish at www.dshs.state.tx.us/thsteps/forms.shtm. Providers may also opt to use an equivalent form of their choice.

The initial lead testing may be performed using a venous or capillary specimen, and must either be sent to the DSHS Laboratory or performed in the provider's office using point-of-care testing. If the client has an elevated blood lead level of 5 mcg/dL or greater, the provider must perform a confirmatory test using a venous specimen. The confirmatory specimen may be sent to the DSHS Laboratory, or the client or specimen may be sent to a laboratory of the provider's choice.

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All blood lead levels in clients who are 14 years of age or younger must be reported to DSHS Texas Childhood Lead Poisoning Prevention Program (TXCLPPP). Reports should include all information as required on the Child Blood Lead Reporting, Form F09-11709 or the Point-of-Care Blood Lead Testing report Form Pb-111, which can be found at www.dshs.state.tx.us/lead/providers.shtm or by calling 1-800-588-1248.

Information related to blood lead screening and reporting for clients who are 15 years of age or older is available on the DSHS Blood Lead Surveillance Group's website at www.dshs.state.tx.us/lead/providers.shtm.

Initial blood lead testing using point-of-care testing (procedure code 83655 with modifier QW) may be reimbursed to THSteps medical providers when performed in the provider's office. Providers must have a *Clinical Laboratory Improvement Amendments of 1988* (CLIA) certificate of waiver.

Blood lead testing is part of the encounter rates for FQHCs and RHCs and is not reimbursed separately.

Providers may obtain more information about the medical and environmental management of lead-poisoned children from the DSHS Childhood Lead Poisoning Prevention Program by calling 1-800-588-1248 or visiting the web page at www.dshs.state.tx.us/lead.

Refer to: Appendix C. Lead Screening in this handbook for more information on lead screening procedures and follow-up.

Dyslipidemia

Screening for dyslipidemia is required once for clients who are 9 through 11 years of age and once again for clients who are 18 through 20 years of age, regardless of risk. These are in addition to the current risk-based screening for clients who are 24 months through 20 years of age. Clients or specimens may be sent to the laboratory of the provider's choice, including the DSHS Laboratory. THSteps does not provide a formal risk assessment tool. Providers may refer to the AAP policy statement on cholesterol screening for more information.

Diabetes

Screening for type 2 diabetes is based on risk assessment. THSteps does not provide a formal risk assessment tool. Clients and specimens may be sent to the laboratory of the provider's choice, including the DSHS Laboratory.

Newborn Screening

Each newborn delivered in Texas must be subjected to two screens to test for a number of genetic and heritable disorders. Each newborn screen is indicated on the THSteps Periodicity Schedule. A current list of screened disorders is available at www.dshs.state.tx.us/newborn/screened_disorders.shtm.

Additional information about newborn screening, is available on the Newborn Screening Program website at www.dshs.state.tx.us/newborn/default.shtm.

The initial newborn screen specimen must be obtained between 24 and 48 hours after birth. Newborns discharged from a hospital or birthing facility before this time criteria is met must have a newborn screen blood specimen obtained immediately prior to discharge. When the newborn is an inpatient in the hospital, the hospital shall ensure that the appropriate screens are done. When the newborn is not in the hospital, the physician or health-care practitioner who attends the newborn outside of the hospital shall be responsible for causing the appropriate screens to be done. TAC Title 25, Part 1, Chapter 37, Subchapter D, Rule §37.55.

A second screen is to be obtained between one and two weeks of age by the newborn's physician or health-care practitioner, and is a required component of the THSteps medical checkup. Clients may not be referred to the local health department or other providers for this service. If there is any doubt that a

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client younger than 12 months of age was properly tested, the provider should submit a screen on DSHS Form NBS 3 to the Texas Department of State Health Services, Laboratory Services Section, Austin, Texas.

Newborn screening tests may be performed in special circumstances, such as adoption, if there is not record of previous test results. Newborn screen results are mailed or faxed to the address that the provider indicated on DSHS Form NBS 3. Providers may sign up to receive results online through the DSHS Laboratory web-based services. For more information visit the DSHS website at www.dshs.state.tx.us/lab/newbornscreening.shtm or call 1-888-963-7111, Ext. 6030.

Note: *Recommendations for necessary follow-up procedures are included with the newborn screen results. Newborn Screening (NBS) Clinical Care Coordination staff will contact providers when there are significant out of range newborn screening laboratory results.*

5.3.11.6.7 Additional Required Laboratory Tests Related to Medical Checkups for Adolescents

The following is a list of required and risk-based laboratory tests related to medical checkups for adolescents and guidelines for testing for sexually transmitted diseases (STDs).

Testing for Sexually Transmitted Diseases

Syphilis Testing

Syphilis testing should be performed on adolescents that are at high risk for infection. Clients and specimens may be sent to the laboratory of the provider's choice, including the DSHS Laboratory.

Gonorrhea and Chlamydia Infection Testing

Testing for gonorrhea and Chlamydia should be performed on adolescents that are at high risk for infection. Specimens must be sent to the DSHS Laboratory in Austin.

HIV Testing

Clients should be informed that the HIV test is routinely available, confidential, and completely anonymous. It is critical to maintain confidentiality when caring for clients, as well as their specimens. Testing should be performed only after informed consent is obtained from the adolescent. Informed consent does not have to be written as long as there is documentation in the medical record that the test has been explained and consent has been obtained.

Screening for HIV is required once for clients who are 16 through 18 years of age, regardless of risk. Clients or specimens may be sent to the laboratory of the providers' choice including the DSHS Laboratory.

Screening for HIV is also based on risk assessment for clients who are 11 through 20 years of age based on risk assessment. Clients or specimens may be sent to the laboratory of the providers' choice, including the DSHS Laboratory.

THSteps does not provide a formal HIV risk assessment tool. Providers may refer to the AAP policy statement on HIV screening and CDC guidelines on HIV screening for more information.

HIV testing may be performed for adolescents without requirement of parental consent. Adolescents at risk for HIV infection should be offered confidential HIV screening. If the client refuses the HIV test, the provider may not perform the test and must explain the option of anonymous testing and refer the client to a testing facility that offers anonymous testing. A notation must be made in the medical record that notification of the HIV test and the right to refuse was given. Providers may call the HIV/STD InfoLine for referrals to HIV/AIDS testing sites; prevention, case management, and treatment providers; STD clinics; and other related service organizations. The HIV/STD InfoLine is 1-800-299-2437. This toll-free HIV/AIDS and STD information and referral service is available for English- and Spanish-speaking callers and for those who are hearing-impaired.

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Communicable Disease Reporting

Diagnoses of STDs, including HIV, are reportable conditions under 25 TAC, Chapter 97. Providers must report confirmed diagnoses of STDs as required by 25 TAC §97.132.

5.3.12 Non-mandated Components

5.3.12.1 Oral Evaluation and Fluoride Varnish (OEFV) in the Medical Home

An OEFV (procedure code 99429) is aimed at improving oral health outcomes for clients who are 6 through 35 months of age by initiating a limited set of preventive dental services (not a dental checkup) in the medical home.

The OEFV must be billed on the same date of service as a medical checkup and is limited to six services per lifetime by any provider. Procedure code 99429 must be billed with modifier U5 and diagnosis code Z00121 or Z00129 for an intermediate oral evaluation with fluoride varnish application.

An OEFV is not a required component of a THSteps medical checkup, but providers are encouraged to participate in this preventive intervention. OEFV is limited to THSteps medical checkup providers who have completed the required benefit education and are certified by the DSHS Oral Health Program to perform OEFV services.

Training for certification is available as a free continuing education course on the THSteps website at www.txhealthsteps.com.

The OEFV add-on includes the following components:

- Intermediate oral evaluation
- Inspection of teeth for signs of early childhood caries, and other caries
- Inspection of the oral soft tissues for any abnormalities
- Inspection for bleeding, swelling, or infection
- Indications of lack of cleaning of the mouth

The intermediate oral evaluation components that may be performed by a trained staff member are:

- Fluoride varnish application
- Dental anticipatory 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
  - THSteps eligibility qualifies the client for dental services
  - Diet, nutrition, and food choices
  - Fluoride needs
  - Injury prevention
  - Antimicrobials, medications, and oral health

If the client has no erupted teeth, additional dental anticipatory guidance is expected.

Note: *The physician must complete the intermediate oral evaluation but can delegate all other components.*

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5.4 Documentation Requirements

All THSteps services require documentation to support the medical necessity of the services rendered including THSteps medical services. THSteps services are subject to retrospective review and recoupment if documentation does not support the services billed.

The following federal and state mandated components must be documented in the client's medical record for the checkup to be considered complete:

- Comprehensive health and developmental history, including physical and mental health development
- Comprehensive unclothed physical examination
- Immunizations appropriate for age and health history
- Laboratory test appropriate to age and risk, including lead toxicity at specific federally mandated ages
- Health education including anticipatory guidance
- Dental referral

The client's medical record must include documentation to support the rationale a component was not completed, and a plan to complete the component(s) if not due to parent or caregiver concern or reasons of conscience, including religious beliefs.

5.4.1 Separate Identifiable Acute Care Evaluation and Management Visit

If an acute or chronic condition that requires E/M beyond the required components for a medical checkup is discovered, a separate E/M procedure code may be considered for reimbursement for the same date of service as a checkup or the client can be referred for further diagnosis and treatment.

- The client's medical record must contain documentation that the separate identifiable service(s) were medically necessary and include a diagnosis in addition to Z0000, Z0001, Z00110, Z00111, Z00121 or Z00129 and treatment. Documentation must be made available to Texas Medicaid upon request.
- An insignificant or trivial problem or abnormality that is encountered in the process of performing a checkup and does not require additional work and performance of the key components of a problem-oriented E/M service cannot be considered a separate established patient E/M acute care visit.
- Modifier 25 must be used to identify a significant, separately identifiable E/M service rendered by the same provider 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 Texas Medicaid upon request.

Refer to: Acute Care Visit on the Same Day as a THSteps Preventive Visit Checkup on the TMHP website at www.tmhp.com.

THSteps Preventive Visit Checkup with Immunization and Vaccine Administration on the TMHP website at www.tmhp.com for a claim form example.

5.5 Claims Filing and Reimbursement

Providers may refer to Volume 1 for general information about claims filing and reimbursement.

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Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims.

Section 6: Claims Filing (*Vol. 1, General Information*) for paper claims completion instructions.

Section 2: Texas Medicaid Fee-for-Service Reimbursement (*Vol. 1, General Information*) for more information about reimbursement.

Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information.

5.5.1 Claims Information

THSteps Medical providers are not required to bill other insurance before billing Medicaid. If a provider is aware of other insurance, the provider must choose whether or not to bill the other insurance. The provider has the following options:

- If the provider chooses to bill the other insurance, the provider must submit the claim to the client's other insurance before submitting the claim to Medicaid.
- If the provider chooses to bill Medicaid and not the client's other insurance, the provider is indicating that he or she accepts the Medicaid payment as payment in full. Medicaid then has the right to recovery from the other insurance. The provider does not have the right to recovery and cannot seek reimbursement from the other insurance after Medicaid has made payment.
- If the provider learns that a client has other insurance coverage after Medicaid has paid a claim, the provider must refund the payment to Medicaid before billing the other insurance.

Providers should bill their usual and customary fee except for vaccines obtained from TVFC. Providers may not charge Medicaid or clients for the vaccine received from TVFC. Providers may charge a usual and customary fee not to exceed $14.85 for vaccine administration when providing immunizations to a client eligible for TVFC. Providers are reimbursed the lesser of the billed amount or the maximum allowable fee.

THSteps medical checkups may be billed electronically 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. Providers may request information about electronic billing or the paper claim form by contacting the TMHP THSteps Contact Center at 1-800-757-5691.

All procedures, including the informational-only procedures, must have a billed amount associated with each procedure listed on the claim. Informational-only procedure codes must be billed in the amount of at least $.01.

Providers must record the following on the CMS-1500 claim form to receive reimbursement for a medical checkup, exception to periodicity checkup, or follow-up visit:

- The provider identifier and benefit code EP1 (exception: FQHC providers do not use benefit code EP1)
- The appropriate THSteps medical checkup procedure code (all ages) with diagnosis code Z00121 or Z00129. All immunizations must be reported with diagnosis code Z23.
    - The condition indicator codes, which must be placed in 24C (ST, S2, or NU only to identify a checkup resulting in a referral)

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- The provider type modifiers
- The exception-to-periodicity modifier, when applicable

Refer to: Subsection 5.3.6, "THSteps Medical Checkups" in this handbook for a listing of modifiers.

- The immunization administration and vaccine procedure codes if any were administered (all ages)
- The place of service must be 72 for RHCs
- The EP modifier must be used for FQHCs

Immunizations performed outside of a THSteps medical checkup must be billed without the benefit code EP1.

5.5.2 Reimbursement

As with all Medicaid services, providers acknowledge compliance with all Texas Medicaid requirements when they submit a claim for reimbursement. THSteps-enrolled providers are reimbursed for THSteps medical checkups and administration of immunizations in accordance with 1 TAC §355.8441.

Note: *NP, CNS, and PA providers who are enrolled in Texas Medicaid as THSteps providers may receive 92 percent of the rate paid to a physician for THSteps services.*

FQHCs are reimbursed using visit rates calculated in accordance with 1 TAC §355.8261.

RHCs are reimbursed using visit rates calculated in accordance with 1 TAC §355.8101.

Providers may refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

6 Claims Resources

Refer to the following sections or forms when filing claims:

Resource	Location
Appendix D: Acronym Dictionary	Appendix D. (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	TMHP Telephone and Fax Communication (*Vol. 1, General Information*)
Claim Form Example	Subsection 6.5 (*Vol. 1, General Information*)
Appendix A: State, Federal, and TMHP Contact Information	Appendix A (*Vol. 1, General Information*)
TMHP Electronic Claims Submission	Subsection 6.2 (*Vol. 1, General Information*)
Section 3: TMHP Electronic Data Interchange (EDI)	(*Vol. 1, General Information*)

7 Contact TMHP

For a complete list of TMHP communications, refer to the TMHP Telephone and Fax Communication (*Vol. 1, General Information*).

7.1 Automated Inquiry System (AIS)

AIS (1-800-925-9126, Option 1) is available 7 days a week, 23 hours a day, with scheduled downtime between 3 a.m. and 4 a.m., and is the main point of contact for client eligibility information. AIS requires the use of a touch-tone telephone in order to access the system.

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7.2 TMHP Website

Additional information about Medicaid enrollment, general customer service, and provider education/training is available on the TMHP website at www.tmhp.com.

7.3 Dental Information and Assistance

For assistance with claims, dental providers may contact a TMHP Contact Center representative on the Dental Inquiry Line (1-800-568-2460).

7.3.1 Dental Inquiry Line

The Dental Inquiry Line (1-800-568-2460) is available Monday through Friday, 7 a.m. to 7 p.m., Central Time, and is the main point of contact for information about dental services and appeals.

Any dental service claim denial may be appealed by telephone if it was not denied as an incomplete claim and does not require one of the following items or conditions:

- Narratives
- Radiographs
- Models
- Other tangible documentation
- Review by the TMHP Dental Director

7.4 THSteps Information and Assistance

Providers with questions, concerns, or problems about claims should contact the TMHP Contact Center (1-800-925-9126). For contact information for their regional TMHP Provider Representative, providers can refer to the TMHP website at www.tmhp.com. Click on the **Regional Support** link.

7.4.1 THSteps Inquiry Line

The THSteps Medical Inquiry Line at 1-800-757-5691 is available Monday through Friday, 7 a.m. to 7 p.m., Central Time, and is the main point of contact for information about THSteps medical services.

7.5 Assistance with Program

Providers with questions, concerns, or problems with program rules, policies, or procedures should contact DSHS regional program staff. THSteps staff contact numbers can be found in Appendix A: State, Federal, and TMHP Contact Information, (*Vol. 1, General Information*), on the THSteps website at www.dshs.state.tx.us/thsteps/default.shtm, or by calling THSteps at 1-512-776-7745.

THSteps regional staff make routine contact with providers to educate and assist them with THSteps policies and procedures.

Clients who are eligible for Medicaid and have questions about THSteps, need to locate medical or dental providers, or need assistance with arranging transportation to appointments should call the THSteps toll-free helpline (1-877-847-8377). Clients with questions about their Medicaid eligibility for THSteps should be directed to their caseworker at the local HHSC office or site.

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8 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
CCP Prior Authorization Request Form Instructions
CCP Prior Authorization Request Form
CCP Prior Authorization Private Duty Nursing 6-Month Authorization
CRCP Prior Authorization Request Form
Criteria for Dental Therapy Under General Anesthesia
DME Certification and Receipt Form
Donor Human Milk Request Form
External Insulin Pump Prior Authorization Form
Home Health Plan of Care (POC)
Home Health Plan of Care (POC) Instructions
Nursing Addendum to Plan of Care (CCP)
Pulse Oximeter Form
Request for CCP Outpatient Therapy
THSteps Dental Mandatory Prior Authorization Request Form
THSteps Referral Form Instructions
THSteps Referral Form
CCP Prior Authorization Request for Non-Face-to-Face Clinician-Directed Care Coordination Services
Specialist or Subspecialist Telephone Consultation Form for Non-Face-to-Face Clinician-Directed Care Coordination Services–Comprehensive Care Program (CCP)
Wheelchair/Scooter/Stroller Seating Assessment Form (CCP/Home Health Services)

9 Claim Form Examples

The following linked claim form examples can also be found on the Claim Form Examples page of the Provider section of the TMHP website at www.tmhp.com:

Claim Form Examples
Acute Care Visit on the Same Day as a THSteps Preventive Visit Checkup
Comprehensive Outpatient Rehabilitation Facility (CORF) (CCP Only)
Diagnosis and Treatment (Referral from THSteps Checkup)
Durable Medical Equipment (CCP Only)
Early Childhood Intervention Specialized Skills Training (SST)
Early Childhood Intervention Targeted Case Management with Face-to-Face Interaction
Early Childhood Therapy
Inpatient Rehabilitation Facility (Freestanding) (CCP Only)
Medical Checkup Follow-up Visit with Immunization Administration
Medical Checkup Follow-up Visit with TB Skin Test (TST)

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Claim Form Examples
Medical Nutrition Counseling (CCP Only)
Occupational Therapists (CCP Only)
Orthotic and Prosthetic Services (CCP Only)
Physical Therapists (CCP Only)
Private Duty Nurses (CCP Only)
School Health and Related Services (SHARS)
Speech-Language Pathologists (CCP Only)
THSteps New Patient, Immunization Without Counseling no Referral and by an NP
THSteps Established Patient Exception to Periodicity and Referral, Immunizations with Counseling, and by a Physician
THSteps Established Patient and Referral, Tuberculin Skin Test (TST), and Physical Examination by a Physician
THSteps Preventive Visit Checkup with Immunization and Vaccine Administration

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APPENDIX A. THSTEPS FORMS

A.1 Claim Forms

Providers must order CMS-1500 and American Dental Association (ADA) Dental Claims Forms from the vendor of their choice. Copies cannot be used. Claims filing instructions and examples of the claim forms are located in Section 6: Claims Filing (*Vol. 1, General Information*).

Refer to: Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

Subsection 6.5.2, "CMS-1500 Claim Form (Paper) Billing" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

Subsection 6.7, "2012 American Dental Association (ADA) Dental Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

A.2 THSteps Medical Checkup Forms

The use of the child health clinical records is optional. These forms were developed to help providers document all components of the medical checkup. Unless required to be submitted to another program, one of the following forms of documentation must be included in the client's medical record: The completed screening tools with results, the completed questions to the tools within a provider-created medical record, and the results of the completed screening tools. Providers may be asked to provide the screening tool used to complete the screening. Texas Health Steps (THSteps) requires the following forms: Tuberculosis (TB) Questionnaire and the Texas Department of State Health Services (DSHS) State Laboratory forms. These forms can be downloaded from the THSteps website at www.dshs.state.tx.us/thsteps/forms.shtm. The Parent Hearing Checklist and Lead Risk Questionnaire are optional forms. Lead poisoning screening questionnaires can be downloaded from the Texas Childhood Lead Poisoning Prevention Program (TX CLPPP) website at www.dshs.state.tx.us/lead/providers.shtm.

Links to growth charts may be found on the THSteps website at www.dshs.state.tx.us/thsteps/forms.shtm.

Form Number	Form Name
ECH-1	Child Health History Form
ECHR-5 Day	Discharge to 5 day Visit Child Health Record
ECHR-2 Week	2 Week Visit Child Health Record
ECHR-2 Month	2 Month Visit Child Health Record
ECHR-4 Month	4 Month Visit Child Health Record
ECHR-6 Month	6 Month Visit Child Health Record
ECHR-9 Month	9 Month Visit Child Health Record
ECHR-12 Month	12 Month Visit Child Health Record
ECHR-15 Month	15 Month Visit Child Health Record
ECHR-18 Month	18 Month Visit Child Health Record
ECHR-24 Month	24 Month Visit Child Health Record
ECHR-30 Month	30 Month Visit Child Health Record
ECHR-3 Year	3 Year Visit Child Health Record
ECHR-4 Year	4 Year Visit Child Health Record
ECHR-5 Year	5 Year Visit Child Health Record

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Form Number	Form Name
ECHR-6 Year	6 Year Visit Child Health Record
ECHR-7 Year	7 Year Visit Child Health Record
ECHR-8 Year	8 Year Visit Child Health Record
ECHR-9 Year	9 Year Visit Child Health Record
ECHR-10 Year	10 Year Visit Child Health Record
ECHR-11 Year	11 Year Visit Child Health Record
ECHR-12 Year	12 Year Visit Child Health Record
ECHR-13 Year	13 Year Visit Child Health Record
ECHR-14 Year	14 Year Visit Child Health Record
ECHR-15 Year	15 Year Visit Child Health Record
ECHR-16 Year	16 Year Visit Child Health Record
ECHR-17 Year	17 Year Visit Child Health Record
ECHR-18 Year	18 Year Visit Child Health Record
ECHR-19 Year	19 Year Visit Child Health Record
ECHR-20 Year	20 Year Visit Child Health Record
ECHR-19-20 Year	19 & 20 Year Visit Child Health Record
	Form Pb-110, Lead Risk Questionnaire
	TB Questionnaire

Providers should refer to sources such as *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* (3rd edition), located at www.brightfutures.org or the Guidelines for Adolescent Preventive Services (GAP) Implementation Materials located at https://brightfutures.aap.org/materials-and-tools/PerfPrevServ/Pages/default.aspx. For nutritional screening for all ages, refer to Bright Futures.

A.3 Laboratory Forms

For information on procedures for submission of laboratory forms, refer to the DSHS Laboratory Services Section's web page at www.dshs.state.tx.us/lab/MRS_forms.shtm.

A.4 Guidelines for Tuberculosis Skin Testing

For information on procedures for tuberculosis skin testing, refer to the DSHS tuberculosis web page at www.dshs.state.tx.us/idcu/disease/tb/.

A.5 Tuberculosis Screening and Guidelines

The screening tool for tuberculosis (TB) exposure risk is to be used annually to determine the need for tuberculin skin testing.

The questions in the screening tool are intended as a minimum screen. Follow-up questions may be necessary to clarify hesitant or ambiguous responses. Questions specific to TB exposure risks in the client's community may need to be added.

The following applies for tuberculin screening and skin testing:

- If all the answers are unqualified negatives, the client is considered at low risk for exposure to TB and will not need tuberculin skin testing.
- If the answer to any question is "Yes" or "I don't know," the client should be tuberculin skin tested.

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- In the case of the client for whom an answer in the past of "Yes" or "I don't know" prompted a skin test, which was negative, the skin test *may* not have to be repeated annually.
- The decision to administer a skin test must be made by the medical provider based upon an assessment of the possibility of exposure. A negative tuberculin skin test never excludes tuberculosis infection or active disease.
- Bacillus of Calmette and Guérin (BCG) vaccinated clients should also have the screening tool administered annually. Previous BCG vaccination is not a contraindication to tuberculin skin testing. Positive tuberculin skin tests in BCG vaccinated children are interpreted using the same guidelines used for non-BCG vaccinated children.
- Clients who have had a positive TB skin test in the past (whether treated or not), should be re-evaluated at least annually by a physician for signs and symptoms of TB.

Care of clients who are newly discovered to be tuberculin skin test positive includes:

- An evaluation for signs and symptoms of TB.
- A chest X-ray to rule out active disease.
- Oral medications to prevent progression to active disease or multi-drug therapy if active disease is present.
- Referral for consultation by a pediatric TB specialist is recommended if active disease is present.
- A report to the local health authority for investigation to find the source of the infection.

Refer to: The TB screening tool on the THSteps website at www.dshs.state.tx.us/thsteps/forms.shtm.

"Frequently Asked Questions About TB" on the DSHS website at www.dshs.state.tx.us/idcu/disease/tb/faqs for information about assessing a child's risk of TB exposure, providers can refer to

The TVFC Provider Manual, Forms, & Resources web page on the DSHS website at www.dshs.state.tx.us/immunize/tvfc/ProviderResources.shtm#forms for the Patient Eligibility Screening Record (Bilingual), Questions & Answers about TVFC, and additional information.

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APPENDIX B. IMMUNIZATIONS

B.1 Immunizations Overview

Clients who are 17 years of age and younger must be immunized according to the Recommended Childhood Immunization Schedule for the United States. If the immunizations are due as part of a Texas Health Steps (THSteps) medical checkup, the medical checkup provider is responsible for the administration of immunizations for clients who are birth through 20 years of age and may not refer clients to local health departments. The Department of State Health Services (DSHS) requires that immunizations be administered during the THSteps medical checkup, unless they are medically contraindicated or excluded from immunization for reasons of conscience, including a religious belief.

Providers, in both public and private sectors, are required by federal mandate to provide a Vaccine Information Statement (VIS) to the responsible adult accompanying a client for an immunization. These statements are specific to each vaccine and inform the responsible adult about the risks and benefits. It is important that providers use the most current VIS.

Providers interested in obtaining copies of current VISs and other immunization forms or literature may call the DSHS Immunization Branch at 1-512-458-7284. VISs may also be downloaded from the DSHS Immunization Branch website at www.immunizetexas.com.

B.1.1 Vaccine Adverse Event Reporting System (VAERS)

The National Childhood Vaccine Injury Act of 1986 (NCVIA) requires health-care providers to report:

- Any reaction listed by the vaccine manufacturer as a contraindication to subsequent doses of the vaccine.
- Any reaction listed in the Reportable Events Table that occurs within the specified time period after vaccination.

Clinically significant adverse events should be reported even if it is unclear whether a vaccine caused the event.

Note: *Documentation of the injection site is recommended but not required. For additional information about documentation, providers can refer to www.vaers.hhs.gov.*

A copy of the Reportable Events Table can be obtained by calling VAERS at 1-800-822-7967 or by downloading it from http://vaers.hhs.gov/resources/vaersmaterialspublications.

B.1.2 TVFC Versus Non-TVFC Vaccines/Toxoids

When single antigen vaccines/toxoids or comparable antigen vaccines/toxoids are available for distribution through the Texas Vaccines for Children (TVFC) Program, but the provider chooses to use a different Advisory Committee on Immunization Practices (ACIP)-recommended product, the vaccine/toxoid will not be reimbursed; however, the administration fee will be considered.

Note: *All administered vaccines/toxoids must be reported to DSHS. DSHS submits all vaccines/toxoids reported with consent to a centralized immunization registry, known as ImmTrac.*

Refer to: Subsection B.3.4, "How to Report Immunization Records to ImmTrac, the Texas Immunization Registry" in this appendix.

B.1.3 Exemption from Immunization for School and Child-Care Facilities

Parents may obtain an exemption from immunization requirements for school and childcare entry for reasons of conscience or religious beliefs. An exemption is also available for clients who are medically contraindicated from receiving a vaccine. For more information on exemptions call 1-512-458-7284, or visit www.immunizetexas.com.

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Refer to: Section 5, "THSteps Medical" in this handbook.

B.2 Recommended Childhood Immunization Schedule

The Recommended Childhood Immunization Schedule indicates the recommended age for routine administration of currently licensed childhood vaccines. This schedule was developed and approved by ACIP, the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

Some combination vaccines are available and may be used whenever any component of the combination is indicated and its other components are not contraindicated. Providers should consult the manufacturer's package insert for detailed recommendations.

Vaccines should be administered at the recommended ages. Any dose not given at the recommended age should be given as a catch-up immunization on any subsequent visit when indicated and feasible.

A current copy of the Recommended Childhood Immunization Schedule can be accessed at www.cdc.gov/vaccines/schedules.

Refer to: Recommended Childhood and Adolescent Immunization Schedule on the [NAME] page of the TMHP website at www.tmhp.com.

B.3 General Recommendations

For information about vaccine administration, dosing, and contraindications, immunization providers should consult vaccine package inserts and the January 28, 2011, issue of the Center for Disease Control and Prevention *Morbidity and Mortality Weekly Report* (MMWR). For copies of the MMWR, contact the Immunization Branch at 1-512-458-7284.

B.3.1 How to Obtain Vaccines at No Cost to the Provider

TVFC provides routinely recommended ACIP vaccines for immunization of THSteps and other Medicaid- and TVFC-eligible clients free of charge to providers who are enrolled in TVFC. The local health department/district or DSHS regional office provides information on how to order, account for, and inventory vaccines. Monthly reports are required in order to receive state-purchased vaccines. Physicians who request and accept state-supplied vaccines must complete and sign the provider enrollment and profile forms annually. The provider may not charge Medicaid or the client for vaccines obtained from TVFC.

Additional information is available at www.immunizetexas.com.

B.3.2 Administrations and Immunizations

B.3.2.1 Administrations

The following administration procedure codes must be submitted in combination with an appropriate vaccine/toxoid procedure code:

Administration Procedure Code					
90460	90461	90471	90472	90473	90474

Procedure codes 90460 and 90461 are benefits for services rendered to clients who are birth through 18 years of age when counseling is provided for the immunization administered. Documentation of counseling by the physician or other qualified health-care professional must be noted in the client's medical record.

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Procedure codes 90471 and 90472 are benefits for services rendered to clients of any age when counseling is not provided for the immunization administered. Procedure codes 90473 and 90474 are benefits for services rendered to clients who are birth through 20 years of age when counseling is not provided for the immunization administered.

Refer to: Subsection 5.3.11.3, "Immunizations" in this handbook for appropriate diagnosis codes for immunization administration.

B.3.2.2 Immunizations (Vaccine/Toxoids)

The following vaccines and toxoids are a benefit of Texas Medicaid:

Procedure Code	Number of Components**	Procedure Code	Number of Components**	Procedure Code	Number of Components**
90620	1	90621	1	90630	1
90632	1	90633*	1	90636	2
90644	2	90647*	1	90648*	1
90649*	1	90650*	1	90654	1
90651*	1	90655*	1	90656*	1
90657*	1	90658*	1	90660*	1
90661	1	90670*	1	90672*	1
90673	1	90680*	1	90681*	1
90685*	1	90686*	1	90687*	1
90688*	1	90696*	4	90698*	5
90700*	3	90702*	2	90707*	3
90710*	4	90713*	1	90714*	2
90715*	3	90716*	1	90723*	5
90732*	1	90733	1	90734*	1
90743	1	90744*	1	90746	1
90748*	2	90749	1		

*** TVFC-distributed vaccine/toxoid**
**** The number of components applies if counseling is provided and procedure code 90460 and 90461 are submitted.**

Providers may use the state-defined modifier U1 in addition to the associated administered vaccine procedure code for clients who are birth through 18 years of age and the vaccine was unavailable through TVFC.

Modifier	Description
U1	State-defined modifier: Vaccines/toxoids privately purchased by provider when TVFC vaccine/toxoid is unavailable

Note: *"Unavailable" is defined as a new vaccine approved by ACIP that has not been negotiated or added to a TVFC contract, funding for new vaccine that has not been established by TVFC, or national supply or distribution issues. Providers will be informed if a vaccine meets the definition of 'not available' from TVFC and when the provider's privately purchased vaccine may be billed with modifier U1.*

Modifier U1 may not be used for failure to enroll in TVFC, maintain sufficient TVFC vaccine/toxoid inventory, or for clients who are 19 through 20 years of age.

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B.3.3 Requirements for TVFC Providers

By enrolling, public and private providers agree to:

- Screen patients for TVFC eligibility at all immunization encounters, and administer TVFC-purchased vaccines only to clients who are 18 years of age and younger who meet one or more of the following criteria:
  - Is an American Indian or Alaska Native.
  - Is enrolled in Medicaid.
  - Has no health insurance.
  - Is underinsured: clients who have other health insurance but the coverage does not include vaccines, clients whose insurance covers only selected vaccines (TVFC-eligible for noncovered vaccines only), clients whose insurance capitates vaccine coverage at a certain amount (once that coverage amount is reached, these clients are categorized as underinsured).
  - Is a client who receives benefits from the Children's Health Insurance Program (CHIP) and the provider bills CHIP for the administration fee.
- Maintain all records related to the TVFC program, including parent, guardian, or authorized representative's responses to screening for patient's eligibility for at least five years. If requested, the provider will make such records available to DSHS, the local health department authority, or the U.S. Department of Health and Human Services (HHS).
- Comply with the appropriate vaccination schedule, dosage, and contraindications, as established by ACIP, unless (a) in making a medical judgment in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate, or (b) the particular requirement is not in compliance with Texas law, including laws relating to religious and medical exemptions.
- Provide VISs to the responsible adult, parent, or guardian, and maintain records in accordance with the NCVIA which include reporting clinically significant adverse events to VAERS. Signatures are required for informed consent. (The Texas Addendum portion of the VIS may be used to document informed consent.)
- Not charge for vaccines supplied by DSHS and administered to a client who is eligible for TVFC.
- Charge a vaccine administration fee to Texas Medicaid but not impose a charge for the administration of the vaccine in any amount higher than the maximum administration fee established by DSHS (providers may charge a vaccine administration fee to Medicaid, but not a fee for the vaccine). Medicaid clients cannot be charged any out-of-pocket expense for the vaccine or the administration of the vaccine.
- Not deny administration of a TVFC vaccine to a client because of the inability of the client's parent or guardian/individual of record to pay an administration fee.
- Comply with the state's requirements for ordering vaccines and other requirements as described by DSHS, and operate within the TVFC program in a manner intended to avoid fraud and abuse.
- Allow DSHS (or its contractors) to conduct scheduled and unannounced storage and handling visits.

The provider or the state may terminate the agreement at any time for failure to comply with the requirements listed above. If the agreement is terminated for any reason, the provider agrees to properly return any unused vaccine.

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B.3.4 How to Report Immunization Records to ImmTrac, the Texas Immunization Registry

Texas law requires all medical providers and payors to report *all immunizations* administered to clients who are 17 years of age and younger, to ImmTrac, the Texas immunization registry operated by DSHS (Texas Health and Safety Code §§161.007-161.009). Providers must report all immunization information within 30 days of administration of the vaccine, and payors must report within 30 days of receipt of data elements from a provider. Prior to reporting immunizations to ImmTrac, providers must first register for registry participation and access.

ImmTrac is a centralized repository of immunization histories for clients of all ages and is a free service and benefit available to all Texans. Registry information is confidential, and by law, may be released only to:

- The client or client's parent, legal guardian, or managing conservator.
- The client's physician, school, or licensed child-care facility in which the client is enrolled.
- Public health districts or local health departments.
- The insurance company, health maintenance organization, or other organization that pays for the provision of the client's health-care benefits.
- A health-care provider authorized to administer a vaccine.
- A state agency that has legal custody of the client.

ImmTrac offers two methods for reporting immunizations to DSHS: direct internet entry into ImmTrac's internet application and electronic data transfer (import).

B.3.4.1 Direct Internet Entry

This method allows providers to access and review clients' immunization histories prior to administering vaccines. Providers then update their client's immunization record directly into the ImmTrac web application after administering vaccines to the patient.

B.3.4.2 Electronic Data Transfer (Import)

This method allows providers to report immunizations from an electronic medical record (EMR) software application by extract file for import into ImmTrac. Providers may still have access to the ImmTrac web application to access and review their clients' immunization histories before administering any vaccines.

Regardless of reporting option selected, all providers must first register for ImmTrac access and receive login credentials from ImmTrac Customer Support. To register for ImmTrac access, providers may obtain and complete an ImmTrac Registration Packet (for providers and schools) from www.immtrac.com or request it from ImmTrac Customer Support at 1-800-348-9158.

B.3.4.3 Obtaining Parental Consent for Registry Participation

Before including a client's immunization information in ImmTrac, DSHS must verify that written consent for registry participation has been granted by the client's parent, legal guardian, or managing conservator. Most parents grant consent for ImmTrac participation during the birth certificate registration process. Written parental consent for ImmTrac participation applies to all past, present, and future immunizations. Texas law also permits a parent, managing conservator, or guardian to withdraw consent for ImmTrac participation at any time.

Providers may offer parents the opportunity to grant consent for their child's participation in ImmTrac using the pre-filled, ImmTrac-generated Immunization Registry (ImmTrac) Consent Form or the manual version (#C-7) of this form, also available from the ImmTrac application. Providers should retain the consent form and affirm parental consent through ImmTrac to establish the client's ImmTrac

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record and report all immunizations administered and add any historical immunization information to the client's record. Entering administered immunizations and historical immunization information to the client's record constitutes "reporting" to ImmTrac as required by current Texas law.

B.4 Texas Vaccines for Children Program Packet

Refer to: The DSHS website for TVFC information at www.dshs.state.tx.us/immunize/tvfc/default.shtm.

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APPENDIX C. LEAD SCREENING

C.1 Blood Lead Screening Procedures and Follow-up Testing

For all children enrolled in Texas Health Steps (THSteps) blood lead testing is mandatory when they are 12 months of age and 24 months of age, or whenever they receive their first checkup after these ages if blood testing was not completed (up to and including the 6-year checkup). Lead-risk assessment should be done at all other checkups through age 6, and may be performed using Form PB 110, Lead Risk Questionnaire. A "yes" or "don't know" answer to any question on the questionnaire indicates that a blood lead test should be administered. All blood lead levels in clients who are birth through 14 years of age must be reported to the Department of State Health Services (DSHS). Reports should include all information as required on the Texas Child Blood Lead Level Report Form F09-11709, which is available at www.dshs.state.tx.us/lead/providers.shtm or by calling 1-800-588-1248. Information related to blood lead screening and reporting for clients who are 15 years of age or older is available on the DSHS Blood Lead Surveillance Group's website at www.dshs.state.tx.us/lead/providers.shtm.

C.2 Symptoms of Lead Poisoning

Children who have EBLLs in the range of 5–45µg/dL may be asymptomatic, although impairment of neurodevelopment may become evident as they get older. Very high lead levels may cause colic, constipation, anorexia, or vomiting. Children with venous blood lead levels (BLLs) over 44µg/dL are eligible for medical intervention. However, it is important not to equate the absence of symptoms with the absence of toxicity.

C.3 * Measuring Blood Lead Levels

A blood lead test is the only definitive method to detect exposure. BLLs are measured as micrograms of lead per deciliter of whole blood (µg/dL). In Texas, a BLL requires medical case management and follow-up testing if the level is greater than or equal to 5 µg/dL.

Blood lead tests, in order of occurrence:

- Screening test—A blood lead test that indicates whether a client may have an EBLL. This test must be sent to the DSHS lab, or may be done using point-of-care technology in the provider's office.
- Diagnostic test—A venous blood lead test that is performed within recommended guidelines to determine the status of a client who has previously had an EBLL on a screening test (See subsection C.5, "Lead Poisoning Prevention Educational Materials and Forms" in this appendix for a link to form Pb-109 and recommended guidelines).
- Follow-up test—A venous blood lead test to monitor the status of a client with a previously elevated diagnostic test for lead.

> ***Note:*** *A follow-up test is not related to the THSteps follow-up visit. A visit to monitor a child with EBLL would be submitted as an acute care evaluation and management (E/M) visit.*

Providers are responsible for conducting a diagnostic test when a screening test finds a lead level of 5 µg/dL or greater. Blood for a screening test may be drawn from a venous or capillary site. A venous blood draw is strongly recommended and preferred. To order venous sample supplies from the DSHS Laboratory, call 1-888-963-7111, Ext. 7661.

> ***Note:*** *The capillary lead screen analysis is subject to a false positive result from skin lead contamination during collection. A soap and water wash of the patient's hands or feet and the collector's hands (or the wearing of gloves) must be performed to minimize the chance of contamination. Alcohol cleansing alone is not sufficient.*

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If the screening test is 5 µg/dL or above, recalling a client for a diagnostic sample may be billed as a THSteps follow-up visit. If the screening test was rejected due to clotting, insufficient quantities, or perceived contamination, the provider must repeat the sample as a diagnostic test. Again, the provider may bill the visit and analysis as an E/M visit. Providers can submit the specimen to the DSHS Clinical Chemistry Laboratory using the appropriate DSHS Laboratory Specimen Submission form (the same way as for all other THSteps laboratory blood specimens). If the initial blood lead test is collected as part of a THSteps medical checkup, it must either be sent to the DSHS lab or performed in the provider's office using point-of-care. The diagnostic and follow-up test for the same client may be sent to a private laboratory.

Refer to: Pb-109: *Reference for Blood Lead Retesting and Medical Case Management* on the DSHS website for interpretation of laboratory test results and guidelines for follow-up for clients with elevated blood lead levels.

Subsection 5.3.11.6.6, "Required Laboratory Tests Related to Medical Checkups" in this handbook.

Subsection 5.3.9, "Newborn Examination" in this handbook.

Providers can find more information about the medical and environmental management of lead-poisoned children on the DSHS Texas Childhood Lead Poisoning Prevention Program (TX CLPPP) website at www.dshs.state.tx.us/lead or by calling 1-800-588-1248.

C.4 Environmental Lead Investigation Services

C.4.1 Enrollment

State and local health departments that employ or contract certified lead risk assessors must be enrolled with Texas Medicaid as a THSteps provider to perform environmental lead investigation (ELI) services.

- State and local health departments that are currently enrolled in Texas Medicaid must complete the THSteps Provider Enrollment Application.
- State and local health departments that are not currently enrolled in Texas Medicaid must complete the Texas Medicaid Provider Enrollment Application and the THSteps Provider Enrollment Application.

C.4.2 Services, Benefits, Limitations, and Prior Authorization

ELI services must be billed with procedure code T1029, which is restricted to the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
T560X1A	T560X1D	T560X1S	T560X2A	T560X2D	T560X2S	T560X3A	T560X3D
T560X3S	T560X4A	T560X4D	T560X4S	Z77011			

Texas Medicaid may only reimburse a state or local health department for the certified lead risk assessor's time and activities during an onsite investigation of a client's home or primary residence. Laboratory analysis of environmental substances (e.g., water, paint, or soil) is not a benefit of Texas Medicaid.

Children who have confirmed and persistent EBLLs may require an ELI to determine the source of the lead exposure. An ELI is completed in a client's home or primary residence by a certified lead risk assessor to determine whether a lead hazard exists and, if so, whether the lead source could be the cause of the EBLL.

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C.4.2.1 Requesting an Environmental Lead Investigation

For the purpose of requesting an ELI, a health-care provider is a physician, nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA) who conducts blood lead tests for a THSteps client. Health-care providers may submit a request for an ELI after a blood lead test has been conducted and there is evidence of persistent and confirmed EBLLs for the client. An EBLL is defined as a BLL of 10µg/dL or higher.

An ELI may be considered medically necessary if the results of the most recent blood lead test indicate any of the following:

- A venous BLL result of 10µg/dL to 19µg/dL from two separate specimens conducted at least 12 weeks apart
- A venous BLL result of 20µg/dL or greater from one specimen

Note: *The ELI must be requested as soon as possible and no later than 30 days after obtaining the most recent BLL that indicates medical necessity. The health-care provider must maintain in the client's medical record the ELI request and the documentation of the BLL that indicates medical necessity.*

The health-care provider can request an ELI by completing Form Pb-101 "Environmental Lead Investigation Request" and submitting it to the TX CLPPP. TX CLPPP will review the request and determine whether the criteria for an ELI have been met. If an ELI request meets the TX CLPPP criteria, TX CLPPP sends a referral for an ELI to a state or local health department that is enrolled as a THSteps provider so that it can be assigned to a certified lead risk assessor. A certified lead risk assessor conducts an ELI using a completed Pb-103 Texas Elevated Blood Lead Level Investigation Questionnaire (all pages).

An ELI can be performed under one of the following circumstances:

- No previous investigation of the current home or primary residence has been performed.
- There is a change in the client's current home or primary residence.

If a previous investigation of the current home or primary residence has been performed and there has been a change in the client's residential environment, TX CLPPP will determine whether the criteria have been met for an additional ELI.

C.4.2.2 Prior Authorization

Prior Authorization is not required for ELI services.

C.4.3 Documentation Requirements

The state or local health department that is responsible for conducting the investigation must maintain the following documentation in the client's medical record:

- The TX CLPPP fax transmittal cover sheet that refers the ELI request to the local health department. The cover sheet must include:
  - The site to be assessed.
  - A statement that identifies the site as the client's primary place of residence.
- A completed Form Pb-101: Environmental Lead Investigation Request (two pages) that includes the:
  - Name of the referring health-care provider.
  - BLLs that indicate medical necessity.
  - Client's diagnosis.
- A completed Form Pb-103: Elevated Blood Lead Level Investigation Questionnaire (all pages) that includes the:

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- Date and location of the investigation.
- Name of the client who received the investigation.
- Identifying information and signature of the certified lead risk assessor who conducted the investigation. The person listed as the assessor must be the same person who signs the report.

Note: *Forms Pb-101 and Pb-103 are located on the TX CLPPP website at www.dshs.state.tx.us/lead/providers.shtm.*

C.4.4 Claims Filing and Reimbursement

C.4.4.1 Claims Filing

ELI services must be submitted to Texas Medicaid & Healthcare Partnership (TMHP) in an approved electronic format or on 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.

The following documentation must be submitted with the claim:

- The TX CLPPP fax transmittal cover sheet that refers the ELI request to the state or local health department. The cover sheet must include:
  - The site to be assessed.
  - A statement that identifies the site as the client's primary place of residence.
- A completed Form Pb-101: Environmental Lead Investigation Request.
- The first and last page of Form Pb-103: Elevated Blood Lead Level Investigation Questionnaire, which has been completed by the lead risk assessor.

An ELI is subject to retrospective review and may be recouped if the documentation maintained by the health-care and ELI providers does not support medical necessity.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information about electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" Section 6, "Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims.

C.4.4.2 Managed Care Clients

ELI services are carved-out of the Medicaid Managed Care Program and must be billed to TMHP for payment consideration. Carved-out services are those that are rendered to Medicaid Managed Care clients but are administered by TMHP and not the client's managed care organization (MCO).

C.4.4.3 Reimbursement

Providers can refer to the online fee lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

C.5 Lead Poisoning Prevention Educational Materials and Forms

Providers may download lead poisoning prevention education materials and forms from the Texas CLPPP website at www.dshs.state.tx.us/lead.

The following table lists materials available to providers for download:

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Lead Poisoning Prevention Materials	
1-26	Protect Your Children From Lead Poisoning (English and Spanish)
1-307	Lead Around the Home (English and Spanish)
1-308	Lead in Your Food and Remedies (English and Spanish)
1-311	How Lead Affects Your Child's Health (English and Spanish)
1-312	Educator's Brochure
1-313	Getting a Good Specimen (Poster)
1-315	Lead-Safe Cleaning Tips: Keep your home clean by following these tips weekly (English and Spanish)
09-13410	How Pica Affects a Pregnant Woman and Her Unborn Baby (English and Spanish)
Pb-100	Possible Sources of Lead Exposure: Interview Questions
Pb-101	Request for Environmental Investigation
Pb-102	Follow-up of an Elevated Blood Lead Level
Pb-103	Elevated Blood Lead Level Investigation Questionnaire
Pb-104	Physician Checklist for Parent Education Topics
Pb-109	Reference for Follow-up Blood Lead Testing and Medical Case Management
Pb-110	Lead Risk Questionnaire (English and Spanish)

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APPENDIX D. TEXAS HEALTH STEPS STATUTORY STATE REQUIREMENTS

D.1 Legislative Requirements

Several specific legislative requirements affect Texas Health Steps (THSteps) and the provider's participation in Texas Medicaid. The legislation includes, but is not limited to, those included in this Appendix.

D.2 Texas Health Steps (THSteps) Program

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is mandated by Title XIX of the Social Security Act. EPSDT is a program of prevention, diagnosis, and treatment for Medicaid-eligible clients who are birth through 20 years of age.

In Texas, EPSDT is known as THSteps. The Texas Department of State Health Services (DSHS), by authorization of Texas Department of Health and Human Services (HHSC), operates and administers the outreach and informing, medical and dental checkup, dental treatment utilization components of this program. State authority is found in Title 25 Texas Administrative Code (TAC), Part 1, Chapter 33, Subchapter A, Rule §33.1.

D.3 Communicable Disease Reporting

Diagnosis of sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV), are reportable conditions under 25 TAC, Chapter 97, Subchapter F. Providers must report confirmed diagnosis of STDs as required by 25 TAC §§97.132-134.

D.4 Early Childhood Intervention (ECI) Referrals

All health-care professionals are required by federal and state regulations to refer children who are birth through 35 months of age to the Texas ECI Program as soon as possible, but no longer than 7 days after identifying a disability or suspected delay in development.

Referrals can be based on professional judgment or a family's concern. A medical diagnosis or a confirmed developmental delay is not required for referrals.

To refer families for services, providers should use the ECI referral form available on the Texas Pediatric Society website at http://txpeds.org/sites/txpeds.org/files/documents/ECI-Referral-Form.pdf. Providers may also refer families for services by calling their local ECI program or the Department of Assistive and Rehabilitative Services (DARS) Inquiry Line at 1-800-628-5115.

To facilitate referrals for ECI services an optional form is available on the Texas Pediatric Society website at http://txpeds.org/sites/txpeds.org/files/documents/ECI-Referral-Form.pdf.

For additional ECI information, providers can visit the DARS website at www.dars.state.tx.us/ecis. Persons who are deaf or hard of hearing can call the TDD/TTY Line at 1-866-581-9328.

D.5 Parental Accompaniment

Texas Human Resource Code (HRC) §§32.024(s)-(2) requires that, as a condition for provider reimbursement, a client who is 14 years of age or younger be accompanied by the client's parent, guardian, or other authorized adult during medical and dental checkups and dental treatment. DSHS implemented this requirement through rules found in 25 TAC §33.2 (Definitions) and 25 TAC §33.6 (THSteps Provider Responsibilities).

The DSHS rules require that the parent, guardian, or authorized adult accompany the client to the checkup, and that the parent, guardian, or authorized adult must wait for the client while the checkup, treatment, or service takes place.

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Providers will not be required to submit documentation to TMHP to verify compliance with this policy in order for TMHP to process claims. By submitting the claim for reimbursement, the provider acknowledges compliance with all Medicaid requirements. Additional assurances are not necessary.

Exception: *School health clinics, Head Start programs, and childcare facilities are exempt from this policy if the clinic, program, or facility encourages parental involvement in the health care of the client and obtains written consent for the services. The consent from the client's parent or guardian must have been received within the one-year period before the date on which the services are provided and must not have been revoked.*

Refer to: HRC §§32.024(s)-(s-1) 25 TAC §33.2 and §33.6.

D.6 Newborn Blood Screening

The Health and Safety Code (HSC), Chapter 33, Section §33.011, implemented by the rules found at 25 TAC, Part 1, Chapter 37, Subchapter D, requires testing of all newborns. A current list of disorders can be found at www.dshs.state.tx.us/newborn/screened_disorders.shtm.

This testing is the responsibility of the physician who is attending a newborn client (defined as up to 30 days of age by rule in 25 TAC, Chapter 37, Subchapter D, §37.52) or the person who is attending the delivery of a newborn client who is not attended by a physician to screen for the disorders within 24 to 48 hours of birth.

All infants must be tested a second time at 1 to 2 weeks of age. If there is any doubt that a client who is 12 months of age or younger was properly tested, the provider should submit a blood sample with the appropriate DSHS Form NBS3 to the DSHS Newborn Screening Laboratory.

D.7 Abuse and Neglect

D.7.1 Requirements for Reporting Abuse or Neglect

Providers are required to report abuse or neglect as outlined in subsection 1.6, "Provider Responsibilities" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

Additionally, the General Appropriations Act, Article II, Rider 23 under DSHS, and Rider 13 under HHSC, of S.B. 1, 79th Legislative Regular Session, 2007, require that DSHS and HHSC distribute or provide appropriated funds only to recipients who show good faith efforts to comply with all child abuse and reporting requirements set forth in the Texas Family Code (TFC), Chapter 261, relating to investigations of reports of child abuse and neglect.

D.7.2 Procedures for Reporting Abuse or Neglect

Professionals, as defined in TFC §261.101 (b), are required to report abuse or neglect no later than the 48th hour after the hour in which the professional first has cause to believe the client has been or may be abused or is the victim of the offense of indecency with a child.

Nonprofessionals shall immediately make a report when the nonprofessional has cause to believe that the client's physical or mental health or welfare has been adversely affected by abuse.

A report must be made regardless of whether the provider staff suspects that a report may have previously been made. Reports of abuse or indecency with a child should be made to one of the following:

- Texas Department of Family and Protective Services (DFPS), if the alleged or suspected abuse involves a person responsible for the care, custody, or welfare of the child (DFPS Texas Abuse Hotline, 1-800-252-5400, 24 hours a day, 7 days a week).
- Call the DFPS Texas Abuse Hotline if:
  - You believe your situation requires action in less than 24 hours.
  - You prefer to remain anonymous.

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- You have insufficient data to complete the required information on the report.
- You do not want an email to confirm your report.

Note: *Providers can also report nonemergency abuse online at www.txabusehotline.org.*

- Any local or state law enforcement agency or the state agency that operates, licenses, certifies, or registers the facility in which the alleged abuse or neglect occurred.
- The agency designated by the court to be responsible for the protection of children.

The law requires that the report include the following:

- Name and address of the minor, if known.
- Name and address of the minor's parent or the person responsible for the care, custody, or welfare of the child if not the parent, if known.
- Any other pertinent information concerning the alleged or suspected abuse, if known.

A provider may not reveal whether the client has been tested or diagnosed with HIV or acquired immunodeficiency syndrome (AIDS). If the minor's identity is unknown (e.g., the minor is at the provider's office to receive testing for HIV or an STD anonymously), no report is required.

D.7.2.1 Staff Training on Reporting Abuse and Neglect

All providers shall develop training for all staff on the policies and procedures in regard to reporting child abuse, including sexual abuse and neglect. New staff shall receive this training as part of their initial training or orientation.

Training shall be documented. As part of the training, staff shall be informed that the staff person who conducts the screening and has cause to suspect abuse has occurred is legally responsible for reporting. A joint report may be made with the supervisor.

Several specific legislative requirements affect THSteps and the provider's participation in Texas Medicaid. The legislation includes, but is not limited to those included in this appendix.

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APPENDIX E. HEARING SCREENING INFORMATION

E.1 Texas Early Hearing Detection and Intervention (TEHDI) Process

The following processes for early hearing detection and intervention are addressed in this section:

- Birth screen
- Outpatient rescreen
- Evaluation using Texas Pediatric Protocol for Audiology
- Referral to an Early Childhood Intervention (ECI) program
- Periodic monitoring by the physician or medical home

Refer to: The *1-3-6 Month Practitioner's Guide* on the DSHS website.

E.1.1 Birth Screen

The hearing screen at birth will be either screening auditory brainstem response (ABR) or transient or distortion product otoacoustic emissions (OAE). The following items apply:

- A newborn's hearing is screened at the birth facility. If a newborn does not pass the screen, hearing is rescreened before discharge.
- The birth facility reports results to the Department of State Health Services (DSHS) using the web-based eScreener Plus (eSP™) system.
- The newborn's family and physician/medical home receive a written report of the hearing screen outcome.
- If a newborn passes the screen, the physician monitors hearing as part of well child checkups.
- If a newborn does not pass the second screen, a referral is made to a local resource who is experienced with the pediatric population for outpatient rescreen.

E.1.2 Outpatient Rescreen

If an outpatient rescreen is necessary, either ABR or OAE will be used. The following items apply:

- The physician/medical home receives the written report of results from the birth facility.
- The screener/physician reports results to the DSHS contractor, OZ Systems, using the web-based eSP™ system, by calling 1-866-427-5768 or faxing 1-817-385-3939.
- If the newborn passes the outpatient rescreen, the physician monitors hearing as part of well child checkups.
- If a newborn does not pass the outpatient rescreen, a referral is made to an audiologist for evaluation using the Texas Pediatric Protocol for Evaluation. Visit www.dshs.state.tx.us/audio/assumpt.shtm for more information.
- Hearing services for clients who are birth through 20 years of age are administered through the Texas Medicaid hearing services benefit. Clients may use the Online Provider Lookup (OPL) to locate a Texas Medicaid provider who provides hearing services for children (clients who are birth through 20 years of age).

E.1.3 Evaluation using Texas Pediatric Protocol for Audiology

These evaluations will include a diagnostic ABR and, if not previously done, a diagnostic OAE will be performed to determine cochlear involvement. The following items apply:

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- Audiologists use equipment norms for newborns, preferably ones that they have collected on their equipment.
- Protocols include air and bone conduction testing using tone burst ABR, as well as click ABR, so the amplification may be appropriately fit.
- The physician/medical home receives results and makes the referral to ECI using the web-based eSP™ system, by calling 1-800-628-5115, or by emailing the Texas Department of Assistive and Rehabilitative Services (DARS) at dars.inquiries@dars.state.tx.us.
- The physician/medical home monitors the child. See the *American Academy of Pediatrics Position Statement* at http://pediatrics.aappublications.org/cgi/content/full/113/Supplement_4/1545.
- The audiologist reports results to the DSHS contractor as noted above and makes the referral to ECI.
- Fitting of hearing aids by an audiologist when appropriate.
- Continued audiological assessment and monitoring as needed (usually monitor each three months for the first year of hearing aid use).

E.1.4 Referral to an ECI Program

The client will be referred to an ECI program by an audiologist or physician as soon as possible, but no longer than 7 days of identification of hearing loss as required by law. The following items apply:

- Service coordination provided by ECI.
- ECI will refer to the Local Education Agency (LEA) for auditory impairment (AI) services as outlined in the *Memorandum of Understanding between TEA and DARS ECI.*
- An evaluation and Individual Family Service Plan (IFSP) will occur within 45 days of referral to ECI.
- ECI services are available to clients birth through 35 months of age when determined by an IFSP.
- ECI and LEA will coordinate transition services upon the child's third birthday.

E.1.5 Periodic Monitoring by the Physician or Medical Home

The physician/medical home will continue to monitor the client periodically and may consult or use the following:

- Providers may refer to the Joint Committee on Infant Hearing (JCIH) 2007 Position Statement for suggested monitoring protocols at http://pediatrics.aappublications.org/cgi/content/full/120/4/898.
- Deaf education and other special education services available from 3 years of age through 20 years of age when determined by an individualized education program.
- Regional specialists from Deaf and Hard of Hearing Services at the Department of Assistive and Rehabilitative Services (DARS) will provide technical assistance to birth facilities, audiologists, and ear, nose, and throat (ENT) physicians to ensure reporting of screening and evaluation results. Providers can call 1-512-407-3250 for assistance.

E.2 JCIH 2007 Position Statement

The JCIH 2007 Position Statement is available on the JCIH website at www.jcih.org/posstatemts.htm. The 2007 Position Statement lists the indicators that are associated with permanent congenital, delayed-onset or progressive hearing loss in childhood.

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APPENDIX F. TEXAS HEALTH STEPS QUICK REFERENCE GUIDE

The Texas Health Steps Quick Reference Guide (THSTeps-QRG) is available on the TMHP website.

APPENDIX G. AMERICAN ACADEMY OF PEDIATRIC DENTISTRY PERIODICITY GUIDELINES

The American Academy of Pediatric Dentistry (AAPD) periodicity guidelines are available on the AAPD website at www.aapd.org.

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Clinics and Other Outpatient Facility Services Handbook

Texas Medicaid Provider Procedures Manual: Vol. 2

April 2016

TEXAS
Health and Human
Services Commission

CLINICS AND OTHER OUTPATIENT FACILITY SERVICES HANDBOOK

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1 General Information

This information is intended for Federally Qualified Health Centers (FQHCs) renal dialysis facilities, Rural Health Clinics (RHCs) and tuberculosis (TB) clinics. This handbook provides information about Texas Medicaid's benefits, policies, and procedures applicable to these providers. This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, refer to the *Texas Medicaid Managed Care Handbook*. Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in Subsection 17, "Carve-Out Services" in the *Texas Medicaid Managed Care Handbook*.

Important: *All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

1.1 National Drug Codes (NDC)

Refer to: Subsection 6.3.4, "National Drug Code (NDC)" in Section 6, "Claims Filing" *(Vol. 1, General Information)*.

1.2 Revenue Codes for UB-04 Submissions

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.

If the non-hospital provider is required to submit a procedure code for reimbursement, the provider must include the procedure code and an appropriate corresponding revenue code on the same detail, even if the chosen revenue code does not require a procedure code for claims processing.

Refer to: Subsection 4.5.5, "Outpatient Hospital Revenue Codes" in *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for a list of revenue codes that do and do not require procedure codes.

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 services were FQHC, RHC, THSteps, or some renal dialysis services.
- The hospital and the physician office or other entity are both owned by a third party, such as a health system.

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- The hospital is not the sole or 100-percent owner of the entity.

Refer to: Subsection 3.7.3.8, "Payment Window Reimbursement Guidelines" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about the payment window reimbursement guidelines.

2 Birthing Center

2.1 Provider Enrollment

A birthing center is a place, facility, or institution where a woman is scheduled to give birth following a normal, uncomplicated (low-risk) pregnancy. This term does not include a hospital, an ambulatory surgical center, or the residence of the woman giving birth.

A birthing center must be licensed as a birthing center by the Department of State Health Services (DSHS) and meet the minimum standards as required by the Texas Health and Safety Code, Chapter 244.010. To enroll in Texas Medicaid, a birthing center must be licensed to provide a level of service commensurate with the professional services of a doctor of medicine (MD), doctor of osteopathy (DO), certified nurse-midwife (CNM), or licensed midwife (LM) who acts as birth attendant. Texas Medicaid may reimburse birthing center providers only for those services that the attending physician or CNM determines to be reasonable and necessary for the care of the mother or newborn child.

Providers cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

Birthing centers are encouraged to refer clients for Texas Health Steps (THSteps) services.

Refer to: Section 1: Provider Enrollment and Responsibilities (*Vol. 1, General Information*) for more information about enrollment procedures.

Section 2, "Medicaid Title XIX Family Planning Services," in the *Gynecological and Reproductive Health and Family Planning Services Handbook* (*Vol. 2, Provider Handbooks*) for information on setting up referral procedures for family planning services.

The DSHS website (www.dshs.state.tx.us/famplan/) for information about family planning and the locations of family planning clinics receiving DSHS Family Planning Program funding from DSHS.

Subsection 9.2.46.14.1, "HIV Testing" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about required human immunodeficiency virus (HIV) testing for pregnant women.

2.2 Services, Benefits, Limitations, and Prior Authorization

Birthing centers may only be reimbursed by Texas Medicaid for their facility labor and delivery services using the following procedure codes:

Service	Procedure Code
Delivery	59409
Labor only	S4005

Note: *Deliveries at a facility licensed as a birthing center by DSHS must be billed with procedure code 59409.*

If the client is discharged prior to delivery, procedure code S4005 may be billed by the facility for labor services only.

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Refer to: Subsection 9.2.35, "Immunization Guidelines and Administration" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* for additional information about immunization administration.

2.2.1 Newborn Hearing Screening

The Texas Health and Safety Code, Chapter 47, requires birthing centers to offer all newborns a hearing screening as a part of the obstetrical care at delivery.

Refer to: Subsection 5.3.9, "Newborn Examination" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about the newborn hearing screening.

Subsection 2.2.2.3, "Abnormal Hearing Screening Results" in the *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about abnormal hearing screens.

2.2.2 Newborn Eligibility Process

If the mother of the newborn is eligible for Medicaid, the newborn may be assigned his or her own Medicaid number. The birthing center must complete form GN.4, "Birthing Center Report (Newborn Child or Children) (Form 7484)" to provide information about each child born to a mother who is eligible for Medicaid.

Refer to: Hospital Report (Newborn Child or Children) (Form 7484) on the TMHP website at www.tmhp.com.

If the newborn's name is known, the name must be on the form. The use of "Baby Boy" or "Baby Girl" delays the assignment of a number.

The form must be completed by the birthing center no later than five days after the child's birth. Birthing centers that submit the birth certificate information using the DSHS, Vital Statistics Unit (VSU) Texas Electronic Registrar for Birth software and the HHSC Form 7484 receive a rapid and efficient assignment of a newborn Medicaid identification number. This process expedites reimbursement to hospitals and other providers that are involved in the care of the newborn.

Additional information about obtaining a newborn Medicaid identification number can be found on the agency website at www.hhsc.state.tx.us/medicaid/mc/proj/newid/newid.html. Providers may also call 1-888-963-7111, Ext. 7368 or 1-512-458-7368 for additional information or comments about this process.

Upon receipt of a completed 7484 form, DSHS verifies the mother's eligibility and, within ten days of the receipt, sends notification letters to the hospital or birthing center, attending physician (if identified), mother, and caseworker. The notice includes the child's Medicaid identification number and the effective date of coverage. After the child has been added to the eligibility file, DSHS issues a Medicaid Identification card (Your Texas Benefits Medicaid card) to the client.

The attending physician's notification letter is sent to the address on file (by license number) at the Texas Medical Board. This address must be kept current to ensure timely notification. Physicians must submit address changes to the following address:

Texas Medical Board
Customer Information, MC-240
PO Box 2018
Austin, TX 78767-2018

2.2.3 Prior Authorization

Prior authorization is not required for services rendered in birthing centers.

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2.2.4 Services Rendered in the Birthing Center Setting

Maternity clinic, physician, CNM, LM, nurse practitioner (NP), clinical nurse specialist (CNS), and physician assistant (PA) providers who render prenatal or family planning services in the birthing center setting must submit separate claims.

Refer to: Subsection 9.2.46, "Obstetrics and Prenatal Care" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about birthing center providers.

2.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered.

Birthing center services are subject to retrospective review and recoupment if documentation does not support the service billed.

2.4 Claims Filing and Reimbursement

2.4.1 Claims Information

Claims for birthing center services must be submitted to Texas Medicaid & Healthcare Partnership (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, providers must include all required information on the claim, as TMHP does not key any information from attachments. Superbills or itemized statements are not accepted as claim supplements.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

2.4.2 Reimbursement

Birthing centers are reimbursed in accordance with 1 TAC §355.8181. See the applicable fee schedule on the TMHP website at www.tmhp.com. Texas Medicaid implemented mandated rate reductions for certain services.

Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

2.4.2.1 National Correct Coding Initiative (NCCI) and Medically Unlikely Edit (MUE) Guidelines

The Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes included in the *Texas Medicaid Provider Procedures Manual* are subject to National Correct Coding Initiative (NCCI) relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. The Centers for Medicare & Medicaid Services (CMS) NCCI and medically unlikely edits (MUE) guidelines can be found in the NCCI Policy and Medicaid Claims Processing manuals, which are available on the CMS NCCI web page. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

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In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

3 Comprehensive Health Center (CHC)

CHCs or physician-operated clinics are funded by federal grants. To apply for participation in Texas Medicaid, they must be certified and participate as health centers under Medicare (Title XVIII).

CHC claims are paid according to each center's encounter rates as established by CMS. Medicaid payments to CHCs are limited to Medicare deductible or coinsurance according to current guidelines. CHC providers that supply laboratory services in an office setting must comply with the rules and regulations for the Clinical Laboratory Improvement Amendments (CLIA). Providers that do not comply with CLIA are not reimbursed for laboratory services.

Refer to: Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 2.7, "Medicare Crossover Claim Reimbursement" (*Vol.1 General Information*).

Section 1: Provider Enrollment and Responsibilities (*Vol. 1, General Information*).

Section 4, "Federally Qualified Health Center (FQHC)," in this Handbook.

Section 7, "Rural Health Clinic," in this Handbook.

4 Federally Qualified Health Center (FQHC)

4.1 Enrollment

To enroll in Texas Medicaid, an FQHC must be receiving a grant under Section 329, 330, or 340 of the Public Health Service Act or designated by the U.S. Department of Health and Human Services (HHS) to have met the requirements to receive this grant. FQHCs and their satellites are required to enroll in Medicare to be eligible for Medicaid enrollment. The CMS has granted a waiver for the Medicare prerequisite at the time of initial enrollment of FQHC parents and satellites. FQHC look-alikes are *not* required to enroll in Medicare but may elect to do so to receive reimbursement for crossovers.

Refer to: Subsection 4.4.2.1, "Medicare Crossover Claims Pricing" in this handbook.

A copy of the Public Health Service's Notice of Grant Award reflecting the project period and the current budget period must be submitted with the enrollment application. A current notice of grant award must be submitted to TMHP Provider Enrollment annually.

FQHCs are required to notify TMHP of all satellite centers that are affiliated with the parent FQHC and their actual physical addresses. All FQHC satellite centers billing Texas Medicaid for FQHC services must also be approved by the United States Department of Health and Human Services Health Resources and Services Administration (HRSA). For accounting purposes, centers may elect to enroll the HRSA-approved satellites using a Federally Qualified Satellite (FQS) provider identifier that ties back to the parent FQHC provider identifier and tax ID number (TIN). This procedure allows for the parent FQHC to have one provider agreement and one cost report that combines all costs from all approved satellites and the parent FQHC. If an approved satellite chooses to submit claims to Texas Medicaid directly, the center must have a provider identifier separate from the parent FQHC and will be required to file a separate cost report.

All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as

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explained in 1 TAC §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

FQHC providers do not need to apply for a separate physician or agency number to provide family planning services.

Refer to: Subsection 1.1, "Provider Enrollment and Reenrollment" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment procedures.

FQHCs must identify and attest to all contractual agreements for those medical services in which the FQHC is receiving Prospective Payment System (PPS) reimbursement. This is a mandate from the 2012 to 2013 General Appropriations Act, H.B. 1, 82nd Legislature, Regular Session, 2011 (Article II, Health and Human Services Commission, Rider 78).

The attestation shall be made using the Federally Qualified Health Center Affiliation Affidavit, which is available on the TMHP website at www.tmhp.com.

4.1.1 Initial Cost Reporting

New FQHCs must file a projected cost report within 90 days of their designation as an FQHC to establish an initial payment rate. The cost report will contain the FQHC's reasonable costs anticipated to be incurred during the FQHC's initial fiscal year. The FQHC must file a cost report within five months of the end of the FQHC's initial fiscal year. The cost settlement must be completed within 11 months of the receipt of a cost report. The cost per visit rate established by the cost settlement process will be the base rate. Any subsequent increases will be calculated as provided herein.

FQHC providers are required to submit a copy of their Medicare-audited cost report for the provider's fiscal year within 30 days of receipt from Medicare to:

Texas Medicaid & Healthcare Partnership
Medicaid Audit
PO Box 200345
Austin, TX 78720-0345

A new FQHC location established by an existing FQHC participating in Texas Medicaid will receive the same effective rate as the FQHC establishing the new location. An FQHC establishing a new location may request an adjustment to its effective rate as provided herein if its costs have increased as a result of establishing a new location.

Refer to: Subsection 1.1, "Provider Enrollment and Reenrollment" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment procedures.

4.2 Services, Benefits, Limitations, and Prior Authorization

The services listed in the tables below may be reimbursed using the FQHC's National Provider Identifier (NPI). Any additional physician services must be submitted for reimbursement using the physician's Medicaid provider identifier. Hospital services are not considered for reimbursement to FQHC providers, and cannot be billed using the facility provider number assigned to the FQHC.

General Medical Services
T1015
General medical services must be submitted using one of the appropriate modifiers AH, AJ, AM, SA, TD, TE, TH, or U7.

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Adult Preventative Care					
99385	99386	99387	99395	99396	99397

Adult preventative care must be submitted with diagnosis codes Z000, Z0001, Z01411, and Z01419.

Case Management
G9012

Comprehensive visit must be submitted using modifiers U2 and U5.
Follow-up face-to-face visit must be submitted using modifiers TS and U5.
Follow-up telephone visit must be submitted using modifier TS.

Family Planning Services									
99201	99202	99203	99204	99205	99211	99212	99213	99214	99215
J7297	J7298	J7300	J7301	J7307					

Annual family planning examination must be submitted with modifier FP.

Mental Health Services									
90791	90792	90832	90833*	90834	90836*	90837	90838*	90847	90853
90865	96101	96118							

*** Procedures cannot be performed by Psychologist. Mental health services must be submitted using one of the appropriate modifiers AH, AJ, AM, U1, or U2.**

THSteps Dental Services									
D0120	D0140	D0145	D0150	D0160	D0170	D0180	D0330	D0340	D0350
D0367	D0470	D1110	D1120	D1208	D1351	D1510	D1515	D1520	D1525
D1555	D2140	D2150	D2160	D2161	D2330	D2331	D2332	D2335	D2390
D2391	D2392	D2393	D2394	D2750	D2751	D2791	D2792	D2930	D2931
D2932	D2933	D2934	D2940	D2950	D2954	D2971	D3220	D3230	D3240
D3310	D3320	D3330	D3346	D3347	D3348	D3351	D3352	D3353	D4277
D4278	D4283	D4285	D4341	D4355	D5211	D5212	D5281	D5610	D5630
D5640	D5650	D5660	D5670	D5671	D5720	D5721	D5740	D5741	D5760
D5761	D5992	D5993	D6549	D7140	D7210	D7220	D7230	D7250	D7270
D7286	D7510	D7550	D7910	D7970	D7971	D7997	D7999	D8050	D8060
D8080	D8210	D8220	D8660	D8670	D8680	D8690	D9110	D9211	D9212
D9223	D9230	D9243	D9248	D9930	D9974	D9999			

Procedure codes D8210, D8220, and D8080 must be submitted with Diagnostic Procedure Code (DPC) remarks codes for correct claims processing.

THSteps Medical Services									
99211	99381	99382	99383	99384	99385	99391	99392	99393	99394
99395	99420								

THSteps medical services must be submitted using modifier EP in addition to one of the appropriate modifiers AM, SA, or U7.
Note: Procedure code 99420 is a benefit for Texas Medicaid clients who are 12 through 18 years of age and is limited to once per lifetime.

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Vision Care Services									
92002	92004	92012	92014	92015	92020	92025	92060	92065	92081
92082	92083	92100	92120	92225	92226	92230	92235	92240	92250
92260	92265	92270	92275	92285	92286	92287	95060	95930	95933
S0620	S0621								

Copayments							
CP001	CP002	CP003	CP004	CP005	CP006	CP007	CP008

Refer to: Subsection 6.3.5, "Modifiers" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for a definition of modifiers.

Section 4, "Texas Health Steps (THSteps) Dental," and Section 5, "THSteps Medical," in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

Section 3, "Texas Women's Health Program," and Section 4, "Department of State Health Services (DSHS) Family Planning Program Services," in the *Gynecological and Reproductive Health and Family Planning Services Handbook (Vol. 2, Provider Handbooks)*.

Section 4, "Vision Care Professionals," in the *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*).

Section 4, "Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), and Licensed Professional Counselor (LPC)," in the *Behavioral Health, Rehabilitation, and Case Management Services Handbook (Vol. 2, Provider Handbooks)*.

Subsection 9.2.58.1.2, "Preventive Care Visits" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)*.

Section 6, "Physician, Psychologist, and Licensed Psychological Associate (LPA) Providers," in the *Behavioral Health, Rehabilitation, and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 6.12.2.2, "Health Maintenance Organization (HMO) Copayments" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

Medicaid coverage is limited to FQHC services that are covered by Texas Medicaid and are reasonable and medically necessary. When furnished to a client of the FQHC, medically necessary services include the following:

- CNM services
- Clinical psychologist services
- Clinical social worker services; other mental health services
- Dental services
- NP services
- Other ambulatory services included in Medicaid such as family planning, THSteps, and maternity service clinic (MSC)
- PA services
- Physician services
- Services and supplies necessary for services that would be covered otherwise, if furnished by a physician or a physician service

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- Vision care services
- Visiting nurse services to a homebound individual, in the case of those FQHCs located in areas with a shortage of home health agencies

Types of FQHC visits are defined in 1 TAC §355.8261. A visit is a face-to-face encounter between an FQHC client and a physician, PA, NP, CNM, visiting nurse, qualified clinical psychologist, clinical social worker, other health-care professional for mental health services, dentist, dental hygienist, or optometrist. Encounters that take place on the same day at a single location with more than one health-care professional or multiple encounters with the same health-care professional constitute a single visit, except where one of the following conditions exists:

- After the first encounter, the client suffers illness or injury requiring additional diagnosis or treatment.
- The FQHC client has a medical visit and an *other* health visit such as a qualified clinical psychologist, clinical social worker, other health professional for mental health services, a dentist, a dental hygienist, an optometrist, or a THSteps medical checkup.

All services provided that are incidental to the encounter, including developmental screening, must be included in the total charge for the encounter. They are not billable as a separate encounter.

Registered nurses may not be the sole provider of a medical checkup in an FQHC. If immunizations are given outside of a THSteps medical checkup, procedure codes given in the THSteps section of this manual should be used. These procedure codes are informational only, and are not payable.

To be reimbursed for Case Management for Children and Pregnant Women, an FQHC must be approved as a case management services provider by the DSHS Case Management Branch.

An annual family planning examination is allowed once per state fiscal year (September 1 through August 31), per client, per provider. An FQHC may be reimbursed for up to three family planning encounters per client, per year, regardless of the reason for the encounter. The three encounters may include any combination of general family planning encounters, an annual family planning examination, or intrauterine devices.

Family planning services must be submitted with the most appropriate evaluation and management (E/M) procedure code and one of the following family planning diagnosis codes:

Family Planning Diagnosis Codes							
Z30011	Z30013*	Z30014*	Z30018	Z3002	Z3009	Z302	Z3040
Z3041	Z3042	Z30430	Z30431	Z30432	Z30433	Z3049	Z308
Z309	Z9851	Z9852*					
***Not covered by the Women's Health Plan**							

Procedure code 58300 must be submitted on the same claim as J7297, J7298, J7300, and J7301. Procedure code 58300 will process as informational only. Only the annual family planning examination requires modifier FP. All other family planning visits do not require the FP modifier. Claims filed incorrectly may be denied.

Laboratory and radiology services or the services of a licensed vocational nurse (LVN), registered nurse (RN), nutritionist, or dietitian are *not* considered an encounter, because they are incidental to an encounter with one of the previously-mentioned payable health-care professionals. Providers should continue to include the cost associated with these services on their cost report (they are allowable but do not constitute an encounter).

Per federal regulations, the provider cannot submit claims to Medicaid or bill the client for vaccines obtained from the Texas Vaccine for Children (TVFC) Program.

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Refer to: Section 5, "THSteps Medical," in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

4.2.1 After-Hours Care

After-hours care for FQHCs is defined as care provided on weekends, on federal holidays, or before 8 a.m. and after 5 p.m., Monday through Friday. After-hours care provided by FQHCs does not require a referral.

4.2.2 Prior Authorization

Prior authorization or authorization may be required for FQHC services. Refer to the individual sections referenced on page 12.

4.2.3 Referral Requirements

Texas Medicaid fee-for-service limited clients, are allowed to choose any enrolled family planning provider.

4.3 Documentation Requirements

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.

4.4 Claims Filing and Reimbursement

4.4.1 *Claims Information

All services provided that are incidental to the encounter must be included in the total charge for the encounter and are not billable as a separate encounter. For example, if an office visit was provided at a charge of $30 and a lab test for $15, the center would submit a claim to TMHP for procedure code T1015 for $45 and would be reimbursed at the center's encounter rate. All services (except for family planning, THSteps medical, THSteps dental, copayments, vision, mental health services, and case management for high-risk pregnant women and infants) provided during an encounter must be submitted for reimbursement using procedure code T1015.

All providers of laboratory services must comply with the rules and regulations of CLIA. Providers who do not comply with CLIA are not reimbursed for laboratory services.

Refer to: Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

To obtain the encounter rate when submitting claims for family planning services that are provided under Title XIX or TWHP, FQHCs must use the most appropriate E/M procedure code, or procedure code J7297, J7298, J7300, and J7301, or J7307 with a family planning or TWHP diagnosis code. Providers must use procedure code J7297, J7298, J7300, or J7307 if the visit is for the insertion of an intrauterine device (IUD) or implantable contraceptive capsule. These procedure codes must be submitted in conjunction with the most appropriate informational procedure codes for services that were rendered. Procedure codes J7297, J7298, J7300, J7301, and J7307 may be reimbursed in addition to the FQHC encounter payment. When seeking reimbursement for an IUD or implantable contraceptive capsule, providers must submit on the same claim the procedure code for the family planning service provided and the procedure code for the contraceptive device. The contraceptive device is not subject to FQHC limitations. Providers must use modifier U8 when submitting claims for a contraceptive device purchased through the 340B Drug Pricing Program. Providers must use modifier FP only to submit claims for the annual family planning examination.

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If an employed physician of an FQHC provides a service in the hospital (e.g., a delivery), the service may be billed using the physician provider number if the terms of the FQHC and physician agreement indicate this occurrence. Physicians must be enrolled in Medicaid separately from the FQHC facility). Physicians are not allowed to bill through their FQHC group number for hospital services. The services will be reimbursed at the physician fee-for-service (FFS) fee schedule rate. The costs that are associated with these physician services must be excluded from the FQHC's cost report and will not be considered during the FQHC cost settlement or encounter rate setting process.

Services rendered in the (inpatient or outpatient) hospital setting are not considered a reimbursable FQHC encounter and are not payable to the FQHC. FQHC services for clients who have only Medicaid must be submitted to TMHP in approved electronic format or on a UB-04 CMS-1450, CMS-1500, or 2017 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. When completing a UB-04 CMS-1450 or 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 ADA Dental Claim Form can be downloaded at www.ada.org/7119.aspx.

The 2017 Claim Form can be found in the Forms section of this manual.

Refer to: 2017 Claim Form on the TMHP website at www.tmhp.com.

Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

Section 11, "Forms" in this handbook.

Claims must be filed as follows:

Services	Claim Form
THSteps medical services	UB-04 CMS-1450 or CMS-1500 paper claim form or approved electronic format
Family planning claims filed by FQHC providers who have contracted with DSHS	2017 Claim Form or approved electronic format
Family planning claims filed by FQHC providers not contracted with DSHS	UB-04 CMS-1450 or 2017 paper claim form or approved electronic format
THSteps dental services	American Dental Association (ADA) Dental Claim Form or approved electronic format
Case Management for Children and Pregnant Women services	UB-04 CMS-1450 or CMS-1500 paper claim form or approved electronic format

When filing for a client who has Medicare and Medicaid coverage, providers must file on the same claim form that was filed with Medicare.

Services provided by a health-care professional require one of the following modifiers with procedure code T1015, to designate the health-care professional providing the services: AH, AJ, AM, SA, TD, TE, or U7.

- If more than one health-care professional is seen during the encounter, the modifier must indicate the primary contact. The primary contact is defined as the health-care professional who spends the greatest amount of time with the client during that encounter.

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- If the encounter is for antepartum care or postpartum care, the modifier TH must be indicated on the claim in addition to any other appropriate modifier.
- If the antepartum or postpartum care is provided by a CNM, the modifier SA must be indicated on the claim in addition to any other appropriate modifiers.

Use modifier TD or TE for home health services provided in areas with a shortage of home health agencies.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

The Claim Form Examples page of the TMHP website at www.tmhp.com.

The *Gynecological and Reproductive Health and Family Planning Services Handbook* (*Vol. 2, Provider Handbooks*).

4.4.2 Reimbursement

FQHCs are reimbursed provider-specific prospective payment system encounter rates in accordance with 1 TAC §355.8261.

FQHCs are exempt from the mandated rate reductions except for DSHS Family Planning services.

Texas Medicaid implemented mandated rate reductions for certain services. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" and subsection 2.3, "Reimbursement Reductions" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

4.4.2.1 Medicare Crossover Claims Pricing

For Medicare Part B cost sharing obligations, all deductible obligations will be reimbursed at 100 percent of the deductible amount owed, even if the cost sharing comparison results in a lower payment. For all other cost sharing obligations (including Medicare Part A, B, and C), the cost sharing comparison is performed according to current guidelines.

For FQHC Medicare crossover claims, Texas Medicaid will reimburse the lesser of the following:

- The coinsurance and full deductible payment.
- The amount remaining after the Medicare payment amount is subtracted from the allowed Medicaid fee or encounter rate for the service. If this amount is less than the deductible, then the full deductible is reimbursed instead.

If the Medicare payment is equal to, or exceeds the Medicaid allowed amount or encounter payment for the service, Texas Medicaid will not make a payment for coinsurance.

The client has no liability for any balance or Medicare coinsurance and deductible related to Medicaid-covered services.

Refer to: Subsection 2.7, "Medicare Crossover Claim Reimbursement" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol.1 General Information*).

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4.4.2.2 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

5 Maternity Service Clinic (MSC)

MSCs are limited provider clinics that are unrelated to a hospital and that only provide maternity services. An MSC will be reimbursed for antepartum and/or postpartum care visits only. Hemoglobin, hematocrit and urinalysis procedures are included in the charge for antepartum care and not separately reimbursed. Services other than antepartum and postpartum care visits will be denied.

Refer to: Section 7, "Maternity Service Clinics (MSC)," in the *Medical and Nursing Specialists, Physicians and Physician Assistants Handbook (Vol. 2, Provider Handbooks).*

6 Renal Dialysis Facility

6.1 Enrollment

To enroll in Texas Medicaid, a renal dialysis facility must be Medicare-certified in the state where it is located. Facilities must also adhere to the appropriate rules, licensing, and regulations of the state where they operate.

Refer to: Subsection 1.1, "Provider Enrollment and Reenrollment" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information.

6.2 Services, Benefits, Limitations, and Prior Authorization

Renal dialysis is a benefit of Texas Medicaid for the following acute renal failure or end stage renal disease (ESRD) diagnosis codes:

Diagnosis Codes							
N170	N171	N172	N178	N179	N181	N182	N183
N184	N185	N186	N189				

All of the services, except for ultrafiltration (revenue code B-881), are diagnosis-restricted to the diagnoses in the above table.

Refer to: Subsection 9.2.49, "Organ/Tissue Transplants" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 3.2.5, "Organ and Tissue Transplant Services" in the *Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for information on organ transplant and facility services.

Dialysis treatments are a benefit for clients in an inpatient or outpatient hospital or a renal dialysis facility according to the guidelines for outpatient maintenance dialysis approved through CMS. Dialysis treatments may also be a benefit in the client's home. Outpatient dialysis includes:

- Staff-assisted dialysis performed by the staff of the center or facility.

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- Self-dialysis performed by a client with little or no professional assistance (the client must have completed an appropriate course of training).
- Home dialysis performed by an appropriately trained client (and the client's caregiver) at home.
- Dialysis furnished in a facility on an outpatient basis at an approved renal dialysis facility.

6.2.1 Physician Supervision

Physician reimbursement for supervision of ESRD clients on dialysis is based on a monthly capitation payment (MCP) that is calculated by Medicare. The MCP is a comprehensive payment that covers all of the physician services that are associated with the continuing medical management of a maintenance dialysis client for treatments received in the facility. An original onset date of dialysis treatment must be included on claims for all renal dialysis procedures in all places of service except inpatient hospital.

Physician supervision of outpatient ESRD dialysis includes services that are rendered by the attending physician in the course of office visits during which 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 that are involved in the prescription of therapy for illnesses that are unrelated to renal disease, if the treatment occurs without increasing the number of physician-client contacts

The following physician services are a benefit 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

Procedure codes 90935, 90937, 90945, and 90947 are a benefit for:

- ESRD or non-ERSD services in the inpatient setting when the physician is present during dialysis treatment. The physician must be physically present and involved during the course of dialysis. These codes are not payable for a cursory visit by the physician. Hospital visit procedure codes must be used for a cursory visit.
- Non-ERSD services when provided by a physician, nurse practitioner, clinical nurse specialist, or physician assistant in an office or outpatient setting.

Only one of the following procedure codes 90935, 90937, 90945, or 90947 may be reimbursed per day by any provider.

If the physician sees the client only when the client is not dialyzing, the physician must submit the appropriate hospital visit procedure code. The inpatient dialysis procedure code must not be submitted for payment.

Providers must use one of the following procedure codes to submit claims for services when the client:

- Is not on home dialysis.
- Has had a complete assessment visit during the calendar month.
- Has received a full month of ESRD related services

Procedure Codes									
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960

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Procedure Codes	
90961	90962

When a full calendar month of ESRD-related services are submitted for clients on home dialysis, providers must use procedure code 90963, 90964, 90965, or 90966.

Providers must submit claims with procedure code 90967, 90968, 90969, or 90970 if ESRD-related services are provided for less than a full month, per day, under the following conditions:

- Partial month during which a client who is not on home dialysis received one or more face-to-face visits but did not receive a complete assessment.
- A client who is 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 a client.
- Client received a kidney transplant.

Procedure codes 90967, 90968, 90969, and 90970 are limited to one per day by any provider. When submitting claims for these procedure codes, providers must indicate the dates of service on which supervision was provided.

Procedure codes 90967, 90968, 90969, and 90970 will be denied if they are submitted with dates of service in the same calendar month by any provider as the following procedure codes:

Procedure Codes									
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960
90961	90962	90963	90964	90965	90966				

Only one of the procedure codes in the previous table will be reimbursed per calendar month by any provider.

The following services may be provided in conjunction with physician supervision of outpatient ESRD dialysis but are considered nonroutine and may be submitted for reimbursement separately.

- Declotting of shunts when performed by the physician.
- Physician services to inpatients.

If one of the following occurs:

- A client is hospitalized during a calendar month of ESRD-related services before a complete assessment is performed.
- The client receives one or more face-to-face assessments, but the timing of inpatient admission prevents the client from receiving a complete assessment.

Then the physician must submit both of the following:

- Procedure code 90967, 90968, 90969, or 90970 for each date of outpatient supervision.
- The appropriate hospital evaluation and management code for individual services provided on the days during which the client was hospitalized.

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If a client has a complete assessment in the month during which the client is hospitalized, one of the following procedure codes must be submitted for the month of supervision:

Procedure Codes									
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960
90961	90962								

The appropriate inpatient evaluation and management codes must be reported for procedures provided during the hospitalization.

- Dialysis at an outpatient facility other than the usual dialysis setting for a client of a physician who bills the MCP. The physician must submit procedure code 90967, 90968, 90969, or 90970 for each date on which supervision is provided. The physician may not submit claims for days that the client dialyzed elsewhere.
- 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. Physicians may submit claims 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.

Inpatient services that are provided to a hospitalized client for whom the physician has agreed to submit monthly claims, may be reimbursed in one of the following ways:

- The physician may elect to continue monthly billing, in which case the physician may not bill for individual services that were provided to the hospitalized client.
- The physician may reduce the monthly amount submitted by 1/30th for each day of hospitalization and may charge fees for individual services that were provided on the hospitalized days.
- The physician may submit a claim for inpatient dialysis services using the inpatient dialysis procedure codes. The physician must be present and involved with the client during the course of the dialysis.

Clients may receive dialysis at an outpatient facility other than the client's usual dialysis setting, even if their physician bills for monthly dialysis coordination. The physician must reduce the monthly amount submitted for reimbursement by 1/30th for each day the client 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 must provide medical documentation with the claim that identifies how 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.

6.2.1.1 Unscheduled or Emergency Dialysis in a Non-Certified ESRD Facility

For some medical situations in which ESRD clients cannot obtain their regularly scheduled dialysis treatment at a certified ESRD facility, Texas Medicaid will allow for non-routine dialysis treatments furnished in the outpatient department of a hospital that does not have a certified dialysis facility.

Unscheduled dialysis for clients may be a benefit for one of the following reasons:

- Dialysis was performed following, or in connection with, a vascular access procedure.
- Dialysis was performed following treatment for an unrelated medical emergency (e.g., a client goes to the emergency room and, as a result, misses a regularly scheduled dialysis treatment that cannot be rescheduled).
- Emergency dialysis was performed for clients who would otherwise have to be admitted as inpatient in order for the hospital to receive payment.

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Providers must submit claims using procedure code G0257 with revenue code 880 in order to receive payment for unscheduled outpatient dialysis.

Procedure code G0257 is only reimbursed to clients with ESRD and 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.

Procedure code G0257 is limited to diagnosis codes N185 and N186 and is limited to one service per day, any provider.

Erythropoietin (procedure code Q4081) may be billed separately and must be billed with revenue code 634 or 635 on the same claim.

Texas Medicaid will provide a single payment to reimburse unscheduled or emergency dialysis treatments furnished to ESRD clients in the outpatient department of a hospital that does not have a certified ESRD facility.

Reimbursement for procedure code G0257 is limited to the same services included in the Method 1 composite. Providers will not be reimbursed for individual services related to dialysis.

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.

Reimbursement of other outpatient hospital services are only reimbursed if they are not related to the dialysis services and are determined to be medically necessary with supporting documentation.

6.2.2 Renal Dialysis Facilities-Method I Composite Rate

The composite rate includes all necessary equipment, supplies, and services for the client receiving dialysis whether in the home or in a facility. The facility's charge must not include the charge for the physician's routine supervision. Examples of services included in the composite rate include, but are not limited to:

- Cardiac monitoring—procedure code 93040 or 93041.
- Catheter changes—procedure code 36000 or 49421.
- Crash cart usage for cardiac arrest.
- Declotting of shunt (procedure code 36593) and any supplies used to declot shunts performed by facility staff in the dialysis unit.
- Dialysate—procedure code A4720, A4722, A4723, A4724, A4725, A4726, or A4765.
- Oxygen—procedure code E0424, E0431, E0434, E0439, E0441, E0442, E0443, or E0444.
- Routine laboratory services for dialysis.

  Note: *When one of these laboratory services is required more frequently, renal dialysis facility providers must submit the appropriate procedure code with modifier 91 for separate reimbursement.*

- Staff time to administer blood, separately billable drugs, and blood collection for laboratory—procedure code 36430 or 36591.
- Suture removal or dressing changes.
- Certain drugs such as those to elevate or decrease blood pressure, antiarrythmics, blood thinners or expanders, antihistamines or antibiotics to treat infections or peritonitis related to peritoneal dialysis are included in the composite rate. Examples include, but are not limited to:
  - Hydralazine—procedure code J0360

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- Diphenenhydramine—procedure code J1200
- Heparin—procedure code J1642 or J1644
- Dopamine—procedure code J1265
- Glucose
- Propranolol—procedure code J1800
- Insulin
- Digoxin—procedure code J1160
- Norepinephrine bitartrate
- Mannitol—procedure code J2150
- Procaine
- Protamine—procedure code J2720
- Saline—procedure code A4216 or A4217
- Hydrocortisone sodium succinate—procedure code J1720
- Verapamil

Medically necessary drugs that are not included in the composite rate may be separately reimbursed when provided by and administered in the dialysis facility by facility staff. Staff time and supplies used to administer the drugs are included in the composite rate. Examples include, but are not limited to, the following:

- Antibiotics, except when prescribed for clients to treat infections or peritonitis related to peritoneal dialysis
- Hematinics
- Anabolics
- Muscle relaxants
- Analgesics
- Sedatives
- Tranquilizers
- Erythropoietin
- Thrombolytics used to declot central venous catheters
- Intravenous levocarnitine (procedure code J1955), for ESRD clients who have been on dialysis for a minimum of three months with one of the following indications (All other indications for levocarnitine are not covered.):
  - Carnitine deficiency, defined as a plasma free carnitine level less than 40 micromoles per liter.
  - Signs and symptoms of erythropoietin-resistant anemia that has not responded to standard erythropoietin with iron replacement, and for which other causes have been investigated and adequately treated.
  - Hypotension on hemodialysis that interferes with delivery of the intended dialysis despite application of usual measures deemed appropriate (e.g., fluid management) (such episodes of hypotension must have occurred during at least two dialysis treatments in a 30-day period).

Note: *Continued use of levocarnitine is not covered if improvement has not been demonstrated within six months of the initiation of treatment.*

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The ordering physician must maintain documentation in the client's medical record to support medical necessity.

6.2.3 Method II Dealing Direct-Support Services

With Method II, the client selects and works with a single supplier to obtain supplies and equipment to dialyze at home. The selected supplier cannot be a dialysis facility, although the supplier must maintain a written agreement with a support dialysis facility to provide backup and support services. Method II support services are reimbursed under revenue codes 845 and 855.

Support services reimbursed monthly under Method II are limited to clients who are 20 years of age and younger, and include, but are not limited to:

- Periodic monitoring of a client's adaptation to home dialysis and performance of dialysis, including provisions for visits to the home or the facility.
- Visits by trained personnel for the 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.
- Individual 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 chronic ambulatory peritoneal dialysis (CAPD) also include, but are not limited to:
    - Changing the connecting tube and administration set.
    - Monitoring the client's performance of CAPD, assuring that it is done correctly, and reviewing proper techniques with the client or informing the client of modifications to 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).
    - Inspecting the catheter site.

Routine laboratory services are included in the support services and are not reimbursed separately.

Equipment and supplies are:

- Reimbursed under Method II to only one provider per month who must agree to submit claims once per month for only one month's quantity per claim.
- Limited to clients who are 20 years of age and younger.
- Reimbursed separately up to the total monthly allowable as determined by HHSC.

The following equipment, supply, and services procedure codes are benefits of Texas Medicaid under Method II:

Procedure Codes									
36000	36430	36591	36593	49421	93040	93041	A4216	A4217	A4651

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Procedure Codes									
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								

Installation and repair of home hemodialysis machines are not a benefit of Texas Medicaid. Home modifications for use of medical equipment are not a benefit of Texas Medicaid.

A Medicaid client may receive CAPD and continuous cycle peritoneal dialysis (CCPD) support services furnished by the facility on a monthly basis. Charges for support services in excess of this frequency must include documentation of medical necessity.

Clients may have a one month reserve of supplies available for use. Renal dialysis services beyond these limitations may be considered for clients who are 20 years of age and younger through the Comprehensive Care Program (CCP) with prior authorization.

6.2.4 Facility Revenue Codes

The following services are a benefit for renal dialysis centers billing under reimbursement methodology I composite rate or II dealing direct.

Service	Revenue Code	Description
Maintenance	821	Hemodialysis (outpatient/home)–composite or other rate
	831	Peritoneal Dialysis (outpatient/home)–composite or other rate
	841	CAPD (outpatient/home)–composite or other rate
	851	CCPD (outpatient/home)–composite or other rate
Training	829	Hemodialysis (outpatient/home)–other
	839	Peritoneal Dialysis (outpatient/home)–other
	849	CAPD (outpatient/home)–other
	859	CCPD (outpatient/home)–other
Support	845	CAPD (outpatient/home)–support services
	855	CCPD (outpatient/home)–support services
Miscellaneous	881	Miscellaneous dialysis–ultrafiltration

Method II is limited to clients who are 20 years of age or younger.

The facility charge must not include the charge for the physician's routine supervision.

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6.2.5 Training for Hemodialysis, Intermittent Peritoneal Dialysis (IPD), Continuous Cycle Peritoneal Dialysis (CCPD), and Chronic Ambulatory Peritoneal Dialysis (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 includes personnel services, parenteral items routinely used in dialysis, training manuals and materials, and routine dialysis laboratory tests.

No frequency limitation is applied to routine laboratory tests during the training period because these tests commonly are given during each day of training. Nonroutine laboratory tests performed during the training period may be reimbursed when documentation of medical necessity is submitted with the claim.

It may be necessary to supplement the patient's dialysis during 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 submitted for the same date of service.

6.2.6 Maintenance Hemodialysis

The facility composite rate applies when a chronic renal dialysis client receives hemodialysis in an approved renal dialysis facility. Reimbursement is based on the facility's per-treatment composite rate, as calculated by Medicare. Services included in the facility's charge are routine laboratory tests, personnel services, equipment, supplies, and other services associated with the treatment.

For hospitals to be reimbursed for maintenance hemodialysis, they must be enrolled as an approved dialysis facility with the appropriate provider identifier. When a client is admitted for hospitalization for no reason other than to receive maintenance renal dialysis, the dialysis services are considered outpatient services and are covered if the hospital has been designated as a CMS certified renal dialysis center.

6.2.7 Maintenance IPD

Maintenance IPD is usually performed in sessions of 10 to 12 hours duration, three times per week. It may also be performed in fewer sessions that are longer in duration. If more than three sessions occur in one week, the provider must supply documentation of medical necessity with the claim.

6.2.8 Maintenance CAPD and CCPD

Support services for maintenance furnished to clients receiving CAPD or CCPD in the home may be reimbursed to dialysis facilities. Home dialysis support services must be furnished by the facility in either the home or the facility. CAPD and CCPD support services are limited to once per day.

6.2.9 Laboratory and Radiology Services

All providers of laboratory services must comply with the rules and regulations of CLIA. Providers who do not comply with CLIA will not be reimbursed for laboratory services.

Refer to: Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

6.2.9.1 In-Facility Dialysis—Routine Laboratory

Laboratory testing may be obtained and processed in the renal dialysis facility or by an outside laboratory. Charges for routine laboratory tests performed according to the established frequencies in the following tables are included in the facility's composite rate submitted to Texas Medicaid regardless

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of where tests were processed. If the routine laboratory testing is processed by an outside laboratory, the outside laboratory will bill the renal dialysis facility. The renal dialysis facility will then submit a claim to Texas Medicaid unless the test results are inclusive tests.

If additional in-facility laboratory testing is medically necessary beyond the routine frequencies identified below, providers must bill with modifier 91 to indicate the billed laboratory procedure is medically necessary. The billing provider must also submit documentation supporting the medical necessity with the claim and maintain the documentation in the client's medical record.

Modifier 91 is used to indicate that a test was performed more than once on the same day for the same client only when it is necessary to obtain multiple results in the course of the treatment. This modifier may not be used to indicate any of the following:

- When tests are rerun to confirm initial results
- Testing problems with specimens or equipment
- When a normal one-time, reportable result is all that is required
- When there are standard Healthcare Common Procedure Coding System (HCPCS) codes available that describe the series of results (e.g., glucose tolerance tests, evocative/suppression testing, etc.).

Modifier 91 may only be used for laboratory tests paid under the clinical diagnostic laboratory fee schedule.

Per Dialysis

Procedure Codes			
85014	85018	85345	85347

Per Week

Procedure Codes		
82565	84520	85610

Per Month

Procedure Codes									
82040	82310	82374	82435	83615	84075	84100	84132	84155	84450
85025	85027								

The routine tests listed in the previous tables are frequently performed as an automated battery of tests such as the sequential multi-channel analysis with computer (SMAC)-12 (chemistry panels). These tests are considered routine and are included in the charge for dialysis, unless there is an additional diagnosis to document medical necessity for performing the tests in excess of the recommended frequencies.

6.2.9.2 In-Facility Dialysis—Nonroutine Laboratory

The following procedure codes are considered necessary, nonroutine tests. They must be submitted separately from the dialysis charge when performed in the renal dialysis facility or by an outside laboratory that bills the facility for laboratory services. All nonroutine laboratory and radiology tests beyond the recommended frequencies below must be medically necessary.

If additional in-facility laboratory testing is medically necessary beyond the nonroutine frequencies identified below, providers must submit the claim with modifier 91 to indicate the billed laboratory procedure is medically necessary. The billing provider must also submit documentation supporting the medical necessity with the claim and maintain the documentation in the client's medical record.

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Once a Month

Procedure Codes
87340

Every 3 Months

Procedure Codes
93005

Every 6 Months

Procedure Codes								
71010	71020	95907	95908	95909	95910	95911	95912	95913

Annually

Procedure Codes		
78300	78305	78306

A handling fee (procedure code 99001) for nonroutine laboratory services may be submitted to Texas Medicaid only if the specimen is obtained by venipuncture or catheterization and sent to an outside lab. The claim form must document that the handling fee is for nonroutine laboratory services.

6.2.9.3 CAPD Laboratory

The following laboratory tests are routine for home maintenance CAPD clients when performed according to the indicated frequency. These laboratory tests may be reimbursed separately when the client is dialyzing in the home and is not undergoing IPD or hemodialysis in the facility. The provider must indicate the client's diagnosis and the type of dialysis on the claim form. Tests in excess of this frequency or tests not listed in the tables require documentation of medical necessity for payment to be made.

Every Month

Procedure Codes									
82040	82310	82374	82565	83615	83735	84075	84100	84132	84155
84295	84450	84520	85018						

Every 3 Months

Procedure Codes					
85004	85007	85008	85014	85027	85041

Every 6 Months

Procedure Codes									
71010	71020	78300	78305	78306	80069	81050	95907	95908	95909
95910	95911	95912	95913						

6.2.9.4 Hematopoietic Injections

Medicaid reimbursement is allowed for hematopoietic injections that are administered to clients who have anemia that is associated with chronic renal failure.

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Providers must submit the client's most recent dated hemoglobin or hematocrit levels in the comments section of the claim form when billing with procedure code Q4081. Frequency and quantity limitations apply.

Refer to: Subsection 9.2.39.13, "Hematopoietic Injections" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information about benefit and limitation criteria.

6.2.9.5 Blood Transfusions

Whole blood transfusions may be reimbursed separately to dialysis facilities when medically indicated for a Medicaid eligible client.

6.2.10 Prior Authorization

Prior authorization is not required for renal dialysis services. Prior authorization must be obtained for transplant-related services provided to clients who are not eligible for Medicare and are eligible only for Medicaid.

6.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including renal dialysis services. Renal dialysis services are subject to retrospective review and recoupment if documentation does not support the service submitted for reimbursement. All physicians', renal dialysis centers', and medical suppliers' supporting documentation is subject to retrospective review.

6.4 Claims Filing and Reimbursement

6.4.1 Claims Information

Renal dialysis facility services must be submitted to TMHP in an approved electronic claims 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 them.

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.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Reminder: *The original onset date must be included on the claim form to prevent claim denial. The original onset date must be the same date entered on Form CMS-2728 sent to the Social Security office.*

6.4.2 Reimbursement

Renal dialysis facilities are reimbursed according to composite rates, which are based on the CMS-specified calculations and the Texas Medicaid Reimbursement Methodology (TMRM). Texas Medicaid may reimburse for dialysis services through either Method I or Method II as defined by CMS.

The hemodialysis, IPD, CAPD and CCPD laboratory and radiology services and the physician supervision of dialysis clients limitations pertain to both Method I and Method II reimbursement.

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Texas Medicaid implemented mandated rate reductions for certain services. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Refer to: Section 2.3, "Reimbursement Methodology" (*Vol. 1, General Information*) for more information about reimbursement.

6.4.2.1 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

6.5 Medicare and Medicaid

Medicaid coverage of a renal dialysis client who may be eligible for Medicare coverage begins with the original onset date of the dialysis treatments and may continue for a period of three months. During this period, Medicare eligibility is reviewed through the Health and Human Services Commission (HHSC). If HHSC determines that the client is Medicare-eligible, Medicaid coverage begins with the original onset date and continues until Medicare coverage begins.

If HHSC determines that the client is not eligible for Medicare, Medicaid coverage of eligible clients begins with the original onset date and continues as long as the dialysis treatments are medically necessary and the client is eligible for Medicaid. The date of onset is the date of the first dialysis treatment and does not change even if the client sees another provider.

Medicare eligibility usually begins after a three-month waiting period has been served. Medicare eligibility begins before the waiting period has expired if the individual receives a transplant or participates in a self-dialysis training program during the waiting period.

6.5.1 Facility Providers

Texas Medicaid pays the Medicare coinsurance less 5 percent and full Medicare deductible for Medicare crossover claims that are submitted by nephrology (hemodialysis, renal dialysis) and renal dialysis facility providers.

6.5.2 Physician Providers

The five percent reduction does not apply to physician-billed services. Nephrologists that are enrolled in Texas Medicaid as physician providers may be reimbursed according to the current payment guidelines.

Refer to: Subsection 2.7, "Medicare Crossover Claim Reimbursement" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. I, General Information*) for additional information about Medicare coinsurance and deductible reimbursement for professional and outpatient services.

7 Rural Health Clinic

7.1 Enrollment

To enroll in Texas Medicaid and qualify for participation as a Title XIX RHC, RHCs must be enrolled in Medicare. A nine-digit provider identifier is issued to the RHC after a certification letter from Medicare is received, stating that the clinic qualifies for Medicaid participation. An RHC can also apply for enrollment as a family planning agency.

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All providers of laboratory services must comply with the rules and regulations of CLIA. Providers who do not comply with CLIA are not reimbursed for laboratory services.

7.1.1 Initial Cost Reporting

New RHCs must file a projected cost report within 90 days of their designation as an RHC to establish an initial payment rate. The cost report will contain the RHC's reasonable costs anticipated to be incurred during the RHC's first full fiscal year. The projected cost report must contain a minimum of six months of information. The RHC must file a cost report within five months of the end of the RHC's initial fiscal year. The cost settlement must be completed within six months of the receipt of a cost report. The cost per visit rate established by the cost settlement process shall be the base rate. Any subsequent increases or decreases shall be calculated as provided herein. A new RHC location established by an existing RHC participating in Texas Medicaid will receive the same effective rate as the RHC establishing the new location. An RHC establishing a new location may request an adjustment to its effective rate as provided herein if its costs have increased as a result of establishing a new location.

Providers must submit initial cost reports to the following address:

Texas Medicaid & Healthcare Partnership
Medicaid Audit
PO Box 200345
Austin, TX 78720-0345

Providers can refer to 1 TAC §355.8101 for more information about reimbursement.

Refer to: Subsection 1.1, "Provider Enrollment and Reenrollment" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information.

Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

7.2 Services, Benefits, Limitations, and Prior Authorization

7.2.1 Services Rendered by the RHC Facility Provider

General services and copayments are billed using the RHC's National Provider Identifier (NPI). All other services billed using the RHC's NPI are processed as informational only.

Important: *If an RHC facility provider submits a claim for THSteps and Family Planning services, the services will process as informational only and will not be reimbursed.*

The following services are benefits of Texas Medicaid when provided in an RHC:

- Physician services
- Services and supplies furnished as incidental to physician services
- Services provided by an NP, a CNM, a clinical social worker, or a PA's services
- Services and supplies furnished as incidental to the NP's or PA's services
- Visiting nurse services on a part-time or intermittent basis to homebound clients in areas determined to have a shortage of home health agencies (A homebound client is someone who is permanently or temporarily confined to his place of residence, not including a hospital or skilled nursing facility (SNF), because of a medical condition.)

When an RHC bills for visiting nurse services, the written plan of treatment to be used for the visiting nurse must be developed by the RHC supervising physician. It must be approved and ordered by the client's treating physician if different from the supervising physician. The plan of treatment must be reviewed and approved by the supervising physician of the clinic at least every 60 days.

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A *visit* is a face-to-face encounter between an RHC client and a physician, PA, NP, CNM, visiting nurse, or clinical NP. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except where one or the other of the following conditions exists:

- After the first encounter, the client suffers illness or injury requiring additional diagnosis or treatment.
- The RHC client has a medical visit and an *other* health visit.

An *other* health visit includes, but is not limited to, a face-to-face encounter between an RHC client and a clinical social worker.

For freestanding RHCs, all laboratory services provided in the RHC's laboratory are included in the encounter. This includes the basic laboratory tests as well as any other laboratory tests provided in the RHC laboratory. Consequently, there is no separate billing for laboratory services. However, if the RHC laboratory becomes a certified Medicare laboratory with its own supplier number, and enrolls in Medicaid as an independent laboratory, all laboratory tests (except the basic laboratory tests) performed for RHC and non-RHC clients can be billed to Medicaid. The claim must be filed under their independent laboratory Medicaid provider identifier and using the appropriate HCPCS codes.

Refer to: The Medicare website at www.cms.gov for more information about Medicare RHC laboratory requirements.

7.2.1.1 Encounter Rates

An encounter rate may be reimbursed to the RHC facility only for the following services:

General Medical Services (encounter may be reimbursed to the RHC facility only)
T1015
General medical services must be submitted using one of the appropriate modifiers AJ, AM, SA, TD, TE, or U7. Adult preventative care must be submitted with diagnosis codes Z0000, Z0001, Z01411, and Z01419.

Note: *If the encounter is for antepartum or postpartum care, use modifier TH in addition to the modifier required to clarify the service that was performed.*

7.2.1.2 Medicaid Fee-for-Service Reimbursement Rates

The following copayments may be reimbursed to RHC providers billing under their own NPI, and are reimbursed at the Medicaid fee-for-service rate.

Copayments			
CP001	CP002	CP005	CP006

7.2.1.3 Freestanding Rural Health Clinic Services

The services listed below cannot be reimbursed to freestanding RHCs using only the RHC provider identifier. Use of the RHC provider identifier for billing these services causes claims to be processed as informational only. Services in any of these categories must be billed using the professional (non-RHC) provider identifier and the appropriate benefit code:

- THSteps medical checkups, which includes immunizations
- Family planning services (including implantable contraceptive capsules provision, insertion, or removal)

These services must be billed with an AM, SA, or U7 modifier.

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Physician supplies are not a benefit of Texas Medicaid. Costs of supplies are included in the reimbursement for office visits. Outpatient hospital services (including emergency room services) and inpatient hospital services provided outside the RHC setting are to be billed using the individual or group physician provider identifier.

Exception: *If later in the same day the client suffers an additional illness or injury requiring diagnosis or treatment, the clinic may submit a claim for a second visit.*

Freestanding RHCs submit an all-inclusive encounter for services provided. All services provided that are incidental to the encounter, including developmental screening, must be included in the total charge for the encounter. A claim for these services may not be submitted as a separate encounter.

If immunizations are given outside of a THSteps medical checkup, procedure codes given in the THSteps section of this manual should be identified on the claim. These procedure codes are informational only, and are not payable.

All services provided during a freestanding 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. If the encounter is for antepartum or postpartum care, use modifier TH in addition to the modifier required to designate the health-care professional providing the service.

Reminder: *The primary initial contact is defined as "the health-care professional who spends the greatest amount of time with the client during that encounter."*

If more than one health-care professional is seen during the encounter, the modifier (if appropriate) must indicate the primary contact. For example, if an NP or a PA performs an antepartum exam, modifiers SA or U7, and TH, must be entered. A maximum of two modifiers may be reported with each encounter.

Providers who render services in an RHC setting for THSteps Medical services or Family Planning services may be reimbursed an encounter rate.

THSteps Medical Services

RHC facility providers may be reimbursed for THSteps medical services using their RHC NPI with the appropriate benefit code.

If the appropriate benefit code is not included, the service will process as informational only and will not be reimbursed.

THSteps Medical Services									
99381	99382	99383	99384	99385	99391	99392	99393	99394	99395
THSteps medical services must be billed using modifier EP and one of the following modifiers: AM, SA, or U7.									

7.2.1.4 Family Planning Services

RHC facility providers may be reimbursed for family planning services using their RHC NPI with the appropriate benefit code.

If the appropriate benefit code is not included, the service will process as informational only and will not be reimbursed.

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Family planning services must be submitted with the most appropriate evaluation and management (E/M) procedure code and the most appropriate family planning diagnosis code:

Family Planning Services*									
99201	99202	99203	99204	99205	99211	99212	99213	99214	99215
J7297	J7298	J7300							
*** Family planning services performed in the RHC setting must be billed with the appropriate modifier: AM, SA, or U7.**									

Refer to: Subsection 4.2, "Services, Benefits, Limitations, and Prior Authorization" in this handbook for the list of family planning diagnosis codes.

Subsection 6.3.5, "Modifiers" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for a definition of modifiers.

Section 9, "Physician," in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Section 5, "THSteps Medical," in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

Section 2, "Medicaid Title XIX Family Planning Services," in the *Gynecological and Reproductive Health and Family Planning Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 6.12.2.2, "Health Maintenance Organization (HMO) Copayments" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

Subsection 9.2.58.1.2, "Preventive Care Visits" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

7.2.2 Services Rendered by Non-RHC Providers In An RHC Setting

Non-RHC providers (i.e., physicians and non-physician practitioners) submitting claims for THSteps and Family Planning services in the RHC setting must use their own NPI and the appropriate benefit code.

The following services, when rendered in an RHC setting by a non-RHC provider, will process as an encounter and will be reimbursed to the non-RHC provider as an encounter rate equivalent to the host facility:

- THSteps medical services
- Family planning services

Non-RHC providers rendering services in an RHC setting must use the appropriate national place of service (72) in order for claims to process as encounters.

7.2.3 Hospital-Based Rural Health Clinic Services

Hospital-based RHCs must use the encounter code T1015. A hospital-based RHC is paid based on an all-inclusive encounter rate. One of the following modifiers must be submitted for general medical services: AH, AJ, AM, SA, TD, TE, or U7.

The services listed below must be submitted using the physician's Texas Provider Identifier (TPI) and the appropriate benefit code:

- THSteps medical checkups
- Family planning services (including implantable contraceptive capsules provision, insertion, or removal)

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- Immunizations provided in hospital-based RHCs

Note: *Refer to the tables in the above sections for procedure codes.*

These services must be submitted with an AM, SA, or U7 modifier if performed in an RHC setting. Claims are paid under the PPS reimbursement methodology. When submitting a claim on the CMS-1450 paper claim form, providers must use the appropriate national POS (72) for an RHC setting.

Outpatient hospital services (including emergency room services) and inpatient hospital services provided outside the RHC setting are to be submitted using the individual or group physician provider identifier. Hospital-based RHCs must submit claims for pneumococcal and influenza vaccines as non-RHC services, under their hospital provider identifier.

7.2.3.1 After-Hours Care

After-hours care for RHCs is defined as care provided on weekends, federal holidays, or before 8 a.m. and after 5 p.m., Monday through Friday.

7.3 Prior Authorization

Prior authorization or authorization is not required for RHC services.

7.4 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including RHC services. RHC services are subject to retrospective review and recoupment if documentation does not support the service billed.

7.4.1 Record Retention

Freestanding RHCs must retain their records for a minimum of six years. Hospital-based RHCs must retain their records for a minimum of ten years.

7.5 Claims Filing and Reimbursement

7.5.1 Claims Information

General services and copayments are billed using the RHC's NPI. For all other services, providers must submit claims using their NPI and the appropriate benefit code.

Refer to: Subsection 8.2, "Services, Benefits, Limitations, and Prior Authorization" in this handbook.

Place of service 72 must be used on all claims when billing for services other than general medical. Benefit code EP1 must be used on claims for THSteps medical services.

Freestanding and hospital-based RHC services 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 TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

7.5.2 Reimbursement

Freestanding and hospital-based RHCs are reimbursed provider-specific per visit rates calculated in accordance with 1 TAC §355.8101. Texas Medicaid implemented mandated rate reductions for certain services. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

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7.5.2.1 Medicare Crossover Claims Pricing

For Medicare Part B cost sharing obligations, all deductible obligations will be reimbursed at 100 percent of the deductible amount owed, even if the cost sharing comparison results in a lower payment. For all other cost sharing obligations (including Medicare Part A, B, and C), the cost sharing comparison is performed according to current guidelines.

For RHC Medicare crossover claims, Texas Medicaid will reimburse the lesser of the following:

- The coinsurance and full deductible payment.
- The amount remaining after the Medicare payment amount is subtracted from the allowed Medicaid fee or encounter rate for the service. If this amount is less than the deductible, then the full deductible is reimbursed instead.

If the Medicare payment is equal to, or exceeds the Medicaid allowed amount or encounter payment for the service, Texas Medicaid will not make a payment for coinsurance.

The client has no liability for any balance or Medicare coinsurance and deductible related to Medicaid-covered services.

Refer to: Subsection 2.7, "Medicare Crossover Claim Reimbursement" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol.1 General Information*).

7.5.2.2 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

8 Tuberculosis Services

TB clinics must be enrolled in Texas Medicaid and provide services in accordance with 1 TAC, §354.1371.

8.1 Enrollment

To enroll in Texas Medicaid, a TB clinic must be either:

- A public entity operating under an HHSC tax identification number (TB regional clinic)
- A public entity operating under a non-HHSC tax identification number (city/county/local clinic)
- A non-hospital-based entity for private providers

Providers of TB-related clinic services must complete a provider application from the TB Services Branch within DSHS. Per Texas DSHS policy, TB clinics must develop and operate under a set of written policies and procedures that specify the criteria for licensed and non-licensed staff to provide services. The policies and procedures must include the following:

- The personnel file requirements for staff who provide directly observed therapy (DOT).
- The training and supervision that are required for outreach workers to be considered qualified to perform the assigned services.
- The written delegation protocol for services that are not performed by a physician, advanced practice registered nurse (APRN), or PA.

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- The documentation that is required for all client encounters.

Upon written notice of approval by TB Services Branch, Medicaid enrollment applications from TMHP Provider Enrollment are sent to HHSC-approved providers of TB-related clinic services.

TMHP is responsible for issuing a group or individual a nine-digit provider identifier. Providers that list additional (satellite) clinics in the TB Services Branch provider application will receive nine-digit performing provider identifiers for each off-site clinic. TB off-site clinics operating under the jurisdiction of the applying provider must use the assigned group provider identifier and their nine-digit performing provider identifier.

Enrollment as a Medicaid provider is not complete until the TMHP enrollment packet has been finalized and a nine-digit provider identifier number is issued to the provider.

The effective date for participation is the date an approved provider application with the TB Services Branch is established.

To receive a TB Services Branch provider application form or provider supplement, send a request to the following address:

Texas Department of State Health Services
TB/HIV/STD/Viral Hepatitis Unit
Tuberculosis Services Branch
Mail Code 1939
1100 West 49th Street
PO Box 149347
Austin, TX 78714-9347

Refer to: Subsection 1.1, "Provider Enrollment and Reenrollment" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment procedures related to the TMHP Medicaid enrollment applications.

8.1.1 Managed Care Program Enrollment

TB clinics do not need to enroll with the Medicaid managed care health plans. All services provided by TB clinics are submitted to TMHP for all Medicaid clients, including Medicaid managed care clients.

8.2 Services, Benefits, Limitations, and Prior Authorization

The level of service provided varies depending on whether the services are delivered by a nonphysician or physician and if medications are prescribed.

8.2.1 TB-Related Clinic Services

The following services may be performed by a physician, APRN, or PA in the TB clinic:

Procedure Codes									
99201	99202	99203	99204	99205	99211	99212	99213	99214	99215

A physician's presence is not required to perform procedure code 99211; however, the physician must provide direct supervision by being present in the clinic and immediately available to furnish assistance and direction at the time service is provided.

Before TB treatment can be initiated, an initial screening (procedure code T1023) by an RN, LPN, or LVN, or a new patient physician E/M visit (procedure code 99201, 99202, 99203, 99204, or 99205) must be performed. If the treatment is initiated by a nursing screening, a new patient physician E/M visit must be completed within 90 days, or subsequent reimbursement for DOT (procedure code H0033) will be denied.

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Following the initial new patient physician E/M visit, an established patient physician E/M visit (procedure code 99212, 99213, 99214, or 99215) must be billed every 90 days throughout the course of treatment, or subsequent reimbursement for DOT (procedure code H0033) will be denied.

Clients with latent TB infection, including those in a high-risk group (children who are 4 years of age and younger, those who are immunocompromised, and clients who are HIV-positive), and those with active TB disease, must be seen by a physician every 90 days throughout the course of treatment.

A physician must evaluate each client with active or latent TB disease prior to discharge from TB treatment.

Procedure codes H0033, T1002, T1003, and T1023 may be provided under established clinic protocols.

The initial TB screening (procedure code T1023), performed by an RN, LPN, or LVN includes, but is not limited to the following:

- Brief mental and physical assessment
- Exposure history
- Referral for lab or X-ray per protocol
- Referral for social or other medical services
- Other assessment

Procedure code T1023 may be reimbursed prior to the client being seen by a physician, and no more often than once per 12 months. One RN or LVN/LPN (procedure codes T1023, T1002, and T1003) service may be reimbursed per day, per client, when physician services are not performed.

Subsequent nursing services (Procedure code T1002 and T1003) may be a benefit when not provided the same day as a physician E/M visit.

Reimbursement for DOT services (procedure code H0033) provided in the clinic or other places of service, excluding inpatient hospitals, SNFs, intermediate care facilities (ICFs), outpatient hospitals, independent laboratories, birthing centers, and extended care facilities will be limited to one per day, and a maximum of five per week, per client, throughout the course of treatment.

Procedure codes T1002 and T1003 are limited to a maximum of eight 15-minute units per day, per client.

- Minutes of nursing services cannot be accumulated over multiple days. Minutes of nursing services can only be billed per calendar day.
- If the total number of minutes of nursing services per procedure code is less than 8 minutes for a calendar day, then no unit of service can be billed for that day. The minutes cannot be added to minutes of nursing services from any previous or subsequent days for billing purposes.
- If more than 1 unit of service is billed, every unit except the last must be for the complete 15 minutes, with the last unit being no less than 8 minutes of nursing service.
- Time spent in contact investigations in not reimbursable.

Reimbursement for new client examinations (procedure code 99201, 99202, 99203, 99204, and 99205) are limited to new clients who have not received services in the same clinic for a period of three years.

One physician E/M service may be reimbursed per day, per client.

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8.2.2 Ancillary Services

The following ancillary TB services are a benefit of Texas Medicaid:

Procedure Codes									
71010	71020	71021	71022	71030	71035	81025	86580	86701*	86703*
89220	96365	96366	96367	96368	96374	96375	99000	99001***	J0278
J1840	J1956	J2020**	J2280**	J3000**					

***Must be billed with QW modifier**

****Must be billed with KX modifier when oral formulation is not appropriate for the client**
***** No longer reimbursed for TB services rendered in an office setting. Limited to services rendered in an outpatient hospital only.**

Certain injectable TB medications (procedure codes J2020, J2280, and J3000), which also have an oral formulation, must be billed with modifier KX to indicate that the oral formulation is not appropriate for the client.

All drugs for which Medicaid is billed must have been purchased by the TB clinic. In the event that the clinic received the drug at no cost through DSHS or another source, it cannot be billed to Texas Medicaid. All medication claims are subject to retrospective review.

Handling or conveyance of a specimen from the patient in the clinic to a laboratory (procedure code 99001) will be reimbursed only when submitted with one of the following professional or nursing services performed on the same date of service. Procedure code 99000 for Tuberculosis (TB) Clinics is a benefit of Texas Medicaid for services rendered in an individual or group TB clinic. Prior authorization is not required for procedure code 99000.

Procedure Codes									
99201	99202	99203	99204	99205	99211	99212	99213	99214	99215
T1002	T1003*	T1023							

*** Reimbursed for individual or group TB clinics for services rendered in the home or other setting.**

8.2.3 Prior Authorization

Prior authorization is not required for TB-related services.

8.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including TB services. TB services are subject to retrospective review and recoupment if documentation does not support the service billed.

8.4 Provider Responsibilities

If approved to submit claims as a TB clinic under Texas Medicaid, the provider must adhere to the following requirements:

- Be a facility that is not an administrative, organizational, or financial part of a hospital, but is organized and operated to provide medical care to outpatients.
- Comply with all applicable federal, state, and local laws and regulations.

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- Employ or have a contract or formal arrangement with a licensed physician (M.D. or D.O.) who is responsible for providing medical direction and supervision over all services provided to the clinic's clients. To meet this requirement, a physician must see the client at least once every 90 days to prescribe the type of care provided and, if the services are not limited by the prescription, periodically review the need for continued care.
- Adhere to the guidelines issued by HHSC, under the authority of the Texas Health and Safety Code, and ensure that services are consistent with the recommendations of the American Thoracic Society and the Centers for Disease Control and Prevention (CDC). For more information, visit the website at www.cdc.gov/tb/default.htm.
- Maintain complete and accurate medical records of each recipient's care and treatment and accurately document all services provided and the medical necessity for the services.
- Ensure that services provided to each client are commensurate with the client's medical needs based on the client's assessment or evaluation, diagnostic studies, plan of care, and physician direction. These services must be documented in the client's medical records.
- Be enrolled and approved for participation in Texas Medicaid.
- Sign a written provider agreement with HHSC or its designee. By signing the agreement, the provider of TB-related clinic services agrees to comply with the terms of the agreement and all requirements of Texas Medicaid including regulations, rules, handbooks, standards, and guidelines published by HHSC or its designee.
- Submit claims for services covered by Texas Medicaid in the manner and format prescribed by HHSC or its designee.
- Be organized and operated to provide TB-related services, which include, but are not limited to, the covered services as indicated in subsection 8.2, "Services, Benefits, Limitations, and Prior Authorization" in this handbook.
- Not provide services within an SNF, ICF, or intermediate care facility for persons with intellectual disability (ICF-ID)

Refer to: Subsection 1.1, "Provider Enrollment and Reenrollment" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information.

8.5 Claims Filing and Reimbursement

8.5.1 Claims Information

TB-related clinic services must use benefit code TB1 on all claims and authorization requests. All TB-related clinic services must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 paper claim form from the vendor of their choice. TMHP does not supply them. 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: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*).

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

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8.5.1.1 Managed Care Clients

TB-related services are carved out of the Medicaid Managed Care Program and must be billed to TMHP for payment consideration. Carved-out services are those that are rendered to Medicaid Managed Care clients, but are administered by TMHP and not the client's MCO.

8.5.2 Reimbursement

The Medicaid reimbursement rates for TB clinics are calculated in accordance with 1 TAC §355.8081.

X-ray services are reimbursed in accordance with 355.8081 and are listed in the current physician fee schedule on the TMHP website at www.tmhp.com. Texas Medicaid implemented mandated rate reductions for certain services. The Online Fee Lookup (OFL) and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

8.5.2.1 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the *Texas Medicaid Provider Procedures Manual*. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

9 Claims Resources

Refer to the following sections or forms when filing claims:

Resource	Location
Automated Inquiry System (AIS)	TMHP Telephone and Fax Communication (*Vol. 1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5 (*Vol. 1, General Information*)
2012 American Dental Association (ADA) Dental Claim Filing Instructions	Subsection 6.7 (*Vol. 1, General Information*)
Appendix A: State, Federal, and TMHP Contact Information	Appendix A (*Vol. 1, General Information*)
TMHP Electronic Claims Submission	Subsection 6.2 (*Vol. 1, General Information*)
Section 3: TMHP Electronic Data Interchange (EDI)	Section 3 (*Vol. 1, General Information*)
Tuberculosis Screening and Guidelines	Subsection A.5, *Children's Services Handbook* (*Vol. 2, Provider Handbooks*)
UB-04 CMS-1450 Paper Claim Filing Instructions	Subsection 6.6 (*Vol. 1, General Information*)

10 Contact TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.

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11 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Federally Qualified Health Center Affiliation Affidavit
Hospital Report (Newborn Child or Children) (Form 7484)

12 Claim Form Examples

Claim Form Examples
Birthing Center
2017 Claim Form
Family Planning Services for Hospitals, FQHCs
FQHC Encounter (T1015)
FQHC Follow-Up
Renal Dialysis Facility CAPD Training
Renal Dialysis Facility CAPD/CCPD
Renal Dialysis CMS-1500 Example
Rural Health Clinic Freestanding
Rural Health Clinic Freestanding (Immunization)
Rural Health Clinic Hospital-Based
Tuberculosis

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Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook

Texas Medicaid Provider Procedures Manual: Vol. 2

April 2016

TEXAS
Health and Human
Services Commission

DURABLE MEDICAL EQUIPMENT, MEDICAL SUPPLIES, AND NUTRITIONAL PRODUCTS

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1 General Information

The information in this handbook is intended for Texas Medicaid durable medical equipment (DME) supplier and medical supply company providers. This handbook provides information about the Texas Medicaid benefits, policies, and procedures that are applicable to these providers.

This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, refer to the Texas Medicaid Managed Care Handbook.

Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in Section 8, "Carve-Out Services" in the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

All providers are required to report suspected child abuse or neglect as outlined in subsection 1.6.1.2, "Reporting Child Abuse or Neglect" in Section 1, "Provider Enrollment and Responsibilities" (*Vol 1, General Information*).

Important: *All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: Section 1: Provider Enrollment and Responsibilities (*Vol. I, General Information*) for more information about enrollment procedures.

1.1 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: Subsection 3.7.3.8, "Payment Window Reimbursement Guidelines" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about the payment window reimbursement guidelines.

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2 Texas Medicaid (Title XIX) Home Health Services

2.1 Enrollment

All DME providers must be Medicare-certified before applying for enrollment in Texas Medicaid.

Providers that render custom DME wheeled mobility systems to Texas Medicaid clients must enroll in Texas Medicaid as a specialized/custom wheeled mobility group provider and must have at least one qualified rehabilitation professional (QRP) performing provider.

Certified QRP providers must enroll in Texas Medicaid as performing providers under DME provider groups.

To enroll in Texas Medicaid as a QRP performing provider, individual professionals must be certified by the National Registry of Rehabilitation Technology Suppliers (NRRTS) or Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) and must enroll as a performing provider under a Specialized /Custom Wheeled Mobility group.

Providers may download the Texas Medicaid Provider Enrollment Application at www.tmhp.com or request a paper application form by contacting Texas Medicaid & Healthcare Partnership (TMHP) directly at 1-800-925-9126.

Providers may also obtain the paper enrollment application by writing to the following address:

Texas Medicaid & Healthcare Partnership
Provider Enrollment
PO Box 200795
Austin, TX 78720-0795
1-800-925-9126
Fax: 1-512-514-4214

Providers may request prior authorization for home health services by contacting:

Texas Medicaid & Healthcare Partnership
Home Health Services
PO Box 202977
Austin, TX 78720-2977
1-800-925-8957
Fax: 1-512-514-4209

2.1.1 Pending Agency Certification

DME providers that submit claims before the enrollment process is complete or without prior authorization for services issued by the TMHP Home Health Services Prior Authorization Department will not be reimbursed. The effective date of enrollment is the date on which all Medicaid provider enrollment forms have been received and approved by TMHP.

Upon the receipt of notice of Medicaid enrollment, the supplier must contact the TMHP Home Health Services Prior Authorization Department before rendering to a Medicaid client, services that require a prior authorization number. Prior authorization cannot be issued before Medicaid enrollment has been completed. Regular prior authorization procedures are followed at that time.

Providers must not submit home health services claims for payment until they have received their Medicaid certification and a prior authorization number has been assigned.

Refer to: Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

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2.1.2 Surety Bond Requirements

All newly enrolling and re-enrolling durable medical equipment (DME) providers must, as a condition of enrollment and continued participation into Texas Medicaid, obtain a surety bond that complies with Title 1, Texas Administrative Code (TAC) §352.15.

Important: *Surety bonds obtained for the purpose of accreditation in the Medicare program, which lists the Centers for Medicare & Medicaid Services (CMS) as obligee, do not fulfill the surety bond requirement for Texas Medicaid.*

The surety bond submitted to Texas Medicaid must meet the following requirements:

- A bond in an amount of no less than $50,000 must be provided for each enrolled location.

  Note: *Only one surety bond is required if the provider has multiple Medicaid DME provider numbers related to the same location. For example, if the provider has a TPI with a suffix for DME and a second suffix for Specialized Custom Wheeled Mobility all for the same practice location, only one surety bond is required.*

- The bond must be submitted on the State of Texas Medicaid Provider Surety Bond Form. No other form will be accepted. The use of this form designates the Health and Human Services Commission (HHSC) as the sole obligee of the bond. Instructions are included with the form.
- The bond must be issued for a term of 12 months. Bonds for longer or shorter terms are not acceptable.
- The bond must be in effect on the date that the provider enrollment application is submitted to TMHP for consideration. The effective date stated on the bond must be:
  - No later than the date that the provider enrollment application is submitted.
  - No earlier than 12 months before the date that the provider enrollment application is submitted.
- The bond must be a continuous bond. A continuous bond remains in full force and effect from term to term unless the bond is canceled.

Important: *An annual bond that specifies effective and expiration dates for the bond, is not acceptable.*

At the time of enrollment or re-enrollment, providers must submit the surety bond form with original signatures and a copy of the Power of Attorney document from the surety company that issued the bond.

Note: *Surety companies may refer to Texas Department of Insurance (TDI) file #9212562912 or TDI link #132456 when filing the bond.*

2.1.2.1 Proof of Continuation

DME providers must maintain a current surety bond to continue participation in Texas Medicaid. Each year, providers must submit documentation that shows proof of continuation of the bond for a new 12-month term. The document may be submitted on the surety bond company's form and must include the following components:

- Bond number
- Principal's name, address, and Tax ID or Medicaid provider number (Texas Provider Identifier)
- Surety's company name and address
- Date of the original bond
- New "good through" date

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To avoid losing Medicaid enrollment status, providers must submit the proof of continuation to the TMHP Provider Enrollment before the expiration date of the bond that is currently on file. The completed proof of continuation document must include the original signatures of the authorized corporate representative of the DME provider (principal), and the attorney-in-fact of the surety company. Providers may submit a copy of the proof of continuation (i.e., scan, FAX, photocopy) pending the submission of the original document.

Submission Information

The surety bond must be submitted to the TMHP Provider Enrollment Department at the following address:

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

2.2 Services, Benefits, Limitations and Prior Authorization

Home health services include home health skilled nursing (SN), home health aide (HHA), physical therapy (PT) and occupational therapy (OT) services; DME; and expendable medical supplies that are provided to eligible Medicaid clients at their place of residence.

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit may receive those services through CCP.*

Refer to: Subsection 5.1.1, "Overview" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information on clients who are birth through 20 years of age.

Section 3, "Home Health Nursing and Therapy Services" in the *Nursing and Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for more information on nursing and therapy services.

2.2.1 Home Health Services

The benefit period for home health professional services is up to 60 days with a current plan of care (POC). For all DME and medical supplies with or without prior authorization requirements, providers must complete a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form except as outlined in subsection 2.2.11 of this handbook. In chronic and stable situations, the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is valid for up to, but no more than, 6 months from the date of the physician's signature on the form, unless otherwise noted in this handbook. If necessary, DME and supplies that are ordered on a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form may be prior authorized for up to 6 months with medical necessity determination. Because Medicaid clients have a one-month eligibility period, providers must bill for a one month supply at a time, even though prior authorization may be granted for up to 6 months. This extended prior authorization period begins on the date that clients receive their first prior-authorized home health service. Texas Medicaid allows additional DME or supplies that have been determined to be medically necessary and have been prior authorized by TMHP Home Health Services Prior Authorization Department. Providers must retain all orders, signed and dated Title XIX forms, delivery slips, and corresponding invoices for all supplies provided to a client and must disclose them to HHSC or its designee on request. These records and claims must be retained for a minimum of five years from the date of service (DOS) or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.

2.2.1.1 Client Eligibility

Home health clients do not have to be homebound to qualify for services.

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To qualify for home health services, the Medicaid client must be eligible on the DOS and must:

- Have a medical need for home health professional services, DME, or supplies that is documented in the client's POC and considered a benefit under home health services.
- Receive services that meet the client's existing medical needs and can be safely provided in the client's home.
- Receive prior authorization from TMHP for most home health professional services, DME, and supplies.

Unless otherwise noted in this handbook, certain DME/supplies may be obtained without prior authorization although providers must retain a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form that has been reviewed, signed, and dated by the treating physician for these clients.

Refer to: "Automated Inquiry System (AIS)" in "State, Federal, and TMHP Contact Informaiton" (*Vol. 1, General Information*).

Section 6: Claims Filing in the *Children's Services Handbook (Vol. 2, Provider Handbooks)* for more information on clients who are 20 years of age and younger.

2.2.1.2 Prior Authorization Requests for Clients with Retroactive Eligibility

Retroactive eligibility occurs when the effective date of a client's Medicaid coverage is before the date on which the client's Medicaid eligibility is added to TMHP's eligibility file, which is called the "add date."

For clients with retroactive eligibility, prior authorization requests must be submitted after the client's add date and before a claim is submitted to TMHP.

For services provided to fee-for-service Medicaid clients during the client's retroactive eligibility period (i.e., the period from the effective date to the add date), prior authorization must be obtained within 95 days of the client's add date and before a claim for those services is submitted to TMHP. For services provided on or after the client's add date, the provider must obtain prior authorization within three business days of the date of service.

The provider is responsible for verifying eligibility. The provider is strongly encouraged to access AIS or TexMedConnect to verify eligibility frequently while providing services to the client. If services are discontinued before the client's add date, the provider must still obtain prior authorization within 95 days of the add date to be able to submit claims.

Refer to: Section 4: Client Eligibility (*Vol. 1, General Information*).

2.2.1.3 Prior Authorization

Prior authorization must be obtained for some supplies and most DME from TMHP within three business days of the DOS. Although providers may supply some DME and medical supplies to a client without prior authorization, they must still retain a copy of the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form that has Section B completed, signed, and dated by the client's attending physician, unless otherwise noted in this handbook.

The following prior authorization requests can be submitted on the TMHP website at www.tmhp.com:

- External Insulin Pump
- Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form
- Home Health Services POC
- Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy

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- Medicaid Certificate of Necessity for Chest Physiotherapy Device Form—Initial Request
- Medicaid Certificate of Necessity for Chest Physiotherapy Device Form—Extended Request
- Statement for Initial Wound Therapy System In-Home Use
- Statement for Recertification of Wound Therapy System In-Home Use
- Wheelchair/Scooter/Stroller Seating Assessment Form (CCP/Home Health Services) (Attachments will be sent separately due to size and detailed information)

Refer to: Subsection 5.5.1, "Prior Authorization Requests Through the TMHP Website" in Section 5, "Prior Authorization" (*Vol. 1, General Information*) for more information, including mandatory documentation requirements.

If a client's primary coverage is private insurance and Medicaid is secondary, prior authorization is required for Medicaid reimbursement. If the primary coverage is Medicare, Medicare approves the service, and Medicaid is secondary, prior authorization is not required. TMHP will pay only the coinsurance or deductible according to current payment guidelines. If Medicare denied the service, then Medicaid prior authorization is required. TMHP must receive a prior authorization request within 30 days of the date of Medicare's final disposition. The Medicare Remittance Advice Notice (MRAN) containing Medicare's final disposition must accompany the prior authorization request. If the service is a Medicaid-only service, prior authorization is required within three business days of the DOS. The provider is responsible for determining whether eligibility is effective by using AIS, TexMedConnect, or an electronic eligibility inquiry through the TMHP EDI gateway.

The provider must contact the TMHP Home Health Services Prior Authorization Department within three business days of the DOS to obtain prior authorization for DME and medical supplies.

If inadequate or incomplete information is provided or medical necessity is lacking, the provider will be asked to furnish any required or additional documentation so that a decision about the request can be made. Because the documentation must often be obtained from the client's physician, providers have two weeks to submit the requested documentation. If the additional documentation is received within the two-week period, prior authorization can be considered for the original date of contact. If the additional documentation is received more than two weeks after the request for the documentation, prior authorization is not considered before the date on which the additional documentation is received. It is the DME supplier's responsibility to contact the physician to obtain the requested additional documentation. The physician must maintain documentation of medical necessity in the client's record.

TMHP Home Health Services toll-free number is 1-800-925-8957.

Refer to: Subsection 2.2.2.2, "* Prior Authorization" in this handbook for DME prior authorization information.

Subsection 2.3.1, "Medicaid Relationship to Medicare" in this handbook.

Client eligibility for Medicaid is for one month at a time. Providers should verify their client's eligibility every month. Prior authorization does not guarantee payment.

2.2.2 Durable Medical Equipment (DME) and Supplies

Texas Medicaid defines DME as:

Medical equipment or appliances that are manufactured to withstand repeated use, ordered by a physician for use in the home, and required to correct or ameliorate a client's disability, condition, or illness.

Since there is no single authority, such as a federal agency, that confers the official status of "DME" on any device or product, HHSC retains the right to make such determinations with regard to DME benefits of Texas Medicaid. DME benefits of Texas Medicaid must have either a well-established history of efficacy or, in the case of novel or unique equipment, valid, peer-reviewed evidence that the equipment corrects or ameliorates a covered medical condition or functional disability.

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Requested DME may be a benefit when it meets the Medicaid definition of DME. The majority of DME and expendable supplies are covered home health services. If a service cannot be provided for a client who is 20 years of age or younger through home health services, these services may be covered through CCP if they are determined to be medically necessary.

To be reimbursed as a home health benefit:

- The client must be eligible for home health benefits.
- The criteria listed for the requested equipment or supply must be met.
- The requested equipment or supply must be medically necessary, and Federal Financial Participation (FFP) must be available.
- The client's health status would be compromised without the requested equipment or supply.
- The requested equipment or supplies must be safe for use in the home.
- The client must be seen by a physician within one year of the DOS.

The provider must sign and have the client sign DME Certification and Receipt Form on the TMHP website at www.tmhp.com for all purchased DME for Medicaid clients before submitting a claim for payment. The client's signature means the DME is the property of the client. The certification form must include the date the client received the DME, the name of the item, and the printed names and signatures of the provider and the client or primary caregiver. This form must be maintained by the DME provider in the client's record.

The signed and dated DME Certification and Receipt Form must be submitted to TMHP for claims and appeals for DME that meet or exceed a billed amount of $2,500.00. The form must also be submitted when multiple items that meet or exceed a total billed amount of $2,500.00 are billed for the same DOS. The form is required in addition to obtaining prior authorization, when applicable.

If the DME Certification and Receipt Form is not submitted to TMHP, the claim payment or appeal will be reviewed and will be eligible for recoupment. Incomplete forms will be returned to the provider for correction and resubmission.

TMHP will contact clients that received DME that meets or exceeds a billed amount of $2,500.00 to verify that services were rendered. If the delivery of the equipment cannot be verified by the client, the claim payment will be eligible for recoupment.

The provider must keep all Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Forms and Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Forms on file. Providers must retain delivery slips or corresponding invoices and the signed and dated DME Certification and Receipt Form documenting the item and date of delivery for all DME provided to a client and must disclose them to HHSC or its designee on request.

- The DME must be used for medical or therapeutic purposes, and supplied through an enrolled DME provider in compliance with the client's POC.
- These records and claims must be retained for a minimum of five years from the DOS or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.

Note: *All purchased equipment must be new upon delivery to client. Used equipment may be utilized for lease, but when purchased, must be replaced with new equipment.*

HHSC/TMHP reserves the right to request the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form or Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form at any time.

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DME must meet the following requirements to qualify for reimbursement under Home Health Services:

- The client received the equipment as prescribed by the physician.
- The equipment has been properly fitted to the client or meets the client's needs.
- The client, the parent or guardian of the client, or the primary caregiver of the client, has received training and instruction regarding the equipment's proper use and maintenance.

DME must:

- Be medically necessary due to illness or injury or to improve the functioning of a body part, as documented by the physician in the client's POC or the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.
- Be prior authorized by the TMHP Home Health Services Prior Authorization Department for rental or purchase of most equipment. Some equipment does not require prior authorization. Prior authorization for equipment rental can be issued for up to six months based on diagnosis and medical necessity. If an extension is needed, requests can be made up to 60 days before the start of the new prior authorization period with a new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.
- Meet the client's existing medical and treatment needs.
- Be considered safe for use in the home.
- Be provided through an enrolled DME provider or supplier.

Note: *Texas Health Steps (THSteps)-eligible clients who qualify for medically necessary services beyond the limits of this home health benefit will receive those services through CCP.*

DME that has been delivered to the client's home and then found to be inappropriate for the client's condition will not be eligible for an upgrade within the first six months following purchase unless there has been a significant change in the client's condition, as documented by the physician familiar with the client. All adjustments and modifications within the first six months after delivery are considered part of the purchase price.

All DME purchased for a client becomes the Medicaid client's property upon receipt of the item. This property includes equipment delivered which will not be prior authorized or reimbursed in the following instances:

- Equipment delivered to the client before the physician signature date on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form or Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.
- Equipment delivered more than three business days before obtaining prior authorization from the TMHP Home Health Services Prior Authorization Department and meets the criteria for purchase.

Additional criteria:

- A determination as to whether the equipment will be rented, purchased, replaced, repaired, or modified will be made by HHSC or its designee based on the client's needs, duration of use, and age of the equipment.
- Periodic rental payments are made only for the lesser of either the period of time the equipment is medically necessary, or when the total monthly rental payments equal the reasonable purchase cost for the equipment.
- Purchase is justified when the estimated duration of need multiplied by the rental payments would exceed the reasonable purchase cost of the equipment or it is otherwise more practical to purchase the equipment.

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- If a DME/medical supply provider is unable to deliver a prior authorized piece of equipment or supply, the provider should allow the client the option of obtaining the equipment or supplies from another provider.

Items or services are reimbursed at the lesser of:

- The provider's billed charges
- The published fee determined by HHSC
- Manual pricing as determined by HHSC based on one of the following:
  - The manufacturer's suggested retail price (MSRP) less 18 percent
  - The provider's documented invoice cost

If an item is manually priced, providers must submit documentation of one of the following for consideration of purchase or rental with the appropriate procedure codes:

- The MSRP or average wholesale price (AWP), whichever is applicable
- The provider's documented invoice cost

2.2.2.1 Modifications, Adjustments, and Repairs

Modifications are the replacement of components because of changes in the client's condition, not replacement because the component is no longer functioning as designed. All modifications and adjustments within the first six months after delivery are considered part of the purchase price.

Modifications to custom equipment may be prior authorized should a change occur in the client's needs, capabilities, or physical and mental status which cannot be anticipated.

Documentation must include the following:

- All projected changes in the client's mobility needs
- The date of purchase, and serial number of the current equipment
- The cost of purchasing new equipment versus modifying the current equipment

All modifications within the first six months after delivery are considered part of the purchase price.

Adjustments do not require supplies. Adjustments made within the first six months after delivery will not be prior authorized. Adjustments made within the first six months after delivery are considered part of the purchase price. A maximum of one hour of labor for adjustments may be prior authorized as needed after the first six months following delivery.

Repairs to client-owned equipment may be prior authorized as needed with documentation of medical necessity. Technician fees are considered part of the cost of the repair. Repairs require the replacement of components that are no longer functional. Providers are responsible for maintaining documentation in the client's medical record specifying the repairs and supporting medical necessity.

A DME repair will be considered based on the age of the item and cost to repair it.

A request for repair of DME must include a statement or medical information from the attending physician substantiating that the medical appliance or equipment continues to serve a specific medical purpose and an itemized estimated cost list from the vendor or DME provider of the repairs. Rental equipment may be provided to replace purchased medical equipment for the period of time it will take to make necessary repairs to purchased medical equipment.

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Repairs will not be prior authorized in situations where the equipment has been abused or neglected by the client, client's family, or caregiver. Routine maintenance of rental equipment is the provider's responsibility. For clients requiring wheelchair repairs only, the date last seen by physician does not need to be filled in on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.

2.2.2.1.1 Accessories

Equipment accessories including, but not limited to, pressure support cushions, may be prior authorized with documentation of medical necessity.

2.2.2.2 * Prior Authorization

Prior authorization is required for most DME and supplies provided through Home Health Services. These services include accessories, modifications, adjustments, and repairs for the equipment.

Providers must submit a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form to the TMHP Home Health Services Prior Authorization Department.

Unless otherwise noted in this handbook, a completed Home Health Services (Title XIX) Durable Medical Equipment (DME) or Medical Supplies Physician Order Form prescribing the DME or supplies must be signed and dated by a physician and by the representative of the DME/Medical Supply provider familiar with the client before requesting prior authorization for all DME equipment and supplies. A current signature and date is valid for no more than 90 days prior to the date of the requested prior authorization or the initiation of service. The completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must include the procedure codes and numerical quantities for services requested.

The completed, signed, and dated form must be maintained by the DME provider and the prescribing physician in the client's medical record. The completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form with the original dated signature must be maintained by the prescribing physician.

To complete the prior authorization process by paper, the provider must fax or mail the completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form to the Home Health Services Prior Authorization Department and retain a copy of the signed and dated form in the client's medical record at the provider's place of business.

To complete the prior authorization process electronically, the provider must submit the prior authorization requirements through any approved electronic methods and retain a copy of the signed and dated Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form in the client's medical record at the provider's place of business.

Retrospective review may be performed to ensure that the documentation included in the client's medical record supports the medical necessity of the requested services.

The date last seen by the physician must be within the past 12 months unless a physician waiver is obtained. The physician's signature on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is only valid for 90 days before the initiation of services. The requesting provider may be asked for additional information to clarify or complete the request.

Providers must obtain prior authorization within three business days of providing the service by calling the TMHP Home Health Services Prior Authorization Department or faxing the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.

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To facilitate a determination of medical necessity and avoid unnecessary denials when requesting prior authorization, the physician must provide correct and complete information supporting the medical necessity of the equipment or supplies requested, including:

- Accurate diagnostic information pertaining to the underlying diagnosis or condition as well as any other medical diagnoses or conditions, to include the client's overall health status.
- Diagnosis or condition causing the impairment resulting in a need for the equipment or supplies requested.

Purchased DME is anticipated to last a minimum of five years, unless otherwise noted, and may be considered for replacement when the time has passed or the equipment is no longer functional or repairable. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent reoccurrence must be submitted.

Prior authorization for equipment replacement is considered within five years of equipment purchase when one of the following occurs:

- There has been a significant change in the client's condition such that the current equipment no longer meets the client's needs.
- The equipment is no longer functional and either cannot be repaired or it is not cost-effective to repair.

Replacement of equipment is also considered when loss or irreparable damage has occurred. The following must be submitted with the prior authorization request:

- A copy of the police or fire report, when appropriate
- A statement about the measures to be taken in order to prevent reoccurrence

Payment may be prior authorized for repair of purchased DME. Maintenance of rental equipment (including repairs) is the supplier's responsibility. The toll-free number for the TMHP Home Health Services Prior Authorization Department is 1-800-925-8957. Requests for repairs must include the cost estimate, reasons for repairs, age of equipment, and serial number.

2.2.3 * Medical Supplies

Medical supplies are benefits of the Home Health Services Program if they meet the following criteria:

- Unless otherwise noted in this handbook, the representative of the DME/medical supply provider and a physician who is familiar with the client must sign and date a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form that prescribes the DME or supplies before requesting prior authorization for the DME or supplies. A current signature and date is valid for no more than 90 days prior to the date of the requested prior authorization or the initiation of service. The completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must include the procedure codes and numerical quantities for the services requested.
- The provider must contact TMHP within three business days of providing the supplies to the client and obtain prior authorization, if required.
- The requesting provider and ordering physician must keep all Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Forms and Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Forms on file. The physician must maintain the original signed and dated Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form in their records.
- Providers must retain individual delivery slips or invoices for each DOS that documents 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:

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  - Delivery slip or corresponding invoice signed and dated by client or caregiver, or
  - A dated carrier tracking document with shipping date and delivery date must be printed from the carrier's website as confirmation that the supplies were shipped and delivered. The dated carrier tracking document must be attached to the delivery slip or corresponding invoice.
- The dated delivery slip or invoice must include the client's full name, the address to which supplies were delivered, and an itemized list of goods that includes the descriptions and numerical quantities of the supplies delivered to the client and the corresponding tracking number from the carrier. This document could also include prices, shipping weights, shipping charges, or other descriptions.
- All claims submitted for medical supplies must include the same quantities or units that are documented on the delivery slip or corresponding invoice and on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. They must reflect the number of units by which each product is measured. For example, diapers are measured as individual units. If one package of 300 diapers is delivered, the delivery slip or corresponding invoice and the claim must reflect that 300 diapers were delivered and not that one package was delivered. Diaper wipes are measured as boxes or packages. If one box of 200 wipes is delivered, the delivery slip or invoice and the claim must reflect that one box was delivered and not that 200 individual wipes were delivered. There must be one dated delivery slip or invoice for each claim submitted for each client. All claims submitted for medical supplies must reflect the same date as the delivery slip or corresponding invoice and the same timeframe covered by the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. The DME Certification and Receipt Form is still required for all equipment delivered.

    Note: *These records and claims must be retained for a minimum of five years from the DOS or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.*
- The requesting provider or ordering physician must document medical supplies as medically necessary in the client's POC or on a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

HHSC/TMHP reserves the right to request the signed and dated Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form or Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form at any time.

Note: *Client eligibility can change monthly. Providers are responsible for verifying eligibility before providing supplies.*

The DOS is the date on which supplies are delivered to the client or shipped by a carrier to the client as evidenced by the dated tracking document attached to the invoice for that date. The provider must maintain the signed and dated records supporting documentation that an item was not billed before delivery. These records are subject to retrospective review.

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this home health benefit will receive those services through CCP.*

Refer to: Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form on the TMHP website at www.tmhp.com.

Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions on the TMHP website at www.tmhp.com.

Subsection 2.6, "Durable Medical Equipment (DME) Supplier (CCP)" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for specific information about certain DME and medical supplies.

Subsection 2.2.1.1, "Client Eligibility" in this handbook.

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2.2.3.1 Supply Procedure Codes

When submitting supplies on the CMS-1500 claim form, itemize the supplies, including quantities, and also provide the Healthcare Common Procedure Coding System (HCPCS) national procedure codes.

Refer to: Subsection 6.3.3, "Procedure Coding" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for more information about HCPCS procedure codes.

2.2.3.2 Prior Authorization

TMHP must prior authorize most medical supplies. They must be used for medical or therapeutic purposes, and supplied through an enrolled DME provider in compliance with the client's POC.

Some medical supplies may be obtained without prior authorization; however, the provider must retain a copy of the completed POC or Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form in the client's file. Unless otherwise noted in this handbook, a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form for medical supplies not requiring prior authorization may be valid for a maximum of six months, unless the physician indicates the duration of need is less. If the physician indicates the duration of need is less than six months, then a new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is required at the end of the determined duration of need.

For a list of DME/medical supplies that do not require prior authorization, providers can refer to Subsection 2.2.25, "Procedure Codes That Do Not Require Prior Authorization" in this handbook.

Clients with ongoing needs may receive up to six months of prior authorizations for some expendable medical supplies under Home Health Services when requested on a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. Providers may deliver medical supplies as ordered on a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form for up to six months from the date of the physician's signature. In these instances, a review of the supplies requested by the physician familiar with the client's condition, and a new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is required for each new prior authorization request. Requests for prior authorization can be made up to 60 days before the start of the new prior authorization period. Professional Home Health Services prior authorization requests require a review by the physician familiar with the client's condition and a physician signature every 60 days when requested on a POC.

Note: *These records and claims must be retained for a minimum of five years from the DOS or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.*

2.2.3.3 Cancelling a Prior Authorization

The client has the right to choose his DME/medical supply provider and change providers. If the client changes providers, TMHP must receive a change of provider letter with a new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. The client must sign and date the letter, which must include the name of the previous provider and the effective date for the change. The client is responsible for notifying the original provider of the change and the effective date. Prior authorization for the new provider can only be issued up to three business days before the date TMHP receives the change of provider letter and the new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.

2.2.4 Augmentative Communication Device (ACD) System

An ACD system, also known as an augmentative and alternative communication (AAC) device system, allows a client with an expressive speech language disorder to electronically represent vocabulary and express thoughts or ideas in order to meet the client's functional speech needs.

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Digitized speech devices and synthesized speech devices are benefits of Texas Medicaid Title XIX Home Health Services.

A digitized speech device, sometimes referred to as a "whole message" speech output device, uses words or phrases that have been recorded by someone other than the ACD system user for playback upon command by the ACD system user.

Providers must use procedure codes E2500, E2502, E2504, and E2506 when billing for a digitized speech device.

A synthesized speech device uses technology that translates a user's input into device-generated speech using algorithms representing linguistic rules. Users of synthesized speech ACD systems are not limited to prerecorded messages, but can independently create messages as their communication needs dictate. Some synthesized speech devices require the user to make physical contact with a keyboard, touch screen, or other display containing letters.

Providers must use procedure code E2508 when billing for a synthesized speech device.

Other synthesized devices allow for multiple methods of message formulation and multiple methods of device access. Multiple methods of message formulation must include message selection by two or more of the following methods:

- Letters
- Words
- Pictures
- Symbols

Multiple methods of access must include the capability to access the device by direct physical contact with a keyboard or touch screen and one or more of the following indirect selection techniques:

- Joystick/switches
- Head mouse
- Optical head pointer
- Light pointer
- Infrared pointer
- Scanning device
- Morse code

Note: *ACD systems that do not meet the criteria through Title XIX Home Health Services may be considered for clients who are birth through 20 years of age under CCP.*

Providers must use procedure code E2510 when billing for other synthesized speech devices.

Items included in the reimbursement for an ACD system and not reimbursed separately include, but are not limited to, the following:

- ACD
- Basic, essential software (except for software purchased specifically to enable a client-owned computer or personal digital assistant [PDA] to function as an ACD system)
- Batteries
- Battery charger
- Power supplies
- Interface cables

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- Interconnects
- Sensors
- Moisture guard
- Alternating current (A/C) or other adapters
- Adequate memory to allow for system expansion within a three-year timeframe
- Access device, when necessary
- Mounting device, when necessary
- All basic operational training necessary to instruct the client and family/caregivers in the use of the ACD system
- Manufacturer's warranty

2.2.4.1 ACD System Accessories

Accessories are a benefit of Texas Medicaid if the criteria for ACD system prior authorization are met and the medical necessity for each accessory is clearly documented in the speech language pathologist (SLP) evaluation.

All accessories necessary for proper use of an ACD system, including those necessary for the potential growth and expansion of the ACD system (such as a memory card), must be included in the initial prescription/Title XIX form. The following accessories for an ACD system may be covered:

- Access devices for an ACD system include, but are not limited to, devices that enable selection of letters, words, or symbols by direct or indirect selection techniques such as optical head pointers, joysticks, and ACD scanning devices.
- Gross motor access devices, such as switches and buttons, may be considered for clients with poor fine motor and head control.
- Fine motor, head control access devices, such as laser or infrared pointers, may be considered for clients with poor hand control and good head control.

Mounting systems are devices necessary to place the ACD system, switches and other access devices within the reach of the client. Mounting devices may be considered for reimbursement when used to attach an ACD system or access device to a wheelchair or table.

A request for prior authorization of a wheelchair mounting device must include the manufacturer name, model, and purchase date of the wheelchair. One additional mounting device, separate from the one included in the system, may be considered for prior authorization for the same client.

Providers must use procedure codes E2512 and E2599 when billing for ACD system accessories.

2.2.4.1.1 Carrying Case

Carrying cases may be considered for separate reimbursement with supporting documentation of medical necessity.

Providers must use procedure code E2599 and modifier U1 when billing for the carrying case. Carrying cases are limited to one every three years.

Carrying cases may be considered for prior authorization. The prior authorization request must include the make, model, and purchase date of the ACD system.

2.2.4.1.2 Nonwarranty Repairs

Nonwarranty repairs of an ACD system may be considered for prior authorization using procedure code V5336 with documentation from the manufacturer explaining why the repair is not covered by the warranty.

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2.2.4.1.3 Trial Period

In order to ensure the client's needs are met in the most cost effective manner and to ascertain the most appropriate system and access device for the client, the ACD system is prior authorized for purchase only after the client has completed a three-month trial period that includes experience with the requested system.

The ACD system for the trial period may be obtained through the rental, the school setting, or another setting determined by the licensed SLP.

In the situation where an ACD system is not available for rental and the client has recent documented experience with the requested ACD system, purchase can be considered.

A trial period is not required when replacing an existing ACD system, unless the client's needs have changed and another ACD system or access device is being considered.

2.2.4.1.4 Rental

Prior authorization may be provided for rental during this trial period. All components necessary for use of the device, such as access devices, mounting devices, and lap trays, must be evaluated during this trial period.

2.2.4.1.5 Purchase

Purchase of an ACD system may be considered for prior authorization when all of the following ACD system criteria are met:

- The evaluation/re-evaluation includes documentation that the client has had sufficient experience with the requested ACD system through trial, rental, school, or another setting. When the SLP has confirmed the appropriateness of a specific device for the client, the trial/rental period may be cancelled.
- A Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form listing the prescribed ACD system, access device, and accessories (such as a mounting device) must be completed, signed by the physician, and dated.

ACD systems, equipment, and accessories that have been purchased are anticipated to last a minimum of three years.

2.2.4.1.6 Replacement

Prior authorization for replacement may be considered within three years of purchase when one of the following occurs:

- There has been a significant change in the client's condition such that the current device no longer meets his or her communication needs.
- The ACD system is no longer functional and either cannot be repaired or it is not cost effective to repair.
- Three years have passed and the equipment is no longer repairable.

Note: *Replacements for clients who are birth through 20 years of age that do not meet the criteria above may be considered through CCP.*

2.2.4.1.7 Software

Computer software that enables a client's computer or PDA to function as an ACD system may be covered as an ACD system. Providers must use procedure code E2511 when billing for a speech generating software. Requests for ACD software may be considered for prior authorization if the software is more cost effective than an ACD system.

If an ACD system is more cost effective than adapting the client's computer or PDA, an ACD system may be prior authorized instead of the ACD software.

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Laptop or desktop computers, PDAs, or other devices that are not dedicated ACD systems are not a benefit of Texas Medicaid, because they do not meet the definition of DME.

2.2.4.2 Non-Covered ACD System Items

Noncovered items that are not necessary to operate the system and are unrelated to the ACD system or software components are not benefits of Texas Medicaid. These items include, but are not limited to:

- Printer
- Wireless Internet access devices

2.2.4.3 Prior Authorization

Prior authorization is required for ACD systems provided through Home Health Services. The prior authorization also includes all related accessories and supplies. The physician must provide information supporting the medical necessity of the equipment or supplies requested, including:

- Accurate diagnostic information pertaining to the underlying diagnosis or condition and any other medical diagnoses or conditions, including the client's overall physical and cognitive limitations.
- Diagnosis or condition causing the impairment of speech.

Prior authorization for an ACD system and accessories (rental or purchase) must be requested using the following information:

- Medical diagnosis and how it relates to the client's communication needs.
- Any significant medical information pertinent to ACD system use.
- Limitations of the client's current communication abilities, systems, and devices.
- Statement as to why the prescribed ACD system is the most effective, including a comparison of benefits using other alternatives.
- Complete description of the ACD system with all accessories, components, mounting devices, or modifications necessary for client use (must include manufacturer's name, model number, and retail price).
- Documentation that the client is mentally, emotionally, and physically capable of operating the device.
- An evaluation and assessment must be conducted by a licensed SLP in conjunction with other disciplines, such as physical or occupational therapies. The prescribing physician must base the prescription on the professional evaluation and assessment.

The prior authorization request must include the specifications for the ACD system, all component accessories necessary for the proper use of the ACD, and all necessary therapies or training. It is recommended that the preliminary evaluation for an ACD system include the involvement of an occupational therapist or physical therapist to address the client's seating/postural needs and the motor skills required to utilize the ACD system.

The prescribing physician familiar with the client must review the SLP evaluation of the client's cognitive and language abilities and base the prescription and treatment plan on the SLP's recommendations.

An evaluation and assessment by a licensed SLP must be signed and dated before the date on the physician's prescription or the Title XIX form and include the following information:

- Documentation of medical necessity for an ACD system, including a formal written evaluation performed by a licensed SLP.
- Medical status or condition and medical diagnoses underlying the client's expressive speech-language disorder that justifies the need for an ACD system.

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- Current expressive speech-language disorder, including the type, severity, anticipated course, and present language skills.
- Description of the practical limitations of the client's current aided and unaided modes of communication.
- Other forms of therapy or intervention that have been considered and ruled out.
- Rationale for the recommended ACD system and each accessory, including a statement as to why the recommended device is the most appropriate and least costly alternative for the client and how the recommended system will benefit the client.
- Documentation that the client possesses the cognitive and physical abilities to use the recommended system.
- Comprehensive description of how the ACD system will be integrated into the client's everyday life, including home, school, or work.
- Treatment plan that includes training in the basic operation of the recommended ACD system necessary to ensure optimal use by the client (if appropriate, the client's caregiver) and a therapy schedule for the client to gain proficiency in using the ACD system.
- Description of the client's speech-language goals and how the recommended ACD system will assist the client in achieving these goals.
- Description of the anticipated changes, modifications, or upgrades with projected time frames of the ACD system necessary to meet the client's short- and long-term speech-language needs.
- Identification of the assistance or support needed by, and available to, the client to use and maintain the ACD system.
- Statement that the licensed SLP is financially independent of the ACD system manufacturer/vendor.
- Speech- and language- skills assessment that includes the prognosis for speech or written communication.
- Interactional/behavioral and social abilities.
- Capabilities, including intellectual, postural, sensory (visual and auditory), and physical status.
- Motivation to communicate.
- Residential, vocational, and educational setting.
- Alternative ACD system considered with comparison of capabilities.
- Ability to meet projected communication needs, growth potential, and length of time it will meet the client's needs.

2.2.5 Bath and Bathroom Equipment

Bath and bathroom equipment is DME that is included in a treatment protocol, serves as a therapeutic agent for life and health maintenance, and is required to treat an identified medical condition. Bath and bathroom equipment may be considered for reimbursement for those clients who have physical limitations that do not allow for bathing, showering, or bathroom use without assistive equipment.

> ***Note:*** *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit may be considered under CCP.*

Bath seats are not considered for clients who are younger than one year of age or weighing less than 30 pounds.

Rental of equipment includes all necessary supplies, adjustments, repairs, and replacement parts.

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2.2.5.1 Hand-Held Shower Wand

A hand-held shower wand with attachments may be considered for prior authorization only if the client currently owns or meets the criteria for a bath or shower chair, tub stool or bench, or tub transfer bench. Prior authorization of a hand-held shower wand includes all attachments and accessories. Providers must use procedure code E1399 when billing for a hand-held shower wand. Hand-held shower wands with attachments are limited to one every five years.

2.2.5.2 Bath Equipment

2.2.5.2.1 Bath or Shower Chairs, Tub Stool or Bench, Tub Transfer Bench

A bath or shower chair is a stationary or mobile seat with or without upper body or head support used to support a client who is unable to stand or sit independently in the shower or tub.

Bath/shower chairs are grouped into three levels of design to assist the client based on their physical condition and mobility status:

- Level 1- standard bath or shower chair is defined as stationary equipment.
- Level 2 - intermediate bath or shower chair is defined as mobile equipment with or without a commode cut out.
- Level 3 - complex bath or shower chair is defined as custom equipment (either stationary or mobile) with or without a commode cut out.

A tub stool or bench is a stationary seat or bench used to support a client who is unable to stand or sit independently in the shower or tub.

A tub transfer bench is a stationary bench that sits in the tub and extends outside the tub. It is used to support a client who is unable to stand or sit independently in the shower or tub and allows the client to scoot or slide over the side of the tub.

Bath or shower chairs, tub stools or benches, and tub transfers are limited to one every five years.

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.

Level 1 Group

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 tub 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).

Providers must use procedure code E0240 without a modifier when billing for Level 1 group bath or shower chairs.

Level 2 Group

A Level 2 device may be considered if the client:

- Has good upper body stability, and
- Has impaired functional ambulation, including, but not limited to, lower body paralysis, osteoarthritis, or
- Is nonambulatory.

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The client must have a shower that is adapted for rolling equipment; ramps will not be prior authorized for access to showers.

Providers must use procedure code E0240 and modifier TF (Intermediate Level) when billing for Level 2 group bath or shower chairs.

Level 3 Group

A Level 3 device may be considered if the client requires:

- Trunk or head or neck support, or
- Positioning to accommodate conditions, including, but not limited to, spasticity, or frequent and uncontrolled seizures.

Providers must use procedure code E0240 and modifier TG (Complex/high Level) when billing for Level 3 group bath/shower chairs.

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. A Level 3 mobile bath or shower chair may be considered for clients who have a shower that is adapted for rolling equipment; ramps will not be prior authorized for access to showers.

A tub stool or bench may be prior authorized for clients who meet the Level 1 criteria. Providers must use procedure code E0245 when billing for a tub stool or bench.

A tub transfer bench may be considered for clients who meet the Level 1 or 2 criteria. Providers must use procedure code E0247 when billing for a tub transfer bench.

A heavy duty tub transfer bench may be considered for clients who meet the Level 1 or 2 criteria and who weigh more than 200 pounds. Providers must use procedure code E0248 when billing for a heavy duty tub transfer bench.

2.2.5.3 Bathroom Equipment

2.2.5.3.1 Non-fixed Toilet Rail, Bathtub Rail Attachment, and Raised Toilet Seat

Nonfixed toilet rails are limited to two every five years. A bathtub rail is limited to one every five years.

Raised toilet seats are limited to one every five years. Nonfixed toilet rails and bathtub rail attachments may be considered for prior authorization for a client who has decreased functional mobility and is unable to safely self-toilet or self-bathe without assistive equipment. Raised toilet seats do not require prior authorization. Providers must use procedure code E0243 when billing for non-fixed toilet rails, procedure code E0244 when billing for raised toilet seats, and procedure code E0246 when billing for bathtub rails.

2.2.5.3.2 Toilet Seat Lifts

A toilet seat lift mechanism is designed for the top of the toilet to assist lifting the body from a sitting position to a standing position.

A toilet seat lift mechanism must be prior authorized. To qualify for prior authorization, clients must meet all the following criteria:

- The client must have severe arthritis of the hip or knee or have a severe neuromuscular disease.
- The toilet 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 the client's home.

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The client's difficulty or incapability of getting up from a chair is not sufficient justification for a toilet 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.

Prior authorization will be given for either mechanical or powered toilet assist devices, not for both. If a client already owns one or more mechanical toilet-assist devices, a powered toilet 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.

Toilet 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 toilet seat lift operated by a spring release mechanism with a sudden, catapult-like motion that jolts the client from a seated to a standing position is not a benefit of Texas Medicaid.

Providers must use procedure code E0172 when billing for a toilet seat lift mechanism. A toilet seat lift mechanism is limited to one purchase very five years.

2.2.5.3.3 Commode Chairs and Foot Rests

Commode chairs, foot rests, and replacement commode pails or pans may be considered as benefits, depending on the client's level of need. The client must meet the criteria for the level of commode chair or foot rest requested.

A commode chair with or without a foot rest may be considered a benefit for the client who also has a stationary bath chair without a commode cutout.

Documentation must support medical necessity for a customized commode chair or the addition of attachments to a standard commode chair.

Level 1: Stationary Commode Chair

A Level 1 commode chair is defined as a stationary commode chair with fixed or removable attachments to support the arms.

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).

Providers must use procedure code E0163 or E0165 when billing for a stationary and mobile commode chair.

Level 2: Mobile Commode Chair

A Level 2 commode chair is defined as a mobile commode chair with fixed or removable attachments to support the arms.

A mobile commode chair with fixed or removable arms may be considered for prior authorization when the following criteria are met:

- In addition to meeting the criteria for a Level 1 commode chair, the client must be on a bowel program and require a combination commode or bath chair for performing the bowel program and bathing after.
- A mobile commode chair will be considered for reimbursement with prior authorization only if the client does not also have any type of bath chair. If the client meets the criteria for a stationary bath chair, prior authorization of a stationary chair may be considered.

Level 3: Custom Commode Chair

A Level 3 commode chair is defined as a custom commode chair with all of the following characteristics:

- Is stationary or mobile

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- Has fixed or removable attachments to support the arms, head, neck, or trunk.

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:

- In addition to meeting the criteria for a Level 1 or 2 commode chair, the client must have a medical condition that results in an inability to support their head, neck, or trunk without assistance.
- A mobile custom commode chair may be considered for reimbursement only if the client does not also have any type of bath chair.

Providers must use procedure code E0163 or E0165 with modifier TG when billing for a custom stationary or mobile commode chair.

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 client who weighs 300 pounds or more.

An extra-wide or heavy-duty commode chair may be considered for prior authorization when the client meets the criteria for a Level 1, 2, or 3 commode chair and weigh 300 pounds or more.

Providers must use procedure code E0168 and the appropriate modifiers when billing for an extra-wide or heavy-duty commode chair. Use modifier TF when billing for a mobile extra-wide, heavy-duty commode chair. Use modifier TG when billing for a custom extra-wide, heavy-duty commode chair.

Commode Chair With Integrated Seat Lift

A commode chair with integrated seat lift is designed to assist lifting the body from a sitting position to a standing position.

A commode chair with integrated seat lift mechanism for top of the commode must be prior authorized for clients who meet all the following criteria:

- The client must have severe arthritis of the hip or knee or have a severe neuromuscular disease.
- The client must be completely incapable of standing up from a regular toilet, commode, or any chair in their home.
- 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 independently for a short distance of no more than ten feet.

Note: *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.*

Providers must use procedure code E0170 or E0171 when billing for a commode chair with integrated seat lift. The purchase of a commode chair with integrated seat lift is limited to one every five years.

Replacement Commode Pail or Pan

Replacement commode pails or pans are a benefit through Title XIX Home Health Services and are limited to one per year. Additional quantities may be considered for prior authorization with documentation of medical necessity.

Providers must use procedure code E0167 when billing for a commode pail or pan.

Foot Rest

A foot rest is used to support feet during use of the commode chair.

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A foot rest may be considered for prior authorization if 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 of clients who are paraplegic or quadriplegic.

Providers must use procedure code E0175 when billing for a foot rest.

2.2.5.3.4 Portable Sitz Bath

Portable sitz baths that fit over commode seats are limited to two per year for clients requiring any of the following:

- Cleaning, irrigation, or pain relief of a perianal wound.
- Relief of pain associated with the pelvic area (hemorrhoids, bladder, vaginal infections, prostate infections, herpes, testicle disorders).
- Muscle toning for bowel and bladder incontinence.

Providers must use procedure codes E0160 or E0161 when billing for portable sitz baths.

2.2.5.3.5 Bath Lifts

The purchase of a bath lift is limited to one every five years. The rental of a bath lift is limited to one per month.

The two types of bath lifts that are considered for reimbursement include:

- An outside the tub bath lift which is a portable transfer system used to move a nonambulatory client a short distance from bed or chair to bath and is designed to accommodate the smaller space. This type of lift is either hydraulic or electric and consists of a base with wheels or casters and a sling which can transfer the client in and out of the bath.
- An inside the tub bath lift is a portable transfer system used to lower and raise a nonambulatory client into and out of the bath tub. This type of lift is either hydraulic or electric and consists of a base which adheres to the tub surface using suction cups and a seat that will lower and raise the client into and out of the tub.

Providers must use procedure code E0625 with the appropriate modifier (U1, U2, or U3) if necessary when billing for a bath lift.

The bath lift must be free standing, it cannot be attached to the floor, walls, or ceiling. Home adaptation for use of medical equipment is not a benefit of Home Health Services.

A hydraulic bath lift is for a client who is unable to assist in their own transfers and is operated by the weight or pressure of a liquid.

An electric bath lift is operated by electricity and may be considered when a hydraulic lift will not meet the client's needs.

A bath lift is not a benefit for the convenience of a caregiver.

There are four levels of bath lifts:

- Level 1 - an outside the tub bath lift (hydraulic or electric) and must accommodate a client weighing up to 300 pounds. Providers must use procedure code E0625 when billing for the purchase of a Level 1 bath lift.
- Level 2 - an in-tub bath lift (hydraulic or electric) and must accommodate a client weighing up to 300 pounds. Providers must use procedure code E0625 and the U1 modifier when billing for the purchase of a Level 2 bath lift.
- Level 3 - a bariatric lift (hydraulic or electric, out of tub type) designed to lift a client weighing greater than 300 pounds. Providers must use procedure code E0625 and the U2 modifier when billing for the purchase of a Level 3 bath lift.

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- Level 4 - a bariatric lift (hydraulic or electric, in tub type) designed to lift a client weighing greater than 300 pounds. Providers must use procedure code E0625 and the U3 modifier when billing for the purchase of a Level 4 bath lift.

A bath lift may be considered for prior authorization if the client:

- Has an inability to transfer to the bathtub or shower independently using assistive devices (including, but not limited to, a cane, walker, bathtub rails).
- Requires maximum assistance by the caregiver to transfer to the bathtub or shower.
- Has bathroom and tub or shower that meets the manufacturer's recommended depth, width, and height for safe bath lift installation and operation.

Providers must use procedure code E0621 when billing for a lift sling. The purchase of a lift sling is limited to one every five years.

The following are payable procedure codes for bath and bathroom equipment:

Procedure Code	Maximum Limitation
E0160	2 per year
E0161	2 per year
E0163	1 every 5 years
E0165	1 every 5 years
E0167	1 per year
E0168	1 every 5 years
E0170	1 every 5 years
E0171	1 every 5 years
E0172	1 every 5 years
E0175	1 every 5 years
E0240	1 every 5 years
E0243	2 every 5 years
E0244	1 every 5 years
E0245	1 every 5 years
E0246	1 every 5 years
E0247	1 every 5 years
E0248	1 every 5 years
E0621	1 per 5 years
E0625	1 purchase every 5 years; 1-month rental
E0630	1 purchase every 5 years; 1-month rental
E1399	1 every 5 years

2.2.5.4 Prior Authorization

Except as otherwise indicated in this section, prior authorization is required for all bath and bathroom equipment and related supplies, including any accessories, modifications, adjustments, replacements and repairs to the equipment. The bath and bathroom equipment must be able to accommodate a 20 percent change in the client's height or weight.

Bathroom and toilet lift rentals may be prior authorized during the period of repair up to a maximum of four months per lifetime per client.

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Prior authorization will not be considered for modifications, adjustments, or repairs to bath or bathroom equipment delivered to a client's home and then found to be inappropriate for the client's condition within the first six months after delivery. This applies unless there is a significant change in the client's condition that is documented by a physician familiar with the client.

2.2.5.5 Documentation Requirements

2.2.5.5.1 Bath and Bathroom Equipment

To request prior authorization for all bath or bathroom equipment, the following documentation must be provided:

- Accurate diagnostic information pertaining to the underlying diagnosis or condition, including the client's overall health status, any other medical needs, developmental level, and functional mobility skills and why regular bath or bathroom equipment will not meet the client's needs.
- The age, height, and weight of the client.
- Assessment of the client's home to ensure the requested equipment can be safely accommodated.
- Anticipated changes in the client's needs, including anticipated modifications or accessory needs and the growth potential of any custom shower and bath equipment.

2.2.5.5.2 Toilet Seat Lifts

In addition to the above documentation, the submitted documentation for a toilet seat lift must include an assessment completed by a physician, physical therapist, or occupational therapist that includes all of the following:

- A description of the client's current level of function without the device
- An explanation why a nonmechanical toilet elevation device, such as toilet rails or elevated toilet seat, will not meet the client's needs
- Documentation that identifies how the toilet seat lift mechanism will improve the client's function
- A list of the mobility related activities of daily living (MRADLs) the client will be able to perform with the toilet seat lift mechanism that the client is unable to perform without the toilet seat lift mechanism and how the device will increase the client's independence
- The client's goals for use of the toilet seat lift mechanism

Supporting documentation must be kept in the client's record that all appropriate therapeutic modalities (e.g., medication or physical therapy) have been tried and that they failed to enable the client to transfer from a chair to a standing position.

2.2.6 Blood Pressure Devices

Blood pressure devices are a benefit of Home Health Services when:

- The devices are medically necessary and appropriate.
- The devices are prescribed by a physician.

A manual blood pressure device requires manual cuff inflation with real-time visualization of the results displayed on the manometer and does not require prior authorization for purchase when provided for one of the diagnosis codes listed in the table below. Providers must use procedure code A4660 when billing for a manual blood pressure device.

An automated blood pressure device inflates the cuff manually or automatically, displays the blood pressure results on a small screen, and does not require prior authorization for purchase when provided for one of the diagnosis codes listed in the table below. Providers must use procedure code A4670 when billing for an automated blood pressure device.

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Repair of equipment may be considered with documentation of why the equipment needs repair. Providers must use procedure code A4660 when billing for the replacement of other components or repair of equipment.

Finger cuff automated blood pressure devices and ambulatory blood pressure devices for diagnostic purposes are not a benefit of Texas Medicaid.

If the client is not eligible for home health services, blood pressure devices may be provided under CCP for clients who are 20 years of age and younger.

2.2.6.1 Prior Authorization

Procedure codes A4660 and A4670 do not require prior authorization if they are billed with one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
I10	I110	I119	I120	I129	I130	I1310	I1311
I132	I150	I151	I152	I158	I159	I2601	I2602
I2609	I2690	I2692	I2699	I270	I271	I2781	I2782
I2789	I279	I340	I341	I342	I348	I349	I350
I351	I352	I358	I359	I360	I361	I362	I368
I369	I370	I371	I372	I378	I379	I421	I422
I424	I425	I428	I429	I43	I440	I441	I442
I4430	I4439	I444	I445	I4460	I4469	I447	I450
I4510	I4519	I452	I453	I454	I455	I456	I4581
I4589	I459	I471	I472	I479	I480	I481	I482
I483	I484	I4891	I4892	I495	I501	I5020	I5021
I5022	I5023	I5030	I5031	I5032	I5033	I5040	I5041
I5042	I5043	I509	I950	I951	I952	I953	I9581
I9589	I959	N010	N011	N012	N013	N014	N015
N016	N017	N018	N050	N051	N052	N053	N054
N055	N056	N057	N058	N059	N08	N1330	N1339
N13721	N13722	N13729	N13731	N13732	N13739	N170	N171
N172	N178	N179	N181	N182	N183	N184	N185
N186	N189	N250	N2589	Q200	Q201	Q202	Q203
Q204	Q205	Q208	Q210	Q211	Q212	Q213	R001

Combination Diagnosis Codes (Must be submitted in pairs)							
T800XXA, I2690	T800XXA, I2699	T81718A, I2690	T81718A, I2699	T8172XA, I2690	T8172XA, I2699	T82817A, I2690	T82817A, I2699
T82818A, I2690	T82818A, I2699						

Manual and automated blood pressure devices should last at least one year and may be considered for replacement after one year has passed. If it is medically necessary to replace nonfunctional and irreparable equipment before one year has passed, providers can submit prior authorization requests with documentation of medical necessity that explains the need for the replacement.

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Prior authorization is required in the following situations:

- Another blood pressure device is medically necessary within the same year. Replacement of equipment within the same year as the purchase requires prior authorization. If equipment must be replaced before the end of the anticipated lifespan, the provider must submit a copy of the police or fire report, when appropriate, and the measures that will be taken to prevent reoccurrence.
- The diagnosis code is not in the table above. If the diagnosis code is not one of those listed in the table above, providers must submit a request for the prior authorization of the initial or replacement device and must include all of the documentation necessary to support the medical necessity of the blood pressure device.

2.2.7 Bone Growth Stimulators

Internal and external bone growth (osteogenic) stimulators are a benefit of Texas Medicaid. Bone growth stimulators are a benefit for skeletally-mature individuals only.

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 that 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.

> ***Note:*** *Bone growth stimulators that do not meet criteria for coverage through Title XIX Home Health Services may be considered through Comprehensive Care Program (CCP) for clients who are birth through 20 years of age.*

A noninvasive electrical bone growth stimulator (procedure codes E0747 and E0748) and noninvasive ultrasound bone growth stimulator (procedure code E0760) are benefits of Texas Medicaid for DME providers when provided in the home setting. An invasive electrical bone growth stimulator (procedure code E0749) is a benefit of Texas Medicaid for freestanding and hospital-based ambulatory surgical centers when provided in the outpatient setting.

Electrical and ultrasonic bone growth stimulator devices for the treatment of orthopedic and neurosurgical conditions are a benefit for Texas Medicaid clients when the client experiences nonunion of a fracture, requires an adjunct to spinal fusion surgery, or experiences congenital pseudarthrosis.

Nonunion is defined as a fractured bone that fails to heal completely. Diagnosis of nonunion is established when a minimum of six months has passed since the injury and the fracture site shows no progressive signs of healing for a minimum of three months and is not complicated by a synovial pseudoarthrosis. Serial radiographs must confirm that fracture healing has ceased for three months or longer before the client begins treatment with the bone growth stimulator.

2.2.7.1 Professional Services

Procedure codes 20974, 20975, and 20979 are a benefit of Texas Medicaid and limited to one per six months. During the six-month limitation period, a subsequent fracture that meets the above criteria for a bone growth stimulator may be reimbursed after the submission of an appeal with documentation of medical necessity that demonstrates the criteria have been met.

2.2.7.2 * Prior Authorization Criteria and Documentation Requirements for Bone Growth Stimulators

Procedure codes E0747, E0748, E0749, and E0760 require prior authorization. Additional bone growth stimulators may be considered for prior authorization with documentation that supports treatment of a different fracture.

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A completed Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form prescribing the DME or medical supplies must be signed and dated by the prescribing physician familiar with the client prior to requesting authorization. The completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must be maintained by the requesting provider and the prescribing physician. The original signature copy must be kept in the physician's medical record for the client.

To avoid unnecessary authorization denials, the physician must provide correct and complete information, including documentation for medical necessity of the equipment or supplies requested. 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 must be maintained by the ordering physician and requesting provider in the client's medical record and is subject to retrospective review.

2.2.7.2.1 Documentation for Noninvasive Electrical Bone Growth Stimulator

Documentation of one of the following is required for prior authorization of the external, electromagnetic bone stimulator (procedure code E0747):

- Nonunions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three or more months despite appropriate fracture care.
- Delayed unions of fractures of failed arthrodesis at high risk sites (e.g., open or segmental tibial fractures, carpal navicular fractures).

Documentation must also indicate all of the following:

- 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 non-weight-bearing restrictions.

Documentation of one of the following is required for prior authorization of the external, electromagnetic bone stimulator 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.

2.2.7.2.2 Documentation for Invasive Electrical Bone Growth Stimulators

Documentation of one of the following is required for prior authorization of the surgically implanted bone growth stimulator (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 two 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.

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- 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, which involves three or more vertebrae (e.g., L3-L5, L4-S1, etc).

2.2.7.2.3 Documentation for Ultrasound Bone Growth Stimulator

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, which is documented by a minimum of two sets of radiographs that were:
  - Obtained prior to starting treatment with the bone growth stimulator.
  - Separated by a minimum of 90 days.
  - Taken with multiple views of the fracture site.
  - Accompanied by a written interpretation by a physician who states that there has been no clinically significant evidence of fracture healing between the two set of radiographs.
- Evidence of all of the following:
  - The fracture is not tumor-related.
  - The fracture is not fresh (less than seven days), closed or grade I open, tibial diaphyseal fractures, or closed fractures of the distal radius (Colles fracture).

2.2.7.3 Claims Reimbursement for Professional Services

Professional claims that are submitted for bone growth stimulation (procedure codes 20974, 20975, and 20979) may be reimbursed if the claim includes documentation of one of the following:

- Documentation of medical necessity as outlined above in subsection 2.2.7.2, "* Prior Authorization Criteria and Documentation Requirements for Bone Growth Stimulators"
- The corresponding bone growth stimulator device was submitted within 95 days of the date the bone growth stimulation procedure was performed.

The appropriate evaluation and management (E/M) procedure code must be billed for monitoring the effectiveness of bone growth stimulation treatment.

2.2.8 Breast Pumps

A manual or non hospital-grade electric breast pump may be considered for purchase only with the appropriate documentation supporting medical necessity. The purchase of a breast pump is limited to one every three years. Providers must use procedure code E0602 or E0603 when billing for the purchase of a manual or non hospital-grade electric breast pump. A hospital-grade breast pump (procedure code E0604) may be considered for rental, not purchase. Rental of a hospital-grade breast pump is not time-limited. If more than one type of breast pump is billed on the same day by the same provider, only one will be reimbursed.

The following procedure codes for replacement parts are benefits of Texas Medicaid: A4281, A4282, A4283, A4284, A4285, and A4286.

Breast pumps are also available through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

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2.2.8.1 Prior Authorization

Electric breast pumps, including non-hospital-grade and hospital grade, and replacement parts require prior authorization. Manual breast pumps do not require prior authorization. The replacement parts may be reimbursed if the client already owns a breast pump device (procedure code E0602 or E0603). The prior authorization request must include documentation of a client-owned device. Additional documentation such as the purchase date, serial number, and purchasing entity of the device may be required. Replacement of the breast pump will be considered when loss or irreparable damage has occurred, with a copy of the police or fire report when appropriate, and with the measures to be taken to prevent reoccurrence. Replacement will not be authorized in situations where the equipment has been abused or neglected by the client, the client's family, or the caregiver.

2.2.9 Cochlear Implants

Cochlear implant services (procedure codes L8499, L8615, L8616, L8617, L8618, L8619, L8623, and L8624) may be reimbursed in the home setting to DME providers.

Refer to: Subsection 9.2.23, "Cochlear Implants" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information about cochlear implant services.

2.2.10 Continuous Passive Motion (CPM) Device

A CPM device is reimbursed on a daily basis and is limited to once per day. Reimbursement includes delivery, set-up and all supplies. Providers must use procedure code E0935 when billing for a CPM machine.

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit may be considered under CCP.*

2.2.10.1 Prior Authorization

A CPM device may be considered for prior authorization through Home Health Services. Reimbursement for a CPM device is considered after joint surgery, such as knee replacement, when prescribed by a physician and submitted with clinical documentation of medical necessity and appropriateness.

2.2.11 * Diabetic Equipment and Supplies

Diabetic equipment and supplies are a benefit through Title XIX Home Health Services and do not require prior authorization unless otherwise specified.

Diabetic equipment and supplies may be obtained through one of the following methods:

- A Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form prescribing the DME or medical supplies. The Title XIX Form must be signed and dated by the prescribing physician who is familiar with the client prior to supplying any medical equipment or supplies.
- A verbal or a detailed written order provided by a physician, physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), or a certified nurse midwife (CNM).

2.2.11.1 Obtaining Equipment and Supplies Through a Title XIX Form

The completed Title XIX Form must be maintained by the dispensing provider and the prescribing physician in the client's medical record. The physician must maintain the original signed and dated copy of the Title XIX Form. The completed Title XIX Form is valid for a period up to six months from the physician's signature date.

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2.2.11.2 Obtaining Equipment and Supplies Through a Verbal or Detailed Written Order

If the dispensing provider does not have a detailed written order then a verbal order is required to be on file until the written order is received from the prescribing provider and before providing diabetic equipment and supplies. The prescribing provider's order may be a written, fax, electronic, or verbal order and must include:

- A description of the item(s).
- The client's name.
- The name of the physician or authorized prescribing provider.
- The date of the order.

A detailed written order must be received by the DME supplier within 90 days from the date of the prescribing provider's signature. The detailed written order for diabetic equipment and supplies is valid for six months from the date of the order or the date of the prescribing provider's signature, whichever is earlier, for initial orders, and from the start date of renewal orders. In the absence of a start date, then the authorized prescribing signature date will be the beginning date of service.

A completed, detailed written order must be signed and dated by the authorized prescribing provider. The prescribing provider is required to retain a copy of the signed and dated detailed written order in the client's medical record. The DME provider must retain the original, faxed, photocopied, or electronic, signed and dated detailed written order in the client's medical record.

A completed detailed written order must contain all the following components:

- The client's name
- The date of the verbal order if different from the date the authorized prescribing provider signed the written order
- Description of item(s) to be provided
- Quantity to dispense (quantity required per day or month)
- Diagnosis code or description supporting the medical necessity

Before submitting a claim to Texas Medicaid, DME providers must have on file a detailed written order with the required information. No other documentation is required.

Prior Authorization

Prior authorization, when necessary, may be considered with documentation of medical necessity, which must include one of the following:

- A completed Title XIX Form that has been signed and dated by the physician who is familiar with the client
- Or all the following:
  - A completed and signed detailed written order.
  - A Title XIX Form with section A completed.

2.2.11.3 Glucose Testing Equipment and Other Supplies

The prescribing provider must indicate on a completed, signed and dated Title XIX Form, or a signed and dated detailed written order 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).

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Glucose tablets or gel (procedure code A9150) may be considered with prior authorization when provided to a client with a diagnosis from the diagnosis code table below. Procedure code A9150 is limited to one per six months.

The procedure codes for the diabetic supplies listed in the following table do not require prior authorization, up to the quantities listed in the table, when provided to a client with a diagnosis from the diagnosis code table below. These limitations are not dependent on the client's use of insulin:

Procedure Code	Limitation
A4233	1 per 6 months
A4234	1 per 6 months
A4235	1 per 6 months
A4236	1 per 6 months
A4252	10 strips per month
A4256	2 per year
A4258	2 per year
A9275	2 per month* *Combined total with code A4253

Insulin-Dependent Clients

The following procedure codes for diabetic supplies do not require prior authorization up to the quantities listed when the supplies are provided to an insulin-dependent client with a valid diagnosis. If the client is insulin-dependent, providers must submit claims for these procedure codes with modifier U9:

Procedure Code	Limitation
A4253*	2 boxes per month
A4259	1 box per month
A9275*	2 per month
***A client may receive a combined total of two per calendar month of procedure codes A4253 and A9275, either two or one procedure code or one of each procedure code**	

Non-Insulin-Dependent Clients

The following procedure codes for diabetic supplies do not require prior authorization up to the quantities listed when they are provided to a non-insulin-dependent client with a valid diagnosis. If the client is not insulin-dependent, providers must submit claims for these procedure codes with no modifier:

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.**	

The following diagnosis codes apply to the tables listed above:

Diabetic Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
E0800	E0801	E0810	E0811	E0821	E0822	E0829	E08311
E08319	E08321	E08329	E08331	E08339	E08341	E08349	E08351

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Diabetic Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
E08359	E0836	E0839	E0840	E0841	E0842	E0843	E0844
E0849	E0851	E0859	E08610	E08618	E08620	E08621	E08622
E08628	E08630	E08638	E08641	E08649	E0865	E0869	E088
E089	E0900	E0901	E0910	E0911	E0921	E0922	E0929
E09311	E09319	E09321	E09329	E09331	E09339	E09341	E09349
E09351	E09359	E0936	E0939	E0940	E0941	E0942	E0943
E0944	E0949	E0951	E0959	E09610	E09618	E09620	E09621
E09622	E09628	E09630	E09638	E09641	E09649	E0965	E0969
E098	E099	E1010	E1011	E1021	E1022	E1029	E10311
E10319	E10321	E10329	E10331	E10339	E10341	E10349	E10351
E10359	E1036	E1039	E1040	E1041	E1042	E1043	E1044
E1049	E1051	E1052	E1059	E10610	E10618	E10620	E10621
E10622	E10628	E10630	E10638	E10641	E10649	E1065	E1069
E108	E109	E1100	E1101	E1121	E1122	E1129	E11311
E11319	E11321	E11329	E11331	E11339	E11341	E11349	E11351
E11359	E1136	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	E13321	E13329	E13331	E13339	E13341
E13349	E13351	E13359	E1336	E1339	E1340	E1341	E1342
E1343	E1344	E1349	E1351	E1352	E1359	E13610	E13620
E13621	E13622	E13628	E13638	E13641	E13649	E1365	E1369
E138	E139	O24011	O24012	O24013	O2402	O2403	O24414
O24424	O24434	O99810	O99814	O99815	P702		

Combination Diagnosis Codes (Must be submitted in pairs)							
E0800, E0865	E0801, E0865	E0821, E0865	E08311, E0865	E08319, E0865	E08321, E0865	E08329, E0865	E08331, E0865
E08339, E0865	E08341, E0865	E08349, E0865	E08351, E0865	E08359, E0865	E0836, E0865	E0839, E0865	E0840, E0865
E0851, E0865	E0865, E0841	E0865, E0842	E0865, E0843	E0865, E0844	E0865, E0849	E0865, E0851	E0865, E0852
E0865, E0859	E0865, E0869	E0865, E088	E0865, E0921	E0865, E09311	E0865, E09319	E0865, E0936	E0865, E0940
E0865, E0951	E0865, E0969	E0865, E098	E0865, E1365	E0865, E138	E0900, E0865	E0901, E0865	E1010, E1065
E1011, E10641	E1011, E1065	E1011, E1311	E1011, E13641	E10319, E1065	E1036, E1065	E1039, E1065	E1040, E1065
E1051, E1065	E1065, E1021	E1065, E1022	E1065, E1029	E1065, E10311	E1065, E10321	E1065, E10329	E1065, E10331
E1065, E10339	E1065, E10341	E1065, E10349	E1065, E10351	E1065, E10359	E1065, E1041	E1065, E1042	E1065, E1043

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Combination Diagnosis Codes (Must be submitted in pairs)							
E1065, E1044	E1065, E1049	E1065, E1052	E1065, E1059	E1065, E10610	E1065, E1069	E1065, E108	E1065, E1141
E1065, E1142	E1065, E1143	E1065, E1144	E1065, E1149	E1065, E11610	E1065, E1340	E1065, E1341	E1065, E1342
E1065, E1343	E1065, E1344	E1065, E1349	E1065, E13610	E1100, E1165	E1101, E1165	E1121, E1122	E1121, E1129
E1121, E1165	E1121, E1321	E1121, E1322	E1121, E1329	E11311, E1165	E11319, E1165	E1136, E1165	E1139, E1165
E1140, E1165	E1151, E1165	E1165, E1169	E1165, E118	E1321, E0865			

Non-diabetic Diagnosis Codes

Non-diabetic Diagnosis Codes (Submitted as stand-alone diagnosis codes)								
E161	E162	E71111	E71310	E71311	E71312	E71313	E71314	E71318
E7132	E7420	E7421	E7429	E8881	K911	R7309	R81	

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this home health benefit will receive those services through CCP.*

Alcohol wipes (procedure code A4245) and urine test or reagent strips or tablets (procedure code A4250) are a benefit of Texas Medicaid when they are necessary for the treatment of some diabetic conditions or other conditions and therefore are not limited to the diagnoses listed in the diagnosis code table above.

Procedure code A4245 is limited to four boxes per month and procedure code A4250 is limited to one box per six months. Prior authorization is not required for these procedure codes up to the quantities listed.

The quantity of glucose testing supplies billed for a one-month supply should relate to the number of tests ordered per day by the prescribing provider.

Glucose testing supplies may be reimbursed for the quantities prescribed or the quantity prior authorized.

Blood glucose test or reagent strips (procedure code A4253) and home glucose disposable monitors with test strips (procedure code A9275) are limited to a combined total of two per month.

2.2.11.3.1 Prior Authorization

Glucose tablets or gel (procedure code A9150) requires prior authorization with documentation supporting medical necessity.

Glucose testing supplies for quantities beyond the limits listed in the procedure code table above or for diagnoses other than those listed in the diagnosis code table above in subsection 2.2.11.3, "Glucose Testing Equipment and Other Supplies" in this handbook may be considered for prior authorization with documentation of medical necessity. Quantities will be prior authorized based on the documentation of medical necessity related to the number of tests ordered per day by the physician.

2.2.11.4 Blood Glucose Monitors

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. Glucose monitors that have been purchased are anticipated to last a minimum of three years and may be considered for replacement when three years have passed or the equipment is no longer repairable.

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Standard home glucose monitors (procedure code E0607) are not a benefit of Texas Medicaid.

Invasive continuous glucose monitoring (CGM) is used for diagnostic purposes to assist the clinician in establishing or modifying the client's treatment plan. A CGM device is worn up to 72 hours for the diagnostic purpose of collecting continuous blood sugar readings. These are later analyzed by the clinician.

Refer to: Subsection 9.2.24, "Continuous Glucose Monitoring (CGM)" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (Vol. 2, Provider Handbooks) for additional information.

2.2.11.4.1 Prior Authorization

Blood glucose monitors with special features (procedure code E2100 or E2101) may be considered for prior authorization with documentation supporting medical necessity for the special feature requested.

Purchase of a blood glucose monitor with integrated voice synthesizer (procedure code E2100) may be considered for prior authorization with documentation that includes a diagnosis of diabetes and significant visual impairment.

Purchase of a blood glucose monitor with integrated lancing and blood sample (procedure code E2101) may be considered for prior authorization with documentation that includes a diagnosis of diabetes and significant manual dexterity impairment related but not limited to neuropathy, seizure activity, cerebral palsy, or Parkinson's disease.

The invasive CGM device will not be prior authorized as it is considered part of the physician interpretation and report for CGM.

2.2.11.5 External Insulin Pump and Supplies

An external insulin infusion pump is a programmable, battery-powered mechanical syringe or reservoir device controlled by a microcomputer to provide a basal continuous subcutaneous insulin infusion (CSII) and release a "bolus" dose at meals and at programmed intervals. The pump is connected to an infusion set with an attached small needle or cannula that is inserted into the subcutaneous tissue. The purpose of the insulin pump is to provide an accurate, continuous, controlled delivery of insulin which can be regulated by the user to achieve intensive glucose control and prevent the metabolic complications of hypoglycemia, hyperglycemia and diabetic ketoacidosis. The typical external insulin pump capacity is two to three days of insulin.

Note: *External insulin pumps that do not require tubing may be considered for clients who are birth through 20 years of age through CCP.*

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 infusion pumps and who is knowledgeable in the use of insulin infusion pumps.

The external insulin pump (procedure code E0784) may be considered for prior authorization with documentation of medical necessity. Procedure code E0784 is limited to one purchase every three years, and one rental per month. External insulin pumps that have been purchased are anticipated to last a minimum of three years and may be considered for replacement when three years have passed or the equipment is no longer repairable.

The following procedure codes for external insulin pump supplies are a benefit through Title XIX Home Health Services and do not require prior authorization up the maximum quantities allowed. Additional quantities may be considered with documentation of medical necessity and prior authorization.

Procedure Code	Limitation
A4230	15 per month
A4231	15 per month

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Procedure Code	Limitation
A4232	10 per month
A4601	1 per 6 months
A4602	1 per 6 months
A6257	15 per month
A6258	15 per month
A6259	15 per month
K0601	4 per 2 months
K0602	4 per 2 months
K0603	4 per 2 months
K0604	1 per 6 months
K0605	1 per 6 months

Providers must bill replacement batteries (procedure codes K0601 through K0605) with modifier U1.

When there is not an appropriate procedure code for supplies providers may request prior authorization using procedure code A9900.

The external insulin pump supplies (including batteries) are not included in the external insulin pump rental. Routine maintenance of rental equipment is the provider's responsibility.

Infusion sets for the external insulin pump (procedure codes A4230 or A4231) are limited to clients with a previously billed external insulin pump device or supply. Infusion sets for clients who did not receive the external insulin pump through Texas Medicaid are considered for reimbursement on appeal with a physician's statement documenting medical necessity.

An internal insulin pump will not be prior authorized as it is considered part of the surgery to place the pump.

2.2.11.5.1 Prior Authorization

Prior authorization is required for an external insulin pump (procedure code E0784) with carrying cases.

Rental of External Insulin Pump

An external insulin pump may be considered for prior authorization of rental with submission of clinical documentation indicating one of the following:

- A client who has a diagnosis of type 1 or 2 diabetes must meet at least two of the following criteria while on multiple daily injections of insulin:
  - Elevated glycosylated hemoglobin level (HbA1c) > 7.0 percent
  - History of dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl
  - History of severe glycemic excursions with wide fluctuations in blood glucose
  - History of recurring hypoglycemia (less than 60 mg/dL) with or without hypoglycemic unawareness
  - Anticipation of pregnancy within three months
- A client with a diagnosis of gestational diabetes must meet at least one of the following criteria:
  - Erratic blood sugars in spite of maximal compliance and split dosing
  - Other evidence that adequate control is not being achieved by current methods

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In addition to the clinical documentation the provider must submit the External Insulin Pump form indicating:

- 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 prescribing provider must attest that:
  - 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.

Purchase of External Insulin Pump

An external insulin pump may be considered for prior authorization of purchase after it has been rented for a three-month trial 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

2.2.11.6 Insulin and Insulin Syringes

Insulin and insulin syringes (0.5 and 1.0 cc sizes only) that are prescribed to fee-for-service clients are reimbursed through the Medicaid Vendor Drug Program and are not covered under Title XIX Home Health Services. The Medicaid Vendor Drug Program (VDP) only enrolls pharmacies.

Refer to: "Appendix B: Vendor Drug Program" (*Vol. 1, General Information*) for more information about VDP.

2.2.12 Hospital Beds and Equipment

A hospital bed and related equipment are considered for reimbursement for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. A hospital bed is not one that is typically sold as home furniture.

The following items are a benefit of Home Health Services with prior authorization:

- Hospital bed
- Air-fluidized bed
- Pressure pads or a nonpowered pressure-reducing mattress overlay
- Nonpowered pressure-reducing mattress
- Powered pressure-reducing mattress overlay system
- Powered pressure-reducing mattress
- Advanced nonpowered pressure-reducing mattress overlay
- Powered pressure-reducing mattress overlay
- Advanced nonpowered pressure-reducing mattress
- Sheepskin and lamb's wool pads

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- Decubitus care accessories

Note: *For clients who are 20 years of age and younger and do not meet criteria through Title XIX Home Health Services, hospital beds and equipment may be considered through CCP.*

Side rails or mattresses may be considered for replacement only and may be considered if it is a client-owned hospital bed and the client's condition requires a replacement of an innerspring mattress or side rails.

2.2.12.1 Hospital Beds

A hospital bed is defined as a medical device with all of the following features:

- An articulating frame that allows adjustment of the head and foot of the bed
- A headboard
- A foot board
- A mattress
- Side rails of any type (A side rail is defined as a hinged or removable rail, board, or panel of any height.)

Note: *Without all the components listed above, Texas Medicaid will not consider a request for any hospital bed.*

2.2.12.2 Prior Authorization

Hospital beds may be considered for prior authorization for clients who cannot safely utilize a regular bed.

Fixed-Height Hospital Bed

A fixed-height bed (procedure code E0250), which allows for manual adjustment to the head and leg elevation but not height, may be considered for prior authorization if at least one of the following criteria exists:

- The client's medical condition requires positioning of the body in ways that are not feasible in an ordinary bed.
- The client's medical condition requires special positioning to alleviate pain.
- It is necessary to elevate the head of the bed 30 or more degrees most of the time due to, but not limited to, congestive heart failure, chronic pulmonary disease, or problems with aspiration, and alternative measures such as wedges or pillows, have been attempted but have failed to manage the client's medical condition.

Note: *Texas Medicaid defines a failed measure as having no clinically significant improvement after being introduced.*

- The client requires traction equipment that can only be attached to a hospital bed.

Variable-Height Hospital Bed

A variable-height hospital bed (procedure E0255), which allows manual adjustments to height as well as to head and leg elevations, may be considered for prior authorization if the client meets the criteria for a fixed -height hospital bed and requires a bed height that is different from a fixed-height hospital bed to permit transfers in and out of the bed to a chair, wheelchair, or to a standing position. Medical conditions that require a variable-height hospital bed include, but are not limited to, the following:

- Severe arthritis and other injuries to lower extremities that require the variable height feature to assist in ambulation by enabling the client to place his or her feet on the floor while sitting on the edge of the bed.

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- Severe cardiac conditions, where the client is able to leave the bed, but must avoid the strain of "jumping" up and down.
- Spinal cord injuries (including quadriplegia and paraplegia), multiple limb amputations, and stroke, where the client is able to transfer from a bed to a wheelchair with or without help.
- Other severely debilitating diseases and conditions if the client requires a bed height different than a fixed-height hospital bed to permit transfers to a chair, wheelchair, or to a standing position.

Semi-Electric Hospital Bed

A semi-electric hospital bed (procedure code E0260), which allows manual adjustments to height and electric adjustments to head and leg elevation, may be considered for prior authorization if the client meets the criteria for a fixed-height hospital bed and has a condition that requires frequent changes in body position or might require an immediate change in body position to avert a life-threatening situation.

Fully-Electric Hospital Bed

A fully-electric bed (procedure code E0265), which allows electric adjustments to height and head and leg elevation, may be considered for prior authorization when all of the following criteria are met:

- The client has paraplegia or hemiplegia.
- The fully-electric hospital bed will allow the client to have functional independence with self-care.

Documentation must include an attestation statement from the client's physician or physical or occupational therapist that verifies a determination has been made that the fully-electric hospital bed will allow the client to independently meet their daily self-care needs.

The following hospital beds may be considered for prior authorization if the client meets the criteria for a hospital bed and the weight requirements for a bariatric bed as listed below:

- Heavy-duty, extra-wide hospital bed (procedure code E0303) capable of supporting a client who weighs more than 350 pounds, but no more than 600 pounds
- Extra heavy-duty, extra-wide hospital bed (procedure code E0304) capable of supporting a client who weighs more than 600 pounds

2.2.12.3 Documentation Requirements

To request prior authorization for a hospital bed, the following documentation must be submitted:

- Accurate diagnostic information pertaining to the underlying medical diagnoses or conditions (e.g., gastrostomy feeding, suctioning, ventilator dependent, other respiratory equipment or ventilation assistance devices) to include the client's overall health status
- Client height and weight
- Client functional mobility status
- Client use of any pressure-reducing support surfaces, if applicable

2.2.12.4 Mattresses and Support Surfaces

A pressure-reducing support surface includes three separate groups of mattress or mattress-like equipment designed to assist in the healing of wounds. These devices are used in conjunction with conventional wound care therapy to prevent the occurrence of said wounds in susceptible clients. Pressure-reducing support surfaces are designed to prevent skin breakdown or to promote the healing of pressure ulcers by reducing or eliminating tissue interface pressure. Most of these devices reduce interface pressure by conforming to the contours of the body so that pressure is distributed over a larger surface area rather than concentrated on a more circumscribed location.

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For all types of pressure-reducing support surfaces, the support surface provided for the client should be one in which the client does not "bottom out." The Centers for Medicare & Medicaid Services (CMS) define "bottoming out" as: when an outstretched hand, palm up, between the undersurface of the overlay or mattress and in an area under the bony prominence can readily palpate the bony prominence (coccyx or lateral trochanter). This "bottoming out" criterion should be tested with the client in the supine position with head flat, in the supine position with head slightly elevated (no more than 30 degrees), and in the side-lying position.

Pressure-reducing support surfaces containing multiple components are categorized according to the clinically predominant component (usually the top-most layer of a multi-layer product) and the presence and stage of pressure ulcers.

The staging of pressure ulcers is as follows:

Stage I: Observable pressure related alteration of intact skin whose indicators are as follows:

- Compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel), or sensation (pain, itching).
- The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.

Stage II: Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.

Stage III: Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

Stage IV: Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.

2.2.12.4.1 Documentation Requirements

A support surface that does not meet the characteristics specified in the criteria for grouping levels may be denied and considered to be not medically necessary.

To request prior authorization for a pressure-reducing support surface, the following documentation must be provided:

- Client's overall health status and all other medical diagnoses or conditions (e.g., history of decubitus)
- Documentation of the client's limited mobility or confinement to a bed
- History of previous use and results of pressure-reducing support surfaces, (e.g., wound improvement, stasis, or degradation)
- Current wound therapy, if any

2.2.12.4.2 Group 1 Support Surfaces

A group 1 Support Surface may be considered for prior authorization with documentation of medical necessity if the client is completely immobile without assistance, or the client has limited mobility or existing pressure ulcer on the pelvis or trunk and at least one of the following conditions:

- Impaired nutritional status
- Fecal or urinary incontinence
- Altered sensory perception

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- Compromised circulatory status

All of the support surfaces described below are considered a benefit of the Home Health Services Program when medical necessity criteria for Group 1 support surfaces are met.

Pressure pads or a nonpowered pressure-reducing mattress overlay for mattresses with the following features may be considered for reimbursement with documentation of medical necessity:

- A gel or gel-like layer with a height of two inches or greater
- An air mattress overlay with interconnected air cells that are inflated with an air pump and a cell height of three inches or greater
- A water mattress overlay with a filled height of three inches or greater
- A foam mattress overlay with all the following features:
  - Base thickness of two inches or greater and peak height of three inches or greater if it is a convoluted overlay (e.g., eggcrate) or an overall height of at least three inches if it is a nonconvoluted overlay
  - Foam with a density and other qualities that provide adequate pressure reduction
  - Durable, waterproof cover

Nonpowered pressure-reducing mattresses, with the following features, may be considered for reimbursement with documentation supporting medical necessity:

- A foam mattress with all the following features may be considered with documentation supporting medical necessity. Documentation must include all of the following features:
  - A foam height of five inches or greater
  - Foam with a density and other qualities that provide adequate pressure reduction
  - Durable, waterproof cover
  - Can be placed directly on a hospital bed frame
- An air, water, or gel mattress with all the following features may be considered for reimbursement:
  - A height of five inches or greater
  - Durable, waterproof cover

A powered pressure reducing mattress overlay system, with all the following features, may be considered for reimbursement when documentation supports medical necessity:

- The system includes an air pump or blower which provides either sequential inflation and deflation of air cells, or a low interface pressure throughout the overlay.
- Inflated cell height of the air cells through which air is being circulated is 2.5 inches or greater.
- Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure provide adequate client lift, reduces pressure, and prevents bottoming out.

2.2.12.4.3 Group 2 Support Surfaces

A Group 2 support surface may be considered for prior authorization with documentation of medical necessity if the client has multiple stage II ulcers on the trunk or pelvis and has been on a comprehensive ulcer treatment program for at least the past month which has included the use of a Group 1 support surface.

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The client must also have at least one of the following:

- The ulcers have remained the same or worsened over the past month.
- There are large or multiple stage III or IV pressure ulcers on the trunk or pelvis.
- Received a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the last 60 days, and have been prescribed or placed on a Group 2 or 3 support surface immediately before discharge (within the last 30 days) from the hospital or a nursing facility

All of the support surfaces described below are considered a benefit of the Home Health Services Program when medical necessity criteria for Group 2 support surfaces are met.

The powered pressure reducing mattress (alternating pressure low air loss, or powered flotation without air loss) device with all the following features may be considered for reimbursement when documentation supports medical necessity:

- The system includes an air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress.
- Inflated cell height of the air cells through which air is being circulated is five inches or greater.
- Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattress), and air pressure to provide adequate client lift, reduce pressure, and prevent bottoming out.
- A surface designed to reduce friction and shear.

A semi-electric hospital bed with fully integrated powered pressure-reducing mattress that has all of the features described above may be considered for reimbursement when documentation supports medical necessity.

The advanced nonpowered pressure-reducing mattress overlay device with all the following features may be considered for reimbursement when documentation supports medical necessity:

- Height and design of individual cells which provide significantly more pressure reduction than Group 1 overlay and prevent bottoming out
- Total height of 3 inches or greater
- A surface designed to reduce friction and shear
- Manufacturer product information that substantiates the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces

The powered pressure-reducing mattress overlay device with all the following features may be considered for reimbursement when documentation supports medical necessity:

- The system includes an air pump or blower that provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the overlay.
- Inflated cell height of the air cells through which air is being circulated is three and a half inches or greater.
- Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure to provide adequate client lift, reduce pressure and prevent bottoming out.

The advanced nonpowered pressure-reducing mattress device with all the following features may be considered for reimbursement when documentation supports medical necessity:

- Height and design of individual cells designed to provide significantly more pressure than a Group 1 mattress and prevent bottoming out

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- Total height of 5 inches or greater
- A surface designed to reduce friction and shear
- Documented evidence substantiates that the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces

Sheepskin and lambs wool pads are considered a benefit of the Home Health Services Program under the same conditions as alternating pressure pads and mattresses (Group 2 pressure-reducing support surfaces) when prior authorized.

2.2.12.4.4 Group 3 Support Surfaces

A Group 3 support surface may be considered for prior authorization with documentation of medical necessity when all the following criteria are met:

- There is a presence of a stage III or IV ulcer.
- Severely limited mobility rendering the client bed or chair bound.
- Without an air-fluidized bed, the client would be institutionalized.
- The client has been placed on a Group 2 support surface for at least a month before ordering the air-fluidized bed with the ulcers not improving or worsening.
- There has been at least weekly assessment of the wound by the physician, a nurse or other licensed health-care professional and the treating physician has done a comprehensive evaluation of the client's's condition within the week before ordering the air-fluidized bed.
- A trained adult caregiver is available to assist the client with activities of daily living, maintaining fluid balance, supplying dietary needs, aiding in repositioning and skin care, administering prescribed treatments, recognizing and managing altered mental status, and managing the air-fluidized bed system and its potential problems, such as leakage.
- The physician continues to re-evaluate and direct the home treatment regimen monthly.
- All other alternative equipment has been considered and ruled out.

The existence of any one of the following conditions may result in noncoverage of the air-fluidized bed:

- Coexisting pulmonary disease (the lack of firm back support can render coughing ineffective and dry air inhalation thickens pulmonary secretions).
- Wounds requiring moist wound dressings that are not protected with an impervious covering such as plastic wrap or other occlusive material (if wet-to-dry dressings are being utilized, dressing changes must be frequent enough to maintain their effectiveness).
- For clients who are 21 years of age and older, the caregiver is unwilling or unable to provide the type of care required by the client who uses an air-fluidized bed.
- The home's structural support or electrical system cannot safely accommodate the air-fluidized bed.

Initial prior authorization for a Group 3 pressure-reducing support surface will be for no more than 30 days. Prior authorized extensions may be considered for reimbursement in increments of 30-day periods, up to a maximum of four months, when documentation supports continued significant improvement in wound healing. Coverage beyond four months will be on a case-by-case basis after review by the medical director or designee.

Air-fluidized beds may be considered for reimbursement when the medical necessity criteria for Group 3 support surfaces are met.

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2.2.12.5 Equipment and Other Accessories

The following equipment or accessories may be considered with documentation of medical necessity:

- Positioning devices
- Bed cradle (keeps bed covers from touching affected skin)
- Trapeze bars

2.2.12.5.1 Accessories

A mattress of any size with innerspring may be considered for prior authorization with procedure code E0271.

Replacement rails and hospital bed frame padding or covers may be considered for prior authorization as a hospital bed accessory (procedure code E0315) with documentation that the padding, covers or rails are required to prevent injury (for example, related to seizure activity) or to prevent entrapment.

2.2.12.5.2 Prior Authorization

Heel or elbow protector (procedure code E0191) does not require prior authorization. Prior authorization is required for all other hospital beds, equipment, and services provided through Texas Medicaid Title XIX Home Health Services. Prior authorization also includes any accessories, modifications, adjustments, and repairs of the equipment. Positioning cushions or pillows (procedure code E0190) may be considered with documentation of medical necessity that the item will provide pressure relief and positioning in the treatment of decubiti, burns, or musculoskeletal injuries. Documentation must include a listing of other devices that have been used and why the devices proved ineffective.

A trapeze bar attached to a bed (procedure code E0910 or E0911) may be considered if the client requires this device to sit up, to change body position, to get in or out of bed, or for other medical reasons with documentation of medical necessity.

"Free-standing" trapeze equipment (procedure code E0940 or E0912) may be considered if the client does not have an eligible hospital bed, but the client needs this device to sit up, to change body position, to get in or out of bed, or for other medical reasons with documentation of medical necessity.

An over-bed table (procedure code E0315) may be considered if the client is bed-bound and needs the over-bed table for treatments.

2.2.12.6 Decubitus Care Accessories

For prior authorization of decubitus care accessories, the following documentation must be provided:

- Wound measurements including location, length, width, and depth
- Any undermining or tunneling
- Odor, if applicable

2.2.12.7 Replacement

Beds rails and frames that have been purchased are anticipated to last a minimum of five years.

2.2.12.7.1 Prior Authorization

Prior authorization for replacement may be considered within five years of purchase when one of the following occurs:

- There has been a significant change in the client's condition, such that the current equipment no longer meets the client's needs.
- The equipment is no longer functional and cannot be repaired or it is not cost effective to repair.

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Replacement of equipment may be considered when loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent reoccurrence must be submitted.

In situations where the equipment has been abused or neglected by the client, the client's family, or the caregiver, a referral to the Department of State Health Services (DSHS) Health Screening and Case Management unit will be made by the Home Health Services prior authorization unit for clients who are 20 years of age and younger. Providers will be notified that the state will be monitoring this client's services to evaluate the safety of the environment for both the client and equipment.

2.2.12.8 Non-covered Items

A safety enclosure (procedure code E0316) used to prevent a client from leaving the bed is not a benefit of Home Health Services. A safety enclosure may be considered through CCP.

Traction equipment (procedure codes E0890, E0947, and E0948) is not a benefit of Home Health Services.

The following types of beds will not be considered for prior authorization, because they are not considered medically necessary or are inappropriate for use in the home setting:

- Institutional type beds (procedure code E0270)
- An ordinary or standard bed typically sold as furniture (may consist of a frame, box spring, and mattress, and is of fixed height with no head or leg elevation adjustments). These types of beds are not primarily medical in nature, not primarily used in the treatment of disease of injury, and are normally of use in the absence of illness or injury. They are not considered durable medical equipment (DME) by Texas Medicaid.
- All non-hospital adjustable beds available to the general public as furniture. These types of beds are not primarily medical in nature, not primarily used in the treatment of disease or injury, and are normally of use in the absence of illness or injury. They are a comfort and convenience item and are not considered DME by Texas Medicaid.
- Hospital beds without rails. Texas Medicaid considers side rails an integral part of medically necessary bed.
- Beds with rails of any height that do not allow head and foot elevation (e.g., platform beds with rails), and are primarily used to prevent clients from leaving the bed. This types of beds are not primarily medical in nature.

2.2.12.9 Hospital Beds and Equipment Procedure Code Table

Procedure Code	Maximum Limitation
E0184	1 purchase every 5 years; 1-month rental
E0185	1 purchase every 5 years; 1-month rental
E0186	1 purchase every 5 years; 1-month rental
E0187	1 purchase every 5 years; 1-month rental
E0188	1 every year
E0189	1 every year
E0193	1 per month
E0194	1 per month
E0196	1 per month
E0197	1 per month
E0198	1 purchase every 5 years; 1-month rental

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Procedure Code	Maximum Limitation
E0199	1 every 5 years
E0250	1 purchase every 5 years; 1-month rental
E0255	1 purchase every 5 years; 1-month rental
E0260	1 purchase every 5 years; 1-month rental
E0265	1 purchase every 5 years; 1-month rental
E0271	1 every 5 years
E0277	1 per month
E0280	1 purchase every 5 years; 1-month rental
E0303	1 purchase every 5 years; 1-month rental
E0304	1 purchase every 5 years; 1-month rental
E0305	1 every 5 years
E0310	1 every 5 years
E0315	1 every 5 years
E0371	1 purchase every 5 years; 1-month rental
E0372	1 purchase every 5 years; 1-month rental
E0373	1 purchase every 5 years; 1-month rental
E0910	1 purchase every 5 years; 1-month rental
E0911	1 purchase every 5 years; 1-month rental
E0912	1 purchase every 5 years; 1-month rental
E0940	1 purchase every 5 years; 1-month rental

2.2.13 Incontinence Supplies

Incontinence supplies billed for a one-month period must be based on the frequency or quantity ordered by the physician on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health benefit will receive those services through CCP.*

Refer to: Subsection 2.2.1.1, "Client Eligibility" in this handbook.

2.2.13.1 Skin Sealants, Protectants, Moisturizers, and Ointments for Incontinence-Associated Dermatitis

Incontinence-associated dermatitis is classified by category:

- Category 1—Small area of skin breakdown (<20 cm2) with mild redness (blotchy and non-uniform) and mild erosion involving the epidermis only.
- Category 2—Moderate area of skin breakdown (20-50 cm2) with moderate redness (severe in spots, but not uniform in appearance) and moderate erosion involving epidermis and dermis with no or little exudate.
- Category 3—Large area of skin breakdown (>50 cm2) with severe redness (uniformly severe in appearance) and severe erosion of epidermis with moderate involvement of the dermis and no or small volume of exudate.
- Category 4—Large area of skin breakdown (>50 cm2) with severe redness (uniformly severe in appearance) and extreme erosion of epidermis and dermis with moderate volume of persistent exudate.

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Skin sealants, protectants, moisturizers, and ointments (procedure code A6250) may be considered for clients who are 4 years of age or older and have documented incontinence-associated dermatitis.

For clients who have Category 1 or Category 2 incontinence-associated dermatitis, prior authorization is not required for a maximum quantity of 2 containers (no less than 4 ounces per container) per month and 12 containers per year of skin sealants, protectants, moisturizers, and ointments. Providers must use procedure code A6250 with modifier UA to bill for these products.

For clients who have Category 3 or Category 4 incontinence-associated dermatitis, prior authorization and documentation of medical necessity is required for skin sealants, protectants, moisturizers, and ointments that are not used for Category 1 or Category 2 incontinence-associated dermatitis. Providers must use procedure code A6250 without a modifier to bill for these products.

Providers must use procedure code A6250 instead of procedure code A5120 when billing for skin sealants, protectants, moisturizers, and ointments.

Note: *Skin sealants, protectants, moisturizers, ointments for diagnoses other than incontinence related dermatitis (i.e., wounds, decubitus ulcers, periwound skin complications, peristomal skin complications) may be considered for reimbursement with prior authorization.*

2.2.13.2 Diapers, Briefs, Pull-ons, and Liners

Diapers and briefs are defined as incontinence items attached with tabs. Pull-ons are defined as incontinence items that do not attach with tabs and are slip-on items, such as "pull-ups." Liners are intended to be worn inside diapers, briefs, and pull-ons to increase absorbency. Reusable diapers or briefs are not a benefit of Home Health Services.

For clients who are 4 years of age and older and have a medical condition that results in chronic incontinence, up to a maximum total combination of 240 per month of diapers, briefs, or liners may be considered without prior authorization. Quantities in excess of 240 per month may be considered with documentation of medical necessity and prior authorization.

Note: *Gloves used to change diapers and briefs are not considered medically necessary unless the client has skin breakdown or a documented disease that may be transmitted through the urine or stool.*

2.2.13.3 Diaper Wipes

For clients who are 4 years of age and older and are receiving diapers/briefs/pull-ons, up to 2 boxes of diaper wipes do not require prior authorization. Exceptions will not be considered through Title XIX Home Health Services. Quantities in excess of 2 boxes per month may be considered through CCP for clients who are 20 years of age and younger with documentation of medical necessity and prior authorization.

Providers must use procedure code A4335 with modifier U9 instead of procedure code A5120 when billing for diaper wipes.

If there is not an appropriate procedure code for supplies, providers may request prior authorization using procedure code A4335.

2.2.13.4 Underpads

For clients who are 4 years of age and older and are receiving diapers/briefs/pull-ons/liners/urine collection devices/bowel management supplies, up to a maximum of 120 underpads per month may be considered without prior authorization. Quantities in excess of 120 per month may be considered with documentation of medical necessity and prior authorization.

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Reusable underpads are not a benefit of Home Health Services.

Note: *The Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form for the supplies listed above must reflect no more than a one-month's supply of the incontinence product. The Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must not reflect more than the maximum allowed quantity per month without requesting prior authorization.*

2.2.13.5 Ostomy Supplies

The physician must specify the type of ostomy device or system to be used and how often it is to be changed on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. The quantity of ostomy supplies billed for a one-month period must relate to the number of changes per month based on the frequency ordered by the physician.

Ostomy supplies may be considered for reimbursement without prior authorization.

2.2.13.6 Indwelling or Intermittent Urine Collection Devices

The home setting is considered a clean environment, not a sterile one. Sterile incontinence supplies, (including the supplies in procedure codes A4311, A4312, A4313, A4314, A4315, A4316, and A4353) are a benefit in the home setting when requested for the following:

- Indwelling urinary catheters
- Intermittent catheters for clients who:
  - Are immunosuppressed
  - Have radiologically documented vesico-ureteral reflux
  - Are pregnant and have a neurogenic bladder due to spinal cord injury
  - Have a history of distinct, recurrent urinary tract infections, defined as a minimum of two within the prior 12-month period, while on a program of clean intermittent catheterization

Nonsterile or sterile gloves for use by a health-care provider in the home setting, such as a registered nurse (RN), licensed vocational nurse (LVN), or attendant, are not a benefit of Home Health Services.

2.2.13.6.1 Indwelling Catheters and Related Insertion Supplies

Indwelling catheters and related supplies may be considered without prior authorization up to a maximum of 2 per month for clients who have a medical condition that results in an impairment of urination. Quantities in excess of 2 per month may be considered with documentation of medical necessity and prior authorization.

2.2.13.6.2 Intermittent Catheters and Related Insertion Supplies

Intermittent catheters and related supplies, up to a maximum of 150 per month, may be considered without prior authorization for clients who have a medical condition that results in an impairment of urination. Quantities in excess of 150 per month may be considered with documentation of medical necessity and prior authorization.

Procedure code A4351 denotes catheters used for intermittent catheterizations. Procedure code A4351 must be accompanied with modifier SC when a hydrophilic catheter is used.

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A completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form may be valid for up to 12 months for intermittent catheters and related insertion supplies for quantities within the stated benefit limits for clients who have one of the following chronic conditions:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
G35	G8221	G8222	G8250	G8253	G8254	G834	N310
N311	N312	N319	Q054	Q057	Q058	Q0701	Q0702
Q0703	Q6410	Q6412	Q6419	Q760	Q794		

Note: *The diagnosis codes R32 and R339 are not specific enough to allow for the extension of the prior authorization to 12 months.*

For clients who have a diagnoses other than those listed in the above table, the completed Title XIX Form may be valid for up to six months for intermittent catheters and related insertion supplies for quantities within the stated benefit limits.

For quantities greater than the stated benefit limits, prior authorization will be required and may be granted for up to six months regardless of diagnosis.

Nonsterile gloves are a benefit with prior authorization when a family member or friend is performing the catheterization.

Providers must use procedure codes A4351 or A4352 when billing for intermittent catheters. Providers must use procedure code A4353 when billing for intermittent catheters with insertion supplies. For hydrophilic catheters, procedure code A4351 must be accompanied with modifier SC.

2.2.13.6.3 External Urinary Collection Devices

For clients who are 4 years of age and older and have a medical condition that results in a permanent impairment of urination, external urinary collection devices, including, but not limited to, male external catheters, female collection devices, and related supplies may be considered without prior authorization. Male external catheters are limited to 31 per month. Female collection devices are limited to 4 per month. Male external catheters in excess of 31 per month and female collection devices in excess of 4 per month may be considered with documentation of medical necessity and prior authorization.

2.2.13.6.4 Urinals and Bed Pans

Urinals and bed pans may be considered without prior authorization for clients who have a medical condition that results in an inability to ambulate to the bathroom safely (with or without mobility aids) up to a limit of 2 per year. Quantities in excess of 2 per year may be considered with documentation of medical necessity and prior authorization.

Urinals and bed pans are purchase only.

2.2.13.7 Prior Authorization

Prior authorization is required for incontinence supplies if amounts greater than the maximum limits are medically necessary.

2.2.13.8 Documentation Requirements

To request prior authorization for incontinence supplies and equipment, the following documentation must be provided:

- Diagnostic information pertaining to the underlying diagnosis or condition, the diagnosis causing incontinence, and any other medical diagnoses or conditions, including the client's overall health status
- Weight and height or waist size, when applicable

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- Number of times per day the physician has ordered the supply be used
- Quantity of disposable supplies requested per month by the physician

Additional information may be requested to clarify or complete a request for the supplies.

2.2.13.9 Incontinence Procedure Codes with Limitations

Any service or combination of services, except diaper wipes, requires prior authorization if the maximum limitation is exceeded. Requests for prior authorization of diaper wipes that exceed more than two boxes per month will not be considered through Home Health Services.

Procedure Code	Maximum Limitation
A4310	2 per month
A4311	2 per month
A4312	2 per month
A4313	2 per month
A4314	2 per month
A4315	2 per month
A4316	2 per month
A4320	2 per month
A4322	4 per month
A4326	31 per month
A4327	4 per month
A4328	4 per month
A4330	As needed
A4331	2 per month
A4332	50 per month
A4333	2 per month
A4334	2 per month
A4335	2 per month
A4338	2 per month
A4340	2 per month
A4344	2 per month
A4346	2 per month
A4349	31 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
A4360	31 per month
A4361	As needed

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Procedure Code	Maximum Limitation
A4362	As needed
A4363	As needed
A4364	As needed
A4366	As needed
A4367	As needed
A4368	As needed
A4369	As needed
A4371	As needed
A4372	As needed
A4373	As needed
A4375	As needed
A4376	As needed
A4377	As needed
A4378	As needed
A4379	As needed
A4380	As needed
A4381	As needed
A4382	As needed
A4383	As needed
A4384	As needed
A4385	As needed
A4387	As needed
A4388	As needed
A4389	As needed
A4390	As needed
A4391	As needed
A4392	As needed
A4393	As needed
A4394	As needed
A4395	As needed
A4396	1 per month
A4397	As needed
A4398	As needed
A4399	1 per month
A4400	As needed
A4402	4 per month
A4404	As needed
A4405	As needed
A4406	As needed
A4407	As needed

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Procedure Code	Maximum Limitation
A4408	As needed
A4409	As needed
A4410	As needed
A4411	As needed
A4412	As needed
A4413	As needed
A4414	As needed
A4415	As needed
A4416	As needed
A4417	As needed
A4418	As needed
A4419	As needed
A4420	As needed
A4421	As needed
A4422	As needed
A4423	As needed
A4424	As needed
A4425	As needed
A4426	As needed
A4427	As needed
A4428	As needed
A4429	As needed
A4430	As needed
A4431	As needed
A4432	As needed
A4433	As needed
A4434	As needed
A4435	As needed
A4455	4 per month
A4456	50 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

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Procedure Code	Maximum Limitation
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
T4521	*240 per month
T4522	*240 per month
T4523	*240 per month
T4524	*240 per month
T4525	*240 per month
T4526	*240 per month
T4527	*240 per month
T4528	*240 per month
T4529	*240 per month
T4530	*240 per month
T4531	*240 per month
T4532	*240 per month
T4533	*240 per month
T4534	*240 per month
T4535	*240 per month
T4543	*240 per month
T4544	*240 per month
E0275	2 per year
E0276	2 per year
E0325	2 per year

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Procedure Code	Maximum Limitation
E0326	2 per year

Note: *Providers must include modifier U1 with procedure code T4528 when submitting claims for bariatric adult size products.*

Refer to: Subsection 2.2.13.2, "Diapers, Briefs, Pull-ons, and Liners" in this handbook for an explanation of the item limitations identified with an asterisk (*).

The following procedure codes always require prior authorization even if the maximum benefit limitation allowed has not been exceeded:

Procedure Code	Maximum Limitation
A4927	1 per month
A6250	2 per month

2.2.14 Intravenous (IV) Therapy Equipment and Supplies

The following equipment and supplies are used in the delivery of IV therapy and are a benefit of Home Health Services. Additional supply procedure codes may be considered with documentation of medical necessity:

Procedure Code									
A4206	A4207	A4208	A4209	A4212	A4222	A4245	A4247	A4248	A4300
A4305	A4306	A4450	A4452	A4602	A4930	A6206	A6207	A6257	A6258
A6402	A9900	E0776	E0779	E0780	E0781	E0791	K0455	K0552	K0601
K0602	K0603	K0604	K0605	S1015					

Types of IV access devices include but are not limited to:

- Peripheral IV lines.
- Central IV lines, including but not limited to, peripherally-inserted central catheters, subclavian catheters, and vena cava catheters.
- Central venous lines, including but not limited to, tunneled and peripherally inserted central venous catheters.
- Implantable ports, including but not limited to, access devices with subcutaneous ports.

Stopcocks increase the risk of infection and should not be routinely used for infusion administration. Routine use of in-line filters is not recommended for infection control.

Note: *Nonsterile or sterile gloves for use by a health-care provider in the home setting, such as an RN, LVN, or attendant, are not a benefit of Home Health Services.*

Stationary infusion pumps may be a benefit when the infusion rate must be more consistent and cannot be obtained with gravity drainage. Ambulatory infusion pumps may be a benefit when the length of infusion is greater than two hours, the client must be involved in activities away from home, and when the infusion rate must be more consistent and cannot be obtained with gravity drainage. Elastomeric infusion pumps may be a benefit for short-term use when the caregiver cannot administer the infusion by pump. Dial flow regulators are a benefit and are incorporated into IV extension sets or IV tubing. Elastomeric devices may be reimbursed using procedure codes A4305 and A 4306.

Rental of an infusion pump may be prior authorized on a monthly basis for a maximum of four months per lifetime. Purchase of an infusion pump (ambulatory or stationary) may be prior authorized with documentation of medical necessity that supports repeated IV administration for a chronic condition.

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For clients who require cardiovascular medications, infusion pumps will be rented, but not purchased.

Repairs to client-owned equipment may be prior authorized as needed with documentation of medical necessity. Technician fees are considered part of the cost of the repair. Providers are responsible for maintaining documentation in the client's medical record that specifies the repairs and supports medical necessity. All repairs and replacement parts within the first six months after delivery are considered part of the purchase price. Batteries for client-owned equipment require prior authorization. Additional documentation, such as the purchase date, serial number, and manufacturer's information, may be required.

IV therapy, supplies, and equipment are not considered a benefit when the infusion or medication being administered:

- Is not considered medically necessary to the treatment of the client's illness.
- Exceeds the frequency or duration ordered by the physician.
- Is a chemotherapeutic agent.
- Is not FDA-approved, unless the physician documents why the off-label use is medically appropriate and not likely to result in an adverse reaction. In order to consider coverage of an off-label (non-FDA approved) use of a drug, documentation must include why a drug usually indicated for the specific diagnosis or condition has not been effective for the client.

Routine maintenance of rental equipment is included in the rental price.

Repairs or replacement parts may be reimbursed with documentation of a client-owned device.

Replacement batteries (procedure codes K0601, K0602, K0603, K0604, and K0605) for client-owned pumps are limited to one battery per 180 days.

2.2.14.1 Prior Authorization

Additional replacement batteries for client-owned pumps (procedure codes K0601, K0602, K0603, K0604, and K0605) beyond the limit of 1 per 180 days may be considered for prior authorization with documentation of medical necessity.

All IV equipment and supplies, with the exception of implantable access catheter (A4300) require prior authorization. Prior authorization of IV equipment and supplies may be considered when administration of the drug in the home is medically necessary and is appropriate in the home setting. IV equipment may be prior authorized for rental or purchase depending on the clinician's predicted length of treatment.

The following standards are used when considering prior authorization of IV supplies:

- The aseptic technique is acceptable for IV catheter insertion and site care; the sterile technique is not required:
  - Nonsterile gloves are acceptable for the insertion of a peripheral IV catheter and for changing any IV site dressing.
  - The sterile technique may be medically necessary. Examples of medical necessity include, but are not limited to, a client who is immuno-compromised.
- A peripheral IV site is rotated no more frequently than every 72 hours, but it is rotated at least weekly.
- The IV administration set (with or without dial flow regulator), extension set (with or without dial flow regulator), and any add-on devices are changed every 72 hours.
- One IV access catheter is used per insertion.
- Saline or heparin-locked catheters:

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  - Use one syringe to flush the catheter before administration of an intermittent infusion to assess.
  - Use two syringes to flush the catheter after the intermittent infusion—one to clear the medication and one to infuse the anticoagulant or other medication used to maintain IV patency between doses, including, but not limited to, heparin.
- An injection port is cleaned before administering an intermittent infusion and capped after the infusion.
- IV catheter site care:
  - Disinfect the site with an appropriate antiseptic (including but not limited to 2 percent chlorhexidine-based preparation, tincture of iodine, or 70 percent alcohol).
  - Cover with sterile gauze, transparent dressing, or semi-permeable dressing.
  - Replace the dressing if it becomes damp, loosened, or visibly soiled.

Elastomeric devices and dial flow regulators are specialized infusion devices that may be considered for prior authorization when the device:

- Will be used for short-term medication administration (less than two weeks duration).
- Is expected to increase client compliance.
- Will better facilitate drug administration.
- Costs less than the cost of pump rental or tubing.
- The caregiver can not administer the infusion by pump.

The following criteria must be met for prior authorization of a stationary infusion pump:

- An infusion pump is required to safely administer the drug.
- The standard method of administration of the drug is through prolonged infusion or intermittent infusion, and the infusion rate must be more consistent than can be obtained with gravity drainage.
- The drug being administered requires IV infusion (i.e., the drug cannot be administered orally, intramuscularly, or by push technique).

The following criteria must be met for prior authorization of an ambulatory infusion pump:

- An infusion pump is required to safely administer the drug.
- The standard method of administration of the drug is through prolonged infusion or intermittent infusion and the infusion rate must be more consistent than can be obtained with gravity drainage.
- The drug being administered requires IV infusion (i.e., the drug cannot be administered orally, intramuscularly, or by push technique).
- The infusion administration is more than two hours and the client is involved in activities away from home, including but not limited to, physician visits.

2.2.14.2 Documentation Requirements

To request prior authorization for IV supplies and equipment, the following documentation must be provided:

- Diagnostic information pertaining to the underlying diagnosis or condition
- A physician's order and documentation supporting medical necessity
- The medication and dose being administered, the duration of drug therapy, and the frequency of administration

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If additional supplies are needed beyond the standards listed, prior authorization may be considered with documentation supporting medical necessity.

For additional IV access catheters, supporting documentation must have evidence that includes, but is not limited to, the following:

- Dehydration
- Vein scarring
- Fragile veins, including but not limited to, clients who are infants or elderly

For more frequent IV site changes, supporting documentation must have evidence that includes, but is not limited to, the following:

- Phlebitis
- Infiltration
- Extravasation

For more frequent IV tubing or add-on changes, supporting documentation must have evidence that includes, but is not limited to, the following:

- Phlebitis
- IV catheter-related infection
- The administered infusion requires more frequent tubing changes

2.2.15 Mobility Aids

Mobility aids and related supplies, including, but not limited to canes, crutches, walkers, wheelchairs, and ramps are a benefit through Title XIX Home Health Services to assist clients to move about in their environment.

Note: *A mobility aid for a client who is birth through 20 years of age is medically necessary when it is required to correct or ameliorate a disability or physical illness or condition.*

2.2.15.1 Canes, Crutches, and Walkers

Canes, crutches, and walkers are a benefit through Title XIX Home Health Services when medically necessary to assist clients to move about in their environment. Walkers require prior authorization. Prior authorization is not required for canes, crutches, or walker accessories.. Documentation of medical necessity must be provided by a physician familiar with the client and must include information on the client's impaired mobility.

2.2.15.2 Wheelchairs

A wheelchair is a non-customized chair mounted on four wheels that incorporates a non-adjustable frame, a sling or solid back and seat, and arm rests. Optional items included in this definition include, but are not limited, to the following:

- Handles at the back
- Foot rest
- Seat belt or safety restraint

A wheelchair includes all of the following:

- Standard (manual) wheelchairs
- Standard hemi (manual) wheelchairs
- Standard reclining (manual) wheelchairs

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- Lightweight (manual) wheelchairs
- High strength lightweight (manual) wheelchairs

2.2.15.2.1 Prior Authorization

A wheelchair may be prior authorized for short-term rental or for purchase with documentation supporting medical necessity and an assessment of the accessibility of the client's residence to ensure that the wheelchair is usable in the home (i.e., doors and halls wide enough, no obstructions). The wheelchair must be able to accommodate a 20 percent change in the client's height or weight.

2.2.15.2.2 Documentation Requirements

Documentation by a physician familiar with the client must include information on the client's impaired mobility and physical requirements. In addition, the following information must be submitted with documentation of medical necessity:

- Why the client is unable to ambulate a minimum of 10 feet due to their condition (including, but not limited to, AIDS, sickle cell anemia, fractures, a chronic diagnosis, or chemotherapy)
- If the client is able to ambulate further than 10 feet, why a wheelchair is required to meet the client's needs

2.2.15.3 Manual Wheelchairs-Standard, Standard Hemi, and Standard Reclining

A standard manual wheelchair is defined as a manual wheelchair that:

- Weighs more than 36 pounds.
- Does not have features to appropriately accept specialized seating or positioning.
- Has a weight capacity of 250 pounds or less.
- Has a seat depth of between 15 and 19 inches.
- Has a seat width of between 15 and 19 inches.
- Has a seat height of 19 inches or greater.
- Is fixed height only, fixed, swing away, or detachable armrest.
- Is fixed, swing away, or detachable footrest.

A standard hemi (low seat) wheelchair is defined as a manual wheelchair that:

- Has the same features as a standard manual wheelchair.
- Has a seat to floor height of less than 19 inches.

A standard reclining wheelchair is defined as a manual wheelchair that:

- Has the same features as a standard or standard hemi manual wheelchair.
- Has the ability to allow the back of the wheelchair to move independently of the seat to provide a change in orientation by opening the seat-to-back angle and, in combination with leg rests, open the knee angle.

2.2.15.3.1 Prior Authorization

A standard manual wheelchair may be considered for prior authorization for short-term rental or purchase when all the following criteria are met:

- The client has impaired mobility and is unable to ambulate more than 10 feet.
- The client does not require specialty seating components.
- The client is not expected to need powered mobility within the next 5-year period.

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A standard hemi wheelchair may be considered for prior authorization for short-term rental or purchase when the client meets criteria for a standard manual wheelchair and the following criteria is met:

- The client requires a low seat-to-floor height.
- The client must use their feet to propel the wheelchair.

A standard reclining wheelchair may be considered for prior authorization for short-term rental or purchase when the client meets criteria for a standard manual wheelchair and one or more of the following criteria are met:

- The client develops fatigue with longer periods of sitting upright.
- The client is at increased risk of pressure sores with prolonged upright position.
- The client requires assistance with respirations in a reclining position.
- The client needs to perform mobility related activities of daily living (MRADLs) in a reclining position.
- The client needs to improve venous return from lower extremity in a reclining position.
- The client has severe spasticity.
- The client has excess extensor tone of the trunk muscles.
- The client has quadriplegia.
- The client has a fixed hip angle.
- The client must rest in a reclining position two or more times per day.
- The client has the inability or has great difficulty transferring from wheelchair to bed.
- The client has trunk or lower extremity casts or braces that require the reclining feature for positioning.

2.2.15.4 Manual Wheelchairs-Lightweight and High-Strength Lightweight

A lightweight manual wheelchair is defined as a manual wheelchair that:

- Has the same features as a standard or hemi manual wheelchair.
- Weighs 34 to 36 pounds.
- Has available arm styles that are height adjustable.

A high-strength lightweight wheelchair is defined as a manual wheelchair that:

- Has the same features as a lightweight manual wheelchair.
- Weighs 30 to 34 pounds.
- Has a lifetime warranty on side frames and cross braces.

2.2.15.4.1 Prior Authorization

A lightweight manual wheelchair may be considered for prior authorization for rental or purchase when all the following criteria are met:

- The client is unable to propel a standard manual wheelchair at home.
- The client is capable of independently propelling a lightweight wheelchair to meet their MRADLs at home.

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A high-strength lightweight wheelchair may be considered for prior authorization for rental or purchase when the client meets all of the criteria for a lightweight manual wheelchair and meets one or more of the following criteria:

- The high-strength lightweight wheelchair will allow the client to self-propel while engaging in frequently performed activities that cannot otherwise be completed in a standard or lightweight wheelchair.
- The client requires frame dimensions (seat width, depth, or height) that cannot be accommodated in a standard, lightweight, or hemi wheelchair and the wheelchair is used at least 2 hours a day.

2.2.15.5 Manual Wheelchairs-Heavy-Duty and Extra Heavy Duty

A heavy duty wheelchair is defined as a manual wheelchair that:

- Meets the standard manual wheelchair definition.
- Has a weight capacity greater than 250 pounds.

An extra heavy duty wheelchair is defined as a manual wheelchair that:

- Meets the standard manual wheelchair definition.
- Has a weight capacity greater than 300 pounds.

2.2.15.5.1 Prior Authorization

A heavy-duty wheelchair may be considered for prior authorization for short-term rental or purchase when the client has severe spasticity or all the following criteria are met:

- The client meets criteria for a standard manual wheelchair.
- The client weighs between 250 and 300 pounds.

An extra heavy duty wheelchair may be considered for prior authorization for short-term rental or purchase when all the following criteria are met:

- The client meets criteria for a standard manual wheelchair.
- The client weighs more than 300 pounds.

2.2.15.6 Wheeled Mobility Systems

A wheeled mobility system is a manual or power wheelchair, or scooter that is a customized power or manual mobility device, or a feature or component of the mobility device, including but not limited to, the following:

- Seated positioning components
- Powered or manual seating options
- Specialty driving controls for powered chairs
- Adjustable frame
- Other complex or specialized components

A wheeled mobility system includes all of the following:

- Tilt-in-space (manual) wheelchairs
- Pediatric size (manual) wheelchairs and strollers
- Custom ultra lightweight (manual) wheelchairs
- All power wheelchairs
- All scooters

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2.2.15.6.1 Definitions and Responsibilities

The following definitions and responsibilities apply to the provision of wheeled mobility systems.

Adjustments—The adjustment of a component or feature of a wheeled mobility system.

Adjustments require labor only and do not include the addition, modification, or replacement of components or supplies needed to complete the adjustment.

Texas Medicaid will consider adjustments only to client-owned equipment that is considered a benefit of Texas Medicaid.

Major Modification—The addition of a custom or specialized feature or component of a wheeled mobility system that did not previously exist on the system due to changes in the client's needs, including, but not limited to, the items listed in this paragraph. This definition also includes the modification of a custom or specialized feature or component due to a change in the client's needs, including, but not limited to, the following:

- Seated positioning components, including, but not limited to, specialized seating or positioning components
- Powered or manual seating options, including, but not limited to, power tilt or recline seating systems and seat elevation systems
- Specialty driving controls, including, but not limited to, non-standard alternative power drive control systems
- Adjustable frame, including, but not limited to, non-standard seat frame dimensions
- Other complex or specialized components, including, but not limited to, power elevating leg rests and specialized electronic interfaces

The replacement of a previously existing custom or specialized feature or component with an identical or comparable component is considered a repair and not a major modification.

Texas Medicaid will consider major modifications only to client-owned equipment that is considered a benefit of Texas Medicaid.

Minor Modification—The addition or modification of non-custom or non-specialized features or components due to changes in the client's needs, including but not limited to, the following:

- Armpads/armrests
- Legrests/Leg extensions
- Modification of seating and positioning components to accommodate for a change in the client's size.

The replacement of a previously existing non-custom or non-specialized feature or component with an identical or comparable component is considered a repair and not a minor modification.

Texas Medicaid will consider minor modifications only to client-owned equipment that is considered a benefit of Texas Medicaid.

Mobility Related Activity to Daily Living (MRADL)—An activity of daily living requiring the use of mobility aids (i.e., toileting, feeding, dressing, grooming, and bathing).

Occupational Therapist—A person who is currently licensed by the Executive Council of Physical Therapy & Occupational Therapy Examiners to practice occupational therapy.

Physical Therapist—A person who is currently licensed by the Executive Council of Physical Therapy & Occupational Therapy Examiners to practice physical therapy.

> ***Note:*** *A physical or occupational therapist is responsible for completing the seating assessment of a client required for obtaining a wheeled mobility system.*

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Qualified Rehabilitation Professional (QRP)—A person who meets one or more of the following criteria:

- Holds a certification as an Assistive Technology Professional (ATP) or a Rehabilitation Engineering Technologist (RET) issued by, and in good standing with, the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).
- Holds a certification as a Seating and Mobility Specialist (SMS) issued by, and in good standing with, RESNA.
- Holds a certification as a Certified Rehabilitation Technology Supplier (CRTS) issued by, and in good standing with, the National Registry of Rehabilitation Technology Suppliers (NRRTS).

The QRP is responsible for:

- Being present at and involved in the seating assessment of the client for the rental or purchase of a wheeled mobility system.
- Being present at the time of delivery of the wheeled mobility system to direct the fitting of the system to ensure that the system functions correctly relative to the client.

Repairs—The replacement of a component or feature of a wheeled mobility system that is no longer functioning as designed, with an identical or comparable component that does not change the size or function of the system.

Texas Medicaid will consider repairs only to client-owned equipment that is considered a benefit of Texas Medicaid.

Additional Benefit Information

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

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- 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

Claims for wheelchairs, components, and accessories must be submitted using the most appropriate procedure code that describes the item.

2.2.15.6.2 Prior Authorization

A wheeled mobility system may be prior authorized for short-term rental or for purchase with documentation supporting medical necessity and an assessment of the accessibility of the client's residence to ensure that the wheelchair is usable in the home (i.e., doors and halls wide enough, no obstructions). The wheelchair must be able to accommodate a 20 percent change in the client's height or weight.

2.2.15.6.3 Documentation Requirements

Documentation by a physician familiar with the client must include information on the client's impaired mobility and physical requirements. In addition, the following information must be submitted with documentation of medical necessity:

- Why the client is unable to ambulate a minimum of 10 feet due to their condition (including, but not limited to, AIDS, sickle cell anemia, fractures, a chronic diagnosis, or chemotherapy), or
- If the client is able to ambulate further than 10 feet, why a wheelchair is required to meet the client's needs.
- A completed Wheelchair/Scooter/Stroller Seating Assessment Form with seating measurements that includes documentation supporting medical necessity
- An itemized component list for custom manual or power wheeled mobility systems.

When medically necessary, prior authorization may also be considered for the rental or purchase of an alternative wheelchair on a case-by-case basis, as follows:

- A manual wheelchair will be considered for a client who owns or is requesting a power wheeled mobility system with no custom features.
- A manual wheelchair or a manual wheeled mobility system will be considered for a client who owns or is requesting a power wheeled mobility system with custom features.

2.2.15.7 Manual Wheeled Mobility System - Tilt-in-Space

A tilt-in-space manual wheeled mobility system is defined as a manual wheelchair that meets the following requirements:

- Has the ability to tilt the frame of the wheelchair greater than or equal to 45 degrees from horizontal while maintaining a constant back to seat angle to provide a change of orientation and redistribute pressure from one area (such as the buttocks and the thighs) to another area (such as the trunk and the head)
- Adult size has a weight capacity of at least 250 pounds

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- Pediatric size has a seat width or depth of less than 15 inches

2.2.15.7.1 Prior Authorization

A tilt-in-space wheeled mobility system may be considered for prior authorization for short-term rental or purchase when all the following criteria are met:

- The client meets criteria for a standard manual wheelchair.
- The client has a condition that meets criteria for a tilt-in-space feature, including but not limited to:
  - Severe spasticity
  - Hemodynamic problems
  - Quadriplegia
  - Excess extensor tone
  - Range of motion limitations prohibit a reclining system, such as hip flexors, hamstrings, or even heterotopic ossification
  - The need to rest in a recumbent position two or more times per day and the client has an inability to transfer between bed and wheelchair without assistance
  - Documented weak upper extremity strength or a disease that will lead to weak upper extremities
  - At risk for skin break down because of inability to reposition body in a chair to relieve pressure areas

2.2.15.8 Manual Wheeled Mobility System- Pediatric Size

A pediatric sized wheeled mobility system is defined as a manual standard/custom wheelchair (including those optimally configured for propulsion or custom seating) that has a seat width or depth of less than 15 inches.

2.2.15.9 Manual Wheeled Mobility System -Custom (Includes Custom Ultra-Lightweight)

Custom manual wheeled mobility systems may be considered for a client who meets criteria for a manual wheelchair, has a condition that requires specialized seating, and cannot safely utilize a standard manual wheelchair.

A custom ultra lightweight wheeled mobility system is defined as an optimally configured wheelchair for independent propulsion which cannot be achieved in a standard, lightweight, or high-strength light-weight wheelchair that:

- Meets the high-strength lightweight definition and weighs less than 30 pounds.
- Has one or more of the following features to appropriately accept specialized seating or positioning:
  - Adjustable seat-to-back angle
  - Adjustable seat depth
  - Independently adjustable front and rear seat-to-floor dimensions
  - Adjustable caster stem hardware
  - Adjustable rear axle
  - Adjustable wheel camber
  - Adjustable center of gravity
- Has a lifetime warranty on side frames and cross braces

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2.2.15.9.1 Prior Authorization

A custom ultra-lightweight wheeled mobility system may be considered for prior authorization for rental or purchase when the client meets all the criteria for a lightweight manual wheelchair and one or more of the following criteria:

- The client is able to self-propel, will have independent mobility with the use of an optimally configured chair, and meets all of the following criteria:
  - The client uses the wheelchair for a significant portion of their day to complete MRADLs.
  - The client uses the wheelchair in the community to complete MRADLs.
  - Powered mobility is not anticipated within the next 5-year period.
- The client is able to self-propel, will have independent mobility with the use of an optimally configured chair, has a medical condition that cannot be accommodated by the seating available on a standard, lightweight, or high-strength lightweight wheelchair and one or more of the following features needed by the client to ensure optimal independence with MRADLs:
  - Adjustable seat to back angle.
  - Adjustable seat depth.
  - Independently adjustable front and rear seat-to-floor dimensions.
  - Adjustable caster stem hardware.
  - Adjustable rear axle (adjustable center of gravity).
  - Powered mobility is not anticipated within the next 5-year period.
- The client meets all of the following criteria:
  - The client is unable to self-propel.
  - The client has a documented condition that requires custom seating, including, but not limited to:
    - Poor trunk control.
    - Contractures of elbow or shoulders.
    - Muscle spasticity.
    - Tone imbalance through shoulders or back.
    - Kyphosis or Lordosis.
    - Lack of flexibility in pelvis or spine.
    - The client requires custom seating that cannot be accommodated on a standard, lightweight, or hemi-wheelchair.

Prior authorization for labor to create a custom molded seating system is limited to a maximum of 15 hours.

2.2.15.10 Seating Assessment for Manual and Power Custom Wheelchairs

A seating assessment is required for:

- The rental or purchase of any device meeting the definition of a wheeled mobility system as defined under subsection 2.2.15.6, “Wheeled Mobility Systems” in this handbook.
- The purchase of any device meeting the definition of a wheelchair as defined under subsection 2.2.15.2, “Wheelchairs” in this handbook for a client with a congenital or neurological condition, myopathy, or skeletal deformity, which requires the use of a wheelchair.

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A seating assessment with measurements, including specifications for exact mobility/seating equipment and all necessary accessories, must be completed by a physician, licensed occupational therapist, or licensed physical therapist.

A QRP directly employed or contracted by the DME provider must be present at and participate in all seating assessments, including those provided by a physician.

Upon completion of the seating assessment, the QRP must attest to his or her participation in the assessment by signing the Wheelchair/Scooter/Stroller Seating Assessment Form. This form must be submitted with all requests for wheeled mobility systems.

When the practitioner completing the seating assessment is an occupational or physical therapist, the occupational or physical therapist may perform the seating assessment as the therapist, or as the QRP, but may not perform in both roles at the same time. If the occupational or physical therapist is attending the seating assessment as the QRP, the occupational or physical therapist must meet the credentialing requirements and be enrolled in Texas Medicaid as a QRP.

If the practitioner completing the seating assessment is a physician, the seating assessment is considered part of the evaluation and management service provided.

Note: *If a client who is birth through 20 years of age requires seating support and meets the criteria for a seating system, a stroller may be considered through CCP, or a wheelchair may be considered through Texas Medicaid Title XIX Home Health Services.*

2.2.15.10.1 Prior Authorization

A seating assessment performed by an occupational therapist, physical therapist, or a physician, with the participation of a QRP, does not require prior authorization. A seating assessment performed by a physician is considered part of the physician evaluation and management service.

The QRP's participation in the seating assessment requires authorization before the service can be reimbursed. Authorization must be requested at the same time and on the same prior authorization request form as the prior authorization request for the QRP fitting and the wheeled mobility system or major modification to the wheeled mobility system.

Prior authorization requests for the QRP's participation in the seating assessment will be returned to the provider if the seating assessment is requested separately from the prior authorization for the QRP fitting and the wheeled mobility system or major modification to the wheeled mobility system.

The QRP participating in the seating assessment must be directly employed by or contracted with the DME provider requesting the wheeled mobility system or major modification to a wheeled mobility system.

An authorization for the QRP's participation in the seating assessment for a wheeled mobility system or major modification to a wheeled mobility system may be issued to the QRP in 15-minute increments, for a time period of up to one hour (4 units).

If the seating assessment is completed by a physician, reimbursement is considered part of the physician office visit and will not be reimbursed separately.

The practitioner (occupational therapist or physical therapist) completing the assessment must submit procedure code 97001 or 97003 with modifier U1, in order to bill for the seating assessment.

Services for the QRP's participation in the seating assessment must be submitted for reimbursement by the DME provider billing for the wheeled mobility system using procedure code 97542 with modifier U1. The DME provider must include the QRP specialty as the performing provider on the claim for all components of the wheeled mobility system, including the QRP's participation in the seating assessment.

Seating assessment services performed by a QRP is limited to four units (one hour).

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2.2.15.10.2 Documentation Requirements

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. A wheelchair must have growth potential that will accommodate a 20 percent change in the client's height and/or weight.
- 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/Scooter/Stroller Seating Assessment Form, which must be signed and dated by the qualified practitioner completing the assessment (occupational therapist, physical therapist, or physician), and the QRP who was present and participated in the assessment. All signatures and dates must be current, unaltered, original, and handwritten. Computerized or 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.

2.2.15.11 Fitting of Custom Wheeled Mobility Systems

The fitting of a wheeled mobility system is defined as the time the QRP spends with the client fitting the various systems and components of the system to the client. It may also include time spent training the client or caregiver in the use of the wheeled mobility system. Time spent setting up the system, or travel time without the client present, is not included.

A fitting is required for any device meeting the definition of a wheeled mobility system as defined under subsection 2.2.15.6, "Wheeled Mobility Systems" in this handbook.

The fitting of a wheeled mobility system must be:

- Performed by the same QRP that was present for, and participated in, the seating assessment of the client.
- Completed prior to submitting a claim for reimbursement of a wheeled mobility system.

The QRP performing the fitting will:

- Verify the wheeled mobility system has been properly fitted to the client.
- Verify that the wheeled mobility system will meet the client's functional needs for seating, positioning, and mobility.

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- Verify that the client, parent, guardian of the client, and/or caregiver of the client has received training and instruction regarding the wheeled mobility system's proper use and maintenance.

The QRP must complete and sign the DME Certification and Receipt form after the wheeled mobility system has been delivered and fitted to the client. Completion of this form by the QRP signifies that all components of the fitting as outlined above have been satisfied. The form must be completed prior to submission of a claim for a wheeled mobility system, and submitted to HHSC's designee according to instructions on the form to allow for proper claims processing.

Services for fitting of a wheeled mobility system by the QRP must be submitted for reimbursement by the DME provider of the wheeled mobility system using procedure code 97542 with modifier U2. The DME provider must list the QRP who participated in the seating assessment as the performing provider on the claim for all components of the wheeled mobility system, including the fitting performed by the QRP.

All adjustments and modifications to the wheeled mobility system, as well as the associated services by the QRP for the seating assessment and fitting, within the first six months after delivery are considered part of the purchase price and will not be separately reimbursed.

Procedure code 97542 with modifier U2 must be billed on the same claim as the procedure code(s) for the wheeled mobility system in order for both services to be reimbursed.

2.2.15.11.1 Prior Authorization

Prior authorization is required for the QRP performing the fitting of a wheeled mobility system, and must be included with the request for the wheeled mobility system.

The QRP must be directly employed by or contracted with the DME company providing the system, and must be the same QRP who was present at and participated in the client's seating assessment.

A prior authorization may be issued to the QRP in 15-minute increments, for a time period of up to two hours (8 units), for the fitting of any manual or power wheeled mobility system. Up to one additional hour (4 units) may be authorized to the QRP with documentation of medical necessity demonstrating that fitting of three or more major systems is required, or that additional client training is required for such systems. Major systems can include, but are not limited to, the following:

- Complete complex seating system (planar system with trunk supports and hip supports or abductor or custom contoured seating system such as a molded system) Off-the-shelf seat and back cushions do not constitute a complex seating system.
- Alternative drive controls (such as a head array, mini-proportional system, etc.).
- Additional specialty control features (such as infrared access).
- Power positioning features (such as power tilt, power recline).
- Specific purpose specialty features (such as power seat elevation systems, power elevating leg rests).

2.2.15.11.2 Documentation Requirements

When the QRP that participated in the assessment of the client is not available to conduct the fitting of the wheeled mobility system, the DME provider must update the prior authorization for the wheeled mobility system and fitting by submitting all of the following information:

- A letter written on the DME provider's letterhead, signed and dated by a representative of the DME provider other than the new QRP.
- Documentation explaining why the original QRP could not conduct the fitting. Examples may include, but are not limited to, documentation that the QRP:
    - Is no longer associated with the DME provider requesting the wheeled mobility system.

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- Is on an extended leave from the DME provider requesting the wheeled mobility system.

Note: *For purposes of this policy, an extended leave is any leave of more than 30 consecutive calendar days.*

- The name, TPI, and NPI of the original QRP who performed the initial assessment, and the date the assessment was completed.
- The name, TPI, and NPI of the QRP who will be performing the fitting.
- A copy of the original, physician-signed Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

A copy of this documentation must be maintained by the provider in the client's medical record and be available upon request by HHSC or its designee.

2.2.15.12 Power Wheeled Mobility Systems- Group 1 through Group 5

A power wheeled mobility system or powered mobility device (PMD) is a professionally manufactured device that provides motorized wheeled mobility and body support specifically for individuals with impaired mobility. PMDs are four- or six-wheeled motorized vehicles whose steering is operated by an electronic device or joystick to control direction, turning, and alternative electronic functions, such as seat controls.

Each PMD must include all of the following basic components that may not be billed 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

The following definitions apply to PMDs:

- No-Power Option - A category of PMDs that cannot accommodate a power tilt, recline, or seat elevation system. A PMD that can accept only power-elevating leg rests is considered to be a no-power option chair.
- Single-Power Option - A category of PMDs that can accept and operate a power tilt, power recline, or a power seat elevation system, but not a combination power tilt and recline seating system. A single-power option PMD might be able to accommodate power elevating leg rests, or seat elevator, in combination with a power tilt or power recline. A PMD does not have to be able to accommodate all features to meet this definition.
- Multiple-Power Option - A category of PMDs that can accept and operate a combination power tilt and recline seating system. A multiple-power option PMD might also be able to accommodate power elevating leg rests, or a power seat elevator. A PMD does not have to accommodate all features to qualify to meet this definition.

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2.2.15.12.1 Prior Authorization

Prior authorization for a power wheeled mobility system/PMD requires the following documentation in addition to all documentation required for a custom manual wheelchair:

- The client's physical and mental ability to receive and follow instructions related to responsibilities of using equipment. The client must be able to operate a PMD independently. The therapist must provide written documentation that the client is physically and cognitively capable of managing a PMD.
- How the PMD will be operated (i.e., joystick, head pointer, puff-and-go).
- The capability of the client to understand how the PMD operates.
- The capability of the caregiver or client to care for the PMD and accessories.

2.2.15.12.2 Group 1 PMDs

All Group 1 PMDs must have all the specified basic components and meet all the following requirements:

- Standard integrated or remote proportional joystick
- Nonexpandable controller
- Incapable of upgrade to expandable controller
- Incapable of upgrade to alternative control devices
- May have cross brace construction
- Accommodates nonpowered options and seating systems (e.g., recline-only backs, manually elevating leg rests [except captains chairs])
- Length - less than or equal to 40 inches
- Width - less than or equal to 24 inches
- Minimum top end speed - 3 mph
- Minimum range - 5 miles
- Minimum obstacle climb - 20 mm
- Dynamic stability incline - 6 degrees

Prior Authorization Requirements

A Group 1 PMD may be considered for prior authorization for rental or purchase when all the following criteria are met:

- The client will use the PMD for less than 2 hours per day.
- The client will use the PMD indoors on smooth, hard surfaces.
- The client will not encounter obstacles in excess of 0.75 inch.

2.2.15.12.3 Group 2 PMDs

All Group 2 PMDs must have all the specified basic components and meet all the following requirements:

- Standard integrated or remote proportional joystick
- May have cross brace construction
- Accommodates seating and positioning items (e.g., seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medical thigh supports [except captains chairs])

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- Length - less than or equal to 48 inches
- Width - less than or equal to 34 inches
- Minimum top end speed - 3 mph
- Minimum range - 7 miles
- Minimum obstacle climb - 40 mm
- Dynamic stability incline - 6 degrees

Prior Authorization Requirements

A Group 2 PMD may be considered for prior authorization for rental or purchase when the following criteria are met:

- The client will use the PMD for 2 or more hours per day.
- The client will not routinely use the PMD for MRADLs outside the home.
- The client will not encounter obstacles in excess of 1.5 inches.

2.2.15.12.4 Group 3 PMDs

All Group 3 PMDs must have all the specified basic components and meet all the following requirements:

- Standard integrated or remote proportional joystick
- Nonexpandable controller
- Capable of upgrade to expandable controller
- Capable of upgrade to alternative control devices
- May not have cross brace construction
- Accommodates seating and positioning items (e.g., seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medial thigh supports [except captains chairs])
- Drive wheel suspension to reduce vibration
- Length - less than or equal to 48 inches
- Width - less than or equal to 34 inches
- Minimum top end speed - 4.5 mph
- Minimum range - 12 miles
- Minimum obstacle climb - 60 mm
- Dynamic stability incline - 7.5 degrees

Prior Authorization Requirements

A Group 3 PMD may be considered for prior authorization for rental or purchase when the following criteria are met:

- The client's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity.
- The client may routinely use the PMD for MRADLs outside of the home.
- The client will use the PMD primarily on smooth or paved surfaces.
- The client will not encounter obstacles in excess of 2.5 inches.

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2.2.15.12.5 Group 4 PMDs

All Group 4 PMDs must have all the specified basic components and meet all the following requirements:

- Standard integrated or remote proportional joystick
- Nonexpandable controller
- Capable of upgrade to expandable controller
- Capable of upgrade to alternative control devices
- May not have cross brace construction
- Accommodates seating and positioning items (e.g., seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medial thigh supports [except captains chairs])
- Drive wheel suspension to reduce vibration
- Length - less than or equal to 48 inches
- Width - less than or equal to 34 inches
- Minimum top end speed - 6 mph
- Minimum range - 16 miles
- Minimum obstacle climb - 75 mm
- Dynamic stability incline - 9 degrees

Prior Authorization Requirements

A Group 4 PMD may be considered for prior authorization for rental or purchase when all the following criteria are met:

- In addition to using the PMD in the home, the client will routinely use the PMD for MRADLs outside the home.
- The client will routinely use the PMD on rough, unpaved or uneven surfaces.
- The client will encounter obstacles in excess of 2.25 inches.
- The client has a documented medical need for a feature that is not available on a lower level PMD.

Documentation Requirements

The submitted documentation for a Group 4 PMD must include a completed assessment that is signed and dated by a physician or a licensed occupational or physical therapist and includes the following:

- A description of the environment where the PMD will be used in the routine performance of MRADLs.
- A listing of the MRADLs that would be possible with the use of a Group 4 PMD that would not be possible without the Group 4 PMD.
- The distance the client is expected to routinely travel on a daily basis with the Group 4 PMD.

Note: *The enhanced features found on a Group 4 PMD must be medically necessary to meet the client's routine MRADL and will not be approved for leisure or recreational activities.*

In addition to meeting criteria for Group 2 through Group 4 PMDs, the submitted documentation of medical necessity must demonstrate that the client requires the requested power option (e.g., the need for a power recline or tilt in space, or a combination power tilt and power recline), the no-power option, single-power option, or multiple-power option as defined in subsection 2.2.15.12, "Power Wheeled Mobility Systems- Group 1 through Group 5" in this handbook.

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2.2.15.12.6 Additional Requirements - Group 2 through Group 4 No-Power Option

Group 2 through Group 4 no-power option PMDs must have all the specified basic components and meet all the following requirements:

- Nonexpandable controller
- Incapable of upgrade to expandable controller
- Incapable of upgrade to alternative control devices
- Meets the definition of no-power option
- Accommodates nonpowered options and seating systems (e.g., recline-only backs, manually elevating leg rests [except captains chairs])

2.2.15.12.7 Group 2 through Group 4 Single-Power Option

Group 2 through Group 4 single-power option PMDs must have all the specified basic components and meet all the following requirements:

- Nonexpandable controller
- Capable of upgrade to expandable controller
- Capable of upgrade to alternative control devices
- Meets the definition of single-power option

2.2.15.12.8 Group 2 through Group 4 Multiple-Power Option

Group 2 through Group 4 multiple-power option PMDs must have all the specified basic components and meet all the following requirements:

- Nonexpandable controller
- Capable of upgrade to expandable controller
- Meets the definition of multiple-power option
- Accommodates a ventilator

2.2.15.12.9 Group 5 PMDs

All Group 5 PMDs must have all the specified basic components and meet all the following requirements:

- Standard integrated or remote joystick
- Nonexpandable controller
- Capable of upgrade to expandable controller
- Seat width - minimum of 5 one-inch options
- Seat depth - minimum of 3 one-inch options
- Seat height - adjustment requirements = 3 inches
- Back height - adjustment requirements minimum of 3 options
- Seat-to-back angle range of adjustment - minimum of 12 degrees
- Accommodates nonpowered options and seating systems
- Accommodates seating and positioning items (e.g., seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medial thigh supports)
- Adjustability for growth (minimum of 3 inches for width, depth, and back height adjustment)

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- Special developmental capability (i.e., seat to floor, standing, etc.)
- Drive wheel suspension to reduce vibration
- Length - less than or equal to 48 inches
- Width - less than or equal to 34 inches
- Minimum top end speed - 4 mph
- Minimum range - 12 miles
- Minimum obstacle climb - 60 mm
- Dynamic stability incline - 9 degrees
- Passed crash test

Prior Authorization Requirements

A Group 5 pediatric PMD may be considered for prior authorization for rental or purchase when all the following criteria are met:

- The client weighs less than 125 pounds.
- The client is expected to grow in height.
- The client may require growth of up to 5 inches in width.
- The client may require a change in seat to floor height up to 3 inches.
- The client may require a seat to back angle range of adjustment in excess of 12 degrees.
- The client requires special developmental capability (i.e., seat to floor, standing, etc.).

2.2.15.12.10 Group 5 Single-PMDs

A group 5 single-power option PMD must have all the specified basic components and have the capability to accept and operate a power tilt or recline or seat elevation system, but not a combination power tilt and recline seating system, and may be able to accommodate power elevating leg rests, or seat elevator, in combination with a power tilt or power recline.

Prior Authorization Requirements

A Group 5 pediatric PMD with single power option may be considered for prior authorization for rental or purchase when all the following criteria are met:

- The client meets criteria for a Group 5 PMD.
- The client requires a drive control interface other than a hand or chin-operated standard proportional joystick (examples include but are not limited to head control, sip and puff, or switch control).

2.2.15.12.11 Group 5 Multiple-PMDs

Group 5 multiple-power option PMD must have all the specified basic components and meet all the following requirements:

- Has the capability to accept and operate a combination power tilt and recline seating system, and may also be able to accommodate power elevating leg rests, or a power seat elevator.
- Accommodates a ventilator.

Prior Authorization Requirements

A Group 5 pediatric PMD with multiple power option may be considered for prior authorization for rental or purchase when the following criteria are met:

- The client meets criteria for a Group 5 PMD.

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- The client requires a drive control interface other than a hand or chin-operated standard proportional joystick (examples include but are not limited to head control, sip and puff, switch control).
- The client has a documented medical need for a power tilt and recline seating system and the system is being used on the wheelchair or the client uses a ventilator which is mounted on the wheelchair.

2.2.15.13 Wheelchair Ramp-Portable and Threshold

Portable and threshold ramps are a benefit of Texas Medicaid.

A portable ramp is defined as a unit that is able to be carried as needed to access a home, weighs no more than 90 pounds, or measures no more than 10 feet in length. A threshold ramp is defined as a unit that provides access over elevated thresholds.

One portable ramp and one threshold ramp for wheelchair access may be considered for prior authorization when documentation supports medical necessity. The following documentation supporting medical necessity is required:

- The date of purchase and serial number of the client's wheelchair or documentation of a wheelchair request being reviewed for purchase
- Diagnosis with duration of expected need
- A diagram of the house showing the access points with the ground-to-floor elevation and any obstacles

Ramps may be considered for rental for short term disabilities and for purchase for long term disabilities. Mobility aid lifts for vehicles and vehicle modifications are not a benefit of Texas Medicaid.

2.2.15.14 Power Elevating Leg Lifts

A power elevation feature involves a dedicated motor and related electronics with or without variable speed programmability, which allows the leg rest to be raised and lowered independently of the recline and/or tilt of the seating system. It includes a switch control which may or may not be integrated with the power tilt and/or recline control(s).

2.2.15.14.1 Prior Authorization

Power elevating leg lifts 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 PMD with a reclining back and at least one of the following:

- The client has a musculoskeletal condition such as flexion contractures of the knees and legs, or the placement of a brace that prevents 90-degree flexion at the knee.
- The client has significant edema of the lower extremities that requires elevating the client's legs.
- The client experiences hypotensive episodes that require frequent positioning changes.
- The client needs power tilt-and-recline and is required to maintain anatomically correct positioning and reduce exposure to skin shear.

2.2.15.14.2 Documentation Requirements

The submitted documentation must include an assessment completed, signed, and dated by a physician or a licensed occupational or physical therapist that includes the following:

- A description of the client's current level of function without the device
- Documentation that identifies how the power elevating leg lifts will improve the client's function
- A list of MRADLs the client will be able to perform with the power elevating leg lifts that the client is unable to perform without the power elevating leg lifts and how the device will increase independence

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- The duration of time the client is alone during the day without assistance
- The client's goals for use of the power elevating leg lifts

2.2.15.15 Power Seat Elevation System

A power seat elevation system is used to raise and lower the client in their seated position without changing the seat angles to provide varying amounts of added vertical access.

The use of a power seat elevation system will:

- Facilitate independent transfers, particularly uphill transfers, to and from the wheelchair, and
- Augment the client's reach to facilitate independent performance of MRADLs in the home.

2.2.15.15.1 Prior Authorization

A power seat elevation system may be prior authorized to promote independence in a client who meets all of the following criteria:

- The client does not have the ability to stand or pivot transfer independently.
- The client requires assistance only with transfers across unequal seat heights, and as a result of having the power seat elevation system, the client will be able to transfer across unequal seat heights unassisted.
- The client has limited reach and range of motion in the shoulder or hand that prohibits independent performance of MRADLs (such as, dressing, feeding, grooming, hygiene, meal preparation, and toileting).

2.2.15.15.2 Documentation Requirements

The submitted documentation must include an assessment completed, signed, and dated by a physician or a licensed occupational or physical therapist that includes the following:

- A description of the client's current level of function without the device
- Documentation that identifies how the power seat elevation system will improve the client's function
- A list of MRADLs the client will be able to perform with the power seat elevation system that the client is unable to perform without the power seat elevation system and how the device will increase independence
- The duration of time the client is alone during the day without assistance
- The client's goals for use of the power seat elevation system

Note: *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.*

2.2.15.16 Seat Lift Mechanisms

A medically necessary seat lift mechanism is one that operates smoothly, can be controlled by the client, and effectively assists the client in standing up and sitting down without other assistance.

The payment for a recliner or chair with the incorporated seat lift mechanism is limited to the amount of the seat lift mechanism.

2.2.15.16.1 Prior Authorization

A seat lift mechanism may be prior authorized for clients who meet all 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.

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- 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.

> ***Note:*** *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.*

Seat lift mechanisms are limited to those types that operate smoothly, can be controlled by the client, and can effectively assist a client in standing up and sitting down without other assistance. A 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 Texas Medicaid.

2.2.15.16.2 Documentation Requirements

The submitted documentation must include an assessment completed, signed, and dated by a physician or a licensed occupational or physical therapist that includes the following:

- A description of the client's current level of function without the device
- Documentation that identifies how the seat lift mechanism will improve the client's function
- A list of MRADLs the client will be able to perform with the seat lift mechanism that the client is unable to perform without the seat lift mechanism and how the device will increase independence
- The duration of time the client is alone during the day without assistance
- The client's goals for use of the seat lift mechanism

Supporting documentation must be kept in the client's record that shows that all appropriate therapeutic modalities (such as medication, physical therapy) have been tried and that they failed to enable the client to transfer from a chair to a standing position.

2.2.15.17 Batteries and Battery Charger

A battery charger and initial batteries are included as part of the purchase of a PMD. Replacement batteries or a replacement battery charger may be considered for reimbursement if they are no longer under warranty.

A maximum of one hour of labor may be considered to install new batteries. Labor is not reimbursed with the purchase of a new PMD or with replacement battery chargers.

2.2.15.17.1 Prior Authorization

Batteries and battery chargers will not be prior authorized for replacement within six months of delivery. Batteries and battery chargers within the first 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.

2.2.15.17.2 Documentation Requirements

To request prior authorization for replacement batteries or a replacement battery charger, the provider must document the date of purchase and serial number of the currently owned wheelchair as well as the reason for the replacement batteries or battery charger.

Documentation required supporting the need to replace the batteries or battery charger must include:

- Why the batteries are no longer meeting the client's needs, or
- Why the battery charger is no longer meeting the client's needs

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2.2.15.18 Power Wheeled Mobility Systems- Scooter

A scooter is a professionally manufactured three- or four-wheeled motorized base operated by a tiller with a professionally manufactured basic seating system for clients who have little or no positioning needs.

A scooter must meet all the following requirements:

- Length- less than or equal to 48 inches
- Width- less than or equal to 28 inches
- Minimum top end speed- 3 mph
- Minimum range- 5 miles
- Minimum obstacle climb- 20 mm
- Radius pivot turn of less than or equal to 54 inches
- Dynamic stability incline- 6 degrees

Custom seating for scooters is not a benefit of Texas Medicaid Title XIX Home Health Services. Repairs to scooters will be considered only for a scooter purchased by the Texas Medicaid.

2.2.15.18.1 Prior Authorization

A scooter may be prior authorized for ambulatory-impaired clients with good head, trunk, and arm/hand control, without a diagnosis of progressive illness (including, but not limited to, progressive neuromuscular diseases such as amyotrophic lateral sclerosis [ALS]).

To request prior authorization for a scooter, the client must not own, or be expected to require, a power wheelchair within five years of the purchase of a scooter.

A scooter may be prior authorized for a short-term rental or an initial three-month trial rental period based on documentation supporting the medical necessity and appropriateness of the device.

Assessment of the accessibility of the client's residence must be completed and included in the prior authorization documentation to ensure that the scooter is usable in the home (i.e., doors and halls wide enough, no obstructions).

A scooter must be able to accommodate a 20 percent change in the client's height and/or weight.

2.2.15.18.2 Documentation Requirements

Prior authorization for a scooter requires all the documentation required for a standard power wheelchair and meets all the following criteria:

- The client's physical and cognitive ability to receive and follow instructions related to the responsibilities of using the equipment.
- The ability of the client to physically and cognitively operate the scooter independently.
- The capability of the client to care for the scooter and understand how it operates.

2.2.15.19 Client Lift

A lift is a portable transfer system used to move a nonambulatory client over a short distance from bed to chair and chair to bed.

A client lift for the convenience of a caregiver is not a benefit of Texas Medicaid.

A hydraulic lift is for a client who is unable to assist in their own transfers and is operated by the weight or pressure of a liquid.

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An electric lift is operated by electricity and may be considered when a hydraulic lift will not meet the client's needs.

Note: *Portable lifts that can be used outside the home setting, hydraulic or electric, are not a benefit through Title XIX Home Health Services. For clients who are birth through 20 years of age, portable lifts that can be used outside the home setting may be considered through CCP.*

2.2.15.19.1 Prior Authorization

A client lift will not be prior authorized for the convenience of a caregiver.

A client limit must be able to accommodate a 20 percent change in the client's height and/or weight.

2.2.15.20 Electric Lift

Prior authorization for an electric lift may be considered when the client meets criteria for a hydraulic lift and additional documentation explains why a hydraulic lift will not meet the client's needs.

Note: *Portable lifts that can be used outside the home setting, hydraulic or electric, are not a benefit through Title XIX Home Health Services. For clients who are birth through 20 years of age, portable lifts that can be used outside the home setting may be considered through CCP.*

2.2.15.21 Hydraulic Lift

Hydraulic lifts require prior authorization.

2.2.15.21.1 Documentation Requirements

Prior authorization for a hydraulic lift may be considered with the following documentation:

- The inability of the client to assist in their own transfers
- The weight of the client and the weight capacity of the requested lift
- The availability of a caregiver to operate the lift
- Training by the provider to the client and the caregiver on the safe use of the lift

2.2.15.22 Standers

A stander is a device used by a client with neuromuscular conditions who is unable to stand alone. Standers and standing programs can improve digestion, increase muscle strength, decrease contractures, increase bone density, and minimize decalcification (this list is not all inclusive).

2.2.15.22.1 Prior Authorization

Standers, including all accessories, require prior authorization. Standers and gait trainers will not be prior authorized for a client within one year of each other.

2.2.15.22.2 Documentation Requirements

Prior authorization may be considered for the standers with the following documentation:

- Diagnoses relevant to the requested equipment, including functioning level and ambulatory status
- Anticipated benefits of the equipment
- Frequency and duration of the client's standing program
- Anticipated length of time the client will require this equipment
- Client's height, weight, and age
- Anticipated changes in the client's needs, anticipated modifications, or accessory needs, as well as the growth potential of the stander

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2.2.15.23 Gait Trainers

Gait trainers are devices with wheels used to train clients with ambulatory potential. They provide the same benefits as the stander, in addition to assisting with gait training.

2.2.15.23.1 Prior Authorization

Prior authorization for a gait trainer may be considered with documentation supporting medical necessity and an assessment of the accessibility of the client's residence to ensure that the gait trainer is usable in the home (i.e., doors and halls are wide enough and have no obstructions), when a physician familiar with the client documents that the client has ambulatory potential and will benefit from a gait training program, and when the client meets the criteria for a stander.

2.2.15.24 Accessories, Modifications, Adjustments and Repairs

Accessories, modifications, adjustments, and repairs are benefits of Texas Medicaid as outlined below.

- All modifications, adjustments, and repairs to standard mobility aid equipment within the first six months after delivery are considered part of the purchase price.
- All modifications and adjustments to a wheeled mobility system, as well as the associated services by the QRP for the seating assessment and fitting, within the first six months after delivery are considered part of the purchase price.

Mobility aids that have been purchased are anticipated to last a minimum of five years.

A major modification to a wheeled mobility system requires the completion of a new seating assessment by a qualified practitioner (physician, occupational therapist, or physical therapist), with the participation of a QRP.

Prior authorization for equipment replacement is considered within five years of equipment purchase when one of the following occurs:

- There has been a significant change in the client's condition such that the current equipment no longer meets the client's needs.
- The equipment is no longer functional and either cannot be repaired or it is not cost-effective to repair.

A wheeled mobility system that has been fitted and delivered to the client's home by a QRP and then found to be inappropriate for the client's condition will not be eligible for an upgrade, replacement, or major modification within the first six months following purchase unless there has been a significant change in the client's condition. The significant change in the client's condition must be documented by a physician familiar with the client.

2.2.15.24.1 Prior Authorization

Modifications

Modifications to custom equipment after the first six months from fitting and delivery may be considered for prior authorization if a change occurs in the client's needs, capabilities or physical/mental capability, that cannot be anticipated.

Documentation supporting the medical necessity of the requested modification must include the following:

- Description of the change in the client's condition that requires accommodation by different seating, drive controls, electronics, or other mobility base components.
- All projected changes in the client's mobility needs.
- The date of purchase, the serial number of the current equipment, and the cost of purchasing new equipment versus modifying current equipment.

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Major modifications to a wheeled mobility system also require that a new seating assessment be completed and submitted with the prior authorization request. A request for authorization of the QRP's participation in the seating assessment for the major modification must be included with the prior authorization request for the major modification.

Minor modifications to a wheeled mobility system do not require the completion of a new seating assessment.

Requests for equipment submitted as a minor modification to a wheeled mobility system must be submitted with modifier RB.

Adjustments

Adjustments within the first six months after delivery, including adjustments to a wheeled mobility system within the first six months after fitting and delivery by a QRP will not be prior authorized.

A seating or positioning component alteration that does not require replacement components to accommodate a change in the client's size (height or weight) is considered an adjustment and not a major modification.

A maximum of one hour of labor for adjustments may be prior authorized as needed after the first six months from delivery.

Documentation must include the date of purchase, the serial number of the current equipment, and the reason for adjustments.

Repairs

Repairs to client-owned equipment may be considered for prior authorization as needed with documentation of medical necessity. Technician fees are considered part of the cost of the repair.

HHSC 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. Requests for repairs when there is documented proof of abuse or neglect will not be authorized.

Requests for equipment submitted as a repair to a wheeled mobility system must be submitted with modifier RB.

Providers are responsible for maintaining documentation in the client's medical record specifying the repairs and supporting medical necessity.

Documentation must include the date of purchase and serial number of the current equipment, the cause of the damage or need for repairs, the steps the client or caregiver will take to prevent further damage if repairs are due to an accident, and when requested, the cost of purchasing new equipment as opposed to repairing current equipment.

2.2.15.25 Replacement

Replacement of equipment is also considered when loss or irreparable damage has occurred. The following must be submitted with the prior authorization request:

- A copy of the police or fire report, when appropriate.
- A statement about the measures to be taken in order to prevent reoccurrence.
- Replacement equipment for clients who are birth through 20 years of age and do not meet the criteria in this handbook may be considered for prior authorization through CCP.

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2.2.15.26 Procedure Codes and Limitations for Mobility Aids

Procedure Code	Maximum Limit
Canes	
E0100	1 per 5 years
E0105	1 per 5 years
Crutches	
A4635	As needed
E0110	1 purchase every 5 years
E0111	1 purchase every 5 years; 1-month rental
E0112	1 purchase every 5 years; 1-month rental
E0113	1 purchase every 5 years; 1-month rental
E0114	1 purchase every 5 years; 1-month rental
E0116	1 purchase every 5 years; 1-month rental
E0153	1 purchase every 5 years
Walkers	
A4636	1 per month
A4637	As needed
E0130	1 purchase every 5 years; 1-month rental
E0135	1 purchase every 5 years; 1-month rental
E0141	1 purchase every 5 years; 1-month rental
E0143	1 purchase every 5 years; 1-month rental
E0144	1 purchase every 5 years; 1-month rental
E0147	1 purchase every 5 years; 1-month rental
E0148	1 purchase every 5 years; 1-month rental
E0149	1 purchase every 5 years; 1-month rental
E0154	1 per 5 years
E0155	1 per 5 years
E0157	1 per 5 years
E0158	1 per 5 years
E0159	1 per 5 years
Gait Trainers	
E8001	1 purchase every 5 years
Seating Assessments	
97001	As needed
97003	As needed
Wheelchairs	
E1050	1 per month
E1060	1 per month
E1070	1 per month
E1100	1 per month
E1110	1 per month

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Procedure Code	Maximum Limit
E1161	1 purchase every 5 years; 1-month rental
E1220	1 per 5 years
E1229	1 per 5 years
E1231	1 purchase every 5 years; 1-month rental
E1232	1 purchase every 5 years; 1-month rental
E1233	1 purchase every 5 years; 1-month rental
E1234	1 purchase every 5 years; 1-month rental
E1235	1 purchase every 5 years; 1-month rental
E1236	1 purchase every 5 years; 1-month rental
E1237	1 purchase every 5 years; 1-month rental
E1238	1 purchase every 5 years; 1-month rental
E1239	1 per 5 years
Power Wheelchairs	
K0001	1 purchase every 5 years; 1-month rental
K0002	1 purchase every 5 years; 1-month rental
K0003	1 purchase every 5 years; 1-month rental
K0004	1 purchase every 5 years; 1-month rental
K0005	1 purchase every 5 years; 1-month rental
K0006	1 purchase every 5 years; 1-month rental
K0007	1 purchase every 5 years; 1-month rental
K0008	1 purchase every 5 years; 1-month rental
K0009	1 purchase every 5 years; 1-month rental
K0010	1 per 5 years
K0011	1 per 5 years
K0012	1 per 5 years
K0013	1 purchase every 5 years; 1-month rental
K0015	As needed
K0017	As needed
K0018	As needed
K0019	As needed
K0020	As needed
K0037	As needed
K0038	As needed
K0039	As needed
K0040	As needed
K0041	As needed
K0042	As needed
K0043	As needed
K0044	As needed
K0045	As needed

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Procedure Code	Maximum Limit
K0046	As needed; 1 per month
K0047	As needed; 1 per month
K0050	As needed
K0051	As needed
K0052	As needed
K0053	As needed; 1 per month
K0056	As needed
K0065	As needed
K0069	As needed; 1 per month
K0070	As needed
K0071	As needed
K0072	As needed
K0073	As needed
K0077	As needed
K0098	As needed
K0105	As needed; 1 per month
K0195	As needed; 1 per month
K0669	As needed
K0813	1 purchase every 5 years; 1-month rental
K0814	1 purchase every 5 years; 1-month rental
K0815	1 purchase every 5 years; 1-month rental
K0816	1 purchase every 5 years; 1-month rental
K0820	1 purchase every 5 years; 1-month rental
K0821	1 purchase every 5 years; 1-month rental
K0822	1 purchase every 5 years; 1-month rental
K0823	1 purchase every 5 years; 1-month rental
K0824	1 purchase every 5 years; 1-month rental
K0825	1 purchase every 5 years; 1-month rental
K0826	1 purchase every 5 years; 1-month rental
K0827	1 purchase every 5 years; 1-month rental
K0828	1 purchase every 5 years; 1-month rental
K0829	1 purchase every 5 years; 1-month rental
K0835	1 purchase every 5 years; 1-month rental
K0836	1 purchase every 5 years; 1-month rental
K0837	1 purchase every 5 years; 1-month rental
K0838	1 purchase every 5 years; 1-month rental
K0839	1 purchase every 5 years; 1-month rental
K0840	1 purchase every 5 years; 1-month rental
K0841	1 purchase every 5 years; 1-month rental
K0842	1 purchase every 5 years; 1-month rental

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Procedure Code	Maximum Limit
K0843	1 purchase every 5 years; 1-month rental
K0848	1 purchase every 5 years; 1-month rental
K0849	1 purchase every 5 years; 1-month rental
K0850	1 purchase every 5 years; 1-month rental
K0851	1 purchase every 5 years; 1-month rental
K0852	1 purchase every 5 years; 1-month rental
K0853	1 purchase every 5 years; 1-month rental
K0854	1 purchase every 5 years; 1-month rental
K0855	1 purchase every 5 years; 1-month rental
K0856	1 purchase every 5 years; 1-month rental
K0857	1 purchase every 5 years; 1-month rental
K0858	1 purchase every 5 years; 1-month rental
K0859	1 purchase every 5 years; 1-month rental
K0860	1 purchase every 5 years; 1-month rental
K0861	1 purchase every 5 years; 1-month rental
K0862	1 purchase every 5 years; 1-month rental
K0863	1 purchase every 5 years; 1-month rental
K0864	1 purchase every 5 years; 1-month rental
K0868	1 purchase every 5 years; 1-month rental
K0869	1 purchase every 5 years; 1-month rental
K0870	1 purchase every 5 years; 1-month rental
K0871	1 purchase every 5 years; 1-month rental
K0877	1 purchase every 5 years; 1-month rental
K0878	1 purchase every 5 years; 1-month rental
K0879	1 purchase every 5 years; 1-month rental
K0880	1 purchase every 5 years; 1-month rental
K0884	1 purchase every 5 years; 1-month rental
K0885	1 purchase every 5 years; 1-month rental
K0886	1 purchase every 5 years; 1-month rental
K0890	1 purchase every 5 years; 1-month rental
K0891	1 purchase every 5 years; 1-month rental
K0898	1 purchase every 5 years; 1-month rental
K0899	1 purchase every 5 years; 1-month rental
K0900	1 purchase every 5 years; 1-month rental
Scooters	
E1230	1 per 5 years
K0800	1 per 5 years
K0801	1 per 5 years
K0802	1 per 5 years

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Procedure Code	Maximum Limit
Wheelchair Parts	
E0942	1 per year
E0944	2 per year
E0945	2 per year
E0950	1 per year
E0951	2 per year
E0952	2 per year
E0955	As needed
E0957	As needed
E0958	1 per year
E0959	As needed; 1 per month
E0960	As needed
E0961	2 per year
E0967	As needed; 1 per month
E0969	1 per 5 years
E0970	1 pair per year
E0971	2 per year
E0973	2 per year
E0974	2 per year
E0978	1 per year
E0980	1 per year
E0981	As needed
E0982	As needed
E0990	2 per year; 1 per month
E0992	1 per year
E0994	2 per year
E0995	2 per year
E1002	1 per 5 years
E1003	1 per 5 years
E1004	1 per 5 years
E1005	1 per 5 years
E1006	1 per 5 years
E1007	1 per 5 years
E1008	1 per 5 years
E1009	1 per 5 years
E1010	1 per 5 years
E1011	As needed
E1014	1 per 5 years
E1015	2 per year
E1016	2 per year

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Procedure Code	Maximum Limit
E1017	2 per year
E1018	2 per year
E1020	1 per 5 years
E1028	1 per 5 years
E1029	1 per 5 years
E1225	As needed; 1 per month
E1226	As needed; 1 per month
E2201	1 per 5 years
E2202	1 per 5 years
E2203	1 per 5 years
E2204	1 per 5 years
E2205	1 per 5 years
E2206	1 per 5 years
E2207	1 purchase every 5 years
E2208	1 purchase every 5 years
E2209	1 purchase every 5 years
E2210	4 per year
E2211	2 per year
E2212	2 per year
E2213	2 per year
E2214	2 per year
E2215	2 per year
E2216	2 per year
E2217	2 per year
E2218	2 per year
E2219	2 per year
E2220	2 per year
E2221	2 per year
E2222	2 per year
E2224	2 per year
E2225	2 per year
E2226	2 per year
E2227	1 per 5 years
E2228	1 per 5 years
E2291	1 per 5 years
E2292	1 per 5 years
E2293	1 per 5 years
E2294	1 per 5 years
E2300	1 per 5 years
E2310	1 per 5 years

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Procedure Code	Maximum Limit
E2311	1 per 5 years
E2312	1 purchase every 5 years; 1-month rental
E2313	1 per 5 years
E2321	1 per 5 years
E2323	1 per 5 years
E2324	1 per 5 years
E2325	1 per 5 years
E2326	1 per 5 years
E2327	1 per 5 years
E2328	1 per 5 years
E2329	1 per 5 years
E2330	1 per 5 years
E2340	1 per 5 years
E2341	1 per 5 years
E2342	1 per 5 years
E2343	1 per 5 years
E2351	1 per 5 years
E2359	1 per 5 years
E2368	1 per 5 years
E2369	1 per 5 years
E2370	1 per 5 years
E2373	1 per 5 years
E2374	1 per 5 years
E2375	1 per 5 years
E2376	1 per 5 years
E2377	1 per 5 years
E2378	1 per 5 years
E2381	2 per year
E2382	2 per year
E2383	2 per year
E2384	2 per year
E2385	2 per year
E2386	2 per year
E2387	2 per year
E2388	2 per year
E2389	2 per year
E2390	2 per year
E2391	2 per year
E2392	2 per year
E2394	1 per 5 years

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Procedure Code	Maximum Limit
E2395	1 per 5 years
E2396	1 per 5 years
Wheelchair/Pressure/Positioning Cushions	
E0190	1 per 3 years
E2601	1 per year
E2602	1 per year
E2603	1 per year
E2604	1 per year
E2605	1 per year
E2606	1 per year
E2607	1 per year
E2608	1 per year
E2609	1 per year
E2611	1 per year
E2612	1 per year
E2613	1 per year
E2614	1 per year
E2615	1 per year
E2616	1 per year
E2617	1 per year
E2619	1 per year
E2620	1 per year
E2621	1 per year
E2622	1 per year
E2623	1 per year
E2624	1 per year
E2625	1 per year
Batteries	
E2361	1 per 5 years
E2363	1 per 5 years
E2366	1 per 5 years
E2371	1 per 5 years
K0733	2 per year
Safety Equipment	
E0700	2 per year
E0705	1 per 5 years
Lifts	
E0628	1 per 5 years
E0629	1 per 5 years
E0630	1 per 5 years

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Procedure Code	Maximum Limit
E0635	1 per 5 years
E0638	1 per 5 years
E0641	1 per 5 years
Miscellaneous	
A9900	As needed
E1399	As needed
K0108	As needed
K0739	As needed

The following mobility aids are not a benefit of Home Health Services:

- Feeder seats, floor sitters, corner chairs, and travel chairs are not considered medically necessary devices
- Items including but not limited to tire pumps, a color for a wheelchair, gloves, back packs, and flags are not considered medically necessary
- Mobile standers, power standing system on a wheeled mobility device
- Vehicle lifts and modifications
- Permanent ramps, vehicle ramps, and home modifications
- Stairwell lifts of any type
- Elevators or platform lifts of any type
- Patient lifts requiring attachment to walls, ceilings, or floors
- Chairs with incorporated seat lifts
- An attendant control, for safety, all power chairs are to include a stop switch
- Powered mobility device for use only outside the home

Texas Medicaid does not reimburse separately for associated DME charges, including battery disposal fees or state taxes. Reimbursement for associated charges is included in the reimbursement for the specific piece of equipment. White canes for the blind are considered self help adaptive aids and are not a benefit of Home Health Services.

Note: *THSteps-eligible clients who have a medical need for services beyond the limits of this Home Health Services benefit may be considered under CCP.*

Refer to: Subsection 2.2.1.1, "Client Eligibility" in this handbook.

2.2.16 Nutritional (Enteral) Products, Supplies, and Equipment

Enteral nutritional products are those food products that are included in an enteral treatment protocol. They serve as a therapeutic agent for health maintenance and are required to treat an identified medical condition. Nutritional products, supplies, and equipment may be a benefit when provided in the home under Home Health Services.

2.2.16.1 Enteral Nutritional Products, Feeding Pumps, and Feeding Supplies

Enteral nutritional products and related feeding supplies and equipment are a benefit through Home Health Services for clients who are 21 years of age and older and require tube feeding as their primary source of nutrition. The enteral product, supply, or equipment must be part of the medical POC outlined and maintained by the treating physician.

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Enteral nutritional products may be reimbursed with the following procedure codes:

Procedure Codes								
B4100	B4104	B4149	B4150	B4152	B4153	B4154	B4155	B4157

Enteral nutritional supplies and equipment may be reimbursed with the following procedure codes and limitations:

Procedure Codes	Limitations
A4322	4 per month
A5200	2 per month
B4034	Up to 31 per month
B4035	Up to 31 per month
B4036	Up to 31 per month
B4081	As needed
B4082	As needed
B4083	As needed
B4087	2 per rolling year
B4088	2 per rolling year
B9000	1 purchase every 5 years; 1 rental per month
B9002	1 purchase every 5 years; 1 rental per month
B9998*	As needed*
B9998 with modifier U1	4 per month
B9998 with modifier U2	2 per rolling year
B9998 with modifier U3	4 per month
B9998 with modifier U4	2 per rolling year
B9998 with modifier U5	4 per month
T1999*	As needed* If procedure code T1999 is used for a needleless syringe, the allowed amount is 8 per month.
*** Appropriate limitations for miscellaneous procedure codes B9998 and T1999 are determined on a case-by-case basis through prior authorization. Specific items may be requested using procedure code B9998 using the modifiers outlined in the table above.**	

A backpack or carrying case for a portable enteral nutrition infusion pump may be a benefit of Home Health Services, when medically necessary and prior authorized, using procedure code B9998.

2.2.16.2 Prior Authorization Requirements

Prior authorization is required for most enteral products, supplies, and equipment provided through Home Health Services. Requests are reviewed for medically necessary amounts based on caloric needs as indicated by the client's physician.

Enteral nutrition and related supplies and equipment may be considered for prior authorization for clients who are 21 years of age and older when all or part of the client's nutritional intake is received through a feeding tube, and the enteral formula is:

- The client's sole source of nutrition
- The client's primary source of nutrition

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- An enteral tube feeding is considered the primary source of nutrition when it comprises more than 70 percent of the caloric intake needed to maintain the client's weight.
- The percent of calories provided by an enteral formula may be calculated by dividing the client's daily calories supplied by the enteral formula by the daily caloric intake ordered by the physician to maintain the client's weight. The result is multiplied by 100 to determine the percentage of calories provided by the enteral formula.

Related supplies and equipment may be considered for prior authorization when criteria for nutritional products are met, and medical necessity is included for each item requested.

Renewal of the prior authorization will be considered based on medical necessity.

Prior authorization may be given for up to 6 months. Prior authorization may be recertified with documentation supporting ongoing medical necessity for the nutritional products requested.

2.2.16.2.1 Enteral Formulas

Enteral formulas require prior authorization. Requests for prior authorization must include the necessary product information.

Enteral formulas consisting of semi-synthetic intact protein or protein isolates (procedure codes B4150 and B4152) are appropriate for the majority of clients requiring enteral nutrition.

Special enteral formulas or additives (procedure code B4104) may be considered for prior authorization with supporting documentation submitted by the client's physician indicating the client's medical needs for these special enteral formulas. Special enteral formula may be reimbursed with the following procedure codes:

Procedure Codes						
B4149	B4153	B4154	B4155	B4157	B4161	B4162

Pediatric nutritional products (procedure codes B4103, B4158, B4159, B4160, B4161, and B4162) are restricted to clients who are 20 years of age and younger.

Food thickener may be considered for clients with a swallowing disorder.

2.2.16.2.2 Nasogastric, Gastrostomy, or Jejunostomy Feeding Tubes

Feeding tubes require prior authorization.

Additional feeding tubes may be prior authorized if documentation submitted supports medical necessity, such as infection at gastrostomy site, leakage, or occlusion.

2.2.16.2.3 Enteral Feeding Pumps

Enteral feeding pumps, with and without alarms, require prior authorization.

Enteral feeding pumps may be considered for prior authorization for lease or purchase with documentation of medical necessity indicating that the client meets the following criteria:

- Gravity or syringe feedings are not medically indicated
- The client requires an administration rate of less than 100 ml/hr
- The client requires night-time feedings
- The client has one of the following medical conditions (this list is not all-inclusive):
  - Reflux or aspiration
  - Severe diarrhea
  - Dumping syndrome

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- Blood glucose fluctuations
- Circulatory overload

2.2.16.2.4 Enteral Supplies

Enteral supplies require prior authorization, with the exception of irrigation syringes (procedure code A4322) and percutaneous catheter or tube anchoring devices (procedure code A4520) within the allowable limits.

Procedure code B4034 will not be prior authorized for use in place of procedure code A4322 for irrigation syringes when they are not part of a bolus administration kit.

Gravity bags and pump nutritional containers are included in the feeding supply kits and will not be prior authorized separately.

Specific items may be considered for prior authorization using miscellaneous procedure code B9998 and modifiers U1, U2, U3, or U5.

Requests for a backpack or carrying case for a portable enteral feeding pump may be considered for prior authorization for purchase only, under miscellaneous code B9998, for clients who meet all of the following medical necessity criteria:

- The client requires enteral feedings lasting greater than eight hours continuously, or feeding intervals exceed the time that the client must be away from home to:
  - Attend school or work.
  - Participate in extensive, physician-ordered outpatient therapies.
  - Attend frequent, multiple medical appointments.
- The client is ambulatory, or uses a wheelchair which will not support the use of a portable pump by other means, such as an IV pole.
- The portable enteral feeding pump is client owned.

2.2.16.3 Documentation Requirements

To request prior authorization for nutritional formula, supplies, or equipment, the following documentation must be provided:

- Accurate diagnostic information pertaining to the underlying diagnosis or condition as well as any other medical diagnoses or conditions, to include the client's overall health status
- Diagnosis or condition (including the appropriate *International Classification of Diseases,* Tenth Revision, Clinical Modification [ICD-10-CM] code)
- A statement from the ordering physician noting that enteral nutritional products for tube feedings are the client's sole or primary source of nutrition
- The goals and timelines on the medical POC
- Total caloric intake prescribed by the physician
- Acknowledgement that the client has a feeding tube in place

2.2.17 Phototherapy Devices

Phototherapy devices are not a benefit of Title XIX Home Health Services. Phototherapy devices are a benefit of Texas Medicaid through CCP for clients who are birth through 20 years of age.

Refer to: Subsection 2.6.13, "Phototherapy Devices" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information on phototherapy devices.

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2.2.18 Prothrombin Time/International Normalized Ratio (PT/INR) Home Testing Monitor

PT/INR home testing monitors are a benefit of Title XIX Home Health Services for clients who require chronic oral anticoagulation due to one of the following:

- Mechanical heart valve
- Chronic atrial fibrillation
- Venous thromboembolism (including both deep vein thrombosis [DVT] and pulmonary embolism)
- Ventricular assist device (VAD) awaiting a heart transplant

The PT/INR home testing monitor is a portable, battery-operated instrument for the quantitative determination of PT/INR from whole blood obtained by finger-stick. This product is designed to aid in the management of high-risk clients who take oral anticoagulants.

> ***Note:*** *For clients who are 20 years of age and younger and do not meet criteria for coverage through Title XIX Home Health Services, home PT/INR monitors and related testing supplies may be considered through CCP.*

The following procedure codes are included in this benefit:

- Procedure code E1399 may be reimbursed for the rental or purchase of the monitor.
- Procedure code A9900 may be reimbursed for the related testing supplies.

Procedure codes E1399 and A9900 may be reimbursed to DME providers for services rendered in the home setting.

2.2.18.1 Prior Authorization

Prior authorization is required for the home PT/INR monitors and related testing supplies.

Prior authorization requests must be submitted within three business days of the date of service and must include documentation of medical necessity and a completed Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

The completed Title XIX Form must be maintained by the requesting provider and the prescribing provider. The original signature copy must be kept in the provider's medical record for the client.

To avoid unnecessary denials, the prescribing provider must provide correct and complete information, including documentation for medical necessity of the equipment and/or supplies requested. The prescribing provider 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 PT/INR monitor.

Prior authorization for the rental or purchase of a home PT/INR monitor and related testing supplies will be considered for clients who meet all the following criteria:

- The client is on anticoagulation therapy and has a current prescription for Warfarin or other oral anticoagulant.
- The client has been on anticoagulation therapy for at least three months prior to the request for the home PT/INR monitor.
- The client is required to self-test at least every two weeks.

Additionally, the client must have at least one of the following conditions documented in the request for prior authorization:

- Fluctuations of INR or PT/PTT levels with titration greater than once per week in anticoagulation dosing with copies of laboratory reports and resultant medication changes.

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- A medical condition that limits physical movement, places the client under medical restrictions for isolation, or requires non-emergency ambulance transport for the purpose of obtaining laboratory specimens.
- Limited venous access that compromises the ability to obtain laboratory specimens for the adequate monitoring of anticoagulation therapy.

The prior authorization request will be evaluated upon receipt to determine whether the equipment will be rented, purchased, repaired, or modified based on the client's needs, duration of use, and age of equipment.

Note: *Skilled nursing (SN) visits will not be approved for the sole purpose of instructing the client on the use of the PT/INR home testing monitor. Any necessary instruction must be performed as part of the office visit with the prescribing physician.*

2.2.19 Respiratory Equipment and Supplies

Respiratory equipment and supplies may be provided in the home under Home Health Services. Rental of equipment includes all necessary supplies, adjustments, repairs, and replacement parts.

Note: *Respiratory equipment and related supplies that are not considered a benefit under Home Health Services may be considered for reimbursement through CCP for clients who are 20 years of age and younger, who are CCP eligible (e.g., clients who are residing in residential treatment centers).*

2.2.19.1 * Prior Authorization

Most respiratory equipment and supplies, with the exception of the codes noted below, require prior authorization.

The following procedure codes do not require prior authorization:

Procedure Codes									
A4481	A4615	A4616	A4617	A4619	A4620	A4623	A7003	A7004	A7005
A7006	A7007	A7009	A7010	A7012	A7015	A7016	A7017	A7018	

Prior authorization is required for rental or purchase of respiratory equipment and supplies not listed above provided through the Texas Medicaid Title XIX Home Health Services. To complete the prior authorization process, the provider should submit the completed Title XIX Form to the Home Health Unit.

- A completed Title XIX Home Health Durable Medical Equipment (DME)/Medical Supplies Physician Order Form prescribing the DME or medical supplies must be signed and dated by the prescribing physician familiar with the client prior to requesting authorization. The completed Title XIX Form must be maintained by the requesting provider and the prescribing physician. The original signature copy must be kept in the physician's medical record for the client.
- In addition to the Texas Medicaid Title XIX Home Health Durable Medical Equipment (DME)/Medical Supplies Physician Order Form, all other required forms must be signed and dated by the prescribing physician who is familiar with the client before requesting authorization.

Requests for prior authorization or recertification must include documentation by the physician who is familiar with the client that the client is compliant with the use of the equipment and that the treatment is effective.

To avoid unnecessary denials, when requesting prior authorization for respiratory equipment and supplies, the physician must provide correct and complete information, supporting the medical necessity of the equipment or supplies requested, including:

- Diagnosis or condition causing impairment of respiratory function.

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- Accurate diagnostic information pertaining to any other medical diagnoses or conditions, to include the clients's overall health status.

The provider may be asked to provide additional information to clarify or complete a request for respiratory supplies or accessories.

The following includes, but is not limited to, respiratory equipment that require prior authorization:

- IPPB device
- Electrical percussor
- HFCWCS
- Cough stimulating device
- CPAP system
- Bi-level positive airway pressure system without backup (such as BiPAP S)
- Bi-level positive airway pressure system with backup (such as BIPAP ST)
- All home ventilation and humidification equipment
- Home oxygen systems
- Controlled dose inhalation drug delivery system
- Aerosols, humidifiers, and nebulizers to add moisture to air or oxygen

2.2.19.2 Nebulizers

Nebulizers may be reimbursed for purchase only, and that purchase is limited to 1 every 5 years. Providers must use procedure code E0570 when billing for the purchase of the nebulizer.

For fee-for-service, medications that are used with the nebulizer will not be reimbursed to a DME company. These medications may be considered under the Vendor Drug Program.

Refer to: "Appendix B: Vendor Drug Program" (*Vol. 1, General Information*) for more information about VDP.

2.2.19.2.1 Prior Authorization

Nebulizers and nebulizer supplies do not require prior authorization for the diagnoses listed below. Other diagnoses require prior authorization and may be considered based on review of documentation by HHSC or its designee.

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
B59	E840	E8411	E8419	E848	E849	J09X1	J09X2
J121	J1281	J15212	J188	J189	J210	J211	J218
J219	J410	J411	J418	J42	J430	J431	J432
J438	J439	J440	J441	J449	J4520	J4530	J4540
J4550	J45901	J45902	J45909	J45990	J45991	J45998	J471
J479	J670	J671	J672	J673	J674	J675	J676
J677	J678	J679	J690	J691	J698	K449	P270
P271	P278						

Purchase of nebulizers may be considered for prior authorization for diagnoses other than those listed in the diagnosis table for nebulizers, with documentation of medical necessity.

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The following procedure codes for nebulizer supplies may be billed with the diagnosis codes listed above:

Procedure Codes								
A4617	A7003	A7004	A7005	A7006	A7007	A7013	A7015	A7018

Ultrasonic nebulizers may be considered for prior authorization for the following diagnoses with documentation for failure of standard therapy:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)						
B59	E840	E8411	E8419	E848	E849	J09X1

Providers must use procedure code A7009, A7014, or A7016 when billing supplies with an ultrasonic nebulizer.

Providers must include documentation by the physician who is familiar with the client that the client is compliant with the use of the equipment and that the treatment is effective.

2.2.19.3 Vaporizers

Vaporizers may be reimbursed for purchase only, and that purchase is limited to 1 every 5 years.

Providers must use procedure code E0605 when billing for vaporizers. Vaporizer use is associated with a risk of bronchospasm, infection, edema of the airway, and client, caregiver, parent or guardian exposure to airborne microorganisms.

2.2.19.3.1 Prior Authorization

Vaporizers require prior authorization for limited indications that includes one of the following:

- Laryngotracheobronchitis
- Subglotic edema
- Post-extubation edema
- Postoperative management of the upper airway
- The need for sputum specimens or mobilization of secretions
- The presence of a bypass upper airway

Prior authorization for use beyond the clinical indications listed above is only considered with clinical documentation that demonstrates that the benefit of the use of the device outweighs the noted risks.

2.2.19.4 Humidification Units

Humidification units for nonmechanically ventilated clients may be purchased when a purchase is determined to be more cost effective than leasing the device with supplies. Providers must use procedure code E1399 when billing for the purchase of humidification units for nonmechanically ventilated clients. Procedure code E1399 will be reimbursed with a maximum fee of $1,230.00 or MSRP less 18 percent, which ever is the lesser cost. Supplies to be used with client owned humidification units may be considered for purchase and must be billed with the appropriate HCPCS code for each item requested. Documentation of medical necessity must be included with submission of the request.

2.2.19.5 Secretion Clearance Devices

Secretion clearance devices and incentive spirometers do not require authorization.

2.2.19.5.1 Intermittent Positive-Pressure Breathing (IPPB) Devices

Purchase of the IPPB device (procedure code E0500) is not a benefit.

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Rental of an IPPB device (procedure code E0500) requires prior authorization. Prior authorization may be granted when the request is submitted with documentation that indicates an ineffective response with other modalities such as treatment with a cough assist device for four months or longer. Rental of the IPPB device includes all supplies, such as humidification and tubing.

Purchase of the IPPB device will not be reimbursed.

In accordance with the American Association for Respiratory Care recommendations, IPPB may be considered when one of the following is documented:

- Presence of clinically significant atelectasis.
- Reduced pulmonary function as evidenced by reductions in timed volumes, and vital capacity.
- Neuromuscular disorders or kyphoscoliosis with associated decreases in lung volumes and capacities.
- Fatigue or muscle weakness with impending respiratory failure.
- Presence of acute severe bronchospasm or exacerbated COPD that fails to respond to other therapy patients who are at risk for the development of atelectasis and are unable or unwilling to deep breathe without assistance.

The IPPB device may be prior authorized for rental with the following diagnoses:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
E840	E8411	E8419	E848	E849	G121	G128	G129
G710	G7111	G7112	G7113	G7114	G7119	J09X1	J182
J449	J811	J8402	J8410	J84111	J84112	J84113	J84114
J84115	J84116	J84117	J842	J84842	J84843	J84848	J951
J952	J953	J95821	J95822				

2.2.19.5.2 Mucous Clearance Valve

Providers must use procedure code S8185 when billing for the purchase of a mucous clearance valve. Purchase of the mucous clearance valve requires prior authorization.

Rental of the mucous clearance valve is not a benefit.

The mucous clearance valve may be prior authorized for the following diagnoses:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
E840	E8411	E8419	E848	E849	J09X1	J40	J410
J411	J418	J42	J430	J431	J432	J438	J439
J441	J449	J4520	J4521	J4522	J4530	J4531	J4532
J4540	J4541	J4542	J4550	J4551	J4552	J45901	J45902
J45909	J45990	J45991	J45998	J471	J479	J670	J671
J672	J673	J674	J675	J676	J677	J678	J679

Other diagnoses may be considered based on review of documentation by HHSC or its designee. Hypertonic saline 7 percent for inhalation therapy is a benefit of Texas Medicaid for clients with a diagnosis of cystic fibrosis. Hypertonic saline 7 percent for inhalation therapy may be billed using procedure code T1999 and requires prior authorization. To request prior authorization, providers must submit either the MSRP, the provider's invoice cost, or the AWP. Providers may be reimbursed 82 percent of the MSRP or 85 percent of the AWP per ampoule or the provider's invoice cost if the MSRP is not available.

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2.2.19.6 Electrical Percussor

The electrical percussor device requires prior authorization. The electrical percussor may be prior authorized for rental or purchase depending on the physician's predicted length of treatment.

In addition to the completed Title XIX order form, a description of all previous courses of therapy and why they did not adequately assist the client in airway mucus clearance is required to obtain authorization for an electrical percussor.

2.2.19.7 Chest Physiotherapy Devices

Either a cough-stimulating device (cofflator) or the High-Frequency Chest Wall Compression System (HFCWCS) generator with vest may be prior authorized. These systems are not prior authorized simultaneously.

Chest physiotherapy to promote bronchial drainage that is performed by a therapist or any other healthcare professional, including a private duty nurse, will not be prior authorized during the period of time that the HFCWCS or cough-stimulating device is prior authorized.

Intrapulmonary percussive ventilation (IPV) is not a benefit of Texas Medicaid.

2.2.19.7.1 HFCWCS

A HFCWCS may be reimbursed only when it is demonstrated that other mechanical devices or chest physiotherapy by a client, parent, guardian, or caregiver have been ineffective.

Rental cost of the HFCWCS applies toward the purchase price. A HFCWCS generator purchase and vest purchase may be reimbursed only once per lifetime, due to the lifetime warranty provided by the manufacturer. Requests for a vest replacement due to growth may be considered with appropriate documentation.

Prior authorization for the rental or purchase of equipment in this section requires a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and the Medicaid Certificate of Medical Necessity for Chest Physiotherapy Device Initial Request or Extended Request form. These signed and dated forms must be maintained by the provider and prescribing physician in the client's medical record.

Providers must use procedure code E0483 when billing for HFCWCS for either a rental or purchase.

Prior authorization of the HFCWCS may be considered for the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
E840	E8411	E8419	E848	E849	G121	G128	G129
G710	G800	G801	G802	G804	G808	G809	G8381
G8382	G8383	G8384	G8389	J09X1	J8410		

Other diagnoses may be considered base on review of documentation by HHSC or its designee.

Rental of the HFCWCS

The HFCWCS requires prior authorization. An initial three-month rental may be authorized for the HFCWC. If the HFCWC 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.

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To obtain prior authorization for the initial three-month rental of a HFCWCS generator and vest, all of the following information must be provided:

- A description of all previous therapy courses that have been tried and why these treatments did not adequately assist the client in airway mucus clearance. This must include the information that the client has used a cough assist device for a minimum of four months before the request and that this therapy has been ineffective.
- A physician's statement of a trial of the HFCWCS in a clinic, hospital, or the home setting documenting the effectiveness and tolerance of the system, including a statement that the client has not exacerbated any gastrointestinal manifestations, nor caused aspiration and exacerbation of pulmonary manifestations, nor an exacerbation of seizure activity secondary to the use of the system.
- Diagnosis and background history including complications, medications used, history of any IV antibiotic therapy with dosage, frequency and duration, history of recent hospitalizations or history of school, work, or extracurricular activity absences due to diagnosis-related complications.
- Any recent illnesses or hospitalizations due to respiratory problems or complications.
- Medical diagnosis or other limitations preventing the client or caregiver from doing chest physiotherapy.

Prior authorization for an extension of another three months rental may be considered with the above documentation.

Purchase of the HFCWCS Generator

Requests for prior authorization of the purchase of a HFCWCS generator may be considered based on the outcome of a six-month rental period and the following required documentation. Documentation of vest tolerance and positive outcomes/results of therapy, including:

- Physician's description or assessment of the effectiveness such as decreased medication use, shorter hospital length of stay, decreased hospitalizations, and fewer school, work, or extracurricular activity absences due to diagnosis related complications.
- The frequency and compliance graphs for the six-month period showing use of the system at least 50 percent of the maximum time prescribed by the physician for each day.
- Respiratory status, including any recent hospitalization.
- A statement that the client has not exacerbated any gastrointestinal manifestations, nor caused aspiration and exacerbation of pulmonary manifestations, nor an exacerbation of seizure activity secondary to the use of the system.

2.2.19.8 Cough-Stimulating Device (Cofflator)

The cough stimulating device requires prior authorization. Prior authorization may be given for monthly rental only. Purchase of the cough stimulating device is not a benefit and will not be considered for prior authorization.

The completed Title XIX Form and the Medicaid Certificate of Medical Necessity for Chest Physiotherapy Devices Initial or Extended form must be maintained by the provider in the client's medical record.

The cough stimulating device (procedure code E0482) may be prior authorized for those clients who have chronic pulmonary disease or neuromuscular disorders that affect the respiratory musculature.

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The cofflator may be approved initially for a three-month rental period based on the following required documentation:

- Diagnosis and background history including recent illnesses, complications, medications used, history of recent hospitalizations, results of pulmonary function studies if applicable, or history of school, work, or extracurricular activity absences due to diagnosis related complications.
- Medical reasons why the client, parent, or guardian/caregiver cannot do chest physiotherapy.

Requests for prior authorization of an extension must include documentation by the physician familiar with the client that the client is compliant with the use of the equipment and that the treatment is effective.

2.2.19.8.1 Tracheostomy Tubes

A tracheostomy tube may be reimbursed for purchase only and is limited to one per month. Add modifier TF when billing a tracheostomy with specialized functions. Add modifier TG when billing a custom-made tracheostomy. The MSRP information and a physician statement addressing the reason the client cannot use a standard tracheostomy tube are required when requesting prior authorization. Disposable tracheostomy inner cannulas are considered a convenience item and are not a benefit.

Prior authorization requests for tracheostomy tubes must provide sufficient information to support the determination of medical necessity for the requested item. Prior authorization for a tracheostomy tube

will be considered with procedure codes A7520, A7521, or A7522. Providers must use procedure code A4623 when requesting prior authorization for the tracheostomy tube inner cannula. An inner cannula is limited to one per month and will not be prior authorized when a custom manufactured tracheostomy tube (procedure code A7520-TG or A7521-TG) is requested.

2.2.19.9 Positive Airway Pressure System Devices

In addition to the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form, a Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy Form must be signed and dated by the physician familiar with the client and submitted by the provider for all positive pressure system devices. The original signed copy must be kept in the medical record.

2.2.19.9.1 Heated and Non-heated Humidification For Use With Positive Airway Pressure System

Humidification devices require prior authorization. Documentation of medical necessity including the diagnosis and expected outcome must be submitted with the request for prior authorization.

2.2.19.9.2 Continuous Positive Airway Pressure (CPAP) System

Purchase is limited to a maximum of once every five years with medical necessity. Reimbursement for rental is limited to once per month and includes all supplies and accessories.

Headgear, tubing, and filters are considered part of the rental and will not be reimbursed separately.

Providers must use procedure code E0601 when requesting prior authorization for the rental or purchase of the CPAP system.

Adult CPAP (19 years of age and older)

CPAP may be approved initially for three months for adults if one of the following conditions are met:

- A Sleep Study Respiratory Disturbance Index (RDI) or Apnea/Hypopnea Index (AHI) greater than or equal to 15 per hour
- A Sleep Study RDI or AHI greater than 5 per hour and at least one of the following:

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- Excessive daytime sleepiness (documented by either Epworth greater than 10 or multiple sleep latency test (MSLT) less than 6
- Documented symptoms of impaired cognition, mood disorders, or insomnia
- Documented hypertension (systolic blood pressure greater than 140 mm Hg or diastolic blood pressure greater than 90 mm Hg)
- Documented ischemic heart disease
- Documented history of stroke
- Greater than 20 episodes of oxygen desaturation less than 85 percent during a full night sleep study
- Any one episode of oxygen desaturation less than 70 percent

Pediatric CPAP Criteria

One of the following AHI or oxygen saturation levels may be used for clients who are 18 years of age and younger:

- Polysomnography documentation AHI greater than 1
- An oxygen saturation less than 92 percent, taken upon exertion breathing room air

2.2.19.9.3 Prior Authorization

The CPAP system requires prior authorization and may be prior authorized for rental or purchase depending on the physician's predicted length of treatment. Headgear, tubing, and filters used with patient owned positive airway pressure devices require prior authorization. Humidifiers may be prior authorized when used with a CPAP with documentation of medical necessity. Clients who have a current prior authorization for a CPAP/BiPAP S may continue to rent these items until the prior authorization period expires. After the current prior authorization period expires, then the criteria in the following paragraph applies to any further prior authorizations of CPAP/BiPAP. Providers must supply a new CPAP/BiPAP to clients at the beginning of the new prior authorization period.

The CPAP system may be approved initially for a three-month rental period based on documentation supporting the medical necessity and appropriateness of the device.

CPAP Prior Authorization Renewal

Prior authorization for purchase after the initial three-month rental period may be granted if the client is continuing to use the equipment at a minimum of four hours per night and symptoms are improved as documented by a physician familiar with the client. This documentation of compliance and effectiveness must be provided with a new completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and a Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy form. Rental of a CPAP/BiPAP system includes all supplies. CPAP/BiPAP S may be rented up to a maximum of 13 months. The equipment is considered purchased after 13 months rental.

2.2.19.9.4 Bi-level Positive Airway Pressure System (BiPAP S) Without Backup

Purchase is limited to a maximum of once every five years with medical necessity. Reimbursement for rental is limited to once per month and includes all supplies.

Providers must use procedure code E0470 when requesting prior authorization for the rental or purchase of the BiPAP S.

The BiPAP S may be approved initially for a three-month rental period based on documentation supporting the medical necessity and appropriateness of the device.

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The BiPAP S may be approved initially for three months if the following conditions are met:

- The client has demonstrated the inability to tolerate the CPAP system.
- The duration of symptoms is at least six months.
- The Sleep Study RDI or AHI is greater than 15 per hour.
- The Sleep Study RDI or AHI greater than 10 per hour with the lowest oxygen saturation during study is less than 80 percent.
- Oxygen saturation is equal to or less than 92 percent for clients who are 20 years of age and younger.

Rental of CPAP/BiPAP S includes all supplies. CPAP/BiPAP S may be rented up to a maximum of 13 months. The equipment is considered purchased after 13 months rental.

Prior Authorization

The BiPAP S requires prior authorization and may be reimbursed for rental or purchase depending on the physician's predicted length of treatment. The BiPAP S will not be prior authorized once a CPAP is purchased. Clients who have a current prior authorization for a CPAP/BiPAP S may continue to rent these items until the prior authorization period expires. After the current prior authorization period expires, then the criteria in the following paragraph applies to any further prior authorizations of CPAP/BiPAP. Providers must supply a new CPAP/BiPAP to clients at the time of purchase, if the item is purchased after a rental period.

Prior authorization for purchase after the initial three-month rental period may be granted if the client is continuing to use the equipment at a minimum of four hours per night and symptoms are improved as documented by a physician familiar with the client. This documentation of compliance and effectiveness must be provided with a new completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and a Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy form.

2.2.19.9.5 Bi-level Positive Airway Pressure System With Backup (BiPAP ST)

Purchase of a BiPAP ST is not a benefit. The BiPAP ST may be approved initially for a three-month rental period based on documentation supporting the medical necessity and appropriateness of the device. Providers must use either procedure code E0471 or E0472 when requesting prior authorization for the rental of the BiPAP ST.

BiPAP ST may be approved initially for three months if the following conditions are met:

- A diagnosis of central sleep apnea or a neuromuscular disease producing respiratory insufficiency, *and*
- Sleep study records central apnea greater than 5 RDI or AHI per hour, *or*
- For clients who are 18 years of age and younger with:
  - Central apneas greater than 20 seconds regardless of bradycardia
  - Desaturation or central apneas of less than 20 seconds with desaturation greater than 4 percent
  - Bradycardia
- The client has an arterial PO2 at or below 56 mm Hg, or an arterial oxygen saturation at or below 89 percent by transcutaneous oximetry associated with a diagnosis of neuromuscular respiratory insufficiency or failure (not COPD).

2.2.19.9.6 Prior Authorization

The rental of a BiPAP ST requires prior authorization and may be reimbursed only once per month.

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Continued prior authorization for rental after the initial three-month rental period may be granted if the client is continuing to use the equipment at a minimum four hours per night and has a transcutaneous saturation greater than 88 percent while using the equipment as documented by a physician familiar with the client or 92 percent or less for clients who are 20 years of age and younger. This documentation of compliance and effectiveness must be provided with the above documentation plus a new completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and a Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy form.

2.2.19.10 Home Mechanical Ventilation Equipment

Continuous use ventilators are used for 12 or more hours per day. Intermittent use ventilators are used for less than 12 hours per day. Mechanical ventilation is either provided by positive pressure ventilation (volume ventilator) or negative pressure ventilation (iron lung).

Prior Authorization

All ventilators require prior authorization. The completed, signed, and dated Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must specify all ventilator settings and must be maintained by the DME provider and the prescribing physician in the client's medical record.

Volume Ventilators

A volume ventilator may be operated in any of the following:

Ventilation Modes

- Control
- Assist control
- Synchronized intermittent mandatory ventilation (SIMV)
- CPAP

Breath Types

- Spontaneous (client triggered and cycled)
- Ventilator assisted (client or machine triggered or cycled) (e.g., pressure support or pressure-assisted)
- Mandatory (machine triggered or machine cycled)

The monthly ventilator rental includes all ventilator supplies, such as (but not limited to):

- Internal filters
- External filters
- Ventilator circuits with an exhalation valve
- High and low pressure alarms
- All humidification systems including supplies and solutions (i.e., sterile or distilled water)
- Compressors and supplies
- Tracheostomy filters/heat moisture exchangers
- Humidifiers

Note: *Oxygen rental is not considered a ventilator supply and may be considered for separate prior authorization.*

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Prior authorization of a volume ventilator rental may be granted for clients who have a tracheostomy. For all ventilator procedure codes, providers must include documentation by the physician who is familiar with the client, which states that the client is compliant with the use of the equipment and that the treatment is effective.

Refer to: Subsection 2.2.19.13, "Procedure Codes and Limitations for Respiratory Equipment and Supplies" in this handbook for additional information about ventilator procedure codes.

2.2.19.10.1 Negative Pressure Ventilators

The ventilator rental includes all component parts (pillow, mattress, gaskets, etc.).

Application devices may be purchased following the initial three-month rental period depending on the physician's predicted length of treatment and the client's compliance.

The purchase of a chest shell (cuirass) and chest wrap is limited to a maximum of 1 every 5 years. Reimbursement for rental is limited to once per month for a total of 4 months.

Prior Authorization

Negative pressure ventilators may be prior authorized for rental only for individuals who have the ability to speak, eat, drink, and do not have a tracheostomy. One of the following devices may be prior authorized with a portable negative pressure ventilator using procedure codes E0457 and E0459. These devices may be reimbursed for an initial three-month rental period. Application devices may be prior authorized for rental of an initial period of three months.

2.2.19.10.2 Ventilator Service Agreement

A ventilator service agreement may be reimbursed only once per month. Providers must use procedure code A9900 when requesting the ventilator service agreement. The ventilator service agreement contract may be considered for renewal every six months.

The provider must agree to include all of the following components in the ventilator service agreement:

- Ensure that all routine service procedures as outlined by the ventilator manufacturer are followed
- Provide all internal filters, external filters, and tracheostomy filters
- Provide all ventilator circuits (with the exhalation valve) as a part of the ventilator service agreement
- Provide a respiratory therapist and back-up ventilator on a 24-hour call basis
- Provide monthly home visits by a certified respiratory therapist to verify proper functioning of the ventilator system and the client's status (and maintain documentation of monthly visits)
- Provide a substitute ventilator while the manufacturer's recommended preventive maintenance is being performed on the client-owned ventilator

Prior Authorization

A ventilator service agreement may be prior authorized for a client who owns their own ventilator, when documentation supports medical necessity/appropriateness for continued ventilator usage. A ventilator service agreement requires prior authorization, which must include submission of a completed Title XIX form and the ventilator service agreement. The completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must include all ventilator settings.

The completed, signed, and dated Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and the Ventilator Service Agreement form must be maintained by the provider and the prescribing physician in the client's medical record. The client-owned ventilator must be functional at the time of the request for prior authorization and documen-

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tation must include the make, model number, serial number, and the date of ventilator purchase and all ventilator settings. Requests for a continued six-month prior authorization of a ventilator service agreement must include the above documentation and the following:

- The recommended preventive maintenance schedule for the ventilator make and model
- Documentation of the monthly ventilator and client assessments
- Documentation of all service performed during the previous service agreement

2.2.19.11 Oxygen Therapy

Oxygen therapy home delivery systems may be reimbursed for rental only once per month.

Moisture exchangers for use with non-mechanically ventilated clients may be considered for reimbursement when billed with procedure code A9900.

Rental of oxygen equipment includes all supplies and refills.

One of the following clinical indications must be present when requesting approval for in-home oxygen therapy:

- Bronchopulmonary dysplasia and other respiratory diagnoses due to prematurity.
- Respiratory failure or insufficiency.
- Musculoskeletal weakness, such as that caused by Duchenne's or spinal muscle atrophy.
- Diagnosis of cluster headaches.
- Hypoxemia-related symptoms and findings that might be expected to improve with oxygen therapy (examples of these symptoms and findings are pulmonary hypertension, recurring congestive heart failure due to chronic cor pulmonale, erythrocytosis, impairment of the cognitive process, nocturnal restlessness, and morning headache).
- Severe lung disease, such as COPD, diffuse interstitial lung disease, whether known or unknown etiology such as cystic fibrosis, bronchiectasis or widespread pulmonary neoplasm.

2.2.19.11.1 Oxygen Therapy Home Delivery System

Providers must use procedure code E1390 when billing for the rental of an oxygen concentrator system. The reimbursement payment for the rental of the oxygen concentrator system includes, but is not limited to, cannula or mask, tubing, and humidification. These items will not be reimbursed separately.

If other types of oxygen therapy home delivery systems are required, documentation of medical necessity exception must be provided.

Other types of delivery systems include:

- Compressed gas cylinder systems (nonportable tanks) (procedure code E0424)
- Liquid oxygen reservoir systems (procedure code E0439)

  Note: *The reimbursement for compressed gas cylinder and liquid oxygen reservoir systems includes all of the supplies that are noted in the procedure code description.*

- Portable oxygen systems—Portable oxygen therapy may be prior authorized if the medical necessity conditions are met and the medical 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 the home environment.
  - Portable oxygen systems are not considered a benefit of the Home Health Services Program for clients who qualify for oxygen solely based on blood gas studies obtained during sleep.

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- Providers must use procedure codes E0431, E0434, and K0738 when billing for the portable oxygen systems. When procedure code K0738 is billed for the same dates of service as procedure code E0431, procedure code E0431 will be denied.

Rental of the portable oxygen system includes all supplies and refills. Refills for a client-owned system must be obtained from a DSHS-licensed vendor.

2.2.19.11.2 Prior Authorization

All oxygen therapy, supplies, and related equipment requires prior authorization. Humidifiers may not be prior authorized separately for rental for use with oxygen equipment. Multiple oxygen delivery systems (e.g., liquid or gas) will not be prior authorized concurrently. Supplies and refills may be prior authorized for those clients who own their own oxygen systems.

Note: *In addition to the completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form, a Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy form must be completed, signed, and dated by the physician familiar with the client and submitted by the provider.*

2.2.19.11.3 Initial Oxygen Therapy Medical Necessity Certification

Prior authorization of home oxygen therapy for the initial period of three months will be granted if the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and the Medicaid Certificate of Medical Necessity for CPAP or BiPAP or Oxygen Therapy form is completed and all of the following conditions are met:

- Symptoms have a duration of at least three months (or less with special circumstances).
- For clients who are 20 years of age and younger, one of the following parameters must be used:
  - An oxygen saturation of 89 to 92 percent, taken at rest, breathing room air.
  - An oxygen saturation less than 92 percent with documentation of medical necessity provided by a physician familiar with the client.
- An arterial PO2 at or below 56 mm Hg or an arterial oxygen saturation at or below 89 percent, taken at rest, breathing room air, or during sleep and associated with signs or symptoms reasonably attributed to hypoxemia.
- Hypoxemia associated with obstructive sleep apnea must be unresponsive to CPAP or BiPAP S therapy before oxygen therapy can be approved. In these cases, coverage is provided only for use of oxygen during sleep, and then only one type of delivery system will be considered a benefit under the Home Health Services Program.
- Portable oxygen systems are considered a benefit of the Home Health Services Program when the medical 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 the home environment. Portable oxygen systems are not considered a benefit of the Home Health Services Program when traveling outside the home environment for clients who qualify for oxygen usage based solely on oxygen saturation levels during sleep.
- A client who demonstrates an arterial PO2 at or above 56 mm Hg, or an arterial oxygen saturation at or above 89 percent, during the day while at rest and who subsequently experiences a decreased arterial PO2 of 55 mm Hg or below, or decreased arterial oxygen saturation of 88 percent or below during exercise. In this case supplemental oxygen can be provided if there is evidence that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the client was breathing room air.

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In-home oxygen therapy can be approved for cluster headaches with the documentation of both the following clinical indications:

- Neurological evaluation with diagnosis
- Documented failed medication therapy

Note: *Lab values are not indicated with this diagnosis*

2.2.19.11.4 Oxygen Therapy Recertification

Prior authorization of oxygen therapy after an initial three-month rental period may be granted with the submission of a new completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and a new Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy form and the following:

- Documentation of continued need
- Documentation of client compliance by the physician familiar with the client

Note: *The initial Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy Form cannot be used for recertification purposes.*

2.2.19.12 Pulse Oximetry

Pulse oximeters are not a benefit of Title XIX Home Health Services. Pulse oximeters are a benefit of Texas Medicaid through CCP for clients who are birth through 20 years of age.

Refer to: Subsection 2.6.6, "Pulse Oximeter" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information on pulse oximeters.

2.2.19.12.1 Prior Authorization

Pulse oximeter sensor probes (procedure code A4606) for client owned equipment are limited to four per month without prior authorization. If additional sensor probes are needed, prior authorization must be requested through Home Health Services with documentation supporting medical necessity.

2.2.19.13 Procedure Codes and Limitations for Respiratory Equipment and Supplies

Procedure Code	Limitations
Nebulizers	
A4617	2 per month
A7003	2 per month
A7004	2 per month
A7005	1 per 6 months
A7006	1 per month
A7007	2 per month
A7010	1 unit (100 ft) per 2 months
A7012	2 per month
A7013	2 per month
A7015	1 per month
A7017	1 every 3 years
A7018	4 per month
E0570	Every 5 years
E0585	Every 3 years
S8101	1 per 180 days

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Procedure Code	Limitations
Ultrasonic Nebulizers	
A7009	4 per month
A7014	1 every 3 months
A7016	2 per year
E0574	Every 2 years
E0575	Every 5 years
Vaporizers	
E0605	Every 5 years
Nonelectric Spirometer	
A9284	1 per 6 months
Intermittent Positive-Pressure Breathing (IPPB) Device	
E0500	4 months per life
Mucous Clearance Valve (i.e., Flutter)	
S8185	Every 5 years
Chest Physiotherapy Devices	
A7026	1 per 6 months
E0480	1 purchase every 5 years; 1-month rental
E0482	1 per month
E0483	1 purchase per lifetime; 1-month rental
CPAP/BiPAP	
A7027	1 per 3 months
A7028	1 per month
A7029	2 per month
A7030	1 per 3 months
A7031	1 per month
A7032	2 per month
A7033	2 per month
A7034	4 per year
A7035	Every 6 months
A7037	1 per month
A7038	2 per month
A7039	1 per 6 months
E0470	1 purchase every 5 years; 1-month rental
E0471	1 purchase every 5 years; 1-month rental
E0472	1 purchase every 5 years; 1-month rental
E0561	1 purchase every 5 years; 1-month rental
E0562	1 purchase every 5 years; 1-month rental
E0601	1 purchase every 5 years; rental allowed 4 per lifetime
Home Mechanical Ventilator Equipment	
A4481	31 per month

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Procedure Code	Limitations
A4483	31 per month
A4611	Every 5 years
A4612	Every 5 years
A4613	Every 5 years
A4614	1 per 6 months
A4623	1 per month
A4629	31 per month
A7520	1 per month
A7521	1 per month
A7522	4 per year
E0457	1 purchase every 5 years; 1-month rental
E0459	1 purchase every 5 years; 1-month rental
E0465	1 per month
E0466	1 per month
E0580	1 per 3 years
S8189	Limited per policy
Ventilator Maintenance Agreement	
A9900	1 per month
Oxygen Therapy	
A4615	2 per month
A4616	4 per year
A4618	4 per month
A4619	2 per month
A4620	2 per month
E0424	4 per lifetime
E0431	4 per lifetime
E0433	1 per month
E0434	4 per lifetime
E0439	4 per lifetime
E0441	4 per lifetime
E0442	4 per lifetime
E0443	1 per month
E0444	1 per month
E0565	1 purchase every 5 years; rental allowed 4 per lifetime
E1353	1 per year
E1355	1 purchase every 3 years; 1-month rental
E1372	1 every 3 years
K0730	1 every 5 years
Suction Pumps	
A4605	10 per month

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Procedure Code	Limitations
A4624	90 per month
A4628	2 per month
A7000	4 per month
A7002	8 per month
E0600	Every 5 years
Miscellaneous	
A4606	4 per month
A4627	Every 6 months
E1399	Limited by policy
S8999	1 per year

2.2.20 Special Needs Car Seats and Travel Restraints

Special needs car seats and travel restraints are not services available under Home Health Services.

Refer to: Subsection 2.6.14, "Special Needs Car Seats and Travel Restraints" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for details about coverage through CCP.

2.2.21 Subcutaneous Injection Ports

A subcutaneous injection port is a sterile medication delivery device through which physician-prescribed medications can be injected directly into the subcutaneous tissue using a standard syringe and needle, an injection pen, or other manual injection device. The device can be used for multiple subcutaneous injections for a period of up to 72 hours, thereby avoiding repeated needle punctures of the skin. The device cannot be used with an injection pump.

A subcutaneous injection port, such as the *I-Port* or *Insuflon*, is a benefit of Texas Medicaid as a Title XIX Home Health service with prior authorization. Claims for a subcutaneous injection port must be submitted with procedure code A4211 and modifier U4.

Texas Medicaid may reimburse the device for clients who require multiple daily injections of a physician-prescribed medication and who meet the medical necessity criteria.

The subcutaneous injection port is not a benefit of Texas Medicaid as an item of convenience or for clients who are already receiving the medication through an ambulatory infusion pump. The device is considered an item of convenience if the client does not meet the criteria for medical necessity.

2.2.21.1 Prior Authorization

Prior authorization is required for a subcutaneous injection port. Initial prior authorizations will be issued for a trial period of up to 3 months. Prior authorizations that are issued after the successful completion of the initial trial period may be issued for a period of up to 6 months. Prior authorizations for subcutaneous injection ports are limited to a quantity of 10 individual ports per month. Additional ports will be considered for prior authorization with documentation of medical necessity.

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2.2.21.2 Documentation Requirements

The initial request for prior authorization must include documentation that indicates the client meets the following criteria for medical necessity:

- The client has a medical condition that requires multiple (i.e., 2 or more) subcutaneous, self-administered injections on a daily basis and has a current prescription for the injectable medication. Documentation must indicate the specific medical condition that is being treated, the name of the injectable medication, and the dosage and frequency of the injections.

  Note: *"Self-administered" includes those injections administered by the client through a subcutaneous injection or by the caregiver to the client through a subcutaneous injection.*

- The client or the caregiver has been unsuccessful with the self-administration of injections using a standard needle and syringe because the client demonstrates trypanophobia (i.e., severe needle phobia), as evidenced by documented physical or psychological symptoms. Documented symptoms may include, but are not limited to, the following:

Condition	Possible Exhibited Symptoms
Vaso-vagal trypanophobia	Physical symptoms such as changes in blood pressure, syncope, sweating, nausea, pallor, and tinnitus
Associate trypanophobia	Psychological symptoms such as extreme anxiety, insomnia, and panic attacks
Resistive trypanophobia	Signs and symptoms such as combativeness, elevated heart rate, high blood pressure, and violent resistance to procedures involving needles or injections

The prescribing physician must include with the prior authorization request a written statement of medical necessity that identifies the client as an appropriate candidate for the subcutaneous injection port device. The physician's statement or medical record documentation that is submitted with the prior authorization request must indicate the following:

- The client or caregiver has received instruction during an office visit on the proper placement and use of the device, with successful return demonstration. (Prior authorization requests for skilled nursing visits for the sole purpose of client instruction on the use of the subcutaneous injection port device will not be approved. Necessary instruction must be performed as part of the office visit with the prescribing physician.)
- The client has no known allergies or sensitivities to adhesives, silicone, or similar materials.
- The client has no skin infection at potential injection sites.
- The client's most recent lab results related to the medical condition requiring treatment with daily subcutaneous injections must also be submitted with the prior authorization request. Lab results may include, but are not limited to, hemoglobin A1c (HbA1c) levels for clients with insulin dependent diabetes mellitus (IDDM) and partial thromboplastin time (PTT) for clients who are receiving anticoagulant therapy.

Requests for the renewal of the prior authorization after the initial trial period has ended must include documentation of the following:

- Ongoing signs and symptoms associated with the client's trypanophobia.
- Improved compliance with the physician-prescribed injection regimen.
- Successful use of the device with no persistent pattern of the client's dislodging the device during the initial trial period.

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- Results of relevant lab tests performed upon completion of the initial trial period, including, but not limited to, HbA1c levels for clients with IDDM and PTT for clients who are receiving anticoagulant therapy.

  Note: *For clients with IDDM, if the HbA1c level has not declined with use of the subcutaneous injection port, additional documentation must be submitted by the physician who documents the clinical determination about the lack of significant improvement in the HbA1c level. The renewal of the prior authorization will not be approved without this information.*

2.2.22 Total Parenteral Nutrition (TPN) Solutions

In-home TPN is a benefit for eligible clients who require long-term nutritional support. "Long-term nutritional support" refers to treatment lasting 30 days or longer.

Conditions that may require TPN include, but are not limited to the following:

- Bowel disease or disorder
- Cancer
- AIDS
- Coma
- Burns
- Peritonitis

  Note: *Conditions or a duration of need not listed above may be considered by HHSC or its designee with documentation of medical necessity.*

TPN services are not a benefit when oral or enteral intake will maintain adequate nutrition.

Parenteral nutrition solution services may be reimbursed using the following procedure codes:

Procedure Codes									
B4164	B4168	B4172	B4176	B4178	B4180	B4185	B4189	B4193	B4197
B4199	B4216	B5000	B5100	B5200					

Parenteral nutrition supplies may be reimbursed using the following procedure codes: B4220, B4222, B4224, and B9999.

Parenteral nutrition infusion pumps may be reimbursed using procedure codes B9004 and B9006.

A backpack or carrying case for a portable parenteral nutrition infusion pump may be a benefit of Home Health Services, when medically necessary and prior authorized, using procedure code B9999.

In-home TPN for clients who are 20 years of age and younger that do not meet the criteria through Title XIX Home Health Services may be considered through CCP. No more than a one-week supply of solutions and additives may be reimbursed if the solutions and additives are shipped and not used because of the client's loss of eligibility, change in treatment, or inpatient hospitalization. Any days that the client is an inpatient in a hospital or other medical facility or institution must be excluded from the daily billing. Payment for partial months will be prorated based upon the actual days of administration.

The administration of intravenous fluids and electrolytes cannot be billed as in-home TPN.

Claims for TPN must contain the 9-character prior authorization number in Block 23. Providers must consult with their vendor for the location of this field in the electronic claims format. The prescribing physician name and provider identifier must be in Block 17 and 17a or in the appropriate field of the provider's electronic software.

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2.2.22.1 Prior Authorization

TPN solutions, lipids, supply kits, and infusion pumps must be prior authorized.

2.2.22.2 Documentation Requirements

Requests for prior authorization must include the following information:

- Medical condition necessitating the need for TPN and long-term nutritional support.
- Documentation of any trials with oral or enteral feedings.
- Percent of daily nutritional needs from TPN.
- A copy of the TPN formula or prescription, including amino acids and lipids, signed and dated by the physician.
- A copy of the most recent laboratory results (to include potassium, calcium, liver function studies and albumin).

The requesting provider may be asked for additional information to clarify or complete a request for TPN services.

Prior authorization requests for a portable parenteral nutrition infusion pump (procedure code B9004) must also include documentation of medical necessity demonstrating that:

- The client requires continuous feedings
- Feeding intervals exceed the time that the client must be away from home to:
  - Attend school or work.
  - Participate in extensive, physician-ordered outpatient therapies.
  - Attend frequent, multiple medical appointments.

Prior authorization for parenteral nutrition infusion pumps will be limited to one portable pump (procedure code B9004) or one stationary pump (procedure code B9006) at any one time, unless medical necessity for two infusion pumps is established. Supporting documentation for the additional pump must be included with the prior authorization request.

Prior authorization requests for miscellaneous procedure code B9999 must include the following:

- A detailed description of the requested item or supply.
- Documentation supporting the medical necessity for the requested item or supply.

Requests for a carrying case or backpack for the portable infusion pump will be considered for prior authorization under miscellaneous code B9999, for clients who meet the medical necessity criteria for the portable pump as outlined above. The following additional criteria apply:

- The client is ambulatory, or uses a wheelchair which will not support the use of a portable pump by other means, such as an intravenous (IV) pole.
- The portable enteral feeding pump is client-owned.

Renewal of the prior authorization will be considered based on medical necessity.

Refer to: Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form on the TMHP website at www.tmhp.com.

2.2.23 Wound Care Supplies or Systems

Wound care supplies and wound care systems are a benefit through Home Health Services when provided to clients in the home setting. Wound care supplies and wound care systems are designed to assist in the healing of wounds in conjunction with an individualized wound care therapy regimen prescribed by a physician.

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Wounds are recognized as acute or chronic:

- Acute wounds are defined as wounds taking less than up to 30 days for complete healing.
- Chronic wounds are defined as wounds taking more that 30 days for complete healing.

Skin ulcers represent the majority of chronic wounds. Skin ulcers include but are not limited to:

- Venous ulcers—also known as venous insufficiency ulcers, stasis ulcers, or varicose veins, and are due to sustained venous hypertension, which results from chronic venous insufficiency or an impaired muscle pump.
- Arterial insufficiency ulcers—ulcers caused by insufficient arterial flow resulting in ischemia and eventual necrosis. Atherosclerosis is the most common cause of arterial ulcers. Other arterial vascular diseases include vasospastic disease and vasculitis. Arterial ulcers are frequently found at the most distal point of arterial perfusion. No drainage is apparent unless the ulcer is infected.
- Pressure ulcers—any skin wound caused by unrelieved pressure resulting in damage to various sections of the skin structure that worsen over time.
- Diabetic ulcers—skin lesions associated with clients with Type 1 and Type 2 diabetes mellitus. The majority of all amputations in diabetic clients are preceded by an infected ulcer.

Wound care includes:

- Optimization of nutritional status
- Debridement by any means to remove devitalized tissue
- Maintenance of a clean, moist bed of granulation tissue
- Any necessary treatment to resolve any infection that may be present

Based on the specific type of wound, wound care may include:

- Use of a compression system for clients with a venous ulcer
- Establishment of adequate circulation for a client with an arterial ulcer
- Frequent repositioning of a client with a pressure ulcer
- Off-loading pressure and good glucose control for a client with a diabetic ulcer

Measurable signs of improved healing include:

- A decrease in wound size, either in surface area or volume
- A decrease in amount of exudate
- A decrease in amount of necrotic tissue

First line wound care therapy may include the following:

- Cleansing, antibiotics, and pressure off-loading
- Debridement
- Dressings
- Compression

Second line wound care therapy may include:

- Negative pressure wound therapy (NPWT)
- Irrigation, including pulsatile jet irrigation

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2.2.23.1 Wound Care Supplies

Medically necessary wound care supplies are designed to assist in wound healing, and include, but are not limited to dressings, cleansers, enzymatic debriders, and fillers.

Wound dressings include:

- Absorptive dressings
- Alginates
- Antimicrobials
- Collagen dressings
- Compression dressings and wraps
- Composite dressings
- Contact layers
- Foam dressings
- Hydrocolloid dressings
- Hydrofiber dressings
- Hydrogel dressings, including sheets and impregnated gauze
- Odor absorbing dressings
- Transparent films

2.2.23.2 Wound Care System

A medically necessary wound care system includes a medical device and its component supplies, and is designed to assist in healing of wounds unresponsive to conventional wound care therapy.

A wound care system may be considered for reimbursement for clients with a Stage III or IV chronic, non-healing wound (such as a pressure, arterial or venous stasis, diabetic ulcer), post-surgical wound dehiscence, non-adhering skin grafts, or surgical flaps required for covering such wounds.

Types of wound care systems include the following:

- NPWT system
- Pulsatile jet irrigation wound care system

2.2.23.2.1 NPWT System

NPWT systems and associated supplies (procedure codes E2402 and A6550) are benefits of Home Health Services.

An NPWT system provides and maintains a moist wound environment, and protects the wound during the healing process by sealing it with an adhesive drape and applying continuous or intermittent suction.

An NPWT system consists of a cell foam dressing that is placed in the wound bed, a suction catheter tip, an adhesive drape to cover the wound, suction tubing, and a computerized vacuum pump. An NPWT system uses continuous or intermittent sub-atmospheric pressure to evacuate the excess interstitial fluid and remove growth factor inhibitors. The removal of inhibitors allows the growth factor to stimulate cell proliferation and migration. Removal of excess fluid also helps decrease periwound induration.

Dressing changes associated with an NPWT system are performed every one to three days depending on the amount of exudate produced by the wound. The computerized vacuum pump is rented on a monthly basis. A licensed health-care provider with appropriate training is required to perform an NPWT system dressing change.

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2.2.23.2.2 Pulsatile Jet Irrigation Wound Care System

Pulsatile jet irrigation wound care systems (procedure code E1399) are a benefit of Home Health Services for rental only.

A pulsatile jet irrigation wound care system uses antibiotics or water under pressure to irrigate the wound and uses suction to remove the irrigation fluid and debris.

A pulsatile jet irrigation wound care system consists of a pistol-style hand piece with a trigger to control the pulsatile jet. A suction pump is used to remove the fluid. The wound is then dressed using standard wound care supplies.

Dressing changes associated with a pulsatile jet irrigation wound care system are performed every one to three days depending on the amount of exudate produced by the wound. A licensed health-care provider with appropriate training is required to perform a pulsatile jet irrigation wound care system dressing change.

2.2.23.3 Noncovered Services

The following services are not a benefit of Texas Medicaid:

- Wound care supplies for use in the office or outpatient setting. Supplies provided in an outpatient setting, such as a wound care clinic, are part of the facility fee and are not separately reimbursed.
- Equipment and supplies for stand-by use.
- Portable hyperbaric oxygen chambers (procedure code A4575) that are placed directly over the wound and provide higher concentrations of oxygen to the damaged tissue.
- Metabolically active skin equivalents or skin equivalents used in wound care, in the home setting.
- Non-contact normothermic wound therapy (NNWT) systems and associated supplies (procedure codes A6000, E0231, and E0232).
- Non-sterile gloves (procedure code A4927), when the gloves are for use by a health care provider, such as a RN, LVN, or attendant, in the home setting.
- Rental or purchase of an electrical stimulation or electromagnetic wound treatment device (procedure code E0769), for use by the client or caregiver in the home setting.

2.2.23.4 Prior Authorization

Prior authorization is required for all wound care supplies and wound care systems addressed below with the exception of procedure code A4455.

> ***Note:*** *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this home health benefit will receive those services through CCP.*

The requesting provider may be asked for additional information to clarify or complete a prior authorization request for the wound care supplies or wound care system.

Retrospective review may be performed to ensure documentation supports the medical necessity of the requested wound care supplies or system.

Recertification will be considered based on medical necessity, with a new prior authorization request.

Providers should only bill for a one month supply at a time, even though prior authorization may be granted for up to six months.

2.2.23.4.1 Wound Care Supplies

Nonsterile/clean wound care supplies may be considered for prior authorization for use in the home setting when documentation supports medical necessity.

> ***Note:*** *The home setting is considered a clean environment, not a sterile environment.*

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Sterile wound care supplies, other than those required with a wound care system, may be considered for prior authorization for use in the home setting when documentation supports medical necessity and justifies that nonsterile/clean wound care supplies will not meet the client's needs.

Note: *Established tracheostomies or gastrostomies/buttons are not considered wounds, therefore dressing supplies will not be considered for prior authorization. Dressing supplies for tracheostomies or gastrostomies may be considered for prior authorization with documentation of medical necessity.*

Nonsterile gloves may be considered for prior authorization when a family member or friend is performing the medical wound care.

2.2.23.4.2 Wound Care System

Prior authorization for a wound care system may be considered for reimbursement for an initial 30-day period.

Medically necessary prior authorized recertifications may be considered for additional 30-day periods at a time, up to a maximum of four, when documentation supports continued significant improvement in wound healing. Wound care systems may be considered for reimbursement beyond four months of treatment on a case-by-case basis after review of the medical necessity documentation by the medical director or designee.

Wound care system supplies are limited to a maximum of:

- 15 dressing kits or supplies per wound per month unless documentation supports that the wound size requires more than one dressing kit for each dressing change, or if the physician has ordered more frequent dressing changes.
- 10 disposable canisters (procedure code A7000) per month, unless documentation provided indicates medical necessity for additional canisters.

Note: *When documentation supports evidence of high-volume drainage, defined as greater than 90 milliliters (ml) per day, a stationary pump with the largest capacity canister must be used. Extra canisters related to the equipment failure are not considered medically necessary.*

Wound care systems and related supplies will not be prior authorized nor considered for reimbursement when:

- The client has one of the following contraindications:
  - A fistula to the body
  - Wound ischemia
  - Gangrene
  - Skin cancer in the wound margins
  - Presence of necrotic tissue, including bone (this does not apply to the pulsatile jet irrigation wound care system)
  - Osteomyelitis (unless it is being treated; the treatment must be identified)
- In the judgment of the treating physician, adequate wound healing has occurred and the wound care system is no longer required.
- No measurable wound healing has occurred over the previous 30-day period.
- A wound care system was used for four months or more in the inpatient setting prior to discharge, except when documentation supports continued significant improvement in wound healing.
- The wound care equipment and supplies are no longer being used by the client.

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2.2.23.5 Documentation Requirements

2.2.23.5.1 Wound Care Supplies

To request prior authorization for wound care supplies, the following documentation must be provided with the completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form:

- Accurate diagnostic information pertaining to the underlying diagnosis/condition as well as any other medical diagnoses/conditions, to include the client's overall health status
- Appropriate medical history related to the current wound including:
  - Wound measurements to include length, width and depth, any tunneling or undermining
  - Wound color, drainage (type and amount), and odor, if present
  - The prescribed wound care regimen, to include 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, when appropriate
- Identification of the client or caregiver who will be instructed how to perform the wound care, and will be responsible for the wound care

2.2.23.5.2 Wound Care Systems

To request prior authorization for a wound care system, the documentation listed below must be provided on the Statement for Initial Wound Therapy System In-Home Use Form for an initial request or on the Statement for Recertification of Wound Therapy System In-Home Use Form for a recertification request, in addition to the Title XIX form.

The prescribing physician and provider must submit the appropriate initial or recertification form, which must also be maintained in the client's medical record.

The following documentation must be submitted with the prior authorization request, and must be maintained in the client's medical record:

- Accurate diagnostic information pertaining to the underlying diagnosis/condition and all other medical diagnoses/conditions, including the client's overall health status.
- The client's use of a pressure reducing support surface, when appropriate.
- Albumin level within the last 30 days (If the albumin level is below 3.0, documentation must show that a nutritional supplement has been prescribed, and that the client is compliant with its use.)
- Hemoglobin A1c obtained within last 30 days, if the client has a diagnosis of diabetes mellitus.
- Appropriate medical history related to the current wound, including:
  - Documentation that the wound is free of necrotic tissue and infection, or if infection is present, that it is being treated with antibiotics.
  - Wound measurements to include length, width, and depth, any tunneling or undermining.
  - Wound characteristics, including color, wound drainage (type and amount), and odor if present.
  - The prescribed wound care regimen, to include frequency, duration and supplies needed.
- Identification of the caregiver who agrees to be available to assist the client during this time and agreement of this person not to operate the negative pressure or the pulsatile jet irrigation system if used.

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- Documentation that a licensed health-care provider who has received the appropriate training in the use of the wound care system is performing the wound care when a negative pressure or pulsatile jet irrigation wound care system is used. All requirements for skilled nursing care must be met.
- For recertification, documentation that the wound is improving.

2.2.23.6 Wound Care Procedures and Limitations

Procedure Code	Maximum Limitation
A4213	As needed
A4216	As needed
A4217	As needed
A4244	As needed
A4246	As needed
A4247	As needed
A4322	As needed
A4450	20 per month
A4452	20 per month
A4455	4 per month without prior authorization
A4461	As needed
A4465	As needed
A4927	As needed
A6010	As needed
A6011	As needed
A6021	As needed
A6022	As needed
A6023	As needed
A6024	As needed
A6025	As needed
A6154	As needed
A6196	As needed
A6197	As needed
A6198	As needed
A6199	As needed
A6203	As needed
A6204	As needed
A6205	As needed
A6206	As needed
A6207	As needed
A6208	As needed
A6209	As needed
A6210	As needed
A6211	As needed
A6212	As needed

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Procedure Code	Maximum Limitation
A6213	As needed
A6214	As needed
A6215	As needed
A6216	As needed
A6217	As needed
A6218	As needed
A6219	As needed
A6220	As needed
A6221	As needed
A6222	As needed
A6223	As needed
A6224	As needed
A6228	As needed
A6229	As needed
A6230	As needed
A6231	As needed
A6232	As needed
A6233	As needed
A6234	As needed
A6235	As needed
A6236	As needed
A6237	As needed
A6238	As needed
A6239	As needed
A6240	As needed
A6241	As needed
A6242	As needed
A6243	As needed
A6244	As needed
A6245	As needed
A6246	As needed
A6247	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

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Procedure Code	Maximum Limitation
A6257	15 per month
A6258	15 per month
A6259	15 per month
A6260	As needed
A6261	As needed
A6262	As needed
A6266	As needed
A6402	As needed
A6403	As needed
A6404	As needed
A6407	As needed
A6410	As needed
A6411	As needed
A6412	As needed
A6441	As needed
A6442	As needed
A6443	As needed
A6444	As needed
A6445	As needed
A6446	As needed
A6447	As needed
A6448	As needed
A6449	As needed
A6450	As needed
A6451	As needed
A6452	As needed
A6453	As needed
A6454	As needed
A6455	As needed
A6456	As needed
A6457	As needed
A6545	As needed, requires modifier AW
A6550	15 per month
A7000	10 per month
E1399	As needed (for use with Pulsatile Jet Irrigation Wound Care System)
E2402	1 per month
T1999	As needed

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2.2.24 Limitations and Exclusions

Payment cannot be made for any service, supply or equipment for which FFP is not available. For clients who are 20 years of age and younger and who are eligible to receive THSteps services, refer to subsection 2.1, "CCP Overview" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) to find which of these items are a benefit for CCP.

Home Health Services does not cover the following:

- Adaptive strollers, travel seats, push chairs, and car seats
- Administration of non-FDA-approved medications/treatments or the supplies and equipment used for administration
- Aids for daily living, such as toothpaste, spoons, forks, knives, and reachers
- Any services, equipment, or supplies furnished to a client who is a resident of a public institution or a client in a hospital, SN facility, or intermediate care facility
- Any services or supplies furnished to a client before the effective date of Medicaid eligibility as certified by HHSC or after the date of termination of Medicaid eligibility
- Any services or supplies furnished without prior approval by TMHP, except as listed
- Any supplies or equipment used in a physician's office, or inserted by a physician (e.g., low profile gastrostomy tube)
- Apnea monitors
- Blood products (the administration or the supplies and equipment used to administer blood products)
- Cardiac telemetry monitoring
- Chemotherapy administration or the supplies and equipment used to administer chemotherapy
- Diapers and wipes for clients who are 3 years of age and younger
- Dynamic orthotic cranioplasty (DOC)
- Environmental equipment, supplies, or services, such as room dehumidifiers, air conditioners, heater/air conditioner filters, space heaters, fans, water purification systems, vacuum cleaners, treatments for dust mites, rodents, and insects
- Home whirlpool baths, spas, home exercisers/gym equipment, hemodialysis equipment, safety wall rails, toys/therapy equipment
- IPV
- Nutritional counseling
- Orthotics, braces, prosthetics including but not limited to voice prosthetic, and artificial larynx
- Parapodiums
- Personal protective equipment (such as gloves, masks, gowns, and sharps containers) for use by a health-care provider, including but not limited to an RN, LVN, or attendant in the home setting
- Pneumocardiograms
- Seat lift chairs
- Shipping, freight, delivery travel time
- Structural changes to homes, domiciles, or other living arrangements
- Vehicle mechanical or structural modifications, such as wheelchair lifts

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Refer to: Subsection 1.11, "Texas Medicaid Limitations and Exclusions" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

2.2.25 Procedure Codes That Do Not Require Prior Authorization

The procedure codes listed in the following table do not require prior authorization for clients who are receiving services under Home Health Services. Although prior authorization is not required, providers must retain a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form for these clients. For medical supplies not requiring prior authorization, a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form may be valid for a maximum of six months unless the physician indicates the duration of need is less. If the physician indicates the duration of need is less than six months, then a new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is required at the end of the duration of need. It is expected that reasonable, medically necessary amounts will be provided.

The use of these services is subject to retrospective review. This is not an all inclusive list.

Procedure Codes									
Nebulizer Supplies/Equipment*									
E0570	E0575	E0580	S8101						
Incontinence Supplies**									
A4310	A4311	A4312	A4313	A4314	A4315	A4316	A4320	A4321	A4322
A4326	A4327	A4328	A4330	A4335	A4338	A4340	A4344	A4346	A4351
A4352	A4353	A4354	A4355	A4356	A4357	A4358	A4402	A4554	A5102
A5105	A5112	A5113	A5114	A5120	A5121	A5122	A5131		
Inhaler Equipment									
A4614	A4627								

*** Prior authorization is required for certain diagnoses and if limitations are exceeded. Refer to Subsection 2.2.19.2, "Nebulizers" in this handbook.**

**** Prior authorization is required for some procedure codes if the maximum limitation is exceeded. Refer to Subsection 2.2.13.9, "Incontinence Procedure Codes with Limitations" in this handbook.**

2.3 Other or Special Provisions

2.3.1 Medicaid Relationship to Medicare

2.3.1.1 Possible Medicare Clients

It is the provider's responsibility to determine the type of coverage (Medicare, Medicaid, or private insurance) that the client is entitled to receive. Home health providers must follow these guidelines:

- Clients who are 64 years of age and younger without Medicare Part A or B:
  - If the agency erroneously submits an SOC notice to Medicare and does not contact TMHP for prior authorization, TMHP does not assume responsibility for any services provided before contacting TMHP. The SOC date is no more than three business days before the date the agency contacts TMHP. Visits made before this date are not considered a benefit of the Home Health Services Program.
- Clients who are 65 years of age and older without Medicare Part A or Part B and clients with Medicare Part A or B regardless of age:

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- In filing home health claims, home health providers may be required to obtain Medicare denials before TMHP can approve coverage. When TMHP receives a Medicare denial, the SOC is determined by the date the agency requested coverage from Medicare. If necessary, the 95-day claims filing deadline is waived for these claims, provided TMHP receives notice of the Medicare denial within 30 days of the date on the MRAN containing Medicare's final disposition.
- If the agency receives the MRAN and continues to visit the client without contacting TMHP by telephone, mail, or fax within 30 days from the date on the MRAN, TMHP will provide coverage only for services provided from the initial date of contact with TMHP. The SOC date is determined accordingly. TMHP must have the MRAN before considering the request for prior authorization.

2.3.1.2 Benefits for Medicare and Medicaid Clients

For eligible Medicare/Medicaid clients, Medicare is the primary payer and providers must bill Medicare before submitting a claim to Medicaid. Medicaid pays the Medicare deductible on Part B claims for qualified home health clients.

Home health service prior authorizations may be given for HHA services, certain medical supplies, equipment, or appliances suitable for use in the home in one of the following instances:

- When an eligible Medicaid client (enrolled in Medicare) who does not qualify for home health services under Medicare because SN care, PT, or OT are not a part of the client's care.
- When the medical supplies, equipment, or appliances are denied by Medicare Part B and are a benefit of Home Health Services.

Federal and state laws require the use of Medicaid funds for the payment of most medical services only after all reasonable measures have been made to use a client's third party resources or other insurance.

Note: *If the client has Medicare Part B coverage, contact Medicare for prior authorization requirements and reimbursement. If the service is a Part B benefit, do not contact TMHP for prior authorization. Texas Medicaid will only pay the deductible and coinsurance according to current payment guidelines on the electronic crossover claim.*

TMHP will not prior authorize or reimburse the difference between the Medicare payment and the retail price for Medicare Part B eligible clients.

Refer to: Subsection 4.12, "Third Party Liability (TPL)" in Section 4, "Client Eligibility" (*Vol. 1, General Information*).

Section 2.7, "Medicare Crossover Claim Reimbursement" (*Vol. 1, General Information*).

2.3.1.3 Medicare and Medicaid Prior Authorization

Contact TMHP for prior authorization of Medicaid services (based on medical necessity and benefits of Home Health Services) within 30 days of the date on the MRAN.

Note: *For MQMB clients, do not submit prior authorization requests to TMHP if the Medicare denial reason states "not medically necessary." Medicaid only will consider prior authorization requests if the Medicare denial states "not a benefit" of Medicare.*

Qualified Medicare Beneficiaries (QMB) are not eligible for Medicaid benefits. Texas Medicaid is only responsible for premiums, coinsurance, or deductibles on these clients according to payment guidelines. Providers should not submit prior authorization requests to the TMHP Home Health Services Prior Authorization Department for these clients.

To ensure Medicare benefits are used first in accordance with Texas Medicaid regulations, the following procedures apply when requesting Medicaid prior authorization and payment of home health services for clients.

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Contact TMHP for prior authorization of Medicaid services (based on medical necessity and benefits of Home Health Services) within 30 days of the date on the MRAN. Fax a copy of the original Medicare MRAN and the Medicare appeal review letter to the TMHP Home Health Services Prior Authorization Department for prior authorization.

Note: *Claims for STAR+PLUS MQMB clients (those with Medicare and Medicaid) must always be submitted to TMHP as noted on these pages. The STAR+PLUS health plan is not responsible for these services if Medicare denies the service as not a benefit.*

When the client is 65 years of age and older or appears otherwise eligible for Medicare such as blind and disabled, but has no Part A or Part B Medicare, the TMHP Home Health Services Prior Authorization Department uses regular prior authorization procedures. In this situation, the claim is held for a midyear status determined by HHSC. The maximum length of time a claim may be held in a "pending status" for Medicare determination is 120 days. After the waiting period, the claim is paid or denied. If denied, the EOB code on the R&S report indicates that Medicare is to be billed.

Refer to: Subsection 3.2.3, "Home Health Skilled Nursing Services" in the *Nursing and Therapy Services Handbook* (*Vol. 2, Provider Handbooks*).

2.4 Claims Filing and Reimbursement

2.4.1 Claims Information

Providers must use only type of bill (TOB) 321 in Form Locator (FL) 4 of the UB-04 CMS-1450. Other TOBs are invalid and result in claim denial.

Home Health services must be submitted to TMHP in an approved electronic format or on a CMS-1500 or a UB-04 CMS-1450 paper claim form. Submit home health DME and medical supplies to TMHP in an approved electronic format, or on a CMS-1500 or on a UB-04 CMS-1450 paper claim form. Providers may purchase UB-04 CMS-1450 and CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply them.

When completing a CMS-1500 or a UB-04 CMS 1450 paper claim form, providers must include all required information on the claim, as TMHP does not key information from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims.

Outpatient claims must have the appropriate revenue code and, if appropriate, the corresponding HCPCS code or narrative description. The prior authorization number must appear on the UB-04 CMS-1450 claim in Block 63 and in Block 23 of the CMS-1500 claim. The certification dates or the revised request date on the POC must coincide with the DOS on the claim. Prior authorization does not waive the 95-day filing deadline requirement.

2.4.2 Reimbursement

DME and expendable medical supplies are reimbursed in accordance with 1 TAC §355.8021. Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com. Providers may also request a hard copy of the fee schedule by contacting the TMHP Contact Center at 1-800-925-9126.

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DME and expendable supplies, other than nutritional products, that have no established fee, are subject to manual pricing at the documented MSRP less 18 percent or the provider's documented invoice cost.

Nutritional products that have no established fee are subject to manual pricing at the documented AWP less 10.5 percent or at the provider's documented invoice cost.

For reimbursement, providers must note the following:

- Claims are approved or denied according to the eligibility, prior authorization status, and medical appropriateness.
- Claims must represent a numerical quantity of 1 month for supplies according to the billing requirements.
- DME/supplies *must* be provided by either a Medicaid enrolled home health agency's Medicaid/DME supply provider or an independently-enrolled Medicaid/DME supply provider. Both *must* enroll and bill using the provider identifier enrolled as a DME supplier. File these services on a CMS-1500 claim form.

  Note: *Medical social services and speech-language pathology services are available to clients who are 20 years of age and younger and are not a benefit of Home Health Services. These services may be considered a benefit for clients who qualify for CCP.*

Texas Medicaid does not reimburse separately for associated DME charges, including but not limited to, battery disposal fees or state taxes. Reimbursement for any associated charges is included in the reimbursement for a specific piece of equipment.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

Texas Medicaid implemented mandated rate reductions for certain services. The Online Fee Lookup (OFL) and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

2.4.3 Prohibition of Medicaid Payment to Home Health Agencies Based on Ownership

Medicaid denies home health services claims when TMHP records indicate that the physician ordering treatment has a significant ownership interest in, or a significant financial or contractual relationship with, the nongovernmental home health agency billing for the services. Federal regulation Title 42 CFR §424.22 (d) states that "a physician who has a significant financial or contractual relationship with, or a significant ownership in a nongovernmental home health agency may not certify or recertify the need for home health services care services and may not establish or review a plan of treatment."

A physician is considered to have a significant ownership interest in a home health agency if either of the following conditions apply:

- The physician has a direct or indirect ownership of five percent or more in the capital, stock, or profits of the home health agency.
- The physician has an ownership of five percent or more of any mortgage, deed of trust, or other obligation that is secured by the agency, if that interest equals five percent or more of the agency's assets.

A physician is considered to have a significant financial or contractual relationship with a home health agency if any of the following conditions apply:

- The physician receives any compensation as an officer or director of the home health agency.

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- The physician has indirect business transactions, such as contracts, agreements, purchase orders, or leases to obtain services, supplies, equipment, space, and salaried employment with the home health agency.
- The physician has direct or indirect business transactions with the home health agency that, in any fiscal year, amount to more than $25,000 or 5 percent of the agency's total operating expenses, whichever is less.

When providing CCP services and general home health services, the provider must file these on two separate UB-04 CMS-1450 paper claim forms with the appropriate prior authorization number, and must send them to the appropriate address.

Claims denied because of an ownership conflict will continue to be denied unless the home health agency submits documentation indicating that the ordering physician no longer has a significant ownership interest in, or a significant financial or contractual relationship with, the home health agency providing services. Documentation must be sent to TMHP Provider Enrollment at the address indicated in "Written Communication With TMHP" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*).

3 Claims Resources

Refer to the following sections or forms when filing claims:

Resource	Location
Appendix A: State, Federal, and TMHP Contact Information	Appendix A (*Vol.1, General Information*)
Appendix D: Acronym Dictionary	Appendix D (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	Appendix A (*Vol.1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5 (*Vol. 1, General Information*)
Section 3: TMHP Electronic Data Interchange (EDI)	Section 3 (*Vol. 1, General Information*)
TMHP Electronic Claims Submission	Subsection 6.2 (*Vol. 1, General Information*)
UB-04 CMS-1450 Paper Claim Filing Instructions	Subsection 6.6 (*Vol. 1, General Information*)

4 Contact TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.

5 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form
DME Certification and Receipt Form
External Insulin Pump Prior Authorization Form
Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions

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Forms
Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form
Home Health Plan of Care (POC) Instructions
Home Health Plan of Care (POC)
Home Health Prior Authorization Checklist
Medicaid Certificate of Medical Necessity for Chest Physiotherapy Device Form—Initial Request
Medicaid Certificate of Medical Necessity for Chest Physiotherapy Device Form—Extended Request
Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy Form
Pulse Oximeter Form
Statement for Initial Wound Therapy System In-Home Use
Statement for Recertification of Wound Therapy System In-Home Use
Texas Medicaid Provider Surety Bond and Instructions
Ventilator Service Agreement
Wheelchair/Scooter/Stroller Seating Assessment Form (CCP/Home Health Services)

6 Claim Form Examples

The following linked claim form examples can also be found on the Claim Form Examples page of the Provider section of the TMHP website at www.tmhp.com:

Claim Form Examples
Home Health Services DME/Medical Supplies

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Expanded Primary Healthcare Program Handbook

Texas Medicaid Provider Procedures Manual: Vol. 2

April 2016

TEXAS
Health and Human
Services Commission

EXPANDED PRIMARY HEALTHCARE PROGRAM HANDBOOK

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1 General Information

The information in this handbook is intended for family planning clinic providers and federally qualified health center (FQHC) providers who are contracted by the Department of State Health Services (DSHS) as Expanded Primary Health Care (EPHC) providers. The handbook provides information about Texas Medicaid's benefits, policies, and procedures that are applicable to EPHC providers.

Important: *All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide healthcare services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver healthcare items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: The *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about providing services to Texas Medicaid and Texas Health Steps (THSteps) clients.

Section 1: Provider Enrollment and Responsibilities (*Vol. 1, General Information*).

Subsection "Medicaid Program Administration" in Preliminary Information (*Vol. 1, General Information*)

1.1 Expanded Primary Health Care (EPHC) Program Overview

DSHS awards contracts to agencies across Texas to provide services to low-income individuals who may not qualify for Texas Medicaid services. These awards are granted through a competitive procurement process.

1.2 EPHC Provider Enrollment

EPHC contractors are required to enroll as Texas Medicaid providers with TMHP. The EPHC contractor must complete the paper or electronic Texas Medicaid Provider Enrollment Application, including all required forms. Providers can access the online application or download all necessary paper forms from the TMHP website at www.tmhp.com.

The EPHC contractor must also enter into a written provider agreement with the Texas Health and Human Services Commission (HHSC), the single state Medicaid agency.

Refer to: The EPHC page of the DSHS website at for additional information.

Section 1: Provider Enrollment and Responsibilities for additional information.

1.3 Services, Benefits, Limitations, and Prior Authorization

EPHC priority services include:

- Diagnosis and treatment.
- Emergency medical services.
- Family planning services.
- Preventive health services.
- Health education.

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- Laboratory, X-ray, nuclear medicine, or other appropriate diagnostic services.
- Medical nutrition therapy and counseling.

Prior authorization is not required for EPHC services except for family planning sterilization services as indicated in subsection 1.3.1, "Sterilization Services" in this handbook.

Note: *EPHC providers can use the Online Fee Look-up (OFL) to determine the reimbursement amounts by procedure code.*

1.3.1 Sterilization Services

1.3.1.1 Sterilization Consent

Providers are required to submit sterilization consent forms for EPHC sterilization services. The consent forms must be kept on file and used for sterilization services.

Note: *Hysterectomy Acknowledgment forms are not sterilization consents.*

Refer to: Sterilization Consent Form (English) on the TMHP website at www.tmhp.com.

Sterilization Consent Form (Spanish) on the TMHP website at www.tmhp.com.

Sterilization Consent Form Instructions on the TMHP website at www.tmhp.com.

1.4 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered.

EPHC services and family planning services are subject to retrospective review and recoupment if documentation does not support the services that are billed.

1.5 EPHC Claims Filing and Reimbursement

1.5.1 Claims Information

Providers must use the 2017 Claim Form to submit EPHC Program claims to TMHP.

Note: *To submit EPHC Program claims using TexMedConnect, providers must choose Family Planning Program "EPHC" on the electronic version of the 2017 claim form.*

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information about third-party electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*) for information about claims filing.

The following applies when filing claims:

- EPHC providers must submit all claims and Sterilization Consent Forms with benefit code FP3.
- When completing a 2017 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.
- EPHC services are not subject to global surgery guidelines (excluding procedure codes 55250, 58600, and 58565).
- All claims must be filed within the required filing deadlines.
- Dates of service that span multiple contract periods must be submitted on separate claims for services performed within each contract period.
- Denied claims may be appealed.

EPHC providers are required to adhere to the Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI) guidelines.

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1.5.1.1 Filing Deadlines

EPHC claims must be filed within the filing deadlines outlined in subsection 6.1.4, "Claims Filing Deadlines" in "Section 1: Claims Filing" (*Vol. 1, General Information*).

Note: *As stated in the DSHS Expanded Primary Health Care Program (EPHC) Policy Manual, all claims and appeals must be submitted and processed within 60 days of the end of the contract period.*

1.5.1.2 Retroactive Medicaid Eligibility

EPHC claims for clients who receive retroactive Texas Medicaid eligibility will be reprocessed by Texas Medicaid. If the EPHC service is not a benefit of Texas Medicaid, the service will be denied.

Group providers can submit EPHC claims without a performing provider number; however, group providers must submit Texas Medicaid claims with a performing provider number. If a client receives retroactive Texas Medicaid eligibility and the claim is reprocessed by Texas Medicaid, the claim will be denied if the performing provider number is omitted from the claim. The provider can appeal the claim with the performing provider number for Texas Medicaid reimbursement.

1.5.2 Reimbursement

Reimbursement information for EPHC procedures is available in the TMHP Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com. EPHC providers will receive funds based on the determined contract year with effective and terminate dates. Contract periods will always be for a full calendar month. The start date is the first day of the calendar month and the end date is the last day of the calendar month. Medicaid cutbacks will apply to the EPHC program.

1.5.2.1 Funds Gone

EPHC providers are contracted to provide services for a specific time period, either the state fiscal year or a contract period within the fiscal year. Providers receive a specific budget amount for their contract period. When their claims payments have reached their budget allowance, providers must continue to submit claims. The amount of funds that they would have received had the funds been available will be tracked as "funds gone." Providers may receive additional funds for a contract period at a later time. Claims identified as "funds gone" may be reimbursed at that time. On the Remittance and Status (R&S) Report, "Claims Paid" is the dollar amount of claims paid during this financial transaction period. "Approved to Pay/Not Funds Gone" is the dollar amount that has been processed and approved to pay, but the payment has not been issued yet. "Funds Gone" is the dollar amount that has been submitted after the provider's budget allowance has been reached. The amount in "Approved to Pay/Not Funds Gone" added to the amount in "Funds Gone" will equal the amount in the "Approved to Pay - New Claims" section.

2 Claims Resources

Resources	
Appendix D: Acronym Dictionary	"Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	Appendix F (Vol. 1, General Information)
Subsection 6.8 (Vol. 1, General Information)	

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3 Contact TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday-Friday from 7 a.m. to 7 p.m., Central Time.

4 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Sterilization Consent Form Instructions
Sterilization Consent Form (English)
Sterilization Consent Form (Spanish)
2017 Claim Form

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Gynecological and Reproductive Health and Family Planning Services Handbook

Texas Medicaid Provider Procedures Manual: Vol. 2

April 2016

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GYNECOLOGICAL AND REPRODUCTIVE HEALTH AND FAMILY PLANNING SERVICES

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1 General Information

The information in this handbook is intended for gynecological and reproductive health services providers, Texas Medicaid Title XIX family planning providers, and DSHS Family Planning Program providers. The handbook provides information about Texas Medicaid's benefits, policies, and procedures that are applicable to these service providers.

Important: *All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide healthcare services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver healthcare items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: *The Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about providing services to Texas Medicaid/Texas Health Steps (THSteps) clients.

Section 1: Provider Enrollment and Responsibilities (*Vol. 1, General Information*)

"Medicaid Program Administration" in "Preliminary Information" (*Vol. 1, General Information*)

Department of State Health Services (DSHS) website at www.dshs.state.tx.us/famplan/ for information about family planning and the locations of clinics receiving family planning funding from DSHS.

This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, providers can refer to the Medicaid Managed Care Handbook.

Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in the Texas Medicaid Managed Care Handbook.

Refer to: Section 8, "Carve-Out Services" in the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

1.1 Family Planning Overview

TMHP processes family planning claims and encounters for two different funding sources:

- The DSHS Family Planning program funding for DSHS-contracted providers
- The Title XIX family planning funding for Texas Medicaid providers

DSHS awards contracts to agencies across Texas to provide services to low-income individuals who may not qualify for Texas Medicaid services. These awards are granted through a competitive procurement process. DSHS contracts with a variety of providers, including local health departments, universities, medical schools, private nonprofit agencies, FQHCs, RHCs, and hospital districts. All DSHS-contracted providers must first be enrolled in Title XIX Texas Medicaid.

Client eligibility requirements, reimbursement methodologies, client copayment guidelines, and covered services may differ for each funding source. Family planning funding cannot be used for elective abortion services.

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- Title XIX funds are available for family planning services provided to Texas Medicaid clients. TMHP processes Title XIX claims and reimburses eligible services on a fee-for-service basis for family planning providers and a prospective payment system basis for FQHC and RHC providers.
- DSHS Family Planning Program contracts annually with family planning providers. TMHP processes claims and reimburses providers for services to eligible clients according to the individually granted funds.
- Funds are also available for limited family planning services provided to Texas Women's Health Program (TWHP) clients. TMHP processes TWHP claims and reimburses eligible services on a fee-for-service basis for family planning providers and a prospective payment system basis for FQHC and RHC providers.

1.1.1 Guidelines for Family Planning Providers

The following guidelines apply for all family planning services:

- Family planning services may be provided by a physician or under the direction of a physician, not necessarily personal supervision. A physician provides direction for family planning services through written standing delegation orders and medical protocols. The physician is not required to be on the premises for the provision of family planning services by a registered nurse (RN), physicians assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), or certified nurse midwife (CNM).
- Services must be provided without regard to age, marital status, sex, race, ethnicity, parenthood, handicap, religion, national origin, or contraceptive preference.
- Texas Medicaid clients, including limited care clients, are allowed to choose any enrolled family planning service provider.
- Family planning clients must be allowed freedom of choice in the selection of contraceptive methods as medically appropriate.
- Family planning clients must be allowed the freedom to accept or reject services without coercion.
- Only family planning clients may consent to the provision of family planning services. Counseling should be offered to adolescents that encourages them to discuss their family planning needs with a parent, an adult family member, or other trusted adult.
- Sterilization services cannot be provided to any person who is 20 years of age or younger. For more information, DSHS-contracted providers may refer to the DSHS website at www.dshs.state.tx.us/famplan/rules.shtm.

1.2 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.

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Refer to: Subsection 3.7.3.8, "Payment Window Reimbursement Guidelines" of the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about the payment window reimbursement guidelines.

2 Medicaid Title XIX Family Planning Services

2.1 Title XIX Provider Enrollment

Physician, FQHC, and RHC providers may provide Title XIX family planning services for Texas Medicaid clients under the provider's Texas Medicaid provider number. No additional enrollment is required to provide Title XIX family planning services.

Refer to: Subsection 7.1, "Provider Enrollment" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)* for information about physician provider enrollment.

Section 4.1, "Enrollment" in the *Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks)* for information about FQHC provider enrollment.

Section 7.1, "Enrollment" in the *Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks)* for information about RHC provider enrollment.

Family planning agencies must apply for enrollment with TMHP to receive an agency provider identifier. To be enrolled in Texas Medicaid, family planning agencies must meet the following requirements:

- Complete an agency enrollment application.
- Ensure that all services are furnished by, prescribed by, or provided under the direction of a licensed physician in accordance with the Texas Medical Board or Texas BON.
- Have a medical director who is a physician currently licensed to practice medicine in Texas, and submit a current copy of the medical director's physician license.
- Have an established record of performance in the provision of both medical and educational counseling of family planning services as verified through client records, established clinic hours, and clinic site locations.
- Provide family planning services in accordance with DSHS standards of client care for family planning agencies.
- Be approved for family planning services by the DSHS Family Planning Program.

Note: *An RHC can also apply for enrollment as a family planning agency.*

The effective date for participation is the date an approved provider agreement with Medicaid is established and the provider is assigned a Medicaid provider identifier.

Providers cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

Refer to: Section 1: Provider Enrollment and Responsibilities (*Vol. 1, General Information*) for more information about enrollment procedures.

Subsection 6.3.6, "Benefit Code" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for more information about benefit codes.

2.2 Services, Benefits, Limitations, and Prior Authorization

This section includes information on family planning services funded through Title XIX Medicaid.

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Family planning services are preventive health, medical, counseling, and educational services that assist individuals in managing their fertility and achieving optimal reproductive and general health. Title XIX services include:

- Family planning annual exams
- Other family planning office or outpatient visits
- Laboratory services
- Radiology services
- Contraceptive devices and related procedures
- Drugs and supplies
- Medical counseling and education
- Sterilization and sterilization-related procedures (i.e., tubal implants, tubal ligation, vasectomy, and anesthesia for sterilization)

Providers must use one of the following diagnosis codes in conjunction with all family planning procedures and services:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
Z30011	Z30013	Z30014	Z30018	Z3002	Z3009	Z302	Z3040
Z3041	Z3042	Z30430	Z30431	Z30432	Z30433	Z3049	Z308
Z309	Z9851	Z9852					

One of the diagnosis codes in this table must be included in Block 24 E of the CMS-1500 claim form referencing the appropriate procedure code. The choice of diagnosis code must be based on the type of family planning service performed.

Note: *Title XIX family planning services are exempt from the limited program and rules.*

2.2.1 Family Planning Annual Exams

An annual family planning exam consists of a comprehensive health history and physical examination, which includes the following:

- Medical laboratory evaluations as indicated
- An assessment of the client's problems and needs
- The implementation of an appropriate contraceptive management plan

Family planning providers must bill the most appropriate evaluation and management (E/M) visit procedure code for the complexity of the annual family planning examination provided. To bill an annual family planning examination, one of the following procedure codes must be billed with modifier FP and a family planning diagnosis code:

Procedure Codes									
99201	99202	99203	99204	99205	99211	99212	99213	99214	99215

Important: *Only the annual family planning examination requires modifier FP. All other family planning office visits do not. One annual family planning examination is allowed per year. Claims filed incorrectly may be denied.*

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The following table summarizes the uses for the E/M procedure codes and the corresponding billing requirements for the annual examination:

Billing Criteria	Frequency
New patient: Most appropriate E/M procedure code with modifier FP and a family planning diagnosis code	One new patient E/M code every 3 years following the last E/M visit provided the client by that provider or a provider of the same specialty in the same group
Established patient: Most appropriate E/M procedure code with modifier FP and a family planning diagnosis code	Once a year*
*** The established patient procedure code will be denied if a new patient procedure code has been billed in the same year.**	

An annual family planning examination (billed with modifier FP) will not be reimbursed when submitted with the same date of service as a surgical procedure or an additional E/M visit.

If another condition requiring an E/M office visit beyond the required components for the annual examination is discovered, the provider may submit a claim for the additional visit using modifier 25 to indicate that the client's condition required a significant, separately identifiable E/M service. Documentation supporting the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request.

2.2.1.1 FQHC Reimbursement for Family Planning Annual Exams

To receive their encounter rate for the annual family planning examination, FQHCs must use the most appropriate E/M procedure code for the complexity of service provided as indicated in the previous table in subsection 2.2.1, "Family Planning Annual Exams" in this handbook.

The annual exam is allowed once per fiscal year, per client, per provider. Two additional family planning office or outpatient visits may be reimbursed to the FQHC within the same year for the same client.

A new patient visit for the annual exam may be reimbursed once every three years following the last E/M visit provided to the client by that provider or a provider of the same specialty in the same group. The annual examination must be billed as an established patient visit if E/M services have been provided to the client within the last three years.

Reimbursement for services payable to an FQHC is based on an all-inclusive rate per visit.

2.2.2 Other Family Planning Office or Outpatient Visits

Other family planning E/M visits are allowed for routine contraceptive surveillance, family planning counseling and education, contraceptive problems, suspicion of pregnancy, genitourinary infections, and evaluation of other reproductive system symptoms.

During any visit for a medical problem or follow-up visit, the following must occur:

- An update of the client's relevant history
- Physical exam, if indicated
- Laboratory tests, if indicated
- Treatment or referral, if indicated
- Education and counseling, or referral, if indicated
- Scheduling of office or clinic visit, if indicated

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Title XIX family planning providers must use one of the following procedure codes based on the complexity of the visit with a family planning diagnosis for other family planning office or outpatient visits:

Procedure Codes									
99201	99202	99203	99204	99205	99211	99212	99213	99214	99215

Important: *Family planning E/M office and outpatient visits should not be billed with modifier FP. Claims filed incorrectly may be denied.*

The following table summarizes the uses for the E/M procedure codes and the corresponding billing requirements for each type of visit:

Billing Criteria	Frequency
New patient: Most appropriate E/M procedure code with a family planning diagnosis code	One new patient E/M code every 3 years following the last E/M visit provided the client by that provider or a provider of the same specialty in the same group
Established patient: Most appropriate E/M procedure code with a family planning diagnosis code	As needed*
*** The established patient procedure code will be denied if a new patient procedure code has been billed in the same year.**	

Refer to: Subsection 2.2, "Services, Benefits, Limitations, and Prior Authorization" in this handbook for the list of family planning diagnosis codes.

A general family planning office or outpatient visit (billed without modifier FP) will not be reimbursed when submitted with the same date of service as a surgical procedure or an additional E/M visit. If another condition requiring an E/M office visit beyond the required components for an office visit, family planning visit, or surgical procedure is discovered, the provider may submit a claim for the additional visit using modifier 25 to indicate that the client's condition required a significant, separately identifiable E/M service. Documentation supporting the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request.

2.2.2.1 FQHC Reimbursement for Other Family Planning Office or Outpatient Visits

FQHCs may be reimbursed for three family planning encounters per year, per client, regardless of the reason for the encounter. The three encounters may include any combination of general family planning, annual family planning exams, or services. Procedure codes J7297, J7298, J7300, J7301, and J7307 may be reimbursed in addition to the FQHC encounter payment. When seeking reimbursement for an IUD or implantable contraceptive capsule, providers must submit on the same claim the procedure code for the family planning service provided and the procedure code for the contraceptive device. The contraceptive device is not subject to FQHC limitations. Providers must use modifier U8 when submitting claims for a contraceptive device purchased through the 340B Drug Pricing Program.

A family planning diagnosis code must be billed along with the most appropriate informational procedure codes for the services that were rendered. Reimbursement for services payable to an FQHC is based on an all-inclusive rate per visit.

Refer to: Section 4, "Federally Qualified Health Center (FQHC)" in the *Clinics and Other Outpatient Facility Services Handbook*, (*Vol. 2, Provider Handbooks*) for more information about FQHC services.

2.2.3 Laboratory Procedures

All family planning laboratory services must be billed with a family planning diagnosis code.

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2.2.3.1 Clinical Laboratory Improvement Amendments (CLIA) Requirement

All providers of laboratory services must comply with the rules and regulations of the CLIA. Providers who are not in compliance with CLIA will not be reimbursed for laboratory services. Only the office or lab that holds the appropriate CLIA certificate and that actually performs the laboratory test procedure may be reimbursed for the procedure.

Refer to: Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*)

2.2.3.2 Medical Record Documentation

Medicaid family planning service providers must document in the client's medical record the medical necessity of all ordered laboratory services. The medical record documentation must also reference an appropriate diagnosis.

2.2.3.3 Lab Specimen Handling and Testing

Any test specimen sent to a laboratory may be reimbursed to the laboratory that performs the test and not to the referring family planning provider.

If the provider that obtains the specimen does not perform the laboratory procedure, the provider that obtains the specimen may be reimbursed one lab handling fee per day, per client, using procedure code 99000 and a family planning diagnosis code for the handling or conveyance of the specimen from the provider's office to a laboratory. More than one lab handling fee may be reimbursed per day if multiple specimens are obtained and sent to different laboratories.

Handling fees are not paid for Pap smears or cultures. The appropriate procedure code may be reimbursed for Pap smear interpretations when billed with modifier SU indicating that the screening and interpretation were actually performed in the office.

2.2.3.4 Providing Information to the Reference Laboratory

When sending any specimen, including Pap smears, to the reference laboratory, the family planning provider must provide the reference laboratory with the client's name, address, Texas Medicaid number, and a family planning diagnosis so the laboratory may bill Texas Medicaid for its family planning lab services.

2.2.4 Radiology Services

Procedure codes 74000, 74010, and 76830 may be reimbursed for services performed for the purpose of localization of an intrauterine device (IUD).

2.2.5 Contraceptive Devices and Related Procedures

2.2.5.1 External Contraceptives

Procedure codes A4261 (cervical cap) and A4266 (diaphragm) may be reimbursed separately from the fitting and instruction (procedure code 57170).

Procedure codes A4261 and A4266 may be reimbursed when they are billed with one of the following diagnosis codes:

Diagnosis Codes							
Z30011	Z30012	Z30018	Z3009	Z302	Z3040	Z3041	Z3042
Z30431	Z30432	Z3049	Z308	Z309	Z641		

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2.2.5.2 Intrauterine Device

2.2.5.2.1 Insertion of the IUD

The IUD and the insertion of the IUD may be reimbursed using procedure code J7297, J7298, J7300, J7301, and 58300.

When a vaginal, cervical, or uterine surgery procedure code is submitted with the same date of service as the IUD insertion procedure code, the following reimbursement may apply:

- The other vaginal, cervical, or uterine surgical procedure may be reimbursed at full allowance, and
- The IUD insertion will be reimbursed at half the allowed amount.

Procedure codes J7297, J7298, J7300, and J7301 may be reimbursed when they are billed with one of the following diagnosis codes:

Diagnosis codes							
Z30011	Z30013	Z30014	Z30018	Z3002	Z3009	Z302	Z3040
Z3041	Z3042	Z30430	Z30431	Z30432	Z30433	Z3049	Z308
Z309	Z9851	Z9852					

2.2.5.2.2 Removal of the IUD

Procedure code 58301 may be reimbursed when an IUD is extracted from the uterine cavity. An office visit will not be reimbursed when billed on the same date of service as procedure code 58301.

When a vaginal, cervical, or uterine surgery procedure code is submitted with the same date of service as the IUD removal procedure code or the IUD replacement procedure code, the following reimbursement may apply:

- The other vaginal, cervical, or uterine surgical procedure may be reimbursed at full allowance.
- The removal or the replacement of the IUD will be denied.

2.2.5.3 Contraceptive Capsules

The contraceptive capsule and the implantation of the contraceptive capsule may be reimbursed using procedure code J7307. Providers must use modifier U8 when submitting claims for a contraceptive device purchased through the 340B Drug Pricing Program.

Procedure code 11981 may be reimbursed for the insertion of the implant device when it is billed with a family planning diagnosis code.

Procedure code 11983 may be reimbursed for the removal with reinsertion of the implant device when it is billed with a family planning diagnosis code. Progesterone-containing subdermal contraceptive capsules (Norplant) were previously used for birth control. Although subdermal contraceptive capsules are no longer approved by the Food and Drug Administration (FDA), the removal of the implanted contraceptive capsule may be considered for reimbursement with procedure code 11976 or 11982.

2.2.5.4 Immediate Postpartum Insertion of IUDs and Implantable Contraceptive Capsules

Procedure codes J7297, J7298, J7300, J7301, and J7307 may be reimbursed in addition to the hospital diagnosis related group (DRG) payment when insertion is performed immediately postpartum. "Immediately postpartum" refers to insertion within 10-15 minutes of placental delivery, after vaginal or cesarean delivery, for IUDs or insertion prior to discharge for implantable contraceptive capsules.

When seeking reimbursement for an IUD or implantable contraceptive capsule inserted immediately postpartum, hospital/facility providers must submit an outpatient claim with the appropriate procedure code for the contraceptive device in addition to the inpatient claim for the delivery services.

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2.2.6 Drugs and Supplies

The following procedure codes may be reimbursed for drugs and supplies:

Procedure Codes								
A4267	A4268	A4269	J1050	J3490*	J7303	J7304	S4993	96372
*** Procedure code J3490 may be reimbursed when a prescription medication to treat a genital infection is provided to the client.**								

Procedure code J1050 with modifier U1 may be reimbursed for services rendered to female clients as medically appropriate for the purpose of contraception. A quantity of 1 must be billed.

Procedure code J1050 (no modifier) may be reimbursed for services rendered to male and female clients of any age for other indications as appropriate. Providers must bill the appropriate quantity based on the amount used in milligrams (mg).

For Texas Medicaid Title XIX services, procedure code J1050 is not diagnosis-restricted. For Title XIX family planning services, procedure code J1050 must be billed with a valid family planning diagnosis code.

Procedure codes A4268, A4269, and S4993 may be reimbursed when they are billed with one of the following diagnosis codes:

Diagnosis Codes							
Z30011	Z30012	Z30018	Z3009	Z302	Z3040	Z3041	Z3042
Z30431	Z30432	Z3049	Z308	Z309	Z641		

Procedure code A9150 is not reimbursed through Title XIX Medicaid for the medication to treat a monilia infection. The drug is available through the Medicaid Vendor Drug Program with a prescription.

Providers must use modifier U8 when submitting claims for a contraceptive device purchased through the 340B Drug Pricing Program.

Refer to: "Appendix B: Vendor Drug Program" (*Vol. 1, General Information*) for information about outpatient prescription drugs and the Medicaid Vendor Drug Program.

2.2.6.1 Prescriptions and Dispensing Medication

Family planning agencies may do one or both of the following:

- Dispense family planning drugs and supplies directly to the client and bill accordingly.
- Write a prescription for the client to take to a pharmacy.

Family planning drugs and supplies that are dispensed directly to the client must be billed to TMHP for Texas Medicaid fee-for-service clients. Only family planning agencies may be reimbursed for dispensing family planning drugs and supplies. Family planning agencies may be reimbursed for dispensing up to a 1-year supply of contraceptives in a 12-month period using procedure code J7303, J7304, or S4993. The appropriate family planning diagnosis code must be included on the claim.

Refer to: Subsection 2.2, "Services, Benefits, Limitations, and Prior Authorization" in this chapter.

Title XIX clients may have prescriptions filled at the clinic pharmacy or at another pharmacy. Pharmacies under the Vendor Drug Program are allowed to fill all prescriptions as prescribed. Family planning drugs and supplies are exempt from the three prescriptions-per-month rule for up to a six-month supply.

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2.2.6.2 Long-Acting Reversible Contraception Products

Certain long-acting reversible contraception (LARC) products are available as a pharmacy benefit of Family Planning and are available through a limited number of specialty pharmacies that work with LARC manufacturers. Providers can refer to the Texas Medicaid/CHIP Vendor Drug Program website at http://www.txvendordrug.com/formulary/larc.shtml for additional information, including a list of covered products and participating specialty pharmacies.

2.2.6.3 Injection Administration

Injection administration billed by a provider is reimbursed separately from the medication. If billed without procedure code J1050 and modifier U1, procedure code 96372 must be billed with a family planning diagnosis and a description of the medication in the Remarks field of the claim. Injection administration is not payable to outpatient hospitals.

Refer to: Subsection 2.2, "Services, Benefits, Limitations, and Prior Authorization" in this handbook for a list of family planning diagnosis codes.

2.2.7 Medical Counseling and Education

Procedure code H1010 for the instruction in natural family planning methods may be reimbursed once per day, per person or per couple, when billed by any provider with one of the following diagnosis codes:

Diagnosis Codes							
Z30011	Z30018	Z3002	Z3009	Z302	Z3040	Z3041	Z3042
Z30430	Z30431	Z30432	Z30433	Z3049	Z308	Z309	Z9851
Z9852							

Procedure code H1010 is intended to instruct a couple or an individual in methods of natural family planning. Two sessions (one per client) may be billed for separate, individual sessions, or one session may be billed for counseling and education if provided in a joint session. Each session may be billed separately or the two sessions may be billed together with a total charge for both sessions.

2.2.8 Sterilization and Sterilization-Related Procedures

For a complete list of Title XIX sterilization procedures, providers can refer to the Texas Medicaid fee schedules located on the TMHP website at http://public.tmhp.com/FeeSchedules/Default.aspx.

2.2.8.1 Sterilization Consent

Per federal regulation 42 CFR 50, Subpart B, all sterilization procedures require an approved Sterilization Consent Form.

Note: *The Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form is not sterilization consent.*

Refer to: Sterilization Consent Form (English) on the TMHP website at www.tmhp.com.

Sterilization Consent Form (Spanish) on the TMHP website at www.tmhp.com.

Sterilization Consent Form Instructions on the TMHP website at www.tmhp.com.

2.2.8.2 Anesthesia for Sterilization

Procedure codes 00840, 00851, and 00940 may be reimbursed for anesthesia for sterilization services in accordance with standard anesthesia billing requirements. Providers must include a valid family planning diagnosis code on the claim.

Refer to: Subsection 6.2.5.2, "Anesthesia" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for more information about anesthesia modifiers.

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2.2.8.3 Occlusive Sterilization Device

Procedure code A4264 may be reimbursed for the occlusive sterilization system (micro-insert), and may be reimbursed separately from the surgery (procedure code 58565) to place the device.

Providers must bill procedure code A4264 on the same date of service by the same provider as the occlusive sterilization system (micro-insert).

Procedure code 58565 is considered bilateral and is limited to once per lifetime, any provider.

2.2.8.4 Tubal Ligation

Procedure code 58600, 58615, 58670, or 58671 may be reimbursed for tubal ligations.

2.2.8.5 Vasectomy

Procedure code 55250 may be reimbursed for any sterilization procedure that is performed on a male by a family planning agency. This procedure code may be reimbursed as a global fee to include preoperative, intra-operative, and postoperative services by all parties involved. Vasectomies are considered to be permanent, once-per-lifetime procedures. If a vasectomy has previously been reimbursed for the client, providers may appeal with documentation that supports the medical necessity for the repeat sterilization.

2.2.8.6 Facility Fees for Sterilization

Hospital-based and freestanding ambulatory surgical centers (HASCs/ASCs) may be reimbursed for procedure code 55250, 58565, 58600, 58615, 58670, or 58671. An appropriate family planning diagnosis code must be billed when reporting facility fees for procedure codes 58565 or 58670.

Refer to: Ambulatory Surgical Center on the TMHP website at www.tmhp.com for a claim form example.

2.2.9 Prior Authorization

Prior authorization is not required for family planning services, including sterilization and sterilization-related procedures.

2.2.10 Non-covered Services

2.2.10.1 Family Planning Services for Undocumented Aliens

Undocumented aliens are identified on the client eligibility card as having limited Medicaid eligibility by the classification of Type Program (TP) 30, 31, 34, and 35. Under Texas Medicaid, these clients are only eligible for emergency services, including emergency labor and delivery. Texas Medicaid emergency-only services do not cover Title XIX family planning services.

2.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including gynecological and reproductive health services, and family planning services.

Gynecological and reproductive health services, and family planning services are subject to retrospective review and recoupment if documentation does not support the service billed.

2.4 Claims Filing and Reimbursement

2.4.1 Claims Information

Providers may use the following claim forms to submit claims to TMHP:

Providers	Forms
Medicaid Fee-For-Service Claims Submitted to TMHP	

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Providers	Forms
All family planning services provided by physicians, PAs, NPs, CNSs, CNMs, and family planning agencies who also contract with DSHS	2017 claim form or approved electronic format
Medicaid family planning providers who do not contract with DSHS	2017 claim form, CMS-1500 claim form, or approved electronic format of either form
Hospitals	UB-04 CMS-1450 claim form or approved electronic format
FQHCs not contracted with DSHS	UB-04 CMS-1450, 2017 claim form, or approved electronic format of either form
FQHC also contracts with DSHS	2017 claim form or approved electronic format

The following applies when filing claims:

- All claims and Sterilization Consent Forms submitted by family planning agencies must be submitted with benefit code FP3.
- Family planning services billed by RHCs must include modifier AJ, AM, SA, or U7. These services must be billed using the appropriate national place of service (72) for an RHC setting.
- When completing a 2017, CMS-1500, or UB-04 CMS-1450 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.
- All claims must be filed within approved filing deadlines.
- Denied claims may be appealed.

Providers may copy 2017 Claim Form on the TMHP website at www.tmhp.com.

Providers may purchase CMS-1500 and UB-04 CMS-1450 claim forms from the vendor of their choice. TMHP does not supply the forms.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.9, "Family Planning Claim Form (Paper Billing)" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

Subsection 6.9.1, "2017 Claim Form" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

Subsection 6.5.4, "CMS-1500 Instruction Table" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

Subsection 6.6.3, "UB-04 CMS-1450 Instruction Table" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

Subsection 6.1.4, "Claims Filing Deadlines" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for information about filing deadlines.

Section 7: Appeals (*Vol. 1, General Information*) for information about appealing claims.

Blocks that are not referenced are not required for processing by TMHP and may be left blank.

RHCs must use their National Provider Identifier (NPI), the appropriate benefit code as applicable, and the appropriate modifier and place of service as outlined in this section.

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2.4.1.1 Family Planning and Third Party Liability

Federal and state regulations mandate that family planning client information be kept confidential. Because seeking information from third party insurance may jeopardize the client's confidentiality, prior insurance billing is not a requirement for billing family planning for any title program.

2.4.2 Billing Procedures for Non-Family-Planning Services Provided During a Family Planning Visit (Title XIX Only)

When a non-family-planning service is provided during a family planning visit or the client is offered family planning services during a medical visit, the following billing process must be used:

- A family planning clinic must bill for non-family-planning services using the performing provider's identifier. The clinic provider identifier is used to bill family planning services only.
- The performing provider must bill both family planning services and non-family-planning services, using the correct provider identifier.
- The FQHC must bill both family planning services and non-family-planning services, using the correct provider identifier.
- An RHC may bill a rural health encounter for a non-family-planning medical condition or use the physician's or NP's provider identifier to bill for family planning services. If the RHC also is enrolled as a family planning agency, the family planning services may be billed using the agency's family planning provider identifier and the appropriate national place of service (72) for an RHC setting.

2.4.3 National Drug Code

Refer to: Subsection 6.3.4, "National Drug Code (NDC)" in Section 6, "Claims Filing" *(Vol. 1, General Information*).

2.4.4 National Correct Coding Initiative (NCCI) and Medically Unlikely Edit (MUE) Guidelines

The Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes included in the *Texas Medicaid Provider Procedures Manual* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals and bulletins. 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 Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

3 Texas Women's Health Program

3.1 Texas Women's Health Program (TWHP) TWHP Overview

The goal of TWHP is to expand access to family planning services to reduce unintended pregnancies in the eligible population.

TWHP is established to achieve the following objectives:

- Implement the state policy to favor childbirth and family planning services that do not include elective abortions or the promotion of elective abortions.
- Ensure the efficient and effective use of state funds in support of these objectives and to avoid the direct or indirect use of state funds to promote or support elective abortions.
- Reduce the overall cost of publicly-funded healthcare (including federally-funded healthcare) by providing low-income Texans access to safe, effective services that are consistent with these objectives.

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- Enforce Human Resources Code, §32.024(c-1) and any other state law that regulates delivery of non-federally funded family planning services.

Refer to: Subsection 1.1, "Family Planning Overview" in this handbook for an overview of family planning funding sources.

The TMHP TWHP web page at www.tmhp.com/Pages/TWHP/TWHP_Home.aspx, for more information about provider certification.

3.1.1 Guidelines for TWHP Providers

TWHP provides an annual family planning exam, family planning services, contraception, and treatment for certain sexually transmitted infections (STIs) for women who meet the following qualifications:

- Must be 18 through 44 years of age
- Must be a United States citizen or eligible immigrant
- Must be a resident of Texas
- Does not currently receive full Medicaid benefits including Medicaid for pregnant women, Children's Health Insurance Program (CHIP), or Medicare Part A or B.
- Does not have other insurance that covers family planning services, or has insurance that covers family planning services, but filing a claim on the health insurance would cause physical, emotional, or other harm from a spouse, parent, or other person
- Has a household income at or below 185 percent of the federal poverty level
- Is not pregnant
- Is not sterile, infertile, or unable to get pregnant because of medical reasons

Note: *Women who have received a sterilization procedure, but have not been confirmed to be sterile, may be eligible for sterilization follow-up services.*

TWHP services are provided by a physician or under physician direction, not necessarily personal supervision. A physician provides direction for family planning services through written standing delegation orders and medical protocols. The physician is not required to be on the premises for the provision of family planning services by an RN, PA, NP, or CNS. TWHP participants may receive services from any provider that participates in TWHP.

TWHP clients must be allowed freedom of choice in the selection of contraceptive methods as medically appropriate. They must also be allowed the freedom to accept or reject services without coercion. All TWHP-covered methods of contraception must be made available to the client, either directly or by referral to another provider of contraceptive services. Services must be provided without regard to age, marital status, sex, race, ethnicity, parenthood, handicap, religion, national origin, or contraceptive preference. Only TWHP clients, not their parents, spouses, or any other individuals may consent to the provision of family planning services.

Providers may use the client's Your Texas Benefits Card to verify the client's TWHP eligibility on the HHSC website at www.yourtexasbenefitscard.com.

Client eligibility may also be verified using the following sources:

- The TMHP website at www.tmhp.com
- The Automated Inquiry System (AIS)
- TexMedConnect

Refer to: Subsection 4.5.3, "Client Eligibility Verification" in Section 4, "Client Eligibility" (Vol. 1, *General Information*).

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TWHP clients will have the following identifiers on the feedback received from the stated source:

- Medicaid Coverage: W - MA - TWHP
- Program Type: 68 - MEDICAL ASSISTANCE - WOMEN'S HEALTH PR
- Program: 100 - MEDICAID
- Benefit Plan: 100 - Traditional Medicaid

A TWHP client can be disenrolled from the program before the 12-month term ends only in the following cases:

- The client dies
- The client voluntarily withdraws from TWHP
- The client no longer satisfies the TWHP eligibility criteria
- The client becomes eligible for full Medicaid, the Children's Health Insurance Program (CHIP), or another publicly-funded health coverage program that is more comprehensive than TWHP
- HHSC discovers the client gave fraudulent information on the application
- The client moves out of Texas

If it is discovered during the visit that the client has received a surgical or nonsurgical sterilization procedure before enrolling with TWHP, but the client did not indicate that information on the TWHP application (e.g., because she filled out the TWHP application incorrectly, she misunderstood the question), the provider should:

- Inform the client that she is no longer eligible to receive TWHP services and that she is responsible for all of the fees for services rendered.
- Encourage the client to call 1-866-993-9972 to voluntarily withdraw from TWHP.

If a provider suspects that a TWHP client has committed fraud on the application, the provider should report the client to the HHSC Office of Inspector General (OIG) at 1-800-436-6184.

3.1.2 Referrals

If a provider identifies a health problem such as diabetes or high blood pressure, the provider must refer the TWHP client to another doctor or clinic that can treat her. As mandated by Texas Human Resources Code, Section 32.024(c-1), TWHP does not reimburse for office visits where TWHP clients are referred for elective abortions.

HHSC prefers that clients be referred to local indigent care services. However, the toll-free Information and Referral hotline 2-1-1, can assist clients and providers with locating low-cost health services for clients in need.

3.1.2.1 Referrals for Breast and Cervical Cancer Screening, Diagnostics, and Treatment

The Breast and Cervical Cancer Services program (BCCS) offers breast and cervical cancer screening and diagnostic services, and cervical dysplasia treatment throughout Texas at no or low-cost to eligible women.

3.1.2.2 Referrals for Clients Diagnosed with Breast or Cervical Cancer

Medicaid for Breast and Cervical Cancer (MBCC) provides access to cancer treatment through full Medicaid benefits for qualified women diagnosed with breast or cervical cancer. Health facilities that contract with BCCS are responsible for assisting women with the MBCC application.

To find a BCCS provider, call 2-1-1. For questions about the BCCS program, contact the state office at (512)-458-7796, or visit www.dshs.state.tx.us/bcccs/.

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3.1.3 Abortions

Elective and non-elective abortions are not benefits of TWHP.

Texas Human Resources Code, Section 32.024(c-1) and Title 25 Texas Administrative Code, §39.38 prohibit the participation of a provider that performs or promotes elective abortion or affiliates with an entity that performs or promotes elective abortions.

A provider that performs elective abortions (through either surgical or medical methods) or that is affiliated with an entity that performs or promotes elective abortions for any patient is ineligible to serve TWHP clients and cannot be reimbursed for any services rendered to a TWHP client. This prohibition only applies to providers delivering services to TWHP clients. The prohibition does not impact services delivered to Medicaid clients who are not enrolled in TWHP.

"Elective abortion" means the intentional termination of a pregnancy by an attending physician who knows that the female is pregnant, using any means that is reasonably likely to cause the death of the fetus. The term does not include the use of any such means: (A) to terminate a pregnancy that resulted from an act of rape or incest; (B) in a case in which a woman suffers from a physical disorder, physical disability, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy, that would, as certified by a physician, place the woman in danger of death or risk of substantial impairment of a major bodily function unless an abortion is performed; or (C) in a case in which a fetus has a severe fetal abnormality, meaning a life-threatening physical condition that, in reasonable medical judgment, regardless of the provision of life-saving treatment, is incompatible with life outside the womb.

Certain providers that want to participate in TWHP must certify that they do not perform or promote elective abortions and do not affiliate with any entity that does, as directed by HHSC.

Refer to: Subsection 3.2, "TWHP Provider Enrollment" in this handbook for more information about certification regarding elective abortions.

3.2 TWHP Provider Enrollment

Certain providers who deliver family planning services, have completed the Medicaid-enrollment process through TMHP, and have certified that they do not perform elective abortions or affiliate with providers that perform elective abortion are eligible to participate.

Refer to: Section 1: Provider Enrollment and Responsibilities (Vol. 1, General Information) for more information about enrollment procedures.
Subsection 2.1, "Title XIX Provider Enrollment" in this handbook.

Certain providers that want to participate in TWHP must certify that they do not perform or promote elective abortions and do not affiliate with any entity that does, as directed by HHSC. Providers may complete the Texas Women's Health Program (TWHP) Provider Certification Form and disclose the required information as part of the Medicaid enrollment process, or at any time after completing the Medicaid enrollment process. New providers may use the TMHP website to submit the Texas Women's Health Program (TWHP) Provider Certification Form through the Provider Enrollment Portal (PEP). Medicaid-only providers may use the TMHP website to submit the Texas Women's Health Program (TWHP) Provider Certification Form through the Provider Information Management System (PIMS).

The following provider types are required to certify:

- Physician or physician group with a general surgery, family practice/general practice, gynecology, OB/GYN, internal medicine, or pediatric specialty, or a clinic/group practice
- Federally Qualified Health Center (FQHC)
- Physician Assistant
- Nurse practitioner/clinical nurse specialist

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- Certified nurse midwife/registered nurse/licensed midwife
- Maternity Services Clinic
- Family Planning Agency
- Rural Health Clinic - Freestanding/Independent
- Rural Health Clinic - Hospital Based
- Ambulatory Surgical Center - Freestanding/Independent

Information that providers submit through PIMS can be searched by clients who use the Find a Doctor Today feature on the TWHP website at www.texaswomenshealth.org.

3.3 Services, Benefits, Limitations, and Prior Authorization

This section includes information on family planning services funded through TWHP. TWHP benefits include:

- Annual family planning exam and Pap test
- Other family planning office or outpatient visits
- Laboratory procedures
- Radiology services
- Contraceptive methods and follow-up visits related to the client's chosen contraceptive method
- Counseling for specific methods and use of contraception (as part of evaluation and management services), including natural family planning and excluding emergency contraception
- Drugs and supplies
- Medical counseling and education
- Female sterilization and sterilization-related procedures and follow-up visits, including procedures to confirm sterilization
- Pregnancy tests and STI screenings during a family planning exam
- Treatments for certain sexually transmitted infections (STIs)

For TWHP family planning claims to process correctly, providers must use one of the following diagnosis codes in conjunction with all TWHP family planning procedures and services:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
A5400	A5402	A5409	A541	Z30011	Z30018	Z3002	Z3009
Z302	Z3040	Z3041	Z3042	Z30430	Z30431	Z30432	Z30433
Z3049	Z308	Z309	Z9851				

The choice of diagnosis code must be based on the type of family planning service performed.

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3.3.1 Family Planning Annual Exams

Family planning providers must bill the most appropriate E/M visit procedure code for the complexity of the annual family planning examination provided. To bill an annual family planning examination, one of the following procedure codes must be billed with modifier FP and a TWHP diagnosis code:

Procedure Codes									
99201	99202	99203	99204	99205	99211	99212	99213	99214	99215
99243									

Important: *Only the annual family planning examination requires modifier FP. All other family planning office visits do not. One annual family planning examination is allowed per year. Claims filed incorrectly may be denied.*

The following table summarizes the uses for the E/M procedure codes and the corresponding billing requirements for the annual examination:

Billing Criteria	Frequency
New patient: Most appropriate E/M procedure code with modifier FP and a TWHP diagnosis code	One new patient E/M code every 3 years following the last E/M visit provided the client by that provider or a provider of the same specialty in the same group
Established patient: Most appropriate E/M procedure code with modifier FP and a TWHP diagnosis code	Once a year*

Refer to: Subsection 3.3, "Services, Benefits, Limitations, and Prior Authorization" in this handbook for the list of TWHP diagnosis codes.

Note: *TWHP does not reimburse for follow-up visits after an abnormal Pap test.*

3.3.1.1 FQHC Reimbursement for Family Planning Annual Exams

To receive their encounter rate for the annual family planning examination for TWHP clients, FQHCs must use the most appropriate E/M procedure code for the complexity of service provided as indicated in the previous tables in subsection 3.3.1, "Family Planning Annual Exams" in this handbook.

The annual exam is allowed once per fiscal year, per client, per provider. Other family planning office or outpatient visits may be billed within the same year.

A new patient visit for the annual exam may be reimbursed once every three years following the last E/M visit provided to the client by that provider or a provider of the same specialty in the same group. The annual examination must be billed as an established patient visit if E/M services have been provided to the client within the last three years.

Reimbursement for services payable to an FQHC is based on an all-inclusive rate per visit.

3.3.2 Other Family Planning Office or Outpatient Visits

TWHP only covers office or other outpatient family planning visits if the primary purpose of the visit is related to contraceptive management, as indicated by the allowable diagnosis codes previously listed. TWHP does not cover office or other outpatient family planning visits when the primary purpose of the visit is not related to contraceptive management, such as visits for the purpose of pregnancy testing only, STI testing, or a repeat Pap test after an abnormal result.

A provider is allowed to bill clients for services that are not a benefit of TWHP.

Refer to: Subsection 1.6.9.1, "Client Acknowledgment Statement" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1. General Information*) for the requirements for billing clients.

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For office or other outpatient family planning E/M visits, providers must bill one of the following procedure codes based on the complexity of the visit with a TWHP family planning diagnosis code:

Procedure Codes									
99201	99202	99203	99204	99205	99211	99212	99213	99214	99215
99253									

Important: *Family planning E/M office and outpatient visits should not be billed with modifier FP. Claims filed incorrectly may be denied.*

The following table summarizes the uses for the E/M procedure codes and the corresponding billing requirements for each type of visit:

Billing Criteria	Frequency
New patient: Most appropriate E/M procedure code with a TWHP diagnosis code	One new patient E/M code every 3 years following the last E/M visit provided the client by that provider or a provider of the same specialty in the same group
Established patient: Most appropriate E/M procedure code with a TWHP diagnosis code	As needed*
*** The established patient procedure code will be denied if a new patient procedure code has been billed in the same year.**	

Refer to: Subsection 3.3, "Services, Benefits, Limitations, and Prior Authorization" in this handbook for the list of TWHP diagnosis codes.

Family planning services provided during a TWHP visit in which only family planning services were provided must be submitted with these procedure codes and the most appropriate informational procedure codes for services that were rendered.

The procedure codes in the previous table are allowed for routine contraceptive surveillance, family planning counseling and education, and contraceptive problems. Depending on the extent of the services provided during the office visit, providers may bill for the maximum allowable fees.

During any visit for a medical problem or follow-up visit the following must occur:

- An update of the client's relevant history
- Physical exam, if indicated
- Laboratory tests, if indicated
- Treatment or referral, if indicated
- Education and counseling, or referral, if indicated
- Scheduling of office or clinic visit, if indicated

3.3.2.1 FQHC Reimbursement for Other Family Planning Office or Outpatient Visits

FQHCs may be reimbursed for three family planning encounters per client, per year regardless of the reason for the encounter. The three encounters may include any combination of general family planning encounters or an annual family planning examination. Procedure codes J7297, J7298, J7300, J7301, and J7307 may be reimbursed in addition to the FQHC encounter payment. When seeking reimbursement for an IUD or implantable contraceptive capsule, providers must submit on the same claim the procedure code for the family planning service provided and the procedure code for the contraceptive device. The contraceptive device is not subject to FQHC limitations. Providers must use modifier U8 when submitting claims for a contraceptive device purchased through the 340B Drug Pricing Program.

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A TWHP diagnosis code must be billed along with the most appropriate informational procedure codes for the services that were rendered. Reimbursement for services payable to an FQHC is based on an all-inclusive rate per visit.

Refer to: Section 4, "Federally Qualified Health Center (FQHC)" in the *Clinics and Other Outpatient Facility Services Handbook*, (*Volume 2, Provider Handbooks*) for more information about FQHC services.

3.3.3 Laboratory Procedures

If the provider who obtains the specimen does not perform the laboratory procedure, the provider who obtains the specimen may be reimbursed one lab handling fee per day, per client. The fee for the handling or conveyance of the specimen for transfer from the provider's office to a laboratory may be reimbursed using procedure code 99000 and a family planning diagnosis code. More than one lab handling fee may be reimbursed per day if multiple specimens are obtained and sent to different laboratories.

Handling fees are not paid for Pap smears or cultures. When billing for Pap smear interpretations, the claim must indicate that the screening and interpretation were actually performed in the office by using the modifier SU, procedure performed in physician's office.

Providers must forward the client's name, address, member ID, and a family planning diagnosis with any specimen, including Pap smears, to the reference laboratory so the laboratory may bill TWHP for its family planning lab services.

When family planning test specimens, such as Pap smears, are collected, providers must direct the laboratory to indicate that the claim for the test is to be billed as a family planning service (i.e., procedure must be billed with a TWHP qualifying diagnosis code).

Refer to: Subsection 2.2.3, "Laboratory Procedures" in this handbook for more information about family planning laboratory services.

Subsection 3.3, "Services, Benefits, Limitations, and Prior Authorization" in this handbook for the list of TWHP diagnosis codes.

Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks)*.

TWHP laboratory services may be submitted using the following procedure codes:

Procedure Codes									
80061	81000	81001	81002	81003	81015	81025	82947	82948	84443
84702	84703	85013	85014	85018	85025	85027	86318	86580	86592
86689	86695	86696	86701	86703	86762	86803	86900	86901	87070
87086	87088	87102	87110	87205	87210	87220	87252	87340	87389
87480	87490	87491	87510	87590	87591	87623	87624	87625	87660
87797	87800	87801	87810	87850	88142	88150	88164	88175	99000
99001									

Appropriate documentation must be kept in the client's record.

Claims may be subject to retrospective review if they are submitted with diagnosis codes that do not support medical necessity.

If more than one of procedure codes 87480, 87510, 87660, or 87800 is submitted by the same provider for the same client with the same date of service, all of the procedure codes will be denied.

TWHP follows the Medicare categorization of tests for CLIA certificate holders.

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Refer to: The CMS website at www.cms.gov/CLIA/10_Categorization_of_Tests.asp for information about procedure code and modifier QW requirements.

3.3.4 Radiology

The following procedure codes may be reimbursed for radiology services:

Procedure Codes							
74000	74010	74740	76830	76856	76857	76881	76882

3.3.5 Contraceptive Devices and Related Procedures

The following procedure codes may be reimbursed for contraceptive devices and related procedures:

Procedure Codes									
11976	11981	57170	58300	58301	96372	A4261	A4266	J7297	J7298
J7300	J7301	J7307							

Providers must use modifier U8 when submitting claims for a contraceptive device purchased through the 340B Drug Pricing Program. Procedure code 11981 may be reimbursed when it is submitted with the most appropriate family planning diagnosis code.

Procedure codes A4261 and A4266 may be reimbursed when they are billed with one of the following diagnosis codes:

Diagnosis Codes							
Z30011	Z30018	Z3009	Z302	Z3040	Z3041	Z3042	Z30431
Z30432	Z3049	Z308	Z309				

Procedure code J7297, J7298, J7300, and J7301 may be reimbursed when it is billed with one of the following diagnosis codes:

Diagnosis Codes							
Z30011	Z30018	Z3002	Z3009	Z302	Z3040	Z3041	Z3042
Z30430	Z30431	Z30432	Z30433	Z3049	Z308	Z309	Z9851

An E/M procedure code will not be reimbursed when it is billed with the same date of service as procedure code 58301, unless the E/M visit is a significant, separately identifiable service from the removal of the IUD. If the E/M visit occurs on the same date of service as the removal of the IUD, modifier 25 may be used to indicate that the E/M visit was a significant, separately identifiable service from the procedure, and documentation must be included in the client's medical record that indicates either the key components (history, physical examination, and medical decision making) or time spent counseling.

Providers must use modifier U8 when submitting claims for a contraceptive device purchased through the 340B Drug Pricing Program.

Note: *TWHP does not reimburse for counseling for, or provision of, emergency contraception.*

3.3.6 Drugs and Supplies

Procedure codes A4267, A4268, A4269, J1050 and modifier U1, J7303, J7304, and S4993 may be reimbursed for drugs and supplies.

Refer to: Subsection 3.3, "Services, Benefits, Limitations, and Prior Authorization" in this handbook for a list of TWHP family planning diagnosis codes.

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Procedure code J1050 with modifier U1 may be reimbursed for services rendered to female clients as medically appropriate for the purpose of contraception. A quantity of 1 must be billed.

For TWHP services, procedure code J1050 is not diagnosis restricted.

Procedure codes A4268, A4269, and S4993 may be reimbursed when they are billed with one of the following diagnosis codes:

Diagnosis Codes							
Z30011	Z30018	Z3009	Z302	Z3040	Z3041	Z3042	Z30431
Z30432	Z3049	Z308	Z309				

Note: *TWHP does not reimburse providers for counseling about emergency contraception or the provision of emergency contraception.*

3.3.6.1 Prescriptions and Dispensing Medication

Family planning drugs and supplies that are dispensed directly to the client must be billed to TMHP. Family planning clinics may be reimbursed for dispensing up to a one year supply of contraceptives in a 12-month period using procedure code J7303, J7304, or S4993. The appropriate family planning diagnosis code must be included on the claim.

Pharmacies under the Vendor Drug Program are allowed to fill all prescriptions as prescribed. Family planning drugs and supplies are exempt from the three prescriptions-per-month rule for up to a six-month supply.

Refer to: "Appendix B: Vendor Drug Program" (*Vol. 1, General Information*) for information about outpatient prescription drugs and the Vendor Drug Program.

3.3.6.1.1 Long-Acting Reversible Contraception Products

Certain long-acting reversible contraception (LARC) products are available as a pharmacy benefit of TWHP and are available through a limited number of specialty pharmacies that work with LARC manufacturers. Providers can refer to the Texas Medicaid/CHIP Vendor Drug Program website at http://www.txvendordrug.com/formulary/larc.shtml for additional information, including a list of covered products and participating specialty pharmacies.

3.3.6.2 Injection Administration

Injection administration may be reimbursed separately from the medication. Administration procedure code 96372 must be billed with a family planning diagnosis code and the National Drug Code (NDC) of the medication that was administered.

Claims for procedure code 96372 may not be submitted by outpatient hospitals.

3.3.7 Instruction in Natural Family Planning Methods

Procedure code H1010 is a benefit of TWHP and is limited to one service per day when billed by any provider with one of the following diagnosis codes:

Diagnosis Codes							
Z30011	Z30018	Z3002	Z3009	Z302	Z3040	Z3041	Z3042
Z30430	Z30431	Z30432	Z30433	Z3049	Z308	Z309	Z9851

Procedure code H1010 is intended to instruct a couple or an individual in methods of natural family planning and may consist of two sessions. Each session may be billed separately or the two sessions may be billed together with a total charge for both sessions.

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3.3.8 Sterilization and Sterilization-Related Procedures

Sterilizations are considered to be permanent, once per lifetime procedures. Denied claims may be appealed with documentation that supports the medical necessity for a repeat sterilization.

The sterilization services that are available to TWHP clients include surgical or nonsurgical sterilization, follow-up office visits related to confirming the sterilization, and any necessary short-term contraception. No other services are covered for TWHP clients who have been sterilized.

TWHP covers sterilization as a form of birth control. To be eligible for a sterilization procedure through TWHP, the client must be 21 years of age or older and must complete and sign a Sterilization Consent Form within at least 30 days of the date of the surgery but no more than 180 days. In the case of an emergency, there must be at least 72 hours between the date on which the consent form is signed and the date of the surgery. Operative reports that detail the need for emergency surgery are required.

TWHP may reimburse providers for a follow-up visit that includes a hysterosalpingogram to ensure tubal occlusion, which is recommended three months after a hysteroscopic sterilization procedure. TWHP may also reimburse providers for short-term contraceptives dispensed following the insertion of an occlusive sterilization system.

3.3.8.1 Sterilization Consent

Per federal regulation 42 Code of Federal Regulations (CFR) 50, Subpart B, all sterilization procedures require an approved Sterilization Consent Form.

Note: *The Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form is not sterilization consent.*

Refer to: Sterilization Consent Form (English) on the TMHP website at www.tmhp.com.

Sterilization Consent Form (Spanish) on the TMHP website at www.tmhp.com.

Sterilization Consent Form Instructions on the TMHP website at www.tmhp.com.

3.3.8.2 Tubal Ligation

Procedure code 58600, 58611, 58615, 58670, or 58671 may be reimbursed for tubal ligations.

3.3.8.3 Anesthesia for Sterilization

Procedure code 00851 must be used when reporting anesthesia services for a tubal ligation sterilization procedure.

3.3.8.4 Facility Fees for Sterilization

Hospital-based and freestanding ASCs may be reimbursed for procedure code 58565, 58600, 58615, 58670, 58671, or A4264. An appropriate TWHP diagnosis code must be billed when reporting facility fees related to tubal ligation.

Refer to: Section 5, "Ambulatory Surgical Center and Hospital Ambulatory Surgical Center" in the *Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks)* for more information about ASC billing procedures.

3.3.8.5 Hysteroscopic Sterilization

Procedure code 58340 or 58565 may be reimbursed for the fallopian tube occlusion sterilization when submitted with diagnosis code Z302. Procedure code 58565 is considered bilateral.

The occlusive sterilization system (micro-insert) is a benefit when billed with procedure code A4264. Procedure code A4264 may be reimbursed for females 10 years through 55 years of age.

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3.3.8.6 TWHP Services After Sterilization

A hysterosalpingogram is recommended three months after a hysteroscopic sterilization procedure to ensure tubal occlusion. Procedure code 74740 is considered for reimbursement in this circumstance when submitted with diagnosis code Z302. Procedure code 58340 may be billed for introduction of saline or contrast material for hysterosalpingography.

FQHC and professionals who render family planning services in the RHC setting may bill procedure codes 99201 and 99211 with an appropriate TWHP diagnosis code to receive their encounter reimbursement for follow-up services to confirm the sterilization of TWHP clients. FQHC providers may be reimbursed up to three family planning encounters per calendar year, per client. Professionals who render family planning services in the RHC setting may be reimbursed one encounter rate per calendar year, per TWHP client for family planning visits provided through TWHP.

3.3.8.6.1 Clients Who Have Received Sterilization Services

After the sterilization and all related services have been completed, the client is no longer eligible for TWHP services. Clients who have been sterilized cannot enroll in TWHP unless they are seeking to have the sterilization confirmed. After sterilization has been confirmed, a client is not eligible for TWHP coverage.

After an occlusive sterilization procedure, if the client's 12-month TWHP coverage lapses before the sterilization is confirmed, the client may reapply for coverage in order to access short-term contraceptives and the hysterosalpingography necessary to confirm that the fallopian tubes are blocked. If it has not been confirmed that the occlusive sterilization system is blocking the fallopian tubes, the client is not considered to have been sterilized.

Providers must inform TWHP clients who seek sterilization that, after the sterilization procedure, TWHP covers only the follow-up visit to confirm the sterilization and the short-term contraceptives that are dispensed for the 12-week period following the insertion of an occlusive sterilization system.

3.3.9 Treatment for Sexually Transmitted Infections (STIs)

TWHP reimbursement for treatment of STIs is available only if the condition was discovered during a visit where the primary purpose was the client's family planning needs, i.e., contraception or contraceptive counseling.

TWHP covers treatment for the following conditions:

- Gardnerella
- Trichomoniasis
- Candida
- Chlamydia
- Gonorrhea
- Herpes

Reimbursement for the treatment of STIs is available through the Texas Vendor Drug Program (VDP). Clients can access their prescribed drugs through pharmacies that are enrolled in the VDP.

Refer to: The Texas VDP website at www.txvendordrug.com/formulary for more information.

Note: *TWHP does not reimburse for the treatment of any non-STD conditions that are diagnosed during a TWHP visit.*

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3.3.9.1 Gonorrhea Treatment

Procedure code J0696 may be reimbursed for gonorrhea treatment services rendered to TWHP clients. Procedure code J0696 may be reimbursed when it is submitted with diagnosis code A5400, A5409, A545, or A546 as the referenced diagnosis code.

Note: *Other TWHP services will not be reimbursed if they are submitted with diagnosis codes A5400, A5409, A545, or A546 as referenced diagnoses.*

3.3.10 Prior Authorization

Prior authorization is not required for TWHP services.

3.4 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including TWHP services.

TWHP services are subject to retrospective review and recoupment if documentation does not support the service billed.

3.5 TWHP Claims Filing and Reimbursement

3.5.1 Claims Information

Providers must use the appropriate claim form to submit TWHP claims to TMHP.

Refer to: Subsection 2.4, "Claims Filing and Reimbursement" in this handbook for more information about filing family planning claims.

3.5.1.1 TWHP and Third Party Liability

Federal and state regulations mandate that family planning client information be kept confidential.

Because seeking information from third party insurance may jeopardize the client's confidentiality, third party billing for TWHP is not allowed.

3.5.2 Reimbursement

Services provided under TWHP are reimbursed according to Medicaid rules at standard Medicaid rates.

3.5.3 National Drug Code

Refer to: Subsection 6.3.4, "National Drug Code (NDC)" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

3.5.4 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manual. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

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4 Department of State Health Services (DSHS) Family Planning Program Services

4.1 Provider Enrollment for DSHS Family Planning Program Contractors

Agencies that submit claims for DSHS Family Planning Program Services must have a contract with DSHS. The DSHS Community Health Services Section determines client eligibility and services policy. Refer to the DSHS Family Planning Policy Manual for specific eligibility and policy information at www.dshs.state.tx.us/famplan.

Refer to: Section 1: Provider Enrollment and Responsibilities (*Vol. 1, General Information*) for more information about enrollment procedures.

Subsection 2.1, "Title XIX Provider Enrollment" in this handbook.

Subsection 1.1, "Family Planning Overview" in this handbook for more information about family planning funding sources, guidelines for family planning providers, and family planning services for undocumented aliens and legalized aliens.

4.2 Services, Benefits, Limitations, and Prior Authorization

This section contains information about family planning services funded through the DSHS Family Planning Program funding source including:

- Family planning annual exams
- Other family planning office or outpatient visits
- Laboratory procedures
- Radiology services
- Contraceptive devices and related procedures
- Drugs and supplies
- Medical counseling and education
- Sterilization and sterilization-related procedures (i.e., tubal ligation, vasectomy, and anesthesia for sterilization)

Providers are encouraged to include one of the following family planning diagnosis codes on the claim in conjunction with all family planning procedures and services:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
Z30011	Z30013	Z30014	Z30018	Z3002	Z3009	Z302	Z3040
Z3041	Z3042	Z30430	Z30431	Z30432	Z30433	Z3049	Z308
Z309	Z9851	Z9852					

One of the diagnosis codes in this table may be included in Block 24 E of the CMS-1500 claim form referencing the appropriate procedure code. The choice of diagnosis code must be based on the type of family planning service performed.

4.2.1 Family Planning Annual Exams

An annual family planning exam consists of a comprehensive health history and physical examination, including medical laboratory evaluations as indicated, an assessment of the client's problems and needs, and the implementation of an appropriate contraceptive management plan.

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DSHS family planning providers must bill the most appropriate E/M visit procedure code for the complexity of the annual family planning examination provided. To bill an annual family planning examination, one of the following procedure codes must be billed with modifier FP:

Procedure Codes							
99201	99202	99203	99204	99211	99212	99213	99214

Refer to: The DSHS Family Planning Policy and Procedure Manual on the DSHS website at www.dshs.state.tx.us/famplan/pol_man.shtm for reimbursement rates.

The following table summarizes the uses for the E/M procedure codes and the corresponding billing requirements for the annual examination:

Billing Criteria	Frequency
New patient: Appropriate E/M procedure code with modifier FP	One new patient E/M code every three years following the last E/M visit provided to the client by that provider or a provider of the same specialty in the same group
Established patient: Appropriate E/M procedure code with modifier FP	Once per state fiscal year*
*** The established patient procedure code will be denied if a new patient procedure code has been billed for the annual examination in the same year.**	

For appropriate claims processing, providers are encouraged to use a family planning diagnosis code to bill the annual family planning exam.

Refer to: Subsection 4.2, "Services, Benefits, Limitations, and Prior Authorization" in this handbook for the list of family planning diagnosis codes.

An annual family planning examination (billed with modifier FP) will not be reimbursed when submitted with the same date of service as an additional E/M visit. If another condition requiring an E/M office visit beyond the required components for an office visit, family planning visit, or surgical procedure is discovered, the provider may submit a claim for the additional visit using Modifier 25 to indicate that the client's condition required a significant, separately identifiable E/M service. Documentation supporting the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request.

4.2.1.1 FQHC Reimbursement for Family Planning Annual Exams

To receive the encounter rate for the annual family planning examination, FQHCs must use the most appropriate E/M procedure code for the complexity of service provided as indicated in the previous table in subsection 4.2.1, "Family Planning Annual Exams" in this handbook and must use modifier FP.

The annual exam is allowed once per fiscal year, per client, per provider. Other family planning office or outpatient visits may be billed within the same year.

A new patient visit for the annual exam may be reimbursed once every three years following the last E/M visit provided to the client by that provider or a provider of the same specialty in the same group. The annual examination must be billed as an established patient visit if E/M services have been provided to the client within the last three years.

Reimbursement for services payable to an FQHC is based on an all-inclusive rate per visit.

4.2.2 Family Planning Office or Outpatient Visits

Other family planning E/M visits are allowed for routine contraceptive surveillance, family planning counseling and education, contraceptive problems, suspicion of pregnancy, genitourinary infections, and evaluation of other reproductive system symptoms.

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During any visit for a medical problem or follow-up visit, the following must occur:

- An update of the client's relevant history
- Physical exam, if indicated
- Laboratory tests, if indicated
- Treatment or referral, if indicated
- Education and counseling, or referral, if indicated
- Scheduling of office or clinic visit, if indicated

For general family planning visits, DSHS Family Planning Program Providers must bill one of the following, most appropriate E/M procedure code:

Procedure Codes							
99201	99202	99203	99204	99211	99212	99213	99214

The following table summarizes the uses for the E/M procedure codes and the corresponding billing requirements for general family planning office or outpatient visits:

Billing Criteria	Frequency
New patient: Appropriate E/M procedure code	One new patient E/M code every three years following the last E/M visit provided to the client by that provider or a provider of the same specialty in the same group
Established patient: Appropriate E/M procedure code	As needed*
*** The established patient procedure code will be denied if a new patient procedure code has been billed for the annual examination in the same year.**	

For appropriate claims processing, providers are encouraged to use a family planning diagnosis code to bill the annual family planning exam.

Refer to: Subsection 4.2, "Services, Benefits, Limitations, and Prior Authorization" in this handbook for the list of family planning diagnosis codes.

4.2.2.1 FQHC Reimbursement for Family Planning Office or Outpatient Visits

To receive the encounter rate for a general family planning visit, FQHCs must use the most appropriate E/M procedure code for the complexity of service provided as indicated previously in the tables in subsection 3.5.3, "National Drug Code" in this handbook.

FQHCs may be reimbursed for three family planning encounters per client, per year regardless of the reason for the encounter. The three encounters may include any combination of general family planning encounters, an annual family planning examination, or procedure code J7297, J7298, J7300, J7301, J7303, 17304, J7307, or S4993.

The new patient procedure codes will be limited to one new patient E/M procedure code three years following the last E/M visit provided to the client by that provider or a provider of the same specialty in the same group. The annual examination must be billed as an established patient visit if E/M services have been provided to the client within the last three years.

Reimbursement for services payable to an FQHC is based on an all-inclusive rate per visit.

A general family planning office or outpatient visit (billed without modifier FP) will not be reimbursed when submitted with the same date of service as an additional E/M visit. If another condition requiring an E/M office visit beyond the required components for an office visit, family planning visit, or surgical procedure is discovered, the provider may submit a claim for the additional visit using Modifier 25 to

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indicate that the client's condition required a significant, separately identifiable E/M service. Documentation supporting the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request.

Refer to: Section 4, "Federally Qualified Health Center (FQHC)" in the *Clinics and Other Outpatient Facility Services Handbook*, (*Volume 2, Provider Handbooks*) for more information about FQHC services.

4.2.3 Laboratory Procedures

4.2.3.1 DSHS Family Planning Program

The following procedure codes may be reimbursed for DSHS Family Planning Program family planning laboratory services:

Procedure Codes									
80061	81000	81001	81002	81003	81015	81025	82947	82948	84443
84702	84703	85013	85014	85018	85025	85027	86580	86592	86689
86695	86696	86701	86702	86703	86762	86803	86900	86901	87070
87086	87088	87102	87110	87205	87210	87220	87252	87340	87389
87480	87490	87491	87510	87535	87590	87591	87624	87625	87660
87800	87810	87850	88142	88150	88164	88175	99000		

Appropriate documentation must be maintained in the client's record.

Refer to: Subsection 3.3.3, "Laboratory Procedures" in this handbook for more information about family planning laboratory services requirements.

Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

Texas Medicaid follows the Medicare categorization of tests for CLIA certificate holders.

Refer to: The CMS website at www.cms.gov/CLIA/10_Categorization_of_Tests.asp for information about procedure code and modifier QW requirements.

4.2.4 Immunization Administration

Procedure codes 90460 and 90471 may be reimbursed when billed for vaccine administration.

Procedure code 90460 will be denied if billed on the same date of service as procedure codes 90630, 90632, or 90636.

4.2.4.1 Human Papilloma Virus (HPV) Vaccine

Procedure codes 90649 and 90650 may be reimbursed for the Human papilloma virus (HPV) vaccine.

4.2.5 Radiology

The following radiology services may be reimbursed for services performed for the purpose of localization of an IUD:

Procedure Code							
73060	74000	74010	76830	76856	76857	76881	76882

Procedure codes 76881 and 76882:

- Must be submitted with the most appropriate family planning diagnosis code
- Will be denied if they are submitted with the same date of service as procedure codes 55250 or 58600

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4.2.6 Contraceptive Devices and Related Procedures

4.2.6.1 External Contraceptives

The following procedure codes may be reimbursed separately from the fitting and instruction (procedure code 57170):

Procedure Code		
57170	A4261 (cervical cap)	A4266 (diaphragm)

4.2.6.2 IUD

IUD services may be reimbursed using the following:

Procedure Code					
58300	58301	J7297	J7298	J7300	J7301

4.2.6.2.1 Insertion of an IUD

The IUD and the insertion of the IUD may be reimbursed using procedure code J7297, J7298, J7300, J7301, and 58300.

The following reimbursement may apply:

- Procedure codes J7297, J7298, J7300, or J7301 may be reimbursed at full allowance.
- Procedure code 58300 may be reimbursed at full allowance.

When a vaginal, cervical, or uterine surgery (e.g., cervical cauterization) is billed for the same date of service as the insertion of the IUD, the following reimbursement will apply:

- The other vaginal, cervical, or uterine surgical procedure may be reimbursed at full allowance.
- Procedure code 58300 (IUD insertion) may be reimbursed at half the allowed amount.

4.2.6.2.2 Removal of the IUD

Procedure code 58301 may be reimbursed when an IUD is extracted from the uterine cavity.

When a vaginal, cervical, or uterine surgery procedure code is submitted with the same date of service as the IUD removal procedure code or the IUD replacement procedure code, the following reimbursement may apply:

- The other vaginal, cervical, or uterine surgical procedure may be reimbursed at full allowance.
- The removal or the replacement of the IUD will be denied.

4.2.6.3 Contraceptive Capsules

The contraceptive capsule and the implantation of the contraceptive capsule may be reimbursed using procedure code J7307 and procedure code 11981 (implantation). Procedure code 11981 may be reimbursed when billed with an appropriate family planning diagnosis code.

Progesterone-containing subdermal contraceptive capsules (Norplant) were previously used for birth control. Although subdermal contraceptive capsules are no longer approved by the FDA, the removal of the implanted contraceptive capsule may be considered for reimbursement with procedure code 11976 (removal).

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4.2.6.4 Medroxyprogesterone Acetate/Estradiol Cypionate

Medroxyprogesterone acetate/estradiol cypionate has been approved by the FDA as a method of contraception. Intramuscular injections of medroxyprogesterone acetate/estradiol cypionate given at 28- to 30-day intervals has been proven to be a short-term method to prevent pregnancy and will be limited to no more frequently than every 28 days.

4.2.7 Drugs and Supplies

The following drug and supply procedure codes may be reimbursed as:

Procedure Code								
A4267	A4268	A4269	A9150	J1050/U1	J3490	J7303	J7304	S4993

Procedure code J1050 with modifier U1 may be reimbursed for services rendered to female clients as medically appropriate for the purpose of contraception. A quantity of 1 must be billed.

For Title XIX family planning services, procedure code J1050 must be billed with a valid family planning diagnosis code.

Procedure code J3490 may be reimbursed when a prescription medication to treat a genital infection is provided to the client. Procedure code A9150 may be reimbursed when a nonprescription medication to treat a monilia infection is provided to the client.

4.2.7.1 Prescriptions and Dispensing Medication

Family planning agencies may do one or both of the following:

- Dispense family planning drugs and supplies directly to the client and bill TMHP.
- Write a prescription for the client to take to a pharmacy.

Family planning drugs and supplies that are dispensed directly to the client must be billed to TMHP. Only family planning agencies may be reimbursed for dispensing family planning drugs and supplies. Family planning agencies may be reimbursed for dispensing up to a one-year supply of contraceptives in a 12-month period using procedure code J7303, J7304, or S4993.

DSHS Family Planning Program clients may have their prescriptions filled at the clinic pharmacy.

DSHS Family Planning Providers can refer to the *DSHS Family Planning Policy and Procedure Manual* for additional guidance on dispensing medication.

Note: *Pharmacies under the Medicaid Vendor Drug Program are allowed to fill all prescriptions as prescribed. Family planning drugs and supplies are exempt from the three-prescriptions-per-month rule for up to a six-month supply.*

Refer to: "Appendix B: Vendor Drug Program" (*Vol. 1, General Information*) for information about outpatient prescription drugs and the Medicaid Vendor Drug Program.

4.2.7.2 Oral Medication Reimbursement

Procedure code S5000 is a benefit of the DSHS Family Planning Program for oral medication reimbursement.

Note: *This benefit is for the DSHS Family Planning Program only. This benefit does not apply for Title XIX family planning or TWHP.*

4.2.8 Family Planning Education

Medical counseling and education may be reimbursed using procedure code H1010.

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4.2.8.1 Medical Nutrition Therapy

For clients requiring intensive nutritional guidance, medical nutritional therapy can be provided as an allowable and billable service using procedure code 97802. Medical nutritional therapy, however, must be provided by a registered dietician in order to be reimbursed. Procedure code 97802 may only be billed up to four times per state fiscal year for the same client by the same provider.

4.2.8.2 Instruction in Natural Family Planning Methods

Counseling with the intent to instruct a couple or an individual in methods of natural family planning may be reimbursed twice a year using procedure code H1010.

4.2.9 Sterilization and Sterilization-Related Procedures

4.2.9.1 Sterilization Consent

Per federal regulation 42 CFR 50, Subpart B, all sterilization procedures require an approved Sterilization Consent Form.

Note: *The Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form is not sterilization consent.*

Refer to: Sterilization Consent Form (English) on the TMHP website at www.tmhp.com.

Sterilization Consent Form (Spanish) on the TMHP website at www.tmhp.com.

Sterilization Consent Form Instructions on the TMHP website at www.tmhp.com.

4.2.9.2 Incomplete Sterilizations

Sterilizations are considered to be permanent, once per lifetime procedures. If the claim is denied indicating a sterilization procedure has already been reimbursed for the client, the provider may appeal with documentation that supports the medical necessity for the repeat sterilization.

4.2.9.3 Tubal Ligation and Hysteroscopic Occlusion

Procedure codes 58600 and 58565 may be reimbursed for sterilization procedures performed on a female client. Reimbursement for procedure codes 58600 and 58565 include all preoperative, intra-operative, and postoperative services by all parties involved (i.e., physician, anesthesiologist, facility, laboratory, and so on).

4.2.9.4 Vasectomy

Procedure code 55250 may be reimbursed for any sterilization procedure performed on a male. Reimbursement for procedure code 55250 includes preoperative, intra-operative, and postoperative services by all parties involved (i.e., physician, anesthesiologist, facility, laboratory, and so on).

Vasectomies are considered to be permanent, once-per-lifetime procedures. If the claim is denied indicating a vasectomy procedure has already been reimbursed for the client, the provider may appeal with documentation that supports the medical necessity for the repeat sterilization.

4.2.10 Prior Authorization

Prior authorization is not required for sterilization and sterilization-related procedures.

4.2.11 Reimbursement for TWHP Wrap-Around Services

FQHC providers and family planning clinic providers contracted through DSHS may receive DSHS Family Planning Program reimbursement for TWHP wrap-around services during a visit. To receive reimbursement, the primary purpose of the visit must not be related to contraception or be reimbursed by TWHP.

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FQHC providers and family planning clinic providers may receive reimbursement for the following services that are rendered to TWHP clients when the primary diagnosis is not related to contraception:

- Follow-up Pap tests - To receive reimbursement, DSHS contractors must file a separate claim with diagnosis code N889. DSHS contractors may be reimbursed for the Pap test, an appropriate counseling code, and the appropriate visit code.
- Follow-up visits for sexually transmitted disease/sexually transmitted infection (STD/STI) testing - To receive reimbursement for a visit that is strictly for the purposes of STD/STI testing for a TWHP client, DSHS contractors must file a separate claim with a diagnosis code of Z202. DSHS contractors may be reimbursed for STD/STI tests and STD/STI related services.
- Pregnancy test-only visits - To receive reimbursement for a visit that is for a pregnancy test only, DSHS contractors must file a separate claim with diagnosis code Z3200.

Claims that are submitted by FQHC providers for wrap-around services, but are considered part of a TWHP encounter, will be subject to retrospective review, as these claims are not eligible for reimbursement. Any wrap-around services that are determined to have been paid in error may be recouped.

4.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including gynecological and reproductive health services and family planning services.

Gynecological and reproductive health services and family planning services are subject to retrospective review and recoupment if documentation does not support the service billed.

4.4 Claims Filing and Reimbursement

4.4.1 Claims Information

Providers must use the appropriate claim form to submit DSHS Family Planning Program claims to TMHP. Claims for dates of service that span multiple contract periods must be submitted on separate claims for services performed within each contract period.

Note: *To submit DSHS Family Planning Program claims using TexMedConnect, providers must choose Family Planning Program "Title X-DFPP" on the electronic version of the 2017 claim form.*

Refer to: Subsection 2.4, "Claims Filing and Reimbursement" in this handbook for more information about filing family planning claims.

4.4.1.1 Filing Deadlines

The following table summarizes the filing deadlines for DSHS Family Planning Program claims:

Deadline	Appeals
95 days from the date of service on the claim or date of any third party insurance explanation of benefits (EOB)	120 days from the date of the Remittance and Status (R&S) Report on which the claim reached a finalized status
If the filing deadline falls on a weekend or TMHP-recognized holiday, the filing deadline is extended until the next business day.	

Note: *As stated in the* DSHS Family Planning Policy and Procedure Manual*, all claims and appeals must be submitted and processed within 60 days after the end of the contract period.*

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4.4.1.2 Third Party Liability

Federal and state regulations mandate that family planning client information be kept confidential. Because seeking information from third party insurance may jeopardize the client's confidentiality, prior insurance billing is not a requirement for billing family planning for any title program.

4.4.2 Reimbursement

Reimbursement for family planning procedures is available in the TMHP Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com and on the DSHS website at www.dshs.state.tx.us/famplan.

4.4.2.1 Funds Gone

DSHS family planning providers are contracted to provide services for a specific time period, either the state fiscal year or a contract period within the fiscal year. The providers receive a specific budget amount for their contract period. When their claims payments have reached their budget allowance, providers must continue to submit claims. The amount of funds that they would have received had the funds been available will be tracked as "funds gone."

Providers may receive additional funds for a contract period at a later time. Claims identified as "funds gone" may be reimbursed at that time.

On the R&S Report, "Claims Paid" is the dollar amount of claims paid during this financial transaction period. "Approved to Pay/Not Funds Gone" is the dollar amount that has been processed and approved to pay, but the payment has not been issued yet. "Funds Gone" is the dollar amount that has been submitted after the provider's budget allowance has been reached. The amount in "Approved to Pay/Not Funds Gone" added to the amount in "Funds Gone" will equal the amount in the "Approved to Pay - New Claims" section.

4.4.3 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manual. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

4.4.4 National Drug Code

Refer to: Subsection 6.3.4, "National Drug Code (NDC)" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

5 Gynecological Health Services

5.1 Services, Benefits, Limitations, and Prior Authorization

Gynecological examinations, surgical procedures, and treatments are benefits of Texas Medicaid.

The following gynecological procedures and services may be benefits of Texas Medicaid:

- Gynecological and family planning examinations
- Contraceptives
- Diagnostic tests
- Surgical procedures
- Gynecological treatments

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Refer to: Section 2, "Medicaid Title XIX Family Planning Services" in this handbook for information about contraception, sterilizations, and family planning annual examinations.

5.2 Surgical and Laparoscopic Treatment of Ectopic Pregnancy

Surgical and laparoscopic treatment of ectopic pregnancy (procedure codes 59120, 59121, 59130, 59135, 59136, 59140, 59150, and 59151) is a benefit of Texas Medicaid.

5.3 Laparoscopic Procedures

Laparoscopic procedures (procedure codes 58545, 58546, and 58578) are a benefit of Texas Medicaid.

5.4 Endometrial Cryoablation

Endometrial cryoablation (procedure codes 58353 and 58356) is a benefit of Texas Medicaid.

5.5 Uterine Suspension

Uterine suspension (procedure codes 58400 and 58410) is a benefit of Texas Medicaid.

5.6 Vulvectomy

Vulvectomy (procedure code 55620) is a benefit of Texas Medicaid.

5.6.1 Prior Authorization for Vulvectomy

Prior Authorization is required for vulvectomy.

The prior authorization request must include documentation of one of the following conditions:

- Vulvar intraepithelial neoplasia (VIN)
- Labial enlargement that results in abrasion, irritation, or intractable skin infection

Note: *A vulvectomy will not be considered for cosmetic reasons.*

5.7 Salpingostomy

Salpingostomy (procedure codes 58673 and 58770) is a benefit of Texas Medicaid.

5.7.1 Prior Authorization for Salpingostomy

Prior authorization is required for salpingostomy.

The prior authorization request must include documentation of one or more of the following conditions:

- Ectopic pregnancy
- Hydrosalpinx unrelated to infertility
- Salpingitis unrelated to infertility
- Torsion of the fallopian tube
- Abscess of the fallopian tube
- Peritubal adhesions unrelated to infertility
- Cyst or tumor of the fallopian tube unrelated to infertility
- Hematosalpinx

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5.8 Ovarian Wedge Resection

Ovarian wedge resection (procedure code 58920) is a benefit of Texas Medicaid.

5.8.1 Prior Authorization for Ovarian Wedge Resection

Prior Authorization is required for ovarian wedge resection.

The prior authorization request must include documentation of polycystic ovarian syndrome (PCOS).

Note: *Ovarian wedge resection will not be considered to improve chances of conceiving if the PCOS lead to infertility.*

5.9 Assays for the Diagnosis of Vaginitis

Vaginitis assay procedure codes 87480, 87510, 87660, 87661, 87797, and 87800 are benefits of Texas Medicaid.

If more than one of procedure code 87480, 87510, 87660, 87661, or 87800 is submitted by the same provider for the same client with the same date of service, all of the procedure codes are denied. Only one procedure code (87480, 87510, 87660, 87661, or 87800) may be submitted for reimbursement, and providers must submit the most appropriate procedure code for the test provided:

- *Single organism test.* A single test must be submitted for reimbursement using the appropriate procedure code (87480, 87510, 87660, or 87661) that describes the organism being isolated.
- *Multiple organism test.* When testing for multiple vaginal pathogens, providers must submit procedure code 87800 for reimbursement. Procedure code 87800 is inclusive of procedure codes 87480, 87510, 87660, and 87661 and is the most appropriate code to request reimbursement for multiple tests.

If the claim is denied because more than one procedure code was submitted with the same date of service, the provider must appeal the denied claim with a statement indicating which procedure code is most appropriate and should be considered for reimbursement. Procedure codes 87800, 87480, 87510, 87660, and 87661 should not be submitted for reimbursement by the same provider with the same date of service for the same client on the same claim form or on separate claim forms.

Providers are reminded to code to the highest level of specificity with a diagnosis to support medical necessity when submitting procedure code 87797.

Claims may be subject to retrospective review if they are submitted with diagnosis codes that do not support medical necessity.

If a positive test result was not treated, documentation must be present indicating why treatment was not rendered.

5.10 Hysteroscopy

Hysteroscopy (procedure codes 58555, 58558, 58559, 58560, 58561, 58562, 58563, and 58579) is a benefit of Texas Medicaid.

5.11 Abortions

According to a revision of the Hyde Amendment, under Public Law 103–112, HHSC implemented the federal directive pertaining to Medicaid reimbursement for abortions. Federal funding is available for a non-elective abortion to save the life of the mother and to terminate pregnancies resulting from rape or incest. Reimbursement is based on the physician's certification that the abortion was performed to save the mother's life, to terminate a pregnancy resulting from rape, or to terminate a pregnancy resulting from incest.

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The following procedure codes may be used to submit claims for non-elective abortion procedures:

Procedure Codes								
59830	59840	59841	59850	59851	59852	59855	59856	59857

In accordance with federal law, providers are required to use specific language regarding the reason the mother's condition is life-threatening. An abortion for a life-threatening condition *must* be due to a physical disorder, injury, or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would place the woman in danger of death unless an abortion was performed.

Reimbursement of an abortion is based on the physician's certification that the abortion was performed to save the life of the mother, to terminate pregnancy resulting from rape, or to terminate pregnancy resulting from incest.

One of the following statements signed by the physician is mandatory for any abortion performed. Substitute wording will not be accepted. One of these statements must accompany any claim for an abortion to be considered for reimbursement:

- "I, (physician's name), certify that on the basis of my professional judgment, an abortion procedure is necessary because (client's full name, Medicaid number, and complete address) suffers from a physical disorder, injury, or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place her in danger of death unless an abortion is performed." (A signature is required.)
- "I, (physician's name), certify that on the basis of my professional judgment, an abortion procedure for (client's full name, Medicaid number, and complete address) is necessary to terminate a pregnancy that was the result of rape. I have counseled the client concerning the availability of health and social support services and the importance of reporting the rape to the appropriate law enforcement authorities." (A signature is required.)
- "I, (physician's name), certify that on the basis of my professional judgment, an abortion procedure for (client's full name, Medicaid number, and complete address) is necessary to terminate a pregnancy that was the result of incest. I have counseled the client concerning the availability of health and social support services and the importance of reporting the incest to the appropriate law enforcement authorities." (A signature is required.)

Refer to: Abortion Certification Statements Form on the TMHP website at www.tmhp.com.

A stamped or typed physician signature is not acceptable on the original certification statement. The physician's signature must be an original signature. A copy of the signed certification statement must be submitted with each claim for reimbursement. Faxes and electronic billing are not acceptable or available at this time. The physician must maintain the original certification statement in the client's files.

Abortion services must be billed with modifier G7.

Performing physicians, facilities, anesthesiologists, and certified respiratory nurse anesthetist (CRNA) providers must submit modifier G7 with the appropriate procedure code when requesting reimbursement for abortion procedures that are within the scope of the rules and regulations of Texas Medicaid. Modifier G7 must be entered next to the procedure code that identifies the abortion services.

Important: *To bill a Texas Medicaid client for a service that TMHP denies as not medically necessary, the billing provider must ensure that the client or client's guardian has signed an acknowledgment statement obtained by the physician who has contact with the client.*

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5.11.1 Services Related to Abortion Procedures

An anesthesia service that is provided for an abortion procedure may be reimbursed if the abortion procedure meets medical necessity and complies with the Texas Medicaid guidelines in the section above.

All other services that are related to an abortion procedure are also subject to medical necessity review. Services that are related to a non-covered abortion procedure are denied or recouped.

5.12 Examination Under Anesthesia

Pelvic examination under anesthesia (procedure code 57410) is considered part of another gynecological surgery performed the same day.

If the examination is performed as an independent procedure or at the time of a nongynecological surgery, the procedure may be reimbursed.

5.13 Laminaria Insertion

Insertion of a laminaria or dilateria (procedure code 59200) is a benefit of Texas Medicaid.

5.14 Hysterectomy Services

Texas Medicaid reimburses hysterectomies when they are medically necessary. Texas Medicaid does not reimburse hysterectomies performed for the sole purpose of sterilization.

Providers can use any of the following procedure codes to submit claims for hysterectomy procedures:

Procedure Codes									
51925	58150	58152	58180	58200	58210	58240	58260	58262	58263
58267	58270	58275	58280	58285	58290	58291	58292	58293	58294
58541	58542	58543	58544	58548	58550	58552	58553	58554	58570
58571	58572	58573	59135	59525					
Providers can refer to the Texas Medicaid fee schedules on the TMHP website at www.tmhp.com for components and fees that may be reimbursed.									

5.14.1 Hysterectomy Acknowledgment

Hysterectomy services are considered for reimbursement when a signed Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form is faxed to TMHP, the claim is filed with a signed Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form, or documentation supporting that the Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form could not be obtained or was not necessary.

All Texas Medicaid clients (including those in a STAR or STAR+PLUS Program health plan) receiving hysterectomy services must sign a Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form. The acknowledgment must be submitted to TMHP with the claim or to the client's health plan.

The Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form must be signed and dated by the client. The statement must indicate that the client was informed both orally and in writing before the surgery that the hysterectomy would leave her permanently incapable of bearing children.

Note: *A client representative's signature will be required for mentally incompetent clients.*

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The client's eligibility file is updated upon receipt of the signed Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form. Claims for services related to the hysterectomy cannot be reimbursed unless the signed Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form is on file; therefore to avoid claim denials, each individual provider involved in the hysterectomy procedure is encouraged to submit a copy of the valid Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form rather than relying on another provider to do so.

The provider is responsible for maintaining the original, signed copy of the Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form in the client's medical record when a claim is submitted for consideration of payment. These records are subject to retrospective review.

When a hysterectomy, whether abdominal or vaginal, is performed without a client's acknowledgement form:

- The hysterectomy procedure code is denied.
- The other surgical procedures are evaluated for their clinical relevance.
- Multiple procedures are processed according to the multiple surgery guidelines.

A Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form is not required if the performing physician certifies that at least one of the following circumstances existed before the surgery:

- The patient was already sterile before the hysterectomy, and the cause of the sterility is stated (e.g., congenital disorder, sterilized previously, or postmenopausal). Providers must use a post menopause or sterilization diagnosis code on the claim form. If the provider submits a claim and does not attach the acknowledgment, the provider must maintain the signed statement in the client's records, and the physician's signature will not be required on the claim form. These records are subject to retrospective review.
- The patient requires a hysterectomy on an emergency basis because of a life-threatening situation. The physician must state the nature of the emergency and certify that it was determined that prior acknowledgment was not possible. Because the acknowledgment may be signed the day of or an hour before surgery, an emergency situation requires that the patient be unconscious or under sedation and unable to sign the acknowledgment.

Although the Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form is not required if the criteria previously listed are met, the performing physician must certify that one or more of the circumstances existed prior to the surgery. This certification may be submitted before the claim is submitted or attached to the claim and signed by the performing provider.

Refer to: Title 42 of CFR 441.255 and 25 TAC Part 1, Chapter 29, Subchapter F, section 25.501 for more information.

Refer to: Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information on the TMHP website at www.tmhp.com.

For clients with retroactive Medicaid coverage, one of the following must be submitted with the Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form:

- A copy of the client's Your Texas Benefits Medicaid Card, which covers the date of the hysterectomy.
- A copy of the retroactive approval notice for Medicaid coverage.

Faxing Forms

All Medicaid providers may fax the Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form to 1-512-514-4218. The form must include the client's Texas Medicaid number. All consent forms should be faxed with a cover sheet that identifies the provider and includes the telephone number and address. If the fax is incomplete or the consent form is invalid, the form is returned by mail

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or fax for correction. Completed consent forms that are faxed for adjustments or appeals are validated in the TMHP system. However, claims associated with the consent forms must be appealed through the mail to Appeals/Adjustments at the following address:

Texas Medicaid & Healthcare Partnership
Attn: Appeals/Adjustments
PO Box 200645
Austin, TX 78720-0645

5.15 Pap Smear (Cytopathology Studies)

Pap smears are benefits of Texas Medicaid for early detection of cancer. Family planning clients are eligible for annual Pap smears. Procurement and handling of the Pap smear are considered part of the E/M of the client and are not reimbursed separately.

The following procedure codes are reimbursed only to pathologists and CLIA-certified laboratories (whose directors providing technical supervision of cytopathology services are pathologists):

Procedure Codes									
88142	88143	88147	88148	88150	88152	88153	88154	88155	88164
88165	88166	88167	88174	88175					

These procedure codes must be billed with the place of service where the Pap smear is interpreted.

Procedure code 88141 is reimbursed in addition to and when billed with the cytopathology procedure codes in the table above.

Procedure code 88155 will only be reimbursed when billed in conjunction with one of the following procedure codes on the same date of service by the same provider:

Procedure Codes									
88142	88143	88147	88148	88150	88152	88153	88154	88164	88165
88166	88167	88174	88175						

Note: *Pap smear procedures will not be reimbursed separately to either the physician or a laboratory when billed on the same day as a THSteps medical check-up visit.*

5.16 Clitoroplasty and Vaginoplasty

Clitoroplasty and vaginoplasty are performed for clients who possess ovaries and are female by genetic sex, but the external genitalia are not those of a normal female. Surgical correction of abnormalities of the external genitalia is the only indicated treatment for this disorder. Clitoroplasty and vaginoplasty procedure codes 56805 and 57335 may be considered for reimbursement for female clients who are 20 years of age and younger when submitted for reimbursement with one of the following diagnosis codes:

Diagnosis Codes							
E250	E258	E259	E271	E272	E2740	E2749	E3450
E3451	E3452	Q560	Q561	Q562	Q563	Q564	

5.17 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including gynecological services.

Gynecological health services are subject to retrospective review and recoupment if documentation does not support the service billed.

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5.18 Claims Filing and Reimbursement

Gynecological services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms. When completing a CMS-1500 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: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Subsection 6.1, "Claims Information" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

Texas Medicaid rates for physicians and other practitioners are calculated in accordance with TAC §355.8085. Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Refer to: Subsection 2.2.1.1, "Non-emergent and Non-urgent Evaluation and Management (E/M) Emergency Department Visits" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

Section 104 of the *Tax Equity and Fiscal Responsibility Act* (TEFRA) of 1982 requires that Medicare and Medicaid limit reimbursement for those physician services furnished in outpatient hospital settings (e.g., clinics and emergency situations) that are ordinarily furnished in physician offices.

5.18.1 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manual. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

5.19 National Drug Code

Refer to: Subsection 6.3.4, "National Drug Code (NDC)" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

6 Claims Resources

Resource	Location
Appendix D: Acronym Dictionary	Appendix F (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	"Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5 (*Vol. 1, General Information*)
2017 Claim Form	Subsection 6.8 (*Vol. 1, General Information*)
2017 Claim Form Instructions	Subsection 6.8.1 (*Vol. 1, General Information*)
Appendix A: State, Federal, and TMHP Contact Information	Appendix A (*Vol. 1, General Information*)

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Resource	Location
TMHP Electronic Claims Submission	Subsection 6.2 (*Vol. 1, General Information*)
Section 3: TMHP Electronic Data Interchange (EDI)	Section 3 (*Vol. 1, General Information*)
UB-04 CMS-1450 Claim Form (Paper) Billing	Subsection 6.6.3 (*Vol. 1, General Information*)
UB-04 CMS-1450 Paper Claim Filing Instructions	Subsection 6.6 (*Vol. 1, General Information*)

7 Contact TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday – Friday from 7 a.m. to 7 p.m., Central Time.

8 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Sterilization Consent Form Instructions
Sterilization Consent Form (English)
Sterilization Consent Form (Spanish)
Abortion Certification Statements Form
Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information
2017 Claim Form
Texas Women's Health Program Certification

9 Claim Form Examples

The following linked claim form examples can also be found on the Claim Form Examples page of the Provider section of the TMHP website at www.tmhp.com:

Claim Form Examples
Family Planning Claim Form
Nurse Practitioner/Clinical Nurse Specialist (Family Planning)

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Inpatient and Outpatient Hospital Services Handbook

Texas Medicaid Provider Procedures Manual: Vol. 2

April 2016

INPATIENT AND OUTPATIENT HOSPITAL SERVICES HANDBOOK

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1 General Information

The information in this handbook is intended for Texas Medicaid hospital (medical and surgical acute care facility) providers and covers services that take place only in an inpatient or outpatient hospital setting. The handbook provides information about Texas Medicaid's benefits, policies, and procedures applicable to acute care hospitals, including military hospitals.

Important: *All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: *Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks)*, for information about services offered in settings such as rural health clinics (RHCs), Federally Qualified Health Centers (FQHCs), dialysis centers, and other similar facilities.

1.1 National Drug Codes (NDC)

Refer to: Subsection 6.3.4, "National Drug Code (NDC)," in Section 6, "Claims Filing" (*Vol. 1, General Information*).

1.2 Medicaid Managed Care Services

This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, refer to the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in Section 8, "Carve-Out Services" in the *Medicaid Managed Care Handbook*, *(Vol. 2, Provider Handbooks)*.

2 Enrollment

To be eligible to participate in Texas Medicaid, a hospital must be certified by Medicare, have a valid provider agreement with the Health and Human Services Commission (HHSC), and have completed the Texas Medicaid & Healthcare Partnership (TMHP) enrollment process.

2.1 Hospital Eligibility Through Change of Ownership

Under procedures set forth by the Centers for Medicare & Medicaid Services (CMS) and the U.S. Department of Health and Human Services (HHS), a change in ownership of a hospital does not terminate Medicare eligibility; therefore, Medicaid participation may be continued subject to the following requirements:

- The provider must obtain recertification as a Title XVIII (Medicare) hospital.
- The hospital under new ownership must submit a new signed and dated HHSC Medicaid Provider Agreement between the hospital and HHSC.

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Providers can download the HHSC Medicaid Provider Agreement from the TMHP website at www.tmhp.com.

Refer to: Subsection 1.4, "Provider Reenrollment," in Section 1, "Provider Enrollment and Responsibilities" *(Vol. 1, General Information).*

2.1.1 Hospital-based Ambulatory Surgical Center (HASC) Enrollment

All hospitals enrolling in Texas Medicaid (except psychiatric and rehabilitation hospitals) are issued an HASC provider number at the time of enrollment.

2.2 Hospital-based Rural Health Clinic Enrollment

To enroll in Texas Medicaid and qualify for participation as a Title XIX RHC, RHCs must be enrolled in Medicare. A nine-digit provider identifier is issued to the RHC after a certification letter from Medicare is received, stating that the clinic qualifies for Medicaid participation. An RHC can also apply for enrollment as a family planning agency.

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers who do not comply with CLIA are not reimbursed for laboratory services.

Refer to: Subsection 8.2, "Services, Benefits, Limitations, and Prior Authorization," in the *Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks)* for RHC benefit and limitation information.

Subsection 1.1, "Provider Enrollment and Reenrollment," in Section 1, "Provider Enrollment and Responsibilities" *(Vol. 1, General Information)* for more information about enrollment procedures, including information on Changes of Ownership.

Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)," in *Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks).*

3 Inpatient Hospital (Medical/Surgical Acute Care Inpatient Facility)

This section contains benefit, limitation, authorization, and claims filing information for inpatient hospital facility accommodation and ancillary services.

Refer to: Section 6: Claims Filing and Section 7: Appeals *(Vol. 1, General Information)* for more comprehensive information about claims filing and appeals.

Hospital providers are encouraged to review the other handbooks for applicable information, prior authorization requirements, and for specific requirements for special programs.

3.1 General Information

Inpatient hospital services include medically necessary items and services ordinarily furnished by a Texas Medicaid hospital or by an approved out-of-state hospital under the direction of a physician for the care and treatment of patients. Services must be medically necessary and are subject to Texas Medicaid's utilization review requirements. Claims submitted to TMHP must comply with the applicable Texas Medicaid policies and procedures.

3.1.1 Reimbursement Limitations

For clients who are 21 years of age and older, Texas Medicaid reimbursement for acute care inpatient hospital services is limited to $200,000 per client, per benefit year (November 1 through October 31). Claims are reviewed retrospectively, and payments that exceed $200,000 are recouped.

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This $200,000 limitation does not apply to the following:

- Services related to certain organ transplants.
- Services rendered to Texas Health Steps (THSteps) clients when provided through the Comprehensive Care Program (CCP).

For clients who are 20 years of age and younger, dollar limitations do not apply.

3.1.2 Spell of Illness

Reimbursement to hospitals for inpatient services is limited to the Medicaid spell of illness. The spell of illness is defined as 30 days of inpatient hospital care, which may accrue intermittently or consecutively.

After 30 days of inpatient care is provided, reimbursement for additional inpatient care is not considered until the client has been out of an acute care facility for 60 consecutive days.

Exceptions to the spell of illness are as follows:

- A prior-approved solid organ transplant. The 30-day spell of illness for transplants begins on the date of the transplant, allowing additional time for the inpatient stay.
- THSteps-eligible clients who are 20 years of age and younger when a medically necessary condition exists.

Texas Medicaid will conduct a quarterly utilization review of inpatient claims to determine whether the claims were paid outside of the spell-of-illness limitation.

The first of these utilization reviews were for claims with dates of service from April 27, 2010, through January 6, 2012.

3.1.3 Take-Home Drugs, Self-Administered Drug, or Personal Comfort Items

Take-home drugs and comfort items that are provided by the hospital during an inpatient hospital stay are included in the hospital reimbursement and are not reimbursed separately.

Take-home drugs and supplies may be a benefit through the Vendor Drug Program (VDP) when supplied by prescription.

Self-administered drugs are defined as drugs that the client administers themselves at home and may include, but are not limited to, prescription drugs, vitamins, and supplements. Self-administered drugs provided by the hospital during an inpatient hospital stay are included in the hospital reimbursement and are not reimbursed separately.

The client cannot be billed for take home drugs, comfort supplies or self-administered drugs that are provided by the hospital during an inpatient hospital stay.

3.1.4 Services Included in the Inpatient Stay

The following services are included in the inpatient stay and are not separately reimbursed:

- *Whole blood and packed red blood cells.* Inpatient services include whole blood and packed red blood cells that are reasonable and necessary for treatment of illness or injury. Whole blood and packed red blood cells that are available without cost are not reimbursed by Texas Medicaid.

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- *Laboratory, radiology, and pathology services.* Inpatient services include all medically necessary services and supplies ordered by a physician to include laboratory, radiology, and pathology services.

  Note: *Ultrasound interpretations in the inpatient hospital setting will be denied if they are billed by the attending physician. Services that are billed by the attending physician are included in the facility fee and are not reimbursed separately.*

  Note: *All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers not complying with CLIA will not be reimbursed for laboratory services.*

Refer to: Subsection 1.1, "Provider Enrollment and Reenrollment,"in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment procedures.

Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)," in *Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks)* for more information about CLIA.

The *Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks)*.

3.2 Services, Benefits, Limitations, and Prior Authorization - Acute Care

Inpatient hospital services include the following:

- Bed and board
- Whole blood and packed red blood cells
- All medically necessary services ordered by a physician to include laboratory, radiology, and pathology
- All medically necessary supplies ordered by a physician
- Medically necessary emergency and non-emergency ambulance transports during the inpatient stay
- Maternity care
- Newborn care
- Inpatient surgery and rehabilitation
- Organ and tissue transplant services
- Colorectal cancer screening services

3.2.1 Bed and Board

Inpatient bed and board include semiprivate accommodations or accommodations in an intensive care or coronary care unit. The accommodations include:

- Meals
- Special diets
- General nursing services

Private accommodations including meals, special diets, and general nursing services may be reimbursed up to the hospital's charge for its most prevalent semiprivate accommodations. Bed and board in private accommodations may be reimbursed in full if required for medical reasons as certified by the physician. The hospital must document the medical necessity for a private room (i.e., the existence of a critical or

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contagious illness, a condition that could result in disturbance to other patients). The medical necessity for the private accommodations must be included in Block 80 of the UB-04 CMS-1450 paper claim form or added as an attachment to the claim submission.

3.2.2 Hysterectomy Services

Hysterectomy services are considered for reimbursement when the claim is filed with a signed Hysterectomy Acknowledgment Form or submitted documentation indicates that the Hysterectomy Acknowledgment Form could not be obtained.

Claims for services related to the hysterectomy cannot be reimbursed unless the signed Hysterectomy Acknowledgement Form is on file; consequently, to avoid claim denials, each individual provider is encouraged to submit a copy of the valid Hysterectomy Acknowledgement Form and not rely on another provider to do so.

Refer to: Subsection 5.14.1, "Hysterectomy Acknowledgment," in *Gynecological and Reproductive Health and Family Planning Services Handbook (Vol. 2, Provider Handbooks)* for additional information.

Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information on the TMHP website at www.tmhp.com.

3.2.3 Maternity Care

Inpatient maternity care includes usual and customary care for all female clients.

3.2.3.1 Emergency Coverage

For women with a family income at or below 185 percent of the Federal Poverty Level (FPL), hospital facility charges are paid through Emergency Medicaid. A client must be determined eligible for Emergency Medicaid by HHSC for a claim to be paid to a Medicaid provider. Claims are sent to Texas Medicaid & Healthcare Partnership (TMHP) for processing.

3.2.3.2 Mother and Newborn Hospital Stay

Circumstances that require the mother and newborn to remain in the hospital longer than two days for a routine vaginal delivery or four days for a cesarean section must be documented in the clients' medical records.

Continuation of hospitalization is a benefit for the infant when the mother is required to remain hospitalized for medical reasons. The reason for the continuation of hospitalization must be documented in the client's medical record.

3.2.3.3 Children's Health Insurance Program (CHIP) Perinatal Coverage

For clients who are eligible for CHIP perinatal services as determined by HHSC, CHIP perinatal services include newborn services and inpatient hospital charges related to the delivery of the newborn. Preterm or false labor that does not result in a birth are not CHIP perinatal services.

Inpatient services limited to labor with delivery for women with income between 186 and 200 percent of FPL will be covered under CHIP perinatal. Newborn services will also be covered under CHIP perinatal.

For CHIP perinatal newborns with a family income at or below 185 percent of the federal poverty level, TMHP will process newborn transfer hospital claims even if the claim from the initial hospital stay has not been received. The hospital transfer must have occurred within 24 hours of the discharge date from the initial delivery hospital stay.

Transfer claims must be filed to TMHP using the admission type 1, 2, 3, or 5 in block 14; source of admission code 4 or 6 in block 15; and the actual date and time the client was admitted in block 12 of the UB-04 CMS-1450 paper claim form.

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Refer to: Subsection 6.19.1, "CHIP Perinatal Newborn Transfer Hospital Claims," in Section 6, "Claims Filing" (*Vol. 1, General Information*).

3.2.4 Newborn Care

Newborn care includes routine newborn care, routine screenings, and specialized nursery care for newborns with specific problems.

Hospital providers must provide all state-mandated newborn screenings and vaccinations.

Refer to: Subsection 5.3.11.2.3, "Hearing Screening," in the *Children's Services Handbook (Vol 2. Provider Handbooks).*

Subsection 5.3.9, "Newborn Examination," in the *Children's Services Handbook (Vol. 2, Provider Handbooks).*

3.2.4.1 Newborn Eligibility

A child is deemed eligible for Texas Medicaid through 12 months of age if the mother is receiving Medicaid at the time of the child's birth, the child continues to live with the mother, and the mother continues to be eligible for Medicaid or would be eligible for Medicaid if she were pregnant. Therefore, it is not acceptable for a hospital to require a deposit for newborn care from a Medicaid client. The child's eligibility ends if the mother relinquishes her parental rights or if it is determined that the child is no longer part of the mother's household.

Hospitals must complete Hospital Report (Newborn Child or Children) (Form 7484) on the TMHP website at www.tmhp.com to provide information about each child born to a mother who is eligible for Medicaid. If the newborn's name is known, the name must be on the form.

Important: *If the newborn's name is not known, the name may be left blank. The use of "Baby Boy" or "Baby Girl" delays the assignment of a number.*

The form must be completed by the hospital no later than five days after the child's birth and sent to HHSC at the address identified on the form. The form should not be completed for stillbirths. Hospitals should duplicate the form as needed, because they are not supplied by HHSC, the Department of Aging and Disability Services (DADS), or TMHP.

Hospitals that submit the birth certificate information using the Department of State Health Services (DSHS), Vital Statistics Unit (VSU) Texas Electronic Registrar for Birth software and the HHSC Form 7484, receive a rapid and efficient assignment of a newborn Medicaid identification number. This process expedites reimbursement to hospitals and other providers involved in newborn care including pharmacies that provide outpatient prescription benefits for medically-needy newborns.

For additional information about obtaining a newborn Medicaid identification number, providers may call 1-888-963-7111, Ext. 7368 or 1-512-458-7368.

After receiving a completed form, HHSC verifies the mother's eligibility. Within 10 days of receiving the completed form, HHSC sends notices to the hospital, mother, caseworker, and attending physician, if identified. The notice includes the child's Medicaid client number and the effective date of coverage. After the child has been added to the eligibility file, HHSC issues a Medicaid Identification (Form H3087).

Claims submitted for services provided to a newborn child who is eligible for Medicaid must be filed using the newborn child's Medicaid client number.

Newborns who are from families with an income at or below 185 percent of the FPL and who receive CHIP perinatal benefits are assigned a client number for Texas Medicaid. This number is only assigned for reimbursement of the newborn's hospital facility charges (on a UB-04 CMS-1450 paper claim form) for the initial hospital stay after delivery. Claims for the newborn's hospital facility charges should be sent to TMHP.

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3.2.5 Organ and Tissue Transplant Services

3.2.5.1 Transplant Facilities

A facility that renders organ transplants must be a designated children's hospital or a facility in continuous compliance with the criteria set forth by the following:

- Organ Procurement and Transportation Network (OPTN)
- United Network for Organ Sharing (UNOS)
- National Marrow Donor Program (NMDP)

Facilities whose status of "good standing" has been suspended for any reason by the national credentialing bodies will not be reimbursed by Texas Medicaid for transplant services until the status of "good standing" is restored.

If a Medicaid client receives a transplant in an in-state or out-of-state facility that is not approved by Texas Medicaid, the client must be discharged from the facility to be considered to receive other medical and hospital benefits under Texas Medicaid. Coverage for other services needed as a result of complications of the transplant may be considered when medically necessary, reasonable, and federally allowable.

Texas Medicaid will not pay for routine post-transplant services for transplant patients in facilities that are not approved by Texas Medicaid.

3.2.5.1.1 Out-of-state Transplant Facilities

Out-of-state facilities may be reimbursed for transplants rendered to Texas Medicaid clients under certain conditions. In order for Texas Medicaid to reimburse for an out-of-state transplant, the out-of-state facility and professional providers must enroll as Texas Medicaid providers. The out-of state transplant facilities must submit proof of transplant facility UNOS or NMDP certification as required by the Texas HHSC.

Physicians who are licensed by the state of Texas may request prior authorization for transplant services to be performed at out-of-state facilities when all of the following criteria are met:

- The required organ transplant is not available in Texas
- The facility is nationally recognized as a Center of Excellence
- The services are medically necessary, reasonable, and federally allowable
- The client is enrolled in Texas Medicaid

The pretransplant evaluation must be performed by a Texas facility. If it is medically necessary that the pretransplant evaluation be performed at the out-of-state facility as well, the prior authorization request for the out-of-state pretransplant evaluation must be submitted with a copy of the evaluation that was performed by the Texas facility. The documentation must support the need for an out-of-state pretransplant evaluation.

Important: *Texas Medicaid does not cover transplant services provided out-of-state that are available in Texas.*

3.2.5.2 Transplant Benefits and Limitations

If a transplant has been authorized as medically necessary by HHSC or its designee because of an emergent, life-threatening situation, a maximum of 30 days of inpatient hospital services during Title XIX spell of illness may be a benefit, beginning with the actual first day of the transplant. This benefit is in addition to covered inpatient hospital days provided before the actual first day of the transplant. This 30-day period is considered a separate inpatient hospital admission for reimbursement purposes, but is included under one hospital stay.

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Refer to: Subsection 3.1.2, "Spell of Illness," in this handbook for additional information about the 30-day spell of illness period.

Reimbursement for transplant is limited to an initial transplant as a lifetime benefit and one subsequent re-transplant because of rejection. Expenses incurred by a living donor will not be reimbursed.

All transplants require prior authorization. If a solid organ transplant is not prior authorized, services that are directly related to the transplant within the three-day pre-operative and six-week postoperative period will be denied, regardless of who provides the services. Services unrelated to the transplant surgery will be paid separately.

If the organ is rejected, the re-transplant requires its own prior authorization. If the re-transplant is not prior authorized, services that are directly related to the re-transplant within the three-day pre-operative and six-week postoperative period will be denied, regardless of who provides the services. Services unrelated to the re-transplant surgery will be paid separately.

Note: *The re-transplant is not included in the prior authorization for the initial transplant. The subsequent re-transplant must be prior authorized separately.*

Refer to: Subsection 9.2.49, "Organ/Tissue Transplants," in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)*.

3.2.5.3 Prior Authorization for Organ and Transplant Services

All solid organ transplant services provided by facilities and professionals must be prior authorized. If a solid organ transplant is not prior authorized, services directly related to the transplant within the three day pre-operative and six-week postoperative period also will be denied, regardless of who provides the service, (e.g., laboratory services, status-post visits, and radiology services). Services unrelated to the transplant surgery will be paid separately.

A transplant request signed by a physician associated with transplant facilities is considered for prior authorization after the client has been evaluated and meets the guidelines of the institution's transplant protocol.

Refer to: Subsection 9.2.49, "Organ/Tissue Transplants," in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)*.

3.2.5.4 Transplants for Medicare-Eligible Clients

Transplants are also a benefit under the Medicare program; therefore, for clients eligible for Medicare and Medicaid, Texas Medicaid will pay only the deductible or coinsurance portion as applicable according to current payment guidelines. Prior authorization must be obtained for Medicaid-only clients; authorization will not be given for Medicare/Medicaid-eligible clients. Texas Medicaid will not pay for a transplant service denied by Medicare for a Medicare-eligible client.

3.2.5.5 Experimental or Investigational Services

Benefits are not available for any experimental or investigational services (including xenotransplantation and artificial/bioartificial liver transplants), supplies, or procedures.

3.2.5.6 Reimbursement for Transplant Services

The hospital diagnosis related group (DRG) payment for the transplant includes procurement of the organ and services associated with the organ procurement. The Omnibus Budget Reconciliation Act of 1986 (OBRA 86) Public Law 99-509 added Section 1138 of the Social Security Act, which defines conditions of participation for institutions in the organ procurement program. Organ procurement costs are not reimbursed to a hospital that fails to meet the conditions of participation. The specific guidelines may be found in the appropriate areas of the Code of Federal Regulations (CFR) Title 42, Parts 405, 413, 441, 482, and 485. Documentation of organ procurement must be maintained in the hospital's medical record.

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Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology," in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" *(Vol. 1, General Information)* for more information about reimbursement.

3.2.5.7 Nonsolid Organ Transplants

Under current Texas Medicaid policy, procedures are considered to be medically necessary and reasonable based on safety and efficacy, as demonstrated by scientific evidence and controlled by clinical studies.

Nonsolid organ transplants that are benefits of Texas Medicaid include:

- Allogeneic and autologous stem cell transplantation
- Allogeneic and autologous bone marrow transplantation
- Autologous islet cell transplantation

All nonsolid organ transplants require prior authorization and 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 Transportation Network (OPTN), the United Network for Organ Sharing (UNOS), or the National Marrow Donor Program (NMDP).

Experimental or investigational services, supplies, or procedures are not a benefit of Texas Medicaid.

3.2.5.7.1 Inpatient Hospitalization

For a nonsolid organ transplant that has been prior authorized for clients who are 21 years of age and older, a maximum of 30 days of inpatient hospital services during a Title XIX spell of illness is covered beginning with the actual first day of the transplant. This coverage is in addition to covered inpatient hospital days provided before the actual first day of the transplant. This 30-day period is considered a separate inpatient hospital admission for reimbursement purposes but is included under one DRG payment.

Autologous harvesting of stem cells (single or multiple sessions) are reimbursed to the facility when prior authorized by HHSC or its designee and performed in the outpatient facility setting. Harvesting of stem cells performed in a hospital inpatient setting is included in the DRG and is not reimbursed separately.

Refer to: Subsection 9.2.49.9, "Nonsolid Organ Transplants," in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*)

3.3 Services, Benefits, Limitations, and Prior Authorization - Inpatient Rehabilitation Services

Inpatient rehabilitation services are a benefit of Texas Medicaid when provided as part of a general acute care inpatient admission, or with prior authorization for clients who are 20 years of age and younger in a freestanding rehabilitation facility.

Inpatient rehabilitation services in an acute care setting are included in the hospital DRG payment. All rehabilitation services are subject to Medicaid benefit limitations including the spell of illness. Exceptions to those limitations may be offered under CCP.

Refer to: Section 4, "Therapists, Independent Practitioners, and Physicians" in the *Nursing and Therapy Services Handbook (Vol. 2, Provider Handbooks)*.

Subsection 2.16, "Inpatient Rehabilitation Facility (Freestanding) (CCP)," in the *Children's Services Handbook (Vol. 2, Provider Handbooks)*.

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3.4 Services, Benefits, Limitations, and Prior Authorization - Inpatient Psychiatric Services

3.4.1 Enrollment

Acute care hospitals and state psychiatric facilities must be certified by Medicare, have a valid provider agreement with the HHSC, and have completed the TMHP enrollment process.

Refer to: Subsection 5.1, "Enrollment," for more information about acute care hospital enrollment.

Freestanding psychiatric facilities must be licensed by DSHS or by the appropriate state board where services are rendered. The provider must be approved by The Joint Commission (TJC).

Providers cannot be enrolled if their licenses are due to expire within 30 days.

To be eligible to participate in the Comprehensive Care Inpatient Psychiatric (CCIP) Program to render services to Texas Health Steps (THSteps) clients, a freestanding or state psychiatric facility must be accredited by TJC, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process. Facilities certified by Medicare must also meet TJC accreditation requirements.

Note: *Acute care hospitals cannot enroll as CCIP facilities.*

3.4.2 General Information

Inpatient admissions to acute care hospitals, freestanding psychiatric facilities, and state psychiatric facilities for psychiatric conditions may be a benefit of Texas Medicaid as outlined in the following table:

Hospital Type	CCIP Clients 0-20 Years of Age	Medicaid Clients of Any Age
Acute care hospital	No	Yes
Freestanding psychiatric facility (IMD)	Yes	Yes (clients 65 years of age and older) No (clients 21 through 64 years of age)
State psychiatric facility (IMD)	Yes	Yes (clients 65 years of age and older) No (clients 21 through 64 years of age)
(IMD) Institution for Mental Diseases.		

When a client requires admission, or once the client becomes Medicaid eligible while in the facility, a certification of need must be completed and placed in the client's record within 14 days of the admission.

Inpatient psychiatric treatment is a benefit of Texas Medicaid if all of the following are met:

- The client has a psychiatric condition that requires inpatient treatment.
- The inpatient treatment is directed by a psychiatrist.
- The inpatient treatment is provided in a nationally accredited facility or hospital.
- The provider is enrolled in Texas Medicaid.

Client services must be provided in the most appropriate setting and in a timely manner to meet the mental health needs of the client.

Inpatient admissions to acute care hospitals, freestanding, and state psychiatric facilities are subject to the Texas Medicaid retrospective utilization review (UR) requirements. The UR requirements are applicable, regardless of the hospital's designation as a psychiatric unit versus a medical or surgical unit.

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3.4.2.1 Professional Services Rendered in the Inpatient Setting

Services rendered in the inpatient hospital setting may be reimbursed to the professional that provides the service.

Refer to: Subsection 6.16, "Psychiatric Services for Hospitals," in the *Behavioral Health, Rehabilitation, and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*) for benefit and limitation information about services that are rendered by psychiatrists, psychologists, LPAs, APNs, and PAs in the inpatient setting.

3.4.2.2 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including all hospital services. Hospital services are subject to retrospective review and recoupment if documentation does not support the service that was submitted for reimbursement.

Documentation of medical necessity for inpatient psychiatric care must specifically address the following issues:

- Why the ambulatory care resources in the community cannot meet the treatment needs of the client.
- Why inpatient psychiatric treatment under the care of a psychiatrist is required to treat the acute episode of the client.
- How the services can reasonably be expected to improve the condition or prevent further regression of the client's condition in a proximate time period.

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 readily available for review whenever requested by the HHSC or its designee.

Psychological or neuropsychological testing, when performed in an acute care hospital or in a freestanding or state psychiatric facility does not require prior authorization; however, these facilities must maintain documentation that supports medical necessity for the testing and the testing results of any psychological or neuropsychological testing services performed while the client is an inpatient.

3.4.2.3 Noncovered Services

Inpatient admissions including, but not limited to, the following are not benefits of Texas Medicaid without an accompanying medical complication or condition:

- Single diagnosis of chemical dependency or abuse (such as alcohol, opioids, barbiturates, and amphetamines).
- Chronic diagnoses (such as mental retardation, organic brain syndrome, or chemical dependency or abuse).

3.4.2.4 CLIA Certification for Laboratory Services

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Providers that do not comply with CLIA are not reimbursed for laboratory services.

Texas Medicaid follows the Medicare categorization of tests for CLIA certificate-holders.

Refer to: The CMS website at www.cms.gov/CLIA/10_Categorization_of_Tests.asp for information about procedure code and modifier QW requirements.

3.4.3 Acute Care Hospital Psychiatric Services

Acute care hospital psychiatric services are those services that are rendered to Texas Medicaid clients of any age who are admitted as an inpatient to an acute care hospital for treatment of a psychiatric condition.

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Admissions to acute care hospitals must be medically necessary.

Refer to: Subsection 3.2, "Services, Benefits, Limitations, and Prior Authorization - Acute Care," in this handbook for additional information about acute care benefits and limitations.

3.4.3.1 Prior Authorization Requirements

Prior authorization is not required for fee-for-service clients admitted to psychiatric units in acute care hospitals.

3.4.4 Freestanding and State Psychiatric Facilities

Psychiatric facility services are those services that are rendered in an Institutions for Mental Diseases (IMD). Freestanding and state psychiatric facilities are enrolled in Texas Medicaid as IMDs. According to TAC Rule §419.453 and based on 42 CFR §435.1009, an IMD is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of individuals with mental illness, including medical attention, nursing care, and related services.

3.4.4.1 CCIP Services

Inpatient psychiatric treatment in a nationally accredited freestanding psychiatric facility or a nationally-accredited state psychiatric hospital is a benefit of Texas Medicaid for clients who are 20 years of age and younger, and who are eligible for THSteps benefits at the time of the service request and service delivery.

Admissions to freestanding and state psychiatric facilities must be medically necessary, unless they are court-ordered services for mental health commitments or they are a condition of probation.

Revenue code 124 must be used for inpatient psychiatric services that are rendered to children and adolescents in freestanding and state psychiatric facilities.

Note: *Outpatient services for hospital-based psychiatric day treatment programs or psychiatric facilities are not a benefit of Texas Medicaid.*

3.4.4.1.1 Prior Authorization Requirements for Children and Adolescents

Prior authorization is required under CCIP for admission to freestanding psychiatric facilities or state psychiatric hospitals for clients who are birth through 20 years of age.

A toll-free telephone and fax line are available to complete the authorization process. Contact the TMHP CCIP Unit at (800) 213-8877 or fax to 1-512-514-4211.

Authorization procedures and approved providers may be different for managed care clients. Contact the client's specific health care plan for details.

To facilitate a determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including accurate documentation of medical necessity for the services requested.

Initial admissions may be prior authorized for a maximum of five days based on Medicaid eligibility and documentation of medical necessity.

The prior authorization requests will be reviewed as follows:

- All psychiatric admission requests for clients who are 11 years of age and younger will be reviewed by a psychiatrist.
- Psychiatric admission requests for clients who are 12 through 20 years of age will be reviewed by a mental health professional. Any requests for psychiatric admissions that do not meet the criteria for admission will be referred to a psychiatrist for final determination.

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- A completed Psychiatric Inpatient Initial Admission Request Form or Psychiatric Inpatient Extended Stay Request Form prescribing the inpatient psychiatric services must be signed and dated by the admitting physician familiar with the client prior to requesting authorization. All signatures must be current, unaltered, original, and handwritten. Computerized or stamped signatures will not be accepted. The completed Psychiatric Inpatient Initial Admission Request Form or Psychiatric Inpatient Extended Stay Request Form must be maintained by the requesting provider and the prescribing physician. The original signature copy must be kept in the hospital's medical record for the client.
- For initial inpatient admissions to freestanding and state psychiatric facilities, the completed Psychiatric Inpatient Initial Admission Request Form must be faxed no later than the date of the client's admission unless the admission is after 5 p.m., on a holiday or a weekend. When the admission occurs after 5 p.m., on a holiday or a weekend, the CCIP unit must receive the faxed request on the next business day following admission. If the admission occurs after 2 p.m., the provider must contact the CCIP unit by telephone and fax the Psychiatric Inpatient Initial Admission Request Form to the CCIP unit on the following business day.
- To complete the prior authorization process, the provider must fax the completed Psychiatric Inpatient Admission Form to the TMHP CCIP prior authorization unit.
- Providers must submit a Psychiatric Inpatient Extended Stay Request Form to the TMHP CCIP unit requesting prior authorization for a continuation of stay. Requests for a continuation of stay must be received on or before the last day authorized or denied. The CCIP unit will notify the provider of the decision in writing by fax. If the date of the CCIP unit determination letter is on or after the last day authorized or denied, the request for continuation of stay is due by 5 p.m. of the next business day.
- The Psychiatric Inpatient Extended Stay Request Form must reflect the need for continued stay in relation to the original need for admission. Any change in the client's diagnosis must be noted on the request. Additional documentation or information supporting the need for continued stay may be attached to the form. Up to seven days may be authorized for an extension request.

Medicaid Clinical Criteria for the Initial Inpatient Psychiatric Stay

The client must have a valid AXIS I, diagnosis as listed in the current version of the DSM as the principal admitting diagnosis and one of the following:

- Outpatient therapy or partial hospitalization has been attempted and failed
- A psychiatrist has documented reasons why an inpatient level of care is required.
- The client's Axis II diagnosis must also be included on the request for inpatient psychiatric treatment.
- The client must meet at least one of the following criteria:
    - The client is presently a danger to self, demonstrated by at least one of the following:
        - Recent suicide attempt or active suicidal threats with a deadly plan, and there is an absence of appropriate supervision or structure to prevent suicide.
        - Recent self-mutilative behavior or active threats of same with likelihood of acting on the threat, and there is an absence of appropriate supervision or structure to prevent self-mutilation (i.e., intentionally cutting/burning self).
        - Active hallucinations or delusions directing or likely to lead to serious self-harm or debilitating psychomotor agitation or retardation resulting in a significant inability to care for self.
- Significant inability to comply with prescribed medical health regimens due to concurrent Axis I psychiatric illness and such failure to comply is potentially hazardous to the life of the client. The medical (AXIS III) diagnosis must be treatable in a psychiatric setting.

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- The client is a danger to others. This behavior must be attributable to the client's specific AXIS I diagnosis as listed in the current version of the DSM, and can be adequately treated only in a hospital setting.

  This danger is demonstrated by one of the following:

  - Recent life-threatening action or active homicidal threats of same with a deadly plan, availability of means to accomplish the plan, and with likelihood of acting on the threat.
  - Recent serious assaultive or sadistic behavior or active threats of same with likelihood of acting on the threat, and there is an absence of appropriate supervision or structure to prevent assaultive behavior.
  - Active hallucinations or delusions directing or likely to lead to serious harm of others.
- The client exhibits acute onset of psychosis or severe thought disorganization, or there is significant clinical deterioration in the condition of someone with a chronic psychosis, rendering the client unmanageable and unable to cooperate in treatment, and the client is in need of assessment and treatment in a safe and therapeutic setting.
- The client has a severe eating or substance abuse disorder that requires 24-hour-a-day medical observation, supervision, and intervention.
- The client exhibits severe disorientation to person, place, or time.
- The client's evaluation and treatment cannot be carried out safely or effectively in other settings due to severely disruptive behaviors and other behaviors, which may also include physical, psychological, or sexual abuse.
- The client requires medication therapy or complex diagnostic evaluation where the client's level of functioning precludes cooperation with the treatment regimen.
- The client is involved in the legal system, manifests psychiatric symptoms, and is ordered by a court to undergo a comprehensive assessment in a hospital setting to clarify diagnosis and treatment needs.
- The proposed treatment or therapy requires 24-hour-a-day medical observation, supervision, and intervention and must include all of the following:

  - Active supervision by a psychiatrist with the appropriate credentials as determined by the Texas Medical Board (TMB) and with documented specialized training, supervised experience, and demonstrated competence in the care and treatment of children and adolescents. Treatment/therapy plans must be guided by the standards of treatment specified by the Texas Society of Child and Adolescent Psychiatry.
  - Implementation of an individualized treatment plan.
  - Provision of services that can reasonably be expected to improve the client's condition or prevent further regression so that a lesser level of care can be implemented.
  - Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a psychiatrist and is being provided in the least restrictive environment available, and ambulatory care resources available in the community do not meet the client's needs.

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Medicaid Clinical Criteria for Continued Stays

Continued stays are considered for THSteps clients in freestanding and state psychiatric hospitals when the client meets at least one of the criteria from above and have a treatment or therapy regimen, which must include all of the following:

- Active supervision by a psychiatrist with the appropriate credentials as determined by the Texas Medical Board (TMB) and with documented specialized training, supervised experience, and demonstrated competence in the care and treatment of children and adolescents. Treatment/therapy plans must be guided by the standards of treatment specified by the Texas Society of Child and Adolescent Psychiatry.
- Treatment/therapy requires an inpatient level of care.
- Initial discharge plans have been formulated and actions have been taken toward implementation, including documented contact with a local mental health provider.

Continued stays are considered for children and adolescents whose discharge plan does not include returning to their natural home. If the party responsible for placement has provided the provider with three documented placement options for which the child meets admission criteria, but cannot accept the child, up to five days may be authorized, per request, to allow alternative placement to be located. Up to three 5-day extensions may be authorized.

Court-Ordered Services

A request for prior authorization of court-ordered services must be submitted no later than seven calendar days after the date on which the services began.

Court-ordered services are not subject to the five-day admission limitation or the seven-day continued stay limitation. Court-ordered services include:

- Mental health commitments
- Condition of probation (COP)

For court-ordered admissions, a copy of the doctor's certificate and all court-ordered commitment papers signed by the judge must be submitted with the psychiatric hospital inpatient form.

Prior Authorization Appeals

All prior authorization requests not submitted or received by the TMHP CCIP unit in accordance with established policies are denied through the submission date, and claim payment is not made for the dates of service denied.

All denials may be appealed. The TMHP CCIP unit must receive these appeals within 15 days of the TMHP CCIP unit denial notice.

Appeals of a denial for an initial admission and/or a continued stay, must be accompanied by the documentation supporting medical necessity that the provider believes warrants reconsideration.

Appeals of a denial for late submission of information, must be accompanied by documentation that the provider believes supports the compliance with HHSC claims submission guidelines.

Appeals are reviewed first by an experienced psychiatric licensed clinical social worker (LCSW) or a registered nurse (RN) to determine if the required criteria is documented and then forwarded to a psychiatrist for final determination. The TMHP CCIP unit will notify the provider of all denial determinations in writing by fax.

3.4.4.2 Psychiatric Services for Clients 65 Years of Age and Older

IMD services for clients who are 65 years of age and older must be medically necessary and do not require prior authorization.

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3.4.4.3 Reimbursement for Services Rendered in an IMD

The following services will not be reimbursed during an inpatient stay when they are rendered to clients who are admitted as inpatients to an IMD:

- Ambulance
- Case management
- Acute care hospital
- Mental health rehabilitation
- School Health and Related Services (SHARS)

IMD providers may be reimbursed only for services that are rendered to clients who are 20 years of age and younger or 65 years of age and older. IMD services and services rendered at an IMD to clients who are 21 years of age through 64 years of age are not eligible for reimbursement.

Services that are rendered in an IMD facility must be identified in the client's plan of care. Services that are not included in the client's plan of care are subject to recoupment.

If the client has not been discharged from the IMD, the IMD provider is responsible for acute care services that are rendered to the client in an acute care facility, and claims that are submitted for these services will be denied as a duplicate service that has been paid to another provider.

Services that are rendered on the date of admission to the IMD and the date of discharge from the IMD may be reimbursed.

Important: *Claims for professional services rendered during an inpatient stay in an Institution for Mental Disease (IMD) must include the IMD facility's ten-digit National Provider Identifier (NPI). Claims that do not include the IMD Facility's NPI will be denied.*

3.4.4.3.1 Medicare Coinsurance and Deductible Reimbursement

Freestanding psychiatric hospitals that are enrolled in Medicare may also receive Medicaid payment for the Medicare coinsurance or deductible according to current Medicaid guidelines.

Exception: IMD services for clients who are 21 through 64 years of age are not benefits of Texas Medicaid. Medicaid will not reimburse coinsurance and deductible payments for psychiatric services that are rendered to these clients in an IMD.

Refer to: Subsection 2.7, "Medicare Crossover Claim Reimbursement," (*Vol. 1, General Information*) for additional information about Medicaid guidelines for Medicare coinsurance and deductible payments.

3.4.4.4 Providing IMD Client Information to TMHP

IMD providers are requested to inform TMHP of the Medicaid clients who are residing in their facilities before submitting inpatient claims for those clients.

IMD providers can use the TMHP secure web page to enter client information and the admission and discharge dates by going to My Account and choosing the Manage IMD Clients Segment link in the Acute Care Online Portal field.

IMD providers can search for Medicaid client records that are associated with their provider identifiers.

Providers will be asked to submit the client's identification number and admission date. After the client is discharged, providers will be requested to enter the discharge date on the same Manage IMD Clients Segment screen.

Providers will not be able to change previously reported client information except for the To Date of Service information.

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Providers that submit inaccurate information can call the Electronic Data Interchange (EDI) Help Desk at 1-888-863-3638 to have that client segment inactivated if the request is made within 24 hours of submission. After the erroneous client segment has been inactivated by TMHP, providers may submit a new client segment to replace it. After 24 hours have elapsed, providers must contact HHSC to request a correction to the information. This change must include the appropriate documentation of the client's patient control number (PCN) and the admission and discharge dates.

The change request and appropriate documentation must be submitted in writing to the following address:

Texas Health and Human Services Commission
Mail Code 91X PO Box 204077
Austin, Texas 78720-4077

3.4.5 Medicaid Clinical Criteria for Inpatient Psychiatric Care for Clients

The client must have a valid AXIS I, DSM diagnosis as the principle admitting diagnosis and outpatient therapy or partial hospitalization has been attempted and failed, or a psychiatrist has documented reasons why an inpatient level of care is required. The client's Axis II diagnosis must also be included on the request for inpatient psychiatric treatment.

The client must meet at least one of the following criteria:

- The client is presently a danger to self, demonstrated by at least one of the following:
  - Recent suicide attempt or active suicidal threats with a deadly plan and an absence of appropriate supervision or structure to prevent suicide.
  - Recent self-mutilative behavior or active threats of same with likelihood of acting on the threat and an absence of appropriate supervision or structure to prevent self-mutilation (i.e., intentionally cutting or burning self).
  - Active hallucinations or delusions directing or likely to lead to serious self-harm or debilitating psychomotor agitation or intellectual disability resulting in a significant inability to care for self.
  - Significant inability to comply with prescribed medical health regimens due to concurrent Axis I psychiatric illness and such failure to comply is potentially hazardous to the life of the client. The medical (AXIS III) diagnosis must be treatable in a psychiatric setting.
- The client is a danger to others. This behavior should be attributable to the client's specific AXIS I or DSM diagnosis and can be adequately treated only in a hospital setting. This danger is demonstrated by one of the following:
  - Recent life-threatening action or active homicidal threats of same with a deadly plan and availability of means to accomplish the plan with likelihood of acting on the threat.
  - Recent serious assaultive or sadistic behavior or active threats of same with likelihood of acting on the threat and an absence of appropriate supervision or structure to prevent assaultive behavior.
  - Active hallucinations or delusions directing or likely to lead to serious harm of others.
- The client exhibits acute onset of psychosis or severe thought disorganization, or there is significant clinical deterioration in the condition of someone with a chronic psychosis, rendering the client unmanageable and unable to cooperate in treatment, and the client is in need of assessment and treatment in a safe and therapeutic setting.
- The client has a severe eating or substance abuse disorder which requires 24-hour-a-day medical observation, supervision, and intervention.
- The client exhibits severe disorientation to person, place, or time.

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- The client's evaluation and treatment cannot be carried out safely or effectively in other settings due to severely disruptive behaviors and other behaviors which may also include physical, psychological, or sexual abuse.
- The client requires medication therapy or complex diagnostic evaluation where the client's level of functioning precludes cooperation with the treatment regimen.
- The client is involved in the legal system, manifests psychiatric symptoms, and is ordered by court to undergo a comprehensive assessment in a hospital setting to clarify the diagnosis and treatment needs.

The proposed treatment or therapy requires 24-hour-a-day medical observation, supervision, and intervention and must include all of the following:

- Active supervision by a psychiatrist with the appropriate credentials as determined by the Texas Medical Board (TMB) and with documented specialized training, supervised experience, and demonstrated competence in the care and treatment of children and adolescents. Treatment or therapy plans must be guided by the standards of treatment specified by the Texas Society of Child and Adolescent Psychiatry.
- Implementation of an individualized treatment plan.
- Provision of services which can reasonably be expected to improve the client's condition or prevent further regression so that a lesser level of care can be implemented.

Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a psychiatrist and is being provided in the least restrictive environment available, and ambulatory care resources available in the community do not meet the client's needs.

3.4.6 Continued Stays

Continued stays are considered when the client meets at least one of the criteria from above and has a treatment or therapy regimen that includes all of the following:

- Active supervision by a psychiatrist with the appropriate credentials as determined by the TMB and with documented specialized training, supervised experience, and demonstrated competence in the care and treatment of children and adolescents. Treatment or therapy plans must be guided by the standards of treatment specified by the Texas Society of Child and Adolescent Psychiatry.
- Treatment or therapy requires an inpatient level of care.
- Initial discharge plans have been formulated and actions have been taken toward implementation, including documented contact with a local mental health provider.

Continued stays are considered for children and adolescents whose discharge plan does not include returning to their natural home. If the party responsible for placement has provided the provider with three documented placement options for which the child meets admission criteria, but which cannot accept the child, up to five days may be authorized, per request, to allow alternative placement to be located. Up to three five-day extensions may be authorized.

3.4.7 Court-Ordered Services

A request for prior authorization of court-ordered services must be submitted no later than seven calendar days after the date on which the services began.

Court-ordered services are not subject to the 12-hour system limitation per provider, per day when billed with modifier H9.

Court-ordered services are not subject to the five day admission limitation or the seven day continued stay limitation. Court-ordered services include:

- Mental health commitments

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- Condition of probation (COP)

For court-ordered admissions, a copy of the doctor's certificate and all court-ordered commitment papers signed by the judge must be submitted with the psychiatric hospital inpatient form.

Specific court-ordered services for evaluations, psychological or neuropsychological testing, or treatment may be prior authorized as mandated by the court. A copy of the court document signed by the judge must accompany prior authorization requests. If the requested services differ from the court order, the additional services will be reviewed for medical necessity. Requested services beyond those court-ordered are subject to medical necessity review.

3.4.8 Denials

All prior authorization requests not submitted or received by the TMHP CCIP Unit in accordance with established policies are denied through the submission date, and claim payment is not made for the dates of service denied.

All denials may be appealed. The TMHP CCIP Unit must receive these appeals within 15 days of the TMHP CCIP Unit denial notice.

- Appeals of a denial for an initial admission or a continued stay must be accompanied by the documentation supporting medical necessity that the provider believes warrants reconsideration.
- Appeals of a denial for late submission of information must be accompanied by documentation which the provider believes supports the compliance with HHSC claims submission guidelines.
- Appeals are reviewed first by an experienced psychiatric LCSW (Licensed Clinical Social Worker) or an RN to determine if the required criteria is documented and then forwarded to a psychiatrist for final determination. The TMHP CCIP Unit will notify the provider of all denial determinations in writing by fax.

3.5 Inpatient Utilization Review

UR activities of all Medicaid services provided by hospitals reimbursed under the DRG prospective payment system or the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 are required by Title XIX of the Social Security Act, Sections 1902 and 1903. The review activities are accomplished through a series of monitoring systems developed to ensure services are appropriate to need of optimum quality and quantity, and rendered in the most cost-effective mode. Clients and providers are subject to UR monitoring. The monitoring focuses on the appropriate screening activities, medical necessity of all services, and quality of care as reflected by the choice of services provided, type of provider involved, and settings in which the care was delivered. This monitoring ensures the efficient and cost-effective administration of Texas Medicaid.

The HHSC Office of Inspector General (OIG) UR Unit is responsible for retrospective review of inpatient DRG and TEFRA admissions. These reviews are accomplished through onsite visits, electronic access, or mail-in.

3.6 Utilization Review Process

The inpatient UR process for admissions reimbursed under the DRG prospective payment system consists of sampling medical records of paid Medicaid claims. The review process consists of three major components:

- *Admission review.* Determination of the medical necessity of the admission. For purposes of the Texas Medical Review Program (TMRP), TEFRA, and facility-specific per diem methodology reviews, medical necessity means the client has a condition requiring treatment that can be safely provided only in the inpatient setting.

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- *Quality review.* Assessment of the quality of care provided to determine if it meets generally accepted standards of medical and hospital care practices or puts the client at risk of unnecessary injury or death. Quality of care review includes the use of discharge screens and generic quality screens.
- *DRG validation.* Determination that the critical elements necessary to assign a DRG are present in the medical record and the diagnosis and procedures are sequenced correctly. The critical elements are age, sex, admission date, discharge date, patient discharge status, principal diagnosis, secondary diagnoses (complications or comorbidities), and principal and secondary procedures.

The HHSC OIG UR Unit staff reviews the complete medical record to make decisions about the medical necessity of the admission, validity of the DRG, including the present on admission (POA) indicator, and quality of care. The medical record must reflect that any services reimbursed by Texas Medicaid were ordered by a physician or non-physician provider.

When an admission denial or a denial of continued stay is issued, or when a technical denial becomes final, all money is recouped from the hospital for the admission or days of stay that are denied. When a DRG is reassigned as a result of UR, the payment to the hospital is adjusted.

Refer to: Subsection 3.6.3, "Technical Denials (DRG Prospective Payment).

If an inpatient admission is denied, but a physician's order is present documenting the client originally was placed in observation, the UR unit may authorize the resubmission of services rendered during the first 48 hours on an outpatient claim.

Compliance with the DRG prospective payment system and aspects of the review as stated above are evaluated quarterly. Identified problems may result in an educational visit or action, such as recoupment or referral to the HHSC OIG Medicaid Program Integrity (MPI) or Sanctions Unit.

3.6.1 Admission Review

All services, supplies, or items submitted as certified on claim submission, must be medically necessary for the client's diagnosis or treatment. Review personnel assess the medical necessity of an admission by comparing documentation present in the medical record using recognized evidence-based guidelines for inpatient screening criteria. The evidence-based guidelines are Milliman Care Guidelines, which replace the physician developed and physician-approved Medicaid hospital screening criteria addressed through a rule revision effective August 1, 2006. Non-physician reviewers use the criteria as guidelines for the initial approval or for the referral of inpatient reviews for medical necessity decisions. Cases that do not meet initial approval are referred to a physician consultant to determine the medical necessity of the inpatient admission. If the criteria are met but the medical necessity of the admission is still questionable, the case is referred to a physician consultant for a determination. If a physician consultant determines the admission is not medically necessary, a denial is issued.

Review personnel assess the medical necessity of admissions prior to September 1, 2006, by comparing documentation present in the medical record with elements in the TMRP Hospitalization Screening Criteria.

3.6.1.1 Readmission Review

If a hospital admission or readmission occurs within 30 days of a discharge from the same or a different hospital for the same or closely related diagnosis, or for a condition identified during the previous admission, it may be reviewed for medical necessity, quality, and DRG validation including POA indicators.

Transfers from one facility to another and readmissions are also subject to review.

3.6.1.2 Hospital-Based Ambulatory (HASC) Surgical Procedures

Inpatient admissions for surgical procedures listed as ambulatory surgical codes in the current fee schedule are denied if documentation does not support the need for the inpatient admission.

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3.6.1.3 Quality Review

Each Medicaid case is evaluated for quality of client care, adequacy of discharge planning, and medical stability of the client at discharge. Quality of care review includes the use of discharge screens and generic quality screens. Potential quality of care issues are identified by the physician. HHSC contracts with physician consultants to review medical records for quality of care. Physician consultants, of the specialty related to the care rendered, may make clinical recommendations or determine corrective actions when deemed appropriate. Child and adolescent psychiatrists may make recommendations based on review of inpatient psychiatric services provided to Medicaid clients younger than 21 years of age. Failure to verify completion of any corrective action recommendation within the specified time frame may result in referral of the case to the HHSC OIG MPI or Sanctions Unit.

3.6.1.4 Diagnosis-Related Group Validation

Each medical record is reviewed to validate the elements critical to the DRG assignment. These elements are the client's age, sex, admission date, patient discharge date, patient discharge status, principal diagnosis, secondary diagnoses (complications or co-morbidities), POA indicators, and principal and secondary procedures. Documentation of these critical DRG elements in the medical record is evaluated for the correlation to the information provided on the claim form.

The principal diagnosis is the diagnosis (condition) established after study to be chiefly responsible for causing the admission of the client to the hospital for care. The condition must be treated or evaluated during this admission to the hospital.

The secondary diagnoses are conditions that affect client care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, increased nursing care and monitoring, or have clinically significant implications for future health-care needs.

The coding of diagnoses that have clinically significant implications for future health-care needs applies only to newborns and must be identified by the physician. Normal newborn conditions or routine procedures are not to be considered as complications or co-morbidities for DRG assignment.

Refer to: Subsection 1.11, "Texas Medicaid Limitations and Exclusions," in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

The POA review will validate the POA indicator assigned to the principal and secondary diagnoses codes reported on claim forms. If it is determined that the principal and/or secondary diagnoses were not present at the time the order for inpatient admission occurs, the Commission will revise the POA indicator for the diagnosis code. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery are considered POA.

If the principal diagnosis, secondary diagnoses (complications or co-morbidities), or procedures are not substantiated in the medical record; sequenced correctly; have an incorrect POA indicator; or have been omitted, codes may be deleted, changed, or added. All diagnosis or procedure coding changes potentially resulting in a DRG change are referred to a physician consultant. When it is determined that the diagnoses and procedures are substantiated and sequenced correctly, the information will be entered into the applicable version of the Grouper software for a DRG determination. The CMS-approved DRG software considers each diagnosis and procedure and the combination of all codes and elements to make a determination of the final DRG assignment. When the DRG is reassigned, the payment to the provider is adjusted.

3.6.2 Recommendations to Enhance Compliance with Texas Medicaid Fee-for-Service Hospital Claims Submission

The following information highlights an area for physician and hospital providers where collaboration in client care delivery exists but can improve. Texas Medicaid, through its hospital UR activities, has identified this area for both compliance with provider responsibilities and the reduction of the submission of inappropriate inpatient hospital claims.

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To enhance compliance with Texas Medicaid fee-for-service hospital claims submission and decrease the submission of inappropriate inpatient hospital claims, providers should adhere to the following:

- For admissions on or after September 1, 2006, physicians and hospital staff should become familiar with the Milliman Care Guidelines for medical necessity for inpatient admission.
- The hospital may admit clients in observation status if the physician has the reasonable expectation that the client will be discharged within 48 hours. If an inpatient claim was denied per retrospective UR, the hospital may resubmit the claim for the first 48 hours as an outpatient claim if the client was initially admitted in observation status (per physician order) and the stay was more than 48 hours.
- When a client is admitted to the hospital as an inpatient and is discharged in less than 48 hours, the hospital may request that the physician change the admission order from inpatient status to outpatient observation status. This practice is acceptable when the physician makes changes to the admitting order before the hospital submits the claim for payment.
- The correction in admission status, when the above criteria are met avoids errors in claims submission and the potential need for a more lengthy appeal process.
- If the physician admitting orders do not accurately reflect the services provided, the hospital inpatient claim may be denied and the inappropriate payment recovered from both the hospital and the admitting physician.

3.6.3 Technical Denials (DRG Prospective Payment)

3.6.3.1 On-Site Reviews

The following information describes on-site reviews:

- If the complete medical record is not made available during the on site review, a preliminary technical denial is issued on site. The hospital is allowed 60 calendar days from the date of the exit conference to provide the complete medical record to HHSC. If the complete medical record is not received by HHSC within this specified time frame, a final technical denial is issued and payment is recouped.
- If a complete medical record is made available on site, but a copy is required for further review, and the copy is not received by HHSC within the specified time frame, a preliminary technical denial is issued by certified mail or fax. The hospital has 60 calendar days from the date of receipt of the notice to submit the complete medical record. If the complete medical record is not received by HHSC within this specified time frame, a final technical denial is issued and payment is recouped.

Note: *A notarized business record affidavit in the format approved by HHSC is required for paper and electronic copies of requested medical records. A provider failing to provide this documentation must resubmit the requested records with the affidavit.*

Refer to: Subsection 1.6.3, "Retention of Records and Access to Records and Premises," in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

3.6.3.2 Mail-In Reviews

If the complete medical record is not received by HHSC within the specified time frame, a preliminary technical denial is issued by certified mail or fax. The hospital has 60 calendar days from the date of receipt of the notice to submit the complete medical record. If the complete medical record is not received by HHSC within this specified time frame, a final technical denial is issued and payment is recouped.

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Hospital inpatient claim payments that have been recouped because of a technical denial may not be resubmitted on an outpatient claim.

Note: *A notarized business record affidavit in the format approved by HHSC is required for paper and electronic copies of requested medical records. A provider who fails to provide this documentation must resubmit the requested records with the affidavit.*

Refer to: Subsection 1.6.3, "Retention of Records and Access to Records and Premises," in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

3.6.4 Acknowledgment of Penalty Notice

Hospitals must have on file a signed acknowledgment from the physician stating that the physician received the following notice:

> **Notice to Physicians:** Medicaid payment to hospitals is based, in part, on each client's principal and secondary diagnoses and the major procedures performed on the client, as attested to by the client's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal or state funds, may be subject to fine, imprisonment, or civil penalty under applicable federal and state laws.

The acknowledgment of penalty notice must be specific to Texas Medicaid. Medicare penalty notices are not accepted.

3.6.5 Sanctions

Compliance with the DRG prospective payment system and aspects of the review as stated above are evaluated quarterly. Identified problems may result in an educational visit or action such as recoupment or referral to HHSC OIG MPI or Sanctions Unit.

3.6.6 Utilization Review Appeals

Hospital providers may appeal adverse decisions by HHSC OIG UR Unit to the HHSC UR Medical Appeals Unit. A UR Medical Appeals decision is the final administrative decision of HHSC. Neither HHSC OIG UR Unit nor TMHP are responsible for Medical UR appeals.

Refer to: Subsection 7.3.3, "Utilization Review Appeals," in Section 7, "Appeals" (*Vol. 1, General Information*).

3.7 Claims Filing and Reimbursement

3.7.1 Medicaid Relationship to Medicare

Texas Medicaid may make deductible or coinsurance payments according to current Medicaid payment guidelines on valid, assigned Part A (hospital) and Part B (medical) Medicare claims.

Refer to: Subsection 2.7, "Medicare Crossover Claim Reimbursement," in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for information about coinsurance and deductible payment guidelines.

Texas Medicaid provides reimbursement for 30 inpatient benefit days per spell of illness. When the 30 days coincide with the first 30 days of the Medicare benefit period and the client is eligible for both Medicare and Medicaid, Texas Medicaid pays the:

- Inpatient hospital deductible under Medicare Part A.
- Medicare Part A deductible for the first three pints of whole blood or packed red cells.

When the client only has Medicare Part B coverage, the hospital must follow these guidelines:

- Submit to Medicare the charges for certain inpatient ancillary services on a Medicare Claim Form 1483 for payment under the client's Part B coverage. The ancillary charges include the following:

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- Diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians
- Surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations
- Prosthetic devices (other than dental) that replace all or part of an internal body organ or member (including contiguous tissue) or all or part of the function of a permanently inoperative or malfunctioning internal body organ or member including replacement or repairs of such devices (e.g., cardiac pacemakers, breast prostheses, maxillofacial devices, colostomy bags, and prosthetic lenses)
- Leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements and adjustments (if required) because of a change in the client's physical condition
- Physical therapy (PT) services
- Speech pathology services
- Dialysis treatments

- Submit to TMHP the remaining Part A charges on a UB-04 CMS-1450 paper claim form (or its electronic equivalent) indicating in Block 80 that the client is eligible for Medicare Part B benefits only. The client's health insurance claim (HIC) number must appear on the Medicaid claim in Block 80. TMHP must receive these charges within 95 days of the last date of service on the claim.

Refer to: Subsection 2.7, "Medicare Crossover Claim Reimbursement," in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

3.7.2 Inpatient Claims Information

Medicaid present on admission (POA) reporting is required for all inpatient hospital claims.

All hospital providers are required to submit a POA value for each diagnosis on the claim form, and no hospital is exempt from this POA requirement. Medicare crossover hospital claims must also comply with the Medicaid requirement to include the POA values.

POA is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient visit, including emergency department, observation, or outpatient surgery, are considered POA.

The following table shows the POA values:

POA Value	Description	Payment
Y	Diagnosis was present at the time of admission	Payment will be made by Medicare when a hospital-acquired condition (HAC) is present
N	Diagnosis was not present at the time of admission	No payment will be made by Medicare when an HAC is present
U	Documentation was insufficient	No payment will be made by Medicaid when an HAC is present
W	Clinically undetermined	Payment will be made by Medicaid when an HAC is present:
(blank)	Exempt from POA reporting	Exempt from POA reporting
Note: Texas Medicaid follows Medicare guidelines for payments referenced in this table.		

Note: *If a diagnosis code is exempt from POA reporting, providers should leave the POA indicator field blank on the claim.*

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TMHP will not recalculate the DRG based on POA indicator values for Medicare crossover claims or MCOs.

Depending on the POA indicator value, the DRG may be recalculated, resulting in a lower payment to the hospital facility provider. If the number of days on an authorization is higher than the number of days allowed as a result of a POA DRG recalculation, the lesser of the number of days will be reimbursed.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*).

"Section 6: Claims Filing" (*Vol. 1, General Information*).

A complete list of POA exempt diagnosis codes can be found on the CMS website at www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1019OTN.pdf

Claims for inpatient hospital 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 attachments. Superbills, or itemized statements, are not accepted as claim supplements.

In Block 44 of the UB-04 CMS-1450, 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.

Hospitals may submit information only claims to TMHP when one of the following situations exists. Hospitals must use TOB 110 to file these claims:

- Inpatient 30-day spell of illness benefit is exhausted.
- Payment made by a third party resource or other insurance exceeds the Medicaid allowed amount.

Additional claims information can be found within individual topic areas in this section.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*).

"Section 6: Claims Filing" (*Vol. 1, General Information*).

The Claim Form Examples page on the TMHP website at www.tmhp.com.

3.7.3 Inpatient Reimbursement

3.7.3.1 Prospective Payment Methodology

Inpatient hospital stays except state-owned teaching hospitals, and psychiatric facilities (CCP) are reimbursed according to a prospective payment methodology based on diagnosis-related groups (DRGs). The reimbursement method itself does not affect inpatient benefits and limitations. Inpatient admissions must be medically necessary and are subject to Texas Medicaid's UR requirements.

The DRG reimbursement 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 he automated or technician-generated reading and reporting of results. The technical services are not billable to Texas Medicaid clients.

Texas Medicaid 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 Medicaid 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,

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Texas Medicaid requires that only one claim be submitted for each inpatient stay with appropriate diagnosis and procedure code sequencing. The discharge and admission hours (military time) are required on the UB-04 CMS-1450 paper claim form, to be considered for payment.

The number of days of care charged to a beneficiary for inpatient hospital or skilled nursing facility (SNF) care 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 or SNF 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 patient returns from leave of absence, counts as a full day. However, the day of discharge, death, or a day on which a patient 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 (November 1 through October 31). Claims may be subject to retrospective review, which may result in recoupment. This limitation does not apply to services related to certain organ transplants or services to THSteps clients when provided through CCP.

Effective September 1, 2013, a hospital that is either located in a county with 60,000 or fewer persons, is a Medicare-designated rural referral center (RRC) or sole community hospital (SCH) that is not located in a metropolitan statistical area (MSA) as defined by the U.S. Office of Management and Budget, or is a Medicare-designated CAH, will be reimbursed the greater of the prospective payment system rate or a cost-reimbursement methodology authorized by DRG using the most recent data.

A new provider is given a reimbursement inpatient interim rate of 50 percent until a cost audit has been performed. A default standard dollar amount (SDA) rate is assigned for newly enrolled providers or newly constructed facilities.

Payment is calculated by multiplying the SDA for the hospital's payment division indicator times the relative weight associated with the DRG assigned by Grouper.

Hospital reimbursement is made in accordance with the following TAC rules:

- 1 TAC §355.761 - Reimbursement Methodology for Institutions of Mental Diseases (IMD)
- 1 TAC §355.8052 - Inpatient Hospital Reimbursement
- 1 TAC §355.8056 - State-Owned Teaching Hospital Reimbursement Methodology
- 1 TAC §355.8058 - Inpatient Direct Graduate Medical Education (GME) Reimbursement
- 1 TAC §355.8060 - Reimbursement Methodology for Freestanding Psychiatric Facilities
- 1 TAC §355.8061 - Outpatient Hospital Reimbursement
- 1 TAC §355.8065 - Disproportionate Share Hospital Reimbursement Methodology
- 1 TAC §355.8066 - Hospital-Specific Limit Methodology

Medicaid providers that are cost-reimbursed are subject to cost reporting, cost reconciliation, and cost settlement processes, as defined in the following TAC rules:

- 1 TAC §355.8061 (a)(2) - Outpatient Hospital Remibursement
- 1 TAC §355.8052 (i)(i) - Inpatient Hospital Reimbursement
- 1 TAC §355.8056 - State-Owned Teaching Hospital Reimbursement Methodology

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3.7.3.2 Client Transfers

3.7.3.2.1 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.

3.7.3.2.2 Continuous Stays – Client Transfers and Readmissions

Client transfers within the same facility are considered one continuous stay and receive only one DRG payment. Texas Medicaid does not recognize specialty units within the same hospital as separate entities; therefore, these transfers must be submitted as one admission under the provider identifier. Readmissions to the same facility within 24 hours of a previous acute hospital or facility discharge are also considered one continuous stay and receive only one DRG payment.

Readmissions are considered a continuous stay regardless of the original or readmission diagnosis. Admissions submitted inappropriately are identified and denied during the UR process and may result in intensified review.

When more than one hospital provides care for the same client, the hospital providing the most significant amount of care receives consideration for a full DRG payment. The other hospitals are paid a per diem rate based on the lesser of either the mean length of stay for the DRG or the eligible days in the facility. The DRG modifier, PT, on the R&S Report indicated per diem pricing related to a client transfer. Services must be medically necessary and are subject to Texas Medicaid's UR requirements.

HHSC 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 discharge.

3.7.3.3 Observation Status to Inpatient Admission

The dates of the inpatient admission must be reported as follows:

- *Date of inpatient admission*: The date of admission must reflect the date that the client was admitted to the hospital as an inpatient.
- *Dates of service*: The from date of service (FDOS) must reflect the date that the client first presented at the hospital for services including, but not limited to, emergency room (ER), 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 preadmission days that are related to the inpatient admission cannot exceed the days of 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

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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 observation hours occurred.

Note: *If the client is admitted as an inpatient more than 24 hours after presenting in the ER without being placed in observation status or more than 48 hours after being placed in observation status, the ER and observation services may be reimbursed separately as outpatient services and must not be included on the inpatient claim.*

3.7.3.4 Outliers

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 20 years of age and 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 R&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 interchange (EDI) companion guide (ANSI ASC X12N 835 Healthcare Claim Payment/Advice-Acute Care Companion Guide) on the TMHP website at www.tmhp.com.

3.7.3.4.1 Day Outliers

The following criteria must be met to qualify for a day outlier payment:

- Inpatient days must exceed the DRG day threshold for the specific DRG.
- Additional payment is based on inpatient days that exceed the DRG day threshold multiplied by 60 percent of the per diem amount of a full DRG payment.
- The per diem amount is established by dividing the full DRG payment amount by the arithmetic mean length of stay for the DRG.

In compliance with 1 TAC §355.8052, all DRG inpatient hospital day outlier payments must not exceed the allowed cost for the service. All hospitals except in-state children's hospitals, both day and cost outlier payments have been reduced by 10 percent.

TMHP calculates payments as follows:

1) Calculate the day outlier.

   Calculate the allowed cost for the service (i.e., the cap amount) by taking the difference between the Tax Equity and Fiscal Responsibility Act (TEFRA) and DRG-payable amounts.

   Take the lesser of the day outlier or the cap amount.

   Reduce the day outlier by 10 percent for all hospitals except in-state children's hospitals.

2) Calculate the cost outlier:

   Reduce the cost outlier by 10 percent for all hospitals except in-state children's hospitals.

Reimbursement is made for day or cost outliers on claims that qualify. 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.

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Example

Calculations	Example amount
Day Outlier Calculation: ([SDA x DRG relative weight / Mean Length of Stay] x Outlier Days) x 0.6 = day outlier amount	$500.00
Apply Cap and Reduce by 10 Percent Calculate the allowed cost for the service (i.e., the cap amount) by taking the difference between the TEFRA and DRG payable amounts (in this example, $600.00). Take the lesser of the day outlier or the cap amount (in this example it would be the day outlier of $500.00). Reduce by 10 percent.	$450.00
Calculation1: Cost Threshold 11.14 x Universal Mean ($6,505.52) = <amount A> 11.14 x SDA = <amount B> 1.5 x DRG Relative Weight x SDA = <amount C> Cost threshold = The greater of <amount C> compared with (the lesser of <amount A>	$550.00
Calculation2: Cost Outlier Allowed amount x reimbursement rate = TEFRA amount TEFRA amount - cost threshold x **0.6** percent = cost outlier amount Reduce by 10 percent.	$495.00

The calculations in this example would result in one of the following payments:

- If the claim qualifies for the day outlier payment only, payment will be made up to $450.00.
- If the claim qualifies for the cost outlier payment only, payment will be made up to $495.00.
- If the claim qualifies for both the day outlier and cost outlier payment, the payment will be made up to $495.00, which is the greater of the day outlier or the cost outlier payment.

3.7.3.5 Children's Hospitals

Children's hospitals are reimbursed using the prospective payment methodology based on APR-DRG methodology.

With the exception of designated children's hospitals, hospitals that are reimbursed by APR-DRG payment methodology receive one SDA rate.

Designated children's hospitals receive two SDA rates:

- One rate for obstetric delivery services rendered to clients who are 18 years of age and older.
- One rate for all other services rendered to clients who are 18 years of age and older and all services rendered to clients who are 17 years of age and younger, including obstetric delivery services.

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3.7.3.6 Potentially Preventable Complications (PPC) and Potentially Preventable Readmissions (PPR)

Potentially Preventable Complications (PPCs)

By definition, potentially preventable complications (PPCs) are harmful events or negative outcomes that develop after hospital admission and may result from processes of care and treatment rather than from the natural progression of the underlying illness. A PPC is an inpatient hospital complication that was potentially preventable based on criteria such as hospital characteristics, reason for admission, procedures, and the interrelationships between underlying medical conditions.

S.B. 7, Chapter 526, the 82nd Texas Legislature, 2011, establishes the authority of HHSC to identify PPCs in the Medicaid population. HHSC must confidentially report the results to each hospital that serves Texas Medicaid clients, and each of those hospitals must distribute the information to its care providers.

HHSC also produces a public version of the report, which does not specifically identify any of the hospitals. A statewide average PPC rate is calculated for all hospitals within Texas. Each hospital has an individual rate. Hospitals are able to compare their rate of PPC to the statewide average.

The PPC analysis is performed in accordance with TAC, §354.1446 Potentially Preventable Complications.

Potentially Preventable Re-admission (PPRs)

By definition, potentially preventable re-admissions (PPRs) are return hospitalizations of a person within a period specified by HHSC that results from deficiencies in the care or treatment provided to the person during a previous hospital stay or from deficiencies in post-hospital discharge follow-up.

Texas Medicaid uses a 15 day re-admission interval.

Section 531.913, House Bill (H.B.) 1218, 81st Legislature, 2009, requires the HHSC to identify PPRs in the Medicaid population. HHSC must confidentially report the results to each hospital that serves Texas Medicaid clients, and each of those hospitals must distribute the information to its care providers.

HHSC delivers an annual, confidential report of the results to each hospital that is enrolled in Texas Medicaid, and each of those hospitals must distribute the information to their care providers. HHSC also produces a public version of the report, which does not specifically identify any of the hospitals. Patients are never identified in the reports.

PPR Analysis

The PPR analysis is performed in accordance with TAC, §354.1446 Potentially Preventable Readmissions.

3.7.3.7 State-owned Teaching Hospitals

Inpatient hospital stays in designated state-owned teaching hospitals are reimbursed according to the payment methodology.

State-owned teaching hospitals are defined specifically in 1 TAC §355.8052 as the following hospitals: University of Texas Medical Branch (UTMB); University of Texas Health Center Tyler; and M.D. Anderson Hospital.

3.7.3.8 Payment Window Reimbursement Guidelines

Guidelines for Services Preceding an Inpatient Admission

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. The three-day (or one-day) payment window does not apply if:

- The hospital and the physician office or other entity are both owned by a third party, such as a health system.

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- The hospital is not the sole or 100 percent owner of the entity.

Texas Medicaid 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 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 the specified time frames 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.*

3.7.3.8.1 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:

Procedure Codes									
G0257									
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	95900	95900

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Procedure Codes									
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								

3.7.3.8.2 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 of the one-day or three-day timeframes indicated above 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.*

3.7.3.8.3 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 up to six digits of the referenced professional diagnosis code match the principle inpatient diagnosis code.
- 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 up to six digits of the referenced outpatient diagnosis code match the principle inpatient diagnosis code.

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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.

3.7.3.9 Potentially Preventable Readmissions (PPR)

H.B. 1218, 81st Legislature, Regular Session 2009, requires that HHSC identify potentially preventable readmissions (PPRs) in the Medicaid population and report results confidentially to each hospital. The law also requires each hospital to distribute the information to its care providers.

Refer to: TMHP Hospital Initiatives web page at www.tmhp.com/Pages/Medicaid/Hospital_PPR.aspx for the new state fiscal year confidential Hospital Specific PPR Report, which includes frequently asked questions (FAQs) that help providers interpret their confidential reports.

3.7.4 Provider Cost and Reporting

The method of determining reasonable cost is similar to that used by Title XVIII (Medicare). Hospitals must include inpatient and outpatient costs in the cost reports submitted annually. The provider must prepare one copy of the applicable CMS Cost Report Form along with the required PCCM supplemental worksheets. The PCCM supplemental worksheets include the Inpatient PCCM D-4 worksheet, available from CMS, and the Outpatient PCCM D, Part V worksheet. A sample of the Outpatient PCCM D, Part V is available on the TMHP website at www.tmhp.com.

Refer to: Subsection 2.2.2, "Cost Reimbursement," in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

If a change of ownership or provider termination occurs, the cost report is due within five months after the date of the change in ownership or termination. Any request for an extension of time to file must be made on or before the cost report due date and sent to TMHP Medicaid Audit at the address indicated under "Written Communication With TMHP" in the "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*). For questions or assistance, call TMHP Medicaid Audit at 1-512-514-3648.

Annual cost reports must be filed as follows:

- Submit one copy of the cost report to TMHP Medicaid Audit within five months of the end of the hospital's fiscal year along with any amount due to Texas Medicaid.
- TMHP Medicaid Audit performs a desk review of the cost report and makes a tentative settlement with the hospital. A tentative settlement letter requests payment for any balance due to Texas Medicaid or instructs TMHP to pay the amount due to the provider. Interim payment rates are changed at this time based on the cost report.
- Field audits are conducted when necessary.
- Medicaid final settlement is made after a copy of all the following information is received from the provider or the Medicare intermediary. The provider must send TMHP a copy of one of the following:
  - Audited or settled without audit Medicare Cost Report
  - Medicare Notice of Amount of Program Reimbursement
  - Medicare Audit Adjustment Report, if applicable

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Medicaid hospitals may request copies of their claim summaries for their cost reporting fiscal year. The summaries for tentative settlements include three additional months of claim payments for the fiscal year. The summaries for final settlements include ten months of claim payments for the fiscal year. TMHP Medicaid Audit uses this data to determine the tentative and final settlements and interim rates.

The Medicaid claim summary data are only generated once each month, and the logs are received by the 15th of the following month. Requests for tentative settlement logs are submitted within 30 days after the fiscal year-end. Final settlement log requests are submitted within nine months after the fiscal year-end.

The Medicaid logs can be requested through the provider's administrator account on the TMHP website at www.tmhp.com. Medicaid logs can also be requested by calling 1-512-506-6117 or by sending a written request to the following address:

Texas Medicaid & Healthcare Partnership
Medicaid Audit
PO Box 200345
Austin, TX 78720-0345

Allow 45 days for receipt of these logs.

3.7.5 Third Party Liability

Hospitals and providers enrolled in Texas Medicaid are required to inform TMHP about circumstances that may result in third party liability for health-care claims. After receiving this information, TMHP pursues reimbursement from responsible third parties.

Hospitals and providers must mail or fax the Other Insurance Form for Health Insurance or the Tort Response Form for accidents to the following address:

Texas Medicaid & Healthcare Partnership
TPL Correspondence
Third Party Liability Unit PO Box 202948
Austin, TX 78720-2948
Fax: 1-512-514-4225

Refer to: Subsection 4.12, "Third Party Liability (TPL)," in Section 4, "Client Eligibility" (*Vol. 1, General Information*).

Other Insurance Form on the TMHP website at www.tmhp.com.

Tort Response Form on the TMHP website at www.tmhp.com.

4 Outpatient Hospital (Medical and Surgical Acute Care Outpatient Facility)

This section contains benefit, limitation, authorization, and claims filing information for outpatient hospital facility emergency, observation, and other services.

Refer to: Section 6: Claims Filing and Section 7: Appeals *(Vol. 1, General Information)* for more comprehensive information about claims filing and appeals.

Hospital providers are encouraged to review the other handbooks for applicable information, prior authorization requirements, and for specific requirements for special programs.

4.1 General Information

Outpatient diagnostic, therapeutic, and surgical services that are rendered in an acute care hospital setting are services that are provided to clients by or under the direction of a physician.

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Outpatient hospital services include those services that are rendered:

- In the emergency room (ER)
- As day surgery
- In the observation room
- By ancillary departments such as the laboratory, radiology, physical or occupational therapy, cardiac rehabilitation, hyperbaric chamber, infusion services, and other areas able to provide services in the outpatient setting.

4.1.1 Drugs and Supplies

4.1.1.1 Self-Administered Drugs

Self-administered drugs are defined as drugs that the client administers themselves at home and may include, but are not limited to, prescription drugs, vitamins, and supplements.

These drugs that are provided by the hospital during an outpatient hospital visit are included in the hospital reimbursement and are not reimbursed separately. The client cannot be billed for self-administered drugs that are provided by the hospital during an outpatient hospital stay.

4.1.1.2 Take-Home Drugs and Supplies

Benefits do not include drugs and biologicals provided by the hospital and taken home by the client. Supplies provided by a hospital for use in physicians' offices are not reimbursable.

Take-home drugs and supplies are a benefit for services rendered to clients in the outpatient setting when supplied by prescription through the VDP.

4.1.2 Outpatient Services Provided Without Charge

Texas Medicaid pays the clinic registration fee in lieu of other benefits when a hospital provides outpatient services without charge, and if the registration fee is less than the allowed Medicaid payment.

Refer to: TAC Rule §354.1073 for information about authorized outpatient hospital services.

Subsection 1.11, "Texas Medicaid Limitations and Exclusions," in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about noncovered items or services.

4.1.3 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.

Refer to: Subsection 3.7.3.8, "Payment Window Reimbursement Guidelines," in this handbook for additional information about the payment window reimbursement guidelines.

4.2 Services, Benefits, Limitations, and Prior Authorization

4.2.1 Prior Authorization Requirements

The hospital is responsible for requesting prior authorization for the non-emergency transport to the client's home or to a nursing home after a non-scheduled outpatient visit.

Refer to: Non-emergency Ambulance Prior Authorization Request on the TMHP website at www.tmhp.com.

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4.2.2 Emergency Department Services

An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to clients who present for immediate medical attention. The facility must be available 24 hours a day, 7 days a week.

Hospital-based emergency departments are reimbursed for services based on a reasonable cost, based on the hospital's most recent tentative Medicaid cost report settlement. The reasonable cost is reduced by a percentage determined by the state.

All claims that are submitted by outpatient hospital providers must include a procedure code with each revenue code for services that are rendered to Texas Medicaid clients. This procedure code must be listed on the same claim detail line as the emergency department revenue code.

The procedure code billed may include, but is not limited to, E/M, surgical or other procedure, or any other service rendered to the client in the emergency room. The procedure code must accurately reflect the services rendered in the hospital's emergency department.

Emergency department reimbursement may include room changes and ancillary changes. Emergency department room charges may be submitted using the following revenue codes:

Revenue Code	Description
450	Emergency room
451	Emergency room-EMTALA emergency medical screening
456	Emergency room, urgent care
459	Emergency room, other

Emergency department ancillary services include, but are not limited to, the following:

- Laboratory services
- Radiology services
- Respiratory therapy services
- Diagnostic studies (including, but not limited to, ECGs, computed tomography (CT) scans, and supplies)

The administration of an injection may be reimbursed to the provider who administers the injection. The administration of the injection will not be reimbursed to outpatient hospital providers. An injection or infusion administered by a nurse is included in the emergency room charge and is not reimbursed separately to the outpatient facility.

Ancillary services must be submitted on the UB-04 CMS-1450 paper claim form using the appropriate procedure codes or revenue codes for rendered services.

If a client visits the emergency room more than once in one day, the times must be given for each visit.

If the client ultimately is admitted as an inpatient within 48 hours of treatment in the ER or clinic, the ER or clinic charges must be submitted on the inpatient hospital claim form as an ancillary charge. The date of inpatient admission is the date the client initially was seen in the ER or clinic.

According to the Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986, if any individual presents at the hospital's emergency department requesting an examination or treatment, the hospital must provide 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 an emergency medical condition exists.

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EMTALA medical screening code (451) may be considered for reimbursement when submitted 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. Services beyond screening (451) can be submitted with the appropriate corresponding emergency services code (450).

Medicaid claims administrators are prohibited from requiring prior authorization or primary care provider notification for emergency services including those needed to evaluate or stabilize an emergency medical condition or emergency behavioral health condition.

Texas Medicaid provides that certain undocumented aliens and legalized aliens who require treatment of an emergency medical condition or emergency behavioral health condition are eligible to receive that treatment. After the emergency condition requiring care is stabilized and is no longer an emergency, the coverage ends. If the alien continues to receive ongoing treatment after the emergency ceases, the ongoing treatment is not a benefit.

Texas Medicaid provides for medical services for eligible clients while out-of-state. The attending physician or other provider must document that the client was treated for an emergency condition. Out-of-state emergency services are also a benefit when the client's health would be in danger if he or she were required to travel back to Texas.

Emergency department services are subject to retrospective review.

In instances of sudden illness or injury, the client may receive treatment in the ER and be discharged, placed on observation status, or admitted as an inpatient.

4.2.2.1 Emergency Department Payment Reductions

Nonemergent and nonurgent evaluation and management (E/M) services rendered in the emergency room may be reimbursed at 125 percent of the adult, physician office visit fee for procedure code 99202. Reimbursement is based on the E/M procedure code submitted on the same line item as the emergency room revenue code.

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.

Note: *Evaluation and management services that are rendered in the emergency room for critically ill or critically injured Texas Medicaid clients of any age, are not subject to reduction in payment.*

Exception: *Rural hospitals, nonemergent and nonurgent E/M services rendered in the emergency room may be reimbursed at 65 percent of the allowed rate.*

4.2.3 Day Surgery

Inpatients may occasionally require a surgery that has been designated as an outpatient procedure. The physician must document the need for this surgery as an inpatient procedure before the procedure is performed. These claims are subject to retrospective review.

These procedures are for clients who are scheduled for a day surgery procedure and are not inpatient at the time the day surgery is performed.

4.2.3.1 Inpatient Admissions for Day Surgeries

If a client is admitted for a day surgery procedure—whether scheduled or emergency—one of the following classifications may be considered an inpatient procedure.

- ASA Classification of Physical Status of III (P3), IV (P4), or V (P5)
- Classification of Heart Disease IV

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The day surgery services must be submitted on an inpatient claim (TOB 111) using the hospital's provider identifier. The reason for the surgery (principal diagnosis), any additional substantiated conditions, and the procedure must be included on one inpatient claim.

Refer to: The Texas Medicaid Hospital Screening Criteria at www.hhs.state.tx.us/OIG/screen/SC_TOC.shtml#asa, for a description of the ASA classes of physical status.

The descriptions for ASA classes of physical status are as follows:

- *Class I.* A normal healthy patient, without organic, physiological, or psychiatric disturbance.

  Example: *Healthy patient with good exercise tolerance.*

- *Class II.* A patient with mild systemic disease, controlled medical conditions without significant systemic effects.

  Example: *Controlled hypertension or diabetes mellitus without system effects, cigarette smoking without evidence of chronic obstructive pulmonary disease (COPD), anemia, mild obesity, age less than 1 or greater than 70 years, or pregnancy.*

- *Class III.* A patient exhibiting *severe* systemic disturbance that may or may not be associated with the surgical complaint and that seriously interferes with the patient's activities.

  Example: *Severely limiting organic heart disease, severe diabetes with vascular complications; moderate to severe degrees of pulmonary insufficiency; angina pectoris or healed myocardial infarction.*

- *Class IV.* A patient exhibiting *extreme* systemic disturbance that may or may not be associated with the surgical complaint, that interferes with the patient's regular activities, and that has already become life-threatening.

  Example: *Organic heart disease with marked signs of cardiac insufficiency present (for example, cardiac decompensation); persistent anginal syndrome, or active myocarditis; advanced degrees of pulmonary, hepatic, renal, or endocrine insufficiency present.*

- *Class V.* The rare person who is *moribund* (in a dying state) before operation, whose pre-operative condition is such that he or she is expected to die within 24 hours even if not subjected to the additional strain of operation.

  Example: *Burst abdominal aneurysm with profound shock; major cerebral trauma with rapidly increasing intracranial pressure; massive embolus.*

The Classification of Heart Disease consists of four classes:

- *Class I.* No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea, or anginal pain.
- *Class II.* Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain.
- *Class III.* Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitation, dyspnea, or anginal pain.
- *Class IV.* Unable to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency, or of the anginal syndrome, may be present even at rest. If any physical activity is undertaken, discomfort occurs.

4.2.3.2 Complications Following Elective or Scheduled Day Surgeries

If a condition of the scheduled day surgery requires additional care beyond the recovery period, the client may be placed in outpatient observation (stay less than 48 hours). The observation period must be submitted on an outpatient claim (TOB 131) using the hospital's provider identifier. If the client requires

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inpatient admission following the observation 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 (excluding the surgical procedure) must be included on the inpatient claim (TOB 111) using the hospital's provider identifier. The principal diagnosis to be used on the inpatient claim is the complication of the surgery that necessitated the extended stay. The day surgery procedure must still be submitted as an outpatient procedure under the HASC provider identifier.

4.2.3.3 Inpatient Admissions After Day Surgery

If a complication occurs for which the client requires inpatient admission immediately following the day surgery (no observation period), the day surgery must be submitted as an outpatient procedure (TOB 131), using the appropriate hospital or HASC provider identifier. The inpatient admission is to be submitted as an inpatient claim (TOB 111), using the hospital's provider identifier. The principal diagnosis to be used on the inpatient claim is the complication of the surgery that necessitated the extended stay. The day surgery procedure must not be included on the inpatient claim. The inpatient admission *must* be medically necessary and is subject to retrospective review.

4.2.3.4 Emergency or Unscheduled Day Surgeries

These procedures are for clients who require an unscheduled (emergency) day surgery procedure and are not inpatient at the time the day surgery is performed.

If a client is first treated in the ER and then requires emergency surgery as an outpatient, claims for emergency, unscheduled outpatient surgical procedures must be filed itemizing each service, such as room charge, laboratory, radiology, anesthesia, and supplies. Providers must submit claims for unscheduled day surgery procedures and emergency services as outpatient procedures using the hospital provider identifier. If a condition of the unscheduled day surgery requires additional care beyond the recovery period, the client may be placed on outpatient observation status. The observation period must be submitted on the same outpatient claim.

Providers *must* submit claims for the unscheduled day surgery procedures and emergency services as outpatient procedures (TOB 131) using the hospital's provider identifier. If a condition of the unscheduled day surgery requires additional care beyond the recovery period, the client may be placed on outpatient observation status (stay less than 48 hours). The observation period must be submitted on the same outpatient claim (TOB 131) using the hospital's provider identifier.

4.2.3.5 Complications Following Emergency or Unscheduled Day Surgery

If the client requires inpatient admission following the observation 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 status (excluding surgical procedures and emergency services) must be included on the inpatient claim (TOB 111) using the hospital's provider identifier. The principal diagnosis to be used on the inpatient claim is the complication of the surgery that necessitated the extended stay. The day surgery and emergency services must not be included on the inpatient claim since they are to be submitted using TOB 131 as outpatient procedures under the hospital's provider identifier.

4.2.3.6 Incomplete Day Surgeries

Facilities must use either one of the following diagnosis codes or one of the following modifiers to indicate that a surgical procedure (type of service F) was not completed:

Diagnosis Codes	
Z5309	Procedure and treatment not carried out because of other contraindication
Z5329	Procedure and treatment not carried out because of patient's decision for other reasons
Z538	Procedure and treatment not carried out for other reasons

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Modifier	Description
73	Discontinued outpatient procedure prior to anesthesia administration
74	Discontinued outpatient procedure after anesthesia administration

Providers must submit the following documentation with the claim:

- The operative report
- The anesthesia report
- The reason that the operation was not complete

Reimbursement to HASC facilities for canceled or incomplete surgeries because of patient complications, is made according to the following criteria, depending on the extent to which the anesthesia or surgery proceeded:

- Reimburse at 0 percent of HASC group payment schedule for a procedure that is terminated for nonmedical or medical reasons before the facility has expended substantial resources.
- Reimburse at 33 percent of HASC group payment schedule up to the administration of anesthesia.
- Reimburse at 67 percent of HASC group payment schedule after the administration of anesthesia but before incision.
- Reimburse at 100 percent of HASC group payment schedule after incision.

Surgeries canceled because of incomplete pre-operative procedures are not reimbursed.

4.2.4 Outpatient Observation Room Services

Observation care is defined by the 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 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 (revenue codes 760, 761, 762, and 769) 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.

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  - 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 careful 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.
- The admitting practitioner anticipates that the client will require observation care for a minimum of eight hours.

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. If a client meets the medical necessity criteria for an inpatient admission and an inpatient admission is ordered by the practitioner, an inpatient admission is a benefit regardless of the length of stay. Claims for observation services may be denied in their entirety if the services should have initially been inpatient admissions or if a reason for an inpatient admission developed, but the observation stay was not converted to inpatient.

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.

4.2.4.1 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.

4.2.4.2 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.

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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.

4.2.4.3 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.

4.2.4.4 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.

4.2.4.5 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 preadmission testing.
- Procedure notes and operative notes that address any complication that would support admission to observation status and must be dated and timed.
- Anesthesia and recovery room/post anesthesia care unit notes from the practitioner and the nurse, which must be dated and timed and detail orders and any complications that require admission to observation status.
- Documentation related to an outpatient clinic visit or critical care service that was provided on the same date of service as the observation service. The documentation must address any need for observation services and be dated and timed.
- All of the client education that was provided during the observation stay.
- The order for discharge from observation care, which must be signed, dated, and timed.
- The discharge notes, including nurse's notes that reflect the date and time at which the client was discharged from observation.

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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 48-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.

4.2.4.6 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. In situations where a diagnostic or therapeutic procedure interrupts the observation stay, hospitals should record for each period of observation services the beginning and ending times of the observation period and add the lengths of time for the periods of observation services together to reach the total number of units reported 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.

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4.2.4.7 Client Status Change

When a client's status changes from outpatient observation to inpatient admission within the allowed 48-hour observation period, both the outpatient observation service and the inpatient admission must be submitted as separate details on the same inpatient claim.

The inpatient claim must include:

- The provider must submit the correct FDOS and Date of Admission (DOA) on the claim header.
- Charges for the observation room on the inpatient claim claim may be coded using the appropriate revenue code (760, 761, 762, or 769).
- The observation services are considered part of the facility's DRG payment, and are not separately reimbursed.

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.

4.2.4.8 Inpatient Admission to Outpatient Observation

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 Texas Medicaid 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 decision is documented in the client's medical record.

Note: *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 billed as an outpatient episode of care.*

Reimbursement for emergency room (ER) and observation services are considered part of the inpatient DRG payment and must be submitted as separate details on the inpatient claim when the client is admitted as an inpatient under one or both of the following circumstances:

- The client has spent fewer than 24 hours after presenting in the ER without being placed in observation status.
- The client has spent fewer than 48 hours in observation status after presenting in the ER.

The date of admission on the inpatient claim must reflect the date the client presents at the hospital.

If the client is admitted as an inpatient more than 24 hours after presenting in the ER without being placed in observation status or more than 48 hours after being placed in observation status, the ER and observation services may be reimbursed separately as outpatient services.

Examples

The following examples indicate the appropriate dates of admission and claim submissions for different scenarios:

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Scenario 1

In scenario 1, the ER and outpatient observation services must be submitted on the inpatient hospital claim, because the ER services are within 24 hours of the observation services, and the observation services are within 48 hours of the inpatient admission, and the client was not discharged and sent home before being admitted as an inpatient.

The inpatient admission date reflects the date the patient presented at the ER.

Date and Time	Patient Services
5/1/12 (11:50 p.m.)	Patient presents in the ER
5/2/12 (12:30 a.m.)	40 minutes later, patient is placed in observation status
5/3/12 (12:00 a.m.)	23.5 hours later, after placement is in observation status, patient is admitted as an inpatient

Claims submissions are as follows:

- ***ER visit:*** Submitted on the inpatient claim as a separate detail (part of the DRG payment)
- ***Observation services:*** Submitted on the inpatient claim as a separate detail (part of the DRG payment)
- ***Date of inpatient admission:*** May 1, 2012

Scenario 2

In scenario 2, the ER service was more than 24 hours before the observation period began and must be submitted on an outpatient hospital claim. The observation service must be billed on the inpatient hospital claim because the service was within 48 hours of the inpatient admission, and the client was not discharged and sent home before being admitted as an inpatient.

The inpatient admission date reflects the date the patient was placed in observation status.

Date and Time	Patient Services
5/1/12 (11:50 p.m.)	Patient presents in the ER
5/2/12 (11:55 p.m.)	24 + hours later, patient is placed in observation status
5/3/12 (4:00 a.m.)	4 hours later, patient admitted as an inpatient

Claims submissions are as follows:

- ***ER visit:*** Submitted on an outpatient claim and reimbursed separately from the observation and inpatient services
- ***Observation services:*** Submitted on the inpatient claim as a separate detail (part of the DRG payment)
- ***Date of inpatient admission:*** May 2, 2012

Scenario 3

In scenario 3, the ER service must be submitted on an outpatient claim as part of the observation service because the ER service was within 24 hours of the observation service. The observation service may be reimbursed separately from the inpatient admission because the observation service was more than 48 hours before the inpatient admission, and the client was not discharged and sent home before being admitted as an inpatient.

The inpatient admission date reflects the date the patient was admitted as an inpatient.

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Date and Time	Patient Services
5/1/12 (11:50 p.m.)	Patient presents in the ER
5/2/12 (12:30 a.m.)	40 minutes later, patient placed in observation status
5/4/12 (12:45 a.m.)	48 + hours later patient admitted as an inpatient

Claims submissions are as follows:

- ***ER visit:*** Submitted on an outpatient claim and reimbursed as part of the outpatient observation services
- ***Observation services:*** Submitted on the outpatient claim and reimbursed separately from the inpatient services
- ***Date of inpatient admission:*** May 4, 2012

Scenario 4

In scenario 4, the ER service may be reimbursed separately because it was more than 24 hours before the client was placed in observation status. The observation service may be reimbursed separately because it was more than 48 hours before the client was admitted as an inpatient.

The inpatient admission date reflects the date the patient was admitted as an inpatient.

Date and Time	Patient Services
5/1/12 (11:50 p.m.)	Patient presents in the ER
5/2/12 (11:55 p.m.)	24 + hours later, patient is placed in observation status
5/4/12 (12:00 p.m.)	48 + hours later, patient admitted as an inpatient

Claims submissions are as follows:

- ***ER visit:*** Submitted on an outpatient claim and reimbursed separately from the observation and inpatient services.
- ***Observation services:*** Submitted on an outpatient claim and reimbursed separately from the inpatient services.
- ***Date of inpatient admission:*** May 4, 2012

Scenario 5

In scenario 5, the ER service must be submitted on an outpatient claim as part of the observation service because the ER service was within 24 hours of the observation service. The observation service may be reimbursed separately from the inpatient admission because the client was discharged and sent home without being admitted as an inpatient.

The inpatient admission date reflects the date the patient presented at the ER after being discharged and sent home 14 hours earlier.

Date and Time	Patient Services
5/1/12 (11:50 p.m.)	Patient presents in the ER
5/2/12 (12:30 a.m.)	40 minutes later, patient is placed in observation status.
5/2/12 (10:00 a.m.)	9.5 hours later, patient is discharged and sent home
5/3/12 (12:05 a.m.)	14 hours later, patient presents at the ER again and is admitted as an inpatient

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Claims submissions are as follows:

- ***ER visit:*** Submitted on an outpatient claim and reimbursed as part of the observation services
- ***Observation services:*** Submitted on the outpatient claim and reimbursed separately from the inpatient services
- ***Date of inpatient admission:*** May 3, 2012

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.

4.2.4.9 Observation Services that are not a benefit

Outpatient observation services that are not medically necessary or appropriate are not benefits of Texas Medicaid, 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, such as for nursing home placement.
- 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.
- For a medical examination for clients who do not require skilled support.

4.2.5 Hospital-Based Rural Health Clinic Services

Hospital-based RHCs must use the encounter code T1015. A hospital-based RHC is paid based on an all-inclusive encounter rate. One of the following modifiers must be submitted for general medical services: AH, AJ, AM, SA, TD, TE, or U7.

The services listed below must be submitted using the RHC provider identifier and the appropriate benefit code:

- THSteps medical checkups
- Family planning services (including implantable contraceptive capsules provision, insertion, or removal)
- Immunizations provided in hospital-based RHCs

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These services must be submitted with an AM, SA, or U7 modifier if performed in an RHC setting. Claims are paid under the Prospective Payment System (PPS) reimbursement methodology.

When submitting a claim on the CMS-1500 paper claim form, providers must use the appropriate national POS (72) for an RHC setting.

Outpatient hospital services (including emergency room services) and inpatient hospital services provided outside the RHC setting are to be submitted using the individual or group physician provider identifier.

Hospital-based RHCs must submit claims for pneumococcal and influenza vaccines as non- RHC services, under their hospital provider identifier.

Note: *A visit is a face-to-face encounter between an RHC client and a physician, PA, nurse practitioner (NP), certified nurse-midwife (CNM), visiting nurse, or clinical NP. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except where one or the other of the following conditions exists:*

- After the first encounter, the client suffers illness or injury requiring additional diagnosis or treatment.
- The RHC client has a medical visit and an other health visit.

An *other* health visit includes, but is not limited to, a face-to-face encounter between an RHC client and a clinical social worker.

4.2.6 Cardiac Rehabilitation

Cardiac rehabilitation is a physician-supervised program that furnishes physician-prescribed exercise, cardiac risk factor modification, psychosocial assessment, and outcomes assessment.

Outpatient cardiac rehabilitation is considered reasonable and necessary for clients who have had one of the following within 12 months of beginning the cardiac rehabilitation program:

- Acute myocardial infarction
- Coronary artery bypass surgery (CABG)
- Percutaneous transluminal coronary angioplasty or coronary stenting
- Heart valve repair or replacement
- Major pulmonary surgery
- Sustained ventricular tachycardia or fibrillation
- Class III or class IV congestive heart failure
- Chronic stable angina

Note: *A cardiac rehabilitation program in which the cardiac monitoring is done using telephonically transmitted electrocardiograms to a remote site is not covered by Texas Medicaid.*

Cardiac rehabilitation must be provided in a facility that has the necessary cardiopulmonary, emergency, diagnostic, and therapeutic life-saving equipment (i.e. oxygen, cardiopulmonary resuscitation equipment, or defibrillator) available for immediate use. If no clinically significant arrhythmia is documented during the first three weeks of the program, the provider may have the client complete the remaining portion without telemetry monitoring by the physician's order.

Although cardiac rehabilitation may be considered a form of physical therapy, it is a specialized program conducted by non-physician personnel who are trained in both basic and advanced cardiac life support techniques and exercise therapy for coronary disease, and provide the services under the direct supervision of a physician.

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Direct supervision of a physician means that a physician must be immediately available and accessible for medical consultations and emergencies at all times when items and services are being furnished under cardiac rehabilitation programs. Outpatient cardiac rehabilitation begins after the client has been discharged from the hospital. A physician's prescription is required after the acute convalescent period and after it has been determined that the client's clinical status and capacity will allow for safe participation in an individualized progressive exercise program. Outpatient cardiac rehabilitation requires close monitoring and direct supervision by a physician and includes:

- Medical evaluation performed by the physician responsible for prescribing the client's rehabilitation program and includes a clinical examination, a medical history, and an initial plan or goal.
- An education and counseling program to modify risk factors (nutritional counseling, stress reduction, smoking cessation, weight loss, etc.).
- Prescribed exercise concurrent with and without electrocardiogram (ECG) monitoring.
- Services performed in an approved facility by trained professionals.

Note: *Direct supervision is met when the services are performed on hospital premises or within 250 yards of the hospital.*

Cardiac rehabilitation will be limited to a maximum of 2 one-hour sessions per day and 36 sessions over 18 weeks per rolling year.

Providers must obtain prior authorization for additional cardiac rehabilitation sessions, which will be limited to a maximum of 36 sessions in an extended period of time in a 52-week period from the date of authorization of additional sessions.

To confirm that a continuation of cardiac rehabilitation is at the request of, and coordinated with the attending physician, the medical record must include evidence of communication between the cardiac rehabilitation staff and either the medical director or the referring physician. If the physician responsible for such follow-up is the medical director, then his or her notes must be evident in each client's medical record.

Cardiac rehabilitation may be considered medically necessary beyond 36 sessions if the medical record contains documentation that the client has had another cardiac event, or if the prescribing physician documents that a continuation of cardiac rehabilitation is medically necessary. Medical necessity documentation must include the following:

- Progress made from the beginning of the cardiac rehabilitation period to the current service request date, including progress towards previous goals
- Information that supports the client's capability of continued measurable progress
- A proposed treatment plan for the requested extension dates with specific goals related to the client's individual needs

Prior authorization must be obtained through the TMHP Special Medical Prior Authorization (SMPA) Department. Providers must send prior authorization requests, along with documentation to support medical necessity, to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway
Austin, TX 78727
Fax: 1-512-514-4213

Requests for prior authorization can also be submitted online through the TMHP website at www.tmhp.com.

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The evaluation provided by the cardiac rehabilitation team at the beginning of each cardiac rehabilitation session is not considered a separate service and will be included in the reimbursement for the cardiac rehabilitation session. Evaluation and management (E/M) services unrelated to cardiac rehabilitation may be submitted with modifier 25 appended to the E/M code when supporting documentation in the medical record demonstrates a separately identifiable E/M service was provided on the same day by the same provider who renders the cardiac rehabilitation.

Physical and occupational therapy will not be reimbursed separately when furnished in addition to cardiac rehabilitation exercise program services unless there is also a diagnosis of a non-cardiac condition requiring such therapy.

Example: *If a client is recuperating from an acute phase of heart disease and has had a stroke that requires physical or occupational therapy, the physical or occupational therapy for the stroke may be reimbursed separately from the cardiac rehabilitation services for the acute phase of heart disease.*

When provided as part of the cardiac rehabilitation program, client education services, such as formal lectures and counseling on diet, nutrition, and sexual activity to assist the client in adjusting living habits because of the cardiac condition, will not be separately reimbursed.

Hospitals that submit claims for cardiac rehabilitation must submit them with revenue code B-943 (other therapeutic services-cardiac rehabilitation), procedure code S9472 (cardiac rehabilitation program nonphysician provider per diem), and one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
I110	I201	I208	I209	I2101	I2102	I2109	I2111
I2119	I2121	I2129	I213	I214	I220	I221	I222
I228	I229	I501	I5020	I5021	I5022	I5023	I5030
I5031	I5032	I5033	I5040	I5041	I5042	I5043	I509
Z941	Z943	Z951	Z952	Z953	Z954	Z955	Z9861

Coverage of cardiac rehabilitation programs is considered reasonable and necessary only for clients who have documentation of acute myocardial infarction, coronary artery bypass surgery (CABG), percutaneous transluminal coronary angioplasty or coronary stenting heart valve repair/replacement, major pulmonary surgery, sustained ventrical tachycardia or fibrillation, class III or class IV congestive heart failure, or chronic stable angina within the past twelve (12) months prior to the beginning of the program.

Note: *Revenue code 943 is the code that will be reimbursed. Procedure code S9472 is required on the claim but is informational only.*

4.2.7 Chemotherapy Administration

Hospitals must submit outpatient charges using the appropriate revenue codes for room charges, supplies, IV equipment, and pharmacy.

Revenue code 636 may be reimbursed for the technical component of prolonged infusion of chemotherapeutic agents. The most appropriate chemotherapy procedure code must be billed with revenue code 636.

Refer to: Subsection 9.2.20, "Chemotherapy," in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks).*

4.2.8 Colorectal Cancer Screening

Procedure code G0122 may be reimbursed once every 5 years for services rendered to clients who are 50 years of age and older.

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Procedure code G0106 may be reimbursed once every 5 years and is limited to one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)						
Z0000*	Z0001*	Z1210	Z1211	Z1213	Z859	Z86010
***Diagnosis code Z0000 or Z0001 may be used for screening if no other diagnosis is appropriate for the service rendered, but no more frequently than recommended by the USPSTF.**						

Procedure code G0120 may be reimbursed when billed with one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone 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	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	K5281	K5282	K5289	K529	Z800	Z8371
Z85038	Z85048	Z859	Z86010				

Procedure code G0328 may be reimbursed once a year for services rendered to clients who are 50 years of age and older.

Procedure code G0122 may be reimbursed once every 5 years for services rendered to clients who are 50 years of age and older.

Refer to: Subsection 9.2.15.2, "Colorectal Cancer Screening," in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks).*

4.2.9 Computed Tomography and Magnetic Resonance Imaging

Prior authorization is required for all outpatient nonemergent (i.e., those that are scheduled) CT, computed tomography angiography (CTA), magnetic resonance imaging (MRI), and magnetic resonance angiography (MRA) studies before services are rendered. Authorization is not required for the emergency department or inpatient hospital radiology services. Retroactive authorization may be required for some outpatient emergent studies.

Reimbursement for procedures with descriptions that specify "with contrast" include payment for contrast materials. Some diagnostic radiopharmaceuticals are benefits of Texas Medicaid. Outpatient hospitals may submit the total component of the following procedure codes:

Procedure Codes							
77371	77372	77373	77422	77423	77520	77525	G0339

Procedure code 77399 may be submitted as either the total component or the technical component.

Providers can refer to the OFL or the applicable fee schedules on the TMHP website at www.tmhp.com to review the diagnostic radiopharmaceuticals that are reimbursed by Texas Medicaid. OFL and static fee schedules available on the TMHP website display fees after applicable rate reductions have been applied. Previously, the OFL and static fee schedules did not reflect all rate reductions, and providers were required to calculate the 1- and 2-percent reductions implemented.

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Refer to: Subsection 4.2.9, "Computed Tomography and Magnetic Resonance Imaging," in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*), for additional information about prior authorization requirements.

Subsection 3.2.6, "Authorization Requirements for CT, CTA, MRI, fMRI, MRA, PET, and Cardiac Nuclear Imaging Services," in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about emergency outpatient imaging services.

4.2.10 Electrodiagnostic (EDX) Testing

Electromyography (EMG) and nerve conduction studies (NCS), collectively known as EDX testing, must be medically indicated and may be reimbursed to outpatient hospitals. Testing must be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for screening purposes rather than diagnoses are not a benefit of Texas Medicaid.

NCS and EMG studies are diagnosis restricted and may require prior authorization.

Refer to: Subsection 9.2.26.7, "Esophageal pH Probe Monitoring," in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

4.2.11 Fluocinolone Acetonide

The fluocinolone acetonide intravitreal implant may be reimbursed for services rendered to clients who are 12 years of age and older. Procedure code J7311 is only payable with a posterior uveitis diagnosis of more than six months duration and the condition has been unresponsive to oral or systemic medication treatment.

4.2.11.1 Prior Authorization for Fluocinolone Acetonide

To request prior authorization, providers must submit requests by fax or mail to the SMPA Department at:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway
Austin, TX 78727
Fax: 1-512-514-4213

Requests for prior authorization can be submitted online through the TMHP website at www.tmhp.com.

4.2.12 Fetal Nonstress Testing and Contraction Stress Test

Claims for nonstress and contraction stress testing conducted in the outpatient setting must be submitted with revenue code 729. Services during an inpatient hospital stay are reimbursed under the hospital's DRG.

Refer to: Subsection 9.2.46.10, "Prenatal Surveillance," in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

4.2.13 * Hyperbaric Oxygen Therapy (HBOT)

HBOT is a type of therapy that increases the environmental oxygen pressure to promote the movement of oxygen from the environment into the client's body tissues. Such treatment may be a benefit of Texas Medicaid when it is performed in specially constructed hyperbaric chambers, pressurized to 1.4 atmosphere absolute (atm abs) or higher, which may hold one or more clients (sea-level pressure is equal to 1 atm.abs). Although oxygen may be administered by mask, cannula, or tube in addition to the hyperbaric treatment, this use of oxygen is not considered hyperbaric oxygen treatment in itself.

HBOT procedure codes 99183 and G0277 require prior authorization before the date that service is initiated.

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The number of billable units of procedure code G0277 is based upon the time that the client 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, air breaks, 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 thirty minutes, and the last unit must be fore 16-30 minutes.

Procedure code 99183 equates to one total treatment (one professional session).

Procedure code G0277 must be billed with revenue code B-413 on the same claim. If procedure code G0277 is not on the same claim as revenue code B-413, the claim will be denied.

Refer to: Subsection 9.2.33, "Hyperbaric Oxygen Therapy (HBOT)," in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information.

4.2.14 Laboratory Services

Routine laboratory services, directly related to the surgical procedure being performed, are not reimbursed separately. Claims for nonroutine laboratory services provided with emergency conditions may be submitted separately with documentation that the complicating condition arose after the initiation of the surgery. Outpatient claims for laboratory services must reflect only tests actually performed by the hospital laboratory.

Exception: Hospital laboratories may submit claims for all the tests performed on a specimen if some but not all the tests are done by another laboratory on referral from the hospital submitting the claim.

The billing hospital must enter the name and provider identifier of the performing laboratory in Block 80 of the UB-04 CMS-1450 paper claim form and must enter the performing laboratory's provider identifier next to the service provided by the performing laboratory.

Hospitals may submit claims for a handling fee (procedure code 99001) for collecting and forwarding a specimen to a referral laboratory when the laboratory handling fee is not being billed through other methods. Only one handling fee may be charged per day, per client, unless specimens are sent to two or more different laboratories; this must be documented on the claim.

Refer to: *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

4.2.14.1 Clinical Laboratory Improvement Amendments (CLIA)

All providers of laboratory services must comply with the rules and regulations of CLIA. Providers not complying with CLIA will not be reimbursed for laboratory services.

Refer to: Subsection 1.1, "Provider Enrollment and Reenrollment," in Section 1, "Provider Enrollment and Responsibilities" *(Vol. 1, General Information)* for more information about enrollment procedures.

Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA),"in the *Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks)* for more information about CLIA.

The *Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks)*.

4.2.15 Lung Volume Reduction Surgery (LVRS)

LVRS surgery must be performed in a facility that meets at least one of the following requirements:

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- Certified under the Disease Specific Care Certification Program for LVRS by the Joint Commission on Accreditation of Health Care Organization (JCAHO)
- Approved by Medicare as a lung or heart-lung transplant facility

The surgery must be both preceded and followed by a program of diagnostic and therapeutic services that are consistent with those provided in the National Emphysema Treatment Trial (NETT) and designed to maximize the client's potential to successfully undergo and recover from surgery. The program must meet all of the following requirements:

- Include a 6-to 10-week series of at least 16, and no more than 20, pre-operative sessions, each lasting a minimum of 2 hours
- Include at least 6, and no more than 10, post-operative sessions, each lasting a minimum of 2 hours, within 8 to 9 weeks after the LVRS
- Be consistent with the care plan that was developed by the treating physician following the performance of a comprehensive evaluation of the client's medical, psychosocial, and nutritional needs
- Be arranged, monitored, and performed under the coordination of the facility where the surgery takes placePrior authorization is required for the LVRS procedure. However; prior authorization is not required for the pre-operative and post-discharge pulmonary services

LVRS must be prior authorized and is limited to clients who have severe emphysema, disabling dyspnea, and evidence of severe air trapping. Prior authorization is not required for the associated preoperative pulmonary surgery services for preparation of LVRS (procedure codes G0302, G0303, and G0304) or the associated postdischarge pulmonary surgery services after LVRS (procedure code G0305).

LVRS and post-discharge LVRS are restricted to the following eemphysema diagnosis codes:

Diangosis Codes				
J430	J431	J432	J438	J983

Procedure codes 32491, G0302, G0303, G0304 and G0305 are limited to one per rolling year per client any provider.

Procedure code G0305 may be reimbursed only if a claim for LVRS (procedure code 32491) has been submitted within the past 12 months.

Refer to: Subsection 9.2.42, "Lung Volume Reduction Surgery (LVRS)" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

4.2.16 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 the submitted procedure code.*

Refer to: Subsection 9.2.64, "Magnetoencephalography (MEG)" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

4.2.17 Neurostimulators

Neurostimulators may be a benefit in the outpatient hospital setting when medically necessary. All procedures require prior authorizations.

Refer to: Subsection 9.2.44, "Neurostimulators," in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 4.2.17.1, "Prior Authorization for Neurostimulators," in this handbook.

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4.2.17.1 Prior Authorization for Neurostimulators

All devices and related procedures for the initial application or surgical implantation of the stimulator device require prior authorization. Requests for prior authorization must be submitted to the SMPA Department.

Refer to: Subsection 9.2.44.1, "Prior Authorization for Neurostimulators," in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2 Provider Handbooks).*

4.2.18 Occupational and Physical Therapy Services

Refer to: *Nursing and Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about therapy services.

4.2.19 Radiation Therapy Services

Take-home drugs given during the course of therapy can be reimbursed separately through the VDP.

Hospitals use revenue code 333, Radiation therapy, on the UB-04 CMS-1450 paper claim form when submitting charges for these services.

The following radiation therapy services provided in an outpatient setting are allowed only once per day unless documentation of medical necessity supports the need for repeated services:

- Therapeutic radiation treatment planning
- Therapeutic radiology simulation-aided field setting
- Teletherapy
- Brachytherapy isodose calculation
- Treatment devices
- Proton beam delivery/treatment
- Intracavity radiation source application
- Interstitial radiation source application
- Remote afterloading high intensity brachytherapy
- Radiation treatment delivery
- Localization, and radioisotope therapy

4.2.19.1 Radiopharmaceuticals

Radiopharmaceuticals may be considered for separate reimbursement when used for therapeutic treatment.

The following procedure codes are payable to outpatient hospitals:

Procedure Codes							
79403*	A9542	A9543	A9545	A9563	A9564	A9600	A9699
***Total or technical component**							

Procedure codes A9542, A9543, and A9545 require prior authorization. Tositumomab or Ibritumomab Tiuxetan will be considered when submitted with one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
C8259	C8399	C8499	C84A9	C84Z9	C8519	C8529	C8589
C8599							

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Strontium-89 chloride may be billed using procedure code A9600 and will be limited to a total of 10 mci intravenously injected every 90 days, any provider.

Strontium-89 chloride is reimbursed as one service per day for the same provider on the same claim.

Strontium-89 chloride will be considered when submitted with diagnosis code C7951 or C7952.

Sodium phosphate p-32, therapeutic, will be considered when submitted with one of the following diagnoses:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
C7951	C7952	C9110	C9112	C9192	C91Z2	C9292	C92Z2
C9512	C9592	D45					

Chromic phosphate p-32 suspension will considered when submitted with diagnosis code C782 (secondary malignant neoplasm of the pleura) and diagnosis code C786 (secondary malignant neoplasm of the retroperitoneum and peritoneum).

Refer to: Subsection 9.2.62, "Radiation Therapy," in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Prior Authorization for Therapeutic Radiopharmaceuticals

Prior authorization is required for A9542, A9543, and A9545, which will be considered with documentation of all of the following:

- A diagnosis of either a low-grade follicular or transformed B-cell non-Hodgkin's lymphoma.
- Client has failed, relapsed, or become refractory to conventional chemotherapy.
- Marrow involvement is less than 26 percent.
- Platelet count is 100,000 cell/mm3 or greater.
- Neutrophil count is 1,500 cells/mm3 or greater.
- Client has failed a trial of rituximab.

Prior authorization must be requested through the SMPA department with appropriate documentation. Requests can be mailed or faxed to:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway
Austin, TX 78727
Fax: 1-512-514-4213

Requests for prior authorization can be submitted online through the TMHP website at www.tmhp.com.

4.2.20 Respiratory Services

4.2.20.1 Aerosol Treatment

Nebulized aerosol treatments with short-acting beta-agonists provided in the outpatient setting are considered medically necessary for certain acute medical problems when breathing is compromised. Authorization is not required for aerosol treatments.

Outpatient facilities must submit claims for aerosol treatments using revenue code 412 and the appropriate beta-agonist procedure code.

4.2.20.2 Pentamidine Aerosol

Aerosol pentamidine treatments are reimbursed using procedure code 94642. Providers may also be reimbursed for pentamidine medication using procedure code J2545.

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Reimbursement for aerosol pentamidine treatment is limited to the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)						
A481	B20	B4481	B59	B9733	B9734	B9735

Aerosol pentamidine treatments are limited to one treatment every 28 days.

Oral trimethoprim-sulfamethoxazole is available from pharmacies for self administration at home. The use of oral trimethoprim-sulfamethoxazole is not a payable benefit of the insured portion of Texas Medicaid.

4.2.20.3 Diagnostic Testing

Nitric oxide expired gas determination (FeNO) measurement provided in the physician's office or outpatient hospital setting is considered medically necessary as an adjunct to the established clinical and laboratory assessments for diagnosing and assessing asthma, predicting exacerbations, and evaluating the response of a patient with asthma to anti-inflammatory therapy.

Claims for nitric oxide treatments may be submitted using procedure code 95012. Hospital providers must include the following when submitting claims for procedure code 95012:

- Revenue code 419 must appear on the same line as procedure code 95012.
- The claim must have a line item for either procedure code 94010 or 94060. This line item must also indicate revenue code 419.

Note: *Procedure code 94010 or 94060, when submitted in conjunction with procedure code 95012, may only be reimbursed in an office or outpatient hospital setting, and is not reimbursed for critical care, emergency care, or anesthesiology.*

4.2.20.4 Pulmonary Function Studies

Pulmonary function studies considered for reimbursement to outpatient hospitals include, but are not limited to, the following procedures when submitted with the total component (TOS 5):

Procedure Codes									
94010	94060	94070	94150	94200	94250	94375	94400	94450	94452
94453	94620	94621	94726	94727	94728	94729	95012		

High Altitude Simulation Test (HAST) procedure codes 94452 and 94453 must be submitted with one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
E840*	E8411	E8419*	E848*	E849*	I270*	I271*	I272*
I2781*	I2789*	I279*	J410*	J411*	J418*	J42*	J430*
J431*	J432*	J438*	J439*	J440*	J441*	J449*	J471*
J479*	J60*	J700*	J701	J708*	J709*	J82*	J8401
J8402	J8403	J8409	J8410	J849	J9610	J9611	J9612
J982	P270*	P271*	P278*	Q332*	Q334	Q336	

Note: *When billing for HAST (procedure code 94452 or 94453) with one of the diagnosis codes indicated in the table with an asterisk (*), evidence of hypoxemia must be documented in the clientâ€™s medical record.*

When multiple procedure codes are submitted, the most inclusive code of the related codes will be reimbursed and all other related codes will be denied.

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When unrelated pulmonary function studies are submitted together, each will be considered for reimbursement.

4.2.21 Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Refer to: Subsection 7, "Screening, Brief Intervention, and Referral to Treatment (SBIRT)" in the *Behavioral Health, Rehabilitation, and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*).

4.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including hospital services. Hospital services are subject to retrospective review and recoupment if documentation does not support the service that was submitted for reimbursement.

4.4 Outpatient Utilization Review

UR activities of all Medicaid services provided by hospitals reimbursed under the DRG prospective payment system are required by Title XIX of the Social Security Act, Sections 1902 and 1903. The review activities are accomplished through a series of monitoring systems developed to ensure services are appropriate to need, of optimum quality and quantity, and rendered in the most cost-effective mode. Clients and providers are subject to UR monitoring. The monitoring focuses on the appropriate screening activities, medical necessity of all services, and quality of care as reflected by the choice of services provided, type of provider involved, and settings in which the care was delivered. This monitoring ensures the efficient and cost-effective administration of Texas Medicaid.

TMHP is responsible for a comprehensive integrated review process to identify misuse and inappropriate claim submission patterns by outpatient hospitals and HASCs. All providers are subject to TMHP's UR monitoring. Providers are selected for review based on a comparison of their individual resource utilization with a peer group of similar specialty and geographic locality. The main goal of the required utilization control is to identify those providers whose practice patterns are aberrant from their peers and provide the necessary educational actions to help the provider achieve Texas Medicaid compliance. An analysis of UR data is completed by a registered nurse analyst for review by the medical director and staff. If the analyst substantiates that a provider's practice and claim submission patterns are inconsistent with the federal requirements and Texas Medicaid's scope of benefits, a TMHP representative contacts the provider. The purpose of the contact is to discuss appropriate claim submission guidelines and to assist the provider in resolving the inappropriate claim submission patterns identified in the review.

TMHP uses the following criteria when reviewing all hospital outpatient medical records. Services must be:

- Medically necessary.
- Ordered by a physician, signed, and dated. Signature stamps are valid if initialed and dated by the physician.
- Submitted in the quantities ordered and documented as provided.
- Program benefits.
- Specifically identified on the charge tickets or itemized statement submitted with the claim or by the HCPCS procedure code on the claim.
- Indicated by the documentation in the medical record.
- Submitted to Texas Medicaid only after other medical insurance resources have been exhausted.

Refer to: Subsection 4.12.1, "Your Texas Benefits Medicaid Card," in Section 4, "Client Eligibility" (*Vol. 1, General Information*).

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The determination of the TMHP UR process may result in the following:

- Educational letters and visits
- Mail-in of medical records for review
- On-site medical record review (outpatient, HASC, or inpatient records not reviewed)
- Referral of questionable claims to HHSC or HHSC OIG
- Recoupment
- Prepayment review

The intent of these actions is to ensure the most effective and appropriate use of available services and facilities and provide appropriate, cost-effective care to clients with Medicaid coverage.

4.5 Claims Filing and Reimbursement

4.5.1 Outpatient Claims Information

Claims for scheduled procedures that are performed in a HASC must be submitted using the HASC provider identifier with type of bill (TOB) 131. Claims for emergency or unscheduled procedures performed in a hospital when the client is an outpatient must be submitted using the hospital provider identifier and appropriate revenue and HCPCS code (if required) with TOB 131.

Claims for outpatient hospital services must be submitted to TMHP in an approved electronic format or on the UB-04 CMS-1450 paper claim form.

Freestanding ambulatory surgical centers must submit claims on the CMS-1500 claim form. The performing surgeon or referring physician name and number must be identified in Block 17. Identification of outpatient charges must be in Block 44 if submitting by HCPCS code. If appropriate, the revenue code must be indicated in Block 42. Texas Medicaid recommends the use of specific procedure codes for claim submission. Do *not* use the revenue code description in Block 43; the HCPCS narrative description must be identified in this block. For example, when submitting charges for physical therapy, do not use the description associated with revenue code 420. To receive reimbursement for physical therapy services, providers must identify the specific modality used (e.g., gait training).

Examples:

- *Emergency Room.* Submit as "Emergency room" or "Emergency room charge per use." If the client visits the emergency room more than once in one day, the time must be given for each visit. The time of the first visit must be identified in Block 13, 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. Claims for emergency CT, CTA, MRI, or MRA studies provided in the emergency department must have the appropriate corresponding emergency services revenue code (450, 451, 456, or 459) to be considered for payment.
- *Observation Room.* Submit as "observation room." (Revenue code 762).
- *Operating Room.* Submit as "Operating Room." (Revenue code 360, 361, or 369).
- *Recovery Room.* Submit as "Recovery Room" or "Cast Room" as appropriate. (Revenue code 710 or 719).
- *Injections.* Must have "Inj.-name of drug; route of administration; the dosage and quantity" or the injection code.
- *Drugs and Supplies.* The drug description must include the name, strength, and quantity. Take-home drugs and supplies are not a benefit of Texas Medicaid:
    - Take-home drugs must be submitted with revenue code 253.

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  - Take-home supplies must be submitted with revenue code 273.
  - Self-administered drugs must be submitted with revenue code 637.
- *Radiology.* Facilities must submit claims using the most appropriate revenue and HCPCS code. The physician must submit claims for professional services by a physician separately. The license number of the ordering physician must be in Block 83. If the client receives the same radiology procedure more than once in one day, the time must be given for each visit. The time of the first visit must be identified in Block 13, using 00 to 23 hours military time (such as 1350 for 1:50 p.m.). Indicate other times on the same line as the procedure code.
- *Laboratory.* Provide a complete description or use the procedure codes for the laboratory procedures. The physician must submit claims for professional services by a physician separately. Blocks 78–79 must have the license number of the ordering physician. If laboratory work is sent out, enter the name of the test and name and address or Medicaid number of the laboratory where the work was forwarded. If the client receives the same laboratory procedure more than once in one day, give the time for each visit. The time of the first visit must be identified in Block 13, 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.
- *Nuclear Medicine.* Provide a complete description.
- *Day Surgery.* Day surgery must be submitted as an inclusive charge using TOS F. Providers must not submit claims for separate services that were provided in conjunction with the surgery (e.g., lab, radiology, and anesthesia). File claims for unscheduled emergency outpatient surgical procedures with separate charges (e.g., lab, radiology, anesthesia, and emergency room) for all services using TOB 131 and the hospital's provider identifier.

Claims for emergency or unscheduled procedures performed in a hospital when the client is an outpatient must be submitted using the hospital provider identifier and appropriate revenue and HCPCS code (if required) with TOB 131.

Refer to the ASC/HASC section for information on scheduled procedures.Additional claims information can be found within individual topic areas within this section.

Charges on claims must be itemized on the face of the UB-04 CMS-1450 paper claim form instead of submitting attachments or charge details. TMHP uses information attached to the claim for clarification purposes only.

If a claim contains more than 28 details, continue the claim on additional UB-04 CMS-1450 paper claim forms or electronic equivalent. Total each claim form as a stand-alone claim. If you do not total each page, your claim may be denied for being over the limitation, and must be resubmitted with 28 or less details.

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. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions," in Section 6, "Claims Filing" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

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Outpatient hospital services must be itemized by date of service. Procedures repeated over a period of time must be submitted for each separate date of service. Do not combine multiple dates of service on the same line detail.

4.5.2 Outpatient Reimbursement

Outpatient services are reimbursed on a reasonable cost based on a percentage of the hospital's most recent tentative Medicaid cost report settlement.

The reimbursement rate for non-high-volume hospitals is as follows with the application of the hospital specific interim rate:

Non-high-volume Provider	Current Allowable Rate
Children's hospitals	72.27 percent of the allowable charges
Rural hospitals	100 percent of the allowable charges
State-owned teaching hospitals	72.27 percent of the allowable charges
Other hospitals	68.44 percent of the allowable charges

The reimbursement rate for high-volume hospitals is as follows with the application of the hospital specific interim rate:

High-volume Provider	Current Allowable Rate
Children's hospitals	76.03 percent of the allowable charges
Rural hospitals	100 percent of the allowable charges
State-owned teaching hospitals	76.03 percent of the allowable charges
Other hospitals	72 percent of the allowable charges
ASCs/HASCs that qualify as high-volume providers	Additional 5.2 percent increase in payment rates

High-volume providers are eligible for additional payments on Texas Medicaid fee-for-service claims. A high-volume outpatient hospital provider is defined as one that was paid at least $200,000 during calendar year 2004.

All clinical laboratory services are reimbursed at a percentage of the prevailing charge. Hospitals that are identified by Medicare as sole community hospitals are reimbursed at a higher percentage of the prevailing charges for services that are provided to clients in the outpatient setting.

Clinical pathology consultations are also allowed for reimbursement.

Refer to: The HHSC Rate Analysis web page at www.hhsc.state.tx.us/rad/hospital-svcs/index.shtml for additional information about hospital reimbursement.

Subsection 3.7.4, "Provider Cost and Reporting," in this handbook for more information about the calculation of the interim rate.

Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)," in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

4.5.3 Provider Cost and Reporting

Refer to: Subsection 3.7.4, "Provider Cost and Reporting," in this handbook.

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4.5.4 National Correct Coding Initiative (NCCI) and Medically Unlikely Edit (MUE) Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* are subject to National Correct Coding Initiative (NCCI) relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. 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 Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

4.5.5 Outpatient Hospital Revenue Codes

UB-04 CMS-1450 revenue codes must be used to submit claims for outpatient hospital facility services. In some instances, a HCPCS procedure code is required in addition to the revenue code for accurate claims processing:

Revenue Code	Description	Comments
Special Charges – Canceled Surgery		
220	Special Charges	Procedure code required
Pharmacy		
250	General classification	
251	Generic drugs	
252	Nongeneric drugs	
253	Take-home drugs	Not a benefit
254	Drugs incident to other diagnostic services	
255	Drugs incident to radiology	
256	Experimental drugs	Not a benefit
257	Nonprescription drugs	
258	IV solutions	
259	Other pharmacy	
260	General classification	
261	Infusion pump	
262	IV therapy/pharmacy services	
263	IV therapy/drug/supply delivery	
264	IV therapy/supplies	
269	Other IV therapy	
Medical/Surgical Supplies and Devices		
270	General classification	
271	Nonsterile supply	
272	Sterile supply	
273	Take-home supplies	Not a benefit
274	Prosthetic/orthotic devices	Not a benefit
275	Pacemaker	
276	Intraocular lens	
277	Oxygen take-home	Not a benefit

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Revenue Code	Description	Comments
278	Medical/surgical supplies and devices- other implants	Procedure code required
279	Medical/surgical supplies and devices- other	Procedure code required
280	General Classification	
289	Other oncology	
300	Laboratory	Procedure code required
301	Laboratory- chemistry	Procedure code required
302	Laboratory- immunology	Procedure code required
303	Laboratory- renal patient (home)	Procedure code required
304	Laboratory- non-routine dialysis	Procedure code required
305	Laboratory- hematology	Procedure code required
306	Laboratory- bacteriology/microbiology	Procedure code required
307	Laboratory- urology	Procedure code required
309	Laboratory- other	Procedure code required
Laboratory – Pathological		
310	Laboratory- pathological	Procedure code required
311	Laboratory- pathological cytology	Procedure code required
312	Laboratory- pathological histology	Procedure code required
314	Laboratory- pathological biopsy	Procedure code required
319	Laboratory- pathological other	Procedure code required
Radiology – Diagnostic		
320	Radiology- diagnostic	Procedure code required
321	Radiology- diagnostic angiocardiography	Procedure code required
322	Radiology- diagnostic, arthrography	Procedure code required
323	Diagnostic, arteriography	Procedure code required
324	Chest X-ray	Procedure code required
329	Other diagnostic radiology	Procedure code required
Radiology – Therapeutic		
330	General classification	Procedure code required
331	Chemotherapy-injected	Procedure code required
332	Chemotherapy-oral	Procedure code required
333	Chemotherapy-radiation therapy	Procedure code required
335	Chemotherapy-IV	Procedure code required
339	Other therapeutic radiology	Procedure code required
Nuclear Medicine		
340	General classification	Procedure code required
341	Nuclear medicine- diagnostic	Procedure code required
342	Nuclear medicine- therapeutic	Procedure code required
349	Nuclear medicine- other	Procedure code required
Computed Tomography (CT) Scan		

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Revenue Code	Description	Comments
350	General classification	Procedure code required
351	CT scan- head scan	Procedure code required
352	CT scan- body scan	Procedure code required
359	CT scan- other CT scans	Procedure code required
Operating Room Services		
360	Operating room services	
361	Minor surgery	
369	Other operating room services	
Anesthesia		
370	Anesthesia	
371	Anesthesia incident to radiology	
372	Anesthesia incident to other diagnostic services	
374	Acupuncture	Not a benefit
379	Other anesthesia	
380	Blood	Procedure code required
381	Blood- packed red cells	Procedure code required
382	Blood- whole blood	Procedure code required
383	Blood- plasma	Procedure code required
384	Blood- platelets	Procedure code required
385	Blood- leucocytes	Procedure code required
386	Blood- other components	Procedure code required
387	Blood- other derivatives (cryoprecipitates)	Procedure code required
389	Other blood	Procedure code required
Blood Storage and Processing		
390	Blood storage and processing	
391	Blood administration	Not a benefit
399	Other blood storage and processing	Not a benefit
Other Imaging Services		
400	Other imaging services	Procedure code required
401	Other imaging services- diagnostic mammography	Procedure code required
402	Other imaging services- ultrasound	Procedure code required
403	Other imaging services- screening mammography	Procedure code required
404	Other imaging services- positron emission tomography	Procedure code required
409	Other imaging services- other	Procedure code required
Respiratory Services		
410	Respiratory services	
412	Inhalation services	
413	Hyperbaric oxygen therapy	
419	Other respiratory services	Procedure code required

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Revenue Code	Description	Comments
Physical Therapy		
420	Physical therapy	Procedure code required
421	Physical therapy- visit charge	Procedure code required
422	Physical therapy- hourly charge	Procedure code required
423	Physical therapy- group rate	Procedure code required
424	Physical therapy- evaluation/reevaluation	Procedure code required
429	Physical therapy- other	Procedure code required
Occupational Therapy		
430	Occupational therapy	Procedure code required
431	Occupational therapy- visit charge	Procedure code required
432	Occupational therapy- hourly	Procedure code required
433	Occupational therapy- group rate	Procedure code required
434	Occupational therapy- evaluation/reevaluation	Procedure code required
439	Occupational therapy- other	Procedure code required
Speech-Language Pathology		
440	Speech-language pathology	
441	Speech-language pathology- visit charge	Procedure code required
442	Speech-language pathology- hourly charge	Procedure code required
443	Speech-language pathology- group rate	Procedure code required
444	Speech-language pathology- evaluation/reevaluation	Procedure code required
449	Speech-language pathology- other	Procedure code required
Emergency Room		
450	Emergency room	Procedure code required
451	EMTALA emergency medical screening services	
456	Urgent care	Procedure code required
459	Other	Procedure code required
460	Pulmonary function	Procedure code required
469	Pulmonary function- other	Procedure code required
Audiology		
470	Audiology	Procedure code required
471	Audiology- diagnostic	Procedure code required
472	Audiology- treatment	Procedure code required
479	Audiology- other	Procedure code required
Cardiology		
480	Cardiology	Procedure code required
481	Cardiology- cardiac cath lab	Procedure code required
482	Cardiology- stress test	Procedure code required
483	Unassigned procedure code	Procedure code required
489	Cardiology- other	Procedure code required

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Revenue Code	Description	Comments
Clinic		
510	Clinic	
511	Chronic pain center	
512	Dental clinic	
513	Psychiatric clinic	
514	Obstetrics-Gynecology (OB/GYN) clinic	
515	Pediatric clinic	
516	Urgent care clinic	
517	Family practice clinic	
519	Other clinic	
Freestanding Clinic		
520	Freestanding clinic	
523	Family practice clinic	
526	Urgent care clinic	
529	Other freestanding clinic	
Skilled Nursing (Home Health)		
550	Skilled nursing	Procedure code required
551	Skilled nursing- visit charge	Procedure code required
552	Skilled nursing- hourly charge	Procedure code required
559	Skilled nursing- other	Procedure code required
Medical Social Services (Home Health)		
560	Medical social services	Procedure code required
561	Medical social services- visit charge	Procedure code required
562	Medical social services- hourly charge	Procedure code required
569	Medical social services- other	Procedure code required
Home Health Aide (Home Health)		
570	Home health aide	Procedure code required
571	Home health aide- visit charge	Procedure code required
572	Home health aide- hourly charge	Procedure code required
579	Home health aide- other	Procedure code required
Other Visits (Home Health)		
580	Other visits (home health)	Procedure code required
581	Other visits (home health)- visit charge	Procedure code required
582	Other visits (home health)- hourly charge	Procedure code required
589	Other visits (home health)- other	Procedure code required
Magnetic Resonance Technology (MRT)		
610	Magnetic resonance imaging- general classification	Procedure code required
611	Magnetic resonance imaging- brain (incl brain stem)	Procedure code required

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Revenue Code	Description	Comments
612	Magnetic resonance imaging- spinal cord (incl spine)	Procedure code required
619	Magnetic resonance imaging- other MRI	Procedure code required
Drugs Requiring Specific Identification		
630	Drugs requiring specific identification	
631	Drugs requiring specific identification, single source drug	
632	Drugs requiring specific identification, multiple source drug	
633	Drugs requiring specific identification, restrictive prescription	
634	Drugs requiring specific identification, erythro-poietin (EPO) less than 10,000 units	
635	Drugs requiring specific identification, erythro-poietin (EPO) 10,000 or more units	
636	Drugs requiring specific identification, drugs requiring detailed coding	
Hospice Service		
650	Hospice services	
651	Routine home care	
652	Continuous home care - 1/2 (at least 8 but less than 16 hrs care)	
655	Inpatient respite care	
656	General inpatient care/non-respite	
657	Physician	
659	Hospice services - other	
Cast Room		
700	General classification	
709	Other cast room	
Recovery Room		
710	General classification	
719	Other recovery room	
Labor Room/Delivery		
720	General classification	
721	Labor	
722	Delivery	
723	Circumcision	
724	Birthing center	
729	Other labor room/delivery	
Electrocardiogram (EKG/ECG)		
730	General classification	Procedure code required
731	Holter monitor	Procedure code required
732	Telemetry	Procedure code required

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Revenue Code	Description	Comments
739	Other EKG/ECG	Procedure code required
Electroencephalogram (EEG)		
740	General classification	Procedure code required
741	Other EEG	Procedure code required
Gastrointestinal Services		
750	General classification	
759	Other gastrointestinal	
Treatment or Observation Room		
760	General classification	
761	Treatment room	
762	Observation room	
769	Other treatment/observation room	
Preventive Care Services		
770	General classification	Procedure code required
771	Vaccine administration	Procedure code required
779	Other preventive care services	Procedure code required
Lithotripsy		
790	General classification	Not a benefit
799	Other lithotripsy	Not a benefit
Miscellaneous Dialysis		
880	Miscellaneous dialysis	Procedure code required
881	Ultrafiltration	
Other Diagnostic Services		
920	General classification	Procedure code required
921	Peripheral vascular lab	Procedure code required
922	Electromyelogram	Procedure code required
923	Pap smear	Procedure code required
924	Allergy test	Procedure code required
925	Pregnancy test	Procedure code required
929	Other diagnostic service	Procedure code required
943	Cardiac rehabilitation	Procedure code required

Refer to: The National Uniform Billing Committee (NUBC) website at www.nubc.org for additonal information.

4.5.6 Third Party Liability

Hospitals and providers enrolled in Texas Medicaid are required to inform TMHP about circumstances that may result in third party liability for health-care claims. After receiving this information, TMHP pursues reimbursement from responsible third parties.

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Hospitals and providers must mail or fax the Other Insurance Form for Health Insurance or the Tort Response Form for accidents to the following address:

Texas Medicaid & Healthcare Partnership
TPL Correspondence
Third Party Liability Unit PO Box 202948
Austin, TX 78720-2948
Fax: 1-512-514-4225

Refer to: Subsection 3.7.1, "Medicaid Relationship to Medicare," in this handbook.

Subsection 4.12, "Third Party Liability (TPL)," in Section 4, "Client Eligibility" *(Vol. 1, General Information)*.

Other Insurance Form on the TMHP website at www.tmhp.com.

Tort Response Form on the TMHP website at www.tmhp.com.

Subsection 3.7.5, "Third Party Liability," in this handbook.

5 Ambulatory Surgical Center and Hospital Ambulatory Surgical Center

5.1 Enrollment

To enroll in Texas Medicaid, an ASC must do the following:

- Meet and comply with applicable state and federal laws, rules, regulations, and provisions of the state plan under Title XIX of the Social Security Act
- Be enrolled in Medicare
- Meet and comply with state licensure requirements for ASCs

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

All hospitals enrolling in Texas Medicaid (except psychiatric and rehabilitation hospitals) are issued an HASC provider number at the time of enrollment.

An out-of-state provider may enroll in Texas Medicaid if it is the customary or general practice for clients in a particular locality to use medical resources in another state. An out-of-state provider located within 50 miles of the Texas border is automatically considered to meet this criterion.

Refer to: Subsection 1.1, "Provider Enrollment and Reenrollment," in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment procedures.

Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)," in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

The *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

5.2 Services, Benefits, Limitations, and Prior Authorization

ASCs, both freestanding and hospital-based, provide same day elective surgery for clients who do not require a hospital admission and who are not expected to require extensive postoperative care.

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5.2.1 Drugs and Supplies

Outpatient prescribed medications are a benefit to eligible clients when obtained through a pharmacy contracted with the Medicaid Vendor Drug Program. Prescribed take-home supplies are a benefit to eligible clients when obtained through Medicaid durable medical equipment (DME).

Refer to: Appendix B: Vendor Drug Program *(Vol. 1, General Information)* for information about outpatient prescription drugs and the Medicaid Vendor Drug Program.

Subsection 2.2.3, "* Medical Supplies," in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2, Provider Handbooks)*.

5.2.2 Incomplete Surgical Procedures

Refer to: Subsection 4.2.3.6, "Incomplete Day Surgeries" in this handbook for information about incomplete surgical procedures.

5.2.3 Complications Following Day Surgery Requiring Outpatient Observation or Inpatient Admission

If the client is placed in outpatient observation or inpatient status following an HASC day surgery, the day surgery procedure must still be submitted as an outpatient procedure under the HASC provider identifier.

Refer to: Subsection 4.2.3.2, "Complications Following Elective or Scheduled Day Surgeries," and Subsection 4.2.3.4, "Emergency or Unscheduled Day Surgeries," in this handbook.

5.2.4 Planned Admission for Day Surgery

Inpatients may occasionally require a surgery that has been designated as an outpatient procedure. The physician must document the need for this surgery as an inpatient procedure before the procedure is performed. These claims are subject to retrospective review.

5.2.5 Cochlear Implants

A cochlear implant is a benefit of Texas Medicaid when medically indicated. ASC and HASC providers may be reimbursed for the implantation procedure using procedure code 69930, and for the cochlear implant devices using procedure code L8614.

Refer to: Subsection 9.2.23, "Cochlear Implants," in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks*).

5.2.6 Colorectal Cancer Screening

Procedure codes G0104 and G0105 are benefits of Texas Medicaid in the ASC or HASC setting.

Procedure codes G0104 and G0106 are a benefit once every five (5) years as recommended by the ACS and US Preventative Services Task Force for the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)						
Z0000*	Z0001*	Z1210	Z1211	Z1213	Z859	Z86010
***Diagnosis code Z0000 or Z0001 may be used for screening if no other diagnosis is appropriate for the service rendered, but no more frequently than recommended by the USPSTF.**						

Authorization is not required for colorectal cancer screening.

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5.2.7 Average-Risk and High-Risk Colonoscopies

Procedure code G0121 may be reimbursed once every ten years for patients who do not meet the criteria for high-risk as recommended by the ACS and USPSTF. Procedure code G0121 must be submitted with one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)					
Z0000*	Z0001*	Z1210	Z1211	Z1213	Z86010
***Diagnosis code Z0000 or Z0001 may be used for screening if no other diagnosis is appropriate for the service rendered, but no more frequently than recommended by the USPSTF.**					

Procedure codes G0105 and G0120 are a benefit once every two years for clients meeting the definition of high-risk for the following diagnosis codes:

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	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	K5281	K5282	K5289	K529	Z800	Z8371
Z85038	Z85048	Z859	Z86010				

5.2.8 Dental Therapy Under General Anesthesia

Facilities must use procedure code 41899 with modifier EP to submit claims for dental therapy under general anesthesia. Prior authorization is not required for ASCs and HASCs unless the client is enrolled in a Medicaid managed care organization.

Refer to: Subsection 4.2.25, "Dental Therapy Under General Anesthesia," in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 4.2.26, "Hospitalization and ASC/HASC," in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

5.2.9 Fluocinolone Acetonide

Procedure code 67027 for implantation may be reimbursed to HASCs. This benefit is limited to clients who are 12 years of age and older and requires prior authorization.

Refer to: Non-emergency Ambulance Prior Authorization Request on the TMHP website at www.tmhp.com.

Subsection 4.2.11, "Fluocinolone Acetonide," in this handbook.

5.2.10 Implantable Infusion Pumps

Implantable infusion pumps are a benefit of Texas Medicaid. Implantable infusion pumps may be medically necessary in the following circumstances:

- Administration of intrathecal or epidural antispasmodic drugs to treat refractory intractable spasticity
- Administration of intrathecal, epidural, or central venous analgesic (opioid or non-opioid) drugs for treatment of severe chronic intractable pain

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- Administration of intrahepatic chemotherapy for primary liver cancer or metastatic cancer with metastases limited to the liver

An IIP is not a benefit for the following uses:

- Continuous insulin infusion for diabetes
- Continuous heparin infusion for recurrent thromboembolic disease
- Continuous intralesional infusion for severe chronic intractable pain
- Continuous intra-arterial infusion
- Continuous intra-articular infusion for severe chronic intractable pain
- Administration of antibiotics for osteomyelitis

All supplies associated with an IIP are included with the reimbursement for the surgery to implant the infusion pump and are not reimbursed separately.

Providers may be reimbursed for implantable infusion pumps using procedure codes E0782, E0783, and E0786.

If procedure codes E0782 and E0783 are billed with the same date of service, only one may be reimbursed.

Refer to: Subsection 9.2.39.22, "Implantable Infusion Pumps," in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)*.

5.2.10.1 Prior Authorization for Implantable Infusion Pump

Implantable infusion pumps (procedure codes E0782, E0783, and E0786) require prior authorization.

Prior authorization is not required for the physician services associated with the insertion, revision, removal, refilling, or maintenance of the IIP.

Providers must request prior authorization for the implantable infusion pump through the SMPA department with the supporting documentation for medical necessity. Send authorization requests to:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway
Austin, TX 78727
Fax: 1-512-514-4213

Requests for prior authorization can be submitted online through the TMHP website at www.tmhp.com.

Refer to: Subsection 9.2.39.22.1, "Prior Authorization for Implantable Infusion Pumps," in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2 Provider Handbooks*).

5.2.11 Stereotactic Radiosurgery

Procedure code S8030 is payable to ASC and HASC facilities. Prior authorization is required.

Refer to: Subsection 9.2.62.2, "Stereotactic Radiosurgery," in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

5.2.12 Brachytherapy

The following procedure codes are payable to ASC and HASC facilities:

Procedure Codes									
19296	19297	19298	31643	55860	55862	55865	55875	57155	58346

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Procedure Codes
92974

Prior authorization is not required for brachytherapy services.

Refer to: Subsection 9.2.62, "Radiation Therapy," in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

5.2.13 Neurostimulators

Neurostimulators are a benefit of Texas Medicaid when medically necessary. All procedures require prior authorization.

Refer to: Subsection 9.2.44, "Neurostimulators," in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks).*

Neurostimulator devices may be reimbursed separately from the global fee.

Refer to: The Texas Medicaid fee schedules on the TMHP website at www.tmhp.com for procedure codes that may be reimbursed to ASC providers.

5.2.14 Prior Authorization

Some procedures require the performing provider to obtain prior authorization. When prior authorization is required, providers can mail or fax the request to:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway
Austin, TX 78727
Fax: 1-512-514-4213

Requests for prior authorization can be submitted online through the TMHP website at www.tmhp.com.

5.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including ASC and HASC services. ASC and HASC services are subject to retrospective review and recoupment if documentation does not support the service submitted for reimbursement.

5.4 Claims Filing and Reimbursement

5.4.1 Claims Information

Freestanding ASC claims must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 paper claim form. Hospital-based ASCs must submit claims to TMHP in an approved electronic claims format or on a UB-04 CMS-1450 paper claim form.

Claims must contain the billing provider's complete name, address, and a provider identifier. When completing a UB-04 CMS-1450 or a CMS-1500 paper claim form, providers must include all required information on the claim; TMHP does not key any information from claim attachments. Providers must purchase UB-04 CMS-1450 and CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply them.

Scheduled procedures performed in a HASC must be submitted for reimbursement using the HASC provider identifier with TOB 131. Emergency or unscheduled procedures performed in a hospital when the client is an outpatient must be submitted for reimbursement using the hospital provider identifier with TOB 131.

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To submit claims for services performed by certified registered nurse anesthetists (CRNAs), an ASC must enroll as a CRNA group provider and indicate the CRNA performing provider identifier on claims for those services.

Refer to: Section 4, "Certified Registered Nurse Anesthetist (CRNA)" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for specific billing instructions for CRNA services.

Section 6: Claims Filing (*Vol. 1, General Information*).

Section 10, "Claim Form Examples" in this handbook.

5.4.2 Reimbursement

Reimbursement of ASC and HASC procedures is based on the CMS-approved Ambulatory Surgical Code Groupings (1 through 9 per CMS and Group 10 per HHSC) payment schedule. Reimbursement is limited to the lesser of the amount reimbursed to an ASC for similar services, the hospital's actual charge, or the allowable cost determined by HHSC. When multiple surgical procedures are performed on the same day, only the procedure with the highest surgical code grouping is reimbursed. A complete list of approved ASC and HASC procedure codes with the assigned payment group can be found on the TMHP website at www.tmhp.com. Click on Fee Schedules. This list can also be obtained by calling the TMHP Contact Center at 1-800-925-9126.

Claims for physician and CRNA services performed in an ASC or HASC must be submitted under the physician or CRNA provider identifier and are reimbursed separately.

5.4.2.1 ASC and HASC Global Services

The ASC or HASC payment represents a global payment and includes room charges and supplies. Covered services provided are submitted as one inclusive charge. All facility services provided in conjunction with the surgery (e.g., laboratory, radiology, anesthesia supplies, medical supplies) are considered part of the global payment and cannot be itemized or submitted separately.

Routine X-ray and laboratory services directly related to the surgical procedure being performed are not reimbursed separately. All nonroutine laboratory and X-ray services provided with emergency conditions may be submitted separately with documentation that the complicating condition arose after the initiation of the surgery.

Medical and prosthetic devices such as intraocular lenses may be supplied by the ASC or HASC and implanted, inserted, or otherwise applied during a covered surgical procedure and is considered part of the global surgical fee.

Exception: *Certain pieces of equipment, (e.g., cochlear implants, implantable infusion pumps, and neurostimulator devices) may be reimbursed separately from the ASC or HASC global rate.*

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology," in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

Subsection 4.2.3, "Day Surgery," in this handbook for information about HASCs.

5.4.2.2 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

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6 Military Hospitals

6.1 Military Hospital Enrollment

To enroll in Texas Medicaid, a military hospital must be certified by Medicare, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process. Veterans Administration (VA) hospitals are eligible to receive Texas Medicaid payment only on claims that have crossed over from Medicare.

Military hospital providers must comply with CLIA rules and regulations. Providers who do not comply with CLIA will not be reimbursed for laboratory services.

6.2 Services, Benefits, Limitations and Prior Authorization

6.2.1 Military Hospital Inpatient Services

Inpatient hospital services include medically necessary items and services ordinarily furnished by a Medicaid hospital or by an approved out-of-state hospital under the direction of a physician for the care and treatment of inpatient clients. Reimbursement to hospitals for inpatient services is limited to the Medicaid "spell of illness." The *spell of illness* is defined as "30 days of inpatient hospital care, which may accrue intermittently or consecutively."

After 30 days of inpatient care have been provided, reimbursement for additional inpatient care is not considered until the client has been out of an acute care facility for 60 consecutive days. Exceptions are made in the following instances:

- THSteps-eligible clients do not have a 30-day spell of illness limitation, if medically necessary conditions exist (covered under THSteps-CCP).

Refer to: *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 3.1.2, "Spell of Illness," in this handbook.

Hospitals may submit *information only* claims to TMHP when one of the following situations exists:

- The inpatient 30-day spell of illness benefit is exhausted.
- Payment that was made by a third party resource or other insurance exceeds the Medicaid allowed amount.

For clients who are 21 years of age and older, there is an inpatient expenditure cap of $200,000 per benefit year (November 1 through October 31). Claims are reviewed retrospectively, and payments exceeding $200,000 will be recouped.

It is appropriate to submit *information only* claims using TOB 110.

The following hospital services must be medically necessary and are subject to the utilization review requirements of Texas Medicaid. Medicaid reimbursement for services cannot exceed the limitations of Texas Medicaid.

Inpatient hospital services include the following items and services:

- Bed and board in semiprivate accommodations or in an intensive care or coronary care unit, including meals, special diets, and general nursing services; or an allowance for bed and board in private accommodations, including meals, special diets, and general nursing services up to the hospital's charge for its most prevalent semiprivate accommodations. Bed and board in private accommodations are provided in full if required for medical reasons, as certified by the physician. Additionally, the hospital must document the medical necessity for a private room, such as the existence of a critical or contagious illness or a condition that could result in disturbance to other patients. This type of information is included in Block 80 or attached to the claim.

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- Whole blood and packed red cells that are reasonable and necessary for treatment of illness or injury, provided they are not available without cost.
- All medically necessary services or supplies ordered by a physician.

Medicaid benefits are not available for take-home or self-administered drugs or personal comfort items except when received by prescription through the VDP.

Only inpatient claims that have an emergency diagnosis on the claim are considered for reimbursement.

6.2.2 Military Hospital Outpatient and Physician Services

Although Medicare reimburses for emergency outpatient and inpatient services, Medicaid does not reimburse for either outpatient or physician services. Military hospitals are not reimbursed for outpatient day surgery.

6.2.3 Prior Authorization

Prior authorization is not required for services rendered in military hospitals.

6.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including military hospital services. Military hospital services are subject to retrospective review and recoupment if documentation does not support the service submitted for reimbursement.

6.3.1 Documentation for Nursing Facility Admissions

The admission Minimum Data Set (MDS) must be used for admissions to a nursing facility. There are instances in which hospital social workers and discharge nurses might also complete the admission MDS, such as:

- If the client is in a long-term care acute center.
- If the potential receiving nursing facility wants a better clinical picture of the client, a paper copy of the admission MDS is completed by the hospital staff before the client is accepted for admission into the nursing facility.

Refer to: The Long Term Care Program page on the TMHP website at www.tmhp.com for additional information, including instructions for all forms and assessments.

6.4 Claims Filing and Reimbursement

6.4.1 Military Hospital Claims Information

If TOB 110 is used to submit a claim, all charges must be noncovered and the claim will finalize with EOB 217, "Payment reduced through hospital action."

It is appropriate to submit *information only* claims using TOB 110.

Military hospitals may submit total charges in one line with appropriate accommodation revenue codes. Emergency hospital services must be submitted to TMHP in an approved electronic format or on the UB-04 CMS-1450 paper claim form. Providers may purchase claim forms from the vendor of their choice. TMHP does not supply the forms.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

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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 claims supplements.

Refer to: Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions," in Section 6, "Claims Filing" (*Vol. 1, General Information*) for paper claims completion instructions. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Military Hospital (Emergency Inpatient) on the TMHP website at www.tmhp.com for a claim form example.

6.4.2 Military Hospital Reimbursement

Reimbursement is limited to claims submitted for emergency inpatient care only.

Allowed inpatient hospital stays are reimbursed according to a prospective payment methodology based on DRGs. The reimbursement method itself does not affect inpatient benefits and limitations. Texas Medicaid requires that one claim be submitted for each inpatient stay with appropriate diagnosis and procedure code sequencing. Providers must submit only one claim per inpatient stay to Medicaid, regardless of the diagnosis, to ensure accurate payment. The DRG reimbursement includes all facility services provided to the client while registered as an inpatient.

Reimbursement to hospitals for inpatient services is limited to $200,000 per client, per benefit year (November 1 through October 31). This limitation does not apply to services related to certain organ transplants or services to clients who are 20 years of age and younger and covered by the CCP.

Military hospitals should keep a Medicaid client as an inpatient for only the length of time necessary to stabilize the client. The Medicaid client, once stabilized, should be transferred to the nearest Medicaid acute care hospital facility for further treatment.

When more than one hospital provides care for the same client, the hospital that furnishes the most significant amount of care receives consideration for a full DRG payment.

The other hospital is paid a per diem rate based on the lesser of the mean length of stay for the DRG or eligible days in the facility.

Client transfers within the same facility or readmissions to the same facility within 24 hours of a previous acute hospital or facility discharge are considered one continuous stay. These readmissions are considered a continuous stay regardless of the original or readmission diagnosis. Texas Medicaid does not recognize specialty units within the same hospital as separate entities; therefore, these transfers must be included in one submission under the provider identifier. Admissions that were submitted inappropriately are identified and denied during the utilization review process and may result in an intensified review.

After all hospital claims have been submitted, TMHP performs a post-payment review to determine if the hospital furnishing the most significant amount of care received the full DRG. If the review reveals that the hospital furnishing the most significant amount of care did not receive the full DRG, an adjustment is initiated.

The inpatient DRG reimbursement includes payment for all radiology and laboratory services, including those sent to referral laboratories.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology," in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

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7 Claims Resources

Refer to the following sections and forms when filing claims:

Resource	Location
Appendix D: Acronym Dictionary	"Appendix D: Acronym Dictionary" (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	"Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5 (*Vol. 1, General Information*)
Appendix A: State and Federal Offices Communication Guide	Appendix A (*Vol. 1, General Information*)
TMHP Electronic Claims Submission	Subsection 6.2 (*Vol. 1, General Information*)
Section 3: TMHP Electronic Data Interchange (EDI)	Section 3 (*Vol. 1, General Information*)
UB-04 CMS-1450 Paper Claim Filing Instructions	Subsection 6.6 (*Vol. 1, General Information*)

8 Contact TMHP

Note: *The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.*

9 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Hospital Report (Newborn Child or Children) (Form 7484)
Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information
Non-emergency Ambulance Prior Authorization Request
Psychiatric Inpatient Initial Admission Request Form
Psychiatric Inpatient Extended Stay Request Form
Radiology Prior Authorization Request Form
Sterilization Consent Form Instructions
Sterilization Consent Form (English)
Sterilization Consent Form (Spanish)

10 Claim Form Examples

The following linked claim form examples can also be found on the Claim Form Examples page of the Provider section of the TMHP website at www.tmhp.com:

Claim Form Examples
Ambulatory Surgical Center

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Claim Form Examples
Hospital-Based ASC
Hospital Inpatient
Military Hospital (Emergency Inpatient)

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Medicaid Managed Care Handbook

Texas Medicaid Provider Procedures Manual: Vol. 2

April 2016

TEXAS
Health and Human
Services Commission

MEDICAID MANAGED CARE HANDBOOK

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1 General Information

The information in this handbook is intended for Texas Medicaid managed care providers, including providers who are enrolled in a managed care organization (MCO) that is contracted by Texas Medicaid to provide managed care coverage for Texas Medicaid clients.

This handbook provides information about the following managed care programs and services:

- STAR
- STAR+PLUS
- NorthSTAR
- STAR Health
- Children's Medicaid Dental Services

Refer to: Medicaid managed care website at www.hhsc.state.tx.us/medicaid/managed-care/mmc.shtml.

2 Overview of Medicaid Managed Care

Texas Medicaid, which is administered by the Texas Health and Human Services Commission (HHSC), operates Medicaid managed care under the authority of federal waivers and state plan amendments that were approved by the Centers for Medicare & Medicaid Services (CMS).

Medicaid managed care is administered by MCOs, dental maintenance organizations (dental plans), and BHOs that are contracted by HHSC to provide services for Medicaid managed care clients. The Medicaid managed care MCOs and dental plans cover the same services that Texas Medicaid covers for the Medicaid fee-for-service clients. Some plans may also elect to cover value-added services.

The principle objectives of Medicaid managed care are to emphasize early intervention and to promote improved access to quality care, thereby significantly improving health outcomes for the target population, with a special focus on prenatal and well-child care.

Higher use of medical services occurs when clients obtain nonurgent or emergent acute care through emergency rooms or access duplicate services for the same medical condition. In Medicaid managed care, clients assume more responsibility for their personal health care by choosing a health plan and primary care provider (PCP) and by making use of preventive primary care services. Eligible clients may also choose a dental plan and a main dentist. This collaborative approach to health-care delivery helps to reduce costs by eliminating duplicate services and unnecessary emergency and inpatient care.

Clients who are enrolled in Medicaid managed care may reside in metropolitan or rural areas. Medicaid managed care consists of the following programs:

- The STAR program uses MCOs to cover acute care services in select groupings of counties known as service areas (SAs). STAR is available statewide. The STAR program operates under a federal 1115 waiver.
- The STAR+PLUS program uses MCOs to cover integrated acute and long term services and supports in specific SAs. The STAR+PLUS program operates under a federal 1115 waiver.
- The STAR Health program uses an MCO to deliver health-care services to children who are in foster care throughout the state. STAR Health is administered by Superior HealthPlan Network and operates under a federal 1915(a) waiver. The STAR Health program only manages the health care of some of the children who are enrolled in foster care. Some foster care clients are enrolled in the Permanency Care Assistance (PCA) program and are not considered eligible for enrollment in Medicaid managed care.

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- The NorthSTAR program is administered by the Department of State Health Services (DSHS). It uses a contracted BHO to provide behavioral health services in the Dallas service area. NorthSTAR operates under a federal 1915(b) waiver.
- Children's Medicaid dental services are administered by dental plans that process dental authorization requests and claims for most Medicaid fee-for-service and Medicaid managed care clients who are 20 years of age and younger regardless of their medical benefit plan.

Refer to: Section 7, "Children's Medicaid Dental Services" in this handbook for exceptions and additional information.

2.1 Managed Care Services

MCOs and dental plans administer almost all of the services that are rendered to Medicaid managed care clients, including, but not limited to, the following:

- Professional, inpatient facility, and outpatient facility medical services
- Prescription drug/pharmacy services.
- Children's Medicaid dental services for most clients who are 20 years of age and younger.
- Orthodontia services.
- Services rendered to Medicaid managed care SSI clients.
- Value-added services that an individual MCO or dental plan elects to cover.

All questions about these services must be directed to the MCO or dental plan that administers the client's Medicaid benefits. TMHP does not have access to the individual MCO or dental plan authorization and claims information.

2.1.1 Medical Services

Most medical service benefits including professional, inpatient, and outpatient services rendered to Medicaid managed care clients are administered by individual MCOs. Medical services include all those administered by TMHP for fee-for-service clients as well as any value-added services covered by the individual MCOs.

Some services rendered to Medicaid managed care clients are considered "carve-out" services. Carve-out services are administered and paid by TMHP and not by the client's MCO.

Refer to: Section 8, "Carve-Out Services" in this handbook.

2.1.2 Prescription Drug/Pharmacy Services

Pharmacy services rendered to Medicaid managed care clients are administered and paid by the clients' MCOs according to S.B. 7, 82nd Legislature, First Called Session, 2011.

Pharmacy providers must first be contracted with the Medicaid/Children's Health Insurance Program (CHIP) Vendor Drug Program before they can contract with the MCOs.

Refer to: Subsection 2.2, "Provider Enrollment and Responsibilities" in this handbook.

Generally, there is no monthly prescription limit for managed care clients.

Refer to: The MCO that administers the clients Medicaid managed care benefits for information about prescription drug and pharmacy benefits.

Each MCO contracts with one Pharmacy Benefit Manager (PBM). The MCOs and PBMs must adhere to Medicaid preferred drug list (PDL) and HHSC Medicaid and CHIP formularies.

HHSC will manage the Texas Medicaid and CHIP formularies.

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The MCOs will:

- Perform drug utilization review for managed care clients.
- Monitor pharmacy providers for compliance.
- Establish help lines for providers and clients.
- Ensure that all clients have access to a minimum of one network pharmacy:
  - Within 15 miles of the client's residence
  - With 24-hour coverage within 75 miles of the client's residence.

Important: *MCOs and PBMs cannot require clients to use a mail-order pharmacy.*

- Provide e-prescribing abilities to:
  - Verify client eligibility.
  - Review medication history.
  - Review formulary and PDL information.
- Process correct pharmacy claims submitted electronically within 18 days of submission

2.1.2.1 Prescription Drug Prior Authorizations

Prescribers may be required to request prior authorization for a prescription drug. The prescriber must contact the client's MCO or PBM and follow MCO or PBM guidelines and procedures for prior authorization requests.

Important: *TMHP does not have access to the MCOs' or PBMs' guidelines and procedures for prior authorizations. The provider must contact the MCOs of PBMs for information. Individual PBMs will have their own PA processes and telephone lines.*

The MCO must notify the prescriber's office of a prior authorization approval or denial:

- Within 24 hours of a request submitted by fax or web.
- Immediately for telephone requests.

Prior authorization is required for non-preferred drugs or any drug requiring a clinical prior authorization.

If the pharmacy cannot dispense the client's prescription because prior authorization is required but has not been requested, the pharmacy should contact the MCO or PBM to request prior authorization. The prescribing provider is required to submit certain prior authorization requests including, but not limited to, non-preferred drug prior authorizations.

2.1.2.1.1 Emergency 72-Hour Prescriptions

If the prescribing provider cannot be reached or is unable to request a prior authorization, the pharmacy should submit an emergency 72-hour prescription. The request for an emergency 72-hour prescription claim should not be used for routine and continuous overrides.

A 72-hour emergency prescription will be paid in full to pharmacy providers and does not count toward the three-prescription limit for adults who have not already received their maximum prescriptions for the month.

Reminder: *There is no prescription limit for clients who are 20 years of age and younger.*

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Federal and Texas law allow a 72-hour emergency supply of prescribed medication to be dispensed any time a prior authorization is not available and the prescription must be filled without delay for a medical condition. This rule applies to non-preferred drugs on the Preferred Drug list and any drug for which prior authorization must be requested by the prescribing physician.

2.1.2.1.2 Formulary

The MCOs or PBMs are responsible for informing network providers about how to access the formulary and PDL.

Refer to: The Medicaid and CHIP formularies on the VDP website at www.txvendordrug.com and at www.epocrates.com for more information.

MCOs may also selectively contract with pharmacies for specialty drugs.

2.2 Provider Enrollment and Responsibilities

Important: *All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: Section 1: Provider Enrollment and Responsibilities (*Vol. 1, General Information*) for more information about enrollment procedures.

"Appendix B: Vendor Drug Program" (*Vol. 1, General Information*) for more information about pharmacy enrollment.

2.2.1 Enrollment, Contracting, and Credentialing

Providers must be enrolled in Texas Medicaid before they can be contracted and credentialed by an MCO or dental plan.

Individual MCOs and dental plans have their own guidelines for contracting and credentialing providers.

Important: *Enrollment in Texas Medicaid does not guarantee that an MCO or dental plan will contract or credential a particular provider.*

Providers must refer all questions about contracting and credentialing to the MCO or dental plan that administers the clients' managed care benefits. TMHP does not have access to the contracting and credentialing requirements for the individual MCOs and dental plans.

All questions about Texas Medicaid enrollment can be referred to the TMHP Contact Center.

Note: *Providers who render only carve-out services are not required to contract with Medicaid MCOs and dental plans.*

Refer to: Section 8, "Carve-Out Services" for a list of services that are carved out of the Medicaid Managed Care Program.

Subsection B.1, "Vendor Drug Program"(*Vol. 1, General Information*) for more information about pharmacy enrollment.

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2.2.2 Online Provider Lookup (OPL)

Providers that participate in specific MCOs and dental plans are responsible for declaring themselves managed care providers on the OPL. Clients can search for providers using a particular county, service area, or name to find providers who participate in a managed care area.

Clients are able to search for providers contracted with the STAR+PLUS MCOs on the OPL. Links to the websites of the MCOs and dental plans are also provided through the OPL and enable clients to search each MCO's and dental plan's network of participating providers.

2.2.3 Terminated Enrollment

Texas Medicaid monitors provider claim activity. Providers that have not submitted a claim to Texas Medicaid or a Medicaid MCO or dental plan within an 18-month period are notified that their Texas Medicaid enrollment will be terminated at 24 months if they have not submitted any claims.

If a provider's Texas Medicaid enrollment is terminated, the provider's Medicaid managed care contracts with individual MCOs or dental plans will also be terminated.

To reactivate a TPI that has been terminated, the provider must complete the Texas Medicaid Provider Enrollment Application.

2.2.4 Excluded Entities and Providers

The Code of Federal Regulations (CFR) section 1003.102(a)(2) states that civil monetary penalties may be imposed against managed care entities (MCEs) that employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid clients. No Medicaid payments can be made to an MCE for any items or services directed or prescribed by an excluded physician or other authorized person if the MCE either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded.

2.2.5 Accounts Receivable

Providers that have outstanding accounts receivables on their weekly Remittance & Status (R&S) reports must settle them with TMHP even if they no longer submit claims to TMHP.

Payments from the MCOs and dental plans may be held until the debt with TMHP is resolved.

Providers can refund payments to TMHP as follows:

- If the provider no longer receives claim payments from TMHP, the provider must issue a check for the refund amount to TMHP. Payment options may be available. If a refund check is mailed to TMHP, the provider must also submit Form 7.2, "Texas Medicaid Refund Information Form."
- If the provider continues to receive claim payments from TMHP, a recoupment of the funds may be requested through the paper appeal process. If the provider requests a recoupment through the paper appeal process, the provider must not issue a check to TMHP. The refund amounts will be deducted from future payments, and the deductions will appear on the provider's R&S reports.

2.2.6 Educating Clients about Managed Care

Providers cannot enroll Medicaid clients; however, providers are encouraged to educate clients about Medicaid managed care.

Providers that participate in one or more Texas Medicaid managed care plans should follow these rules when educating clients:

- Providers may not influence clients to choose one MCO or dental plan over another.
- Providers must inform clients of all Medicaid managed care health plans and dental plans in which the providers participate.

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- Providers and subcontractors may only directly contact potential clients with whom they have an established relationship.
- Providers may inform clients of special services offered by all Medicaid managed care health and dental plans in which the providers participate.
- Providers may inform clients of particular hospital services, specialists, or specialty care available in all plans in which the providers participate.
- Providers may assist a client by contacting a plan (or plans) to determine if a particular specialist or service is available, if the client requests this information.
- Providers may not influence clients based on reimbursement rates or methodology used by a particular plan.
- At the member's request, providers can provide the necessary information for the client to contact a particular plan but cannot promote any plan over another.
- In no instances can providers stock, reproduce, assist in filling out, or otherwise handle the enrollment form. Information can be provided as outlined on the previous page, and clients can be reminded that they can easily enroll over the telephone with the enrollment broker. However, the call must be made by the client, not by the provider or the provider's agent.
- Providers may assist clients with completing the Medicaid application.
- Providers may display stickers that indicate that they participate in a particular Medicaid managed care health or dental plan as long as they do not indicate anything more than "(health plan or dental plan) is accepted or welcomed here" (provided the sticker meets Medicaid/CHIP Marketing Guidelines regarding size limitations).
- Providers may display state-approved, health-related marketing materials in their offices, provided it is done equally for all MCOs and dental plans in which they participate. MCO and dental plan providers cannot give out or display plan-specific marketing items or giveaways to clients.
- **Important:** Providers must comply with their applicable licensing agency's laws and regulations, including any related to marketing and advertising, and any applicable state and federal laws and regulations, contractual requirements, and other guidance documents. Providers are encouraged to review the Provider Marketing Guidelines page of the TMHP website at www.tmhp.com.

2.3 General Information About Client Enrollment in Managed Care

Most of the clients who have been determined to be eligible for Texas Medicaid are first enrolled in fee-for-service. Specific client groups within the Texas Medicaid population are eligible for managed care based on certain established criteria. If the client is eligible for Medicaid managed care, the client will choose an MCO and PCP or a dental plan and main dentist or both. The managed care enrollment date is separate from the Medicaid eligibility date. In most cases, Medicaid managed care enrollment is not retroactive.

Refer to: The STAR, STAR+PLUS, STAR Health, and NorthSTAR sections of this handbook for exceptions.

Claim and authorization transactions for services rendered during the client's fee-for-service eligibility must be submitted to TMHP, and claim and authorization transactions for services rendered during the client's Medicaid managed care enrollment must be submitted to the appropriate entity (i.e., TMHP for carve-out services and the MCO or dental plan for managed care services).

If a client loses Medicaid eligibility and then regains eligibility, the client is automatically reassigned to the same health plan and PCP or dental plan that the client had before the client lost Medicaid eligibility.

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Refer to: Subsection 2.4, "PCP/Main Dentist Guidelines for Medicaid Managed Care Clients" in this handbook.

Section 4: Client Eligibility (*Vol. 1, General Information*).

2.3.1 Managed Care Enrollment Broker

Medicaid clients who are eligible for STAR or STAR+PLUS choose an MCO and a PCP, and those eligible for Children's Medicaid Dental Services choose a dental plan and a main dentist using the official state enrollment form or by calling the Enrollment Broker.

The Help Line (Enrollment Broker) is available 8 a.m. to 8 p.m., Central Time, Monday through Friday at:

- Telephone: 1-800-964-2777
- Telecommunications device for the deaf (TDD): 1-800-267-5008

2.3.2 * Eligibility Verification Resources

The provider is responsible for verifying the client's eligibility before providing services. The provider must also verify and abide by prior authorization or administrative requirements established by the MCO or dental plan.

Refer to: Section 4: Client Eligibility (*Vol. 1, General Information*) for more information.

The client's managed care MCO and dental plan enrollment information can be verified by:

- Checking the client's health plan or dental plan ID card (if applicable).
- Visiting the client's Medicaid MCO or dental plan's website.
- Calling the client's health or dental plan.
- Visiting the Your Texas Benefits card website at www.yourtexasbenefitscard.com or calling the help line at 1-855-827-3747.

Refer to: Interactive Voice Response (IVR) User's Guide on the Your Texas Benefits Card website at www.yourtexasbenefitscard.com.

- Calling the help line at 1-855-827-3747.

Note: *Help line personnel are not able to answer questions regarding eligibility.*

The client's managed care eligibility can also be verified using:

- The TMHP Automated Inquiry System (AIS) at 1-800-925-9126.
- Third-party software that uses the TMHP EDI Gateway.
- Batched electronic verifications.
- National Council for Prescription Drug Programs (NCPDP) Eligibility Verification (E1) transaction. The E1 transaction is submitted through the pharmacy's point-of-sale system.
- The Vendor Drug Eligibility Verification Portal (EVP). EVP is a browser-based application that is free for all contracted pharmacy providers.

Refer to: Subsection 4.5.3, "Client Eligibility Verification" in Section 4: Client Eligibility (*Vol. 1, General Information*) for additional information about verifying client eligibility.

The Texas Medicaid Vendor Drug Program website at www.txvendordrug.com/claims/eligibility-verification.shtml for more information.

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2.3.3 Client Rights

In Texas, Medicaid managed care clients have defined rights and responsibilities. Each health plan and PCP share the responsibility to ensure and protect client rights and to assist clients in understanding and fulfilling their responsibilities as plan clients.

Medicaid managed care clients have the right to:

- Be treated fairly and with dignity and respect.
- Know that their medical records and discussions with their providers will be kept private and confidential.
- Request changes to their medical records (if incorrect).
- A reasonable opportunity to choose a health-care plan and PCP (the doctor or health-care provider they will see most of the time and who will coordinate their care) and to change to another plan or provider in a reasonably easy manner. These opportunities include the right to:
  - Be informed of available health plans and PCPs in their areas.
  - Be informed of how to choose and change health plans and PCPs.
  - Choose any health plan that is available in their area and choose a PCP.
  - Change their PCP at any time for any reason.
  - Change health plans without penalty.
  - Be educated about how to change health plans or PCPs.
  - Know that doctors, hospitals, and others who provider care can advise clients about their health status, medical care, and treatment. The health plan cannot prevent them from giving clients this information, even if the care or treatment is not a covered service."
  - Know that clients are not responsible for paying for covered services. Doctors, hospitals, and others cannot require clients to pay copayments or any other amounts for covered services.
- Ask questions and get answers about anything the client doesn't understand, and that includes the right to:
  - Have their provider explain their health-care needs to them and talk to them about the different ways their health-care problems can be treated.
  - Be told why care or services were denied and not given.
- Consent to or refuse treatment and actively participate in treatment decisions, and that includes the right to:
  - Work as part of a team with their provider in deciding what health care is best for them.
  - Say yes or no to the care recommended by their provider.
- Utilize each available complaint and appeal process through the MCO and through Medicaid, receive a timely response to complaints, appeals, and fair hearings. These processes include the right to:
  - Make a complaint to their health plan or to the state Medicaid program about their health-care, provider, or health plan.
  - Receive a timely answer to their complaint.
  - Access the health plan appeal process and the procedures for doing so.
  - Request a fair hearing from the state Medicaid program and request information about the process for doing so.

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- Timely access to care that does not have any communication or physical access barriers. They have the right to:
  - Have telephone access to a medical professional 24 hours a day, 7 days a week in order to obtain any needed emergency or urgent care.
  - Receive medical care in a timely manner.
  - Be able to get in and out of a health-care provider's office, including barrier free access for persons with disabilities or other conditions limiting mobility, in accordance with the *Americans with Disabilities Act*.
  - Have interpreters, if needed, during appointments with their providers and when talking to their health plan. Interpreters include people who can speak in their native language, assist with a disability, or help them understand the information.
  - Be given an explanation they can understand about their health plan rules, including the health-care services they can get and how to get them.
- Not be restrained or secluded when doing so is for someone else's convenience, or is meant to force them to do something they are unwilling to do, or to punish them.

2.3.3.1 Advance Directives

Federal and state law require providers to maintain written policies and procedures for informing and providing written information to all adult clients who are 18 years of age and older about their rights under state and federal law, in advance of their receiving care (*Social Security Act* §§1902[a][57] and 1903[m][1][A]). The written policies and procedures must contain procedures for providing written information regarding the client's right to refuse, withhold, or withdraw medical treatment advance directives.

These policies and procedures must comply with provisions contained in 42 *Code of Federal Regulations* (CFR) §§434.28 and 489, SubPart I, relating to the following state laws and rules:

- A client's right to self-determination in making health-care decisions.
- The Advance Directives Act, Chapter 166, Texas Health and Safety Code, which includes:
  - A client's right to execute an advance written directive to physicians and family or surrogates, or to make a nonwritten directive to administer, withhold or withdraw life-sustaining treatment in the event of a terminal or irreversible condition.
  - A client's right to make written and nonwritten Out-of-Hospital Do-Not-Resuscitate Orders.
  - A client's right to execute a Medical Power of Attorney to appoint an agent to make health-care decisions on the client's behalf if the client becomes incompetent.
- The Declaration for Mental Health Treatment, Chapter 137, Texas Civil Practice and Remedies Code, which includes a Member's right to execute a Declaration for Mental Health Treatment in a document making a declaration of preferences or instructions regarding mental health treatment.

These policies can include a clear and precise statement of limitation if a participating provider cannot or will not implement a client's advance directive. A statement of limitation on implementing a client's advance directive should include at least the following information:

- A clarification of the provider's conscience objections.
- Identification of the state legal authority permitting a provider's conscience objections to carrying out an advance directive.
- A description of the range of medical conditions or procedures affected by the conscience objection.

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A provider cannot require a client to execute or issue an advance directive as a condition for receiving health-care services. A provider cannot discriminate against a client based on whether or not the client has executed or issued an advance directive.

A provider's policies and procedures must require the provider to comply with the requirements of state and federal law relating to advance directives.

2.3.3.2 PCP/Main Dentist and Health/Dental Plan Changes

A client who is enrolled in a Medicaid MCO or dental plan may request a PCP or Main Dentist change at any time and for any reason. PCP or main dentist changes are processed by the MCO or dental plan.

Clients also have the right to change health or dental plans if other options are available in the service area in which the client resides. Plan change requests are processed by the enrollment provider.

Refer to: Subsection 2.4.3, "PCP and Main Dentist Changes" in this handbook.

2.3.4 Client Responsibilities

Medicaid managed care health plans and PCPs should help clients understand their responsibilities. These include the responsibility to:

- Learn and understand each right they have under Medicaid. That includes the responsibility to:
  - Learn and understand their rights under the Medicaid program.
  - Ask questions if they do not understand their rights.
  - Learn what choice of health plan is available in their area.
- Abide by the health plan and Medicaid managed care policies and procedures. That includes the responsibility to:
  - Learn and follow their health plan rules and Medicaid rules.
  - Choose their health plan and a PCP.
  - Make any changes in their health plan and PCP in the ways established by Medicaid managed care and by the health plan.
  - Keep their scheduled appointments.
  - Cancel appointments in advance when they cannot keep them.
  - Always contact their PCP first for nonemergency medical needs.
  - Be sure they have approval from their PCP before going to a specialist (except for self-referred services).
  - Understand when they should and should not go to the ER.
- Share information relating to their health status with their PCP and become fully informed about service and treatment options. That includes the responsibility to:
  - Tell their PCP about their health.
  - Talk to their providers about their health-care needs and ask questions about the different ways their health-care problems can be treated.
  - Help their providers get their medical records.
- Actively participate in decisions relating to service and treatment options, make personal choices, and take action to maintain their health. That includes the responsibility to:
  - Work as a team with their providers in deciding what health care is best for them.
  - Understand how the things they do can affect their health.

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- Do the best they can to stay healthy.
- Treat providers and staff with respect.

2.4 PCP/Main Dentist Guidelines for Medicaid Managed Care Clients

In Medicaid managed care, eligible Medicaid clients choose a primary care provider (PCP) or a main dentist who will work with the client to coordinate the client's health care or dental services.

The managed care client's PCP/main dentist is responsible for the following:

- Furnishes primary-care related services
- Arranges for and coordinates referrals for all medically necessary specialty services
- Is available directly or through on-call arrangements 24 hours a day, 7 days a week for urgent or emergency care

Refer to: Subsection 2.4.4, "Continuous Access" in this handbook.

Primary care includes ongoing responsibility for preventive health or dental care, health or dental maintenance, treatment of illness and injuries, and the coordination of access to needed specialist providers or other services.

PCPs/main dentists can choose to contract with various MCOs or dental plans.

Provider types who are eligible to serve as a PCP include:

- Pediatricians
- Family/general practitioners
- Internists
- Obstetrician/gynecologists
- Advanced Practice Registered Nurses (APRNs) under the supervision of a physician
- Certified nurse-midwives (CNM) practicing under the supervision of a physician
- Physician assistants (PAs) practicing under the supervision of a physician
- Rural health clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)
- Community Clinics
- Specialists willing to provide medical homes to clients who have special needs

The following provider types are eligible to serve as a main dentist:

- General dentist
- Pediatric dentist
- Federally qualified healthcare center (FQHC)

The PCP or main dentist either furnishes or arranges for most of the client's health-care or dental-care needs, including well-checkups, office visits, referrals, outpatient surgeries, hospitalizations, and health- and dental-related services.

Although PCPs are encouraged to assist clients in accessing these services, Medicaid managed care enrollees may self-refer for the following services:

- Emergency services

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- Family planning
- THSteps medical services
- Immunizations
- Early Childhood Intervention (ECI) targeted case management
- Case Management for Children and Pregnant Women
- Obstetric or gynecological services
- School Health and Related Services (SHARS)
- Department of Assistive and Rehabilitative Services (DARS) case management
- DSHS case management
- Department of Aging and Disability Services (DADS) case management
- Behavioral health services (contact client's health plan for specific requirements)
- Vision care (including ophthalmologic or therapeutic optometry)

2.4.1 Enrolling as a PCP or Main Dentist

Various providers may be eligible to enroll in Medicaid managed care as primary care providers or main dentist. Providers must contact the individual Medicaid managed care health plans or dental plans for enrollment information.

2.4.2 PCP Requirements for THSteps Medical Services

THSteps providers must be enrolled with Medicaid to be reimbursed for services provided to clients. THSteps medical services are self-referred. Medicaid MCOs determine how their clients will access THSteps services. The MCO may require the client to go to an in-network THSteps provider or may allow the client to go to any Medicaid THSteps provider, whether or not they are in the MCO's network. Providers that render THSteps services must work in collaboration with the client's PCP to ensure continuity of care.

THSteps providers are required to bill claims as an exception to periodicity when the clients visit is outside of the periodicity schedule because of extenuating circumstances.

Refer to: Section 5, "THSteps Medical", subsection 5.3.7, "Exception-to-Periodicity Checkups", and subsection 4.2.10.1, "Exceptions to Periodicity" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about billing an exception-to-periodicity checkup.

2.4.3 PCP and Main Dentist Changes

PCP and main dentist changes may be requested or initiated by any of the following:

- A client who is enrolled in a Medicaid MCO or dental plan may request a PCP or main dentist change at any time and for any reason.
- The MCO or dental plan may reassign the client to another PCP or main dentist for any of the following reasons:
  - The PCP or main dentist is sanctioned by HHSC.
  - The PCP or main dentist exhibits a documented pattern of unacceptable quality of care.
  - The PCP or main dentist inappropriately reduces the client's right to access specialty services covered under Medicaid managed care.
  - The provider leaves Medicaid, retires, or dies.

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- A provider may request a client be reassigned to another PCP or main dentist for any of the following reasons:
  - The client is not included in the PCP's or main dentist's scope of practice.
  - The client is noncompliant with medical or dental advice.
  - The client consistently displays unacceptable office decorum.
  - The client's relationship with the PCP or main dentist is not mutually agreeable.

Any request by a provider to reassign a client to another PCP or main dentist must be processed through the applicable Medicaid MCO or dental plan. Before a request for reassignment can be initiated, reasonable measures must be taken to correct the client's behavior. Reasonable measures may include education or counseling by the MCO or dental plan staff. The MCO or dental plan will notify the client of the reassignment if all attempts to remedy the situation have failed. Providers should also notify the client about the reassignment in writing and send a copy of the notification to the MCO or dental plan.

The MCOs and dental plans can affect a PCP or main dentist change immediately if necessary; however, the Medicaid client eligibility verification systems may not immediately reflect the change.

2.4.4 Continuous Access

Continuous access is an important feature of Medicaid managed care. Twenty-four-hour PCP and main dentist availability enables clients to access and use services appropriately, instead of relying on ERs for after-hours care.

Continuous access can be provided through direct access to a PCP's or main dentist's office or through on-call arrangements with another office or service. Clients should be informed of the PCP's or main dentist's normal office hours and should be instructed how to access urgent medical care after normal office hours.

2.4.4.1 After-Hours Guidelines

PCPs and main dentists are required to have at least one of the following arrangements in place to provide 24-hour, 7-day a week access for managed care clients:

- The office telephone is answered after-hours by an answering service, which meets language requirements of the major population groups and which can contact the PCP, main dentist, or another designated provider. All calls answered by an answering service must be returned within 30 minutes.
- The office telephone is answered after normal business hours by a recording in the language of each of the major population groups served, directing the patient to call another number to reach the PCP, main dentist, or another provider designated by the PCP or main dentist. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable.
- The office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP, main dentist, or another designated medical practitioner, who can return the call within 30 minutes.

2.4.4.2 Unacceptable Telephone Arrangements

The telephone answering procedures listed below are *not* acceptable:

- The office telephone is only answered during office hours.
- The office telephone is answered after-hours by a recording that tells clients to leave a message.
- The office telephone is answered after-hours by a recording that directs clients to go to an Emergency Room for any services needed.
- Returning after-hours calls outside of 30 minutes.

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2.5 Cultural Competency and Sensitivity

HHSC values the diversity of the Texas Medicaid population and requires Medicaid managed care to provide programs to support clients from diverse cultural backgrounds:

- Helplines are staffed by both Spanish- and English-speaking customer service representatives who, at any time, may access a multi-language translation service for assistance.
- Articles in the *Texas Medicaid Bulletin* and educational workshops include topics that focus on cultural sensitivity and the need for culturally competent staff in PCP or main dentist offices.

Providers are expected to comply with the laws concerning discrimination on the basis of race, color, national origin, or sex.

2.5.1 Limited English Proficiency

Medicaid providers are required to provide services in the languages of the major Medicaid population groups they serve and to ensure quality appropriate translations. Title VI, section 601, of the *Civil Rights Act* of 1964 states that "no person in the United States shall on the basis of race, color, or national origin, be excluded from participating in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

HHSC requires Medicaid providers to ensure persons with limited English proficiency have equal access to the medical services to which they are legally entitled.

Meeting the requirements of Title VI may require the PCP or main dentist to take all or some of the following steps at no cost or additional burden to the beneficiary with limited English proficiency:

- Have a procedure for identifying the language needs of patients/clients.
- Have access to proficient interpreters during hours of operation (MCOs or dental plans arrange interpreters).
- Develop written policies and procedures regarding interpreter services (MCOs or dental plans arrange interpreters).
- Disseminate interpreter policies and procedures to staff and ensure staff awareness of these policies and procedures and of their Title VI obligations to persons with limited English proficiency.

In order to meet interpretation requirements, providers may choose to incorporate into their business practice any of the following (or equally effective) procedures:

- Hire bilingual staff. (Does not apply to MCOs.)
- Hire staff interpreters. (Does not apply to MCOs.)
- Use qualified volunteer staff interpreters. (Does not apply to MCOs.)
- Arrange for the services of volunteer community interpreters—excluding the client's family or friends. (Does not apply to MCOs.)
- Contract with an outside interpreter service. (MCO or dental plan must provide.)
- Use a telephone interpreter service.
- Develop a notification and outreach plan for beneficiaries with limited English proficiency.

It is the provider's responsibility to ensure that interpretive services are available to his practice to meet requirements on limited English proficiency and communication disabilities. Interpretive services include language and American Sign Language (ASL) interpreters.

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Language Line Services operate 24 hours a day, 7 days a week. Language Line Services provides over-the telephone interpretation, video interpreting, document translation, interpreter testing and training, and other language products as well. Language Line Services charges a fee for the service. For complete details about their billing practices and services, providers should visit the Language Line Services website at www.languageline.com or call 1-800-752-6096.

Complaints and reports of non-compliance with Title VI regulations are handled by the Office for Civil Rights (OCR). Additional information, including the complete guidance memorandum on prohibition of discrimination against persons with limited English proficiency issued by the OCR, can be found on the Internet at www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/index.html.

Note: *MCOs are responsible for providing interpreter services.*

2.6 Reimbursement

Providers must read and comply with Section 2: Texas Medicaid Fee-for-Service Reimbursement (*Vol. 1, General Information*).

Reimbursement for benefits that are administered by a Texas Medicaid MCO or dental plan is determined by the MCO or dental plan. Providers should contact the MCO or dental plan for additional information.

Note: *The MCOs and dental plans are not limited to following the Texas Medicaid fee schedules. There may be some differences in reimbursement based on decisions made by the individual health and dental plans.*

Texas Medicaid reimburses carve-out services according to the appropriate reimbursement methodology defined in the applicable Texas Medicaid Provider Procedures Manual handbook and the applicable Texas Medicaid fee schedules, which are available on the TMHP website at www.tmhp.com.

2.6.1 Coinsurance and Deductible Payments for Dual-Eligible Clients

Crossover claims for payment for deductibles or coinsurance according to current payment guidelines are processed by TMHP and not the client's MCO.

For clients who are enrolled in a Medicare Advantage Plan (MAP) and/or Special Needs Plan (SNP), crossover claims for coinsurance and deductible payments are processed by the MAP and/or SNP. These claims are not processed by TMHP.

2.6.2 Third Party Liability (TPL)

A third-party resource (TPR) is a source of payment for services other than Medicaid, Medicaid MCOs, Medicaid dental plans, the client, or non-TPR sources. Federal and state laws require that all reasonable measures be made to use a client's TPR or other insurance to pay for most medical services before Medicaid funds are used.

MCO and dental plan claims payments for services rendered to Texas Medicaid managed care clients are subject to this federal and state requirement. Texas Medicaid will collect overpayments based on claims data processed by the MCO or dental plan.

TPL includes payments from any of the following sources:

- Other health insurance, including assignable indemnity contracts
- Commercial MCOs (private insurance available through a source other than Texas Medicaid or Medicare)

A provider who furnishes services and participates in Texas Medicaid may not refuse to furnish services to an eligible client because of a third party's potential liability for the payment of the services.

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2.6.2.1 TPL Overview and Provider Responsibilities for Medicaid Managed Care Clients

The Third Party Liability program helps reduce Medicaid costs by shifting claims expenses to third party payers. Third party payers are entities or individuals that are legally responsible for paying the medical claims of Medicaid clients. As a condition of eligibility, Medicaid clients assign their rights (and the rights of any other eligible individuals on whose behalf he or she has legal authority under state law to assign such rights) to medical support and payment for medical care from any third party to Medicaid. Federal law and regulations require states to ensure Medicaid clients use all other resources available to them to pay for all or part of their medical care before turning to Medicaid. Medicaid pays only after the third party has met its legal obligation to pay (i.e., Medicaid is the payer of last resort). A third party is any individual, entity, or program that is, or may be, liable to pay for any medical assistance provided to a client under the approved state Medicaid plan. Third parties may include any of the following:

- Private health insurance
- Employment-related health insurance
- Medical support from absent parents
- Casualty coverage resulting from an accidental injury such as automobile or property insurance (including no-fault insurance)
- Court judgments or settlements from a liability insurer
- State workers' compensation
- First party probate-estate recoveries
- Other federal programs (e.g., Indian Health, Community Health, and Migrant Health programs), unless excluded by statute

Refer to: Other Insurance Form on the TMHP website at www.tmhp.com.

Tort Response Form on the TMHP website at www.tmhp.com.

Note: *Adoption agencies or foster parents are no longer considered a TPR. Medicaid is primary in the STAR Health program (except when court-ordered to provide health insurance). This is an exception to the rule that Medicaid is payer of last resort. Providers must not bill other health insurance unless there is a court order that places this responsibility elsewhere. For THSteps or pharmacy TPL, providers must refer to the MCO, PBM, or dental plan that administers the client's managed care benefits for additional information.*

2.6.3 Health Insurance Premium Payment Program

Health Insurance Premium Payment (HIPP) Program clients access their benefits as Texas Medicaid fee-for-service clients and are not enrolled in managed care unless they choose to leave the HIPP program.

Note: *STAR Health program clients are not eligible to receive HIPP benefits and will continue to receive benefits through the STAR Health program. Some STAR+PLUS clients are eligible to receive HIPP benefits and continue to receive benefits through the STAR+PLUS program.*

Refer to: Subsection 4.13, "Health Insurance Premium Payment (HIPP) Program" in Section 4, "Client Eligibility" (*Vol. 1, General Information*).

2.6.4 Providers With Unsatisfied Medicaid Accounts Receivables

TMHP notifies MCOs when a provider has an outstanding accounts receivable balance.

Providers who have an outstanding balance should contact the TMHP Contact Center to make repayment arrangements, even if they are no longer submitting fee-for-service claims.

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If providers do not make repayment arrangements, the MCO in which they participate may withhold future payments from them.

2.7 Managed Care Plan Changes

The MCO or dental plan changes can be affected any of the following ways:

- Client initiated.
- Medical or dental plan initiated

2.7.1 Client-Initiated Plan Changes

Clients have the right to change plans. Clients must call the Enrollment Broker at 1-800-964-2777 to initiate a plan change. If a plan change request is received before the middle of the month, the plan change is effective on the first day of the following month. If the request is received after the middle of the month, the plan change will be effective on the first day of the second month following the request, as shown below.

Example	
Request received on or before	Mid-May
Change effective	June 1
Request received after	Mid-May
Change effective	July 1

Note: *All plan change requests must be processed by the Enrollment Broker.*

The STAR Health Program only has one plan choice available. As a result, clients cannot change plans, but may change PCPs within their assigned STAR Health MCO.

2.7.2 Plan Administrator-Initiated Changes

Each health plan and dental plan has a limited right to request that a client be disenrolled without the client's consent. HHSC must approve any request for such disenrollment.

Health plans and dental plans may request that a client be disenrolled for the following reasons:

- The client loans his or her Your Texas Benefits Medicaid card to another person to obtain services.
- The client continually disregards the advice of his PCP or main dentist.
- The client repeatedly uses the ER inappropriately.
- Client is disruptive, unruly, threatening, or uncooperative to the extent that client's membership seriously impairs MCO's, dental plan's, or provider's ability to provide services to the client or to obtain new patients, and the client's behavior is not caused by a physical or behavioral health condition.
- Client refuses to comply with managed care restrictions (e.g., repeatedly using emergency room in combination with refusing to allow MCO to treat the underlying medical condition).
- For STAR+PLUS MCOs, under limited conditions, the MCO may request disenrollment of members who are totally dependent on a ventilator or who have been diagnosed with End Stage Renal Disease.

Before a request for disenrollment can be initiated, reasonable measures must be taken to correct the client's behavior. Reasonable measures may include education or counseling conducted by health plan or dental plan staff. HHSC will notify the client in writing of the disenrollment if all attempts to remedy the situation have failed. HHSC will also notify the client in writing of the availability of appeal procedures and the HHSC fair hearing process.

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Health plans, dental plans, and providers can not request a client's disenrollment because of an adverse change in the client's health or the utilization of services that are medically necessary for the treatment of a client's condition.

2.7.3 Managed Care Organization (MCO) Clients Who Transition to Medicaid Fee-For Service (FFS)

When clients transition from an MCO to FFS, providers can request that previously approved authorizations for Comprehensive Care Program (CCP) services, occupational therapy (OT), physical therapy (PT), private duty nursing (PDN), and speech therapy (ST) be transferred from the MCO to FFS.

2.7.3.1 Submission Guidelines

To consider the reimbursement of claims for services that were rendered on or after the MCO disenrollment date, TMHP must receive the request to transition the authorization from the MCO to FFS within the following time frames:

- Providers have three business days from the client's MCO disenrollment date to submit a request to TMHP to transfer the authorization for PDN and Skilled Nursing/Aide visit services from the MCO to FFS.
- Providers have five business days from the client's MCO disenrollment date to submit a request to TMHP to transfer the authorizations of all therapy services from the MCO to FFS.

2.7.3.2 Documentation Requirements

All of the requests to transfer the authorizations from the MCO to FFS must include:

- A copy of the authorization letter.
- All of the documentation that was sent in the original authorization request, including any physician orders that were used to determine the start of care. TMHP will accept the physician orders as the required documentation for the requested services.
- The completed CCP prior authorization form, Special Medical Prior Authorization (SMPA) form, or Home Health Plan of Care, whichever is applicable for the requested service. The form must include:
  - The dates of service and quantities that are being requested from TMHP, which must match the dates of service and quantities that were approved in the original authorization.
  - It is not necessary to obtain signatures or dates on the forms listed above when submitted to TMHP for the purpose of transferring an authorization from an MCO to FFS Medicaid.

Note: *Authorizations for services transferred from an MCO to FFS Medicaid are subject to retrospective review.*

TMHP will verify the client's eligibility, the dates of service, and the quantities requested.

If a request to transfer an authorization is submitted after the deadline, TMHP will process reimbursement claims as follows:

- Claims for services that were rendered before the date on which the transfer request was received will be denied as a late submission, and the provider will be notified of their administrative appeal rights through the Health and Human Services Commission (HHSC).
- Claims for services that were rendered on or after the date of receipt use the required information from the transferred authorization and will be processed as if the request was received in a timely manner.

If a client transfers from an MCO to FFS and the provider does not have an authorization letter from the MCO, TMHP will process the request to transfer the authorization based on established TMHP authorization submission guidelines for OT, PT, PDN, and ST services.

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All new requests for rendered services must meet the documentation requirements.

For therapy services, the prescribing physician's signature is required unless one of the following from the prescribing physician is attached to the request: a signed and dated prescription, a dated written order, or a dated documented verbal order.

2.7.3.3 New Services and Extension of Services

For new services that occur after the client's MCO disenrollment change date, the provider is responsible for submitting all TMHP required paperwork and meeting all established submission guidelines for prior authorization.

Requests for the extension of services that occur after the MCO disenrollment change date must include all of the paperwork that is required by TMHP. The requests must be submitted within the following time frames:

- Within seven calendar days of the extension start of care for CCP-PDN
- No more than 30 days before the current authorization expires for all therapy services

2.7.3.4 Loss of Eligibility

If an MCO disenrolled a client and the client also loses Medicaid eligibility, providers must anticipate, if and when Medicaid eligibility is restored, that the client will initially be considered a Medicaid FFS client and will have a retroactive eligibility period.

All requests for services that require prior authorization and that occur during the client's retroactive eligibility period, must be submitted to TMHP following the process that is outlined in subsection 5.1.1, "Prior Authorization Requests for Clients with Retroactive Eligibility" in Section 5: Fee-for-Service Prior Authorizations (*Vol.1, Provider Handbooks*).

If a client is retroactively disenrolled by an MCO, all of the services that are rendered by the provider during this retroactive disenrollment period (specifically from the date on which the client was eligible for FFS to the date of the client's MCO eligibility change) will be denied by TMHP, and the provider will be notified of their administrative appeal rights.

TMHP may consider services for the MCO transition beginning on the date of the client's MCO eligibility change date and going forward. TMHP uses the MCO transition process for the submission of paperwork and the processing of provider requests.

2.8 Authorizations for Managed Care Services

Authorization requests for services administered by the client's MCO or dental plan must be submitted to the client's MCO or dental plan according to the guidelines specific to the plan under which the client is covered.

Health plan prior authorizations do not transfer with a client between plans. For payment to be considered when a client changes plans, providers must obtain prior authorization through the plan under which the client is covered for the date of service.

Dental prior authorizations may transfer from one dental plan to another.

> ***Note:*** *Authorizations and claims for SSI clients who are enrolled in the STAR Program are submitted to the client's MCO or dental plan.*

2.9 Claims Filing for Managed Care Services

Claims for services administered by an MCO or dental plan must be submitted to the client's MCO or dental plan. Providers may submit the managed care claims either of the following ways:

- Submit directly to the appropriate MCO or dental plan using the methods established by the MCO or dental plan

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- Submit electronically to TMHP for routing to the appropriate MCO or dental plan

Providers who submit claims directly to the MCO or dental plan must follow the guidelines established by the MCO or dental plan for claims submissions. Providers must contact the appropriate MCO or dental plan for information about filing electronic or paper claims directly to the MCO or dental plan.

Refer to: The TMHP website at www.tmhp.com/Pages//Medicaid/Medicaid_Managed_Care.aspx for additional information, including MCO and dental plan contact information.

Providers also have the option to submit STAR, STAR+PLUS, STAR Health, and Children's Medicaid Dental Services claims to TMHP using TexMedConnect or the TMHP EDI Gateway. These claims are automatically routed to the appropriate MCO or dental plan based on the client's eligibility on file.

Note: *TMHP will not forward electronic claim submissions for pharmacy benefits, NorthSTAR, CHIP, or long term care services, and TMHP will not forward any managed care paper claim submissions. These submissions must be submitted directly to the MCO or dental plan that administers the client's Medicaid managed care benefits.*

To submit MCO and dental plan claims to TMHP for proper routing:

- Using TexMedConnect: Log in to the TMHP secure website and submit the claims to TMHP.
- Through EDI: Log in to the claims billing software and submit the claims through EDI to TMHP.

Note: *Each claim must contain services administered by a single entity, either all fee-for-service (including services for fee-for-service clients and carve-out services), all MCO services, or all dental plan services. Fee-for-service procedures and MCO procedures for the same client cannot be billed on the same claim. Each claim may be submitted individually or in a batch. Each batch may contain claims destined for a variety of plans including fee-for-service and managed care.*

Providers receive a message that indicates whether the claim was transmitted successfully or unsuccessfully. The provider can correct the submission and submit the claim until the transmission is successful.

Once the claims have been transmitted successfully, the portal will route each claim to the appropriate entity based on the client's eligibility on file. For MCO and dental plan claims, the provider will receive an electronic claim transmission report that indicates the claim was accepted or rejected by the MCO or dental plan:

- If the claim has been accepted, the provider will receive no more transmissions from TMHP. Notices for payment determinations and all payments will be sent to the provider by the MCO or dental plan according to their individual practices and procedures.
- If the claim has been rejected by the MCO or dental plan, the provider will receive an electronic claim status report, and will be able to correct the submission and submit the claim until the transmission is successful.

Important: *Providers must call the client's MCO or dental plan who processed the claim for information about the MCO's or dental plan's explanation of benefits (EOB), claims payment, claim rejection, how to correct a rejected claim, or any other questions about the MCO or dental plan claim guidelines and processes. TMHP does not have any information about the MCO's or dental plan's claims, benefits, or processes.*

Electronic claims submitted to TMHP require an NPI. If an electronic claim is submitted without an NPI, the claim will be denied. If a claim is submitted electronically with a TPI instead of the NPI, the claim will be denied.

For assistance with enrollment for filing eligible electronic claims to TMHP, providers can contact the TMHP Electronic Data Interchange (EDI) Help Desk at 1-888-863-3638.

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Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions to TMHP.

Subsection 6.3.4, "National Drug Code (NDC)" in Section 6, "Claims Filing" (*Vol. 1, General Information*), for NDC requirements.

Reminder: *Claims for Medicaid managed care clients must be submitted to the MCO or dental plan in which the client is enrolled at the time of service (or date of admission for inpatient hospital claims). The MCO or dental plan, as a payor of last resort, does not determine payment based on the primary payor's (i.e., TPR or other primary source of insurance) authorization of services or approval of hospital stays.*

Refer to: Subsection 2.6.2, "Third Party Liability (TPL)" in this handbook for additional information about primary insurance sources.

Refer to: The TMHP Medicaid Managed Care web page at www.tmhp.com/Pages/Medicaid/Medicaid_Managed_Care.aspx for additional information.

2.9.1 Newborn Claims Filing for MCO Services

Newborns are automatically assigned to the MCO in which the mother is enrolled at the time of the newborn's birth. The effective date of the newborn's enrollment is the same as the newborn's date of birth. Claims for services provided to newborns should be filed with the mother's MCO. Health-care providers should file newborn claims using the newborn's Medicaid identification number as soon as the number is made available. Providers filing claims for services provided to newborns are still responsible for meeting the Medicaid filing deadlines, which in most cases is within 95 days of each date of service.

MCOs must pay providers for inpatient and professional services related to neonatal care for up to 48 hours after vaginal delivery and 96 hours after Cesarean delivery. (Prior authorizations and PCP assignment cannot be a reason for denial of claims.)

MCOs may require prior authorizations for hospital and professional services beyond the 48-hour and 96-hour time limits.

Authorization requests, utilization review questions, and claim status inquiries and appeals should be directed to the MCO in which the client is enrolled.

Note: *Telephone numbers and addresses for MCO claims submission and appeals can be found in the appropriate MCO provider policies and procedures manual for the appropriate service area.*

2.9.2 Filing Deadlines

The following table summarizes the filing deadlines that apply for MCO and dental plan claim submissions:

Submission	Filing Deadline
Initial submission submitted to the correct plan	95 days from the DOS
Initial submission submitted to the wrong plan	95 days of the date on the Remittance and Status (R&S) Report from the other (wrong) carrier (documentation of timely filing is required)
Initial submission to TPR (not the Medicaid MCO or dental plan)	95 days from the date of disposition by the other insurance resource
Initial submission for newborns	Submit to the client's or mother's MCO within 95 days of the DOS

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Claims must be submitted to the appropriate entity whether TMHP or the MCO or dental plan within 95 days of the date of service. If the claim is not received by the MCO or dental plan within 95 days, the claim will be denied.

If the provider files with the wrong plan within the 95 day submission requirement (e.g., State Claims Administrator but not with the MCO or dental plan), the provider must resubmit the claim with documentation that shows the claim was submitted within the appropriate time frame but to the wrong plan. The MCO or dental plan must honor the initial filing date and process the claim without denying the resubmission for the sole reason of passing the filing timeframe. The provider must file the claim with the correct MCO within 95 days of the date on the Remittance and Status (R&S) Report from the other (wrong) carrier.

When a service is billed to a third party insurance resource, the claim must be refiled and received by the Medicaid MCO or dental plan within 95 days from the date of disposition by the other insurance resource. The MCO or dental plan will determine, as a part of its provider claims filing requirements, the documentation required when a provider refiles these types of claims with the MCO or dental plan.

MCOs and dental plans are subject to the requirements related to coordination of benefits for secondary payers in the Texas Insurance Code section 843.349 (e) and (f).

Refer to: Subsection 2.9, "Claims Filing for Managed Care Services" in this handbook for details about MCO claims processed by TMHP and not the client's MCO.

2.9.3 System Requirements for MCO and Dental Plan Claim Submissions Through TMHP

Before a claim can be routed to the MCO or dental plan through TMHP's electronic claims filing system, TMHP must certify that both the system the provider uses to submit the claim and the system the MCO or dental plan uses to receive the claim are compatible with the EDI 5010 standard.

Refer to: Subsection 3.7, "Third Party Vendor Implementation" in Section 3, "TMHP Electronic Data Interchanges (EDI)" (*Volume 1, General Information*), for information about EDI 5010 compatibility and certification.

MCOs or dental plans must also complete trading partner testing with TMHP to certify EDI 5010 compatibility and verify that routed claims can be received. Providers that submit claims through TMHP to MCOs or dental plans that have not completed trading partner testing will receive a claim rejection.

If the system requirements are not met, providers must submit claims directly to the MCO or dental plan using the MCO's or dental plan's established methods for claims submission. Providers must contact the client's MCO or dental plan with questions about the MCO's or dental plan's billing guidelines and methods.

Note: *Use of TMHP's electronic claim submission system is optional. Providers may continue to submit claims directly to the appropriate MCO or dental plan. Regardless of submission method, adjudication and reimbursement for managed care services is the responsibility of the appropriate MCO or dental plan and not TMHP.*

2.10 MCO/Dental Plan Appeals, Complaints, and Fair Hearings

Providers can submit their appeals directly to the MCO or dental plan that administers the clients' managed care benefits.

Claims that were originally submitted to TMHP for routing to the appropriate MCO or dental plan can be appealed to TMHP using TexMedConnect or EDI. The appeals will be routed to the appropriate entity for processing.

Refer to: Subsection 5.4, "Complaints and Appeals" in this handbook for additional information about NorthSTAR complaints and appeals.

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2.10.1 Medicaid Managed Care Complaints and Fair Hearings

Medicaid managed care providers may file complaints with HHSC if they find they did not receive full due process from the respective managed care health plan.

Appeals, grievances, or dispute resolution is the responsibility of each MCO or dental plan. Providers must exhaust the complaints or grievance process with their MCO or dental plan before filing a complaint with HHSC.

Refer to the respective MCO or dental plan for information about specific complaint policies and procedures. For NorthSTAR, see subsection 5.4, "Complaints and Appeals" in this section. For MCO appeals and fair hearing process, refer to the respective health plan's policies and procedures. For paper appeals, refer to subsection 7.1.4, "Paper Appeals" in Section 7, "Appeals" (*Vol. 1, General Information*).

Once the MCO's or dental plan's complaints or grievance process has been exhausted, complaint requests may be sent to HHSC.

STAR, STAR+PLUS, STAR Health, and dental plan complaint requests may be emailed or mailed to HHSC:

- STAR, STAR+PLUS, and dental plan complaints may be emailed to HPM_Complaints@hhsc.state.tx.us.
- STAR Health complaints may be emailed to STAR.Health@hhsc.state.tx.us.
- STAR, STAR+PLUS, STAR Health, and dental plan complaints may be mailed to HHSC at the following address:

Health and Human Services Commission
Health Plan Management
4900 N. Lamar Blvd.
MC H320
Austin, TX 78751

3 STAR Program

The principal objectives of the STAR Program are to emphasize early intervention and to promote improved access to quality care thereby significantly improving health outcomes for the target populations. The special focus of the STAR Program is on prenatal and well-child care.

In the STAR Program, each MCO contracts with PCPs, hospitals, and other providers to create a healthcare delivery network. Eligible clients whose enrollment in the STAR Program is mandatory are required to select a health plan and a PCP. The client selects the PCP from the MCO provider listing.

Refer to: The TMHP website at www.tmhp.com/Pages/Medicaid/Medicaid_Managed_Care.aspx for a current list of STAR Program service areas.

3.1 STAR Program Clients

HHSC has targeted these client groups within the Texas Medicaid population for STAR Program enrollment:

Medicaid Base Plan	Medicaid Cat.	Medicaid Type Prog.	Description	SA Group 1	SA Group 2
10	01, 03,04	12	SSI Manually Certified-with Medicare living in a Title XIX facility (also Medicare skilled nursing care)	X	X

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Medicaid Base Plan	Medicaid Cat.	Medicaid Type Prog.	Description	SA Group 1	SA Group 2
10	01, 03, 04	12	SSI Manually Certified without Medicare living in a Title XIX facility (also Medicare skilled nursing care)	X	C
10	01, 03, 04	13	SSI Recipient-with Medicare living in a Title XIX facility (also Medicare skilled nursing care)	X	X
10	01, 03, 04	13	SSI Recipient without Medicare living in a Title XIX facility (also Medicare skilled nursing care)	X	C
10	01, 03, 04	14	MAO and deemed SSI with Medicare in a Title XIX facility	X	X
10	01, 03, 04	14	MAO and deemed SSI without Medicare in a Title XIX facility	X	C
13	1	3	MAO RSDI Increases-with Medicare	X	X
13	1	3	MAO RSDI Increases without Medicare	X	M
13	1	12	SSI Manually Certified-with Medicare	X	X
13	1	12	SSI Manually Certified - without Medicare	X	M
13	1	13	SSI Recipient-with Medicare	X	X
13	1	13	SSI Recipient-without Medicare	X	M
13	1	14	MAO and SSI Clients in 1915 (c) waiver programs-with Medicare	X	X
13	1	14	MAO and SSI Clients in 1915(c) waiver programs - without Medicare	X	M
13	1	18	Disabled Adult / Children denied SSI due to increase in SS benefits-with Medicare	X	X
13	1	18	Disabled Adult/Children denied SSI due to increase in SS benefits - without Medicare	X	M
13	1	22	Early Age Widows/Widowers-with Medicare	X	X
13	1	22	Early Age Widow/Widowers without Medicare	X	M
13	1	51	Rider 51 MAO-with Medicare	X	X

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Medicaid Base Plan	Medicaid Cat.	Medicaid Type Prog.	Description	SA Group 1	SA Group 2
13	1	51	Rider 51 MAO-without Medicare	X	M
13	03, 04	3	MAO RSDI Increases-no Medicare (21 and over)	X	M
13	03, 04	3	MAO RSDI Increases no Medicare (Under 21)	X	V
13	03, 04	3	MAO RSDI Increases-Medicare	X	X
13	03, 04	12	SSI Manually Certified-no Medicare Under 21	X	V
13	03, 04	12	SSI Manually Certified-no Medicare 21 and Over	X	M
13	03, 04	12	SSI Manually Certified-Medicare Under 21	X	X
13	03, 04	12	SSI Manually Certified-Medicare 21 and Over	X	X
13	03, 04	13	SSI Recipient-no Medicare - 21 and Over	X	M
13	03, 04	13	SSI Recipient-no Medicare - Under 21	X	V
13	03, 04	13	SSI Recipient-Medicare - 21 and Over	X	X
13	03, 04	13	SSI Recipient-Medicare - Under 21	X	X
13	03, 04	14	MAO and SSI Clients in 1915 (c) waiver programs-no Medicare (21 and Over)	X	M
13	03, 04	14	MAO & SSI Clients in 1915(c) waiver programs no Medicare (Under 21)	X	V
13	03, 04	14	MAO and SSI Clients in 1915 (c) waiver programs-Medicare	X	X
13	03, 04	18	Disabled Adult / Children denied SSI due to increase in SS benefits-No Medicare (21 and over)	X	M
13	03, 04	18	Disabled Adult/Children denied SSI due to increase in SS benefits - No Medicare (Under 21)	X	V
13	03, 04	18	Disabled Adult / Children denied SSI due to increase in SS benefits-Medicare	X	X
13	03, 04	19	Transitional SSI-no Medicare	X	V
13	03, 04	19	Transitional SSI-Medicare	X	X

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Medicaid Base Plan	Medicaid Cat.	Medicaid Type Prog.	Description	SA Group 1	SA Group 2
13	03, 04	22	Early Age Widows/Widowers-No Medicare	X	M
13	03, 04	22	Early Age Widows/Widowers-Medicare	X	X
13	03, 04	51	Rider 51 MAO-No Medicare	X	M
13	03, 04	51	Rider 51 MAO-Medicare	X	X
32	2	9	Medical Assistance Only (MAO) Foster Care	X	X
	2	3	MAO RSDI increase	M	M
	2	20	04 months post Medicaid resulting from Child Support	M	M
	2	29	12 months transitional Medicaid following end of state time limited TANF	M	M
	2	37	12 months transitional Medicaid coverage resulting from loss of 90% earned income disregard	M	M
	2	40	Pregnant women	M	M
	2	43	Children under age 1 with income below 185% FPIL	M	M
	2	44	Children age 6-19 with income below 100%FPIL	M	M
	2	45	Children to age 1 born to Medicaid eligible mother	M	M
	2	47	Children ineligible for TANF, TANF-SP, or the age-appropriate medical program due to stepparent or grandparents' applied income, or stepparent's income when included in the case	M	M
	2	48	Children who are 1 to 5 years of age with income below 133% FPIL	M	M
	2	61	TANF State Program (TANF-SP)--two parent household eligible for money grant and Medicaid with income below TANF recognized needs	M	M
	2	1	Money Grant and Medicaid for caretakers and deprived children with income below TANF recognizable needs	M	M

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Medicaid Base Plan	Medicaid Cat.	Medicaid Type Prog.	Description	SA Group 1	SA Group 2
	2	7	12 months transitional Medicaid resulting from increase in earnings or combined increase in earnings and child support	M	M
	03, 04	88	Medicaid Buy-in for Children with Disabilities No Medicare	X	V
	03, 04	88	Medicaid Buy-in for Children with Disabilities with Medicare	X	X
	1, 3, 4	87	Medicaid Buy-in for Adults No Medicare	X	M
	1, 3, 4	87	Medicaid Buy-in for Adults with Medicare	X	X
C = Conditional, V = Voluntary, M = Mandatory, X = Not Eligible **Group 1 SAs- Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Nueces, Tarrant, Travis** **Group 2 SA - Medicaid Rural Service Area (Medicaid RSA)**					

Health-care providers must verify eligibility before medical care is provided to STAR Program clients, except in cases of emergency. In situations where emergency care must be provided, the client's MCO and PCP should be determined as soon as possible.

The client's Your Texas Benefits Medicaid card will provide the client's managed care enrollment and health plan. Additionally, STAR MCOs provide their clients an MCO identification card. Both forms of identification should be required when determining whether or not the client is a STAR Program client.

Refer to: Subsection 4.2, "Eligibility Verification" in Section 4, "Client Eligibility" (*Vol. 1, General Information*).

3.2 STAR Client Enrollment

Eligible clients in a STAR service area choose an MCO and a PCP. To maximize enrollment, clients may enroll any of the following ways:

Method of Enrollment	Description
Telephone	Clients may call 1-800-964-2777. A customer care representative will provide essential education about the program and details needed for enrollment.
Mail	Clients may complete the STAR Program enrollment form and send the form to the address on the postage-paid, self-addressed envelope provided with the form. Enrollment forms are mailed to all eligible mandatory clients along with a brochure explaining the program and provider listings for each health plan.

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Method of Enrollment	Description
Onsite	Clients can meet with a STAR Program customer care representative at any of the following locations: • Local HHSC offices • Women, Infants, and Children (WIC) classes • Community facilities • Enrollment events
Default	Clients may be enrolled through an assignment process. If a client does not exercise the right to choose an MCO and PCP, the client will be assigned to a health plan and PCP. The following factors are considered when processing a default enrollment: • Client's past claims history, taking into account an established relationship with a participating PCP • Client's age, sex, and geographic proximity to the PCP

STAR Example 1

Benefits under the STAR Program usually begin on the first day of the next month following the client's selection of a managed care plan and PCP. The following example shows the managed care enrollment date for a client who selects a health plan and PCP before the designated cutoff date (approximately the 15th of the month):

Task	Date
Client certified for Texas Medicaid	January 1
Medicaid benefits begin	January 1
Client selects health plan and PCP (before the 15th of the month)	January 1
Managed care benefits begin	February 1

STAR Example 2

The following example shows the managed care enrollment date for a client who selects a health plan and PCP after the designated cutoff date (approximately the 15th of the month):

Task	Date
Client certified for Texas Medicaid	January 1
Medicaid benefits begin	January 1
Client selects health plan and PCP (after the 15th of the month)	January 20
Managed care benefits begin	March 1

3.2.1 * Expedited Enrollment of Pregnant Women (Program Type 40)

A pregnant woman who applies for program type 40 has 16 days from the date of application to choose a STAR MCO. If she does not choose a STAR MCO, one will be chosen for her.

The Enrollment Broker contacts the client to begin the enrollment process and assists the client in selecting an MCO. The client may also contact the Enrollment Broker directly at 1-800-964-2777 (STAR Help Line). To protect continuity of care and client choice, the Enrollment Broker will work with each pregnant woman to select a health plan that includes her current prenatal care provider or to choose an obstetrical care provider that meets her needs.

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Clients will be covered under Texas Medicaid fee-for-service until their Medicaid MCO coverage begins. To ensure proper billing, providers should call the Enrollment Broker at 1-800-964-2777 (STAR Help Line) to obtain the name of the client's health plan. However, client eligibility should always be verified at the time the service is to be rendered.

Women certified as Medicaid program type 40 may be retroactively enrolled in STAR. Women who are certified as Medicaid program type 40 on or before the 10th of the month will be enrolled in STAR beginning the first of the month of certification. Those who are certified after the 10th of the month will be on Texas Medicaid fee-for-service the month of certification and will be enrolled in STAR beginning the first of the month following the month of certification.

There are two exceptions to this rule:

- Women who are certified at any time in their estimated month of delivery will be enrolled in STAR the first of the following month (prospective enrollment).
- Women who are certified at any time in their actual month of delivery (if known by HHSC before certification) will be enrolled in STAR the first of the following month (prospective enrollment).

Important: *Providers must verify the client's plan and PCP information.*

The following examples show when benefits begin in relation to certification:

Example 1: Woman Certified in Her 6th Month	
Client certified for Texas Medicaid	August 1
Medicaid benefits begin	August 1
STAR Program benefits begin	August 1

Example 2: Woman Certified in Her 6th Month	
Client certified for Texas Medicaid	August 12
Medicaid benefits begin	August 1
STAR Program benefits begin	September 1

Example 3: Woman Certified in Her 9th Month	
Client certified for Texas Medicaid	August 5
Medicaid benefits begin	August 1
STAR Program benefits begin	September 1

Within 14 days of enrolling in an MCO, a plan representative will contact the new client to help arrange the first prenatal appointment. Providers should also expect contact from the health plans to facilitate prenatal appointments for new clients. Physicians and other prenatal care providers are encouraged to make prenatal appointments within two weeks.

Note: *Expedited enrollments of pregnant women (program type 40) into the STAR Program may be retroactive.*

3.2.2 Enrollment of Newborns

In the STAR Program, newborns are automatically assigned to the STAR MCO the mother is enrolled with at the time of the newborn's birth for at least 90 days following the date of birth unless the mother requests a plan change as a special condition. The effective date of the newborn's enrollment is the same as the newborn's DOB. STAR MCOs are responsible for all covered services provided to newborn members.

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There may be a delay of up to several months from the DOB for a newborn to receive a Medicaid client number. Providers should check with each STAR MCO for claim filing requirements for newborns who do not yet have a Medicaid client number.

If the newborn has not yet been assigned a PCP, the Your Texas Benefits Medicaid card will indicate that the client is "Newborn" and instruct the provider to "Call Plan" to inquire about filing a claim.

Refer to: Subsection 2.9.1, "Newborn Claims Filing for MCO Services" in this section.

STAR Example

Enrollments of newborns born to mothers enrolled in STAR are retroactive to the newborn's date of birth. The following example shows the managed care enrollment date for a newborn:

Task	Date
Client's date of birth (mother enrolled in STAR)	January 3
Client certified for Texas Medicaid	February 1
Medicaid benefits begin	January 3 (retroactive to DOB)
STAR enrollment begins (mother's STAR plan at time of birth)	January 3 (retroactive to DOB)

3.2.3 Timely Notification and Assignment of Medicaid ID for Newborns

Hospitals that submit their birth certificate information utilizing the DSHS, Bureau of Vital Statistics (BVS) electronic Certificate Manager software and the Hospital Report (Newborn Child or Children) (Form 7484), receive a rapid and efficient assignment of a newborn Medicaid identification number. This process expedites reimbursement to hospitals and other providers involved in newborn care including pharmacies providing outpatient prescription benefits for medically-needy newborns.

For more information or to comment on this process, call 1-512-458-7367.

Note: *The enrollment of newborns that are born to mothers who are enrolled in an MCO on the date of birth are retroactive to the newborn's date of birth (DOB).*

3.3 STAR Program Benefits

STAR Program clients receive all the benefits of Texas Medicaid fee-for-service and the following additional benefits:

- Removal of the inpatient spell of illness limitation for adults
- Unlimited medically necessary prescription drugs for adults

3.3.1 Spell of Illness

STAR clients are not limited to the 30-day spell of illness. The spell of illness limitation is defined as 30 days of inpatient hospital care, which may accrue intermittently or consecutively. After 30 days of inpatient care is provided, reimbursement for additional inpatient care is not considered until the client has been out of an acute care facility for 60 consecutive days. All Medicaid clients who are 20 years of age and younger already are not limited to the 30-day spell of illness.

3.3.2 Prescriptions

STAR Program clients who are 21 years of age and older receive unlimited medically necessary prescription drugs. The elimination of the three prescription limit per month for adult clients enrolled in STAR allows the provider greater flexibility in treating and managing a client's health-care needs. All Medicaid clients who are 20 years of age and younger already receive unlimited medically necessary prescription drugs.

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3.3.3 National Drug Code

All STAR providers that submit professional or outpatient claims with physician-administered prescription drug procedure codes are required to use the associated NDC. Drug claims submitted with procedure codes in the "A" code series do not require an NDC. The NDC is only required on outpatient hospital claims and physician claims.

N4 can 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.

Refer to: Subsection 6.3.4, "National Drug Code (NDC)" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

3.3.4 Behavioral Health Billing

Behavioral health claims for services rendered to STAR clients residing in ICF-IIDs or nursing facilities in the Dallas SA must be submitted to TMHP and processed through Medicaid FFS.

Note: *Behavioral health claims for Dallas SA nursing facility residents who are dual eligible for Medicare and Medicaid must continue to be submitted to Medicare first. Medicaid will continue to reimburse providers for the appropriate cost-sharing liabilities.*

4 STAR+PLUS Program

The STAR+PLUS Program is designed to improve access to care, provide care in the least restrictive setting, and provide more accountability and control on costs. The STAR+PLUS program integrates acute care and long-term care services and supports into a Medicaid managed care delivery system for SSI-eligible Medicaid clients.

In the STAR+PLUS Program, each MCO contracts with providers and delegated networks to create a health-care provider delivery network.

Refer to: The TMHP website at www.tmhp.com/Pages/Medicaid/Medicaid_Managed_Care.aspx for a current list of STAR+PLUS Program service areas.

4.1 STAR+PLUS Program Clients

HHSC has targeted these client groups within the Texas Medicaid population for STAR+PLUS Program enrollment:

Program Type	Description
Enrollment for category 01, 03, 04 (SSI, aged, and blind and disabled clients), and the following program types are mandatory for STAR+PLUS:	
02	Medicaid Buy-In
03	Denied SSI clients who are Medicaid-eligible under Pickle provisions.
12	SSI client
13	SSI client
14	STAR+PLUS Waiver (SPW) clients only ***Note:*** *Clients in program type 14 who are not determined eligible for the Home and Community-Based Services (HCBS) STAR+PLUS Waiver (SPW) will be excluded from participation in STAR+PLUS.*

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Program Type	Description
18	Disabled adult children who are denied SSI coverage due to increase in Social Security benefits
22	Clients who are denied SSI coverage and who receive widow/widower Social Security benefits
Enrollment for category 03 and 04 (SSI blind and disabled children), and the following program type may enroll in a STAR+PLUS MCO.	
19	Medicaid and community-based waiver program for children who are 20 years of age and younger

Clients who are eligible for Medicaid under the SSI Program and who reside in a STAR+PLUS service area can enroll in STAR+PLUS. Enrollment in STAR+PLUS is mandatory for clients who are 21 years of age and older and voluntary for clients who are 20 years of age and younger.

SSI clients who meet the following conditions are required to select a PCP from the MCO provider directory:

- Reside in one of the STAR+PLUS service area counties
- Have selected an MCO
- Are not covered by Medicare

SSI clients who are also covered by Medicare (i.e., dual-eligible clients) must select a STAR+PLUS MCO to receive Medicaid community based long term care services.

Clients enrolled in any of the following Texas Department of Aging and Disability Services (DADS) programs can enroll in STAR+PLUS for acute care benefits, unless the client is dual eligible for Medicaid and Medicare:

- Community-based Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)
- Community Living Assistance and Support Services (CLASS)
- Deaf Blind with Multiple Disabilities (DBMD)
- Home and Community-Based Services (HCS)
- Texas Home Living (TxHmL)

Note: *Enrollment in STAR+PLUS is mandatory for clients who are 21 years of age and older and voluntary for clients who are 20 years of age and younger.*

Exception: *Clients who receive Medicare Part B in addition to Medicaid, will remain in FFS for all Medicaid services.*

4.1.1 STAR+PLUS Program Dual-Eligible Clients

Many STAR+PLUS clients are eligible for Medicaid and Medicare. STAR+PLUS MCOs are not at risk for the delivery of acute care services needed by dual-eligible clients.

Most STAR+PLUS clients with Medicare and Medicaid are Medicaid Qualified Medicare Beneficiaries (MQMBs). MQMBs receive Medicare benefits through a Medicare risk product (MCO) or Medicare fee-for-service insurance program. To reduce confusion, HHSC has mandated that STAR+PLUS MQMBs continue to receive all their acute care services as they do today, with Medicare being the primary payor and Texas Medicaid fee-for-service, through TMHP, the secondary payor.

MQMB clients qualify for Medicaid benefits that are not covered by Medicare.

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Providers are to continue billing for Medicare acute care services through the client's Medicare MCO or fee-for-service insurer following the rules of the Medicare insurer. If the client is in both a Medicare MCO and a Medicaid MCO, the client uses the Medicare PCP, and providers follow the Medicare MCO's medical management rules for authorization, concurrent review, etc. MQMBs choose a Medicaid MCO but do not choose a Medicaid PCP.

HIPP Program clients access their benefits through Texas Medicaid fee-for-service, and are not enrolled in managed care unless they choose to leave the HIPP program.

Note: *STAR+PLUS clients who are receiving services through the 1915(c) waiver for individuals with intellectual and developmental disabilities (IDD) or residing in a community-based intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID) may also be enrolled in HIPP.*

Refer to: Subsection 4.11, "Medicare and Medicaid Dual Eligibility" in Section 4, "Client Eligibility" (*Vol. 1, General Information*) for more information and further MQMB instructions.

Subsection 4.13, "Health Insurance Premium Payment (HIPP) Program" in Section 4, "Client Eligibility" (*Vol. 1, General Information*).

4.1.2 Clients Who Are Ineligible For The STAR+PLUS Program

Clients who meet the following criteria are not eligible to enroll in STAR+PLUS and will remain in Texas Medicaid fee-for-service:

- Residents in a State Supported Living Center
- Residents in an ICF-IID who are dual eligible in Medicare and Medicaid
- Residents of state hospitals or institutions for mental diseases
- Frail Elderly (or 1929B) Program clients
- In-Home and Family Support Program Services clients
- Qualified Medicare Beneficiaries (QMBs) that do not receive Medicaid benefits other than Medicare deductible or coinsurance liabilities according to current payment guidelines
- Undocumented aliens
- Clients who receive limited Medicaid benefits and do not qualify for participation in the VDP
- Clients who participate in one of the following Home and Community-Based Waiver programs (other than the Nursing Facility Waiver):
  - Medically Dependent Children's Program (MDCP) Waiver Program
  - Mental Retardation Local Authority (MRLA) Waiver Program

4.2 STAR+PLUS Client Enrollment

Clients in a STAR+PLUS service area must choose an MCO and a PCP. To maximize enrollment, clients may enroll any of the following ways:

Method of Enrollment	Description
Telephone	Clients may call 1-800-964-2777. A customer care representative will provide essential education about the program and details needed for enrollment.

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Method of Enrollment	Description
Mail	Clients may complete the STAR+PLUS Program enrollment form and send the form to the address on the postage-paid, self-addressed envelope provided with the form. Enrollment forms are mailed to all eligible mandatory clients along with a brochure explaining the program and provider directories for each health plan.
Onsite	Clients can meet with a STAR+PLUS Program customer care representative at any of the following locations: • Local HHSC offices • Women, Infants, and Children (WIC) classes • Community facilities • Enrollment events
Default	Clients may be enrolled through an assignment process. If a client does not exercise the right to choose an MCO and PCP, the client will be assigned to a health plan and PCP. The following factors are considered when processing a default enrollment: • Client's past claims history, taking into account an established relationship with a participating PCP • Client's age, sex, and geographic proximity to the PCP

Benefits under the STAR+PLUS Program usually begin on the first day of the next month following the client's selection of a managed care plan and PCP.

STAR+PLUS Example 1

The following example shows the eligibility dates for a client who selects a health plan and PCP before the designated cutoff date (approximately the 15th of the month):

Task	Date
Client certified for Texas Medicaid	January 1
Medicaid benefits begin	January 1
Client selects health plan and PCP (before the 15th of the month)	January 1
Managed care benefits begin	February 1

STAR+PLUS Example 2

The following example shows the eligibility dates for a client who selects a health plan and PCP after the designated cutoff date (approximately the 15th of the month):

Task	Date
Client certified for Texas Medicaid	January 1
Medicaid benefits begin	January 1
Client selects health plan and PCP (before the 15th of the month)	January 20
Managed care benefits begin	March 1

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4.2.1 Enrollment of Newborns

Children born to STAR+PLUS clients will be automatically enrolled with the STAR MCO in the service area operated by the same STAR+PLUS MCO if available. The effective date of the newborn's enrollment is the same as the newborn's date of birth. If the STAR+PLUS MCO does not also operate a STAR MCO in the service area, the newborn is placed into Texas Medicaid fee-for-service, and the mother is given the opportunity to choose a STAR MCO for the newborn.

Reminder: *Hospitals that submit the newborn's birth certificate information using the DSHS Bureau of Vital Statistics (BVS) electronic Certificate Manager software and the Hospital Report (Newborn Child or Children) (Form 7484), receive a rapid and efficient assignment of a newborn Medicaid identification number. This process expedites reimbursement to hospitals and other providers involved in newborn care including pharmacies providing outpatient prescription benefits for medically-needy newborns.*

For more information or to comment on the process for expedited assignment of a newborn Medicaid identification number, providers can call 1-512-458-7367.

4.3 STAR+PLUS Program Benefits

STAR+PLUS Program clients receive all the benefits of Texas Medicaid fee-for-service and the following additional benefits:

- Unlimited medically necessary prescription drugs for adults who are not dual-eligible
- A service coordinator

Refer to: Subsection 3.3.2, "Prescriptions" in this handbook for more information about prescription benefits.

Note: *Dual eligible adults continue to be limited to three prescriptions unless they have joined the Medicare MCO also offered by their STAR+PLUS MCO.*

4.3.1 Prescriptions

STAR+PLUS clients who are 21 years of age and older and do not receive Medicare receive unlimited medically necessary prescription drugs. The elimination of the three prescription limit per month for adult clients enrolled in STAR+PLUS allows the provider greater flexibility in treating and managing a client's health care needs. All Medicaid clients who are 20 years of age and younger already receive unlimited medically necessary prescription drugs.

4.3.2 Spell of Illness

The spell-of-illness limitation applies to clients in the STAR+PLUS Program.

A spell-of-illness is defined as 30 days of inpatient hospital care, which may accrue intermittently or consecutively. After 30 days of inpatient care is provided, reimbursement for additional inpatient care is not considered until the client has been out of an acute care facility for 60 consecutive days.

An individual may be discharged from and readmitted to a hospital several times, regardless of the admittance reasons, and still be considered to be in the same spell of illness if 60 days have not elapsed between discharge and readmission.

The spell-of-illness limitation does not apply is the following situations:

- A prior-approved solid organ transplant has an additional 30-day spell of illness, which begins on the date of the transplant.
- No spell-of-illness limitation exists for THSteps-eligible clients who are 20 years of age and younger when a medically necessary condition exists.
- The client is enrolled in the Medicaid managed care STAR program.

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4.3.3 Service Coordination and Care Management

The MCO must furnish a service coordinator to all STAR+PLUS clients who request one, or when the MCO determines the need for a service coordinator through an assessment. A service coordinator is the person with primary responsibility for providing service coordination and care management to STAR+PLUS clients.

4.3.4 Behavioral Health Billing

Behavioral health claims for services rendered to STAR+PLUS clients residing in ICF-IIDs or nursing facilities in the Dallas SA must be submitted to TMHP and processed through Medicaid FFS.

Note: *Behavioral health claims for Dallas SA nursing facility residents who are dual eligible for Medicare and Medicaid must continue to be submitted to Medicare first. Medicaid will continue to reimburse providers for the appropriate cost-sharing liabilities.*

5 NorthSTAR Program

Behavioral health providers that practice in the Dallas SA must be enrolled as a network provider in the NorthSTAR BHO to be reimbursed for services provided to STAR and STAR+PLUS clients.

Note: *Behavioral health providers that render services to clients in services areas other than the Dallas service area must enroll with each MCO to be reimbursed for services rendered to Medicaid managed care clients. Although managed care clients may self-refer for behavioral health services, providers should contact the client's MCO for specific in-network requirements.*

NorthSTAR provides behavioral health services (mental health, chemical dependency, and substance abuse treatment) for Medicaid clients who are enrolled in a BHO in the Dallas service area. NorthSTAR also serves a clinically and financially eligible non-Medicaid population.

NorthSTAR is known as a *behavioral health carve-out* of the STAR and STAR+PLUS Programs in the Dallas SA. Medicaid provides access to physical health care while NorthSTAR provides mental health and chemical dependency (behavioral health) services.

NorthSTAR provides easier access to a comprehensive array of behavioral health services and providers. The program's goal is to provide clinically necessary behavioral health services to enrollees, through a network of qualified and credentialed providers.

In the NorthSTAR Program, ValueOptions is the sole BHO and is responsible for contracting with providers and maintaining a behavioral health-care provider delivery network. The BHO also:

- Offers education and support to the provider network.
- Performs utilization management through authorization of services, concurrent review, and special studies.
- Performs quality assurance monitoring and activities.
- Provides client services including education and outreach.
- Processes claims.

In the STAR and STAR+PLUS Programs, clients select a PCP from among the providers who have contracted with a STAR or STAR+PLUS MCO. In the NorthSTAR Program, a client may have several different providers for different specialty behavioral health services. The BHO will arrange behavioral health services and make referrals to specific providers within the BHO network.

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Providers are encouraged to coordinate care with physical health providers in the Medicaid managed care and Texas Medicaid fee-for-service programs. Behavioral health providers may do this by notifying the Medicaid managed care or Texas Medicaid fee-for-service provider. Behavioral health providers may also notify the BHO that the client is receiving services.

Providers interested in becoming a ValueOptions network provider can obtain additional information by contacting ValueOptions at 1-888-800-6799.

Note: *If a behavioral health provider practices in the Dallas SA, he must be enrolled as a network provider in the NorthSTAR BHO (ValueOptions) to provide services to NorthSTAR enrollees. Providers who serve NorthSTAR enrollees without being in the provider network or without prior authorization in nonemergency situations risk non-payment of claims.*

5.1 NorthSTAR Program Clients

Most Medicaid clients residing in the Dallas SA must enroll in NorthSTAR. All STAR and STAR+PLUS Program enrollees are subject to mandatory enrollment in NorthSTAR. Once enrolled in NorthSTAR, ValueOptions will coordinate enrollee behavioral health services.

Refer to: Your Texas Benefits Medicaid Card (English and Spanish) on the TMHP website at www.tmhp.com.

Note: *NorthSTAR Program enrollment information is not reflected in the Medicaid ID verification, but enrollment can be confirmed by the BHO or the enrollment broker.*

Medicaid clients residing in the Dallas SA that are not eligible to enroll in a NorthSTAR BHO are:

- Medicaid clients living in a nursing facility
- Medicaid clients living in an ICF-IID
- Medicaid clients living in state hospitals' Institutions for Mental Disease Over Age 65 Program
- Children who are in the custody of the Department of Family and Protective Services (DFPS) (in foster care)
- Certain Medicaid clients that are ineligible for NorthSTAR such as program type 55

When a Medicaid enrollee requests services, the provider should contact ValueOptions or the Enrollment Broker to verify enrollment in NorthSTAR. If the client is not currently enrolled in NorthSTAR, the provider may give the client the telephone number of the Enrollment Broker so the client may become enrolled in NorthSTAR.

The Enrollment Broker staff is trained to assist potential clients in their understanding of the STAR, STAR+PLUS, and NorthSTAR programs.

5.2 NorthSTAR Client Enrollment

Medicaid clients must enroll through the Enrollment Broker during regular business hours. If it is an emergency and after regular business hours, the NorthSTAR BHO can enroll a Medicaid client into NorthSTAR.

Medicaid clients may also mail in their enrollment using the NorthSTAR enrollment form. Non-Medicaid clients may be enrolled by NorthSTAR at designated enrollment sites.

NorthSTAR eligibility is retroactive to the NorthSTAR eligibility certification date. NorthSTAR does not require a PCP.

NorthSTAR Example

Task	Date
Client certified for Texas Medicaid in NorthSTAR SA	January 1

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Task	Date
Medicaid benefits begin	January 1
Client enrolls in NorthSTAR	January 20
NorthSTAR benefits begin	January 1

5.3 NorthSTAR Program Benefits

ValueOptions is the NorthSTAR BHO in the Dallas SA that administers all NorthSTAR benefits and process authorizations and claims for NorthSTAR services.

5.3.1 Hospital Billing

In the Dallas SA, SSI clients are subject to mandatory enrollment in Medicaid managed care through the NorthSTAR Program. In some instances, general acute care hospitals treat a NorthSTAR client with a primary behavioral health diagnosis. In that instance, the general acute care hospital needs to seek authorization and reimbursement from ValueOptions using the CMS-1500 form for outpatient services and UB-04 CMS-1450 for inpatient services.

5.3.2 Behavioral Health Billing

Services provided under the STAR and STAR+PLUS Programs are billed to the STAR or STAR+PLUS MCO in which the client is enrolled. The STAR and STAR+PLUS Programs in the Dallas SA covers medically necessary physical health-care services and behavioral health services that are delivered by medical providers, such as primary care providers, FQHCs, and RHCs. STAR and STAR+PLUS also cover ambulatory laboratory and ancillary services required to diagnose or treat behavioral health conditions and psychological testing for certain non-behavioral health diagnoses.

The program-related forms are the CMS-1500 and UB-04 CMS-1450.

5.3.3 Prior Authorization Requirements

To receive payment for services provided to ValueOptions clients, providers must be enrolled with ValueOptions. (Exceptions include emergency care and medically necessary treatment episodes that began before the client joined NorthSTAR.) ValueOptions requires that the provider obtain prior authorization for most nonemergency services. If the provider does not obtain prior authorization, they may not get payment for services. These rules apply whether the provider's practice or facility is located in or out of the Dallas SA.

Exception: *Expedited enrollments of pregnant women (program type 40) into the STAR Program may be retroactive; and NorthSTAR has enrollment that is retroactive to the NorthSTAR eligibility certification date.*

5.4 Complaints and Appeals

A *complaint* is defined as any dissatisfaction expressed in writing by the provider, or on behalf of that provider, concerning any aspect of the health plan. The term *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.

Appeals and grievances, hearings, or dispute resolution is the responsibility of ValueOptions. Providers must exhaust the appeals and grievance process with ValueOptions before filing a complaint with NorthSTAR Provider Relations. Under the complaint process, NorthSTAR Provider Relations works with ValueOptions and providers to verify the validity of the complaint, determine if the established due process was followed in resolving appeals and grievances, and addresses other program/contract issues,

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as applicable. When filing a complaint, providers must submit a letter explaining the specific reasons they believe the final appeal decision by the NorthSTAR health plan is incorrect and copies of the following documentation as appropriate:

- All R&S Reports of the claims and services in question, if applicable
- Provider's claims and billing records (electronic or manual) related to the complaint
- Provider's internal notes and logs when pertinent
- Memos from the state or the health plan indicating any problems, policy changes, or claims processing
- Discrepancies that may be relevant to the complaint
- Other documents such as receipts (e.g., certified mail)
- Original date-stamped envelopes, in-service notes
- Minutes from meetings, etc., if relevant to the complaint

All NorthSTAR providers must exhaust the ValueOptions complaint and appeals process first. After this process is exhausted and if the outcome is unsatisfactory, NorthSTAR providers may file complaints or appeals with NorthSTAR Provider Relations at the following address:

Department of State Health Services
NorthSTAR Enrollee/Provider Relations
PO Box 149347
Mail Code 2012
Austin, TX 78714-9347

Quality of care concerns can be submitted to ValueOptions or NorthSTAR Provider Relations at the following address:

ValueOptions
Attn: Complaint and Grievance Coordinator
1199 South Beltline, Suite 100
Coppell, TX 75019

Refer to: Subsection 7.1.4, "Paper Appeals" in Section 7, "Appeals" (*Vol. 1, General Information*) for more information on paper appeals.

6 STAR Health Program

The STAR Health program ensures that children taken into state conservatorship are able to receive all services they need immediately upon entry into conservatorship.

HHSC has selected Superior HealthPlan Network as the MCO administrator for this program. Superior HealthPlan is responsible for assigning a PCP to clients when they are enrolled in the STAR Health Program. Foster care families are given the opportunity to change their PCP after this initial assignment.

6.1 STAR Health Program Clients

All Medicaid clients in foster care are placed in this program with the following exceptions:

- Children adjudicated and placed in a Texas Youth Commission (TYC) or Texas Juvenile Probation Commission (TJPC) facility
- Children from other states who are placed in Texas Children in Medicaid-paid facilities such as children in nursing homes, ICF-IIDs, or State-Supported Living Centers
- Children who are dual eligible clients in Medicare and Medicaid

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- Children who are active SSI-related Medicaid clients
- Children who are in state conservatorship who are placed outside of Texas
- Children who are in adoption assistance

Clients who participate in the Medicaid for Transitioning Foster Care Youth (MTFCY) program and the Former Foster Care in Higher Education (FFCHE) program are eligible for the STAR Health program.

The following table shows the age ranges for clients who may be eligible for the STAR Health program:

Group Clients Belong to	Age Ranges
Client under DFPS conservatorship	DFPS can retain conservatorship through the month of the client's 18th birthday. (Eligibility ends the month conservatorship ends.)
Clients who voluntarily continue in a foster care placement after DFPS conservatorship ends	18 through 21 years of age (Eligibility ends the month of their 22nd birthday.)
Clients who are participating in the MTFCY program	18 through 20 years of age (Eligibility ends the month of their 21st birthday.)
Clients who are participating in the FFCHE program	21 through 22 years of age (Eligibility ends the month of their 23rd birthday.)

STAR Health members can gain eligibility on any day of the month. To ensure the accurate confirmation of STAR Health eligibility, it is essential that all health-care providers verify eligibility by contacting the STAR Health MCO. The STAR Health MCO receives updated eligibility information on a daily basis, so it will have the most current eligibility information.

The Department of Family and Protective Services (DFPS) Form 2085 as well as the Your Texas Benefits Medicaid card may also be used to verify eligibility in the STAR Health Program.

Newborns born to a mother who is enrolled in the STAR Health program are automatically enrolled in STAR Health.

Newborns born to a mother who is enrolled in STAR Health through the Former Foster Care in Higher Education (FFCHE) Program are not eligible to be enrolled in STAR Health.

Newborns that are taken into State conservatorship while still in the hospital will be enrolled in STAR Health on the date the State takes conservatorship.

6.2 STAR Health Client Enrollment

Benefits under STAR Health begin when the client is placed in conservatorship.

STAR Health Example

Task	Date
Client placed in conservatorship	January 26
Client certified for Texas Medicaid	January 26
Medicaid benefits begin	January 26
STAR Health benefits begin	January 26

6.3 STAR Health Program Benefits

STAR Health Program clients receive all the benefits of traditional Texas Medicaid as well as service coordination to assist in making appointments and accessing services; and service management to assist with managing the health care of those with ongoing and serious medical needs.

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Refer to: "Appendix B: Vendor Drug Program" (*Vol. 1, General Information*) for information about outpatient prescription drugs.

Most Medicaid foster care claims are capitated services and must be submitted to Superior HealthPlan.

Refer to: Section 8, "Carve-Out Services" in this handbook for the list of non-capitated services that may be reimbursed by TMHP.

All THSteps dental, medical, vision, and mental health providers should submit claims for services rendered to foster care clients to Superior HealthPlan's dental, vision, and mental health contractors.

For general provider information, contact STAR Health at 1-866-439-2042.

For authorizations, contact:

Contractor	Contact Information
Physical Health authorizations:	1-800-218-7508 (Fax 1-800-690-7030)
Cenpatico Behavioral Health authorizations:	1-866-218-8263 (Fax 1-866-534-5958)
Total Vision Health Plan (TVHP) vision services authorizations:	1-800-642-9488 (Fax 1-252-451-2140)
DentaQuest authorization:	Prior authorization requests must be sent to the following address: DentaQuest 12121 North Corporate Parkway Mequon, WI 53092 Fax: (262) 241-7150 or 1-888-313-2883 Telephone: 1- 888-308-9345 (provider line).

Note: *HIPP program clients who are enrolled in STAR HEALTH should be removed from the HIPP program and continue to receive their benefits under the STAR Health program.*

Refer to: Subsection 4.13, "Health Insurance Premium Payment (HIPP) Program" in Section 4, "Client Eligibility" (*Vol. 1, General Information*), for more information about outpatient prescription drugs that are provided by VDP contracted pharmacies.

"Appendix B: Vendor Drug Program" (*Vol. 1, General Information*) for information about VDP.

6.3.1 STAR Health Mental Health Rehabilitation Mental Health Claims Submissions

STAR Health providers must submit their mental health rehabilitation claims for Superior HealthPlan foster care clients to Cenpatico at the following address:

Cenpatico Claims
PO Box 6300
Farmington, MO 63640-3806

Providers should submit their electronic claims to one of the clearinghouses that are trading partners with Cenpatico. Information about these clearinghouses can be found on the Cenpatico website at www.cenpatico.com. Click **Providers,** click **Resources**, and then click **Electronic Transactions (EDI)**. Texas mental health providers can use the following:

Clearing House Trading Partner	Payer ID
Availity	68058

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Clearing House Trading Partner	Payer ID
Emdeon	68053
Gateway EDI	68053
McKesson	68058
SSI	68053

For more information on the use of other clearinghouses, providers should call Cenpatico at 1-800-225-2573, extension 25525 or visit the Cenpatico website at www.cenpatico.com.

The following procedure codes and modifier combinations must be submitted to Cenpatico for mental health rehabilitation services:

Procedure Code	Modifier
G0177	
G0177	HK
H0034	
H0034	HK
H0034	HQ
H0034	HK and HQ
H0034	HA
H0034	HA and HR or UK
H0034	HA and HQ
H0034	HA and HQ and HR or UK
H2011	
H2011	HK
H2011	HA
H2014	
H2014	HQ
H2014	HA
H2014	HA and HR or UK
H2017	
H2017	HK
H2017	TD
H2017	HK and TD
H2017	HQ
H2017	HK and HQ
H2017	HQ and TD
H2017	HQ and HK and TD
H2017	ET
H2017	HK and ET

The services listed above may be reimbursed when rendered to clients who satisfy the criteria of the mental health, priority population and who are determined to need inpatient rehabilitation. These services may be provided to a person with a single severe mental disorder (excluding mental retardation,

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pervasive developmental disorder, or substance use disorder) or a combination of severe mental disorders as defined in the *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition, Text Revision (DSM-IV-TR).

7 Children's Medicaid Dental Services

7.1 Overview

The principal objectives of children's Medicaid managed care dental services are to provide quality, comprehensive dental services in a manner that improves oral health of clients through preventative care, health education, and early intervention and to promote improved access to quality care, thereby significantly improving health outcomes for the target populations.

7.2 Children's Medicaid Dental Services Model

Clients primary and preventive Medicaid dental services are provided statewide through Medicaid managed care dental plans. Each Medicaid managed care dental plan is responsible for contracting with general dentists, pediatric dentists, and dental specialists to create a delivery network. Clients who receive their dental services through a Medicaid managed care dental plan are required to select a dental plan and a Main Dentist (or Main Dental Home provider or Dental Home). The client selects the Main Dentist from a provider directory.

A Main Dentist means a provider who has agreed with a Dental Contractor to provide a Dental Home to Members and who is responsible for providing routine preventive, diagnostic, urgent, therapeutic, initial, and primary care to patients, maintaining the continuity of patient care, and initiating referral for care. Provider types that can serve as Main Dental Home Providers are general dentist and pediatric dentist.

The First Dental Home Initiative is included in this model.

Refer to: Section 4.2.7, "First Dental Home" in the *Children's Services Handbook (Vol. 2, Provider Handbooks)*.

Services provided through children's Medicaid dental plans are separate from the medical services provided by the STAR, STAR+PLUS, and STAR Health managed care organizations.

7.3 Client Eligibility

Most children who are 20 years of age and younger will receive their dental services through Medicaid managed care dental plan.

Populations that will not receive services through the children's Medicaid managed care dental plans are:

- Medicaid recipients who are 21 years of age or older.
- Recipients who reside in an institution, i.e. nursing homes, state supported living centers, or ICF-IID.
- Recipients in the STAR Health Program (Managed Care Foster Care Program)

7.4 Client Enrollment

Clients choose a dental plan and Main Dentist. To maximize enrollment, the children's Medicaid dental services offer four alternative ways that clients can enroll:

- Telephone Enrollment. A client can enroll in a dental plan by calling 1-800-964-2777 (telecommunications device for the deaf (TDD): 1-800-267-5008) A customer care representative will provide essential education about the program and details needed for enrollment.

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- Mail-in Enrollment. If calling is not convenient, a client may enroll by completing the an enrollment form and dropping it in the mail using the postage-paid, self-addressed envelope. Enrollment forms are mailed to all eligible mandatory clients along with information explaining the services and how to choose a Main Dentist.
- Onsite Enrollment. In addition to telephone and mail-in enrollment, clients can enroll by talking with customer care representative at a local HHSC office, at Women, Infants, and Children (WIC) classes, community facilities, or during enrollment events.
- Default Enrollment. The final method of enrollment is through an assignment process. If a client does not exercise the right to choose a dental and Main Dentist, the client will be assigned to a dental plan. After the default assignment is made, the dental plan will assign the client a Main Dentist.

7.5 Children's Medicaid Dental Plan Choices

Children's Medicaid dental services benefits are administered by two dental managed care organizations (i.e., dental plans) across the state of Texas.

Medicaid Managed Care Dental Plan	Dental Plan Provider Services
DentaQuest	1-800-685-9971
MCNA Dental	1-855-776-6262

7.6 Authorizations for Children's Medicaid Managed Care Dental Services (Non-orthodontia Services)

Authorization requests for services administered by the client's dental plan must be submitted to the client's dental plan according to the guidelines specific to the plan under which the client is covered.

If a member is new to a dental plan and has an open authorization for covered dental services from TMHP or another HHSC-contracted Medicaid managed care dental plan, the dental plan must accept that authorization and cannot require additional authorization or review.

TMHP authorizes and processes dental and emergent orthodontic services for clients who are 20 years of age and younger but have not yet enrolled in a dental plan.

TMHP also authorizes services for the following clients:

- Dental services for Medicaid clients who are 21 years of age and older
- Dental and orthodontia services for all Medicaid clients, regardless of age, who reside in Medicaid-paid facilities such as nursing homes, state-supported living centers, or ICF-IIDs

Exception: *STAR Health Foster Care Program clients receive dental and orthodontic services through DentaQuest.*

7.7 Children's Medicaid Dental Orthodontia Services

The Medicaid managed care dental plans will be responsible for prior authorizing, processing, and reimbursing any orthodontic services rendered to Texas Medicaid fee-for-service and managed care clients. Claims for orthodontic services that were initially authorized by TMHP but later transitioned to a managed care dental plan will be processed and reimbursed by the dental plan. Providers should check client eligibility to identify the managed care dental plan in which the client is enrolled.

TMHP will continue to processes claims and claims adjustments for:

- Orthodontia services with dates of service on or before February 29, 2012.
- Clients who had orthodontia services that were prior authorized by TMHP and who lost Medicaid eligibility before March 1, 2012.

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- Orthodontia services claims for clients who are ICF-IID residents.

8 Carve-Out Services

Some services are "carved out" of one or more of the managed care programs. Carved out services are those that are rendered to Medicaid managed care clients, but are processed for payment consideration by TMHP and not an MCO or dental plan.

The following table shows the services that are partially or completely carved out of the MCO and dental plan managed care program as well as services that are no longer carved out as of March 1, 2012:

Carve Out	STAR	STAR+PLUS	STAR Health
Nutritional products through WIC	TMHP	TMHP	TMHP
DSHS MH rehabilitation	TMHP	TMHP	MCO
County Indigent Health Care Program (CIHCP)	TMHP	TMHP	TMHP
Early Childhood Intervention (ECI) case management	TMHP	TMHP	TMHP
ECI specialized skills training	TMHP	TMHP	TMHP
Family planning services for Seton managed care health plan	TMHP	N/A	N/A
SHARS	TMHP	TMHP	TMHP
Elevated lead investigation services	TMHP	TMHP	TMHP
DSHS TB providers	TMHP	TMHP	TMHP
DSHS targeted case management	TMHP	TMHP	TMHP
DARS Blind Children's Vocational Discovery and Development Program	TMHP	TMHP	TMHP
Case Management for Children and Pregnant Women	TMHP	TMHP	TMHP
Community First Choice (CFC)	TMHP	MCO	MCO
Personal Care Services (PCS)	TMHP	MCO	MCO
Medical Transportation	TMHP	TMHP	TMHP
Youth Empowerment Services (YES) Waiver	TMHP	TMHP	TMHP

Dental Carve Out	Children's Medicaid Dental	STAR Health
THSteps Dental	Dental plan	MCO
Orthodontia for most clients who are 20 years of age and younger	Dental plan	MCO
Orthodontia for clients who turned 21 years of age before March 1, 2012, and whose services were authorized by TMHP before March 1, 2012	TMHP	TMHP
ICF-IID Dental Services	TMHP	TMHP

Note: *Authorizations and claims for SSI clients who are enrolled in the STAR Program are submitted to the client's MCO or dental plan.*

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Authorization requests for services that are carved out of the managed care program must be submitted to TMHP according to the fee-for-service guidelines that are established for the same service.

Claims filing for services that are carved out of the managed care program must be submitted to TMHP according to the fee-for-service guidelines that are established for the same service.

Providers should refer to the appropriate *Texas Medicaid Provider Procedures Manual* handbook for the applicable authorization request and claims filing guidelines.

8.1 Family Planning Carve-Out Services

Some family planning services are carved-out services for Texas Medicaid clients whose managed care benefits are administered through Seton Health Plan. These carved out services may be considered for payment by Texas Medicaid through TMHP if the service has been denied by the health plan as a family planning service.

All Seton Medicaid providers should submit family planning claims using the CMS-1500 paper claim form, or electronic equivalent, to the client's managed care health plan in order to receive the health plan's denial.

Important: *Services that are denied by the health plan for any other reason will not be considered for reimbursement by Texas Medicaid.*

8.1.1 Professional and Outpatient Claims

For affected claims to be eligible for reimbursement through TMHP, providers must do the following:

1) Submit the claim to the client's managed care health plan in order to receive the health plan's denial. Claims that are submitted electronically using TexMedConnect will automatically be forwarded to the client's Medicaid managed care plan.
2) Submit a paper claim to TMHP upon receipt of the health plan's denial. All applicable documentation must be included with the paper claim, including, but not limited to:
    - The health plan's EOB document that indicates the denial code with its description and the date the EOB was issued. The denial must indicate that the service was denied because it was a family planning service. The EOB date will be used to calculate the filing deadline for the claim submission.
    - All documentation for family planning services including Sterilization Consent Forms and Hysterectomy Acknowledgements Forms, and any other documentation that is required by Texas Medicaid.

Note: *A paper claim is required because TMHP automatically forwards electronic claims to the client's health plan without processing. Providers must comply with all filing deadlines unless otherwise specified below in this article.*

Refer to: *The Gynecological and Reproductive Health and Family Planning Services Handbook* (*Vol. 2, Provider Handbooks*) for Texas Medicaid guidelines for family planning services.

8.1.1.1 Claim Forms for Submission to TMHP

After receiving the health plan's denial, Medicaid family planning services providers should submit paper claim forms to TMHP as follows:

- Providers that contract with the DSHS Family Planning Program should submit claims on a 2017 paper claim form along with the health plan's denial.
- Providers that do not contract with the DSHS Family Planning Program should submit claims on a CMS-1500 paper claim form along with the health plan's denial.

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Providers should submit the health plan's EOB document that indicates the denial code with its description and the date that the EOB was issued. The denial must indicate that the service was denied because it was a family planning service. The EOB date will be used to calculate the filing deadline for the claim submission.

Providers must comply with all filing deadlines.

The initial paper claim will be denied by TMHP. TMHP will automatically reprocess for payment consideration any claim that has been denied only with EOB 00081, "Services billed to TMHP in error. Bill HMO."

TMHP will reprocess only those claims that were denied with EOB 00081 as the only EOB message on the claim. If a claim has been denied with other EOB messages in addition to EOB 00081, the provider must resolve the other reasons for denial through the standard appeals process before TMHP can reprocess the claim for payment of the carved-out services.

8.1.2 Inpatient Claims

For affected claims to be eligible for reimbursement through TMHP, providers must do the following:

1) Submit the claim to the client's managed care health plan in order to receive the health plan's denial. Claims that are submitted electronically using TexMedConnect will automatically be forwarded to the client's Medicaid managed care plan.
2) Submit a paper claim to HHSC Administrative Appeals upon receipt of the health plan's denial. All applicable documentation must be included with the paper claim, including, but not limited to:
    - The health plan's EOB document that indicates the denial code with its description and the date the EOB was issued. The denial must indicate that the service was denied because it was a family planning service. The EOB date will be used to calculate the filing deadline for the claim submission.
    - All documentation for family planning services including Sterilization Consent Forms and Hysterectomy Acknowledgements Forms, and any other documentation that is required by Texas Medicaid.

HHSC Administrative Appeals will send the family planning services inpatient claims to TMHP for reprocessing. Medical portions of the claims will be denied by Texas Medicaid because they are covered under the client's health plan and will not be considered for reimbursement through TMHP. The services that were denied by the health plan as family planning services will be considered for payment according to Medicaid guidelines.

Refer to: *The Gynecological and Reproductive Health and Family Planning Services Handbook* (*Vol. 2, Provider Handbooks*) for Texas Medicaid guidelines for family planning services.

Section 7: Appeals (*Vol. 1, General Information*) for additional information about administrative appeals.

8.1.3 Provider Working With Clients Enrolled in the Christus Health Plan

Christus Health Plan is entirely owned by a Catholic health system and is bound by the Ethical and Religious Directives for Catholic Health Care Services and will not directly or indirectly provide, arrange, or pay for the following family planning carve-out services:

- Family planning annual exams, outpatient visits, and laboratory and radiology services
- Contraceptive devices and related procedures
- Contraceptive drugs, supplies, and counseling (unless prescribed for purposes other than family planning)
- Sterilization and related procedures

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- Abortions

The above carve-out services may be covered through Medicaid when provided by family planning providers that are not contracted through Christus Health Plan. Providers should submit their claims for these carve-out services to Christus Health Plan. The claims are then routed to HealthSmart for processing of the family planning carve-out services.

Refer to: *The Gynecological and Reproductive Health and Family Planning Services Handbook* (*Vol. 2, Provider Handbooks*) for family planning services.

9 PCCM and Managed Care Claims Processed by TMHP Before March 1, 2012

On or after March 1, 2012, TMHP will continue to process all transactions for PCCM and managed care claims that were submitted to TMHP before March 1, 2012.

9.1 PCCM Appeals

The following types of managed care claims must be appealed to TMHP and not the MCO or dental plan:

- Services that were carved-out before March 1, 2012
- Other managed care exceptions that were processed by TMHP before March 1, 2012

Providers can find benefit, limitation, and claims filing information in the appropriate Texas Medicaid Provider Procedures Manual or Texas Medicaid website article for the dates of service on the claim.

9.2 PCCM Cost and Reporting

Providers who rendered services to Texas Medicaid PCCM clients on or before February 29, 2012, must continue to prepare one copy of the applicable CMS Cost Report Form along with the required PCCM supplemental worksheets. The PCCM supplemental worksheets include the Inpatient PCCM D-4 worksheet, available from CMS, and the Outpatient PCCM D, Part V worksheet. A sample of the Outpatient PCCM D, Part V is available on the TMHP website at www.tmhp.com.

Hospitals must include inpatient and outpatient costs in the cost reports submitted annually.

Refer to: Subsection 2.2.2, "Cost Reimbursement" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

Subsection 3.7.4, "Provider Cost and Reporting" in the *Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks*) for additional information about cost reporting.

9.2.1 PCCM Outpatient Services Cost Reporting

PCCM Outpatient Services are subject to cost report settlements. PCCM outpatient services providers are not required to submit any additional forms or reports, because HHSC has required providers to submit the necessary PCCM supplemental worksheets along with the CMS form number CMS-2552-96, "Cost Report for Electronic Filing of Hospitals," for hospital cost reports that end on or after October 1, 2007. The PCCM supplemental worksheets include the Inpatient PCCM D-4 worksheet and the Outpatient PCCM D, Part V worksheet.

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The interim cost report settlement process will be completed within six months of the date on which the TMHP Medicaid Audit Department receives the workable cost report. The cost settlement is determined by comparing the total Medicaid-allowable costs to the provider's interim payments for PCCM outpatient hospital services that were delivered during the reporting period. HHSC will then issue a notice of settlement that specifies the amount due to or from the PCCM outpatient hospital.

10 Other State Health-Care Programs

The services available under the following programs are administered by TMHP or other state programs and not by the client's MCO or dental plan:

- Texas Women's Health Program (TWHP) - HHSC/TMHP
- DSHS Family Planning Program contracted services - DSHS/TMHP
- Medicaid Breast and Cervical Cancer (MBCC) - HHSC
- Medicaid Medical Transportation Program (MTP)
- CHIP Perinatal Program - The CHIP Perinatal Program provides prenatal care to the unborn children of pregnant women up to 200 percent of the federal poverty level who are not eligible for other Medicaid programs or traditional CHIP. The professional services are administered by the health plan, and some inpatient services are administered by TMHP.

Refer to: Subsection 6.19, "Children's Health Insurance Program (CHIP) Perinatal Claims" in Section 6, "Claims Filing" (*Vol.1, General Information*).

Claims and authorization requests for the services listed above must be submitted according to the established guidelines.

11 Contact Information

The following information can be used to communicate with TMHP:

Correspondence	Contact Information
All correspondence for services rendered to clients who are enrolled with a Texas Medicaid health/dental plan	Contact the client's health/dental plan.
Claims, authorizations, and other TMHP correspondence for transactions that are processed by TMHP.	Volume 1, "Written Communication With TMHP," for the list of post office box addresses that must be used for specific items.
HHSC contact information for STAR+PLUS, STAR, STAR Health, NorthSTAR, Children's Medicaid dental services, and PCCM	1-800-252-8263
Questions about PCCM claims and appeals after March 1, 2012	1-800-925-9126

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Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook

Texas Medicaid Provider Procedures Manual: Vol. 2

April 2016

TEXAS
Health and Human
Services Commission

MEDICAL AND NURSING SPECIALISTS, PHYSICIANS, AND PHYSICIAN ASSISTANTS

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1 General Information

The information in this handbook is intended for Texas chiropractors, nurse practitioners (NP), clinical nurse specialists (CNS), certified nurse midwives (CNM), certified registered nurse anesthetists (CRNA), podiatrists, geneticists, maternity service clinics, physicians, and physician assistants. The handbook provides information about Texas Medicaid's benefits, policies, and procedures.

Important: *All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide healthcare services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers may also be subject to Texas Medicaid sanctions for failure, at all times, to deliver healthcare items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: Section 1: Provider Enrollment and Responsibilities (*Vol. 1, General Information*).

Subsection 2.2, "Provider Enrollment and Responsibilities," in the *Medicaid Managed Care Handbook* (*Vol. 2, Provider handbooks*).

Section 5, "THSteps Medical" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

For information on Advanced Practice Registered Nurses (APRNs), refer to the following subsections in this handbook:

Section 3, "Certified Nurse Midwife (CNM)"

Section 4, "Certified Registered Nurse Anesthetist (CRNA)" Subsection 4.1, "Enrollment"

Section 5, "Geneticists" Subsection 5.2, "Services, Benefits, Limitations, and Prior Authorization"

Section 8, "Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS)" Subsection 8.1, "Enrollment"

Section 9, "Physician" Subsection 9.2, "Services, Benefits, Limitations, and Prior Authorization"

1.1 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.

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Refer to: Subsection 3.7.3.8, "Payment Window Reimbursement Guidelines," in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about the payment window reimbursement guidelines.

2 Chiropractic Manipulative Treatment (CMT)

2.1 Enrollment

To enroll in Texas Medicaid, a doctor of chiropractic medicine (DC) must be licensed by the Texas Board of Chiropractic Examiners and enrolled as a Medicare provider.

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

2.2 Services, Benefits, Limitations, and Prior Authorization

CMT performed by a chiropractor licensed by the Texas State Board of Chiropractic Examiners is a benefit of Texas Medicaid.

CMT is limited to an acute condition or an acute exacerbation of a chronic condition for a maximum of 12 visits in a consecutive 12-month period, and a maximum of one visit per day. The 12-month period consists of 12 consecutive months, beginning with the date the client receives the first treatment.

If the condition persists more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute.

CMT is not a benefit of Texas Medicaid for maintenance therapy when:

- Further clinical improvement cannot reasonably be expected from continuous ongoing care.
- The chiropractic treatment becomes supportive rather than corrective in nature.

CMT may be reimbursed when billed using procedure codes 98940, 98941, or 98942.

Procedure codes 98940, 98941, and 98942 must be submitted with the AT modifier. The AT modifier is used to identify treatment provided for an acute condition or an exacerbation of a chronic condition that persists for 180 days or less from the start date of treatment. Providers may file an appeal for a claim denied beyond the 180 days of treatment with documentation supporting that further clinical improvement can be reasonably expected, maximal improvement has not been reached, and further improvement has not ceased.

Procedure code 98940 will be denied as part of another service when billed for the same date of service as 98941 or 98942 by any provider.

Procedure code 98941 will be denied as part of another service when billed for the same date of service as 98942 by any provider.

Texas Medicaid does not reimburse chiropractors for X-ray services, office visits, injections, supplies, appliances, spinalator treatments, laboratory services, physical therapy, or other adjunctive services furnished by themselves or by others under their orders or directions. Additionally, braces or supports, even though ordered by a physician (doctor of medicine [MD] or doctor of osteopathy [DO]) and supplied by a chiropractor are not reimbursable items.

CMT is reimbursed only for a diagnosis of subluxation of the spine. The level of subluxation must be indicated by the appropriate diagnosis codes listed below:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)						
M9900	M9901	M9902	M9903	M9904	M9905	M9908

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2.2.1 Prior Authorization

Prior authorization is not required for CMT services.

2.3 Documentation Requirements

Manipulations must be provided in accordance with an ongoing, written treatment plan that supports medical necessity of an acute condition or an acute exacerbation of a chronic condition.

Documentation that supports medical necessity for the treatment plan includes all of the following:

- Diagnosis
- Region(s) treated
- Degree of severity
- Impairment characteristics
- Physical examination findings, X-ray, or other pertinent findings
- Specific statements of short- and long-term goals
- A reasonable estimate of when the goals will be reached (estimated duration of treatment)
- Frequency of treatment (number of times per week)
- Equipment and/or the techniques utilized

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.

2.4 Claims Filing and Reimbursement

2.4.1 Claims Information

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

When completing a CMS-1500 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: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions," in Section 6, "Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

2.4.2 Reimbursement

The Medicaid rates for chiropractic manipulative treatment (CMT) are reimbursed in accordance with 1 TAC §355.8081 and 355.8085. See the online fee lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

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Texas Medicaid implemented mandated rate reductions for certain services. The Online Fee Lookup (OFL) and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

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

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology," in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

3 Certified Nurse Midwife (CNM)

3.1 Provider Enrollment

To enroll in Texas Medicaid, a CNM must be licensed as a registered nurse and as an advanced practice registered nurse (APRN) by the Texas Board of Nursing (BON), and be authorized to practice as a nurse-midwife. A registered nurse under the multistate licensure compact may be licensed in another state but certified as an APRN for the state of Texas by the Texas BON. Texas Medicaid accepts a signed letter of certification from the Texas BON as documentation of appropriate licensure and certification for enrollment.

Refer to: The Texas Department of State Health Services (DSHS) website at www.dshs.state.tx.us/famplan for information about family planning and the locations of family planning clinics that receive funding from the DSHS Family Planning Program.

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers not complying with CLIA are not reimbursed for laboratory services.

All APRNs (including CNMs, CRNAs, CNSs, and NPs) are enrolled within the categories of practice as determined by the Texas BON. CNSs and NPs must enroll as an APRN; CNMs and CRNAs may enroll using their specific titles.

A CNM must identify the licensed physician or group of physicians with whom there is an arrangement for referral and consultation if medical complications arise. Upon initial enrollment and upon re-enrollment, the CNM must complete and submit to TMHP, along with the Texas Medicaid Provider Enrollment Application, the Physician's Letter of Agreement form that affirms the CNM's referring or consulting physician arrangement. A separate letter of agreement must be submitted for each physician or group of physicians with whom an arrangement is made. This agreement must be signed by the CNM and the physician. The collaborating physician does not have to be a participating provider in Texas Medicaid. According to TAC, §354.1252 (3), if the collaborating physician or group is not a participating provider in Texas Medicaid, the CNM must inform clients of their potential financial responsibility. If the arrangement is changed or canceled, the CNM must notify TMHP Provider Enrollment in writing and a new letter of agreement must be completed and submitted to TMHP within 10 business days of the change or cancellation.

CNMs are encouraged to participate in or make referrals to family planning agencies.

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Refer to: Section 1: Provider Enrollment and Responsibilities (*Vol. 1, General Information*) for more information about enrollment in Texas Medicaid.

Subsection 5.2, "Enrollment," in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about enrollment in the THSteps Program.

Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)," in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

3.1.1 Enrollment in Texas Health Steps (THSteps)

CNMs may enroll as providers of THSteps medical checkups for newborns and adolescent females.

3.2 Services, Benefits, Limitations, and Prior Authorization

CNM providers may be reimbursed for family planning, obstetrical, neonatal, and primary care services.

3.2.1 Deliveries

CNM providers may be reimbursed for procedure code 59409, 59410, 59612, or 59614 for delivery services.

Refer to: Subsection 9.2.46, "Obstetrics and Prenatal Care," in this handbook for billing requirements.

3.2.2 Newborn Services

Routine newborn care may be reimbursed to CNM providers.

Refer to: Subsection 5.3.9, "Newborn Examination," in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 9.2.45, "Newborn Services," in this handbook for additional guidelines and limitations.

3.2.3 Prenatal and Postpartum Services

CNM and physician providers are limited to a combined total of 20 outpatient prenatal care visits and 1 postpartum care visit per pregnancy. Normal pregnancies are anticipated to require around 11 visits per pregnancy and high-risk pregnancies are anticipated to require around 20 visits per pregnancy. If more than 20 visits are medically necessary, the provider can appeal with documentation supporting pregnancy complications. The high-risk client's medical record documentation should reflect the need for increased visits and is subject to retrospective review.

When billing for prenatal services, use modifier TH with the appropriate evaluation and management procedure code to the highest level of specificity.

Postpartum care provided after discharge must be billed using procedure code 59430. Only one postpartum visit is allowed per pregnancy.

Refer to: Subsection 9.2.46, "Obstetrics and Prenatal Care," in this handbook for additional information about postpartum care.

3.2.4 Laboratory and Radiology Services

Laboratory (including pregnancy tests) and radiology services that are rendered during pregnancy must be billed separately from prenatal care visits.

3.2.5 Prior Authorization

Prior authorization is not required for any of these services except delivery in the home. For prior authorization of a home delivery and the related supplies (procedure code S8415), the CNM must submit a written request for prior authorization during the client's third trimester of pregnancy. The CNM must include a statement signed by a licensed physician who has examined the client during the third

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trimester and determined at that time that she is not at high risk and is suitable for a home delivery. Documentation must also include a plan for access to emergency transport for mother and neonate, if needed. Requests for home delivery prior authorizations must be submitted to the TMHP Medical Director at the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax: 1-512-514-4213

Claims submitted for home deliveries performed by a CNM without prior authorization will be denied.

3.2.6 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including CNM services.

CNM services are subject to retrospective review and recoupment if documentation does not support the service billed.

3.2.7 Claims Filing and Reimbursement

CNMs must bill maternity services in one of two ways: itemizing each service individually on one claim form and filing at the time of delivery (the filing deadline is applied to the date of delivery) or itemizing each service individually and submitting claims as the services are rendered (the filing deadline is applied to each individual date of service).

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

When completing a CMS-1500 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.

According to 1 TAC §355.8161(a), the Medicaid rate for CNMs is 92 percent of the rate paid to a physician (doctor of medicine [MD] or doctor of osteopathy [DO]) for the same service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections.

> ***Note:*** *CNM providers who are enrolled in Texas Medicaid as THSteps providers also receive 92 percent of the rate paid to a physician for THSteps services when a claim is submitted with their THSteps provider identifier as the billing provider.*

Physicians who submit a claim using the physician's own provider identifier for services provided by a CNM must submit modifier SB 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.

Physicians may be reimbursed 92 percent of the established reimbursement rate for services provided by a CNM 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. This 92 percent reimbursement rate does not apply to laboratory services, X-ray services, and injections provided by a CNM.

Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

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Refer to: Subsection 4.1, "General Medicaid Eligibility," in Section 4, Client Eligibility (*Vol. 1, General Information*) for information about crossover payments.

Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Subsection 6.1, "Claims Information," in Section 6, "Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions," in Section 6, "Claims Filing" (*Vol. 1, General Information*).

Subsection 2.2, "Fee-for-Service Reimbursement Methodology," in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

4 Certified Registered Nurse Anesthetist (CRNA)

4.1 Enrollment

To enroll in Texas Medicaid, a CRNA must be licensed as a registered nurse (RN) and as an APRN by the Texas BON and must be currently certified by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists. An RN under the multistate licensure compact may be licensed in another state but certified as an APRN for the state of Texas by the Texas BON. Texas Medicaid accepts a signed letter of certification from the Texas BON as acceptable documentation of appropriate licensure and certification for enrollment.

Medicare enrollment is a prerequisite for enrollment as a Medicaid provider. A current copy of the provider's Council on Certification of Nurse Anesthetists or Recertification of Nurse Anesthetists Certificate must be submitted with the Medicaid provider enrollment application.

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

4.2 Services, Benefits, Limitations, and Prior Authorization

Medically necessary services that are performed by a CRNA are benefits if the services are within the scope of the CRNA's practice as defined by state law; are prescribed, supervised by, and provided under the direction of a supervising physician (MD or DO), dentist, or podiatrist licensed in the state in which they practice and to the extent allowed by state law; and are provided under one of the following conditions:

- There is no physician anesthesiologist on the medical staff of the facility where the services are provided (e.g., rural settings).
- There is no physician anesthesiologist available to provide the services, as determined by the policies of the facility in which the services are provided.
- The physician, dentist, or podiatrist who performs the procedure that requires the services specifically requests the services of a CRNA.
- The eligible client who requires the services specifically requests the services of a CRNA.
- The CRNA is scheduled or assigned to provide the services according to the policies of the facility in which the services are provided.
- The services are provided by the CRNA in connection with a medical emergency.

Texas Medicaid does not reimburse the CRNA for equipment, drugs, or supplies.

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Refer to: Subsection 4.2, "Services, Benefits, Limitations, and Prior Authorization," in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for information about drugs, equipment and supplies.

4.2.1 Prior Authorization

Services performed by a CRNA are subject to the same prior authorization guidelines as services performed by other provider types.

4.3 Documentation Requirements

All services require documentation to support the medical necessity of the services rendered, including CRNA services. CRNA services are subject to retrospective review and recoupment if documentation does not support the service billed.

4.4 Claims Filing and Reimbursement

4.4.1 Claims Information

All CRNA services must be billed with a CRNA individual provider identifier or a CRNA group provider identifier. No payment for CRNA services will be made under a hospital or physician provider identifier.

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

When completing a CMS-1500 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: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions," in Section 6, "Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Subsection 9.2.6.9.3, "CRNA and AA Services," in this handbook for more information on billing for CRNA services.

4.4.1.1 Interpreting the R&S Report

The Billed Qty field on the Remittance and Status (R&S) Report reflects only the number of time units TMHP processes. The Relative Value Units (RVUs) assigned for the procedure code are not shown in the Billed Qty field.

4.4.2 Reimbursement

A CRNA is reimbursed the lesser of either the CRNA's billed charges or 92 percent of the reimbursement for the same service paid to a physician (MD or DO) anesthesiologist in accordance with 1 TAC §355.8221.

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Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

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

Refer to: Subsection 9.2.6.8, "Reimbursement Methodology," in this handbook for more information about flat fees and time based fees.

5 Geneticists

5.1 Enrollment

5.1.1 Geneticists

Geneticists may enroll in Texas Medicaid as both a physician or physician group and as a geneticist. Enrollment as a geneticist allows enhanced reimbursement for specific procedure codes when a claim is submitted using the geneticist provider identifier.

A provider of genetic services that wishes to enroll in Texas Medicaid as a geneticist must complete the required Medicaid provider enrollment application forms and enter into a written agreement with HHSC. Texas Medicaid provider enrollment forms are available from TMHP, and may be downloaded on the TMHP website at www.tmhp.com. Completed applications are submitted to:

Texas Medicaid & Healthcare Partnership
Provider Enrollment
PO Box 200795
Austin, TX 78720

Prior to enrollment, applicant qualifications for the provision of genetic services are verified and approved by DSHS. Verification and approval are administered through the Newborn Screening Unit. Basic contract requirements are as follows:

- The provider must be a clinical geneticist (MD or DO) who is board eligible or board certified by the American Board of Medical Geneticists (ABMG).

  Note: *Board eligible providers are required to provide documentation reflecting completion of education requirements in a residency program in genetics.*

- The provider must use a team of professionals to provide genetic evaluative, diagnostic, and counseling services. The team rendering the services must consist of professional staff including the clinical geneticist and at least one of the following: nurse, social worker, medical geneticist, or genetic counselor.
- Upon DSHS approval, TMHP issues a provider identifier and a performing provider identifier for the provision of genetic services.
- Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

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5.2 Services, Benefits, Limitations, and Prior Authorization

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, physician assistant, nurse practitioner, or clinical nurse specialist 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
- Genetic laboratory tests
- 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

Pharmacogenetics encompasses the use of information encoded in DNA to help predict responses to medicines and thereby enhance the effectiveness and safety of medicines for individual clients. Testing for drug efficacy is not a benefit of Texas Medicaid, except as outlined in other sections of the *Texas Medicaid Provider Procedures Manual*.

5.2.1 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.

5.2.2 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 non-directive 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.

The interpretation of certain tests, such as nuchal translucency, requires additional education and experience. Texas Medicaid supports national certification standards when available.

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5.2.3 Laboratory Practices

For many heritable diseases and conditions, test performance and interpretation of test results require information about client race/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 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-Medicaid client to provide genetic information for a Medicaid client are not benefits of Texas Medicaid.

5.2.4 Genetic Counselors

Genetic counselor services may be billed by a physician when the genetic counselor is under physician supervision and is an employee of the physician. Services provided by independent genetic counselors are not a benefit of Texas Medicaid.

5.2.5 Genetic Evaluation and Counseling by a Geneticist

A provider enrolled in Texas Medicaid as a geneticist may bill the following evaluation and management codes and receive an enhanced reimbursement. All other procedure codes must be billed under the geneticist's individual, group, or laboratory provider identifier.

Procedure Code	Limitations
96040	None
99213	None
99214	None
99215	One per year, any provider
99244	One every three years, per provider
99245	One every three years, per provider
99254	One every three years, per provider
99255	One every three years, per provider
99402	One per pregnancy, per provider*
99404	One every three years, per provider
*** Exception: Additional services are allowed when documentation of medical necessity to repeat a procedure accompanies a claim.**	

One office consultation, performed by a geneticist, (procedure code 99244 or 99245) may be considered for reimbursement if procedure code 99244, 99245, 99254, or 99255 has not been submitted by and reimbursed to that geneticist in the previous three years.

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Inpatient consultations, performed by a geneticist, (procedure codes 99254 and 99255) may be considered for reimbursement once every three years even if an office consultation has been reimbursed in the previous three years.

5.2.6 Prior Authorization

Prior authorization is not required for services billed by a geneticist.

5.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including genetic services. Genetic services are subject to retrospective review and recoupment if documentation does not support the service billed.

5.4 Claims Filing and Reimbursement

5.4.1 Claims Information

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

When completing a CMS-1500 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.

TMHP representatives are available for provider questions about genetic services, such as reimbursement rates and procedures. For more information, call the TMHP Contact Center at 1-800-925-9126.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions," in Section 6, "Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

5.4.2 Reimbursement

Genetic services providers are reimbursed according to the established allowable maximum fee schedule. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology," in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

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6 Licensed Midwife (LM)

6.1 Provider Enrollment

To enroll in Texas Medicaid, an LM must be licensed as a midwife by the Texas Midwifery Board.

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

An LM must identify the licensed physician or group of physicians with whom there is an arrangement for referral and consultation if medical complications arise. Upon initial enrollment and upon re-enrollment, the LM must complete and submit to TMHP, along with the Texas Medicaid Provider Enrollment Application, the Physician's Letter of Agreement form that affirms the LM's referring or consulting physician arrangement. A separate letter of agreement must be submitted for each physician or group of physicians with whom an arrangement is made. This agreement must be signed by the LM and the physician.

If the arrangement is changed or canceled, the LM must notify TMHP Provider Enrollment in writing and a new letter of agreement must be completed and submitted to TMHP within 10 business days after the change or cancellation.

The referral physician or group does not have to be a participating provider in Texas Medicaid. According to TAC, §354.1253(c), if the referral physician or group is not a participating provider in Texas Medicaid, the LM must inform clients of their potential financial responsibility.

Refer to: Section 1: Provider Enrollment and Responsibilities (*Vol. 1, General Information*) for more information about enrollment in Texas Medicaid.

6.2 Services, Benefits, Limitations, and Prior Authorization

LM providers may be reimbursed for obstetrical and newborn care services provided in a freestanding birthing center that is also enrolled as a Texas Medicaid provider.

6.2.1 Deliveries

LM providers may be reimbursed for procedure code 59409 for delivery services.

Refer to: Subsection 9.2.46, "Obstetrics and Prenatal Care," in this handbook for billing requirements.

6.2.2 Newborn Services

Newborn care procedure codes 99460 and 99463 may be reimbursed to LM providers.

Refer to: Subsection 9.2.45, "Newborn Services," in this handbook for additional guidelines and limitations.

6.2.3 Prenatal Services

LM providers must include modifier TH with the appropriate evaluation and management procedure code (99201, 99202, 99211, or 99212) for prenatal services.

LM providers are limited to a total of 20 outpatient prenatal care visits, performed in a birthing center, per pregnancy. Normal pregnancies are anticipated to require around 11 visits per pregnancy and high-risk pregnancies are anticipated to require around 20 visits per pregnancy. If more than 20 visits are medically necessary, the provider can appeal with documentation supporting pregnancy complications. The high-risk client's medical record documentation should reflect the need for increased visits and is subject to retrospective review.

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If a client is discharged before delivery, LM providers may submit procedure code 99218, 99219, or 99220 for labor services only. Clinical documentation that clearly demonstrates the level of medical decision-making (i.e., moderate or complex) must be included in the client's medical record. All medical documentation is subject to retrospective review. Services that are not supported by the medical documentation are subject to recoupment.

Refer to: Subsection 9.2.46, "Obstetrics and Prenatal Care," in this handbook for billing requirements.

6.2.4 Prior Authorization

Prior authorization is not required for services billed by an LM.

6.2.5 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including LM services.

LM services are subject to retrospective review and recoupment if documentation does not support the service billed.

6.2.6 Claims Filing and Reimbursement

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

When completing a CMS-1500 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.

According to 1 TAC §355.8161 (b), the Medicaid rate for LMs is 70 percent of the rate paid to a physician (doctor of medicine [MD] or doctor of osteopathy [DO]) for the same service.

Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

7 Maternity Service Clinics (MSC)

7.1 Provider Enrollment

To enroll in Texas Medicaid, MSCs must submit a complete application and meet the following requirements:

- Must be a facility that is not an administrative, organizational, or financial part of a hospital.
- Must be organized and operated to provide maternity clinic services to outpatients.
- Must comply with all applicable federal, state, and local laws and regulations.
- Must employ or have a contractual agreement or formal arrangement with a licensed MD or DO who assumes professional responsibility for the services provided to the clinic's patients.
- Must adhere to the Bureau of Maternal and Child Health Maternity Guidelines, dated June 20, 1988, and subsequent revisions issued by the Texas Department of Health, unless otherwise specified by the department or its designee.

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- Must ensure that services provided to each patient are commensurate with the patient's risk assessment and are documented in the patient's medical record.

The supervising physician's license information must be provided. Providers cannot be enrolled in Texas Medicaid if their licenses are due to expire within 30 days.

Medicare certification is not a prerequisite for MSC enrollment.

7.1.1 Physician Responsibility

To meet the requirement to assume professional responsibility for the services provided to the clinic's clients, the supervising physician must do the following:

- See the client at least once
- Prescribe the type of care to be provided or approve the client's plan of care (POC)
- Periodically review the need for continued care (if the services are not limited by the prescription)

The physician must base the POC on a risk assessment completed by the physician or by licensed, professional clinic staff. The assessment must be based on findings obtained through a health history, laboratory or screening services, and a physical examination.

7.1.2 Case Management Services to High-Risk Individuals

An MSC that wants to bill and receive reimbursement for case management services to high-risk individuals including infants, pregnant adolescents, and women must meet the eligibility criteria for case management services. To be considered for reimbursement for case management for these clients, the MSC must enroll as a group in Case Management for Children and Pregnant Women, and each eligible case manager must enroll as a performing provider.

Refer to: Section 3, "Case Management for Children and Pregnant Women" in the *Behavioral Health, Rehabilitation, and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*), for case management services provider eligibility criteria.

7.2 Services, Benefits, Limitations, and Prior Authorization

Services billed by an MSC are those provided by a physician or by licensed, professional clinic staff and are determined to be reasonable and medically necessary for the care of a pregnant adolescent or woman during the prenatal period and subsequent 60-day postpartum period. MSC benefits do not include deliveries.

MSCs are limited to 20 prenatal care visits and 1 postpartum care visit per pregnancy. Normal pregnancies are anticipated to require around 11 visits per pregnancy and high-risk pregnancies are anticipated to require around 20 visits per pregnancy. If more than 20 visits are medically necessary, the provider can appeal with documentation supporting pregnancy complications. The high-risk client's medical record documentation must reflect the need for increased visits and is subject to retrospective review.

Procedure codes in the following table are for prenatal and postpartum care visits:

Procedure Codes						
59430*	99201-TH	99202-TH	99203-TH	99204-TH	99205-TH	99211-TH
99212-TH	99213-TH	99214-TH	99215-TH			
*** Procedure code 59430 is not submitted with modifier TH** **Note: The prenatal visits must be billed with modifier TH**						

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Providers must bill the most appropriate new or established prenatal visit code or postpartum visit code. New patient codes may be used when the client has not received any professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years (36 months).

An MSC may be reimbursed for prenatal and postpartum care visits only. Hemoglobin, hematocrit, and urinalysis procedures are included in the charge for prenatal care and not separately reimbursed. Services other than prenatal and postpartum care visits will be denied. MSCs that are enrolled in Case Management for Children and Pregnant Women as a group may be reimbursed for these services under the group provider identifier assigned to their facility.

Medical services must be furnished on an outpatient basis by the physician or by licensed, professional clinic staff under the direction of the physician and must be within the staff's scope of practice or licensure as defined by state law. Although the physician does not necessarily have to be present at the clinic when services are provided, the physician must assume professional responsibility for the medical services provided at the clinic and ensure through approval of the POC that the services are medically appropriate. The physician must spend as much time in the clinic as is necessary to ensure that clients are receiving medical services in a safe and efficient manner in accordance with accepted standards of medical practice.

MSCs must follow the procedures outlined throughout this manual. All service, frequency, and documentation requirements are applicable.

Providers submitting charges for high-risk prenatal care must document the high-risk diagnosis on the claim form and document the condition in the client's medical record.

Refer to: Subsection 9.2.46.14.1, "HIV Testing," in this handbook for information about required HIV testing for pregnant women.

7.2.1 Initial Prenatal Care Visit Components

The following initial prenatal care visit components should be completed as early as possible in the client's pregnancy.

7.2.1.1 History

History includes OB-GYN, present pregnancy, medical and surgical, substance use, environmental, nutritional, psychosocial (including violence), and family support system.

7.2.1.2 Physical Examination

Physical examination includes height, weight, blood pressure; head, neck, lymph, breasts, heart, lungs, back, abdomen, pelvis, rectum, extremities, and skin; and uterine size, fetal heart rate, and location.

7.2.1.3 Laboratory Tests

The initial hematocrit or hemoglobin and each subsequent hematocrit or hemoglobin is included in the visit fee and is not separately reimbursable to MSCs.

The laboratory services listed may not be billed using the MSC provider identifier. These services may be ordered by MSC personnel and provided by a reference laboratory.

MSCs must supply the client's Medicaid number and the MSC provider identifier to the reference laboratory when laboratory services are requested.

The laboratory services requested by an MSC may include, but are not limited to, the following:

- Hemoglobin, hematocrit, or complete blood count (CBC)
- Urinalysis
- Blood type and Rh

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- Antibody screen
- Rubella antibody titer
- Serology for syphilis
- Hepatitis B surface antigen
- Cervical cytology
- Other laboratory tests

The following tests may be performed at the initial prenatal care visit, as indicated:

- Pregnancy test
- Gonorrhea test
- Urine culture
- Sickle cell test
- Tuberculosis (TB) test
- Chlamydia test

As stated in the Health and Safety Code §81.090, screening for Hepatitis B virus infection, HIV, and Syphilis must be performed at the initial prenatal care visit. In addition, HIV testing must be performed in the third trimester. HBV and Syphilis must be performed at labor and delivery.

Multiple marker screens for neural tube defects must be offered if the client initiates care between 16 and 20 weeks.

7.2.1.4 Assessment

Assessment includes pregnancy, general health, medical, and psychosocial.

7.2.1.5 Plan

Plan includes pregnancy, preventive health, medical, and referral as indicated.

7.2.1.6 Education and Counseling

Education and counseling includes pregnancy, delivery, nutrition, breast-feeding, family planning, and preventive health. The education and counseling should also include the need for a medical home and information about THSteps medical and dental checkups for the client.

The complete physical examination may be completed at the second visit if the MSC's routine involves a two-stage initial evaluation.

7.2.2 Subsequent Prenatal Care Visits

The following is a recommended guide for the frequency of subsequent prenatal visits for a regular pregnancy:

- One visit every 4 weeks for the first 28 weeks of pregnancy.
- One visit every 2 to 3 weeks from 28 to 36 weeks of pregnancy.
- One visit per week from 36 weeks to delivery.

More frequent visits may be medically necessary. Physicians, CNMs, and MSCs are limited to 20 prenatal care visits per pregnancy and 1 postpartum care visit per pregnancy after discharge from the hospital, without documentation of a complication of pregnancy.

Each subsequent visit must include the following:

- Interim History

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- Problems
- Maternal status
- Fetal status

7.2.2.1 Physical Examination

The physical examination must include the following:

- Weight and blood pressure
- Fundal height, fetal position and size, and fetal heart rate
- Extremities

7.2.2.2 Laboratory Tests

Required laboratory tests include the following:

- Urinalysis for protein and glucose every visit

  Note: *The urinalysis for protein and glucose, hemoglobin, and hematocrit is included in the visit fee and is not separately reimbursable to MSCs.*

- Hematocrit or hemoglobin repeated once a trimester and at 32 to 36 weeks of pregnancy
- Multiple marker screen for fetal abnormalities offered at 16 to 20 weeks of pregnancy
- Repeated antibody screen for Rh negative women at 28 weeks (followed by Rho immune globulin administration if indicated)
- Gestational diabetes screen at 24 to 28 weeks of pregnancy, one hour post 50 gram glucose load
- Blood sample for HBsAg screening at the first examination and visit followed by a second blood sample for HBsAg screening on admission for delivery
- Other laboratory tests as indicated by the medical condition of the client

7.2.3 Postpartum Care Visit

Postpartum care provided by MSCs must be billed using procedure code 59430. A maximum of 1 postpartum visit is allowed per pregnancy.

Refer to: Subsection 9.2.46, "Obstetrics and Prenatal Care," in this handbook for additional information about postpartum care.

7.2.4 Prior Authorization

Prior authorization is not required for services rendered in MSCs.

7.3 Documentation Requirements

Each client must have a complete and accepted standard medical record with documentation for the initial visit with procedures, as well as each subsequent visit with procedures. Such records must be made available when requested by HHSC or TMHP for utilization and quality assurance reviews as required by federal regulations. The documentation record or a true copy or narrative abstract must be sent to the hospital of delivery by the client's 35th week of pregnancy. The record must be made available to the client if the client transfers care to another institution. Records completed by licensed professional clinic staff under the direction of a physician must be signed by the supervising physician.

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7.4 Claims Filing and Reimbursement

MSC services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms. When completing a CMS-1500 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: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions," in Section 6, "Claims Filing" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

MSCs are reimbursed in accordance with 1 TAC §355.8081. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

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

8 Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS)

For other APRNs, see Section 4, "Certified Registered Nurse Anesthetist (CRNA)" in this handbook for information regarding CRNAs, and Section 3, "Certified Nurse Midwife (CNM)" in this handbook for information about certified nurse midwives (CNMs).

8.1 Enrollment

To enroll in Texas Medicaid, an NP or CNS must be licensed as a registered nurse and as an APRN by the Texas BON. A registered nurse under the multistate licensure compact may be licensed in another state but certified as an APRN for the state of Texas by the Texas BON. Texas Medicaid accepts a signed letter of certification from the Texas BON as documentation of appropriate licensure and certification for enrollment.

Providers cannot be enrolled if their license is due to expire within 30 days.

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers not complying with CLIA are not reimbursed for laboratory services.

All APRNs (including CNMs, CRNAs, CNSs, and NPs) are enrolled within the categories of practice as determined by the Texas BON. CNSs and NPs must enroll as an APRN; CNMs and CRNAs may enroll using their specific titles.

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Refer to: Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)," in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

Section 3, "Certified Nurse Midwife (CNM)" in this handbook for more information on CNM enrollment.

Section 4, "Certified Registered Nurse Anesthetist (CRNA)" in this handbook for more information on CRNA enrollment.

8.1.1 Enrollment in Texas Health Steps (THSteps)

APRNs, including NPs, and CNSs, who are recognized by the Texas BON can enroll as THSteps providers and provide checkup services within their scope of practice. Specific information is found in the Children's Services Handbook.

Refer to: Subsection 5.2, "Enrollment," in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information on enrollment procedures.

8.2 Services, Benefits, Limitations, and Prior Authorization

Services performed by NPs and CNSs are benefits if the services meet the following criteria:

- Are within the scope of practice for NPs and CNSs, as defined by Texas state law.
- Are consistent with rules and regulations promulgated by the Texas BON or other appropriate state licensing authority.
- Are covered by Texas Medicaid when provided by a licensed physician (MD or DO).
- Are reasonable and medically necessary as determined by HHSC or its designee.

NPs and CNSs who are employed or remunerated by a physician, hospital, facility, or other provider must not bill Texas Medicaid for their services if the billing results in duplicate payment for the same services.

Physicians who submit a claim using the physician's own provider identifier for services provided by an NP or CNS 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.

Benefit limitation information for services can be found in Section 9, "Physician" in this handbook, the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*), and the *Gynecological and Reproductive Health and Family Planning Services Handbook* (*Vol. 2, Provider Handbooks*).

Payment for supplies is not a benefit of Texas Medicaid. Costs of supplies are included in the reimbursement for office visits.

Refer to: Section 2, "Medicaid Title XIX Family Planning Services" in the *Gynecological and Reproductive Health and Family Planning Services Handbook* (*Vol. 2, Provider Handbooks*).

Section 9, "Physician" in this handbook.

Section 5: "THSteps Medical" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information on THSteps services.

8.2.1 Prior Authorization

Services performed by an NP or CNS are subject to the same prior authorization guidelines as services performed by other provider types.

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8.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including NP and CNS services. NP and CNS services are subject to retrospective review and recoupment if documentation does not support the service billed.

8.4 Claims Filing and Reimbursement

8.4.1 Claims Information

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

When completing a CMS-1500 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: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions," in Section 6, "Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

8.4.2 Reimbursement

According to 1 TAC §355.8281, the Medicaid rate for NPs and CNSs is 92 percent of the rate paid to a physician (MD or DO) for the same professional service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections. When NPs or CNSs bill Medicaid directly for services they performed, they must use their individual provider identifier. If the services are performed by the NP or CNS but billed by a physician or physician group, the billing provider is the physician or physician group. Physicians may be reimbursed 92 percent of the established reimbursement rate for services provided by an NP or CNS 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. This 92 percent reimbursement rate does not apply to laboratory services, X-ray services, and injections provided by an NP or CNS.

Note: *NP and CNS providers who are enrolled in Texas Medicaid as THSteps providers also receive 92 percent of the rate paid to a physician for THSteps services when a claim is submitted with their THSteps provider identifier as the billing provider.*

Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Refer to: Subsection 1.1, "Provider Enrollment and Reenrollment," in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

Subsection 2.2, "Fee-for-Service Reimbursement Methodology," in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

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9 Physician

9.1 Enrollment

9.1.1 Physicians and Doctors

To enroll in Texas Medicaid to provide medical services, physicians (MD or DO), doctors of dental surgery [DDS], and doctors of podiatric medicine (DPM) must be authorized by the licensing authority of their profession to practice in the state where the services are performed at the time they are provided.

Providers cannot be enrolled in Texas Medicaid if their licenses are due to expire within 30 days. A current Texas license must be submitted.

Important: *The Centers for Medicare & Medicaid Services (CMS) guidelines mandate that physicians who provide durable medical equipment (DME) products such as spacers or nebulizers are required to enroll as Texas Medicaid DME providers.*

All physicians except gynecologists, pediatricians, pediatric subspecialists, pediatric psychiatrists, and providers performing only Texas Health Steps (THSteps) medical or dental checkups must be enrolled in Medicare before enrolling in Medicaid. TMHP may waive the Medicare enrollment prerequisite for pediatricians or physicians whose type of practice and service may never be billed to Medicare.

9.2 Services, Benefits, Limitations, and Prior Authorization

The Administrative Simplification provisions of the *Health Insurance Portability and Accountability Act* (HIPAA) of 1996 mandates the use of national coding and transaction standards. HIPAA requires that the American Medical Association's (AMA) Current Procedural Terminology (CPT) system be used to report professional services, including physician services. Correct use of CPT coding requires using the most specific code that matches the services provided, based on the code's description. Providers must pay special attention to the standard CPT descriptions for the evaluation and management (E/M) services. The medical record must document the specific elements necessary to satisfy the criteria for the level of services as described in CPT. Reimbursement may be recouped when the medical record documents a different level of service from what is submitted on the claim. The level of service provided and documented must be medically necessary, based on the clinical situation and needs of the client.

To receive reimbursement, providers must document the following information in the client's medical record:

- The service
- The date rendered
- Pertinent information about the client's condition supporting the need for the service
- The care given

Physician services include those reasonable and medically necessary services ordered and performed by physicians or under physician supervision that are within the scope of practice of their profession as defined by state law.

9.2.1 Teaching Physician and Resident Physician

The roles of the teaching physician and resident physician occur in the context of an accredited graduate medical education (GME) training program.

The teaching physician is the Medicaid-enrolled physician who is professionally responsible for the particular services that were provided and are being submitted for reimbursement; the physician must be affiliated and in good standing with an accredited GME program and must possess all appropriate licensure.

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Physician services must be performed personally by the teaching physician or by the person to whom the physician has delegated the responsibility. The level of supervision required may be direct or personal.

In all cases, the client's medical record must clearly document that the teaching physician provided identifiable supervision of the resident. As defined below, the supervision must be direct or personal depending on the setting and the clinical circumstances:

- Direct supervision means that the teaching physician must be in the same office, building, or facility when and where the service is provided and must be immediately available to furnish assistance and direction.
- *Personal supervision* means that the teaching physician must be physically present in the room when and where the service is being provided.

Personal supervision by the teaching physician is required during the key portions of all major surgeries and the key portions of all other physician services billed to Texas Medicaid if the immediate supervision, participation, or intervention of the supervising physician is medically prudent in order to assure the health and safety of the client. Physician services that require personal supervision may include invasive procedures and evaluation and management services that require complex medical decision making. Situations that require personal supervision include those in which:

- The clinical condition of the client is unstable or will likely become unstable during, or as a result of, the planned medical intervention.
- The planned medical intervention, even under optimal conditions will result in a medically reasonable risk for significant morbidity or death following the procedure.
- Deviation from the expected technique at the time the procedure or service is performed presents a medically reasonable, causally-related, foreseeable risk to the patient's life or health.

This criterion applies regardless of the place of service.

The teaching physician must provide medically appropriate, identifiable direct supervision for all other services that do not require personal supervision.

The following prerequisites apply when the teaching physician submits claims for services performed, in whole or in part, by the resident physician in the inpatient hospital setting, the outpatient hospital setting, and surgical services and procedures.

9.2.1.1 Teaching Physician Prerequisites

Services provided in an outpatient setting.

For services provided in an outpatient setting, a face-to-face encounter between the teaching physician providing direct supervision and the client is not required in the context of a GME program. All other requirements for personal or direct supervision in this division must be met for the services to qualify for reimbursement. The following tasks must be performed by the teaching physician and their completion must be documented in the patient's medical record before the claims are submitted for consideration of reimbursement:

- Review the patient's history and physical examination.
- Confirm or revise the patient's diagnosis.
- Determine the course of treatment to be followed.
- Assure that any necessary supervision of interns or residents was provided.

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- Confirm that documentation in the medical record supports the level of service provided.

Exception: *Exception for E/M services furnished in certain primary care centers. Teaching physicians that meet the primary care exception under Medicare are allowed to bill for low-level and mid-level E/M services for residents. Facilities that meet the primary care exception under Medicare may bill Texas Medicaid, Family Planning, or the Children with Special Health Care Needs (CSHCN) Services Program for new patient services (procedure codes 99201, 99202, and 99203) and established patient services (procedure codes 99211, 99212, and 99213).*

Note: *All services provided in an outpatient setting that do not qualify for the exception above require that the teaching physician examine the patient.*

Services provided in an inpatient setting.

For services provided in an inpatient setting, the teaching physician must demonstrate that medically appropriate supervision was provided. The following tasks must be performed and their completion must be documented in the patient's medical record before the claims are submitted for consideration of reimbursement. The documentation must be made in the same manner as required by federal regulations under Medicare:

- Review the patient's history, review the resident's physical examination, and examine the patient no later than 36 hours after the patient's admission and before the patient's discharge.
- Confirm or revise the patient's diagnosis.
- Determine the course of treatment to be followed.
- Document the teaching physician's presence and participation in the major surgical or other complex and dangerous procedure or situation.
- Confirm that documentation in the medical record supports the level of service provided.
- A face-to-face encounter with the client on the same day as any services provided by the resident physician.

Surgical services and procedures.

The teaching surgeon is responsible for the patient's preoperative, operative, and postoperative care. The teaching physician must demonstrate that medically appropriate supervision was provided. The following tasks must be performed and their completion must be documented in the patient's medical record before the claims are submitted for consideration of reimbursement. The documentation must be made in the same manner as required by federal regulations under Medicare:

- Review the patient's history, review the resident's physical examination, and examine the patient within a reasonable period of time after the patient's admission and before the patient's discharge.
- Confirm or revise the client's diagnosis.
- Determine the course of treatment to be followed.
- Document the teaching physician's presence and participation in the major surgical or other complex and dangerous procedure or situation.

Important: *Reimbursement may be reduced, denied, or recouped if the prerequisites are not documented in the medical record. The documentation must be made in the same manner as required by federal regulations under Medicare.*

9.2.2 Substitute Physician

Physicians may bill for the service of a substitute physician who sees clients in the billing physician's practice under either a reciprocal or locum tenens arrangement.

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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 of 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.

The substitute physician must be enrolled in Texas Medicaid and must not be on the Texas Medicaid or DSHS Family Planning Program 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 office or 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, 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.

When physicians in a group practice bill substitute physician services, the performing provider identifier of the physician for whom the substitute provided services must be in Block 24J.

Physicians 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.

9.2.3 Aerosol Treatment

Nebulized aerosol treatments (procedure codes 94640, 94644, and 94645) with short-acting beta-agonists are a benefit of Texas Medicaid and considered medically necessary when breathing is compromised by certain acute medical conditions. Documentation to support an aerosol treatment for the worsening of an acute or chronic condition must be maintained in the client's medical record and is subject to retrospective review.

Procedure code 94645 is only a benefit in the outpatient setting, specifically in a hospital emergency department or an urgent care clinic.

Pulse oximetry and evaluation of the client's use of an aerosol generator, nebulizer, or metered-dose inhaler are considered part of an evaluation and management (E/M) visit and will not be reimbursed separately.

Hypertonic saline used in aerosol therapy will be denied if billed separately.

Refer to: Subsection 4.2.20.1, "Aerosol Treatment" in the I*npatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*).

9.2.3.1 Diagnostic Testing

Nitric oxide expired gas determination (FeNO) measurement (procedure code 95012) is a benefit for Texas Medicaid.

FeNO measurement provided in the physician's office is considered medically necessary as an adjunct to the established clinical and laboratory assessments for diagnosing and assessing asthma, predicting exacerbations, and evaluating the response of a client who has asthma to anti-inflammatory therapy. FeNO measurement may be reimbursed by Texas Medicaid when the test is used as follows:

- To assist in 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).

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- To establish a baseline FeNO during non-exacerbations for subsequent monitoring of chronic persistent asthma.
- To guide changes in dosing of anti-inflammatory medications, i.e., step-down dosing, step-up dosing, or discontinuation of anti-inflammatory medications.
- To assist in the evaluation of adherence to anti-inflammatory medications.
- To assess whether airway inflammation is contributing to respiratory symptoms.

The technical and interpretation components of procedure code 95012 will not be reimbursed separately, as the instrument produces an exhaled nitric oxide (NO) measurement that requires little interpretation. Procedure code 95012 will be limited to once per day and must be submitted with procedure code 94010 or 94060.

If FeNO is measured during an office visit where additional E/M components are fulfilled, a separate E/M procedure code may be reimbursed if it is submitted with modifier 25.

9.2.4 Allergy Services

Texas Medicaid uses the following guidelines for reimbursement of allergy services.

9.2.4.1 Allergy Immunotherapy

Allergen immunotherapy consists of the parenteral administration of allergenic extracts as antigens at periodic intervals, usually on an increasing dosage scale to a dosage which is maintained as maintenance therapy.

Preparation of the allergy vial or extracts is a benefit of Texas Medicaid when preparations are made in accordance with the American Academy of Allergy, Asthma, and Immunology. Claims for preparations should be submitted using the following procedure codes:

Procedure Codes for Preparation of Allergy Vial or Extract							
95145	95146	95147	95148	95149	95165	95170	95180

Administration of the allergy extract may be reimbursed using procedure codes 95115 and 95117.

Allergen immunotherapy is a benefit for clients who have allergy conditions when the following criteria are met:

- A diagnosed hypersensitivity to an allergen can be indicated by one of the valid diagnosis codes listed below.
- Hypersensitivity cannot be managed by avoidance or pharmacologic therapy to control allergic symptoms, or the client has unacceptable side effects with pharmacologic therapy.
- The pharmacologic treatment is refused by the client or leads to significant side effects.
- The allergen content is based on appropriate skin testing, and the allergens are prepared for the client individually.

The preparation of the allergy vial or extract and the administration of an injection may be reimbursed for the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
H1045	H6501	H6502	H6503	H6504	H6505	H6506	H65111
H65112	H65113	H65114	H65115	H65116	H65191	H65192	H65193
H65194	H65195	H65196	H6521	H6522	H6523	H65491	H65492
H65493	J301	J302	J305	J3081	J3089	J309	J441
J449	J4520	J4521	J4522	J4530	J4531	J4532	J4540

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
J4541	J4542	J4550	J4551	J4552	J45901	J45902	J45909
J45998	L500	T531X4D	T532X4D	T533X4D	T534X4D	T536X4D	T59812D
T63001A	T63002A	T63003A	T63003D	T63003S	T63004A	T63004D	T63004S
T63011A	T63011D	T63011S	T63012A	T63013A	T63014A	T63021A	T63022A
T63023A	T63023D	T63023S	T63024A	T63024D	T63024S	T63031A	T63031D
T63031S	T63032A	T63033A	T63034A	T63041A	T63042A	T63043A	T63043D
T63043S	T63044A	T63044D	T63044S	T63061A	T63061D	T63062A	T63063A
T63063D	T63064A	T63064D	T63064S	T63071A	T63071D	T63072A	T63073A
T63073D	T63073S	T63074A	T63074D	T63074S	T63081A	T63081D	T63081S
T63082A	T63083A	T63083D	T63084A	T63084D	T63084S	T63091A	T63091D
T63092A	T63093A	T63093D	T63093S	T63094A	T63094D	T63094S	T63111A
T63111D	T63112A	T63113A	T63113D	T63113S	T63114A	T63114D	T63114S
T63121A	T63121D	T63122A	T63123A	T63123D	T63123S	T63124A	T63124D
T63124S	T63191A	T63191D	T63192A	T63193A	T63193D	T63193S	T63194A
T63194D	T63194S	T632X1A	T632X1D	T632X2A	T632X3A	T632X3D	T632X3S
T632X4A	T632X4D	T632X4S	T63301A	T63301D	T63302A	T63303A	T63303D
T63304A	T63304D	T63304S	T63311A	T63311D	T63312A	T63313A	T63314A
T63314D	T63314S	T63321A	T63321D	T63322A	T63323A	T63323D	T63323S
T63324A	T63324D	T63324S	T63331A	T63331D	T63332A	T63333A	T63333D
T63333S	T63334A	T63334D	T63334S	T63391A	T63391D	T63392A	T63393A
T63393D	T63393S	T63394A	T63394D	T63394S	T63411A	T63411D	T63412A
T63413A	T63413D	T63414A	T63414D	T63414S	T63421A	T63421D	T63422A
T63423A	T63423D	T63424A	T63424D	T63424S	T63431A	T63431D	T63432A
T63433A	T63433D	T63434A	T63434D	T63434S	T63441A	T63441D	T63442A
T63443A	T63443D	T63444A	T63444D	T63444S	T63451A	T63451D	T63452A
T63453A	T63453D	T63453S	T63454A	T63454D	T63454S	T63461A	T63461D
T63462A	T63463A	T63463D	T63463S	T63464A	T63464D	T63464S	T63481A
T63481D	T63482A	T63483A	T63483D	T63483S	T63484A	T63484D	T63484S
T63511A	T63511D	T63512A	T63513A	T63514A	T63591A	T63591D	T63592A
T63593A	T63594A	T63611A	T63611D	T63612A	T63613A	T63614A	T63621A
T63621D	T63622A	T63623A	T63624A	T63631A	T63631D	T63632A	T63633A
T63634A	T63691A	T63691D	T63692A	T63693A	T63694A	T63711A	T63711D
T63712A	T63713A	T63714A	T63791A	T63791D	T63792A	T63793A	T63794A
T63811A	T63811D	T63812A	T63813A	T63814A	T63821A	T63821D	T63822A
T63823A	T63824A	T63831A	T63831D	T63832A	T63833A	T63834A	T63891A
T63891D	T63892A	T63893A	T63894A	T6391XA	T6391XD	T6392XA	T6393XA
T6394XA	T65824D						

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9.2.4.1.1 Prior Authorization for Allergy Immunotherapy

Authorization is not required for immunotherapy services; however, requests for services beyond the established limits of 160 doses per one-year period for procedure code 95165 may be considered for prior authorization with documentation of medical necessity. Documentation must be submitted to the Special Medical Prior Authorization Department and include the following information:

- Copy of the allergen testing results
- Severity and periodicity of symptoms
- Physical limitations created by the symptoms
- Concurrent drug treatment
- Explanation of how efficacy has not been achieved with prior treatment and the objectives of the new anticipated treatment program

9.2.4.1.2 Limitations of Allergy Immunotherapy

The quantity billed for the allergy extract preparation procedure must represent the total number of doses to be administered from the vial. If the number of doses is not stated on the claim, a quantity of one is allowed.

> ***Note:*** *A "dose" is defined as the amount of antigen(s) administered in a single injection from a multidose vial.*

Procedure code 95165 is limited to a total of 160 doses per one-year period, which begins the date the immunotherapy is initiated. Additional doses may be considered for reimbursement through prior authorization with documentation of medical necessity. Procedure code 95165 is limited to no more than ten doses per vial.

When an injection is given from a vial, providers should use an administration-only procedure code (95115 or 95117). Reimbursement for the administration is limited to one per day.

An office visit, clinic visit, or observation room visit is not considered for reimbursement in addition to the fee for the preparation or the administration of the allergy vial or extract unless the additional visit results in a non-allergy-related diagnosis or a re-evaluation of the client's condition. The following E/M procedure codes may be submitted with modifier 25:

Procedure Codes									
99201	99202	99203	99204	99205	99211	99212	99213	99214	99215
99217	99218	99219	99220						

Allergen immunotherapy that is considered experimental, investigational, or unproven is not a benefit of Texas Medicaid.

Single dose vials (procedure code 95144) are not a benefit of Texas Medicaid.

9.2.4.2 Allergy Testing

Texas Medicaid benefits include allergy testing for clients with clinically significant allergic symptoms. Allergy testing is focused on determining the allergens that cause a particular reaction and the degree of the reaction. Allergy testing also provides justification for recommendations of particular medicines, of immunotherapy, or of specific avoidance measures in the environment.

An initial evaluation of a new patient is considered for reimbursement in addition to allergy testing on the same day.

Established patient visits are not considered for reimbursement in addition to allergy testing on the same day. The allergy testing is considered for reimbursement and the visit is denied as part of another procedure on the same day.

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The following allergy tests are benefits of Texas Medicaid:

- *Percutaneous and intracutaneous skin test*. The skin test for IgE-mediated disease with allergenic extracts is used in the assessment of allergy-prone clients. The test involves the introduction of small quantities of test allergens below the epidermis. Procedure codes 95004, 95017, 95018, 95024, 95027, and/or 95028 should be used to submit skin tests for consideration of reimbursement.
- *Patch or application tests*. Patch testing (procedure code 95044) is used for diagnosing contact allergic dermatitis.
- *Photo or photo patch skin test*. Procedure codes 95052 and 95056 may be used for diagnosing contact allergic dermatitis.
- *Ophthalmic mucous membrane or direct nasal mucous membrane tests*. Nasal or ophthalmic mucous membrane tests (procedure codes 95060 and 95065) are used for the diagnosis of either food or inhalant allergies and involve the direct administration of the allergen to the mucosa.
- *Inhalation bronchial challenge testing (not including necessary pulmonary function tests)*. Bronchial challenge testing with methacholine, histamine, or allergens (procedure codes 95070 and 95071) is used for defining asthma or airway hyperactivity when skin testing results are not consistent with the client's medical history. Results of these tests are evaluated by objective measures of pulmonary function.

Procedure code 95199 may be used for an unlisted allergy or clinical immunologic service or procedure if there is not a specific procedure code that describes the service performed. Prior authorization is required for unlisted procedure codes. Every effort must be used to bill with the appropriate CPT code that describes the procedure being performed. If a code does not exist to describe the service performed, prior authorization may be requested using unlisted procedure code 95199 and must be submitted with 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 this particular procedure
- A CPT or HCPCS procedure code that is comparable to the procedure being requested
- Documentation that this procedure is not investigational or experimental
- Place of service (POS) the procedure is to be performed
- The physician's intended fee for this procedure

Prior authorization requests for Texas Medicaid fee-for-service clients must be submitted by the physician to the Special Medical Prior Authorization (SMPA) department.

The number of allergy tests performed must be indicated on the claim. When the number of tests is not specified, a quantity of one is allowed.

9.2.4.2.1 Allergy Blood Tests

Allergy blood testing procedure codes 86001, 86003, and 86005 are a benefit when the test is performed for a reason that includes, but is not limited to, the following:

- The client is unable to discontinue medications
- An allergy skin test is inappropriate for the client for the following reasons:
  - The client is pediatric

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- The client is disabled
- The client suffers from a skin condition such as dermatitis

Radioallergosorbent tests (RAST) and multiple antigen simultaneous tests (MAST) are benefits of Texas Medicaid. RAST testing is used to detect specific allergens. RAST testing is usually performed by an independent lab; however, there are physicians who have the capability of performing these tests in their offices. Physicians who submit RAST/MAST tests performed in the office setting must use modifier SU to be considered for reimbursement. Without the use of the SU modifier, RAST/MAST testing submitted with POS 1 (office) is denied with the message, "Lab performed outside of office must be billed by the performing facility."

RAST/MAST tests must be submitted using procedure codes 86003 and 86005.

Procedure code 86001 is limited to 20 allergens per rolling year, any provider.

Procedure code 86003 is limited to 30 allergens per rolling year, any provider.

Procedure code 86005 is limited to 4 multiallergen tests per rolling year, same provider.

9.2.4.2.2 Collagen Skin Test

Collagen skin tests are a benefit of Texas Medicaid 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 that utilizes collagen.

Collagen injections that are used for cosmetic surgery are not considered medically necessary and are not a benefit of Texas Medicaid.

9.2.4.2.3 Prior Authorization for Collagen Skin Tests

Prior authorization is required for collagen skin test procedure code Q3031.

Prior authorization requests for Texas Medicaid fee-for-service clients must be submitted by the physician to the Special Medical Prior Authorization (SMPA) department.

Prior authorization is not required for other allergy testing procedure codes unless the limits are exceeded. The following medical documentation must be submitted to the SMPA Department with the prior authorization request for additional procedures:

- Results of any previous treatment
- Documentation that explains why 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
- Client outcomes that the requested procedures will achieve

9.2.4.2.4 Ingestion Challenge Test

Ingestion challenge tests are a benefit of Texas Medicaid using procedure code 95076. Ingestion challenge tests are used to confirm an allergy to a food or food additive.

Procedure code 95076 is limited to one service per day, any provider.

9.2.5 Ambulance Transport Services - Nonemergency

Nonemergency ambulance services require prior authorization in circumstances not involving an emergency. Facilities and other providers must request and obtain prior authorization before contacting the ambulance provider for nonemergency ambulance services.

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Refer to: Non-emergency Ambulance Prior Authorization Request on the TMHP website at www.tmhp.com.

Subsection 2.2.2, "Nonemergency Ambulance Transport Services," in the *Ambulance Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about ambulance services.

Subsection 5.1.8, "Prior Authorization for Nonemergency Ambulance Transport," in Section 5, "Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for more information about nonemergency ambulance transport prior authorization.

9.2.6 Anesthesia

Anesthesia services are a benefit of Texas Medicaid with specific benefits and limitations to reimbursement.

Medicaid may reimburse anesthesiologists, certified registered nurse anesthetists (CRNAs), and anesthesiologist assistants (AAs) for administering anesthesia as defined within their individual scope of practice.

9.2.6.1 Medical Direction by an Anesthesiologist

Medical direction by an anesthesiologist of an anesthesia practitioner (CRNA, AA, or other qualified professional) is a benefit of Texas Medicaid if the following criteria are met:

- No more than four anesthesia procedures are being performed concurrently.
- The anesthesiologist is physically present in the operating suite.

Exception: *Anesthesiologists may be considered for reimbursement when they medically direct more than four anesthesia services or simultaneously supervise a combination of more than four CRNAs, AAs, or other qualified professionals under emergency circumstances only.*

Medical direction provided by an anesthesiologist is a benefit of Texas Medicaid if 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 portions of the anesthesia plan, including induction and emergence.
- The anesthesiologist ensures that a qualified professional can perform the procedures in the anesthesia plan that the anesthesiologist does not perform personally.
- The anesthesiologist monitors the course of anesthesia administration at intervals.
- The anesthesiologist provides 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 postanesthesia care.

The anesthesiologist does not perform any other services (except as noted below) during the same time period. The anesthesiologist who directs 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
- Provide periodic, rather than continuous, monitoring of an obstetrical patient
- Receive clients entering the operating suite for the next surgery

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- Check or discharge clients in the recovery room
- Handle scheduling matters

As noted above, an anesthesiologist may concurrently medically direct up to four 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 Medicaid client. For example, if three procedures are medically directed but only two involve Medicaid clients, the Medicaid claims must be billed as concurrent medical direction of three procedures.

For medical direction, the anesthesiologist must document in the client's medical record that he or she did the following:

- Performed the pre-anesthetic exam and evaluation.
- Provided 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.

The following information must be available to state agencies upon request and is subject to retrospective review:

- The name of each CRNA, AA, or other qualified professional that was concurrently medically directed or supervised and a description of the procedure that was performed must be documented and maintained.
- Signatures of the anesthesiologist, CRNA, AA, or other qualified professional involved in administering anesthesia services must be documented in the client's medical record.

9.2.6.2 Anesthesia for Sterilization

Refer to: Subsection 2.2, "Services, Benefits, Limitations, and Prior Authorization," in the *Gynecological and Reproductive Health and Family Planning Services Handbook* (*Vol. 2, Provider Handbooks*) for the complete list of family planning diagnosis codes.

Subsection 2.2.8, "Sterilization and Sterilization-Related Procedures," in the *Gynecological and Reproductive Health and Family Planning Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 3.3.8.3, "Anesthesia for Sterilization," in the *Gynecological and Reproductive Health and Family Planning Services Handbook* (*Vol. 2, Provider Handbooks*).

Section 4, "Federally Qualified Health Center (FQHC)" in the *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about FQHCs and billing the annual family planning examination for Title XIX clients.

9.2.6.3 Anesthesia for Labor and Delivery

Providers must bill the most appropriate procedure code for the service provided. Other time-based procedure codes cannot be submitted if either 01960 or 01967 is the most appropriate procedure code.

The following procedure codes must be used for obstetrical anesthesia:

Procedure Codes					
01960	01961	01963	01967	01968	01969

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Procedure codes 01960 and 01967 are limited to once every 210 days when billed by any provider and are reimbursed a flat fee. The time reported must be in minutes. Providers should refer to the definition of time in the CPT manual in the "Anesthesia Guidelines—Time Reporting" section.

Procedure code 01968 or 01969 may be considered for reimbursement when submitted with procedure code 01967. For a Cesarean delivery following a planned vaginal delivery, the anesthesia administered during labor must be billed with procedure code 01967 and must indicate the time in minutes that represents the time between the start and stop times for the procedure. The additional anesthesia services administered during the operative session for a Cesarean delivery must be submitted using procedure code 01968 or 01969 and must indicate the time spent administering the epidural and the actual face-to-face time spent with the client. The insertion and injection of the epidural are not considered separately for reimbursement.

All time must be documented in block 24D of the claim form or the appropriate field of the chosen electronic format.

For continuous epidural analgesia procedure codes (other than procedure codes 01960 and 01967), Texas Medicaid reimburses providers for the time when the physician is physically present and monitors the continuous epidural. Reimbursable time refers to the period between the catheter insertion and when the delivery commences.

Texas Medicaid reimburses the epidural anesthesia services and the delivery at full allowance when they are provided by the delivering obstetrician.

9.2.6.4 Anesthesia Provided by the Surgeon (Other Than Labor and Delivery)

Local, regional, or general anesthesia provided by the operating surgeon is not reimbursed separately from the surgery. A surgeon billing for a surgery will not be reimbursed for the anesthesia when billing for the surgery, even when using the CPT modifier 47. The anesthesia service is included in the global surgical fee.

9.2.6.5 Complicated Anesthesia

The following procedure codes may be reimbursed in addition to an anesthesia procedure or service: 99100, 99116, 99135, and 99140. Documentation supporting the medical necessity for use of the procedure codes may be subject to retrospective review.

Procedure code 99140 is not reimbursed for diagnosis code O80 or O82 when one of these diagnoses is documented as the referenced diagnosis on the claim. The referenced diagnosis must indicate the complicating condition. An emergency is defined as existing when delay in treatment of the client would lead to a significant increase in the threat to life or body part.

9.2.6.6 Multiple Procedures

When billing for anesthesia and other services on the same claim, the anesthesia charge must appear in the first detail line for correct reimbursement. Any other services billed on the same day must be billed as subsequent line items.

When billing for multiple anesthesia services performed on the same day or during the same operative session, use the procedure code with the higher RVU. For accurate reimbursement, apply the total minutes and dollars for *all* anesthesia services rendered on the higher RVU code. Multiple services reimbursement guidelines apply.

9.2.6.7 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 of the client's vital physiological signs in anticipation of the need for general anesthesia

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- Monitoring of the client's development of an adverse physiological reaction to a surgical procedure

Anesthesiologists, CRNAs, or AAs may use modifier QS to report monitored anesthesia care.

The QS modifier is an informational modifier.

9.2.6.8 Reimbursement Methodology

There are two types of reimbursement for anesthesia procedure codes.

- Flat fee
- Time-based fees, which require documentation of the exact amount of face-to-face time with the client

The anesthesiologist's reimbursement for medical direction of CRNAs and non-CRNA qualified professionals is 100 percent of the maximum allowable fee.

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.

Both the flat-fee and time-based-fee procedure codes must be submitted with modifiers and are subject to medical direction/supervision reimbursement adjustments.

Flat Fees

Both OB related anesthesia procedure codes 01960 and 01967 are considered for reimbursement with a flat-fee rate.

- Flat fees are subject to medically-directed modifier combination adjustments based on the modifier submitted with the anesthesia procedure code.
- The time-based add-on procedure code 01968 must be billed in addition to the flat fee when anesthesia for Cesarean delivery following neuraxial labor analgesia/anesthesia has occurred.

For flat-fee anesthesiology codes, 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, that is, when the client may be safely placed under postoperative supervision.

Time-Based Fees

For time-based anesthesiology procedure codes, anesthesia time is the time during which an anesthesia practitioner is present with the client. 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).

For time-based anesthesiology codes, anesthesia practitioners must document interruptions in anesthesia time in the client's medical record.

The documented time must be the same in the records or claims of the anesthesiologist and other anesthesia practitioners who were medically directed by the anesthesiologist.

One time unit is equal to 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.

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Reimbursement of time-based anesthesia services is derived by adding the RVUs (e.g., base units) for the procedures performed (when multiple procedures are performed use the procedure with the highest RVUs) to the total face-to-face anesthesia time in minutes divided by 15 minutes, multiplied by the appropriate conversion factor, and then by the appropriate modifier combination adjustment:

[RVUs + (Minutes / 15] x Conversion Factor x Modifier Combination Adjustment = Anesthesia Reimbursement

Provider Type Description - Physician Pricing Example				
Time: 120 minutes	=	120/15	=	8 (quantity billed)
Procedure code: 00851	=	(6 RVUs) 6.00 + 8	=	14.00
Conversion factor: $19.58	=	14.00 x 19.58	=	$274.12 (physician reimbursement)

Conversion Factor

A conversion factor is the multiplier that transforms relative values into payment amounts. There is a standard conversion factor for anesthesia services.

9.2.6.9 Anesthesia Modifiers

Each anesthesia procedure code must be submitted with the appropriate anesthesia modifier combination whether billing as the sole provider or for the medical direction of CRNAs, AAs, or other qualified professionals.

When an anesthesia service is billed without the appropriate reimbursement modifiers or is billed with modifier combinations other than those listed below in the Modifier Combinations section, the claim will be denied.

A procedure billed with a modifier indicating that the anesthesia was personally performed by an anesthesiologist (modifier AA) will be 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 will be 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.

9.2.6.9.1 State-Defined Modifiers

Modifiers U1 (indicating one Medicaid claim billed by an anesthesia practitioner and U2 (indicating two Medicaid claims) are state-defined modifiers that must be billed by an anesthesiologist, CRNA, or AA.

Modifier U1, indicating that only one Medicaid claim will be submitted, cannot be billed by two providers for the same procedure, client, and date of service. Modifier U2, indicating that two Medicaid claims will be submitted, can only be billed by two providers for the same procedure, client, and date of service if one of the providers was medically directed by the other. Denied claims may be appealed with supporting documentation of any unusual circumstances.

Anesthesia providers must submit the U1 or U2 modifier with an appropriate pricing modifier (AA, QY, QK, AD, QZ, QX) when billing for anesthesia procedure codes.

9.2.6.9.2 Modifier Combinations

Modifiers AA and U1 must be submitted when an anesthesiologist has personally performed the anesthesia service.

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Anesthesiologists may be reimbursed for medical direction of CRNAs, AAs, or other qualified professional by using one of the following modifier combinations:

Modifier Combination Submitted by Anesthesiologist	When is it used?	Who will submit claims?
Anesthesiologist Directing Other **Qualified Professionals**		
QY and U1	When directing one procedure provided by one other qualified professional.	Only the anesthesiologist
QK and U1	When directing two, three, or four concurrent procedures provided by other qualified professionals.	Only the anesthesiologist
AD and U1 (*Emergency circumstances only*)	When directing five or more concurrent procedures provided by other qualified professionals. Used in emergency circumstances only and limited to 6 units (90 minutes) per case for each occurrence requiring five or more concurrent procedures.	Only the anesthesiologist
Anesthesiologist Directing CRNAs or AAs		
QY and U2	When directing one procedure provided by a CRNA or AA.	Both the anesthesiologist and CRNA, or AA
QK and U2	When directing two, three, or four concurrent procedures involving CRNA(s) or AA(s).	Both the anesthesiologist and CRNA or AA
AD and U2 (Emergency circumstances only)	When directing five or more concurrent procedures involving CRNA(s) or AAs. Used in emergency circumstances only and limited to 6 units (90 minutes) per case for each occurrence requiring five or more concurrent procedures.	Both the anesthesiologist and CRNA or AA

9.2.6.9.3 CRNA and AA 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 surgeon.

Modifiers QX and U2 must be submitted by a CRNA or AA who provided services under the medical direction of an anesthesiologist.

9.2.6.10 Prior Authorization for Anesthesia

9.2.6.10.1 *Anesthesia for Medical Services*

Anesthesia services provided in combination with most medical surgical procedures do not require prior authorization. However, some medical surgical procedures 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 will be denied.

9.2.6.11 Claims Filing

Texas Medicaid reimburses anesthesiologists based on the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Anesthesiologists must identify the following information on their claims:

- Procedure performed (CPT anesthesia code in Block 24 of the CMS-1500 paper claim form).
- Person (physician, CRNA, or AA) administering anesthesia (modifiers must be used to designate this provider type).

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- Time in minutes.
- Any other appropriate modifier (refer to subsection 6.3.5, "Modifiers" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for a list of the most common modifiers).

9.2.6.12 Anesthesia (General) for THSteps Dental

Refer to: Section 4, "Texas Health Steps (THSteps) Dental" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information.

9.2.7 Abdominal Aortic Aneurysm Screening

Procedure code G0389 is a benefit for male clients who are 65 through 75 years of age with diagnosis code Z0000, Z0001, or Z87891.

Procedure code G0389 is limited to once per lifetime any provider.

9.2.8 Bariatric Surgery

Bariatric surgery is considered medically necessary when used as a means to treat covered medical conditions that are caused or significantly worsened by the client's obesity in cases where those comorbid conditions cannot be adequately treated by standard measures unless significant weight reduction takes place. The pathophysiology of the covered comorbid conditions must be sufficiently severe that the expected benefits of weight loss subsequent to this surgery significantly outweigh the risks associated with bariatric surgery.

The following procedure codes may be reimbursed for medically necessary bariatric surgery services with prior authorization: 43644, 43645, 43659, 43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845, 43846, 43847, 43848, 43886, 43887, and 43888.

Bariatric surgery is not a benefit when the primary purpose of the surgery is any of the following:

- For weight loss for its own sake
- For cosmetic purposes
- For reasons of psychological dissatisfaction with personal body image
- For the client's or provider's convenience or preference

9.2.8.1 Prior Authorization for Bariatric Surgery

All clients must meet the criteria outlined below.

The same contraindications exist for bariatric surgery as for any other elective abdominal surgery. Documentation provided for prior authorization must attest that none of the following additional contraindications exist:

- Endocrine cause for obesity, inflammatory bowel disease, chronic pancreatitis, cirrhosis, portal hypertension, or abnormalities of the gastrointestinal tract
- Chronic, long-term steroid treatment
- Pregnant, or plans to become pregnant within 18 months
- Noncompliance with medical treatment
- Significant psychological disorders that would be exacerbated or interfere with the long-term management of the client after the operation
- Active malignancy

All clients must undergo preoperative psychological evaluation by a behavioral health provider and have clearance for surgery if any of the following conditions exist:

- They have a history of psychiatric or psychological disorders.

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- They are currently under the care of a psychologist or psychiatrist.
- They are on psychotropic medications.

The client's medical record must include documentation of the evaluation.

Clients without a history of psychiatric or psychological disorder must also undergo a preoperative psychological evaluation by a behavioral health provider and have clearance for surgery. The client's medical record must include documentation that the client is psychologically mature and able to cope with the postsurgical changes of the surgery.

Documentation must be submitted with the prior authorization request that is signed by the surgeon and attests that the services are provided by a facility in Texas that is one of the following:

- Accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP).
- A children's hospital that has a bariatric surgery program and provides access to an experienced surgeon who employs a team that is capable of long-term follow-up of the metabolic and psychosocial needs of the client and family.

Bariatric surgery for clients who are 20 years of age and younger may be prior authorized when the client meets all of the following criteria:

- The client has reached a Tanner Scale stage IV or V plus 95 percent of adult height based on bone age.
- The client has a body mass index (BMI) of greater than or equal to 40 kg/m2.
- The client has one or more comorbid conditions that are exacerbated by or attributable to obesity.
- Female clients must be at least 13 years of age and menstruating.
- Male clients must be at least 15 years of age.

Bariatric surgery for clients who are 21 years of age and older may be prior authorized when the client meets all of the following criteria:

- The client has a BMI of greater than or equal to 35 kg/m2.
- The client has one or more of the following comorbid conditions that are exacerbated by or attributable to obesity:
  - Obesity-associated hypoventilation
  - Moderate to severe sleep apnea (defined as apnea/hypoapnea index of 16 or more events per hour)
  - Congestive heart failure
  - Obesity-induced cardiomyopathy
  - Refractory hypertension resistant to pharmacotherapy (defined as blood pressure greater than 140mmHg systolic or greater than 90mmHg diastolic, despite maximally tolerated doses of at least three different classes of antihypertensive medications)
  - Pseudotumor cerebri (documented idiopathic intracerebral hypertension)
  - Adult onset (Type II) diabetes (with or without complications) with Hgb A1c greater than 9 percent, regardless of therapy, or 7 to 9 percent on maximal medical therapy (defined as taking insulin or maximally tolerated doses of at least two different classes of oral hypoglycemic medications)
  - Cardiovascular or peripheral vascular disease

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- Refractory hyperlipidemia (defined as triglycerides greater than 250 mg/dl, cholesterol greater than 220/mg/dl, HDL less than 35 mg/dl, or LDL greater than 200 mg/dl, despite maximally tolerated doses of at least two different classes of lipid-lowering medications)
- Recurrent or chronic skin ulcerations with infection
- Pulmonary hypertension
- Chronic joint disease, deterioration of the joint cartilage, and the formation of new bone (bone spurs) at the margins of the joints, with symptoms that severely affect work or leisure activities, on maximal medical therapy (defined as maximally tolerated dose of a non-steroidal anti-inflammatory drug (NSAID) or COX-II inhibitor or acetaminophen and the completion of at least one physical-therapist-supervised exercise program)
- Hepatic steatosis without evidence of active inflammation

Documentation must include a summary of the treatment provided for the client's comorbid conditions, including descriptions of how the client's response to standard treatment measures are unsatisfactory and why the bariatric surgery is medically necessary in the context of current treatment and medically-reasonable alternatives that are available.

Referral for bariatric surgery to the bariatric surgeon is required from the practitioner who is treating the comorbid condition(s). The bariatric surgeon will determine the client's eligibility for bariatric surgery. Documentation of the referral must be submitted with the prior authorization request.

The client must have had previous unsuccessful medical treatment for obesity, as documented in the medical record. All of the following minimal requirements must be met:

- The client has made a diligent effort to achieve healthy body weight with such efforts described in the medical record and certified by the operating surgeon.
- The client has failed to maintain a healthy weight despite a minimum of 6 months documented regular participation in a structured dietary program overseen by a physician (M.D. or D.O.) within 12 months of the request date.

Documentation that is submitted for prior authorization must also include all of the following:

- The process by which the client will receive postoperative surgical, nutritional, and psychological services.
- Affirmation that the client and the parent/guardian (if applicable) understand and will support the changes in eating habits that must accompany the surgery and the extensive postoperative follow-up.

Repeat bariatric surgery may be considered medically necessary in either of the following circumstances:

- To correct complications from bariatric surgery such as band malfunction, obstruction, or stricture
- To convert to a Roux-en-Y gastroenterostomy or to correct pouch failure in an otherwise compliant client when the initial bariatric surgery met medical necessity criteria

  Note: *Conversion to a Roux-en-Y gastroenterostomy may be considered medically necessary for clients who have not had adequate success (defined as a loss of more than 50 percent of excess body weight) two years following the primary bariatric surgery procedure, and the client has been compliant with a prescribed nutrition and exercise program following the procedure.*

All documentation required for prior authorization is to be maintained in the client's medical record and is subject to retrospective review. This includes medical records from both the practitioner treating the comorbid condition(s) and the bariatric surgeon.

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Providers may fax or mail prior authorization requests for bariatric surgery services for clients who are 20 years of age and younger to the TMHP Comprehensive Care Program (CCP) Prior Authorization Department. Prior authorization requests for clients who are 21 years of age and older may be faxed or mailed to the TMHP Special Medical Prior Authorization Department.

Clients may be eligible under Texas Medicaid or CCP for separate reimbursement for nutritional and psychological assessment and counseling associated with bariatric surgery.

Behavioral health services provided as part of the preoperative or postoperative phase of bariatric surgery are subject to behavioral health guidelines, and are not considered part of the bariatric surgery.

Refer to: Subsection 6.16, "Psychiatric Services for Hospitals," in the *Behavioral Health, Rehabilitation, and Case Management Services Handbook* (*Vol. 2, Provider Handbook*) for information about behavioral health services.

9.2.9 Bacillus Calmette-Guérin (BCG) Intravesical for Treatment of Bladder Cancer

Live BCG for intravesical (procedure code 90586) or transvesical (procedure code J9031) are benefits of Texas Medicaid for the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
C670	C671	C672	C673	C674	C675	C676	C677
C678	C679	C7911	D090				

Procedure code 90585 is a benefit of Texas Medicaid for diagnosis code Z23. Authorization is not required for the BCG vaccine.

Bladder instillation of anticarcinogenic agent (procedure code 51720) may be reimbursed separately when billed with BCG instillation (procedure code 90586 or J9031).

9.2.10 Behavioral Health Services

Refer to: The *Behavioral Health, Rehabilitation, and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*).

9.2.11 Biopsy

A biopsy refers to the surgical excision of tissue for pathological examination.

If a surgeon bills separate charges for a surgical procedure and a biopsy on the same organ or structure on the same day, the charges are reviewed and reimbursed only for the service with the higher of the allowed amounts.

9.2.12 Biofeedback Services

Biofeedback services are a benefit of Texas Medicaid for clients who are 4 years of age and older with the following conditions:

- Urinary incontinence
- Fecal incontinence
- Migraine and tension headache

Biofeedback services may be reimbursed using procedure codes 90901 and 90911.

Biofeedback services are limited to a maximum of 18 sessions rendered by any provider for the lifetime of each client for each condition.

Biofeedback services that are not a benefit of Texas Medicaid are the following:

- Biofeedback performed in the home setting

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- Neurofeedback (such as, but not limited to, electroencephalography [EEG])
- Treatment for muscle tension, except tension headache
- Psychological, psychophysiological, and behavioral health therapy and psychosomatic conditions
- Investigational or experimental biofeedback services and procedures

Procedure code 90901 or 90911 are limited to one service per day. The reimbursement for procedure codes 90901 and 90911 include all modalities of the biofeedback training performed on the same day, regardless of the time increments or the number of modalities performed.

Any device used during a biofeedback session is considered part of the procedure and will not be reimbursed separately.

9.2.12.1 Biofeedback Certification

A staff member who is certified by Biofeedback Certification International Alliance (BCIA) must perform biofeedback services.

The certification types accepted by Texas Medicaid are the following:

- General biofeedback certification (BCB)
- Pelvic muscle dysfunction biofeedback certification (BCB-PMD)

Providers must maintain documentation in the client's medical record to support the medical necessity of the biofeedback service provided. Documentation must include the name of the staff person who provided the biofeedback and the prescribing physician must maintain in the office a record of the current certification of the staff member(s) who perform biofeedback. Documentation is subject to retrospective review.

9.2.12.2 Prior Authorization for Biofeedback Services

Prior authorization is required for biofeedback services.

- Any combination of procedure codes 90901 and 90911 are a benefit for biofeedback sessions for urinary or fecal incontinence conditions in clients who are 4 years of age and older.
- Procedure code 90901 is a benefit for biofeedback sessions for migraine or tension headache conditions.

The initial request may include up to 12 visits and not exceed a total duration of 12 weeks. Documentation of the following must be submitted for consideration of prior authorization:

- Conventional treatments that were given but were not successful, including, but not limited to, pharmacotherapy, exercise, rest, and heating and cooling modalities.
- Statements from the prescribing physician that the client is capable of understanding the requirements and agrees actively to participate in the biofeedback sessions.
- Name and certification information for the person performing the training.

In addition, documentation must be submitted to support the specific type of biofeedback requested.

Urinary and Fecal Incontinence

- Diagnosis of fecal or urinary stress, urge, overflow, or a mix of stress and urge incontinence in a client who is 4 years of age or older.
- Exclusion by the physician of any underlying medical conditions that could be causing the problem.
- Failed pelvic floor muscle exercise (PME) training for clients who are 21 years of age and older.

Note: *Failed trial of PME training is defined as no clinically significant improvement in urinary incontinence after completing four weeks of an ordered plan of PME exercises.*

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Migraine and tension headache

- A diagnosis of migraine, tension headache, or mixed migraine and tension headache.
- Symptoms that occur with a duration of at least 4 hours for at least 15 days a month over at least 3 months.
- Failure of first-line approaches, including avoidance of precipitating stimuli and pharmacological prophylaxis.

Prior authorization requests must be submitted by the physician to the Special Medical Prior Authorization (SMPA) Department. The request must be submitted with documentation that supports medical necessity. Providers may submit prior authorization requests online through the TMHP website at www.tmhp.com, by fax to 1-512-514-4213, or by mail to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway
Austin, TX 78727

After the client completes the initial biofeedback treatment course, prior authorization may be considered for a total of six follow-up sessions not to exceed three sessions per week and total duration not to exceed eight weeks. Providers must submit prior authorization documentation for the same condition as the original request, and must include each original symptom and how it has objectively improved. Documentation may include, but is not limited to, the following:

- For treatment of urinary incontinence, improvement in continence scores, vitality, health, a decrease in high-grade stress incontinence, nocturnal enuresis, and urine loss with activity. In clients who are 21 years of age and older, evidence of increased pelvic floor contraction strength and the ability to hold the contractions longer and to perform more repetitions.
- For treatment of fecal incontinence, improvement in continence scores, squeeze and anal pressures, squeeze duration, vitality, and health. In clients who are 21 years of age and older, evidence of increased pelvic floor contraction strength and the ability to hold the contractions longer and to perform more repetitions.
- For migraine and tension headaches, diminished intensity, frequency, and duration of the headache activity.

9.2.13 Blepharoplasty Procedures

Procedure codes 15820, 15821, 67911, 67961, 67966, 67971, 67973, 67974, and 67975 are not diagnosis-restricted.

Procedure codes 67901, 67902, 67903, 67904, 67906, 67908, and 67909 may be reimbursed for clients who are 20 years of age and younger without prior authorization when performed for one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)			
Q100	Q101	Q102	Q103

Procedure codes 67901, 67902, 67903, 67904, 67906, and 67908 do not require prior authorization for clients who are 21 years of age and older when billed for the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
H0231	H0232	H0234	H0235	H02411	H02412	H02413	H02421
H02422	H02423	H02431	H02432	H02433			

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Blepharoplasty for clients who are 21 years of age and older requires mandatory prior authorization. The following information from the physician is required at the time of the request for blepharoplasty for procedure codes 15820, 15821, 67901, 67902, 67903, 67904, 67906, 67908, 67909, 67911:

- A brief history and physical evaluation
- Photographs of the eyelid problem
- Visual field measurements
- Diagnosis code

The following blepharoplasty and eyelid repair procedures do *not* require prior authorization:

Procedure Codes									
67916	67917	67923	67924	67961	67966	67971	67973	67974	67975

All supporting documentation must be included with the request for authorization. Send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax: 1-512-514-4213

Retroactive authorization may be granted on an appeal basis when submitted with the appropriate documentation.

9.2.14 Bone Growth Stimulation

Professional services for bone growth stimulation (procedure codes 20974, 20975, and 20979) are a benefit of Texas Medicaid

Prior authorization is required for a bone growth stimulator device (procedure codes E0747, E0748, E0749, and E0760).

Refer to: Subsection 2.2.7, "Bone Growth Stimulators," in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*) for prior authorization criteria.

9.2.14.1 Invasive Bone Growth Stimulation

Invasive bone growth stimulation (procedure code 20975) is indicated for the following conditions:

- 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, which involves three or more vertebrae (e.g., L3-L5, L4-S1, etc.).

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9.2.14.2 Non-invasive Bone Growth Stimulation

Non-invasive bone growth stimulation (procedure code 20974) is indicated for the following conditions:

- Nonunions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three or more months despite appropriate fracture care.
- Delayed unions of fractures of failed arthrodesis at high risk sites (e.g., open or segmental tibial fractures, carpal navicular fractures).

Documentation must also indicate all of the following:

- 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 non-weight-bearing restrictions.

Non-invasive bone growth stimulation for spinal application is indicated for the following conditions:

- 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.

9.2.14.3 Ultrasound Bone Growth Stimulation

Ultrasound bone growth stimulation (procedure code 20979) is indicated for nonunion of a fracture, other than the skull or vertebrae, in a skeletally mature person, which is documented by a minimum of two sets of radiographs that were:

- Obtained prior to starting treatment with the osteogenesis stimulator.
- Separated by a minimum of 90 days.
- Taken with multiple views of the fracture site.
- Accompanied by a written interpretation by a physician who states that there has been no clinically significant evidence of fracture healing between the two set of radiographs.

Documentation must also indicate evidence of all of the following:

- 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).

9.2.14.4 Reimbursement

Professional claims that are submitted for bone growth stimulation (procedure codes 20974, 20975, and 20979) may be reimbursed if the claim includes documentation of one of the following:

- Documentation of medical necessity as outlined for each type of bone growth stimulation.
- The corresponding bone growth stimulator device was submitted within 95 days of the date the bone growth stimulation procedure was performed.

The appropriate evaluation and management (E/M) procedure code must be billed for monitoring the effectiveness of bone growth stimulation treatment.

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Procedure codes 20974, 20975, and 20979 are limited to one per six months. During the six-month limitation period, a subsequent fracture that meets the criteria for a bone growth stimulator may be reimbursed after the submission of an appeal with documentation of medical necessity that demonstrates the criteria have been met.

9.2.15 Cancer Screening and Testing

9.2.15.1 BRCA Testing

Refer to: Subsection 2.2.6, "Breast Cancer Gene 1 and 2 (BRCA) Testing" in the Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks).

9.2.15.2 Colorectal Cancer Screening

Fecal occult blood tests, barium enemas, screening colonoscopies, and sigmoidoscopies are benefits of Texas Medicaid. Screening refers to the testing of asymptomatic persons in order to assess their risk for the development of colorectal cancer. Screening has been shown to decrease mortality due to this cancer by detecting cancers at earlier stages and allowing the removal of adenomas, thus preventing the subsequent development of cancer.

The American Cancer Society (ACS) and U.S. Preventive Services Task Force (USPSTF) both recommend screening people at average risk for colorectal cancer beginning at 50 years of age by any of the following methods:

- A fecal occult blood test (FOBT)* or fecal immunochemical test (FIT) every year
- Flexible sigmoidoscopy every five years
- A FOBT* or FIT every year plus flexible sigmoidoscopy every five years, or (of these three options, the combination of FOBT or FIT every year plus flexible sigmoidoscopy every five years is preferable)
- Double-contrast barium enema every five years
- Colonoscopy every ten years

**For FOBT, the take-home multiple sample method should be used.*

The ACS and USPSTF recommends screening for people at high-risk for colorectal cancer once every two years.

Indications/characteristics of a high-risk individual:

- A close relative (sibling, parent or child) has had colorectal cancer or an adenomatous polyp.
- There is a family history of familial adenomatous polyposis.
- There is a family history of hereditary nonpolyposis colorectal cancer.
- There is a personal history of adenomatous polyps.
- There is a personal history of colorectal cancer.
- There is a personal history of colonic polyps.
- There is a personal history of inflammatory bowel disease, including Crohn's disease and ulcerative colitis.

Colorectal screening services are considered for reimbursement when submitted using procedure codes G0104, G0105, G0106, G0120, G0121, G0122, and G0328 by associated risk category based on the ACS and USPSTF frequency recommendations. Reimbursement for these procedure codes is considered when medical necessity is documented in the client's record.

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Fecal Occult Blood Tests

Procedure code G0328 may be reimbursed once per year for clients who are 50 years of age and older.

Barium Enemas

Procedure code G0122 is considered for reimbursement once every 5 years for clients who are 50 years of age and older.

Sigmoidoscopies

Procedure codes G0104 and G0106 are considered for reimbursement once every five years when submitted with diagnosis code Z0000, Z0001, Z1210, Z1211, Z1213, Z859, or Z89010, as recommended by the ACS and USPSTF. Diagnosis code Z0000 or Z0001 may be used for screening if no other diagnosis is appropriate for the service rendered, but not more frequently than recommended by the USPSTF.

A screening barium enema may be substituted for a screening flexible sigmoidoscopy if the effectiveness has been established by the physician for substitution. Procedure code G0106 may be used as an alternative to procedure code G0104 respectively.

If during the course of screening flexible sigmoidoscopy, a lesion or growth is detected that results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a flexible sigmoidoscopy with biopsy or removal must be reported rather than procedure code G0104 or G0106.

Colonoscopies: Average Risk

Procedure code G0121 is considered for reimbursement once every ten years when submitted with diagnosis code Z0000, Z0001, Z1210, Z1211, Z1213, or Z86010, as recommended by the ACS and USPSTF for clients who do not meet the criteria for high-risk. Diagnosis code Z0000 or Z0001 may be used for screening if no other diagnosis is appropriate for the service rendered, but not more frequently than recommended by the USPSTF.

If during the screening colonoscopy 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 rather than procedure code G0121.

Colonoscopies: High-Risk

Procedure codes G0105 and G0120 are considered for reimbursement once every two years for clients who meet the definition of high-risk. Procedure codes G0105 and G0120 must be submitted with one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone 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	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	K5281	K5282	K5289	K529	Z800	Z8371
Z85038	Z85048	Z859	Z86010				

A screening barium enema may be substituted for a screening colonoscopy if the effectiveness has been established by the physician for substitution. Procedure code G0120 may be used as an alternative to procedure code G0105 respectively.

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If during the screening colonoscopy 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 rather than procedure code G0105 or G0120.

9.2.15.2.1 Prior Authorization for Colorectal Cancer Screening

Prior authorization is not required for colorectal screening.

9.2.15.3 Genetic Testing for Colorectal Cancer

Genetic testing for colorectal cancer may be considered for reimbursement to independent laboratories with prior authorization.

Genetic testing may be provided to clients who have a known predisposition (i.e., having a first- or second-degree relative) for colorectal cancer. Results of the testing may indicate whether the client has an increased risk of developing colorectal cancer. A first-degree relative is defined as a sibling, parent, or offspring. A second-degree relative is defined as an 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 or family members have been given information on the nature, inheritance, and implications of genetic disorders to help them make informed medical and personal decisions before the genetic testing.

Genetic testing for colorectal cancer may be considered for reimbursement with the following procedure codes:

Procedure Codes									
81201	81202	81203	81210	81275	81288	81292	81293	81294	81295
81296	81297	81298	81299	81300	81301	81317	81318	81319	

Diagnosis code Z800 is acceptable as a diagnosis for the procedure codes in the table above. Prior authorization is still required and must be obtained for these services. Interpretation of gene mutation analysis results is not reimbursed separately. Interpretation is part of the physician E/M service.

The following procedure codes are limited to once per lifetime for any procedure code by any provider. Testing is limited to once per lifetime for any procedure code by any provider, regardless of whether additional services are authorized.

Procedure Codes									
81201	81202	81203	81210	81275	81288	81292	81293	81294	81295
81296	81297	81298	81299	81300	81301	81317	81318	81319	

Providers must maintain the following documentation in the client's medical record for genetic testing for colorectal cancer:

- Documentation of formal pre-test counseling, including assessment of the client's ability to understand the risks and limitations of the test.
- The client's informed choice to proceed with the genetic testing for colorectal cancer.

The provider must order the most appropriate test based on familial medical history and the availability of previous family testing results.

The medical record is subject to retrospective review.

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9.2.15.3.1 Testing for Familial Adenomatous Polyposis

Testing for familial adenomatous polyposis (procedure codes 81201, 81202, and 81203) may be offered to clients who have well-defined hereditary cancer syndromes and for whom a positive or negative result will change medical care. Testing for familial adenomatous polyposis may be considered for reimbursement with documentation of at least one of the following:

- The client has more than 20 polyps.
- The client has a first-degree relative with familial adenomatous polyposis and a documented mutation.
- For clients who are 7 years of age and younger, testing must be medically necessary and supported by documentation with a clear rationale for testing, which must be retained in the client's medical record.

9.2.15.3.2 Hereditary Nonpolyposis Colorectal Cancer (HNPCC)

Testing for HNPCC (procedure codes 81288, 81292, 81293, 81294, 81295, 81296, 81297, 81298, 81299, 81300, 81301, 81317, 81318, and 81319) is used to determine whether a client has an increased risk of colorectal cancer or other HNPCC-associated cancers, including Lynch Syndrome. Results of the test may influence clinical management decisions. Testing for HNPCC may be considered for reimbursement with documentation of at least one of the following:

- The client has three or more family members, one of whom is a first-degree relative, with colorectal cancer; two successive generations are affected; one or more of the colorectal cancers was diagnosed before the family member was 50 years of age; and familial adenomatous polyposis has been ruled out for the client.
- The client has had two previous HNPCCs.
- The client has colorectal cancer and a first-degree relative who has one of the following:
  - Colorectal cancer or HNPCC extracolonic cancer at 50 years of age and younger
  - Colorectal adenoma at 40 years of age and younger
- The client has had colorectal cancer or endometrial cancer at 50 years of age and younger.
- The client has had right-sided colorectal cancer with an undifferentiated pattern of histology at 50 years of age and younger.
- The client has had signet-cell type colorectal cancer at 50 years of age and younger.
- The client has had a colorectal adenoma at 40 years of age and younger.
- The client is asymptomatic and has a first- or second-degree relative who has a documented HPNCC mutation.
- The client has a family history of malignant neoplasm in the gastrointestinal tract.
- For clients who are 20 years of age and younger, testing must be medically necessary and supported by documentation with a clear rationale for testing, which must be retained in the client's medical record.

9.2.15.3.3 * Prior Authorization for Genetic Testing for Colorectal Cancer

Prior authorization is required for genetic testing for colorectal cancer. A written authorization request that is signed and dated by the referring provider must be submitted. A provider's signature, including the prescribing provider's, on a submitted document indicates that the provider certifies, to the best of the provider's knowledge, the information in the document is true, accurate, and complete.

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Medical documentation that is submitted by the physician must verify the client's diagnosis or family history. Requisition forms from the laboratory are not sufficient for verification of the personal and family history.

To complete the prior authorization process, the provider must mail or fax the request to the TMHP Special Medical Prior Authorization Unit and include documentation of medical necessity. The form may be faxed to 1-512-514-4213 or mailed to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization Department
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727

A request for retroactive authorization must be submitted no later than 7 calendar days after the lab draw is performed. To facilitate a determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including the accurate medical necessity of the services requested.

9.2.15.4 Mammography (Screening and Diagnostic Studies of the Breast)

The following breast imaging studies are benefits of Texas Medicaid:

- Screening mammogram
- Diagnostic mammogram
- Diagnostic breast ultrasound

A screening mammogram may be billed using procedure code 77057 or G0202. Procedure code 77057 will be denied when billed if it is submitted for the same date of service as procedure code G0202 by any provider.

> ***Note:*** *The American Cancer Society recommends annual screening mammography for women beginning at 40 years of age.*

A diagnostic mammogram may be billed using procedure code 77055, 77056, G0204, or G0206.

Procedure code 77055 will be denied if it is submitted for the same date of service as procedure code 77056, G0204, or G0206 by any provider.

Procedure code 77056 will be denied if it is submitted for the same date of service as procedure code G0204 by any provider.

Procedure code G0206 will be denied if it is submitted for the same date of service as procedure code 77056 or G0204 by any provider.

Screening mammograms may be reimbursed for the same date of service as a diagnostic mammogram if the diagnostic mammography procedure codes are submitted with a GG modifier.

A mammogram may be indicated for a male client based on medical necessity due to existing signs and symptoms. In such rare circumstances, procedure codes 77055, 77056, G0204, and G0206 may be considered for reimbursement.

Other breast diagnostic radiology procedures may be medically necessary based on existing signs and symptoms. When indicated, such procedures may be considered for reimbursement using procedure code 76098, 77053, or 77054. Procedure code 77053 will be denied if it is submitted for the same date of service as procedure code 77054 by any provider. Procedure code 76098 may be reimbursed for both male and female clients.

Computer-aided detection (CAD) procedure codes 77051 and 77052 may be reimbursed in addition to screening and diagnostic mammography.

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Procedure codes 77051 and 77052 are add-on codes and must be submitted with the primary procedure code to be considered for reimbursement. Procedure code 77051 must be submitted for reimbursement with procedure code 77055, 77056, G0204, or G0206. Procedure code 77052 must be submitted for reimbursement with procedure code 77057 or G0202.

Breast ultrasound may be considered for reimbursement using procedure code 76641 or 76642.

Authorization is not required for these services.

The prescribing physician must maintain documentation of medical necessity in the client's medical record. The radiologist or interpreting physician at the testing facility may determine and document that, because of the abnormal result of the diagnostic test performed, additional studies are medically necessary. The radiologist or interpreting physician ordering the additional studies must provide documentation to the prescribing physician.

9.2.15.5 Prognostic Breast and Gynecological Cancer Studies

Prognostic breast and gynecological cancer studies are benefits of Texas Medicaid when ordered by a physician for the purpose of determining the best course of treatment for a patient with breast/gynecological cancers.

Prognostic breast and gynecological cancer studies are divided into three categories: Receptor assays, Her-2/neu, and gene expression profiling.

- Receptor Assays (procedure codes 84233 and 84234) - The estrogen receptor assay (ERA) and the progesterone receptor assay (PRA) are tests in which a tissue sample is exposed to radioactively tagged estrogen or progesterone. The presence of these receptors can have prognostic significance in breast and endometrial cancer.
- Her-2/neu (procedure codes 83950, 88237, 88239, 88271, 88274, 88291, 88341, 88342, 88344, 88360, 88361, 88364, 88365, 88366, 88367, 88368, 88369, 88373, 88374, and 88377) - Human epidermal growth factor receptor 2 (Her-2/neu) is responsible for the production of a protein that signals cell growth. The overexpression of Her-2/neu in breast cancer is associated with decreased overall survival and response to some therapies. Each procedure used in the analysis should be coded separately.
- Gene expression profiling (procedure code 81519) - Gene expression profiling using the Oncotype DX® Breast Cancer Assay analyzes the expression of a panel of 21 genes to predict the likelihood of breast cancer recurrence in clients with newly diagnosed early stage invasive breast cancer.

Reimbursement for procedure codes 84233, 84234, 88360, and 88361 is limited to claims with a diagnosis of breast or uterine cancer as listed in the following table:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
C50011	C50012	C50021	C50022	C50111	C50112	C50121	C50122
C50211	C50212	C50221	C50222	C50311	C50312	C50321	C50322
C50411	C50412	C50421	C50422	C50511	C50512	C50521	C50522
C50611	C50612	C50621	C50622	C50811	C50812	C50821	C50822
C50921	C50922	C540	C541	C542	C543	C548	C792
C7981	D0501	D0502	D0511	D0512	D0581	D0582	

Testing for other diagnoses will be denied.

Interpretation of receptor assays, and Her-2/neu results is not considered separately for reimbursement. Interpretation is part of the physician's E/M service.

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Gene expression profiling (procedure code 81519) is a benefit when all of the following criteria are met:

- The test is ordered by an oncologist.
- The client is a female, with newly diagnosed breast cancer. ("Newly diagnosed" means that not more than six months have elapsed since the initial diagnosis.)
- The clinical stage of the breast cancer is I or II.
- Axillary node biopsy is negative for tumor, and there is no evidence of metastatic breast cancer.
- The primary tumor is estrogen receptor-positive, and Her-2/neu receptor negative, or the primary tumor is Her-2/neu receptor positive and less than 1 cm in diameter.
- The client is a candidate for adjuvant chemotherapy.
- The outcome of the test will guide decision-making regarding adjuvant chemotherapy.
- The client has one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
C50011	C50012	C50111	C50112	C50211	C50212	C50311	C50312
C50411	C50412	C50511	C50512	C50611	C50612	C50811	C50812
D0501	D0502	D0511	D0512	D0581	D0582		

Gene expression profiling is limited to once per lifetime, but may be considered for reimbursement more than once per lifetime for the same client on appeal. The provider must submit documentation that demonstrates that the client has a new, second, primary breast cancer diagnosis that meets the criteria described above.

The provider must maintain documentation of medical necessity in the client's medical record. Retrospective review may be performed to ensure that the documentation supports the medical necessity of the service.

Gene expression profiling is not covered for the following:

- Repeat testing or testing of multiple tumor sites in the same client.
- Use in predicting the likelihood of distant recurrence in male breast cancer.

Tests for gene expression profiling other than Oncotype DX® are considered experimental and investigational, and are not benefits of Texas Medicaid.

9.2.16 Capsulotomy

A capsulotomy is a benefit when not performed with a joint surgery.

9.2.17 Cardiac Rehabilitation

Cardiac rehabilitation is a physician-supervised program that furnishes physician-prescribed exercise, cardiac risk factor modification, psychosocial assessment, and outcomes assessment. Cardiac rehabilitation programs must include all of the following:

- Physician-prescribed exercise for each day on which cardiac rehabilitation items and services are furnished
- Cardiac risk factor modification, including education, counseling, and behavioral intervention, tailored to a client's individual needs
- Psychosocial assessment
- Outcomes assessment

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- An individual treatment plan that specifies how components are used for a client and that is reviewed and signed by the prescribing physician every 30 days

Cardiac rehabilitation procedure codes 93797 and 93798 are benefits of Texas Medicaid.

The appropriate procedure code must be billed with one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
I110	I201	I208	I209	I2101	I2102	I2109	I2111
I2119	I2121	I2129	I213	I214	I220	I221	I222
I228	I229	I501	I5020	I5021	I5022	I5023	I5030
I5031	I5032	I5033	I5040	I5041	I5042	I5043	I509
Z941	Z943	Z951	Z952	Z953	Z954	Z955	Z9861

Coverage of cardiac rehabilitation programs is considered reasonable and necessary only for clients for whom there is documentation of any of the following conditions within the 12 months immediately preceding the beginning of the program:

- Acute myocardial infarction
- Coronary artery bypass surgery (CABG)
- Percutaneous transluminal coronary angioplasty or coronary stenting
- Heart valve repair or replacement
- Major pulmonary surgery
- Sustained ventricular tachycardia or fibrillation
- Class III or class IV congestive heart failure
- Chronic stable angina

Note: *A cardiac rehabilitation program in which the cardiac monitoring is done using telephonically transmitted electrocardiograms (ECGs) to a remote site is not a benefit of Texas Medicaid.*

Cardiac rehabilitation must be provided in a facility that has the necessary cardiopulmonary, emergency, diagnostic, and therapeutic life-saving equipment (e.g., oxygen, cardiopulmonary resuscitation equipment, or defibrillator) available for immediate use.

Cardiac rehabilitation is limited to 2 one-hour sessions per day for 18 weeks per rolling year and can not exceed 36 sessions.

Cardiac rehabilitation may be considered medically necessary beyond 36 sessions if the client has another documented cardiac event or if the prescribing physician documents that a continuation of cardiac rehabilitation is medically necessary. To confirm that a continuation of cardiac rehabilitation is at the request of or is coordinated with the prescribing physician, the medical record must include evidence of communication between the cardiac rehabilitation staff and the prescribing physician. If the physician responsible for such follow-up is the medical director, then the physician's notes must be evident in each client's chart.

Additional cardiac rehabilitation sessions must be prior authorized and must not exceed a total of 36 sessions for 52 weeks from the date of authorization of additional sessions.

If no clinically-significant arrhythmia is documented during the first three weeks of the program, the physician may give the order for the client to complete the remaining portion of the cardiac rehabilitation without telemetry monitoring.

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Although cardiac rehabilitation may be considered a form of physical therapy, it is a specialized program that is conducted by personnel who are not physicians but are trained in both basic and advanced cardiac life support techniques and exercise therapy for coronary disease and who provide the services under the direct supervision of a physician.

Direct supervision of a physician means that a physician must be immediately available and accessible for medical consultations and emergencies at all times when items and services are being furnished under cardiac rehabilitation programs.

9.2.17.1 Prior Authorization for Cardiac Rehabilitation

Prior authorization is not required for the initial 36 sessions of cardiac rehabilitation.

Cardiac rehabilitation may be considered medically necessary beyond 36 sessions in the following circumstances:

- The medical record must support the client has had another cardiac event; or
- The prescribing physician documents that a continuation of cardiac rehabilitation is medically necessary. Documentation must include the following:
  - Progress made from the beginning of cardiac rehabilitation period to the current service request date, including progress towards previous goals.
  - Information that supports the client's capability of continued measurable progress.
  - A proposed treatment plan for the requested extension dates with specific goals related to the client's individual needs.

Requests for prior authorization for additional sessions that exceed a total of 36 sessions in 52 weeks will not be granted. Prior authorization must be obtained through the TMHP Special Medical Prior Authorization (SMPA) Department.

9.2.17.2 Reimbursement

The evaluation provided by the cardiac rehabilitation team at the beginning of each cardiac rehabilitation session is not considered a separate service and will be included in the reimbursement for the cardiac rehabilitation session. Evaluation and management (E/M) services unrelated to cardiac rehabilitation may be billed with modifier 25 appended to the E/M code when a separately identifiable E/M service was provided on the same day by the provider that rendered cardiac rehabilitation. 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 Texas Medicaid upon request.

Physical and occupational therapy will not be reimbursed when furnished in addition to cardiac rehabilitation exercise program services unless there is also a diagnosis of a non-cardiac condition that requires such therapy, e.g., a client who is recuperating from an acute phase of heart disease and may have had a stroke that requires physical and/or occupational therapy.

Client education services, such as formal lectures and counseling on diet, nutrition, and sexual activity, that help a client adjust living habits because of the cardiac condition; will not be separately reimbursed when the services are provided as part of the cardiac rehabilitation program.

9.2.18 Casting, Splinting, and Strapping

Casting, splinting, and strapping supplies are considered part of the procedure and are not reimbursed separately. The following procedure codes for casting, splinting, and strapping are a benefit of Texas Medicaid:

Procedure Codes									
29000	29010	29015	29035	29040	29044	29046	29049	29055	29058
29065	29075	29085	29086	29105	29125	29126	29130	29131	29200

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Procedure Codes									
29220	29240	29260	29280	29305	29325	29345	29355	29358	29365
29405	29425	29435	29440	29445	29450	29505	29515	29520	29530
29540	29550	29580							

When a claim for casting, splinting, or strapping is submitted with the same date of service as a surgery, the surgery may be reimbursed and the procedure codes listed in the table above will be denied as part of another procedure.

The replacement of a cast, splint, or strapping is not included in the original surgical fee and may be reimbursed separately. Reimbursement for cast removal, windowing, wedging, or repair will be denied if submitted for reimbursement within six weeks of the initial cast application, splinting, or strapping by the same provider.

Procedure Codes					
29700	29705	29710	29720	29730	29740

The following procedure codes for cast removal, windowing, wedging, or repair may be reimbursed to a provider other than the provider who applied the initial cast, splint, or strap:

Procedure Codes							
29700	29705	29710	29720	29730	29740	29750	29799

Authorization is not required for casting, splinting, or strapping services.

The following table includes the procedure codes that will be denied when submitted for reimbursement with other casting, splinting, and strapping procedure codes:

Procedure Codes That Will Be Denied	When Submitted With Any of These Procedure Codes
36000, 36410, 37202, 51701, 51702, 51703, 62318, 62319, 64415, 64416, 64417, 64450, 96360, 96365, 96372, 96374, or 96375	29000, 29010, 29015, 29035, 29040, 29044, 29046, 29049, 29055, 29058, 29065, 29075, 29085, 29086, 29105, 29125, 29126, 29130, 29131, 29200, 29220, 29240, 29260, 29280, 29305, 29325, 29345, 29355, 29358, 29365, 29405, 29425, 29435, 29440, 29445, 29450, 29505, 29515, 29520, 29530, 29540, 29550, 29580, 29700, 29705, 29710, 29720, 29730, 29740, 29750, or 29799
29035	29040, 29044, or 29046
29044	29046
29075	29065, 29105, or 29425
29085, 29125, 29126, or 29705	29065 or 29075
29105	29065
11055, 11056, 11057, or 29125	29425
12001, 12002, 12035, 29125, or 29705	29105
12001, 28190, 28192, 28193, 29130, 29131, 29260, or 29700	29075
29705	29435
12002	29125, 29530, or 29580
12001, 12032, 12042, 12044, 13121, 13132, 29130, or 29260	29125
29305	29325

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Procedure Codes That Will Be Denied	When Submitted With Any of These Procedure Codes
29365 or 29425	29345
29405	29345, 29425, or 29740
29345, 29365, 29405, or 29425	29355
29440, 29580, 29700, or 29705	29405 or 29425
29580	29515 or 29705
29730	29405
29540	29425, 29505, 29515, or 29580
29730 or 29740	29445
29515	29505
11055, 11056, or 29550	29515
11900, 12004, or 29550	29540
12004, 15852, 29550, or 29700	29580
G0127, 11719, or 11900	29550
15852	29705

9.2.19 Cardiopulmonary Resuscitation (CPR)

CPR (procedure code 92950) is a benefit of Texas Medicaid and may be reimbursed when medical necessity is documented in the client's medical record. Only the primary provider performing CPR may be reimbursed for procedure code 92950. CPR billed as an ambulance service by an ambulance provider will be denied.

CPR may be billed with the same date of service as critical care when reported as a separately identifiable procedure. The time spent performing CPR must not be included in the time reported as critical care.

9.2.20 Chemotherapy

Chemotherapy infusion procedure codes listed in the following table are comprehensive codes that include all supplies, catheters, and solutions necessary to safely administer the necessary chemotherapeutic agents either by or under the supervision of the physician, but do not include the provision of the chemotherapeutic agents:

Procedure Codes									
96401	96402	96405	96406	96409	96411	96413	96415	96416	96417
96420	96422	96423	96425	96440	96446	96450	96521	96522	96523
96542	96549								

The appropriate E/M procedure code must be billed by a physician for a face-to-face visit with the patient to review chemotherapy options.

9.2.20.1 Chemotherapy Procedure Codes

Procedure code 51720 should be used for intravesical instillation of anti carcinogenic agents into the bladder including retention time.

The chemotherapy administration procedure codes 96440, 96446, and 96450 include payment for the surgical procedure; separate reimbursement for the surgical codes will not be allowed. These procedure codes may be paid in addition to E/M procedure codes billed on the same day, regardless of the place of service billed.

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Chemotherapeutic drugs and other injections given in the course of chemotherapy may be billed separately and reimbursed using the appropriate procedure codes.

For the first 15 minutes, up to the first hour of chemotherapy infusion, procedure code 96409 or 96413 must be used for a single or initial chemotherapeutic medication. Procedure code 96411 must be used for each additional chemotherapeutic medication given and must be billed with procedure code 96409 or 96413.

Procedure code 96415 must be used for each additional hour beyond the initial hour and must be used in conjunction with procedure code 96413.

Procedure code 96417 must be used for one additional hour per subsequent infusion and must be used in conjunction with procedure code 96413. Procedure code 96415 may be used for each additional hour.

Procedure code 96425 must be used when initiating an infusion that will take more than eight 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.

Chemotherapy administration by push technique (procedure codes 96409 and 96420) and by infusion technique (procedure codes 96413 and 96422) are reimbursed when billed for the same date of service.

Only one intravenous push administration (procedure code 96409) and only one intra-arterial push administration (procedure code 96420) will be allowed per day, regardless of whether separate drugs are given.

Evaluation and management (E/M) services related to other services and procedures being performed may be billed with modifier 25 appended to the E/M code. Documentation that supports the provision of that significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request. Modifier 25 use is subject to retrospective review.

Prolonged infusion of chemotherapeutic agents is reimbursed using procedure codes 95991, 96413, 96415, 96416, 96417, 96422, 96423, and 96425.

Inpatient and outpatient hospitals must use revenue code 636 for the reimbursement of the technical component. The appropriate chemotherapy procedure code must be listed on the claim.

9.2.21 Circumcisions

Texas Medicaid may provide reimbursement for circumcisions billed with procedure code 54150 or procedure code 54161. Circumcisions performed on clients who are 1 year of age and older must be documented with medical necessity.

Refer to: Subsection 9.2.45.1, "Circumcisions for Newborns," in this handbook for additional benefit information.

9.2.22 Closure of Wounds

The repair of wounds is defined as simple, intermediate, or complex. Simple repair involves the dermis and subcutaneous tissue and requires a one-layer closure. Intermediate repair requires some layered closure of deeper layers of subcutaneous tissue and superficial fascia. Complex repair involves more layered closure, debridement, extensive undermining, stints, or retention sutures.

Wound closures may use sutures, staples, or tissue adhesives. Wounds closed with adhesive strips must not be reported using wound closure procedure codes. When adhesive strips are the only wound closure material used, providers must report the most appropriate E/M visit procedure code on their claim.

Simple exploration of nerves, blood vessels, or tendons exposed in an open wound is considered inclusive to the wound closure and will not be reimbursed separately.

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The lengths of multiple closures of wounds must be added together and billed as one procedure code if they meet at least one of the following criteria:

- The closures have the same CPT classification (see "Repair [Closure]" in the CPT manual).
- The closures are in anatomic sites that are grouped together in the same procedure code descriptor.

Providers must submit the procedure code that represents the total length of the repairs. Lengths of repairs from different CPT classifications or groupings of anatomic sites must be billed as separate procedure codes.

Wound closures must be billed using the following procedure codes:

Procedure Codes									
Repair Simple									
12001	12002	12004	12005	12006	12007	12011	12013	12014	12015
12016	12017	12018	12020	12021					
Repair Intermediate									
12031	12032	12034	12035	12036	12037	12041	12042	12044	12045
12046	12047	12051	12052	12053	12054	12055	12056	12057	
Repair Complex									
13100	13101	13102	13120	13121	13122	13131	13132	13133	13151
13152	13153	13160							

Multiple wounds on the same day will be paid the full allowed amount for the major (largest total length of the repair at the same anatomic site) wound and one-half the allowed amount for each additional laceration (total length of the repair at the same anatomic site).

No separate payment will be made for incision closures billed in addition to a surgical procedure when the closure is part of that surgical procedure.

No separate payment will be made for supplies in the office.

When the debridement is carried out separately without immediate primary closure, when gross contamination requires prolonged cleansing, or when large amounts of devitalized or contaminated tissue are removed, debridement may be reimbursed separately. Debridement rendered during the same surgical session as wound closure is considered inclusive to the closure and is not reimbursed separately.

Refer to: Subsection 9.2.71.11, "Supplies, Trays, and Drugs," in this handbook for the hospital-based emergency department.

Wound suture and wound closure are considered part of any surgical procedure performed on the same area, except for excision of benign or malignant lesion procedure codes that require more than simple closure. Providers may be reimbursed for the appropriate intermediate or complex closure procedure code. Multiple surgery guidelines apply.

The exceptions listed above apply to the following excision and closure procedure codes:

Excision of Benign Lesion Procedure Code									
11400	11401	11402	11403	11404	11406	11420	11421	11422	11423
11424	11426	11440	11441	11442	11443	11444	11446		

Excision of Malignant Lesion Procedure Codes									
11600	11601	11602	11603	11604	11606	11620	11621	11622	11623

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Excision of Malignant Lesion Procedure Codes							
11624	11626	11640	11641	11642	11643	11644	11646

Intermediate Closure Procedure Codes									
12031	12032	12034	12035	12036	12037	12041	12042	12044	12045
12046	12047	12051	12052	12053	12054	12055	12056	12057	

Complex Closure Procedure Codes									
13100	13101	131022	13120	13121	13122	13131	13132	13133	13151
13152	13153	13160							

9.2.23 Cochlear Implants

Cochlear implants, when medically indicated, are benefits of Texas Medicaid with prior authorization. A cochlear implant device (procedure code 69930) is an electronic instrument, part of which is implanted surgically to stimulate auditory nerve fibers, and part of which is worn externally to capture and amplify sound. These devices are available in single and multichannel models. Cochlear implants are used to provide awareness and identification of sound and to facilitate communication for persons who are profoundly hearing impaired.

Refer to: Subsection 3.2.1, "Cochlear Implants," in the *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information on benefit and authorization requirements for cochlear implants.

9.2.24 Continuous Glucose Monitoring (CGM)

CGM (procedure codes 95250 and 95251) is a benefit of Texas Medicaid with prior authorization.

Procedure codes 95250 and 95251 are limited to once per 12 calendar months by any provider.

The rental or purchase of a continuous glucose monitoring system (CGMS) is considered part of the CGM and is not reimbursed separately.

9.2.24.1 Prior Authorization for Continuous Glucose Monitoring

CGM requires prior authorization and must be prescribed by a physician performing the glucose monitoring.

CGM may be prior authorized for clients with Type I diabetes or diabetes during pregnancy, including gestational diabetes. The client must be compliant with his or her current medical regimen, use insulin injections three or more times per day or be on an insulin pump, and have documented self-blood glucose monitoring at least four times per day. At least one or more of the following conditions must also be present:

- Frequent unexplained hypoglycemic episodes
- Unexplained large fluctuations in daily, preprandial blood glucose
- Episodes of ketoacidosis or hospitalization for uncontrolled glucose

Additional CGM services may be considered with documentation of medical necessity that indicates the client meets the criteria above and has a change in condition that would warrant a second procedure within 12 calendar months.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the requested services. 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 use of CGM.

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9.2.25 Developmental and Neurological Assessment and Testing

The following types of developmental and neurological assessment and testing are benefits of Texas Medicaid when medically necessary:

- Assessment of aphasia (procedure code 96105)
- Developmental screening when performed outside of a Texas Health Steps (THSteps) medical checkup (procedure code 96110)
- Developmental testing (procedure code 96111)
- Neurobehavioral testing (procedure code 96116)

The physician must maintain documentation of medical necessity in the client's medical record. Retrospective review may be performed to ensure that the documentation supports the medical necessity of the service. The following information is required at least every six months to establish medical necessity:

- The physician's prescription that includes a description of the specific service being prescribed
- The treatment plan that includes a copy of the current evaluation and documented age of the child at the time of the evaluation

Re-evaluations are a benefit of Texas Medicaid only to address a clinical need, to provide the documentation needed to measure a client's status over time, and to direct the plan of care.

Procedure codes 96105, 96110, 96111, and 96116 are used to report medically necessary developmental and neurological assessment and testing.

Administration of the Mini-Mental State Exam (MMSE) is considered part of an E/M service and will not be reimbursed separately.

Prior authorization is not required for aphasia assessment, developmental screening, developmental testing, and neurobehavioral status exam.

9.2.25.1 Assessment of Aphasia

Aphasia assessment (procedure code 96105) is a benefit of Texas Medicaid when medically necessary and is limited to diagnosis codes R4701, R4702, R471, R4781, and R4789. Procedure code 96105 is limited to two services per rolling year, any provider.

9.2.25.2 Developmental Screening

Developmental screening using a recommended standardized screening tool (procedure code 96110) is a benefit of Texas Medicaid for clients who are birth through 20 years of age. Separate reimbursement for developmental screening completed without the use of one of the recommended standardized screening tools is not a benefit.

Developmental screening is limited to once per rolling year, any provider, outside of a THSteps medical checkup when medically necessary. This screening should only be completed for a diagnosis of suspected developmental delay or to evaluate a change in the client's developmental status outside of a THSteps medical checkup.

Developmental screening should be used to identify clients who are birth through 6 years of age and who may need a more comprehensive evaluation. Results of developmental screening may guide or identify the need for further testing. Clients who have 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) within 48 hours.

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Refer to: Subsection 2.7, "Early Childhood Intervention (ECI) Services," in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information on the Texas ECI program.

Subsection 5.3.11.1.2, "Developmental Surveillance or Screening," in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information on developmental screening for THSteps checkups.

Standardized screening (procedure code 96110) is not a benefit when completed to meet day care, Head Start, or school program requirements unless completed during an acute care visit in a clinic setting.

9.2.25.3 Developmental Testing

Developmental testing (procedure code 96111) is a benefit of Texas Medicaid for clients who are birth through 20 years of age.

Developmental testing must consist of an extended evaluation and include the use of a standardized assessment tool. Developmental testing is medically necessary when there is suspected developmental delay supported by clinical evidence. Developmental testing is only medically indicated when clinical evidence suggests the following:

- Suspected developmental delay or atypical development cannot be clearly diagnosed 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.

Procedure code 96111 is limited to two services per rolling year, any provider.

Developmental testing performed when a development delay or a change in the client's developmental status is not suspected, is not a benefit of Texas Medicaid. Standardized testing (procedure code 96111) is not a benefit when completed to meet day care, Head Start, or school program requirements unless completed during an acute care visit in a clinic setting.

Providers cannot bill the client for developmental testing that is considered developmental screening.

9.2.25.4 Neurobehavioral Testing

A neurobehavioral examination (procedure code 96116) is a benefit of Texas Medicaid only when a medical or psychiatric diagnosis exists that establishes the need for a detailed evaluation of neurological impairment. Neurobehavioral testing is not medically necessary if a clinical interview alone would provide all the necessary diagnostic information.

Neurobehavioral testing is limited to the diagnosis codes or combination diagnosis codes listed in the following table:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
A8100	A8101	A8109	A8181	A8183	A8189	A819	B1001
B1009	B451	D8681	E7500	E7501	E7502	E7509	E7510
E7511	E7519	E7523	E7525	E7529	E754	F0150	F0151
F0280	F0281	F0390	F0391	F04	F05	F060	F061
F062	F0630	F0631	F0632	F0633	F0634	F064	F068
F070	F0781	F0789	F09	F1010	F10121	F1014	F10150
F10180	F10181	F10188	F1019	F1020	F10221	F1024	F10250
F1026	F1027	F10280	F10281	F10288	F1029	F10921	F1094
F10950	F1096	F1097	F10980	F10981	F10988	F1099	F1110
F11121	F11150	F11151	F1120	F11220	F11221	F11229	F1123

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
F11250	F11251	F11920	F11921	F11929	F1193	F11950	F11951
F1210	F12120	F12121	F12129	F12150	F12151	F12220	F12221
F12229	F12250	F12251	F1290	F12920	F12921	F12929	F12950
F12951	F1310	F13120	F13121	F13129	F13150	F13151	F13220
F13221	F13229	F13230	F13231	F13232	F13239	F13250	F13251
F13920	F13921	F13929	F13930	F13931	F13932	F13939	F13950
F13951	F1410	F14120	F14121	F14129	F14150	F14151	F14182
F14220	F14221	F14229	F1423	F14250	F14251	F14920	F14921
F14929	F14950	F14951	F1510	F15120	F15121	F15129	F15150
F15151	F15220	F15221	F15229	F1523	F15250	F15251	F15920
F15921	F15929	F1593	F15950	F15951	F1610	F16121	F16129
F16150	F16151	F16220	F16221	F16229	F16250	F16251	F16920
F16921	F16929	F16950	F16951	F17203	F17213	F17223	F17293
F1810	F18120	F18121	F18129	F18150	F18151	F18220	F18221
F18229	F18250	F18251	F18920	F18921	F18929	F18950	F18951
F1910	F19120	F19121	F19129	F19150	F19151	F1919	F19220
F19221	F19229	F19230	F19231	F19232	F19239	F19250	F19251
F1929	F19920	F19921	F19929	F19930	F19931	F19932	F19939
F19950	F19951	F1999	F200	F201	F202	F203	F205
F2081	F2089	F209	F21	F22	F23	F24	F250
F251	F258	F259	F28	F29	F3010	F3011	F3012
F3013	F302	F303	F304	F308	F309	F3110	F3111
F3112	F3113	F312	F3130	F3131	F3132	F314	F315
F3160	F3161	F3162	F3163	F3164	F3170	F3173	F3174
F3175	F3176	F3177	F3178	F3181	F3189	F319	F320
F321	F322	F323	F324	F325	F328	F329	F330
F331	F332	F333	F3341	F3342	F338	F339	F340
F341	F348	F349	F39	F4001	F4002	F4010	F4011
F40210	F40218	F40220	F40228	F40230	F40231	F40232	F40233
F40240	F40241	F40242	F40243	F40248	F40290	F40291	F40298
F408	F409	F410	F411	F413	F418	F419	F42
F430	F4310	F4311	F4312	F4320	F4321	F4322	F4323
F4324	F4325	F4329	F438	F439	F440	F441	F442
F444	F445	F446	F447	F4481	F4489	F449	F450
F451	F4520	F4521	F4522	F4529	F4541	F4542	F458
F459	F481	F482	F488	F489	F5000	F5001	F5002
F502	F508	F509	F5101	F5102	F5103	F5104	F5105
F5109	F5111	F5112	F5113	F5119	F513	F514	F515
F518	F519	F520	F521	F5221	F5222	F5231	F5232
F524	F525	F526	F528	F529	F53	F600	F601

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
F602	F603	F604	F605	F606	F607	F6081	F6089
F609	F630	F631	F632	F633	F6381	F6389	F639
F641	F642	F648	F649	F650	F651	F652	F653
F654	F6551	F6552	F6581	F6589	F659	F66	F6810
F6811	F6812	F6813	F688	F70	F71	F72	F73
F79	F801	F802	F804	F819	F82	F840	F842
F843	F845	F848	F849	F88	F89	F900	F901
F902	F908	F909	F910	F911	F912	F913	F918
F919	F930	F938	F939	F940	F941	F942	F948
F950	F951	F952	F958	F959	F980	F981	F9821
F9829	F983	F984	F985	F988	F989	G000	G001
G002	G003	G008	G009	G01	G02	G030	G031
G032	G038	G039	G0400	G0401	G0402	G042	G0430
G0431	G0432	G0439	G0481	G0489	G0490	G0491	G053
G054	G060	G061	G062	G07	G210	G300	G301
G308	G309	G3101	G3109	G311	G3181	G3182	G3183
G3185	G319	G3289	G35	G40001	G40009	G40011	G40019
G40101	G40109	G40111	G40119	G40201	G40209	G40211	G40219
G40301	G40309	G40311	G40319	G40501	G40509	G40801	G40802
G40803	G40804	G40811	G40812	G40813	G40814	G40821	G40822
G40823	G40824	G4089	G40901	G40909	G40911	G40919	G40A01
G40A09	G40A11	G40A19	G40B01	G40B09	G40B11	G40B19	G450
G451	G452	G454	G458	G459	G468	G910	G911
G912	G92	G930	G931	G9340	G9341	G9349	G937
G9381	G9389	G939	G94	H93291	H93292	H93293	I6000
I6001	I6002	I6010	I6011	I6012	I6020	I6021	I6022
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	I6300	I63011	I63012	I63019	I6302	I63031
I63032	I63039	I6309	I6310	I63111	I63112	I63119	I6312
I63131	I63132	I63139	I6319	I6320	I63211	I63212	I63219
I6322	I63231	I63232	I63239	I6329	I6330	I63311	I63312
I63319	I63321	I63322	I63329	I63331	I63332	I63339	I63341
I63342	I63349	I6339	I6340	I63411	I63412	I63419	I63421
I63422	I63429	I63431	I63432	I63439	I63441	I63442	I63449
I6349	I6350	I63511	I63512	I63519	I63521	I63522	I63529
I63531	I63532	I63539	I63541	I63542	I63549	I6359	I6501
I6502	I6503	I6509	I651	I6521	I6522	I6523	I6529
I658	I659	I6601	I6602	I6603	I6609	I6611	I6612

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
I6613	I6619	I6621	I6622	I6623	I6629	I663	I668
I669	I671	I672	I674	I675	I676	I677	I6781
I6782	I6789	I679	I680	I682	I688	I6900	I6901
I69020	I69021	I69022	I69023	I69028	I69031	I69032	I69033
I69034	I69039	I69041	I69042	I69043	I69044	I69049	I69051
I69052	I69053	I69054	I69059	I69061	I69062	I69063	I69064
I69065	I69069	I69090	I69091	I69092	I69093	I69098	I6910
I6911	I69120	I69121	I69122	I69123	I69128	I69131	I69132
I69133	I69134	I69139	I69141	I69142	I69143	I69144	I69149
I69151	I69152	I69153	I69154	I69159	I69161	I69162	I69163
I69164	I69165	I69169	I69190	I69191	I69192	I69193	I69198
I6920	I6921	I69220	I69221	I69222	I69223	I69228	I69231
I69232	I69233	I69234	I69239	I69241	I69242	I69243	I69244
I69249	I69251	I69252	I69253	I69254	I69259	I69261	I69262
I69263	I69264	I69265	I69269	I69290	I69291	I69292	I69293
I69298	I6930	I6931	I69320	I69321	I69322	I69323	I69328
I69331	I69332	I69333	I69334	I69339	I69341	I69342	I69343
I69344	I69349	I69351	I69352	I69353	I69354	I69359	I69361
I69362	I69363	I69364	I69365	I69369	I69390	I69391	I69392
I69393	I69398	I6980	I6981	I69820	I69821	I69822	I69823
I69828	I69831	I69832	I69833	I69834	I69839	I69841	I69842
I69843	I69844	I69849	I69851	I69852	I69853	I69854	I69859
I69861	I69862	I69863	I69864	I69865	I69869	I69890	I69891
I69892	I69893	I69898	I6990	I6991	I69920	I69921	I69922
I69923	I69928	I69931	I69932	I69933	I69934	I69939	I69941
I69942	I69943	I69944	I69949	I69951	I69952	I69953	I69954
I69959	I69961	I69962	I69963	I69964	I69965	I69969	I69990
I69991	I69992	I69993	I69998	P102	P103	P520	P521
P5221	P5222	P523	P525	P84	P90	P9160	P9161
P9162	P9163	R0901	R0902	R37	R41840	R41841	R41842
R41843	R41844	R4189	R450	R453	R454	R45850	R45851
R4586	R4587	R4589	R5600	R569	S060X0A	S060X0D	S060X0S
S060X1A	S060X1D	S060X1S	S060X2A	S060X2D	S060X2S	S060X3A	S060X3D
S060X3S	S060X4A	S060X4D	S060X4S	S060X5A	S060X5D	S060X5S	S060X6A
S060X6D	S060X6S	S060X9A	S060X9D	S060X9S	S06306A	S06306D	S06306S
S06310A	S06310D	S06310S	S06311A	S06311D	S06311S	S06312A	S06312D
S06312S	S06313A	S06313D	S06313S	S06314A	S06314D	S06314S	S06315A
S06315D	S06315S	S06316A	S06316D	S06316S	S06319A	S06319D	S06319S
S06320A	S06320D	S06320S	S06321A	S06321D	S06321S	S06322A	S06322D
S06322S	S06323A	S06323D	S06323S	S06324A	S06324D	S06324S	S06325A

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
S06325D	S06325S	S06326A	S06326D	S06326S	S06329A	S06329D	S06329S
S06330A	S06330D	S06330S	S06331A	S06331D	S06331S	S06332A	S06332D
S06332S	S06333A	S06333D	S06333S	S06334A	S06334D	S06334S	S06335A
S06335D	S06335S	S06336A	S06336D	S06336S	S06339A	S06339D	S06339S
S06340A	S06340D	S06340S	S06341A	S06341D	S06341S	S06342A	S06342D
S06342S	S06343A	S06343D	S06343S	S06344A	S06344D	S06344S	S06345A
S06345D	S06345S	S06346A	S06346D	S06346S	S06349A	S06349D	S06349S
S06350A	S06350D	S06350S	S06351A	S06351D	S06351S	S06352A	S06352D
S06352S	S06353A	S06353D	S06353S	S06354A	S06354D	S06354S	S06355A
S06355D	S06355S	S06356A	S06356D	S06356S	S06359A	S06359D	S06359S
S06360A	S06360D	S06360S	S06361A	S06361D	S06361S	S06362A	S06362D
S06362S	S06363A	S06363D	S06363S	S06364A	S06364D	S06364S	S06365A
S06365D	S06365S	S06366A	S06366D	S06366S	S06369A	S06369D	S06369S
S06370A	S06370D	S06370S	S06371A	S06371D	S06371S	S06372A	S06372D
S06372S	S06373A	S06373D	S06373S	S06374A	S06374D	S06374S	S06375A
S06375D	S06375S	S06376A	S06376D	S06376S	S06379A	S06379D	S06379S
S06380A	S06380D	S06380S	S06381A	S06381D	S06381S	S06382A	S06382D
S06382S	S06383A	S06383D	S06383S	S06384A	S06384D	S06384S	S06385A
S06385D	S06385S	S06386A	S06386D	S06386S	S06389A	S06389D	S06389S
S064X0A	S064X0D	S064X0S	S064X1A	S064X1D	S064X1S	S064X2A	S064X2D
S064X2S	S064X3A	S064X3D	S064X3S	S064X4A	S064X4D	S064X4S	S064X5A
S064X5D	S064X5S	S064X6A	S064X6D	S064X6S	S064X9A	S064X9D	S064X9S
S065X0A	S065X0D	S065X0S	S065X1A	S065X1D	S065X1S	S065X2A	S065X2D
S065X2S	S065X3A	S065X3D	S065X3S	S065X4A	S065X4D	S065X4S	S065X5A
S065X5D	S065X5S	S065X6A	S065X6D	S065X6S	S065X7A	S065X7D	S065X7S
S065X8A	S065X8D	S065X8S	S065X9A	S065X9D	S065X9S	S066X0A	S066X0D
S066X0S	S066X1A	S066X1D	S066X1S	S066X2A	S066X2D	S066X2S	S066X3A
S066X3D	S066X3S	S066X4A	S066X4D	S066X4S	S066X5A	S066X5D	S066X5S
S066X6A	S066X6D	S066X6S	S066X9A	S066X9D	S066X9S	S06890A	S06890D
S06890S	S06891A	S06891D	S06891S	S06892A	S06892D	S06892S	S06893A
S06893D	S06893S	S06894A	S06894D	S06894S	S06895A	S06895D	S06895S
S06896A	S06896D	S06896S	S06897A	S06897D	S06897S	S06899A	S06899D
S06899S	S069X0A	S069X0D	S069X0S	S069X1A	S069X1D	S069X1S	S069X2A
S069X2D	S069X2S	S069X3A	S069X3D	S069X3S	S069X4A	S069X4D	S069X4S
S069X5A	S069X5D	S069X5S	S069X6A	S069X6D	S069X6S	S069X9A	S069X9D
S069X9S	T5801xA	T5801xD	T5801xS	T5802xA	T5802xD	T5802xS	T5803xA
T5803xD	T5803xS	T5804xA	T5804xD	T5804xS	T5811xA	T5811xD	T5811xS
T5812xA	T5812xD	T5812xS	T5813xA	T5813xD	T5813xS	T5814xA	T5814xD
T5814xS	T582X1A	T582X1D	T582X1S	T582X2A	T582X2D	T582X2S	T582X3A
T582X3D	T582X3S	T582X4A	T582X4D	T582X4S	T588X1A	T588X1D	T588X1S

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
T588X2A	T588X2D	T588X2S	T588X3A	T588X3D	T588X3S	T588X4A	T588X4D
T588X4S	T5891xA	T5891xD	T5891xS	T5892xA	T5892xD	T5892xS	T5893xA
T5893xD	T5893xS	T5894xA	T5894xD	T5894xS	T71111A	T71111D	T71111S
T71112A	T71112D	T71112S	T71113A	T71113D	T71113S	T71114A	T71114D
T71114S	T71121A	T71121D	T71121S	T71122A	T71122D	T71122S	T71123A
T71123D	T71123S	T71124A	T71124D	T71124S	T71131A	T71131D	T71131S
T71132A	T71132D	T71132s	T71133A	T71133D	T71133S	T71134A	T71134D
T71134S	T71141A	T71141D	T71141S	T71143A	T71143D	T71143S	T71144A
T71144D	T71144S	T71151A	T71151D	T71151S	T71152A	T71152D	T71152S
T71153A	T71153D	T71153S	T71154A	T71154D	T71154S	T71161A	T71161D
T71161S	T71162A	T71162D	T71162S	T71163A	T71163D	T71163S	T71164A
T71164D	T71164S	T71191A	T71191D	T71191S	T71192A	T71192D	T71192S
T71193A	T71193D	T71193S	T71194A	T71194D	T71194S	T7120XA	T7120XD
T7120XS	T7121XA	T7121XD	T7121XS	T71221A	T71221D	T71221S	T71222A
T71222D	T71222S	T71223A	T71223D	T71223S	T71224A	T71224D	T71224S
T71231A	T71231D	T71231S	T71232A	T71232D	T71232S	T71233A	T71233D
T71233S	T71234A	T71234D	T71234S	T7129XA	T7129XD	T7129XS	T719XXA
T719XXD	T719XXS	T751XXA	T751XXD	T751XXS	Z134	Z13850	Z13858
Z1389	Z634	Z658	Z69021	Z6982	Z72810	Z72811	Z73810
Z73811	Z73812	Z73819	Z818	Z8651	Z8659	Z87820	Z87890

Combination Diagnosis Codes (Must be submitted in pairs)							
F0390 F05	S0190XA S06330A	S0190XA S06331A	S0190XA S06332A	S0190XA S06333A	S0190XA S06334A	S0190XA S06335A	S0190XA S06336A
S0190XA S06339A	S0190XA S06360A	S0190XA S06361A	S0190XA S06362A	S0190XA S06363A	S0190XA S06364A	S0190XA S06365A	S0190XA S06366A
S0190XA S06369A	S0190XA S06370A	S0190XA S06371A	S0190XA S06372A	S0190XA S06373A	S0190XA S06374A	S0190XA S06375A	S0190XA S06376A
S0190XA S06379A	S0190XA S06380A	S0190XA S06381A	S0190XA S06382A	S0190XA S06383A	S0190XA S06384A	S0190XA S06385A	S0190XA S06386A
S0190XA S06389A	S0190XA S064X0A	S0190XA S064X1A	S0190XA S064X2A	S0190XA S064X3A	S0190XA S064X4A	S0190XA S064X5A	S0190XA S064X6A
S0190XA S064X9A	S0190XA S065X0A	S0190XA S065X1A	S0190XA S065X2A	S0190XA S065X3A	S0190XA S065X4A	S0190XA S065X5A	S0190XA S065X6A
S0190XA S065X9A	S0190XA S066X0A	S0190XA S066X1A	S0190XA S066X2A	S0190XA S066X3A	S0190XA S066X4A	S0190XA S066X5A	S0190XA S066X6A
S0190XA S066X9A	S0190XA S06890A	S0190XD S06330D	S0190XD S06331D	S0190XD S06332D	S0190XD S06333D	S0190XD S06334D	S0190XD S06335D
S0190XD S06336D	S0190XD S06339D	S0190XD S06360D	S0190XD S06361D	S0190XD S06362D	S0190XD S06364D	S0190XD S06363D	S0190XD S06365D
S0190XD S06366D	S0190XD S06369D	S0190XD S06370D	S0190XD S06371D	S0190XD S06372D	S0190XD S06373D	S0190XD S06374D	S0190XD S06375D
S0190XD S06376D	S0190XD S06379D	S0190XD S06380D	S0190XD S06381D	S0190XD S06382D	S0190XD S06383D	S0190XD S06384D	S0190XD S06385D

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Combination Diagnosis Codes (Must be submitted in pairs)							
S0190XD S06386D	S0190XD S06389D	S0190XD S064X0D	S0190XD S064X1D	S0190XD S064X2D	S0190XD S064X3D	S0190XD S064X4D	S0190XD S064X5D
S0190XD S064X6D	S0190XD S064X9D	S0190XD S065X0D	S0190XD S065X1D	S0190XD S065X2D	S0190XD S065X4D	S0190XD S065X3D	S0190XD S065X5D
S0190XD S065X6D	S0190XD S065X9D	S0190XD S066X0D	S0190XD S066X1D	S0190XD S066X2D	S0190XD S066X3D	S0190XD S066X4D	S0190XD S066X5D
S0190XD S066X6D	S0190XD S066X9D	S0190XD S06890D	S0190XS S06330S	S0190XS S06331S	S0190XS S06332S	S0190XS S06333S	S0190XS S06334S
S0190XS S06335S	S0190XS S06336S	S0190XS S06339S	S0190XS S06360S	S0190XS S06361S	S0190XS S06362S	S0190XS S06363S	S0190XS S06364S
S0190XS S06365S	S0190XS S06366S	S0190XS S06369S	S0190XS S06370S	S0190XS S06371S	S0190XS S06372S	S0190XS S06373S	S0190XS S06374S
S0190XS S06375S	S0190XS S06376S	S0190XS S06379S	S0190XS S06380S	S0190XS S06381S	S0190XS S06382S	S0190XS S06383S	S0190XS S06384S
S0190XS S06385S	S0190XS S06386S	S0190XS S06389S	S0190XS S064X0S	S0190XS S064X1S	S0190XS S064X2S	S0190XS S064X3S	S0190XS S064X4S
S0190XS S064X5S	S0190XS S064X6S	S0190XS S064X9S	S0190XS S065X0S	S0190XS S065X1S	S0190XS S065X2S	S0190XS S065X3S	S0190XS S065X4S
S0190XS S065X5S	S0190XS S065X6S	S0190XS S065X9S	S0190XS S066X0S	S0190XS S066X1S	S0190XS S066X2S	S0190XS S066X3S	S0190XS S066X4S
S0190XS S066X5S	S0190XS S066X6S	S0190XS S066X9S	S0190XS S06890S				

Testing performed for other diagnoses constitute screening and are not covered by Texas Medicaid. Documentation maintained in the client's medical record must support medical necessity for each test performed.

Procedure code 96116 is limited to four hours per day and eight hours per calendar year, any provider.

Providers must bill the preponderance of each half hour of neurobehavioral testing and indicate that number of units on the claim form.

9.2.25.5 12-Hour Limitation for Procedure Codes 96110, 96111, and 96116

APRNs, PAs, and psychologists are limited to a maximum, combined total of 12 hours per day for developmental screening and testing, neurobehavioral testing, and inpatient and outpatient behavioral health services.

Because physicians (M.D. and D.O.) can delegate and may submit claims for services in excess of 12 hours per day, they are not subject to the 12-hour system limitation.

Developmental screening, developmental testing, and neurobehavioral testing are included in the 12-hour per day, per provider, system limitation. The following table lists the procedure codes that are included in the 12-hour per day system limitation, along with the time increments the system will apply based on the billed procedure code. The time increments applied will be used to calculate the 12-hour per day system limitation.

Procedure Code	Time Assigned by Procedure Code Description	Time Applied by System
96110	N/A	30 Minutes
96111	N/A	60 Minutes
96116	60 Minutes	60 Minutes

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Refer to: Subsection 6.3, "The 12-Hour System Limitation," in the *Behavioral Health, Rehabilitation, and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about procedure codes included in the 12-hour system limitation.

All providers, including physicians and all providers to whom they delegate services, are subject to retrospective review. HHSC and TMHP routinely perform retrospective reviews of all providers. All providers are subject to retrospective review for the total hours of services performed and billed in excess of 12 hours per day. Retrospective review may include:

- All E/M procedure codes, including those listed in the Evaluation and Management Section of the *CPT Manual,* billed with a diagnosis listed in the diagnosis table above under Neurobehavioral Testing
- All developmental and neurological assessment and testing procedure codes included in the 12-hour system limitation

Note: *Developmental and neurological assessment and testing procedure codes and behavioral health procedure codes are included in the review. If a provider provides developmental and neurological assessment and testing at more than one location, any of these services may be retrospectively reviewed.*

9.2.26 Diagnostic Tests

9.2.26.1 Ambulatory Blood Pressure Monitoring

Ambulatory blood pressure monitoring is a benefit of Texas Medicaid 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.

Ambulatory blood pressure monitoring may also be used for the following:

- Clients with established hypertension under treatment
- Evaluating refractory or resistant blood pressure
- Evaluating symptoms such as light-headedness corresponding with blood pressure changes
- Evaluating nighttime blood pressure
- Examining diurnal patterns of blood pressure

Ambulatory blood pressure monitoring is indicated for the evaluation of one of the following conditions:

- White coat hypertension, which is defined as the following:
  - Blood pressure measurements taken in the clinic or office are greater than 140/90 mm Hg on at least three separate visits, with two separate measurements made at each visit.
  - At least two separately documented blood pressure measurements taken outside of the clinic or office that are less than 140/90 mm Hg.
  - There is no evidence of end-organ damage.
- Resistant hypertension
- Hypotensive symptoms as a response to hypertension medications
- Nocturnal angina
- Episodic hypertension
- Syncope

Ambulatory blood pressure monitoring is for diagnostic purposes only.

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Use procedure codes 93784, 93786, 93788, and/or 93790 to bill in 24-hour increments for ambulatory blood pressure monitoring. Ambulatory blood pressure monitoring is limited to two services per lifetime, any provider. Ambulatory blood pressure monitoring performed more than twice per lifetime may be considered when documentation of medical necessity is submitted with the claim.

9.2.26.2 Ambulatory Electroencephalogram (Ambulatory EEG)

Ambulatory EEG monitoring or 24-hour ambulatory monitoring is a covered benefit for clients in whom a seizure diathesis is suspected but not defined by history, physical, and resting EEG.

Benefits are limited to 3 units (each unit 24 hours) for each physician for the same client per 6 months when medically necessary.

Use the following procedure codes to bill ambulatory EEG: 95950, 95951, 95953, and 95956.

Procedure codes 95950, 95951, 95953, and 95956 may be reimbursed when billed with the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
F05	F060	F068	G253	G3101	G3109	G3183	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	G4089	G40901	G40909
G40911	G40919	G40A11	G40A19	G40B01	G40B09	G40B11	G40B19
G912	O99351	O99352	O99353	O99354	O99355	P90	P912
R410	R4182	R5601	R561	R569	S060X1A	S060X1D	S060X1S
S060X2A	S060X2D	S060X2S					

Other diagnosis codes may be considered on appeal with supporting medical documentation to the TMHP Medical Director.

9.2.26.3 Bone Marrow Aspiration, Biopsy

Physicians may bill procedure code 85097 if interpretation is for smear interpretation, or procedure code 88305 if interpretation is for preparation and interpretation of cell block. If both procedure codes 85097 and 88305 are billed, procedure code 88305 is paid and procedure code 85097 is denied.

Physicians may bill procedure code 85097 or 88305 for preparation and interpretation of the specimen.

9.2.26.4 Cytopathology Studies—Other Than Gynecological

Procurement and handling of the specimen for cytopathology of sites other than vaginal, cervical, or uterine is considered part of the client's E/M and will not be reimbursed separately.

Procedure codes 88160, 88161, and 88162 are reimbursed according to the POS where the cytopathology smear is interpreted.

9.2.26.5 Echoencephalography

Echoencephalography (procedure code 76506) is medically indicated for the following conditions or diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
A066	A170	A171	A1781	A1782	A1789	C410	C6961
C6962	C700	C710	C711	C712	C713	C714	C715

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
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	D480	D487	D492
D496	D497	F0390	G060	G062	G07	G08	G132
G138	G232	G300	G301	G308	G309	G3101	G3109
G311	G312	G3183	G3184	G3185	G3189	G319	G910
G911	G912	G930	G932	G9340	G9341	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	I6020	I6021	I6022	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	I63329	I63331	I63332
I63339	I6339	I6340	I63411	I63412	I63419	I63421	I63422
I63429	I63431	I63432	I63439	I6349	I6350	I63511	I63512
I63519	I63521	I63522	I63529	I63531	I63532	I63539	I6601
I6602	I6603	I6609	I6611	I6612	I6613	I6619	I6621
I6622	I6623	I6629	I668	I669	I671	I6781	I6782
I6783	I6789	I680	I69098	I6921	I69220	I69221	I69222
I69223	I69269	I69290	I69291	I69292	I69293	I69298	O99411
O99412	O99413	O99419	O9942	O9943	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

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
P370	P371	P372	P373	P374	P378	P520	P521
P5221	P5222	P523	P524	P525	P526	P528	P529
P90	P912	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	S060X2A	S060X2D
S060X2S	S060X3A	S060X3D	S060X3S	S060X4A	S060X4D	S060X4S	S060X5A
S060X5D	S060X5S	S060X6A	S060X6D	S060X6S	S060X8A	S060X8D	S060X8S
S060X9A	S060X9D	S060X9S	S061X0A	S061X0D	S061X0S	S061X1A	S061X1D
S061X1S	S061X2A	S061X2D	S061X2S	S061X3A	S061X3D	S061X3S	S061X4A
S061X4D	S061X4S	S061X5A	S061X5D	S061X5S	S061X6A	S061X6D	S061X6S
S061X7A	S061X7D	S061X7S	S061X8A	S061X8D	S061X8S	S061X9A	S061X9D
S061X9S	S06305A	S06305D	S06305S	S06306A	S06306D	S06306S	S06307A
S06307D	S06307S	S06308A	S06308D	S06308S	S06310A	S06310D	S06310S
S06311A	S06311D	S06311S	S06312A	S06312D	S06312S	S06313A	S06313D
S06313S	S06314A	S06314D	S06314S	S06315A	S06315D	S06315S	S06316A
S06316D	S06316S	S06317A	S06317D	S06317S	S06318A	S06318D	S06318S
S06319A	S06319D	S06319S	S06320A	S06320D	S06320S	S06321A	S06321D
S06321S	S06322A	S06322D	S06322S	S06323A	S06323D	S06323S	S06324A
S06324D	S06324S	S06325A	S06325D	S06325S	S06326A	S06326D	S06326S
S06327A	S06327D	S06327S	S06328A	S06328D	S06328S	S06329A	S06329D
S06329S	S06330A	S06330D	S06330S	S06331A	S06331D	S06331S	S06332A
S06332D	S06332S	S06333A	S06333D	S06333S	S06334A	S06334D	S06334S
S06335A	S06335D	S06335S	S06336A	S06336D	S06336S	S06337A	S06337D
S06337S	S06338A	S06338D	S06338S	S06339A	S06339D	S06339S	S06340A
S06340D	S06340S	S06341A	S06341D	S06341S	S06342A	S06342D	S06342S
S06343A	S06343D	S06343S	S06344A	S06344D	S06344S	S06345A	S06345D
S06345S	S06346A	S06346D	S06346S	S06347A	S06347D	S06347S	S06348A
S06348D	S06348S	S06349A	S06349D	S06349S	S06350A	S06350D	S06350S
S06351A	S06351D	S06351S	S06352A	S06352D	S06352S	S06353A	S06353D
S06353S	S06354A	S06354D	S06354S	S06355A	S06355D	S06355S	S06356A
S06356D	S06356S	S06357A	S06357D	S06357S	S06358A	S06358D	S06358S
S06359A	S06359D	S06359S	S06360A	S06360D	S06360S	S06361A	S06361D
S06361S	S06362A	S06362D	S06362S	S06363A	S06363D	S06363S	S06364A
S06364D	S06364S	S06365A	S06365D	S06365S	S06366A	S06366D	S06366S
S06367A	S06367D	S06367S	S06368A	S06368D	S06368S	S06369A	S06369D
S06369S	S06370A	S06370D	S06370S	S06371A	S06371D	S06371S	S06372A
S06372D	S06372S	S06373A	S06373D	S06373S	S06374A	S06374D	S06374S
S06375A	S06375D	S06375S	S06376A	S06376D	S06376S	S06377A	S06377D

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
S06377S	S06378A	S06378D	S06378S	S06379A	S06379D	S06379S	S06380A
S06380D	S06380S	S06381A	S06381D	S06381S	S06382A	S06382D	S06382S
S06383A	S06383D	S06383S	S06384A	S06384D	S06384S	S06385A	S06385D
S06385S	S06386A	S06386D	S06386S	S06387A	S06387D	S06387S	S06388A
S06388D	S06388S	S06389A	S06389D	S06389S	S064X0A	S064X0D	S064X0S
S064X1A	S064X1D	S064X1S	S064X2A	S064X2D	S064X2S	S064X3A	S064X3D
S064X3S	S064X4A	S064X4D	S064X4S	S064X5A	S064X5D	S064X5S	S064X6A
S064X6D	S064X6S	S064X7A	S064X7D	S064X7S	S064X8A	S064X8D	S064X8S
S064X9A	S064X9D	S064X9S	S065X0A	S065X0D	S065X0S	S065X1A	S065X1D
S065X1S	S065X2A	S065X2D	S065X2S	S065X3A	S065X3D	S065X3S	S065X4A
S065X4D	S065X4S	S065X5A	S065X6A	S065X6D	S065X6S	S065X7A	S065X7D
S065X7S	S065X8A	S065X8D	S065X8S	S065X9A	S065X9D	S065X9S	S066X0A
S066X1A	S066X1D	S066X2A	S066X3A	S066X4A	S066X5A	S066X6A	S066X7A
S066X8A	S066X8S	S066X9A	S066X9D	S066X9S	S06890A	S06890D	S06890S
S06891A	S06891D	S06891S	S06892A	S06892D	S06892S	S06893A	S06893D
S06893S	S06894A	S06894D	S06894S	S06895A	S06895D	S06895S	S06896A
S06896D	S06896S	S06897A	S06897D	S06897S	S06898A	S06898D	S06898S
S06899A	S06899D	S06899S	S069X0A	S069X0D	S069X0S	S069X1A	S069X1D
S069X1S	S069X2A	S069X2D	S069X2S	S069X3A	S069X3D	S069X3S	S069X4A
S069X4D	S069X4S	S069X5A	S069X6A	S069X6D	S069X6S	S069X7A	S069X7D
S069X7S	S069X8A	S069X8D	S069X8S	S069X9A	S069X9D	S069X9S	S0990xA
S0990xD	S0990xS						

9.2.26.6 Electrocardiogram (ECG)

Electrocardiograms (ECG) are a benefit of Texas Medicaid when used for the evaluation and management (E/M) of a confirmed or suspected primary disease of the heart, pericardium, and coronary arteries or when necessary for management of diseases that are not primarily cardiac, but can affect the heart directly or indirectly.

ECGs are limited to six treatments for each client, by any provider per benefit period.

For ECGs, a benefit period is defined as 12 consecutive months, beginning with the month the client receives the first ECG.

The following procedure codes may be reimbursed for ECGs: 93000, 93005, 93010, 93040, 93041, and 93042.

Claims that are denied for exceeding the six-ECG limitation may be appealed with documentation supporting medical necessity. The documentation must include the following:

- Diagnosis
- Treatment history
- Documentation of why additional ECGs are needed

The report of the professional component (the interpretation) for the ECG must be a complete written report that includes relevant findings and appropriate comparisons.

The interpretation may appear on the actual tracing.

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When the ECG is performed in conjunction with the performance of an evaluation and management (E/M) service, the interpretation may appear with a progress note or other report of the E/M service; however, if the ECG is billed as a separate service from the E/M service, the interpretation should contain the same information as a report made upon the tracing itself.

A simple notation of "ECG/EKG normal" without an accompanying tracing will not suffice as documentation of a separately payable interpretation.

Appropriate documentation, which includes a copy of the ECG tracing, must be kept in the client's medical record. Documentation must support the medical necessity of the ECG. Documentation may appear on the actual tracing or with a progress note or report. Documentation is subject to retrospective review.

Only an ECG interpretation that directly contributes to the diagnosis and treatment of a client may be considered for reimbursement. Services, such as routine admission ECGs performed without medical indications, that do not directly contribute to the diagnosis and treatment of an individual client are not considered medically necessary.

9.2.26.6.1 * Prior Authorization for ECG

Prior authorization is not required for ECGs performed in the emergency room or inpatient hospital setting.

Prior authorization is required for more than six ECGs in a rolling 12-month period.

Requests for additional ECGs must be submitted on the Special Medical Prior Authorization (SMPA) Request Form along with documentation of medical necessity.

Providers may request a prior authorization up to 12 months in advance. When requesting retroactive authorization, a provider must submit the request no later than 14 calendar days after the ECG is completed.

Before submitting a prior authorization request for an ECG, a provider must have a completed SMPA Request Form that has been signed and dated by a physician who is familiar with the client. The completed SMPA Request Form must include the procedure codes and numerical quantities for the services requested. The completed SMPA Request Form with the original dated signature must be maintained by the prescribing physician in the client's medical record.

The SMPA Request Form must include all of the following information, which is related to medical necessity:

- Procedure requested (CPT)
- Diagnosis
- Treatment history
- Treatment plan

Prior authorization requests submitted by paper, must be faxed or mailed with the completed SMPA Request Form to the SMPA department and a copy of the signed and dated form must be retained in the client's medical record at the provider's place of business. Requests may be faxed or mailed to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway
Austin, TX 78727
Fax: 1-512-514-4213

Requests for prior authorization can also be submitted online through the TMHP website at www.tmhp.com.

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9.2.26.7 Esophageal pH Probe Monitoring

Esophageal pH monitoring uses an indwelling pH microelectrode positioned just above the esophageal sphincter. The pH electrode and skin reference electrode are connected to a battery-powered pH meter and transmitter worn as a shoulder harness. The esophageal pH is monitored continuously and a strip chart is used to record the pH determinations. The patient is usually monitored for a 24-hour period. Esophageal pH monitoring is a medically appropriate adjunct procedure to help establish the presence or absence of gastroesophageal reflux.

Esophageal pH probe monitoring should be coded with procedure codes 91034, 91035, and 78262.

Esophageal pH probe testing (procedure codes 78262, 91034, and 91035) are limited to two services per rolling year, same procedure, any provider.

Claims that are denied for exceeding two services per rolling year may be considered on appeal with documentation of one of the following:

- The client is new and the provider has been unsuccessful in obtaining the client's previous records from a different provider.
- The provider is not aware that the client received previous esophageal testing.

Only one appeal will be considered per client, for the same provider. Providers must request prior authorization for any additional esophageal testing performed after the appealed service.

9.2.26.7.1 Prior Authorization

Esophageal pH probe testing (procedure codes 78262, 91034, and 91035) require prior authorization for services that exceed two per rolling year.

Requests for additional testing may be considered when submitted with documentation of medical necessity that supports, but is not limited to, the following:

- Adult's unintentional weight loss is more than 5 percent of their normal body weight in a span of 12 months or less
- Child's weight loss is 3 to 5 percent of their body mass in less than 30 days
- Symptoms of gastroesophageal reflux disease (GERD) that include heartburn and regurgitation that do not respond to treatment with medication
- Atypical symptoms of GERD, such as chest pain, coughing, wheezing, hoarseness, and sore throat

Prior authorization requests must be submitted to the Special Medical Prior Authorization Department using the Special Medical Prior Authorization (SMPA) Request Form. The completed prior authorization request form must be maintained by the requesting provider and the prescribing physician. The original, signed copy must be kept by the physician in the client's medical record.

9.2.26.8 Helicobacter Pylori (H. pylori)

Initial testing for H. pylori may be performed using the following tests:

- Serology testing (procedure codes 83009 and 86677)
- Stool testing (procedure code 87338)
- Breath testing (procedure codes 78267, 78268, 83013, and 83014)

Serology testing for H. pylori is a noninvasive diagnostic procedure that is preferred for initial diagnosis but is not indicated after a diagnosis has been made. Serology testing is not indicated or covered for monitoring a response to therapy.

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.

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Urea breath tests (UBTs) and fecal antigen tests provide reliable means of identifying active H. pylori infection before antibiotic therapy. UBTs are the most reliable non-endoscopic test to document eradication of H. pylori infection.

H. pylori is accepted as an etiologic factor in duodenal ulcers, peptic ulcer disease, gastric carcinoma, and primary B cell gastric lymphoma. H. pylori testing may be indicated for symptomatic clients who have a documented history of chronic/recurrent duodenal ulcer, gastric ulcer, or chronic gastritis. The history must delineate the failed conservative treatment for the condition.

H. pylori testing is not indicated or covered for any of the following:

- New onset uncomplicated dyspepsia.
- New onset dyspepsia responsive to conservative treatment (e.g., withdrawal of nonsteroidal anti-inflammatory drugs [NSAID] and/or use of antisecretory agents). If the treatment does not prove successful in eliminating the symptoms, further testing may be indicated to determine the presence of H. pylori.
- Screening for H. pylori in asymptomatic clients.
- Dyspeptic clients requiring endoscopy and biopsy.

H. pylori testing is not indicated under the following circumstances:

- There has been a negative endoscopy in the previous 90 days.
- An endoscopy is planned.
- H. pylori is of new onset and still being treated.

H. pylori testing will be denied if it is performed within 90 days of an upper gastrointestinal endoscopy. Procedure codes 78267, 78268, 83013, 83014, and 87338 may be reimbursed within the 90 days if the provider submits documentation that indicates the client was tested for eradication after treatment.

If a follow-up breath or stool test is used to document eradication of H. pylori, the medical record documentation must verify the history of the following previous complication(s):

- The client remains symptomatic after a treatment regimen for H. pylori.
- The client is asymptomatic after H. pylori eradication therapy but has a history of hemorrhage, perforation, or outlet obstruction from peptic ulcer disease.
- The client has a history of ulcer on chronic NSAID or anticoagulant therapy.

Testing for H. pylori eradication after the completion of antibiotic therapy (procedure codes 78267, 78268, 83013, 83014, and 87338) will be denied if billed less than 35 days after the initial test.

Procedure code 87339 is not a benefit of Texas Medicaid.

9.2.26.9 Myocardial Perfusion Imaging

Refer to: Subsection 3.2.1, "Cardiac Nuclear Imaging," in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

9.2.26.10 Pediatric Pneumogram

A pediatric pneumogram (procedure code 94772) is a 12-hour 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.

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The following diagnosis codes may be reimbursed for a pediatric pneumogram in infants from birth through 11 months of age:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
K200	K208	K209	K210	K219	K220	P220	P228
P270	P271	P278	P282	P283	P284	P285	P2881
P2889	P84	R0600	R0609	R062	R063	R0681	R0682
R0683	R0689	R6813					

A pediatric pneumogram is limited to two services without prior authorization when submitted with one of the diagnosis codes listed above. Additional studies may be considered under CCP with documentation of medical necessity, and will require prior authorization.

Refer to: Section 2: "Medicaid Children's Services Comprehensive Care Program (CCP)" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

EMGs, polysomnography, EEGs, and ECGs are denied when billed on the same day as a pediatric pneumogram.

Pediatric pneumograms are reimbursed on the same day as an apnea monitor (rented monthly) if documentation supports the medical necessity.

Pneumogram supplies are considered part of the technical component and are denied if billed separately.

9.2.27 Diagnostic Doppler Sonography

Diagnostic Doppler sonography is a benefit of Texas Medicaid when treatment decisions depend on the results. Authorization is not required for diagnostic Doppler services.

A vascular diagnostic study may be personally performed by a physician or by a technologist. The accuracy of noninvasive vascular diagnostic studies depends on the knowledge, skill, and experience of the technologist and physician performing and interpreting the study. Consequently, the physician who performs and/or interprets the study must be able to document training through recent residency training or post-graduate continuing medical education and experience and must maintain that documentation for post-payment review.

If noninvasive vascular diagnostic studies are performed by a technologist, the technologist must have demonstrated competency in ultrasound by receiving one of the following credentials in vascular ultrasound technology:

- Registered Vascular Specialist (RVS) provided by Cardiovascular Credentialing International (CCI)
- Registered Vascular Technologist (RVT) provided by the American Registry of Diagnostic Medical Sonographers (ARDMS)
- Vascular Sonographer (VS) provided by the American Registry of Radiologic Technologists (ARRT), Sonography

Alternately, such studies must be performed in a facility or vascular laboratory accredited by one of the following nationally recognized accreditation organizations. If a vascular laboratory or facility is accredited, the technologists performing noninvasive cerebrovascular arterial studies in that laboratory are considered to have demonstrated competency in cerebrovascular ultrasound:

- American College of Radiology (ACR) Vascular Ultrasound Accreditation Program
- Intersocietal Commission for the Accreditation of Vascular Laboratories (ICAVL)

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Cerebrovascular Doppler Studies

Cerebrovascular Doppler sonography includes both extracranial and transcranial (intracranial) studies. Cerebrovascular Doppler sonography should not be used when treatment decisions will not be affected by the findings.

Cerebrovascular Doppler studies for the diagnosis of migraine are considered experimental and are not a benefit of Texas Medicaid.

Extracranial arterial Doppler (procedure codes 93880 and 93882) are limited to the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
D446	D447	D7801	D7802	D7811	D7812	D7821	D7822
E3601	E3602	E3611	E3612	G450	G453	G454	G458
G459	G8100	G8101	G8102	G8103	G8104	G8110	G8111
G8112	G8113	G8114	G8190	G8191	G8192	G8193	G8194
G9731	G9732	G9748	G9749	G9751	G9752	H3401	H3402
H3403	H3411	H3412	H3413	H34211	H34212	H34213	H34231
H34232	H34233	H34811	H34812	H34813	H34821	H34822	H34823
H34831	H34832	H34833	H349	H3582	H5310	H53121	H53122
H53123	H53131	H53132	H53133	H532	H5340	H53411	H53412
H53413	H53421	H53422	H53423	H53431	H53432	H53433	H53451
H53452	H53453	H53461	H53462	H5347	H53481	H53482	H53483
H59111	H59112	H59113	H59119	H59121	H59122	H59123	H59129
H59211	H59212	H59213	H59219	H59221	H59222	H59223	H59229
H59311	H59312	H59313	H59319	H59321	H59322	H59323	H59329
H9521	H9522	H9531	H9532	H9541	H9542	I610	I611
I612	I613	I614	I615	I616	I618	I619	I6300
I63011	I63012	I6302	I63031	I63032	I6309	I6310	I63111
I63112	I6312	I63131	I63132	I6319	I6320	I6329	I63311
I63312	I63321	I63322	I63331	I63332	I63411	I63412	I63421
I63422	I63431	I63432	I63511	I63512	I63521	I63522	I63531
I63532	I6359	I638	I6501	I6502	I6503	I651	I6521
I6522	I6523	I658	I659	I6601	I6602	I6603	I6609
I6611	I6612	I6613	I6619	I6621	I6622	I6623	I663
I669	I671	I672	I677	I6781	I6782	I67848	I6789
I679	I680	I682	I6990	I69920	I69921	I69922	I69923
I69961	I69962	I69963	I69964	I69965	I69969	I69990	I69991
I69992	I69993	I7100	I720	I728	I770	I771	I772
I773	I776	I7789	I779	I97410	I97411	I97418	I9742
I9751	I9752	I97610	I97611	I97618	I9762	J9561	J9562
J9571	J9572	J95830	J95831	K9161	K9162	K9171	K9172
K91840	K91841	L7601	L7602	L7611	L7612	L7621	L7622
M300	M303	M310	M311	M312	M3130	M3131	M314

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
M315	M316	M96810	M96811	M96820	M96821	M96830	M96831
N9961	N9962	N9971	N9972	N99820	N99821	R0989***	R200
R201	R202	R203	R208	R209	R220**	R221**	R260
R261	R2681	R2689	R269	R270	R278	R279	R295
R4701	R4702	R471	R4781	R4789	R5084	R55*	R561
S090XXA	S090XXD	S090XXS	S15001A	S15001D	S15002A	S15002D	S15009A
S15009D	S15011A	S15011D	S15012A	S15012D	S15021A	S15021D	S15022A
S15022D	S15091A	S15091D	S15092A	S15092D	S15211A	S15211D	S15212A
S15212D	S15221A	S15221D	S15222A	S15222D	S15291A	S15291D	S15292A
S15292D	S15311A	S15311D	S15312A	S15312D	S15321A	S15321D	S15322A
S15322D	S15391A	S15391D	S15392A	S15392D	S158XXA	S158XXD	S159XXA
S159XXD	S159XXS	S178XXA	S178XXD	S25111A	S25111D	S25112A	S25112D
S25121A	S25121D	S25122A	S25122D	S25191A	S25191D	S25192A	S25192D
T794XXA	T794XXD	T8030XA	T8030XD	T8030XS	T80310A	T80310D	T80310S
T80311A	T80311D	T80311S	T80319A	T80319D	T80319S	T8039XA	T8039XD
T8039XS	T8040XA	T8040XD	T8040XS	T80410A	T80410D	T80410S	T80411A
T80411D	T80411S	T80419A	T80419D	T80419S	T8049XA	T80910A	T80910D
T80910S	T80911A	T80911D	T80911S	T80919A	T80A0XA	T80A0XD	T80A0XS
T80A10A	T80A10D	T80A10S	T80A11A	T80A11D	T80A11S	T80A19A	T80A19D
T80A19S	T80A9XA	T80A9XD	T80A9XS	T8130XA	T8130XD	T8131XA	T8131XD
T8131XS	T8132XA	T8132XD	T8132XS	T8133XA	T8133XD	T8133XS	T81500A
T81500D	T81500S	T81501A	T81501D	T81501S	T81502A	T81502D	T81502S
T81503A	T81503D	T81503S	T81504A	T81505A	T81505D	T81505S	T81506A
T81506D	T81506S	T81507A	T81507D	T81507S	T81508A	T81508D	T81508S
T81509A	T81510A	T81510D	T81510S	T81511A	T81511D	T81511S	T81512A
T81512D	T81512S	T81513A	T81513D	T81513S	T81514A	T81515A	T81515D
T81515S	T81516A	T81516D	T81516S	T81517A	T81517D	T81517S	T81518A
T81518D	T81518S	T81519A	T81520A	T81520D	T81520S	T81521A	T81521D
T81521S	T81522A	T81522D	T81522S	T81523A	T81523D	T81523S	T81524A
T81525A	T81525D	T81525S	T81526A	T81526D	T81526S	T81527A	T81527D
T81527S	T81528A	T81528D	T81528S	T81529A	T81530A	T81530D	T81530S
T81531A	T81532A	T81533A	T81534A	T81535A	T81536A	T81537A	T81538A
T81539A	T81590A	T81591A	T81592A	T81593A	T81594A	T81595A	T81596A
T81597A	T81598A	T81599A	T8160XA	T8160XD	T8160XS	T8161XA	T8169XA
T8169XD	T8169XS	T8183XA	T8183XD	T8183XS	T82390A	T82390D	T82390S
T82391A	T82391D	T82391S	T82392A	T82392D	T82392S	T8249XA	T8249XD
T8249XS	T82590A	T82590D	T82590S	T82591A	T82591D	T82591S	T82593A
T82593D	T82593S	T82595A	T82595D	T82595S	T82598A	T82598D	T82598S
T888XXA	T888XXD	T888XXS	Z09	Z95820	Z95828	Z978	Z983

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)	
Z9862	Z9889

*** Use R55 when symptomatology indicates a strong clinical suspicion of vertebrobasilar insufficiency**
**** Use R220 or R221 to report pulsatile neck mass**
***** Use R0989 to report carotid bruit**

Transcranial Doppler (procedure codes 93886, 93888, 93890, 93892, and 93893) are limited to the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
D7801	D7802	D7811	D7812	D7821	D7822	E3601	E3602
E3611	E3612	G450	G453	G454	G458	G459	G8100
G8101	G8102	G8103	G8104	G8110	G8111	G8112	G8113
G8114	G8190	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	G839	G9381
G9382	G9389*	G9731	G9732	G9748	G9749	G9751	G9752
H3401	H3402	H3403	H3411	H3412	H3413	H34211	H34212
H34213	H34231	H34232	H34233	H34811	H34812	H34813	H34821
H34822	H34823	H34831	H34832	H34833	H349	H3582	H4901
H4902	H4903	H4911	H4912	H4913	H4921	H4922	H4923
H4931	H4932	H4933	H4941	H4942	H4943	H499	H52511
H52512	H52513	H5310	H53121	H53122	H53123	H53131	H53132
H53133	H532	H5340	H53411	H53412	H53413	H53421	H53422
H53423	H53431	H53432	H53433	H53451	H53452	H53453	H53461
H53462	H5347	H53481	H53482	H53483	H59111	H59112	H59113
H59119	H59121	H59122	H59123	H59129	H59211	H59212	H59213
H59219	H59221	H59222	H59223	H59229	H59311	H59312	H59313
H59319	H59321	H59322	H59323	H59329	H9521	H9522	H9531
H9532	H9541	H9542	I6000	I6001	I6002	I6010	I6011
I6012	I6020	I6021	I6022	I6030	I6031	I6032	I604
I6050	I6051	I6052	I606	I607	I608	I609	I610
I611	I612	I613	I614	I615	I616	I618	I619
I6300	I63011	I63012	I6302	I63031	I63032	I6309	I6310
I63111	I63112	I6312	I63131	I63132	I6319	I6320	I6329
I63311	I63312	I63321	I63322	I63331	I63332	I63411	I63412
I63421	I63422	I63431	I63432	I63511	I63512	I63521	I63522
I63531	I63532	I638	I6501	I6502	I6503	I651	I6521
I6522	I6523	I658	I659	I6601	I6602	I6603	I6609
I6611	I6612	I6613	I6619	I6621	I6622	I6623	I663
I669	I671	I672	I675	I677	I6781	I6782	I67848
I6789	I679	I680	I682	I69098	I6990	I69920	I69921

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
I69922	I69923	I69961	I69962	I69963	I69964	I69965	I69969
I69990	I69991	I69992	I69993	I7090	I7091	I720	I728
I749**	I770	I771	I772	I773	I776	I7789	I779
I97410	I97411	I97418	I9742	I9751	I9752	I97610	I97611
I97618	I9762	J9561	J9562	J9571	J9572	J95830	J95831
K9161	K9162	K9171	K9172	K91840	K91841	L7601	L7602
L7611	L7612	L7621	L7622	M300	M303	M310	M311
M312	M3130	M3131	M314	M315	M316	M96810	M96811
M96820	M96821	M96830	M96831	N9961	N9962	N9971	N9972
N99820	N99821	Q282	Q283	R0989****	R200	R201	R202
R203	R208	R209	R260	R261	R2681	R2689	R269
R270	R278	R279	R295	R42	R4701	R471	R5084
R55***	R561	R683	S090XXA	S090XXD	S090XXS	S15001A	S15001D
S15002A	S15002D	S15009A	S15009D	S15011A	S15011D	S15012A	S15012D
S15021A	S15021D	S15022A	S15022D	S15091A	S15091D	S15092A	S15092D
S15211A	S15211D	S15212A	S15212D	S15221A	S15221D	S15222A	S15222D
S15291A	S15291D	S15292A	S15292D	S15311A	S15311D	S15312A	S15312D
S15321A	S15321D	S15322A	S15322D	S15391A	S15391D	S15392A	S15392D
S158XXA	S158XXD	S159XXA	S159XXD	S159XXS	S178XXA	S178XXD	S25111A
S25111D	S25112A	S25112D	S25121A	S25121D	S25122A	S25122D	S25191A
S25191D	S25192A	S25192D	T794XXA	T794XXD	T8030XA	T8030XD	T8030XS
T80310A	T80310D	T80310S	T80311A	T80311D	T80311S	T80319A	T80319D
T80319S	T8039XA	T8039XD	T8039XS	T8040XA	T8040XD	T8040XS	T80410A
T80410D	T80410S	T80411A	T80411D	T80411S	T80419A	T80419D	T80419S
T8049XA	T80910A	T80910D	T80910S	T80911A	T80911D	T80911S	T80919A
T80A0XA	T80A0XD	T80A0XS	T80A10A	T80A10D	T80A10S	T80A11A	T80A11D
T80A11S	T80A19A	T80A19D	T80A19S	T80A9XA	T80A9XD	T80A9XS	T8130XA
T8130XD	T8131XA	T8131XD	T8131XS	T8132XA	T8132XD	T8132XS	T8133XA
T8133XD	T8133XS	T81500A	T81500D	T81500S	T81501A	T81501D	T81501S
T81502A	T81502D	T81502S	T81503A	T81503D	T81503S	T81504A	T81505A
T81505D	T81505S	T81506A	T81506D	T81506S	T81507A	T81507D	T81507S
T81508A	T81508D	T81508S	T81509A	T81510A	T81510D	T81510S	T81511A
T81511D	T81511S	T81512A	T81512D	T81512S	T81513A	T81513D	T81513S
T81514A	T81515A	T81515D	T81515S	T81516A	T81516D	T81516S	T81517A
T81517D	T81517S	T81518A	T81518D	T81518S	T81519A	T81520A	T81520D
T81520S	T81521A	T81521D	T81521S	T81522A	T81522D	T81522S	T81523A
T81523D	T81523S	T81524A	T81525A	T81525D	T81525S	T81526A	T81526D
T81526S	T81527A	T81527D	T81527S	T81528A	T81528D	T81528S	T81529A
T81530A	T81530D	T81530S	T81531A	T81532A	T81533A	T81534A	T81535A
T81536A	T81537A	T81538A	T81539A	T81590A	T81591A	T81592A	T81593A

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
T81594A	T81595A	T81596A	T81597A	T81598A	T81599A	T8160XA	T8160XD
T8160XS	T8161XA	T8169XA	T8169XD	T8169XS	T8183XA	T8183XD	T8183XS
T82390A	T82390D	T82390S	T82391A	T82391D	T82391S	T82392A	T82392D
T82392S	T8249XA	T8249XD	T8249XS	T82590A	T82590D	T82590S	T82591A
T82591D	T82591S	T82593A	T82593D	T82593S	T82595A	T82595D	T82595S
T82598A	T82598D	T82598S	T888XXA	T888XXD	T888XXS	Z09	Z95820
Z95828	Z9862						

*** Use G9389 to identify assessment of suspected brain death**
**** Use I749 to report paradoxical cerebral embolism**
***** Use R55 when symptomatology indicates a strong clinical suspicion of vertebrobasilar insufficiency**
****** Use R0989 to report carotid bruit**

In addition to the diagnosis codes listed in the table above, procedure codes 93886 and 93888 are benefits for clients who are 2 through 16 years of age with sickle cell disease to evaluate the risk of stroke when submitted with the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
D5700	D5702	D571	D5720	D57212	D57219	D5780	D57812
D57819							

Peripheral Arterial Doppler Studies

Peripheral arterial Doppler (procedure codes 93922, 93923, 93924, 93925, 93926, 93930, and 93931) are limited to the following diagnosis codes or combination diagnosis codes (unless otherwise indicated):

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
D7801	D7802	D7811	D7812	D7821	D7822	E1051	E1052
E1059	E1151	E1159	E1351	E1359	E3601	E3602	E3611
E3612	G540	G9731	G9732	G9748	G9749	G9751	G9752
H59111	H59112	H59113	H59119	H59121	H59122	H59123	H59129
H59211	H59212	H59213	H59219	H59221	H59222	H59223	H59229
H59311	H59312	H59313	H59319	H59321	H59322	H59323	H59329
H9521	H9522	H9531	H9532	H9541	H9542	I200	I201
I208	I209	I2101	I2102	I2109	I2111	I2119	I2129
I214	I240	I241	I248	I249	I2510	I25110	I25111
I25118	I25119	I252	I253	I2541	I2542	I25700	I25701
I25708	I25709	I25710	I25711	I25718	I25719	I25730	I25731
I25738	I25739	I25750	I25751	I25758	I25759	I25760	I25761
I25768	I25769	I25790	I25791	I25798	I25799	I25810	I25811
I25812	I2589	I2602	I2692	I700	I70201	I70202	I70203
I70211	I70212	I70213	I70221	I70222	I70223	I70231	I70232
I70233	I70234	I70238	I70241	I70242	I70243	I70244	I70248
I70261	I70262	I70263	I70301	I70302	I70303	I70308	I70309
I70311	I70312	I70313	I70318	I70319	I70321	I70322	I70323
I70328	I70329	I7035	I70368	I70369	I70391	I70392	I70393

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
I70411	I70412	I70413	I70421	I70422	I70423	I70501	I70502
I70503	I70508	I70509	I70511	I70512	I70513	I70518	I70519
I70521	I70522	I70523	I70528	I70529	I70538	I70539	I70548
I70549	I70561	I70562	I70563	I70568	I70569	I70591	I70592
I70593	I70598	I70599	I70601	I70602	I70603	I70608	I70609
I70611	I70612	I70613	I70618	I70619	I70621	I70622	I70623
I70628	I70629	I70639	I70649	I7065	I70668	I70669	I70691
I70692	I70693	I70698	I70699	I70701	I70702	I70703	I70708
I70709	I70711	I70712	I70713	I70718	I70719	I70721	I70722
I70723	I70728	I70729	I70738	I70739	I70748	I70749	I7075
I70761	I70762	I70763	I70768	I70769	I70791	I70792	I70793
I70798	I70799	I7092	I7100	I7101	I7102	I7103	I711
I712	I713	I714	I715	I716	I718	I723	I728
I7300	I731	I7381	I7389	I739	I7401	I7409	I7411
I745	I748	I749	I7581	I7589	I76	I770	I771
I772	I773	I775	I776	I7771	I7772	I7773	I7774
I7779	I7789	I779	I798	I96	I97410	I97411	I97418
I9742	I9751	I9752	I97610	I97611	I97618	I9762	J9561
J9562	J9571	J9572	J95830	J95831	K9161	K9162	K9171
K9172	K91840	K91841	L7601	L7602	L7611	L7612	L7621
L7622	L98411	L98412	L98413	L98414	L98419	L98421	L98422
L98423	L98424	L98429	L98491	L98492	L98493	L98494	L98499
M25551	M25552	M314	M315	M316	M340	M341	M342
M3489	M349	M79601	M79602	M79604	M79605	M79621	M79622
M79631	M79632	M79641	M79642	M79651	M79652	M79661	M79662
M79671	M79672	M96810	M96811	M96820	M96821	M96830	M96831
N183	N184	N185	N186	N9961	N9962	N9971	N9972
N99820	N99821	Q279	R1900	R1901	R1902	R1903	R1904
R1905	R1906	R1907	R5084	R561	S2590XA	S2590XD	S358X9A
S358X9D	S45091A	S45091D	S45092A	S45092D	S45111A	S45111D	S45112A
S45112D	S45191A	S45191D	S45192A	S45192D	S45211A	S45211D	S45212A
S45212D	S45291A	S45291D	S45292A	S45292D	S45811A	S45811D	S45812A
S45812D	S45891A	S45891D	S45891S	S45892A	S45892D	S45892S	S55011A
S55011D	S55012A	S55012D	S55091A	S55092A	S55111A	S55111D	S55112A
S55112D	S55191A	S55192A	S65011A	S65011D	S65012A	S65012D	S65091A
S65092A	S65111A	S65112A	S65191A	S65192A	S65211D	S65212D	S65291A
S65292A	S65311A	S65311D	S65312A	S65312D	S65391A	S65392A	S65411A
S65412A	S65419A	S65491A	S65491D	S65492A	S65492D	S65499D	S65499S
S65510A	S65511A	S65512A	S65513A	S65514A	S65515A	S65516A	S65517A
S65518A	S65590A	S65591A	S65592A	S65593A	S65594A	S65595A	S65596A

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
S65597A	S65598A	S65598D	S65599D	S75011A	S75011D	S75012A	S75012D
S75021A	S75021D	S75022A	S75022D	S75091A	S75091D	S75092A	S75092D
S75111A	S75111D	S75112A	S75112D	S75121A	S75121D	S75122A	S75122D
S75191A	S75191D	S75192A	S75192D	S75211A	S75211D	S75212A	S75212D
S75221A	S75221D	S75222A	S75222D	S75291A	S75291D	S75292A	S75292D
S85001A	S85001D	S85002A	S85002D	S85011A	S85011D	S85012A	S85012D
S85091A	S85091D	S85092A	S85092D	S85101A	S85101D	S85102A	S85102D
S85109A	S85131A	S85131D	S85132A	S85132D	S85141A	S85141D	S85142A
S85142D	S85151A	S85151D	S85152A	S85152D	S85171A	S85171D	S85172A
S85172D	S85181A	S85181D	S85182A	S85182D	S85311A	S85311D	S85312A
S85391A	S85392A	S85411A	S85412A	S85491A	S85492A	S85501A	S85501D
S85502A	S85502D	S85511A	S85511D	S85512A	S85512D	S85591A	S85591D
S85592A	S85592D	S85811A	S85811D	S85812A	S85812D	S85891A	S85891D
S85892A	S85892D	S95111A	S95111D	S95112A	S95112D	S95191A	S95191D
S95192A	S95192D	T8030XA	T8030XD	T8030XS	T80310A	T80310D	T80310S
T80311A	T80311D	T80311S	T80319A	T80319D	T80319S	T8039XA	T8039XD
T8039XS	T8040XA	T8040XD	T8040XS	T80410A	T80410D	T80410S	T80411A
T80411D	T80411S	T80419A	T80419D	T80419S	T8049XA	T80910A	T80910D
T80910S	T80911A	T80911D	T80911S	T80919A	T80A0XA	T80A0XD	T80A0XS
T80A10A	T80A10D	T80A10S	T80A11A	T80A11D	T80A11S	T80A19A	T80A19D
T80A19S	T80A9XA	T80A9XD	T80A9XS	T8131XA	T8131XD	T8131XS	T8132XA
T8132XD	T8132XS	T81718A	T81718D	T81718S	T81719A	T81719D	T81719S
T8172XA	T8172XD	T8172XS	T82390A	T82390D	T82390S	T82391A	T82391D
T82391S	T82392A	T82392D	T82392S	T8249XA	T8249XD	T8249XS	T82590A
T82590D	T82590S	T82591A	T82591D	T82591S	T82593A	T82593D	T82593S
T82595A	T82595D	T82595S	T82598A	T82598D	T82598S	T827XXA	T827XXD
T827XXS	T82817A	T82817D	T82817S	T82818A	T82818D	T82818S	T82827A
T82827D	T82827S	T82828A	T82828D	T82828S	T82837A	T82837D	T82837S
T82838A	T82838D	T82838S	T82847A	T82847D	T82847S	T82848A	T82848D
T82848S	T82857A	T82857D	T82857S	T82858A	T82858D	T82858S	T82867A
T82867D	T82867S	T82868A	T82868D	T82868S	T82897A	T82897D	T82897S
T82898A	T82898D	T82898S	T829XXA	T829XXD	T829XXS	T8381XA	T8381XD
T8381XS	T8382XA	T8382XD	T8382XS	T8383XA	T8383XD	T8383XS	T8384XA
T8384XD	T8384XS	T8385XA	T8385XD	T8385XS	T8386XA	T8386XD	T8386XS
T8389XA	T8389XD	T8389XS	T839XXA	T839XXD	T839XXS	T8481XA	T8481XD
T8481XS	T8482XA	T8482XD	T8482XS	T8483XA	T8483XD	T8483XS	T8484XA
T8484XD	T8484XS	T8485XA	T8485XD	T8485XS	T8486XA	T8486XD	T8486XS
T8489XA	T8489XD	T8489XS	T849XXA	T849XXD	T849XXS	T8581XA	T8581XD
T8581XS	T8582XA	T8582XD	T8582XS	T8583XA	T8583XD	T8583XS	T8584XA
T8584XD	T8584XS	T8585XA	T8585XD	T8585XS	T8586XA	T8586XD	T8586XS

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
T8589XA	T8589XD	T8589XS	T859XXA	T859XXD	T859XXS	T8600	T8601
T8602	T8603	T8609	T8610	T8611	T8612	T8613	T8619
T8620	T8621	T8622	T8623	T86290	T86298	T8640	T8641
T8642	T8643	T8649	T86810	T86811	T86812	T86818	T86819
T86850	T86851	T86852	T86858	T86859	T86890	T86891	T86892
T86898	T86899	T8690	T8691	T8692	T8693	T8699	T871X1
T871X2	T888XXA	Z01810	Z01818	Z09	Z4803	Z48812	Z86711
Z951	Z955	Z95820	Z95828	Z9861	Z9862		
Combination Diagnosis Codes (Must be submitted together)							
E1151, E1165							

Diagnosis Codes for Upper Extremity Conditions (Submitted as stand-alone diagnosis codes)							
I742	I75011	I75012	I75013	M79A11	M79A12	Q2731	S45311A
S45311D	S45311S	S45312A	S45312D	S45312S	S45391A	S45391D	S45391S
S45392A	S45392D	S45392S	S45811A	S45811D	S45811S	S45812A	S45812D
S45812S	S45891A	S45891D	S45891S	S45892A	S45892D	S45892S	S45899A
S45899D	S45899S	S45911A	S45911D	S45911S	S45912A	S45912D	S45912S
S45991A	S45991D	S45991S	S45992A	S45992D	S45992S	S55211A	S55211D
S55211S	S55212A	S55212D	S55212S	S55291A	S55291D	S55291S	S55292A
S55292D	S55292S	S55811A	S55811D	S55811S	S55812A	S55812D	S55812S
S55891A	S55891D	S55891S	S55892A	S55892D	S55892S	S55911A	S55911D
S55911S	S55912A	S55912D	S55912S	S55991A	S55991D	S55991S	S55992A
S55992D	S55992S	S65811A	S65811D	S65811S	S65812A	S65812D	S65812S
S65891A	S65891D	S65891S	S65892A	S65892D	S65892S	S65911A	S65911D
S65911S	S65912A	S65912D	S65912S	S65991A	S65991D	S65991S	S65992A
S65992D	S65992S	T870X1	T870X2	T870X9			

Diagnosis Codes for Lower Extremity Conditions(Submitted as stand-alone diagnosis codes)							
L89500	L89501	L89502	L89503	L89504	L89509	L89510	L89511
L89512	L89513	L89514	L89519	L89520	L89521	L89522	L89523
L89524	L89529	L97111	L97112	L97113	L97114	L97119	L97121
L97122	L97123	L97124	L97129	L97211	L97212	L97213	L97214
L97219	L97221	L97222	L97223	L97224	L97229	L97311	L97312
L97313	L97314	L97319	L97321	L97322	L97323	L97324	L97329
L97401	L97411	L97412	L97413	L97414	L97419	L97421	L97422
L97423	L97424	L97429	L97511	L97512	L97513	L97514	L97519
L97521	L97522	L97523	L97524	L97529	L97911	L97912	L97913
L97914	L97919	L97921	L97922	L97923	L97924	L97929	M79A21
M79A22	Q2732	S75811A	S75811D	S75811S	S75812A	S75812D	S75812S
S75819A	S75819D	S75819S	S75891A	S75891D	S75891S	S75892A	S75892D

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Diagnosis Codes for Lower Extremity Conditions(Submitted as stand-alone diagnosis codes)							
S75892S	S75911A	S75911D	S75911S	S75912A	S75912D	S75912S	S75991A
S75991D	S75991S	S75992A	S75992D	S75992S	S85811A	S85811D	S85811S
S85812A	S85812D	S85812S	S85891A	S85891D	S85891S	S85892A	S85892D
S85892S	S85911A	S85911D	S85911S	S85912A	S85912D	S85912S	S85991A
S85991D	S85991S	S85992A	S85992D	S85992S	S95811A	S95811D	S95811S
S95812A	S95812D	S95812S	S95891A	S95891D	S95891S	S95892A	S95892D
S95892S	S95911A	S95911D	S95911S	S95912A	S95912D	S95912S	S95991A
S95991D	S95991S	S95992A	S95992D	S95992S			

Peripheral Venous Doppler Studies

Peripheral venous Doppler (procedure codes 93965, 93970, and 93971) are limited to the following diagnosis codes or combination diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
D7811	D7812	E3611	E3612	G9748	G9749	H59211	H59212
H59213	H59219	H59221	H59222	H59223	H59229	H9531	H9532
I2602	I2690	I2692	I2699	I2782	I7401	I7409	I749
I8001	I8002	I8003	I8011	I8012	I8013	I80211	I80212
I80213	I80221	I80222	I80223	I80231	I80232	I80233	I80291
I80292	I80293	I803	I808	I809	I82220	I82221	I82290
I82291	I82401	I82402	I82403	I82411	I82412	I82413	I82421
I82422	I82423	I82431	I82432	I82433	I824Y1	I824Y2	I824Y3
I824Z1	I824Z2	I824Z3	I82501	I82502	I82503	I82511	I82512
I82513	I82521	I82522	I82523	I82531	I82532	I82533	I82541
I82542	I82543	I825Y1	I825Y2	I825Y3	I825Z1	I825Z2	I825Z3
I82601	I82602	I82603	I82611	I82612	I82613	I82621	I82622
I82623	I82701	I82702	I82703	I82711	I82712	I82713	I82721
I82722	I82723	I82811	I82812	I82813	I82890	I82891	I82A11
I82A12	I82A13	I82A21	I82A22	I82A23	I82B11	I82B12	I82B13
I82B21	I82B22	I82B23	I82C11	I82C12	I82C13	I82C21	I82C22
I82C23	I83011	I83012	I83013	I83014	I83015	I83018	I83019
I83021	I83022	I83023	I83024	I83025	I83028	I83029	I8311
I8312	I83204	I83211	I83212	I83213	I83214	I83215	I83218
I83219	I83221	I83222	I83223	I83224	I83225	I83228	I83229
I83811	I83812	I83813	I83891	I83892	I83893	I8390	I87001
I87002	I87003	I87011	I87012	I87013	I87021	I87022	I87023
I87031	I87032	I87033	I87091	I87092	I87093	I871	I87301
I87302	I87303	I87311	I87312	I87313	I87321	I87322	I87323
I87331	I87332	I87333	I87391	I87392	I87393	I9751	I9752
J9571	J9572	K9171	K9172	L7611	L7612	L89500	L89501
L89502	L89503	L89504	L89509	L89510	L89511	L89512	L89513

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
L89514	L89519	L89520	L89521	L89522	L89523	L89524	L89529
L97111	L97112	L97113	L97114	L97119	L97121	L97122	L97123
L97124	L97129	L97211	L97212	L97213	L97214	L97219	L97221
L97222	L97223	L97224	L97229	L97311	L97312	L97313	L97314
L97319	L97321	L97322	L97323	L97324	L97329	L97401	L97411
L97412	L97413	L97414	L97419	L97421	L97422	L97423	L97424
L97429	L97511	L97512	L97513	L97514	L97519	L97521	L97522
L97523	L97524	L97529	L97911	L97912	L97913	L97914	L97919
L97921	L97922	L97923	L97924	L97929	M7121	M7122	M79601
M79602	M79604	M79605	M79621	M79622	M79631	M79632	M79641
M79642	M79651	M79652	M79661	M79662	M79671	M79672	M79A11
M79A12	M79A21	M79A22	M96820	M96821	N9971	N9972	O2220
O2221	O2222	O2223	O2230	O2231	O2232	O2233	O2290
O2291	O2292	O2293	O870	O871	O879	O88211	O88212
O88213	O88219	O8822	O8823	Q2731	Q2732	Q278	Q279
R220	R221	R222	R2231	R2232	R2233	R2241	R2242
R2243	R5084	R561	R600	R601	R609	S2590XA	S2590XD
S358X9A	S358X9D	S45091A	S45091D	S45092A	S45092D	S45111A	S45111D
S45112A	S45112D	S45191A	S45191D	S45192A	S45192D	S45211A	S45211D
S45212A	S45212D	S45291A	S45291D	S45292A	S45292D	S45311A	S45312A
S45391A	S45392A	S45811A	S45811D	S45812A	S45812D	S45891A	S45891D
S45891S	S45892A	S45892D	S45892S	S45899A	S45911A	S45912A	S45991A
S45992A	S55011A	S55011D	S55012A	S55012D	S55091A	S55092A	S55111A
S55111D	S55112A	S55112D	S55191A	S55192A	S55211A	S55212A	S55291A
S55292A	S55811A	S55812A	S55891A	S55892A	S55911A	S55912A	S55991A
S55992A	S65011A	S65011D	S65012A	S65012D	S65091A	S65092A	S65111A
S65112A	S65191A	S65192A	S65211D	S65212D	S65291A	S65292A	S65311A
S65311D	S65312A	S65312D	S65391A	S65392A	S65411A	S65412A	S65419A
S65491A	S65491D	S65492A	S65492D	S65499D	S65499S	S65510A	S65511A
S65512A	S65513A	S65514A	S65515A	S65516A	S65517A	S65518A	S65590A
S65591A	S65592A	S65593A	S65594A	S65595A	S65596A	S65597A	S65598A
S65598D	S65599D	S65811A	S65811D	S65812A	S65812D	S65891A	S65892A
S65911A	S65911D	S65912A	S65991A	S65992A	S75011A	S75011D	S75012A
S75012D	S75021A	S75021D	S75022A	S75022D	S75091A	S75091D	S75092A
S75092D	S75111A	S75111D	S75112A	S75112D	S75121A	S75121D	S75122A
S75122D	S75191A	S75191D	S75192A	S75192D	S75211A	S75211D	S75212A
S75212D	S75221A	S75221D	S75222A	S75222D	S75291A	S75291D	S75292A
S75292D	S75811A	S75812A	S75819A	S75891A	S75892A	S75911A	S75912A
S75991A	S75992A	S85001A	S85001D	S85002A	S85002D	S85011A	S85011D
S85012A	S85012D	S85091A	S85091D	S85092A	S85092D	S85101A	S85101D

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
S85102A	S85102D	S85109A	S85131A	S85131D	S85132A	S85132D	S85141A
S85141D	S85142A	S85142D	S85151A	S85151D	S85152A	S85152D	S85171A
S85171D	S85172A	S85172D	S85181A	S85181D	S85182A	S85182D	S85311A
S85311D	S85312A	S85391A	S85392A	S85411A	S85412A	S85491A	S85492A
S85501A	S85501D	S85502A	S85502D	S85511A	S85511D	S85512A	S85512D
S85591A	S85591D	S85592A	S85592D	S85811A	S85811D	S85812A	S85812D
S85891A	S85891D	S85892A	S85892D	S85911A	S85912A	S85991A	S85992A
S95111A	S95111D	S95112A	S95112D	S95191A	S95191D	S95192A	S95192D
S95811A	S95811D	S95812A	S95812D	S95891A	S95891D	S95892A	S95892D
S95911A	S95912A	S95991A	S95992A	T801XXA	T801XXD	T801XXS	T8030XA
T8030XD	T8030XS	T80310A	T80310D	T80310S	T80311A	T80311D	T80311S
T80319A	T80319D	T80319S	T8039XA	T8039XD	T8039XS	T8040XA	T8040XD
T8040XS	T80410A	T80410D	T80410S	T80411A	T80411D	T80411S	T80419A
T80419D	T80419S	T8049XA	T80910A	T80910D	T80910S	T80911A	T80911D
T80911S	T80919A	T80A0XA	T80A0XD	T80A0XS	T80A10A	T80A10D	T80A10S
T80A11A	T80A11D	T80A11S	T80A19A	T80A19D	T80A19S	T80A9XA	T80A9XD
T80A9XS	T81718A	T81718D	T81718S	T81719A	T81719D	T81719S	T8172XA
T8172XD	T8172XS	T82390A	T82391A	T82392A	T8249XA	T82590A	T82591A
T82593A	T82595A	T82598A	T82818A	T82818D	T82828A	T82828D	T82838A
T82838D	T82848A	T82848D	T82858A	T82858D	T82868A	T82868D	T82898A
T888XXA	Z01818	Z86711	Z940	Z951			
Combination Diagnosis Codes (Must be submitted in pairs)							
T8172XA I2690	T800XXA I2690	T81718A I2690	T82817A I2690	T82818A I2690			

Doppler echocardiography color flow velocity mapping (procedure code 93325) must be billed with one of the corresponding procedure codes in column B to be considered for reimbursement:

Column A Procedure Code	Column B Procedure Codes
93325	76825, 76826, 76827, 76828, 93303,93304, 93307, 93308, 93312, 93314, 93315, 93317, 93320, 93321, or 93350

Limitations for Diagnostic Doppler Sonography

Documentation of medical necessity for the diagnostic Doppler study must be maintained by the ordering provider in the client's medical record.

Procedure codes described as complete bilateral studies are inclusive codes, and right and left studies billed on the same day will be reimbursed at a quantity of one.

Diagnostic Doppler procedure codes are limited to one study per day, same provider.

When medically necessary, multiple Doppler procedures (e.g., studies of extracranial arteries and intracranial arteries) billed on the same day by the same provider will be reimbursed at full fee for the first study and one-half fee for each additional study, regardless of the number of services billed.

The use of transcranial Doppler studies performed for the assessment of stroke risk in clients who are 2 through 16 years of age who have sickle cell anemia should be limited to once every 6 months.

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The use of a simple hand-held or other Doppler device that does not produce hard copy output or that does not permit analysis of bidirectional vascular flow is considered part of the physical examination of the vascular system and is not separately reported.

9.2.28 Evoked Response Tests and Neuromuscular Procedures

The following services are a benefit of Texas Medicaid:

- Autonomic function test (AFT)
- Electromyography (EMG)
- Nerve conduction studies (NCS)
- Evoked potential (EP) testing
- Motion analysis studies

9.2.28.1 Autonomic Function Tests

AFTs are a benefit of Texas Medicaid when submitted with procedure codes 95921, 95922, 95923, 95924, and 95943.

Procedure codes 95921, 95922, and 95923 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

The reason for the referral, the specific autonomic function being tested, and a clear diagnostic impression must be documented in the client's medical record for each AFT performed.

The client's medical records must clearly document the medical necessity for the AFT. The medical record documentation must reflect the actual results of specific tests (such as latency and amplitude).

Medical necessity for reevaluation of a client (beyond the initial consultation and testing) must be clearly documented in the client's medical record. Supporting documentation includes, but is not limited to, the following:

- The client has new symptoms unrelated to those previously evaluated, suggestive of a new diagnosis.
- Evidence that the client's condition is changing rapidly, supported by the following:
    - Diagnosis

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- 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. Wave form recordings obtained during the testing will aid documentation requirements in cases where a review becomes necessary.

9.2.28.2 Electromyography and Nerve Conduction Studies

Electromyography (EMG) and nerve conduction studies (NCS), collectively known as electrodiagnostic (EDX) testing, must be medically indicated and may be reimbursed with the diagnosis codes listed below. Testing must be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for screening purposes rather than diagnoses are not a benefit of Texas Medicaid.

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
C701	C720	C721	E0842	E0942	E1041	E1042	E10610
E1141	E1142	E1144	E11610	E1342	E5111	E5112	E512
E518	E519	E560	E568	E786	E851	E852	E853
E858	E859	G120	G121	G1221	G1222	G1229	G128
G129	G130	G243	G2589	G26	G320	G360	G370
G375	G501	G510	G511	G512	G513	G514	G518
G519	G522	G523	G527	G528	G540	G541	G542
G543	G544	G545	G548	G549	G5601	G5602	G5611
G5612	G5621	G5622	G5631	G5632	G5641	G5642	G5681
G5682	G5691	G5692	G5701	G5702	G5711	G5712	G5721
G5722	G5731	G5732	G5741	G5742	G5751	G5752	G5761
G5762	G5771	G5772	G5781	G5782	G5791	G5792	G587
G588	G589	G59	G600	G601	G602	G603	G608
G609	G610	G6181	G6189	G619	G620	G621	G622
G6281	G6282	G629	G63	G650	G651	G652	G7000
G7001	G701	G702	G7081	G7089	G709	G710	G7111
G7112	G7113	G7114	G7119	G712	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	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

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
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	M05811	M05812	M05821	M05822	M05831
M05832	M05841	M05842	M05851	M05852	M05861	M05862	M05871
M05872	M0589	M06011	M06012	M06021	M06022	M06031	M06032
M06041	M06042	M06051	M06052	M06061	M06062	M06071	M06072
M0608	M0609	M06811	M06812	M06821	M06822	M06831	M06832
M06841	M06842	M06852	M06861	M06862	M06871	M06872	M0688
M0689	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	M358
M360	M4321	M4322	M4323	M4324	M4325	M4326	M4327
M4328	M436	M438X9	M4644	M4645	M4646	M4647	M4711
M4712	M4713	M4714	M4715	M4716	M4717	M4718	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	M4806	M4807	M4808	M5000
M5001	M5002	M5003	M5011	M5012	M5013	M5020	M5021
M5022	M5023	M5030	M5031	M5032	M5033	M5080	M5081
M5082	M5083	M5091	M5092	M5093	M5104	M5105	M5106
M5107	M5124	M5125	M5126	M5127	M5134	M5135	M5136
M5137	M5184	M5185	M5186	M5187	M5410	M5411	M5412
M5413	M5414	M5415	M5416	M5417	M5431	M5432	M545
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	M609	M6250	M62511	M62512	M62519	M62521	M62522
M62529	M62531	M62532	M62539	M62541	M62542	M62549	M62551
M62552	M62559	M62561	M62562	M62569	M62571	M62572	M62579
M6258	M6259	M6281	M629	M791	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

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
N39498	N94819	R150	R151	R152	R159	R200	R201
R202	R203	R208	R209	R260	R261	R2681	R2689
R269	R290	R295	R32	R3914	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	S34109A	S34109D	S34111A	S34111D
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

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
S344XXS	S345XXA	S345XXD	S345XXS	S4400XA	S4400XD	S4400XS	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	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	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	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	S9431XS	S9432XA	S9432XD	S9432XS	S948X1A	S948X1D	S948X1S
S948X2A	S948X2D	S948X2S	S948X9D	S948X9S	S9490XD	S9491XA	S9491XS
S9492XA	S9492XD	S9492XS					

Any EDX testing procedures may be reimbursed up to four different dates of service per calendar year, same provider. Any E/M 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.

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The reason for the referral, the specific site(s) tested, and a clear diagnostic impression must be documented in the client's medical record for each NCS or EMG study performed.

The client's medical records must clearly document the medical necessity for the NCS and EMG testing. The medical record documentation must reflect the actual results of specific tests (such as latency and amplitude).

Medical necessity for re-evaluation of a client (beyond the initial consultation and testing) must be clearly documented in the client's medical record. Supporting documentation includes, but is not limited to, the following:

- The client has new symptoms unrelated to those previously evaluated, suggestive of a new diagnosis. Examples may include suspected:
  - Peripheral nerve entrapment syndromes
  - Other neuropathies (traumatic, metabolic, or demyelinating)
  - Neuromuscular junction disorders (myasthenia gravis, botulism)
  - Myopathies (dermatomyositis, congenital myopathies)
  - Unexplained symptoms suggestive of peripheral nerve, muscle or neuromuscular junction pathology, manifested by muscle weakness, muscle atrophy, loss of dexterity, spasticity, sensory deficits, swallowing dysfunction, diplopia, or dysarthria
- The client's diagnosis could not be confirmed on previous studies, although suspected.
- Evidence exists that the client's condition is changing rapidly, supported by the following:
  - Diagnosis
  - Current clinical signs and symptoms
  - Prior clinical condition
  - Expected clinical disease course
- There is clinical benefit of additional electrodiagnostic studies.

The client's medical records are subject to retrospective review. NCS hard copies of the wave form recordings obtained during the testing will aid documentation requirements in cases where a review becomes necessary.

9.2.28.2.1 EMG

The following EMG procedure codes may be reimbursed for one service per day, each procedure, by the same provider:

Procedure Codes									
51784	51785	95860	95861	95863	95864	95865	95867	95868	95869
95872	95875								

Procedure code 95866 may be reimbursed up to two services per day, same provider. Procedure code 95870 may be reimbursed in multiple quantities if specific muscles are documented.

The needle EMG examination must be performed by a physician specially trained in electrodiagnostic medicine, as these tests are simultaneously performed and interpreted.

Surface or macro-EMG testing is considered experimental and is not a benefit of the Texas Medicaid.

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9.2.28.2.2 NCS

NCS are reimbursed by Texas Medicaid with documentation of medical necessity using the following procedure codes:

Procedure Codes									
95885	95886	95887	95905	95907	95908	95909	95910	95911	95912
95913	95933	95937							

NCS must be performed by one of the following:

- A physician
- 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, or XU, indicating a distinct procedural service. Modifier 59 should be used 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.

Authorization is required when the number of nerve conduction studies performed during an evaluation exceeds the following maximum number of studies:

Procedure Code	Limitation
95885, 95886	Reimbursed once per extremity up to 4 units, using any combination of procedure codes, per day, any provider.
95885, 95886, 95887	Must be billed with one of the primary procedure codes 95907, 95908, 95909, 95910, 95911, 95912, or 95913.
95905	1 study per limb, per day, same provider. Claims may be submitted with a quantity of no more than 2 per detail line. Will be denied if billed on the same date of service by the same provider as procedure codes 95907, 95908, 95909, 95910, 95911, 95912, or 95913.
95933	Up to 2 studies per day, same provider.
95937	Up to 3 studies per day, per procedure, same provider without prior authorization.

Since the need for additional NCS or alternate procedures may be determined following initiation of the evaluation, a request for retroactive authorization may be submitted no later than seven calendar days beginning the day after testing is completed.

Medical record documentation must establish medical necessity for the additional studies, including:

- Other diagnosis in the differential that require consideration. The provider should note:
  - The additional diagnoses considered.
  - The clinical signs, symptoms, or electrodiagnostic findings that necessitated the inclusion.
- Multiple diagnoses are established by nerve conduction studies; the recommendations in the table above for a single diagnostic category do not apply. The provider should document all diagnoses established as a result of EDX testing.

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- 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 [ETOH] usage).
- Comorbid clinical conditions are identified. The clinical condition must be one that may cause sensory or motor symptoms, for example:
  - Underlying metabolic disease (such as thyroid condition or diabetes mellitus)
  - Nutritional deficiency (alcoholism)
  - Malignant disease
  - Inflammatory disorder (including but not limited to lupus, sarcoidosis or Sjögren's syndrome)

Texas Medicaid recognizes that EDX testing is tailored to the clinical findings of an individual client. It is, however, the expectation that testing be guided by accepted practice parameters and physician guidelines. The number of studies performed should be the minimum needed to establish an accurate diagnosis. Texas Medicaid, consistent with the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommendations, believes the recommendations of the AANEM to be a reasonable maximum number of studies for the documented clinical conditions as noted in the CPT manual. The AANEM recommendations will be used in determination of medical necessity of additional tests requested with prior authorization.

9.2.28.3 Evoked Potential Testing

Evoked potential (EP) tests are a benefit of Texas Medicaid when medically necessary. The most common EP tests are:

- Brainstem auditory evoked potentials (BAEPs)
- Motor evoked potentials (MEPs)
- Somatosensory evoked potentials (SEPs)
- Visual evoked potentials (VEPs)

Each EP test (procedure codes 92585, 92586, 95925, 95926, 95927, 95928, 95929, 95930, 95938, or 95939) is considered a bilateral procedure and is limited to once per date of service any provider regardless of modifiers that indicate multiple sites were tested.

EP tests may be reimbursed up to four services per rolling year, any combination of services by any provider. Claims that exceed the limitation of four services per rolling year may be considered for reimbursement on appeal with documentation that supports the medical necessity.

Intraoperative neurophysiology testing (procedure codes 95940 and 95941) is a benefit when performed in addition to each evoked potential test on the same day.

The documentation for the intraoperative neurophysiology testing must include the time for which each test is performed.

Procedure codes 95940 and 95941 are limited to a maximum of two hours per date of service, per client, per provider.

Procedure codes 95940 and 95941 must be billed in conjunction with one of the following procedure codes or the service will be denied:

Procedure Codes									
92585	95822	95860	95861	95867	95868	95870	95907	95908	95909
95910	95911	95912	95913	95925	95926	95927	95928	95929	95930
95933	95937								

Procedure codes 95940 and 95941 cannot be reported by the surgeon or anesthesiologist.

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The reason for the referral, the specific nerve evoked potential being tested, and a clear diagnostic impression must be documented in the client's medical record for each EP study performed.

The client's medical records must clearly document the medical necessity for the EP testing. The medical record documentation must reflect the actual results of specific tests (such as latency and amplitude).

Medical necessity for re-evaluation of a client (beyond the initial consultation and testing) must be clearly documented in the client's medical record. Supporting documentation includes, but is not limited to, the following:

- The client has new symptoms unrelated to those previously evaluated, suggestive of a new diagnosis.
- Evidence exists that the client's condition is changing rapidly, supported by the following:
  - Diagnosis
  - Current clinical signs and symptoms
  - Prior clinical condition
  - Expected clinical disease course
- There is clinical benefit of additional studies.

The client's medical records are subject to retrospective review. Wave form recordings obtained during the testing will aid documentation requirements in cases where a review becomes necessary.

9.2.28.3.1 Visual Evoked Potentials

Some of the conditions under which VEP testing (procedure code 95930) may be appropriate include, but are not limited to, the following:

- Identification of persons at increased risk for developing clinically definite multiple sclerosis.
- Diagnosing, monitoring, and assessing treatment response in multiple sclerosis.
- Localizing the cause of a visual field defect not explained by lesions seen on CT or MRI, or by metabolic disorders or infectious disease.
- Evaluating the signs and symptoms of visual loss in persons who are unable to communicate (e.g., unresponsive persons, non-verbal persons).
- Evaluating clients who experience double vision, blurred vision, loss of vision, eye injuries, head injuries, or weakness of the eyes, arms, or legs.

9.2.28.4 Motion Analysis Studies

Motion analysis studies (procedure codes 96000, 96001, 96002, and 96003) are a benefit of Texas Medicaid for clients who are 3 through 20 years of age.

Procedure codes 96000, 96001, 96002, and 96003 are limited to one per date of service by the same provider and two per rolling year, any provider.

In the following table, the procedure codes in Column A will be denied when they are submitted on the same date of service by the same provider as the procedure codes in Column B:

Column A (Denied)	Column B
96000	96001
95860, 95861, 95863, 95864, 95865, 95866, 95869, 95870, 95872	96002 or 96003

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Documentation must include the following information that indicates the client meets all the requirements for motion analysis studies. The client must be:

- Ambulatory for a minimum of ten consecutive steps, with or without assistive devices.
- At least three years of age.
- Physically able to tolerate up to three hours of testing.

The reason for the referral and a clear diagnostic impression must be documented in the client's medical record for each motion analysis study performed.

The client's medical records must clearly document the medical necessity for the motion analysis study. The medical record documentation must reflect the actual results of specific tests.

Medical necessity for re-evaluation of a client (beyond the initial consultation and testing) must be clearly documented in the client's medical record. Supporting documentation includes, but is not limited to, the following:

- The client has new symptoms unrelated to those previously evaluated, suggestive of a new diagnosis.
- Evidence exists that the client's condition is changing rapidly, supported by the following:
  - Diagnosis
  - Current clinical signs and symptoms
  - Prior clinical condition
  - Expected clinical disease course
- There is clinical benefit of additional studies.

The client's medical records are subject to retrospective review.

9.2.29 Extracorporeal Membrane Oxygenation (ECMO)

ECMO may be effective on a short-term basis for clients with life-threatening respiratory and/or cardiac insufficiency.

ECMO may be reimbursed for clients who have the following clinical indications (this is not an all-inclusive list):

- Persistent pulmonary hypertension
- Meconium aspiration syndrome
- Respiratory distress syndrome
- Adult respiratory distress syndrome
- Congenital diaphragmatic hernia
- Sepsis
- Pneumonia
- Preoperative and postoperative congenital heart disease or heart transplantation
- Reversible causes of cardiac failure
- Cardiomyopathy
- Myocarditis
- Aspiration pneumonia
- Pulmonary contusion

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- Pulmonary embolism

The following procedure codes may be used when billing ECMO:

Procedure Codes									
33946	33947	33948	33949	33951	33952	33953	33954	33955	33956
33957	33958	33959	33962	33963	33964	33965	33966	33969	33984
33985	33986	33987	33988	33989					

Terminal disease with expectation of short survival, advanced multiple organ failure syndrome, irreversible central nervous system injury and severe immunosuppression are contraindications to ECMO. Claims for ECMO services may be recouped if the services are provided in the presence of these conditions.

The initial 24 hours of veno-venous (VV) ECMO should be submitted using procedure code 33946. Procedure code 33948 should be used for each additional 24 hours. Procedure code 33946 is denied as part of procedure code 33948 if submitted with the same date of service. Procedure codes 33946 and 33948 are limited to one per day when billed by any provider.

The initial 24 hours of veno-arterial (VA) ECMO should be submitted using procedure code 33947. Procedure code 33949 should be used for each additional 24 hours. Procedure code 33947 is denied as part of procedure code 33949 if submitted with the same date of service. Procedure codes 33947 and 33949 are limited to one per day when billed by any provider.

If insertion of VV cannula (procedure codes 33951, 33952, 33953, 33954, 33955, and 33956) for prolonged extracorporeal circulation for cardiopulmonary insufficiency is submitted by the same provider with the same date of service as procedure code 33946 or 33948, the insertion of the cannula is denied, and the ECMO (procedure code 33946 or 33948) is considered for reimbursement.

If insertion of VA cannula (procedure codes 33951, 33952, 33953, 33954, 33955, and 33956) for prolonged extracorporeal circulation for cardiopulmonary insufficiency is submitted by the same provider with the same date of service as procedure code 33947 or 33949, the insertion of the cannula is denied, and the ECMO (procedure code 33947 and 33949) is considered for reimbursement.

9.2.30 Family Planning

Physicians, PAs, NPs, CNSs, and CNMs are encouraged to provide family planning services to Texas Medicaid clients, especially pregnant and postpartum clients. No separate enrollment is required. Providers are reimbursed for family planning services through Texas Medicaid (Title XIX) or through the DSHS Family Planning Program.

Refer to: Section 2, "Medicaid Title XIX Family Planning Services" in the *Gynecological and Reproductive Health and Family Planning Services Handbook* (*Vol. 2, Provider Handbooks*).

Section 3, "Texas Women's Health Program" in the *Gynecological and Reproductive Health and Family Planning Services Handbook* (*Vol. 2, Provider Handbooks*).

9.2.31 Gynecological Health Services

Gynecological examinations, surgical procedures, and treatments are benefits of Texas Medicaid.

Refer to: Section 5, "Gynecological Health Services" in the *Gynecological and Reproductive Health and Family Planning Services Handbook* (*Vol. 2, Provider Handbooks*) for information about contraception, sterilizations, and family planning annual examinations.

9.2.32 Hospital Visits

Refer to: Subsection 9.2.58, "Physician Evaluation and Management (E/M) Services," in this handbook.

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9.2.33 Hyperbaric Oxygen Therapy (HBOT)

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.

Note: *Although oxygen may be administered by mask, cannula, or tube in addition to the hyperbaric treatment, the use of oxygen by mask, or other device, or applied topically is not considered hyperbaric treatment in itself.*

Texas Medicaid recognizes the following indications for HBOT, as approved by the Undersea and 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
- Delayed radiation injury (soft tissue and bony necrosis)
- Diabetic foot ulcer
- Severe anemia
- Clostridial myositis and myonecrosis (gas gangrene)
- Intracranial abscess
- Necrotizing soft tissue infections
- Refractory osteomyelitis
- Acute thermal burn injuries

HBOT is not a replacement for other standard successful therapeutic measures.

Texas Medicaid 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.

The physician must be in constant attendance of hyperbaric oxygen therapy during compression and decompression of the chamber and may not delegate the rendering of the 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 direct supervision of the compression and decompression phases of the HBOT treatment. All documentation pertaining to HBOT is subject to retrospective review.

9.2.33.1 Prior Authorization for HBOT

HBOT procedure codes 99183 and G0277 require prior authorization. Prior authorization requests submitted for procedure code G0277 must also include revenue code 413. When requesting prior authorization, providers should use the Special Medical Prior Authorization (SMPA) Request Form on the TMHP website at www.tmhp.com.

Refer to: Section 5: Fee-for-Service Prior Authorizations for detailed information about prior authorization requirements.

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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 30-Minute Intervals Allowed for Procedure Code G0277	Total 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
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

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

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Covered Indication	Total 30-Minute Intervals Allowed for Procedure Code G0277	Total Professional Sessions Allowed for Procedure Code 99183	Medical Necessity Documentation of the Following is Required
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 clinical response to conventional treatment
Delayed radiation injury - one subsequent authorization	40	10	Evidence of improvement demonstrated by clinical response
Refractory osteomyelitis - initial authorization	40	10	Evidence of unsatisfactory clinical response to conventional multidisciplinary treatment
Refractory osteomyelitis - one subsequent authorization	15	5	Evidence of improvement demonstrated by clinical response
Acute thermal burn injury - initial authorization	45	15	Partial or full thickness burns covering greater than 20% of total body surface area OR with involvement of the hands, face, feet or perineum
Acute thermal burn injury - three subsequent authorizations	30	10	Evidence of continuing improvement demonstrated by clinical response
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

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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.

Limitations beyond those listed in the table above are considered experimental and investigational.

In emergency situations, the prior authorization request must be submitted no later than three business days after the date the service is rendered. Providers must not submit a claim until the prior authorization request has been approved. If the request has not been approved, the claim will be denied.

9.2.34 Ilizarov Device and Procedure

Providers must use procedure codes 20692, 20693, 20694, and 20999 when submitting claims for the Ilizarov procedure. A global fee payment methodology is applied to the Ilizarov device procedure codes. Procedure codes 20692, 20693, 20694, and 20999 include the preconstruction, surgical application, adjustments to the device for up to 6 months, and the removal of the device.

Providers who bill for other external fixator devices, such as the Monticelli device, should continue to use procedure codes 20690 or 20692, where applicable, when billing for the surgical applications.

9.2.35 Immunization Guidelines and Administration

Texas Medicaid reimburses immunizations (vaccines and toxoids) that the Advisory Committee on Immunization Practices (ACIP) recommends as routine.

Providers must follow the most current ACIP recommendations unless they conflict with guidelines from the Texas Vaccines for Children (TVFC) Program, in which case providers must follow TVFC guidelines. Providers must also provide the appropriate vaccine information statements (VISs) produced by the Centers for Disease Control and Prevention (CDC). VISs explain the benefits and risks of the vaccines and toxoids administered.

Note: *Administered vaccines and toxoids must be reported to DSHS. After obtaining consent, DSHS submits all reported vaccines and toxoids to a centralized repository of immunization histories. This lifespan registry is known in Texas as ImmTrac.*

9.2.35.1 Administration Fee

An administration fee may be reimbursed for all covered vaccines and toxoids that are administered according to the ACIP. The following procedure codes may be reimbursed when billed for vaccine and toxoid administration:

Procedure Code					
90460	90461	90471	90472	90473	90474

Procedure codes 90460 and 90461 are benefits for services rendered to clients who are birth through 18 years of age when counseling is provided for the immunization administered.

Procedure codes 90471, 90472, 90473, and 90474 are benefits when counseling is not provided for the immunization administered. Procedure codes 90471 and 90472 may be reimbursed for services rendered to clients of any age. Procedure codes 90473 and 90474 are restricted to clients who are 20 years of age and younger.

The administration fee may be reimbursed when the procedure code for the vaccine or toxoid administered (regardless of the source of the vaccine or toxoid) and the administration fee procedure code are billed on the same claim with the same date of service. Only one administration fee may be reimbursed to any provider for each vaccine or toxoid administered per day.

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The following vaccines and toxoids procedure codes are a benefit of Texas Medicaid for clients who are 20 years of age and younger based on the number of recognized components as follows:

Procedure Code	Number of Recognized Components**	Procedure Code	Number of Recognized Components**
90620*	1	90621*	1
90632	1	90633*	1
90636	2	90644	2
90647*	1	90648*	1
90649*	1	90650*	1
90651*	1	90654	1
90655*	1	90656*	1
90657*	1	90658*	1
90660*	1	90661	1
90670*	1	90673	1
90680*	1	90681*	1
90685*	1	90686*	1
90687*	1	90688*	1
90696*	4	90698*	5
90700*	3	90702*	2
90707*	3	90710*	4
90713*	1	90714*	2
90715*	3	90716*	1
90723*	5	90732*	1
90733	1	90734*	1
90743	1	90744*	1
90746	1	90748*	2
90749	1		

*** TVFC-distributed vaccine/toxoid**
**** The number of components applies if counseling is provided and procedure codes 90460 and 90461 are submitted.**

Each vaccine or toxoid and its administration must be submitted on the claim in the following sequence: the vaccine procedure code immediately followed by the applicable immunization administration procedure code(s). All of the immunization administration procedure codes that correspond to a single vaccine or toxoid procedure code must be submitted on the same claim as the vaccine or toxoid procedure code.

Each vaccine or toxoid procedure code must be submitted with the appropriate "administration with counseling" procedure code(s) (procedure codes 90460 and 90461) or the most appropriate "administration without counseling" procedure code (procedure code 90471, 90472, 90473, or 90474). If an "administration with counseling" procedure code is submitted with an "administration without counseling" procedure code for the same vaccine or toxoid, the second administration of the vaccine or toxoid will be denied.

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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 first component.
- Procedure code 90461 is submitted for the administration of each additional component identified in the vaccine.

Procedure code 90461 will be denied if procedure code 90460 has not been submitted on the same claim for the same vaccine or toxoid.

The necessary counseling that is conducted by a physician or other qualified health-care professional must be documented in the client's medical record.

The following is an example of how to submit claims for immunization administration procedure codes when counseling is provided:

Procedure Code	Quantity Billed
Vaccine or toxoid procedure code with 1 component	1
90460 (1st component)	1
Vaccine or toxoid procedure code with 3 components	1
90460 (1st component)	1
90461 (2nd and 3rd components)	2

Note: *The term "components" refers to the number of antigens that prevent disease(s) caused by one organism. Combination vaccines are those that contain multiple vaccine components.*

Administration without Counseling

Procedure codes 90471, 90472, 90473, and 90474 may be reimbursed per vaccine based on the 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

9.2.35.2 Documentation

Providers must document the following information in the client's medical record, which is subject to retrospective review to determine appropriate utilization and reimbursement of this service:

- The vaccine or toxoid given
- The date of the vaccine or toxoid administration (day, month, year)
- The name of the vaccine or toxoid manufacturer and the vaccine or toxoid lot number

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- The signature and title of the person administering the vaccine or toxoid
- The organization's name and address
- The publication date of the VIS issued to the client, parent, or guardian
- The site at which the vaccine was given (recommended)

9.2.35.3 Vaccine Adverse Event Reporting System (VAERS)

VAERS encourages providers to report any adverse event that occurs after the administration of any vaccine in the United States, even if it's unclear whether a vaccine caused it. 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 listed in the VAERS Reportable Events Table that occurs within the specified time period after vaccination.

Clinically significant adverse events should be reported even if it is unclear whether a vaccine caused the event.

Documentation of the injection site is recommended but not required.

A copy of the Reportable Events Table can be obtained by calling VAERS at 1-800-822-7967 or by downloading it from http://vaers.hhs.gov/resources/vaersmaterialspublications.

9.2.36 Immunizations for Clients Birth through 20 Years of Age

Administration of vaccines and toxoids to clients who are birth through 20 years of age may be a benefit of THSteps when provided as part of a THSteps medical checkup. A THSteps provider who bills vaccines and toxoids with diagnosis or age restrictions is subject to those restrictions. In addition to the age appropriate diagnosis for the THSteps preventive care medical checkup, providers must bill the claim with the diagnosis code that indicates the condition that necessitates the vaccine or toxoid.

If an immunization is administered as part of the preventive care medical checkup, diagnosis code Z23 may also be included on the claim, in addition to the age-appropriate diagnosis.

If an immunization is the only service provided during an office visit, providers may submit only diagnosis code Z23 on the claim.

Administration of vaccines and toxoids to clients who are birth through 20 years of age may be a benefit of CCP when the vaccine or toxoid is provided as part of an acute medical visit outside of a THSteps medical checkup.

Refer to: Section 5, "THSteps Medical" in the *Children's Services Handbook* (V*ol. 2, Provider Handbooks*) for more information on THSteps age related diagnosis codes.

9.2.36.1 Vaccine Coverage Through the TVFC Program

Providers may refer to the TVFC web site at www.dshs.state.tx.us/immunize/tvfc/default.shtm for information about the program and for a list of vaccines available through the program.

Note: *TVFC program resolutions do not always match the ACIP's general usage recommendations, but rather represent the rules that providers must follow when administering each specific vaccine under the TVFC.*

When a single antigen vaccine or toxoid or a comparable antigen vaccine or toxoid is available through TVFC, but the provider chooses to use a different ACIP-recommended product, the administration fee will be reimbursed but the vaccine or toxoid will not be reimbursed.

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Although Texas Medicaid does not mandate that providers enroll in TVFC, Texas Medicaid will not reimburse providers when the vaccine is available through TVFC. Only the administration fee will be reimbursed through Texas Medicaid when the vaccine or toxoid procedure code is identified on the claim. Clients may not be billed for vaccines and toxoids that are available through TVFC.

If a vaccine or toxoid meets the definition of "not available" through TVFC, it may be separately reimbursed through CCP when billed with modifier U1. Modifier U1 may be used in the following situations:

- The TVFC, based on their federal resolution (distribution/guidelines), does not distribute an HHSC-approved vaccine or toxoid following the ACIP recommendation, and the provider purchases vaccine to administer to all ACIP-recommended ages or risk groups.
- A new vaccine or toxoid approved by the ACIP with established guidelines, but has not been negotiated or added to a TVFC contract
- Funding for new vaccine or toxoid has not been established by TVFC
- Insufficient vaccine and toxoid supply due to national supply or distribution issues, as reported to HHSC by TVFC

HHSC will notify providers if a vaccine or toxoid meets the definition of "not available" from TVFC and when the provider's privately purchased vaccine or toxoid may be billed with modifier U1. Modifier U1 must not be used due to a provider's failure to enroll in TVFC or to maintain sufficient TVFC vaccine or toxoid inventory.

Refer to: Subsection 5.1.3, "Texas Vaccines for Children (TVFC) Program," in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about TVFC and immunizations for infants and children.

9.2.36.2 Vaccine and Toxoid Procedure Codes

The following vaccine and toxoid procedure codes may be reimbursed for Texas Medicaid clients who are birth through 20 years of age:

<table>
<tr><th colspan="5">Procedure Code</th></tr>
<tr><td colspan="5">Bacillus Calmette-Guérin (BCG)</td></tr>
<tr><td colspan="5">Refer to: Subsection 9.2.9, "Bacillus Calmette-Guérin (BCG) Intravesical for Treatment of Bladder Cancer," in this handbook.</td></tr>
<tr><td colspan="5">Hepatitis A and B</td></tr>
<tr><td>90632</td><td>90633*</td><td>90636</td><td>90723*</td><td>90740</td></tr>
<tr><td>90743</td><td>90744*</td><td>90746</td><td>90747</td><td>90748*</td></tr>
<tr><td colspan="5">Providers must document in the client's medical record the indication for the hepatitis B vaccine, for dialysis patients. These records are subject to retrospective review to determine appropriate utilization of and reimbursement for this service.

Procedure codes 96372 and 96374 may be reimbursed for the administration of hepatitis B vaccine procedure codes 90740 and 90747.

Providers are expected to follow the ACIP recommendations for administration.</td></tr>
<tr><td colspan="5">Hepatitis B Immune Globulin</td></tr>
<tr><td>90371</td><td>96372</td><td>96374</td><td>J1571</td><td>J1573</td></tr>
<tr><td colspan="5">* Indicates a vaccine or toxoid distributed through TVFC. Vaccines and toxoids available through TVFC for clients who are birth through 18 years of age will not be reimbursed through Texas Medicaid. These vaccines and toxoids will be processed as informational.</td></tr>
</table>

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Procedure Code				
Providers must document in the client's medical record the indication for the immunoglobulin. These records are subject to retrospective review to determine appropriate utilization of and reimbursement for this service. Intramuscular hepatitis B immune globulin (HBIg) may be reimbursed when medically necessary to provide coverage for acute exposure to the hepatitis B virus. HBIg is not provided through TVFC. Procedure codes 90371, J1571, and J1573 must be billed with diagnosis code Z205, Z206, or Z20828. Only one HBIg procedure code will be paid if billed with the same date of service by any provider as any other HBIg procedure code. Procedure codes 96372 and 96374 may be reimbursed for HBIg administration. Providers are expected to follow the ACIP recommendations for administrations.				
Hib				
90647*	90648*			
Human Papilloma (HPV)				
90649*	90650*	90651*		
Influenza				
90654	90655*	90656*	90657*	90658*
90660*	90661	90672*	90673	90685*
90686*	90687*	90688*		
Influenza vaccine is a benefit of Texas Medicaid for high-risk clients who are not covered by THSteps or TVFC or when the vaccine is not declared available through the TVFC. Texas Medicaid considers the influenza season in the United States to be October through the end of May.				
MMR and MMRV				
90707*	90710*			
Pneumococcal and Meningococcal				
90620*	90621*	90670*	90732*	90733
90734*				
The pneumococcal polysaccharide vaccine (procedure code 90732) is a benefit for Texas Medicaid clients who are not covered by the THSteps or TVFC programs The initial pneumococcal polysaccharide vaccine is limited to one per client per lifetime. For high-risk clients, revaccination is recommended once in a lifetime five years after the initial dose. Revaccination after a second dose is not a benefit of Texas Medicaid. Pneumococcal polysaccharide vaccine is not recommended for children who are birth through 23 months of age. Providers are expected to follow the ACIP recommendations for administrations.				
Poliovirus (IPV)				
90713*				
Rotavirus				
90680*	90681*			
*** Indicates a vaccine or toxoid distributed through TVFC. Vaccines and toxoids available through TVFC for clients who are birth through 18 years of age will not be reimbursed through Texas Medicaid. These vaccines and toxoids will be processed as informational.**				

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Procedure Code				
Tetanus and Diphtheria				
90696*	90698*	90700*	90702*	90714*
90715*	90723*			
Unlisted				
90749				
Varicella Virus				
90716*				
*** Indicates a vaccine or toxoid distributed through TVFC. Vaccines and toxoids available through TVFC for clients who are birth through 18 years of age will not be reimbursed through Texas Medicaid. These vaccines and toxoids will be processed as informational.**				

9.2.37 Immunizations for Clients Who Are 21 Years of Age and Older

Vaccines and toxoids may be reimbursed through Texas Medicaid at a fee determined by HHSC when the vaccine is medically necessary. Providers are expected to follow the ACIP recommendations for administration.

The following immunizations are identified and recommended by the ACIP as medically-necessary for clients who are 21 years of age and older (this list is not all-inclusive):

Immunization Procedure Codes				
BCG				
Refer to: Subsection 9.2.9, "Bacillus Calmette-Guérin (BCG) Intravesical for Treatment of Bladder Cancer," in this handbook.				
Hepatitis A				
90632				
Hepatitis B				
90740	90746	90747		
Providers must document in the client's medical record the indication for the hepatitis B vaccine, for dialysis patients. These records are subject to retrospective review to determine appropriate utilization of and reimbursement for this service. Procedure codes 96372 and 96374 may be reimbursed for the administration of hepatitis B vaccine procedure codes 90740 and 90747.				
Hepatitis B Immune Globulin				
90371	96372	96374	J1571	J1573
Providers must document in the client's medical record the indication for the immunoglobulin. These records are subject to retrospective review to determine appropriate utilization of and reimbursement for this service. Intramuscular HBIg may be reimbursed when medically necessary to provide coverage for acute exposure to the hepatitis B virus. HBIg is not provided through TVFC. Procedure codes 90371, J1571, and J1573 must be billed with diagnosis code Z205, Z206, or Z20828. Only one HBIg procedure code will be paid if billed with the same date of service by any provider as any other HBIg procedure code. Procedure codes 96372 and 96374 may be reimbursed for HBIg administration.				
Hepatitis A and B				
90636				

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Immunization Procedure Codes				
Human Papilloma (HPV)				
90649	90650	90651		
Influenza				
90630	90654	90656	90658	90661
90662	90673	90686	90688	
Influenza vaccine is a benefit of Texas Medicaid for all clients. Texas Medicaid considers the influenza season in the United States to be October through the end of May. The optimal time to receive influenza vaccine is as early in the season as it is available. However, clients should continue to receive influenza vaccine through March. The vaccine may be administered one time per influenza season.				
Measles, Mumps, Rubella Vaccine (MMR)				
90707				
Pneumococcal and Meningococcal				
90620	90621	90670	90732	
The initial pneumococcal polysaccharide vaccine is limited to one per client per lifetime. Revaccination is recommended five years (not interpreted to mean every five years) after the initial dose for high-risk individuals. Revaccination after a second dose is not reimbursed.				
Shingles				
90736				
Shingles vaccine is a benefit of Texas Medicaid for clients who are 60 years of age and older.				
Tetanus				
90714				
Tetanus, Diphtheria, and Acellular Pertussis Vaccine (Tdap)				
90715				

The specific diagnosis necessitating the vaccine or toxoid is required when billing the administration fee procedure code in combination with the appropriate vaccine procedure code. All immunizations must be reported with diagnosis code Z23. The type of immunization given will be identified by the procedure code.

9.2.38 Postexposure Prophylaxis for Rabies

Postexposure prophylaxis for rabies procedure codes 90375, 90376, and 90675 is a benefit of Texas Medicaid. Rabies vaccine for pre-exposure procedure code 90676 is not a benefit of Texas Medicaid.

Postexposure rabies vaccine is limited to clients with diagnosis code Z203.

Animal bites to people must be reported as soon as possible to the Local Rabies Control Authority (LRCA).

Postexposure prophylaxis for rabies is not necessary following exposure to an animal that tests negative for the rabies virus.

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 injection should be given in or near the wound area.

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HRIG that is not administered when vaccination begins can be administered up to seven 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.

The recommended dose of HRIG is 20 IU/kg body weight. This formula is applicable to all age groups, including children.

The postexposure treatment will also include five doses of rabies vaccine (1.0 ml. intramuscular). The first dose should be given as soon as possible after the exposure (day 0). Additional doses should be given on days 3, 7, 14, and 28 after the first shot. For an exposed person who has previously been vaccinated with a complete pre- or postexposure vaccine series, two doses of rabies vaccine should be given on days 0 and 3.

Health care providers, who determine their client requires the preventative 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.

Injection administration is a benefit for administration of rabies vaccine for post exposure.

9.2.38.1 Prior Authorization for Postexposure Rabies Vaccine

Prior authorization is not required for postexposure rabies vaccine. The physician must maintain documentation of the exposure in the client's medical record.

9.2.38.2 Limitations for Postexposure Rabies Vaccine

Reimbursement for postexposure rabies vaccine is limited to one per client per day, by any provider.

Reimbursement for postexposure rabies vaccine is limited to 5 occurrences per 90 rolling days. Claims billed for any vaccine given beyond 90 rolling days will be denied.

9.2.38.2.1 Obtaining Rabies Vaccine and HRIG from DSHS for PEP Use

Providers may obtain the vaccine and HRIG directly from the manufacturer. If a provider is not able to obtain the vaccine and/or HRIG directly, providers may contact DSHS local or state public health professionals.

For each potential rabies exposure, providers must consult with their local health department or the DSHS regional ZC program office that serves their area. Requests for consultations made to DSHS after-hours or on holidays should be directed to the DSHS On-Call Physician at 1-888-963-7111.

Local public health professionals or regional ZC staff will help providers determine whether or not the exposure situation warrants PEP. If the exposure situation is determined to be valid, providers will be given detailed information about how to obtain rabies vaccine and HRIG for the patient.

Providers can refer to the following DSHS web pages for the contact information of local public health professionals:

- Full Service Local Health Departments and Districts of Texas at www.dshs.state.tx.us/regions/lhds.shtm
- Zoonosis Control Branch at www.dshs.state.tx.us/idcu/health/zoonosis/contact/
- Use of a Reduced (4-Dose) Vaccine Schedule for Postexposure Prophylaxis to Prevent Human Rabies, Recommendations of the Advisory Committee on Immunization Practices March 19, 2010 www.cdc.gov/mmwr/pdf/rr/rr5902.pdf
- DSHS rabies website at www.dshs.state.tx.us/idcu/disease/Rabies/
- Regional DSHS ZC offices

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- "Human Rabies Prevention—United States, 2008 Recommendations of the Advisory Committee on Immunization Practices"
- CDC rabies website at www.cdc.gov/rabies/

9.2.39 Medications—Injectable

Providers are responsible for administering drugs based on the FDA-approved guidelines. In the absence of FDA indications, a drug needs to meet the following criteria:

- The drug is recognized by the American Medical Association Drug Evaluations (AMA-DE), American Hospital Formulary Service Drug Information, the *U.S. Pharmacopoeia Dispensing Information*, Volume I, or two articles from major peer-reviewed journals that have validated and uncontested data supporting the proposed use for the specific medical condition as safe and effective.
- It is medically necessary to treat the specific medical condition, including life-threatening conditions or chronic and seriously debilitating conditions.
- The off-label use of the drug is not investigational or experimental.

Retrospective review may be performed to ensure documentation supports the medical necessity of the service.

Injections given in the physician's office, the client's home, or the nursing home may be reimbursed using the correct procedure code for the specific drug and dosage given. The following injections are benefits of Texas Medicaid and are subject to the indicated limitations:

Injected Drug	Procedure Code(s)	Limitation(s)
Azacitidine (*Vidaza*)	J9025	Diagnosis limitations: C9202, C9210, C9212, C9220, C9222, C9232, C9242, C9252, C9262, C9290, C9292, C92A2, C92Z2, C9310, C9312, C9330, C9332, C9502, C9510, C9512, C9592, D460, D461, D4620, D4621, D4622, D464, D469, D46A, D46B, D46C, D46Z, D640, D641, D642, D643
Cladribine (*Leustatin*)	J9065	Diagnosis limitations: C8441, C8442, C8443, C8444, C8445, C8446, C8447, C8448, C8449, C9140, C9141, C9142
Denileukin diftitox (*Ontak*)	J9160	Benefit for clients who have advanced or recurrent cutaneous T-cell lymphoma with the CD25 component of IL-2 and failure of at least one type of traditional therapy. Documentation of diagnosis and treatment must be submitted with the claim.
Dimethyl sulfoxide	J1212	Diagnosis limitation: N3010, N3011
Eculizumab	J1300	Diagnosis limitations: D588, D591, D593, D594, D595, D596, D598
Ferric carboxymaltose	J1439	Treatment may be indicated for, but is not limited to, treatment of iron deficiency anemia for adult clients with the following: • Intolerance or unsatisfactory response to oral iron • Non-dialysis-dependent chronic kidney disease
Galsulfase	J1458	Diagnosis limitation: E7601, E7602, E7603, E761, E76210, E76211, E76219, E7622, E7629, E763, E768, or E769
Granisetron hydrochloride	J1626	Diagnosis limitations: Z1589, Z510, Z5111, Z5112
(Diagnosis limitations) The procedure code must be billed with one of the diagnosis codes listed.		

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Injected Drug	Procedure Code(s)	Limitation(s)
Ibutilide fumarate	J1742	Diagnosis limitations: I480, I481, I482, I483, I484
Idursulfase (*Elaprase*)	J1743	Diagnosis limitation: E7601, E7602, E7603, E761, E76210, E76211, E76219, E7622, E7629, E763, E768, or E769
Iron Dextran	J1750	Treatment may be indicated for, but is not limited to, the following condition: Iron deficiency anemia when oral administration is unsatisfactory or impossible.
Iron Sucrose (*Venofer*)	J1756	Treatment may be indicated for, but is not limited to, the following conditions: • Non-dialysis-dependent chronic kidney disease (NDD-CKD) for clients who are receiving erythropoietin. • NDD-CKD for clients who are not receiving erythropoietin. • Hemodialysis-dependent chronic kidney disease (HDD-CKD) for clients who are receiving erythropoietin. • Peritoneal dialysis-dependent chronic kidney disease (PDD-CKD) clients who are receiving erythropoietin.
Natalizumab	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
Porfimer (*Photofrin*)	J9600	Diagnosis limitations: C153, C154, C155, C158, C159, C787, C7889
Sodium Ferric Gluconate Complex in Sucrose (*Ferrlecit*)	J2916	Treatment may be indicated for, but is not limited to the following condition: Iron deficiency anemia in clients who are six years of age and older who are undergoing long term hemodialysis treatments and who are receiving supplemental epoetin therapy.
Sumatriptan succinate (*Imitrex*)	J3030	Diagnosis limitations: G43001, G43009, G43011, G43019, 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
Thyrotropin alpha for injection (*Thyrogen*)	J3240	Diagnosis limitations: C323, C73, D020, D093, D098, D380, D440, D442, D449, D497, E010, E011, E012, E040, E042, E048, E049, E0500, E0520, or Z85850
Valrubicin sterile solution for intravesical instillation (*Valstar*)	J9357	Benefit for clients with the diagnosis of bladder cancer *in situ* who have been treated unsuccessfully with BCG therapy and have an unacceptable morbidity or mortality risk if immediate cystectomy should be performed. Documentation of diagnosis and treatment must be submitted with the claim.
(Diagnosis limitations) The procedure code must be billed with one of the diagnosis codes listed.		

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Important: *The 11-digit National Drug Code (NDC) must be submitted on the claim with the appropriate procedure code. The NDC submitted to Texas Medicaid must be the NDC on the package or container from which the medication was administered.*

Refer to: Subsection 6.3.4, "National Drug Code (NDC)," in Section 6, "Claims Filing" (*Vol. 1, General Information*) for more information about filing claims with the NDC.

Refer to: Subsection 6.3.4.3, "Drug Rebate Program," in Section 6, "Claims Filing"(*Vol. 1, General Information*) for information about the reimbursement of clinician-administered drugs and biologicals.

Note: *Physicians billing for injections, either intramuscular (IM) or subcutaneous (SQ) or intravenous administration (IV) in the inpatient hospital setting, skilled nursing facility or outpatient hospital will be denied, as these costs are included in the reimbursement methodology of the inpatient facility, skilled nursing facility, or the outpatient facility.*

Refer to: Subsection 2.2.1.3, "Drugs and Biologicals," in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for the reimbursement methodology for injections.

9.2.39.1 Abatacept (Orencia)

Abatacept is a benefit of Texas Medicaid for clients who have moderately to severely active rheumatoid arthritis. These clients may also have an inadequate response to one or more non-biological, disease-modifying antirheumatic drugs (DMARDs).

9.2.39.1.1 Prior Authorization for Abatacept (Orencia)

Providers must obtain prior authorization for procedure code J0129 to request reimbursement for abatacept. The prior authorization requests must include medical necessity documentation that contains the following information:

- Dates of treatment
- Diagnosis of adult RA or juvenile idiopathic arthritis (JIA)

  Note: *A diagnosis of adult RA must conform to the American College of Rheumatology (ACR) RA classification that requires the following:*

  - Presence of synovitis in at least one joint
  - Absence of an alternative diagnosis to explain the synovitis
  - A combined score of at least six out of ten on the level of involved joints, abnormality, and symptom duration from the individual scores in four domains:
    - The number and sites of involved joints
    - Serologic abnormality
    - Elevated acute-phase response
    - Symptom duration
- The number of anticipated doses
- The dosage to be administered

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Prior authorization for an initial request for abatacept injections may be granted for six months for eight doses. Prior authorization will be considered when the client has an inadequate response after 12 weeks to a nonbiological DMARD such as methotrexate or sulfasalazine or one or more biological (injectable) DMARDs, such as adalimumab, etanercept, or tumor necrosis factor (TNF) antagonists. The inadequate response must be indicated by all of the following commonly used prognostic factors:

- Visual Analogue scale (VAS) (4 or greater on a pain scale from 0-10)
- Global Arthritis Score (GAS) (3 or greater with remission defined as less than 3)
- Health Assessment Questionnaire Disability Index (HAQDI) score (greater than 1)
- Evidence of radiographic erosions
- Elevated erythrocyte sedimentation rate (greater than 20 millimeters/hour)
- Elevated C-reactive protein level (greater than zero milligrams/deciliter)
- Elevated rheumatoid factor (RF) level (greater than 60 units/millimeter or a titer greater than 1:80 titer)
- Elevated anti-cyclic citrullinated peptide (anti-CCP) antibody level (20 units/millimeter or greater)

Prior authorization for a subsequent request must include all of the following:

- Documentation from the physician stating that there has been at least a 20-percent improvement as defined by the ACR
- The number of anticipated doses
- The dosage to be administered

Prior authorization for subsequent dosing may be given for a maximum of six doses when documentation supports medical necessity for continued treatment with abatacept.

The documentation of medical necessity must be maintained by the requesting provider in the client's medical record and is subject to retrospective review.

Prior authorization is a condition for reimbursement; it is not a guarantee of payment. Providers may fax or mail the prior authorization request to the TMHP Special Medical Prior Authorization Department at:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization Department
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax: 1-512-514-4213

9.2.39.2 Adalimumab

Procedure code J0135 is a benefit when billed with one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone 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	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

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
K5180	K51811	K51812	K51813	K51814	K51818	K5190	K51911
K51912	K51913	K51914	K51918	K51919	L400	L401	L402
L403	L404	L4050	L4051	L4052	L4053	L4054	L4059
L408	L409	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
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	M0560	M05611
M05612	M05619	M05621	M05622	M05629	M05631	M05632	M05639
M05641	M05642	M05649	M05651	M05652	M05659	M05661	M05662
M05669	M05671	M05672	M05679	M0569	M05711	M05712	M05721
M05722	M05731	M05732	M05741	M05742	M05751	M05752	M05761
M05762	M05769	M05771	M05772	M05779	M0579	M05811	M05812
M05821	M05822	M05831	M05832	M05841	M05842	M05851	M05852
M05861	M05862	M05871	M05872	M0589	M06011	M06012	M06021
M06022	M06031	M06032	M06041	M06042	M06051	M06052	M06061
M06062	M06071	M06072	M0608	M0609	M061	M06811	M06812
M06819	M06821	M06822	M06829	M06831	M06832	M06839	M06841
M06842	M06849	M06851	M06852	M06859	M06861	M06862	M06869
M06871	M06872	M06879	M0688	M0689	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	M488X1	M488X2	M488X3	M488X4
M488X5	M488X6	M488X7	M488X8	M488X9			

9.2.39.3 Ado-trastuzumab entansine (Kadcyla)

Ado-trastuzumab emtansine (Kadcyla), procedure code J9354, is a benefit of Texas Medicaid for clients of any age.

Documentation must be maintained by the treating physician in the client's medical record to support administration of Ado-trastuzumab emtansine (Kadcyla).

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At initiation of treatment, documentation must include all of the following:

- Evidence of HER2 positive breast cancer as evidenced by immunochemistry (IHC) test or fluorescent in situ hybridization (FISH) test
- Evidence of metastatic breast cancer
- Evidence demonstrating prior treatment for this diagnosis with trastuzumab and a taxane oncology agent separately or in combination
- Evidence demonstrating receipt of prior therapy for this diagnosis or recurrent disease, including the previous treatment protocol, within six months of completing adjuvant therapy.

9.2.39.4 Alglucosidase Alfa (Myozyme)

Aglucosidase alfa is a benefit of Texas Medicaid for clients of any age who are diagnosed with glycogen storage disease Type II (GSD Type II) (Pompe disease). The most appropriate diagnosis code must be indicated on the prior authorization request and on the claim.

9.2.39.4.1 Prior Authorization for Alglucosidase Alfa (Myozyme)

Providers must obtain prior authorization for procedure code J0220 or J0221 to request reimbursement for alglucosidase alfa. The prior authorization request must include medical necessity documentation that contains laboratory evidence of acid alpha-glucosidase (GAA) deficiency (i.e., below the laboratory-defined cutoff value as determined by the laboratory performing the GAA enzyme activity assay). Tissues used for the determination of GAA deficiency include blood, muscle, or skin fibroblasts.

Prior authorization is a condition for reimbursement; it is not a guarantee of payment. Providers may fax or mail prior authorization requests, including all required documentation, to the TMHP Special Medical Prior Authorization Department at:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization Department
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax: 1-512-514-4213

9.2.39.5 Amifostine

Amifostine is a benefit of Texas Medicaid for the reduction of the cumulative renal toxicity associated with administration of cisplatin in clients who have advanced ovarian cancer or non-small cell lung cancer with documentation of a creatinine clearance of 50 or less and where no other chemotherapeutic agent can be used.

Amifostine may also be used to reduce the incidence of moderate-to-severe xerostomia in clients undergoing postoperative radiation treatment for head and neck cancers where the radiation port includes a substantial portion of the parotid glands.

Amifostine may be reimbursed for the following indications:

- Bone marrow toxicity
- Cisplatin- and cyclophosphamide-induced (prophylaxis)
- Advanced solid tumors
- Head and neck carcinoma
- Malignant lymphoma
- Non-small cell lung cancer
- Myelodysplastic syndromes
- Nephrotoxicity

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- Advanced ovarian carcinoma
- Melanoma
- Advanced solid tumors of non-germ cell origin
- Neurotoxicity
- Reduction in the incidence of mucositus in clients receiving radiation therapy, or radiation combined with chemotherapy
- Reduction in the incidence of xerostomia associated with postoperative radiation treatment of head and neck cancer, where the radiation port includes a substantial portion of the parotid glands

Providers must use procedure code J0207 with one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
A690	A691	C000	C001	C002	C003	C004	C005
C006	C008	C01	C020	C021	C022	C023	C024
C028	C029	C030	C031	C039	C040	C041	C048
C049	C050	C051	C052	C058	C059	C060	C061
C062	C0689	C069	C07	C080	C081	C089	C090
C091	C098	C099	C100	C101	C102	C103	C104
C108	C109	C110	C111	C112	C113	C118	C119
C12	C130	C131	C132	C138	C139	C140	C142
C148	C153	C154	C155	C158	C159	C160	C161
C162	C163	C164	C165	C166	C168	C169	C170
C171	C172	C173	C178	C179	C180	C181	C182
C183	C184	C185	C186	C187	C188	C189	C19
C20	C210	C211	C218	C220	C221	C222	C223
C227	C228	C229	C23	C240	C241	C248	C249
C250	C251	C252	C253	C254	C257	C258	C259
C260	C261	C269	C300	C301	C310	C311	C312
C313	C318	C319	C320	C321	C322	C323	C328
C329	C33	C3400	C3401	C3402	C3410	C3411	C3412
C342	C3430	C3431	C3432	C3480	C3481	C3482	C3490
C3491	C3492	C37	C380	C381	C382	C383	C384
C388	C390	C399	C4000	C4001	C4002	C4010	C4011
C4012	C4020	C4021	C4022	C4030	C4031	C4032	C4081
C4082	C410	C411	C412	C413	C414	C419	C430
C4310	C4311	C4312	C4320	C4321	C4322	C4330	C4331
C4339	C434	C4351	C4352	C4359	C4360	C4361	C4362
C4370	C4371	C4372	C438	C439	C4491	C4492	C4499
C460	C461	C462	C463	C464	C4650	C4651	C4652
C467	C469	C478	C480	C481	C482	C488	C490
C4910	C4911	C4912	C4920	C4921	C4922	C493	C494
C495	C496	C498	C499	C50011	C50012	C50019	C50021

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
C50022	C50029	C50111	C50112	C50119	C50121	C50122	C50211
C50212	C50219	C50221	C50222	C50311	C50312	C50319	C50321
C50322	C50411	C50412	C50419	C50421	C50422	C50511	C50512
C50519	C50521	C50522	C50611	C50612	C50619	C50621	C50622
C50811	C50812	C50819	C50821	C50822	C50911	C50912	C50919
C50921	C50922	C50929	C510	C511	C512	C519	C52
C530	C531	C538	C539	C540	C541	C542	C543
C548	C549	C55	C561	C562	C569	C5700	C5701
C5702	C5710	C5711	C5712	C5720	C5721	C5722	C573
C574	C577	C578	C579	C58	C600	C601	C602
C608	C609	C61	C6200	C6201	C6202	C6210	C6211
C6212	C6290	C6291	C6292	C6300	C6301	C6302	C6310
C6311	C6312	C632	C637	C638	C639	C641	C642
C649	C651	C652	C659	C661	C662	C669	C670
C671	C672	C673	C674	C675	C676	C677	C678
C679	C680	C681	C688	C689	C6900	C6901	C6902
C6910	C6911	C6912	C6920	C6921	C6922	C6930	C6931
C6932	C6940	C6941	C6942	C6950	C6951	C6952	C6960
C6961	C6962	C6980	C6981	C6982	C6990	C6991	C6992
C700	C701	C709	C710	C711	C712	C713	C714
C715	C716	C717	C718	C719	C720	C721	C7221
C7222	C7231	C7232	C7241	C7242	C7250	C7259	C729
C73	C7401	C7402	C7411	C7412	C7490	C750	C751
C752	C753	C754	C755	C758	C759	C760	C761
C762	C763	C7640	C7641	C7642	C7650	C7651	C7652
C768	C770	C771	C772	C773	C774	C775	C778
C779	C7800	C7801	C7802	C781	C782	C7839	C784
C785	C786	C787	C7889	C7900	C7901	C7902	C7911
C7919	C792	C7931	C7932	C7949	C7951	C7952	C7960
C7961	C7962	C7970	C7971	C7972	C7981	C7982	C7989
C800	C801	C802	C8100	C8101	C8102	C8103	C8104
C8105	C8106	C8107	C8108	C8109	C8110	C8111	C8112
C8113	C8114	C8115	C8116	C8117	C8118	C8119	C8120
C8121	C8122	C8123	C8124	C8125	C8126	C8127	C8128
C8129	C8130	C8131	C8132	C8133	C8134	C8135	C8136
C8137	C8138	C8139	C8140	C8141	C8142	C8143	C8144
C8145	C8146	C8147	C8148	C8149	C8170	C8171	C8172
C8173	C8174	C8175	C8176	C8177	C8178	C8179	C8190
C8191	C8192	C8193	C8194	C8195	C8196	C8197	C8198
C8199	C8201	C8202	C8203	C8204	C8205	C8206	C8207

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
C8208	C8209	C8211	C8212	C8213	C8214	C8215	C8216
C8217	C8218	C8219	C8221	C8222	C8223	C8224	C8225
C8226	C8227	C8228	C8229	C8231	C8232	C8233	C8234
C8235	C8236	C8237	C8238	C8239	C8241	C8242	C8243
C8244	C8245	C8246	C8247	C8248	C8249	C8251	C8252
C8253	C8254	C8255	C8256	C8257	C8258	C8259	C8261
C8262	C8263	C8264	C8265	C8266	C8267	C8268	C8269
C8280	C8281	C8282	C8283	C8284	C8285	C8286	C8287
C8288	C8289	C8290	C8291	C8292	C8293	C8294	C8295
C8296	C8297	C8298	C8299	C8330	C8331	C8332	C8333
C8334	C8335	C8336	C8337	C8338	C8339	C8350	C8351
C8352	C8353	C8354	C8355	C8356	C8357	C8358	C8359
C8370	C8371	C8372	C8373	C8374	C8375	C8376	C8377
C8378	C8379	C8380	C8381	C8382	C8383	C8384	C8385
C8386	C8387	C8388	C8389	C8391	C8392	C8393	C8394
C8395	C8396	C8397	C8398	C8399	C8400	C8401	C8402
C8403	C8404	C8405	C8406	C8407	C8408	C8409	C8410
C8411	C8412	C8413	C8414	C8415	C8416	C8417	C8418
C8419	C8491	C8492	C8493	C8494	C8495	C8496	C8497
C8498	C8499	C84A1	C84A2	C84A3	C84A4	C84A5	C84A6
C84A7	C84A8	C84A9	C84Z1	C84Z2	C84Z3	C84Z4	C84Z5
C84Z6	C84Z7	C84Z8	C84Z9	C8511	C8512	C8513	C8514
C8515	C8516	C8517	C8518	C8519	C8521	C8522	C8523
C8524	C8525	C8526	C8527	C8528	C8529	C8580	C8581
C8582	C8583	C8584	C8585	C8586	C8587	C8588	C8589
C8591	C8592	C8593	C8594	C8595	C8596	C8597	C8598
C8599	C860	C861	C862	C863	C864	C865	C866
C880	C882	C883	C888	C889	C9000	C9001	C9002
C9010	C9011	C9012	C9020	C9021	C9022	C9030	C9031
C9032	C9140	C9141	C9142	C960	C962	C964	C965
C966	C969	C96A	C96Z	D030	D0310	D0311	D0312
D0320	D0321	D0322	D0330	D0339	D034	D0351	D0352
D0359	D0360	D0361	D0362	D0370	D0371	D0372	D038
D039	D588	D589	D590	D591	D592	D593	D594
D595	D596	D598	D599	D6101	D6109	D61810	D61811
D61818	D6182	D619	D62	D630	D631	D638	D640
D641	D642	D643	D644	D6481	D6489	D649	G620
H903	H905	H933X1	H933X2	H933X3	H933X9	K117	N059
T451X1A	T451X1D	T451X1S	T451X2A	T451X2D	T451X2S	T451X3A	T451X3D
T451X3S	T451X4A	T451X4D	T451X4S	T4591xA	T4591xD	T4591xS	T4592xA

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
T4593xA	T4594xA	T50905A	T50905D	T50905S	T66xxxA	T66xxxD	T66xxxS
Z510	Z5111						

9.2.39.6 Antibiotics and Steroids

Injectable antibiotic or steroid medications may be considered for reimbursement even if the same oral medications are appropriate and available. Injected antibiotics or steroid medications, when used in place of oral medications, require the use of the modifier KX.

Physicians billing for injectable antibiotic and steroid medications *must* indicate the appropriate modifiers with the appropriate injection code and quantity:

Modifier	Use
AT	For acute conditions*
KX	To indicate any of the following: • Oral route contraindicated or an acceptable oral equivalent is not available. • Injectable medication is the accepted treatment of choice. Oral medication regimen has proven ineffective or is not applicable. • The patient has a temperature over 102 degrees and a high level of antibiotic is needed immediately. • Injection is medically necessary into joints, bursae, tendon sheaths, or trigger points to treat an acute condition or the acute flare-up of a chronic condition.
*** If a steroid medication is injected into joints, bursae, tendon sheaths, or trigger points, modifier AT must be used to indicate an acute condition. When performed for a chronic condition, these procedures are denied.**	

9.2.39.7 Blood Factor Products

Reimbursement is available when the antihemophilic product is administered by or under personal physician supervision.

The following blood factor products are a benefit of Texas Medicaid:

Procedure Codes									
J7178	J7180	J7181	J7183	J7185	J7186	J7187	J7188	J7189	J7190
J7191	J7192	J7193	J7194	J7195	J7196	J7197	J7198	J7199	J7200
J7201	J7205								

Prior authorization through the SMPA department is required for procedure code J7199. Supporting documentation that must be submitted with electronic or paper requests for prior authorization must include the following:

- The client's diagnosis
- A clear, concise description of the drug or biological such as the manufacturer's prescribing information
- A CPT or HCPCS procedure code that is comparable to the drug or biological being requested
- Documentation of the medical necessity of the requested drug or biological
- The rationale for the recommendation of this particular drug or biological
- Documentation of prior treatment or that prior treatment was considered but ruled out in favor of a new drug for this diagnosis

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- Documentation that the drug or biological is not investigational or experimental
- The place of service in which the drug or biological is to be administered
- The physician's intended charge for the drug or biological

All documentation must include the authorization request form and be maintained in the client's medical record and is subject to retrospective review.

9.2.39.8 Botulinum Toxin Type A and Type B

Procedure code J0585 is a benefit when billed with one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
G114	G2401	G241	G243	G244	G245	G248	G250
G251	G252	G253	G35	G360	G370	G371	G372
G374	G375	G378	G379	G43701	G43709	G43711	G43719
G800	G801	G802	G803	G804	G808	G809	G8110
G8111	G8112	G8113	G8114	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	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	H5069	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	K600
K601	K602	M436	M62838	M722	N318	N3281	N3644
R490	R498						

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Procedure code J0586 is a benefit when billed with one of the following diagnosis codes:

Diagnosis Codes for J0586 (Submitted as stand-alone diagnosis codes)									
G114	G241	G243	G244	G245	G248	G35	G360	G370	G371
G372	G374	G375	G378	G379	G800	G801	G802	G804	G808
G809	G8110	G8111	G8112	G8113	G8114	J385	M436	M62838	M722

Procedure code J0587 is a benefit when billed with diagnosis code G243 or K117.

Procedure code J0588 is a benefit when billed with diagnosis code G243, G245, G8110, G8111, G8112, G8113, G8114.

Claims for botulinum toxin type A and B must indicate the number of units used. If the number of units is not specified, the claim will be paid a quantity of one. Claims that exceed the following quantity limitations, per day, may be considered on appeal with documentation of medical necessity:

Procedure Codes	Quantity Limitations of Medication	Billing Units
J0585	360 units	One billing unit is equal to 1 unit of medication. **Example:** A provider that administers 360 units of medication would submit a claim for a quantity of 360.
J0586	1,000 units	One billing unit is equal to 5 units of medication. **Example:** A provider that administers 1,000 units of medication would submit a claim for a quantity of 200.
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	120 units	One billing unit is equal to 1 unit of medication. **Example:** A provider that administers 120 units of medication would submit a claim for a quantity of 120.

If a client is administered botulinum toxins more frequently than every 12 weeks, the claims must be submitted with documentation of medical necessity that justifies why the medication was given at an interval sooner than 12 weeks. The following documentation must be included in the client's medical record:

- Support for the medical necessity of the botulinum toxin injection
- A covered diagnosis
- Dosage and frequency of the injections
- Support for the clinical effectiveness of the injections
- Specific site(s) injected

All documentation is subject to retrospective review.

Procedures that are billed in conjunction with botulinum toxin injections are subject to current reimbursement guidelines. Any supplies billed by the physician for the administration of botulinum toxin type A or type B are not paid separately. Only the actual amount of drug that is administered is a benefit of Texas Medicaid. Providers cannot submit claims for discarded amounts of botulinum toxin drugs.

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Procedure code J0588 will be denied when it is billed with procedure code J0585 or J0586.

Procedure code J0587 will be denied when it is billed with procedure code J0585, J0586, or J0588.

Procedure code J0586 will be denied when it is billed with procedure code J0585.

9.2.39.9 Chelating Agents

Chelating agent procedure codes J0470, J0600, J0895, and J3520 are benefits of Texas Medicaid.

9.2.39.9.1 Dimercaprol

Procedure code J0470 is a benefit when billed with one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
T560X1A	T560X1D	T560X1S	T560X2A	T560X2D	T560X2S	T560X3A	T560X3D
T560X3S	T560X4A	T560X4D	T560X4S	T561X1A	T561X1D	T561X1S	T561X2A
T561X2D	T561X2S	T561X3A	T561X3D	T561X3S	T561X4A	T561X4D	T561X4S
T564X1A	T564X1D	T564X1S	T564X2A	T564X2D	T564X2S	T564X3A	T564X3D
T564X3S	T564X4A	T564X4D	T564X4S	T565X1A	T565X1D	T565X1S	T565X2A
T565X2D	T565X2S	T565X3A	T565X3D	T565X3S	T565X4A	T565X4D	T565X4S
T566X1A	T566X1D	T566X1S	T566X2A	T566X2D	T566X2S	T566X3A	T566X3D
T566X3S	T566X4A	T566X4D	T566X4S	T56811A	T56811D	T56811S	T56812A
T56812D	T56812S	T56813A	T56813D	T56813S	T56814A	T56814D	T56814S
T56891A	T56891D	T56891S	T56892A	T56892D	T56892S	T56893A	T56893D
T56893S	T56894A	T56894D	T56894S	T5691XA	T5691XD	T5691XS	T5692XA
T5692XD	T5692XS	T5693XA	T5693XD	T5693XS	T5694XA	T5694XD	T5694XS
T570X1A	T570X1D	T570X1S	T570X2A	T570X2D	T570X2S	T570X3A	T570X3D
T570X3S	T570X4A	T570X4D	T570X4S				

9.2.39.9.2 Edetate calcium disodium

Procedure code J0600 is a benefit when billed with one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
T560X1A	T560X1D	T560X1S	T560X2A	T560X2D	T560X2S	T560X3A	T560X3D
T560X3S	T560X4A	T560X4D	T560X4S	T564X1A	T564X1D	T564X1S	T564X2A
T564X2D	T564X2S	T564X3A	T564X3D	T564X3S	T564X4A	T564X4D	T564X4S
T565X1A	T565X1D	T565X1S	T565X2A	T565X2D	T565X2S	T565X3A	T565X3D
T565X3S	T565X4A	T565X4D	T565X4S	T566X1A	T566X1D	T566X1S	T566X2A
T566X2D	T566X2S	T566X3A	T566X3D	T566X3S	T566X4A	T566X4D	T566X4S
T56811A	T56811D	T56811S	T56812A	T56812D	T56812S	T56813A	T56813D
T56813S	T56814A	T56814D	T56814S	T56891A	T56891D	T56891S	T56892A
T56892D	T56892S	T56893A	T56893D	T56893S	T56894A	T56894D	T56894S
T5691XA	T5691XD	T5691XS	T5692XA	T5692XD	T5692XS	T5693XA	T5693XD
T5693XS	T5694XA	T5694XD	T5694XS				

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9.2.39.9.3 Deferoxamine mesylate (*Desferal*)

Procedure code J0895 must be billed with one of the following diagnosis codes to be considered for reimbursement of deferoxamine mesylate:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
D560	D561	D562	D563	D568	D569	D5700	D5701
D5702	D571	D5720	D57211	D57212	D57219	D5740	D57411
D57412	D57419	D5780	D57811	D57812	D57819	E83111	E83118
N181	N182	N183	N184	N185	N186	N189	N19
T454X1A	T454X1D	T454X1S	T454X2A	T454X2D	T454X2S	T454X3A	T454X3D
T454X3S	T454X4A	T454X4D	T454X4S	T470X1A	T470X1D	T470X1S	T470X2A
T470X2D	T470X2S	T470X3A	T470X3D	T470X3S	T470X4A	T470X4D	T470X4S
T471X1A	T471X1D	T471X1S	T471X2A	T471X2D	T471X2S	T471X3A	T471X3D
T471X3S	T471X4A	T471X4D	T471X4S	T564X1A	T564X1D	T564X1S	T564X2A
T564X2D	T564X2S	T564X3A	T564X3D	T564X3S	T564X4A	T564X4D	T564X4S
T565X1A	T565X1D	T565X1S	T565X2A	T565X2D	T565X2S	T565X3A	T565X3D
T565X3S	T565X4A	T565X4D	T565X4S	T566X1A	T566X1D	T566X1S	T566X2A
T566X2D	T566X2S	T566X3A	T566X3D	T566X3S	T566X4A	T566X4D	T566X4S
T56811A	T56811D	T56811S	T56812A	T56812D	T56812S	T56813A	T56813D
T56813S	T56814A	T56814D	T56814S	T56891A	T56891D	T56891S	T56892A
T56892D	T56892S	T56893A	T56893D	T56893S	T56894A	T56894D	T56894S
T5691XA	T5691XD	T5691XS	T5692XA	T5692XD	T5692XS	T5693XA	T5693XD
T5693XS	T5694XA	T5694XD	T5694XS				

9.2.39.9.4 Edetate disodium

Procedure code J3520 is a benefit when billed with one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
E8352	T460X1A	T460X1D	T460X1S	T460X2A	T460X2D	T460X2S	T460X3A
T460X3D	T460X3S	T460X4A	T460X4D	T460X4S			

Procedure codes J0470, J0600, J0895, and J3520 are denied if they are billed with diagnosis codes other than the codes listed above.

9.2.39.10 Clofarabine

Clofarabine is used for the treatment of relapsed or refractory acute lymphoblastic leukemia. Clofarabine is administered by IV infusion once daily for five days and is repeated every two to six weeks, as needed.

9.2.39.10.1 Prior Authorization for Clofarabine

Prior authorization is required for treatment with clofarabine (procedure code J9027) and may be granted for a maximum of six weeks.

Clofarabine may be prior authorized for the treatment of relapsed or refractory acute lymphoblastic leukemia. The following criteria apply to requests for prior authorization:

- The number of anticipated injections needed as well as the dosage per injection must be submitted with the request for prior authorization.

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- Prior authorization must be obtained before services are rendered whenever possible. If authorization cannot be obtained prior to the rendering of the service, the authorization request must be submitted within three business days from the date the treatment is initiated.

Prior authorization requests may be considered with documentation of both of the following:

- A diagnosis of refractory or relapsed acute lymphoblastic leukemia
- A history of at least two prior failed chemotherapy regimens

The prior authorization number must be included on the claim along with the number of units, based on the dosage given.

Failure to place the prior authorization number on the claim or to obtain prior authorization within the allotted timeframe will result in denied claims.

9.2.39.11 Colony Stimulating Factors (Filgrastim, Pegfilgrastim, and Sargramostim)

Colony stimulating factors (CSFs) are growth factors (glycoproteins) that support survival, clonal expansion and differentiation of blood forming cells and are a benefit of Texas Medicaid. CSFs reduce the likelihood of neutropenic complications due to chemotherapy and bone marrow transplant. Filgrastim (procedure codes J1442, J1447, and Q5101) and pegfilgrastim (procedure code J2505) are granulocyte colony stimulating factors (G-CSFs). Sargramostim (procedure code J2820) is a granulocyte-macrophage colony stimulating factor (GM-CSF). GM-CSF and G-CSF stimulate neutrophil production after autologous bone marrow transplant and significantly reduce the duration and impact of neutropenia. To submit claims for reimbursement of colony stimulating factors, providers must submit the most appropriate procedure code with the number of units administered.

One of the following diagnosis codes must be billed with the appropriate procedure code:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
C000	C001	C002	C003	C004	C005	C006	C008
C01	C020	C021	C022	C023	C024	C028	C029
C030	C031	C039	C040	C041	C048	C049	C050
C051	C052	C059	C060	C061	C062	C0689	C069
C07	C080	C081	C089	C090	C091	C099	C100
C101	C102	C103	C104	C108	C109	C110	C111
C112	C113	C118	C119	C12	C130	C131	C132
C138	C139	C140	C142	C148	C153	C154	C155
C158	C159	C160	C161	C162	C163	C164	C165
C166	C168	C169	C170	C171	C172	C173	C178
C179	C180	C181	C182	C183	C184	C185	C186
C187	C188	C189	C19	C20	C210	C211	C218
C220	C221	C222	C223	C227	C228	C229	C23
C240	C241	C248	C249	C250	C251	C252	C253
C254	C257	C258	C259	C260	C261	C269	C300
C301	C310	C311	C312	C313	C318	C319	C320
C321	C322	C323	C328	C329	C33	C3401	C3402
C3411	C3412	C342	C3431	C3432	C3481	C3482	C3491
C3492	C37	C380	C381	C382	C383	C384	C388
C390	C399	C4001	C4002	C4011	C4012	C4021	C4022

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
C4031	C4032	C4081	C4082	C410	C411	C412	C413
C414	C430	C4311	C4312	C4321	C4322	C4331	C4339
C434	C4351	C4352	C4359	C4361	C4362	C4371	C4372
C438	C439	C460	C461	C462	C463	C464	C4651
C4652	C467	C469	C478	C480	C481	C482	C488
C490	C4911	C4912	C4921	C4922	C493	C494	C495
C496	C498	C499	C4A0	C4A11	C4A12	C4A21	C4A22
C4A31	C4A39	C4A4	C4A51	C4A52	C4A59	C4A61	C4A62
C4A71	C4A72	C4A8	C50011	C50012	C50021	C50022	C50111
C50112	C50121	C50122	C50211	C50212	C50221	C50222	C50311
C50312	C50321	C50322	C50411	C50412	C50421	C50422	C50511
C50512	C50521	C50522	C50611	C50612	C50621	C50622	C50811
C50812	C50821	C50822	C50911	C50912	C50921	C50922	C510
C511	C512	C519	C52	C530	C531	C538	C539
C540	C541	C542	C543	C548	C55	C561	C562
C5701	C5702	C5711	C5712	C5721	C5722	C573	C574
C577	C578	C579	C58	C600	C601	C602	C608
C609	C61	C6201	C6202	C6211	C6212	C6291	C6292
C6301	C6302	C6311	C6312	C632	C637	C638	C639
C641	C642	C651	C652	C661	C662	C670	C671
C672	C673	C674	C675	C676	C677	C678	C679
C680	C681	C688	C689	C6901	C6902	C6911	C6912
C6921	C6922	C6931	C6932	C6941	C6942	C6951	C6952
C6961	C6962	C6981	C6982	C6991	C6992	C700	C701
C710	C711	C712	C713	C714	C715	C716	C717
C718	C719	C720	C721	C7221	C7222	C7231	C7232
C7241	C7242	C7259	C729	C73	C7401	C7402	C7411
C7412	C750	C751	C752	C753	C754	C755	C758
C759	C760	C761	C762	C763	C7641	C7642	C7651
C7652	C768	C770	C771	C772	C773	C774	C775
C778	C779	C7801	C7802	C781	C782	C7839	C784
C785	C786	C787	C7889	C7901	C7902	C7911	C7919
C792	C7931	C7949	C7951	C7952	C7961	C7962	C7971
C7972	C7981	C7982	C7989	C7A010	C7A011	C7A012	C7A020
C7A021	C7A022	C7A023	C7A024	C7A025	C7A026	C7A090	C7A091
C7A092	C7A093	C7A094	C7A095	C7A096	C7A098	C7A1	C7A8
C7B01	C7B02	C7B03	C7B04	C7B09	C7B1	C7B8	C800
C801	C802	C8101	C8102	C8103	C8104	C8105	C8106
C8107	C8108	C8109	C8111	C8112	C8113	C8114	C8115
C8116	C8117	C8118	C8119	C8121	C8122	C8123	C8124

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
C8125	C8126	C8127	C8128	C8129	C8131	C8132	C8133
C8134	C8135	C8136	C8137	C8138	C8139	C8141	C8142
C8143	C8144	C8145	C8146	C8147	C8148	C8149	C8171
C8172	C8173	C8174	C8175	C8176	C8177	C8178	C8179
C8191	C8192	C8193	C8194	C8195	C8196	C8197	C8198
C8199	C8201	C8202	C8203	C8204	C8205	C8206	C8207
C8208	C8209	C8211	C8212	C8213	C8214	C8215	C8216
C8217	C8218	C8219	C8221	C8222	C8223	C8224	C8225
C8226	C8227	C8228	C8229	C8231	C8232	C8233	C8234
C8235	C8236	C8237	C8238	C8239	C8241	C8242	C8243
C8244	C8245	C8246	C8247	C8248	C8249	C8251	C8252
C8253	C8254	C8255	C8256	C8257	C8258	C8259	C8261
C8262	C8263	C8264	C8265	C8266	C8267	C8268	C8269
C8281	C8282	C8283	C8284	C8285	C8286	C8287	C8288
C8289	C8291	C8292	C8293	C8294	C8295	C8296	C8297
C8298	C8299	C8301	C8302	C8303	C8304	C8305	C8306
C8307	C8308	C8309	C8311	C8312	C8313	C8314	C8315
C8316	C8317	C8318	C8319	C8331	C8332	C8333	C8334
C8335	C8336	C8337	C8338	C8339	C8351	C8352	C8353
C8354	C8355	C8356	C8357	C8358	C8359	C8371	C8372
C8373	C8374	C8375	C8376	C8377	C8378	C8379	C8381
C8382	C8383	C8384	C8385	C8386	C8387	C8388	C8389
C8391	C8392	C8393	C8394	C8395	C8396	C8397	C8398
C8399	C8401	C8402	C8403	C8404	C8405	C8406	C8407
C8408	C8409	C8411	C8412	C8413	C8414	C8415	C8416
C8417	C8418	C8419	C8441	C8442	C8443	C8444	C8445
C8446	C8447	C8448	C8449	C8461	C8462	C8463	C8464
C8465	C8466	C8467	C8468	C8469	C8471	C8472	C8473
C8474	C8475	C8476	C8477	C8478	C8479	C8491	C8492
C8493	C8494	C8495	C8496	C8497	C8498	C8499	C84A1
C84A2	C84A3	C84A4	C84A5	C84A6	C84A7	C84A8	C84A9
C84Z1	C84Z2	C84Z3	C84Z4	C84Z5	C84Z6	C84Z7	C84Z8
C84Z9	C8511	C8512	C8513	C8514	C8515	C8516	C8517
C8518	C8519	C8521	C8522	C8523	C8524	C8525	C8526
C8527	C8528	C8529	C8581	C8582	C8583	C8584	C8585
C8586	C8587	C8588	C8589	C8591	C8592	C8593	C8594
C8595	C8596	C8597	C8598	C8599	C860	C861	C862
C863	C864	C865	C866	C880	C882	C883	C884
C888	C9000	C9001	C9002	C9010	C9011	C9012	C9020
C9021	C9022	C9030	C9031	C9032	C9100	C9101	C9102

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
C9110	C9111	C9112	C9130	C9131	C9132	C9140	C9141
C9142	C9150	C9151	C9152	C9160	C9161	C9162	C91A0
C91A1	C91A2	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	C92Z0	C92Z1	C92Z2	C9292
C92A0	C92A1	C92A2	C9300	C9301	C9302	C9310	C9311
C9312	C9330	C9331	C9332	C93Z0	C93Z1	C93Z2	C9400
C9401	C9402	C9420	C9421	C9422	C9430	C9431	C9432
C9440	C9441	C9442	C946	C9480	C9481	C9482	C9500
C9501	C9502	C9510	C9511	C9512	C9590	C9591	C9592
C960	C962	C964	C965	C966	C96A	C96Z	D0001
D0002	D0003	D0004	D0005	D0006	D0007	D0008	D001
D002	D010	D011	D012	D013	D0149	D015	D017
D020	D021	D0221	D0222	D023	D030	D0311	D0312
D0321	D0322	D0339	D034	D0351	D0352	D0359	D0361
D0362	D0371	D0372	D038	D039	D040	D0411	D0412
D0421	D0422	D0439	D044	D045	D0461	D0462	D0471
D0472	D048	D0501	D0502	D0511	D0512	D0581	D0582
D060	D061	D067	D070	D071	D072	D0739	D074
D075	D0761	D0769	D090	D0919	D0921	D0922	D093
D098	D45	D4981	D4989	D600	D601	D608	D6109
D611	D612	D613	D6189	D700	D701	D702	D703
D704	P615	T451X1A	T451X1D	T451X1S	T451X2A	T451X2D	T451X2S
T451X3A	T451X3D	T451X3S	T451X4A	T451X4D	T451X4S	T8601	T8602
T8603	T8609	Z5111	Z5112	Z5189	Z9481	Z9484	

Procedure code J2505 is not reimbursed when submitted with the same date of service as procedure code J1442.

9.2.39.12 Fluocinolone Acetonide (Retisert)

Procedure code J7311 is a benefit of Texas Medicaid for clients of all ages.

Procedure code J7311 is only considered for reimbursement with a posterior uveitis diagnosis of more than six months in duration and only when the condition has been unresponsive to oral or systemic medication treatment. Prior authorization is required.

To request prior authorization, providers must submit requests to the Special Medical Prior Authorization Department by fax at 1-512-514-4213.

9.2.39.13 Hematopoietic Injections

Hematopoietic agents erythropoietin alfa or epoetin alfa (EPO) and darbepoetin alfa are benefits of Texas Medicaid and reimbursed using procedure codes J0881, J0882, and J0885 and an appropriate diagnosis code.

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Providers must maintain medical records in their offices that document regular monitoring of hemoglobin or hematocrit levels and explain the rationale for the dosing of epoetin alfa and darbepoetin alfa. These records are subject to retrospective review to determine appropriate utilization and reimbursement for this service.

When billing procedure code J0882 providers must submit the client's most recent dated hemoglobin or hematocrit levels in the comments section of the claim form.

EPO and darbepoetin alfa injections are limited to specific diagnosis codes as indicated in this section.

Refer to: Subsection 6.2.9.4, "Hematopoietic Injections" in the *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*) for information about outpatient facility criteria.

9.2.39.13.1 Epoetin Alfa (EPO)

EPO (procedure code J0885) is a glycoprotein that stimulates the formation of red blood cells and the production of the precursor red blood cells of the bone marrow. EPO is indicated for:

- Anemia associated with chronic renal failure (CRF), including clients on dialysis (end-stage renal disease or ESRD) and clients not on dialysis.
- Anemia related to therapy with zidovudine (AZT) in HIV-infected clients.
- Anemia due to the effects of concomitantly administered chemotherapy in clients who have non-myeloid malignancies.
- Anemia of prematurity.
- Clients scheduled to undergo elective noncardiac, nonvascular surgery to decrease need for allogenic blood transfusion.

Procedure code J0885 must be billed with one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
B20	C9000	C9001	C9002	D460	D461	D4621	D4622
D464	D469	D46A	D46B	D46C	D46Z	D471	D479
D47Z9	D611	D612	D613	D6189	D619	D630	D631
D644	D6481	D6489	D649	N181	N182	N183	N184
N185	N186	N189	N19	P612			

EPO may be considered for reimbursement when the dose is titrated consistent with prevailing, evidence-based clinical guidelines, as published by the National Kidney Foundation Kidney Disease Outcomes Quality Initiative, including appropriate monitoring of the rise and fall of the hemoglobin or hematocrit levels.

EPO is limited to three injections per calendar week (Sunday through Saturday).

9.2.39.13.2 Darbepoetin Alfa

Darbepoetin alfa (procedure codes J0881 and J0882) is an erythropoiesis-stimulating protein closely related to erythropoietin. Darbepoetin stimulates erythropoiesis by the same mechanism as EPO. Darbepoetin alfa has approximately a three-fold longer half-life than EPO, resulting in a sustained erythopoietic effect and less frequent dosing. Darbepoetin alfa is indicated for:

- Treatment of anemia associated with chronic renal failure (CRF), including clients on dialysis and clients not on dialysis.
- Treatment of anemia in clients who have non-myeloid malignancies where anemia is due to the effect of chemotherapy.

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Procedure code J0881 must be billed with one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
C9000	C9001	C9002	D460	D461	D4621	D46A	D46B
D611	D612	D613	D6189	D619	D630	D631	D644
D6481	D6489	D649	N181	N182	N183	N184	N185
N186	N189	N19	Z5111	Z5112			

Procedure code J0882 must be billed with one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
D631	N181	N182	N183	N184	N185	N186	N189
N19							

Darbepoetin is limited to 100 units per day (100 mcg). Darbepoetin should be administered as follows:

- Once a week if the client was receiving EPO two to three times weekly
- Once every two weeks if the client was receiving EPO once a week

9.2.39.14 Hydroxyprogesterone Caproate

Hydroxyprogesterone caproate is a benefit of Texas Medicaid. Hydroxyprogesterone caproate, whether compounded or the trademarked drug is a benefit for clients who are 10 through 55 years of age, and is restricted to diagnosis code V2341.

Hydroxyprogesterone caproate is administered intramuscularly at a dose of 250 mg once a week (every 7 days). All of the following must be documented and maintained in the client's medical record to support medical necessity for administration of a hydroxyprogesterone caproate injection:

- The client’s treatment is initiated between 16 weeks, 0 days and 20 weeks, 6 days gestation.
- The client’s treatment continues, as medically indicated, through 36 weeks, 6 days gestation or delivery, whichever occurs first.
- The client has a singleton pregnancy.
- The client has had a prior, singleton, spontaneous, preterm delivery before 37 weeks gestation.

The maximum amount for hydroxyprogesterone caproate is 21 doses per pregnancy.

Providers must submit claims for a compounded drug using procedure code J1725, modifier U1, and the NDC number. Trademarked hydroxyprogesterone caproate (such as *Makena*®) must be submitted with procedure code J1725 and the NDC number.

9.2.39.14.1 Prior Authorization for Hydroxyprogesterone Caproate

Initiation of the client’s treatment after 20 weeks, 6 days gestation but before 24 weeks gestation must be approved by the Medical Director. Prior authorization requests must be submitted to the Special Medical Prior Authorization Department using the Special Medical Prior Authorization (SMPA) Request Form. Documentation supporting medical necessity for starting treatment at that stage of gestation must be submitted with the prior authorization request.

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9.2.39.15 Immune Globulin

Immune globulins may be indicated for treatment of certain immune disorders and states of immunodeficiency. The following immune globulin procedure codes are benefits of Texas Medicaid:

Procedure Codes									
90284	90291	J0850	J1459	J1460	J1556	J1557	J1559	J1560	J1561
J1566	J1568	J1569	J1572	J1575	J1599	J1670	J2788	J2791	J2792
J7504	J7511								

Note: *Procedure codes 90291 and J0850 may only be reimbursed when billed with diagnosis code Z940, Z941, Z942, Z943, Z944, or Z9483.*

9.2.39.16 Medroxyprogesterone Acetate (Depo Provera)

Medroxyprogesterone acetate injectable suspension (*Depo-Provera*) has been approved by the FDA as a method of contraception. Intramuscular injections of medroxyprogesterone acetate given at 90-day intervals has been proven to be a long-term method of preventing pregnancy. Medroxyprogesterone acetate injectable suspension is reimbursed by Texas Medicaid to providers of family planning services.

Medroxyprogesterone acetate must be billed using procedure code J1050 with modifier U1 and a valid family planning diagnosis codes.

Refer to: Subsection 2.2, "Services, Benefits, Limitations, and Prior Authorization," in the *Gynecological and Reproductive Health and Family Planning Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about family planning contraceptives.

9.2.39.17 Immunosuppressive Drugs

The following procedure codes are benefits of Texas Medicaid:

Procedure Codes							
J0202	J0215	J0257	J0480	J0485	J0490	J0717	J1595
J1602	J7501	J7505	J7513	J7516	J7525		

The following procedure codes may be indicated for, but are not limited to, treatment of the following conditions:

Procedure Code	Conditions
J0202	**Multiple sclerosis (MS):** For treatment of relapsing forms of MS and should be reserved for clients who have had an inadequate response to two or more drugs indicated for the treatment of MS.
J0215	**Plaque psoriasis:** Treatment of adult clients with moderate to severe chronic plaque psoriasis who are candidates for systemic therapy or phototherapy.
J0257	**Alpha-1 proteinase inhibitor deficiency:** For the treatment of clients who have a deficiency of the alpha-1 proteinase inhibitor enzyme (also known as alpha-1 antitrypsin deficiency) in the treatment of emphysema.
J0480	**Organ rejection:** For the prophylaxis of acute organ rejection in patients receiving renal transplantation when used as part of an immunosuppressive regimen that includes cyclosporine and corticosteroids.

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Procedure Code	Conditions
J0485	**Organ rejection:** For the prophylaxis of organ rejection in adults receiving a kidney transplant, to be used in combination with basiliximab injection, mycophenolate mofetil, and corticosteroids.
J0490	**Systemic lupus erythematosus (SLE):** For use in clients with moderate to severe SLE when other forms of treatment have failed to control moderate to severe symptoms
J0717	**Psoriatic arthritis** **Ulcerative colitis** **Ankylosing spondylitis** **Crohn's disease**
J1595	**Multiple sclerosis (MS):** For the reduction of the frequency of relapses in clients with relapsing remitting MS, including clients who have experienced a first clinical episode and have magnetic resonance imaging (MRI) features consistent with MS.
J1602	**Psoriatic arthritis** **Rheumatoid arthritis** **Ankylosing spondylitis**
J7501	**Renal homotransplantations:** Adjunct for the prevention of rejection in renal homotransplantation. **Rheumatoid arthritis:** Azathioprine is indicated only in adult patients meeting the criteria for classic or definite rheumatoid arthritis as specified by the American Rheumatism Association.
J7505	**Renal allograft rejection** **Cardiac/hepatic allograft rejection**
J7513	**Organ rejection:** For the prophylaxis of acute organ rejection in clients receiving renal transplants, to be used as a part of an immunosuppressive regimen that includes cyclosporine and corticosteroids.
J7516	**Allogeneic transplants**: For prophylaxis of organ rejection in kidney, liver, and heart allogeneic transplants.
J7525	**Organ rejection prophylaxis**: For the prophylaxis of organ rejection in clients receiving allogeneic liver, kidney, or heart transplants.

Note: *Oral, self-administered immunosuppressive drugs may be reimbursed for Medicaid fee-for-service clients through the Medicaid Vendor Drug Program (VDP).*

Refer to: Subsection 9.2.40, "Medications—Oral," in this handbook for more information about oral self-administered drugs.

Authorization is not required for immunosuppressive drugs.

Retrospective review may be performed to ensure documentation supports the medical necessity of the service.

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9.2.39.18 Infliximab (Remicade)

Procedure code J1745 is a benefit when billed with one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone 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	K5120
K51211	K51212	K51213	K51214	K51218	K5130	K51311	K51312
K51313	K51314	K51318	K5150	K51511	K51512	K51513	K51514
K51518	K5180	K51811	K51812	K51813	K51814	K51818	K5190
K51911	K51912	K51913	K51914	K51918	K603	K632	L400
L401	L402	L403	L404	L4050	L4051	L4052	L4053
L4054	L4059	L408	M05011	M05012	M05021	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	M05511	M05512	M05521	M05522	M05531	M05532	M05541
M05542	M05551	M05552	M05561	M05562	M05571	M05572	M0559
M05611	M05612	M05621	M05622	M05631	M05632	M05641	M05642
M05651	M05652	M05661	M05662	M05671	M05672	M0569	M05711
M05712	M05721	M05722	M05731	M05732	M05741	M05742	M05751
M05752	M05761	M05762	M05769	M05771	M05772	M05779	M0579
M05811	M05812	M05821	M05822	M05831	M05832	M05841	M05842
M05851	M05852	M05861	M05862	M05871	M05872	M0589	M06011
M06012	M06021	M06022	M06031	M06032	M06041	M06042	M06051
M06052	M06061	M06062	M06071	M06072	M0608	M0609	M06811
M06812	M06819	M06821	M06822	M06829	M06831	M06832	M06839
M06841	M06842	M06849	M06851	M06852	M06859	M06861	M06862
M06869	M06871	M06872	M06879	M0688	M0689	M069	M08011
M08012	M08021	M08022	M08031	M08032	M08041	M08042	M08051
M08052	M08061	M08062	M08071	M08072	M0809	M08811	M08812
M08821	M08822	M08831	M08832	M08841	M08842	M08851	M08852
M08861	M08862	M08871	M08872	M0888	M0889	M08931	M08932
M08941	M08942	M08951	M08952	M08961	M08962	M08971	M08972
M0898	M450	M451	M452	M453	M454	M455	M456
M457	M458						

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9.2.39.19 Interferon

The following interferon procedure codes are benefits of Texas Medicaid:

Procedure Codes								
J1826	J1830	J9212	J9213	J9214	J9215	J9216	Q3027	Q3028

The following procedure codes may be indicated for, but are not limited to, treatment of the conditions listed below:

Procedure Code	Condition(s)
J1826, J1830, Q3027, and Q3028	Relapsing forms of multiple sclerosis
J9212	Chronic hepatitis C virus
J9213	AIDS-related Kaposi sarcoma Chronic hepatitis C virus Chronic myelogenous leukemia Hairy cell leukemia Metastatic melanoma Renal cell carcinoma
J9214	Acute leukemias AIDs-related Kaposi sarcoma Basal- and squamous-cell cancer Behcet syndrome Bladder tumors (local use for superficial tumors) Carcinoid tumor Chronic granulocytic leukemia Chronic hepatitis B virus Chronic hepatitis C virus Chronic myelogenous leukemia Condylomata acuminata Cutaneous T-cell lymphoma Cytolomegavirus Essential thrombocytopenia Essential thrombocytosis Follicular lymphoma Hairy cell leukemia Herpes simplex Hodgkin's disease Hypereosinophilic syndrome Melanoma Multiple myeloma Mycosis fungoides Non-Hodgkin's lymphoma Ovarian and cervical carcinoma Papilloma viruses Polycythemia vera

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Procedure Code	Condition(s)
	Renal cell carcinoma Rhino viruses Varicella zoster
J9215	Condylomata acuminata
J9216	Chronic granulomatous disease Malignant osteoporosis

Note: *Pegylated interferons are self-administered weekly and are available through Texas Medicaid Vendor Drug Program for Medicaid fee-for-service clients.*

9.2.39.20 Joint Injections and Trigger Point Injections

Procedure codes 20600, 20604, 20605, 20606, 20610, 20611, and 20612 must be used to submit claims for injections into joints.

Procedure codes 20526, 20550, 20551, 20552, and 20553 must be used to submit claims for trigger point injections.

These procedures are valid only in the treatment of acute problems. Procedures billed for reimbursement with chronic diagnosis codes are denied. The provider must use the AT modifier to indicate an acute condition. The cost of the injection does not include the drugs used. The drug can be reimbursed separately.

Multiple joint injections may be reimbursed when billed with the same date of service if the claim indicates the specific site of each injection. The first injection or aspiration is reimbursed at the full profile allowance and any subsequent injections are reimbursed at half allowance.

9.2.39.21 Leuprolide Acetate (*Lupron Depot*)

Procedure codes J9217, J1950, J9218, or J9219 may be reimbursed for leuprolide acetate injections with the following limitations:

Procedure Code	Limitation(s)
J1950	Reimbursed once per month
J9219	Reimbursed once per year

Procedure code J9217 may be reimbursed in monthly, three-month, four-month, and six-month doses as follows:

Frequency	Dosage	Limitation(s)
Monthly	7.5 mg	Billed with a quantity of 1 Reimbursed once per month
3-month	22.5 mg	Billed with a quantity of 3 Reimbursed once every three months
4-month	30 mg	Billed with a quantity of 4 Reimbursed once every 4 months
6-month	45 mg	Billed with a quantity of 6 Reimbursed once every 6 months
The total dosage allowed within a 6-month period is 45 mg.		

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9.2.39.22 Melphalan

Procedure code J9245 is a benefit when billed with one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
C50011	C50012	C50019	C50021	C50022	C50029	C50111	C50112
C50119	C50121	C50122	C50211	C50212	C50219	C50221	C50222
C50311	C50312	C50319	C50321	C50322	C50411	C50412	C50419
C50421	C50422	C50511	C50512	C50519	C50521	C50522	C50611
C50612	C50619	C50621	C50622	C50811	C50812	C50819	C50821
C50822	C50911	C50912	C50919	C50921	C50922	C50929	C561
C562	C569	C6200	C6201	C6202	C6210	C6211	C6212
C6290	C6291	C6292	C9000	C9001			

9.2.39.23 Omalizumab

Omalizumab is an injectable drug that is FDA approved for the treatment of clients who are 12 years of age and 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) or moderate to severe chronic idiopathic urticaria.

9.2.39.23.1 Prior Authorization for Omalizumab

Omalizumab is a benefit to Medicaid- eligible clients when medically necessary and must be prior authorized. THSteps-eligible clients who are 11 years of age and younger will be considered on an exception basis through CCP.

When requesting prior authorization, the exact dosage must be included with the request using procedure code J2357. Doses are determined by body weight and frequency is determined by clinical severity. Each prior authorization of omalizumab for treatment of asthma is based on provider documentation with the following medical necessity criteria:

- Positive skin test or RAST to a perennial (not seasonal) aeroallergen within the past 36 months.
- Total IgE level greater than 30 IU/ml but less than 700 IU/ml within the past 12 months.

  Note: *The total IgE level is required only for the initial prior authorization request and is not required for subsequent prior authorization requests.*

- Documentation of client compliance with inhaled steroid regimen.
- Client is not currently smoking.
- Clinical evidence of inadequate asthma control. Pulmonary function tests must have been performed within a three-month period and be documented for all clients when requesting prior authorization for omalizumab. This clinical evidence of inadequate asthma control may include any of the following:
  - Dependence upon daily systemic steroids or maximal inhaled steroid regimen with frequent systemic steroid pulses.
  - Frequent hospitalizations or acute care visits for severe asthma exacerbations in the face of adequate maximal standard therapy. The client must have been on daily therapy for persistent asthma for at least one year with frequent use of beta agonist.
  - Persistence of significantly decreased pulmonary function testing (spirometry), demonstrating refractory lower airways' obstruction and hyper-reactivity over time, despite the rigorous medical regimen delineated above.

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- Exceptions may be considered with documentation of medical reasons as to why pulmonary function tests cannot be performed.

Prior authorization requests for clients with chronic idiopathic urticaria must include the following documentation of medical necessity:

- Documented failure of, or contraindiction to, antihistamine, leukotriene inhibitor, and immunno-suppressive therapies
- Evidence of an evaluation that excludes other medical diagnoses associated with chronic urticaria

Prior authorization approvals for omalizumab are for intervals of six months at a time. Clients must be fully compliant with their omalizumab regimen in order to qualify for any additional authorizations. The provider must submit a statement documenting full compliance with the requests for each renewal. After 12 continuous months of omalizumab authorizations, the requesting provider must submit documentation of satisfactory clinical response to omalizumab in order to qualify for any additional authorizations. Prior authorizations will be considered on an individual basis for lapses in treatment with provider documentation.

Requests for clients who are 20 years of age and younger who do not meet the criteria above will be reviewed for medical necessity, on a case-by-case basis, by the TMHP medical director.

9.2.39.24 Implantable Infusion Pumps

Implantable infusion pumps are a benefit of Texas Medicaid. An implantable infusion pump may be medically necessary in the following circumstances:

- Administration of intrathecal or epidural antispasmodic drugs to treat refractory intractable spasticity
- Administration of Intrathecal, epidural, or central venous analgesic (opioid or non-opioid) drugs for treatment of severe chronic intractable pain
- Administration of intrahepatic chemotherapy for primary liver cancer or metastatic cancer with metastases limited to the liver
- Administration of intra-arterial chemotherapy in head and neck cancers

An implantable infusion pump is not a benefit for the following uses:

- Continuous insulin infusion for diabetes
- Continuous heparin infusion for recurrent thromboembolic disease
- Continuous intralesional infusion for severe chronic intractable pain
- Continuous intra-arterial infusion
- Continuous intra-articular infusion for severe chronic intractable pain
- Administration of antibiotics for osteomyelitis

All supplies associated with an IIP are included with the reimbursement for the surgery to implant the infusion pump and are not reimbursed separately.

Providers may be reimbursed for implantable infusion pumps using procedure codes E0782, E0783, and E0786.

If procedure codes E0782 and E0783 are billed with the same date of service, only one may be reimbursed.

9.2.39.24.1 * Prior Authorization for Implantable Infusion Pumps

Implantable infusion pumps (procedure codes E0782, E0783, and E0786) require prior authorization.

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Prior authorization is not required for the physician services associated with the insertion, revision, removal, refilling, or maintenance of the IIP.

Providers must request prior authorization through the Special Medical Prior Authorization (SMPA) department. The ASC or DME provider may submit a request for prior authorization using the Special Medical Prior Authorization (SMPA) Form, which must be completed and signed by a physician.

The completed, signed, and dated SMPA form must be maintained by the provider and the prescribing physician in the client's medical record.

The completed SMPA Form must include the procedure code and quantity for the services that are requested. Documentation that is submitted with the prior authorization request must indicate whether the IIP will be provided by the ASC or the DME provider.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the requested IIP. The requesting provider may be asked for additional information to clarify or complete a request for the IIP.

Documentation submitted with the prior authorization request must indicate the client or caregiver has:

- The ability to provide a return demonstration performance.
- The attention, desire, interest, flexibility, and independence.
- An understanding of cause and effect and object permanence.

As indicated in the following sections, supporting documentation that is based on the type of IIP requested must be included with the request for prior authorization.

IIP for Administration of Anti-spasmodic Drug to Treat Severe Refractory Spasticity

The following documentation is required for prior authorization:

- Initial evaluation
- Type of surgical implantation and description of IIP requested
- Symptoms:
  - Degree of spasticity
  - Affected muscle groups
  - Functional impact
- Duration of symptoms
- Any recent hospitalizations (within past 12 months)
- Comorbid conditions
- All pertinent laboratory and radiology results
- Treatment history of self administration with evidence of:
  - A minimum of six weeks of non-invasive methods of spasticity control, including, but not limited to, oral antispasmodics, that either:
    - Failed to adequately control the spasticity, or
    - Produced intolerable side effects
- The role, participation, and compliance of the family or client that demonstrate the following:
  - The ability to provide a return demonstration performance
  - Attentiveness, desire, interest, flexibility, and independence

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  - An understanding of cause and effect and object permanence
- Favorable response to a trial intrathecal dose of the antispasmodic
- No contraindications to implantation exist, including, but not limited to, the following:
  - Coagulopathy
  - Infection
  - Other implanted devices where the "crosstalk" between devices may inadvertently change the prescription
  - Allergy or hypersensitivity to the drug being administered
- Treatment plan, including the following:
  - Antispasmodic to be infused
  - Follow-up, including pump refilling, maintenance, and monitoring of changes in infusion rate
  - Expected outcome
  - Treatment goals

IIP for Administration of Analgesic (Opioid or Nonopioid) Drug for Treatment of Severe Intractable Pain

The following documentation is required for prior authorization:

- The initial evaluation
- Type of surgical implantation and description of IIP requested
- Symptoms
  - Severity of pain
  - Functional impact
- Source of pain or location, including whether pain is malignant or non-malignant
- Duration of symptoms
- Any recent hospitalizations (within the past 12 months)
- Comorbid conditions
- All pertinent laboratory and radiology results
- A life expectancy of at least three months

  Note: *The standard of care for treatment of severe intractable pain for a client with a life expectancy of less than three months is to use less invasive techniques such as an external infusion pump.*
- For malignant pain:
  - Treatment history with evidence of a favorable response to a trial intrathecal dose of the analgesic drug, defined as a minimum of 50 percent reduction in pain
  - Failure of more conservative methods of pain control, including, but not limited to, oral analgesics, surgery, or therapy, that were ineffective due to one of the following:
    - Failed to adequately control the pain, or
    - Produced intolerable side effects
- For nonmalignant pain:

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    - A minimum of six months of more conservative methods of pain control, including but not limited to oral analgesics, surgery, attempts to eliminate physical and behavioral abnormalities that may cause an exaggerated pain reaction, that were ineffective due to one of the following:
        - Failed to adequately control the pain, or
        - Intolerable side effects were produced
- Examples of non-malignant severe intractable pain include, but are not limited to, the following:
    - Complex regional pain syndrome I & II (causalgia/RSD) refractory to other treatments.
    - Post herpetic neuralgia
    - Failed back syndrome
    - Phantom limb pain
    - Arachnoiditis (proven with MRI/increased CSF protein levels)
    - Spinal cord myelopathy (refractory to conservative measurements)
- The role, participation, and compliance of the family or client that demonstrate the following:
    - The ability to provide a return demonstration performance
    - Attentiveness, desire, interest, flexibility, and independence
    - An understanding of cause and effect and object permanence
- No contraindications to implantation exist, including, but not limited to, the following:
    - Coagulopathy
    - Infection
    - Other implanted devices where the "crosstalk" between devices may inadvertently change the prescription
    - Tumor encroachment on the thecal sac
    - Allergy or hypersensitivity to the drug being administered
- Treatment plan, including the following:
    - Analgesic to be infused
    - Follow-up including pump refilling, maintenance, and monitoring of changes in infusion rate
    - Expected outcome
    - Treatment goals

IIP for Administration of Intrahepatic Chemotherapy in Primary Liver Cancer or Colorectal Cancer with Liver Metastases

The following documentation is required for prior authorization:

- The initial evaluation
- Type of surgical implantation and description of IIP requested
- Diagnosis of one of the following:
    - Primary liver cancer
    - Metastatic cancer with metastases limited to the liver
- Any recent hospitalizations (within the past 12 months)

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- Comorbid conditions
- All pertinent laboratory and radiology results
- The role, participation, and compliance of the family and/or client demonstrating:
  - The ability to provide a return demonstration performance
  - Attentiveness, desire, interest, flexibility, and independence
  - An understanding of cause and effect and object permanence
- No contraindications to implantation exist, including, but not limited to, the following:
  - Coagulopathy
  - Infection
  - Other implanted devices where the "crosstalk" between devices may inadvertently change the prescription
  - Allergy or hypersensitivity to the drug being administered
- Treatment plan, including the following:
  - Chemotherapeutic agent to be infused. The prescribed drug must be approved by the U.S. Food and Drug Administration (FDA) for the intended use and must be compatible with the implantable device (such as floxuridine or methotrexate)
  - Follow-up, including pump refilling, maintenance, and monitoring of changes in infusion rate
  - Expected outcome
  - Treatment goals

IIP for Administration of Intra-Arterial Chemotherapy in Head and Neck Cancers

The following documentation is required for prior authorization:

- Initial evaluation
- Type of surgical implantation and description of IIP requested
- Diagnosis and site(s) of any metastases
- Any hospitalizations (within the past 12 months) and all other diagnoses
- All pertinent laboratory and radiology results
- The role, participation, and compliance of the family or client that demonstrates the following:
  - The ability to provide a return demonstrate performance
  - Attentiveness, desire, interest, flexibility, and independence
  - An understanding of cause and effect and object permanence
- No contraindications to implantation exist, including, but not limited to, the following:
  - Coagulopathy
  - Infection
  - Other implanted devices where the "crosstalk" between devices may inadvertently change the prescription
  - Allergy or hypersensitivity to the drug being administered
- Treatment plan, including the following:

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- Chemotherapeutic agent to be infused
- Follow-up, including pump refilling, maintenance, and monitoring of changes in infusion rate
- Expected outcome
- Treatment goals

Replacement of an IIP

An IIP is expected to last a minimum of five years. Prior authorization for replacement of an IIP is considered within five years when one of the following occurs:

- There has been a significant change in the client's condition and the current equipment no longer meets the client's needs.
- The equipment is no longer functional and either cannot be repaired or it is not cost-effective to repair.
- Loss or irreparable damage to the IIP has occurred. The following must be submitted with the prior authorization request:
  - A copy of the police or fire report, when appropriate
  - A statement about the measures to be taken in order to prevent reoccurrence

Replacement of an IIP for a client who is birth through 20 years of age that does not meet the criteria above may be considered for prior authorization through CCP.

The DME Certification and 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 DME provider must maintain the signed and dated form in the client's medical record.

Refer to: Subsection 2.6.3.5, "DME Certification and Receipt Form," in the *Children's Services Handbook* (Vol. 2, *Provider Handbooks*) for more information about this form.

9.2.39.24.2 Implantation of Catheters, Reservoirs, and Pumps

The following procedure codes may be used to bill the implantation of catheters and infusion pumps or devices for long term medication administration:

Procedure Codes				
62350	62351	62360	62361	62362

Procedure code 62350 or 63251 may be reimbursed when billed for the same date of service as procedure code 62360, 62361, or 62362.

Procedure codes 62355 and 62365 do not require prior authorization.

The following procedure codes are denied as included in the total anesthesia time when billed with the same date of service as an anesthesia procedure by the same physician:

Procedure Codes						
62350	62351	62355	62360	62361	62362	62365

These procedure codes are considered for reimbursement according to multiple surgery guidelines when billed with the same date of service as another surgical procedure performed by the same physician.

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Procedure codes 95990, 96521, and 96522 are considered for reimbursement when used for refilling an implantable pump.

Procedure codes 62367, 62368, 62369, and 62370 may be used to bill for electronic analysis of an implantable infusion pump.

Procedure codes 62369 and 62370 will be denied when billed for the same date of service by the same provider as procedure code 62362.

The following procedure codes may be used to bill the insertion, revision, removal, or repair associated with implantable infusion pumps:

Procedure Codes						
36260	36261	36262	36563	36576	62355	62365

9.2.39.25 Trastuzumab

Procedure code J9355 is a benefit of Texas Medicaid. Reimbursement for this drug is considered when it is used as a single agent for the treatment of clients who have metastatic breast cancer whose tumors overexpress the Her-2 protein and who have received one or more chemotherapy regimens for their metastatic disease. Trastuzumab may also be reimbursed when:

- Used in combination with paclitaxel for the treatment of clients who have metastatic breast cancer whose tumors overexpress the Her-2 protein and who have not received chemotherapy for their metastatic disease.
- Used as part of a treatment regimen containing doxorubicin, cyclophosphamide, and paclitaxel for the adjuvant treatment of clients who have Her-2-overexpressing, node-positive breast cancer.

Trastuzumab is a benefit for clients whose tumors have Her-2 protein overexpression.

When billing for the test used to determine whether a client overexpresses the Her-2 protein, use procedure code 83950. Diagnosis of overexpression of the Her-2 protein must be made before Texas Medicaid will consider reimbursement for trastuzumab. This test may be reimbursed only once in a client's lifetime to the same provider. An additional test by the same provider requires documentation to support the medical necessity.

9.2.39.26 Vitamin B12 (Cyanocobalamin) Injections

Vitamin B12 injections are a benefit of Texas Medicaid. Vitamin B12 injections should only be considered for clients with conditions that are refractory to, or have a contraindication to, oral therapy.

Vitamin B12 injections may be considered for the following indications:

- Dementia secondary to vitamin B12 deficiency
- Resection of the small intestine
- Schilling test (vitamin B12 absorption test)

Procedure code J3420 must be used when billing for Vitamin B12 (cyanocobalamin) injections.

Vitamin B12 (cyanocobalamin) injections are limited to the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
B700	D510	D511	D512	D513	D518	D520	D521
D528	D529	D531	D649	E538	E710	E71110	E71111
E71118	E71120	E71121	E71128	E7119	E712	E7210	E7211
E7212	E7219	E723	E7251	E7259	E728	G621	G63
H4611	H4612	H4613	H463	K5660	K900	K901	K902

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
K903	K9089	K909	K911	K912	Z903	Z9221	Z980

Claims that are denied for indications or other diagnosis codes may be considered on appeal with documentation of medical necessity. For the list of diagnosis codes above, documentation in the medical record must include rationale as to why the client was unable to be treated with oral therapy.

9.2.39.27 Injection Administration

Injectable medications and the administration of medications through the intramuscular (IM), subcutaneous (SQ), or intravenous (IV) route is a benefit of Texas Medicaid.

For the administration of drugs through intramuscular (IM), subcutaneous (SQ), or intravenous (IV) route providers should submit claims using procedure codes 96372, 96374, 96375, and 96376.

Injection administration is reimbursed separate from the medication.

Procedure codes 96372 and 96374 are limited to one per day, unless the claim clearly indicates that the medication could not be mixed.

Procedure codes 96375 and 96376 will only be reimbursed when billed in conjunction with 96374 on the same date of service by the same provider on the same claim.

9.2.39.28 Billing for Injectable Medications

Providers must use oral medication in preference to injectable medication in the office and outpatient hospital. If an oral medication cannot be used, the claim must be billed as follows:

Claim Form	Reason for Injection
Modifier KX	• 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 degrees Fahrenheit (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 (must be documented on the claim and in the medical record). • Previously attempted oral medication regimens have proven ineffective (must be supported by documentation in the medical record). • Situation is emergent.

The claim and the client's medical record must include documentation of medical necessity to support the need for the service. Retrospective review may be performed to ensure that the documentation supports the medical necessity of the service and any modifier used when billing the claim.

Refer to: Subsection 9.2.35, "Immunization Guidelines and Administration," in this handbook.

"Appendix B. Immunizations" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 5.3.11.3, "Immunizations," in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for information on immunizations for infants and children.

Providers may utilize the "white bagging" delivery method, in which the treating provider submits prescriptions to pharmacies and the prescription is shipped or mailed to the provider's office.

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Refer to: Subsection B.1.2, "Pharmacy Delivery Method for Physician-Administered Drugs," in Appendix B: Vendor Drug Program (*Vol. 1, General Information*) for additional information on the "white bagging" delivery method.

9.2.39.29 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 use to calculate the appropriate quantity of units to bill is:

> 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	2,500 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 NDC of the drug actually dispensed should be entered on the claim form. Additional information about entering NDC codes is available on the NDC page of the TMHP website at www.tmhp.com.

9.2.40 Medications—Oral

Oral medications that are given in the hospital or physician's office are a benefit to Texas Medicaid clients through Texas Medicaid. Take-home and self-administered drugs are not benefits of Texas Medicaid and should not be billed to TMHP except when they are provided to eligible Texas Medicaid fee-for-service clients through the Medicaid Vendor Drug Program (VDP) with a prescription.

Refer to: "Appendix B: Vendor Drug Program" (*Vol. 1, General Information*).

9.2.40.1 Drug Monitoring Services

Providers must use the most appropriate procedure codes when submitting claims for drug monitoring services that monitor prescribed medications that can be abused when used for the treatment of chronic pain. These claims are subject to retrospective review. Claims may be reprocessed and recouped if they are submitted for these drug monitoring services in the office setting using a procedure code for a quantitative test rather than a qualitative or semiquantitative test.

An enzyme immunoassay (EIA) device can be used to provide preliminary qualitative or semiquantitative test results for point-of-care monitoring purposes. EIA devices and the reagents used to perform in-office drug testing are cleared by the FDA only to obtain qualitative or semiquantitative initial screen or preliminary results.

Immunoassay and enzyme assay are tests that produce qualitative and semiquantitative results, so these tests must not be reported with procedure codes for quantitative tests. A qualitative or semiquantitative test is not a quantitative test and must not be billed as such.

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The initial drug screen or preliminary result testing yields qualitative and semiquantitative results, which must be reported with an appropriate drug testing procedure code, as categorized in the CPT manual as "Drug Testing." Only those procedure codes that are a benefit of Texas Medicaid may be reimbursed.

CPT-categorized "Chemistry" and "Therapeutic Drug Assay" procedure codes are for quantitative tests and must not be reported for an initial screen or preliminary result that was performed in the point-of-care setting.

Refer to: The CPT manual for drug testing, chemistry, and therapeutic drug assay procedure codes, and to the Texas Medicaid fee schedule for procedure codes that may be reimbursed by Texas Medicaid.

Using procedure codes for quantitative tests to report preliminary qualitative or semiquantitative test results is considered systematic upcoding and may lead to administrative sanctions, civil monetary penalties, and criminal prosecution.

Providers may refer to the CMS website for more information about laboratory tests that may be rendered in the office setting. For tests that require a CLIA certificate of waiver, CMS publishes a list of all waived tests. The list is updated quarterly and includes the procedure code to use when billing a test.

9.2.41 Laboratory Services

Texas Medicaid benefits are provided for professional and technical services ordered by a physician and provided under the supervision of a physician in a setting other than a hospital (inpatient or outpatient). All laboratory services must be documented in the client's medical record as medically necessary and referenced to an appropriate diagnosis. Texas Medicaid does not reimburse baseline or screening laboratory studies.

Providers may bill only for laboratory tests that are actually provided in their office. Any test sent to an outside laboratory must not be billed on the provider's claim. Laboratories bill Texas Medicaid directly for the tests they perform.

Unless otherwise noted, interpretation of laboratory tests is considered part of the provider's professional services (hospital, office, or emergency room visits) and must not be billed separately. Modifier Q4 is required for laboratory, radiology, and ultrasound interpretations by any provider other than the attending physician.

Laboratory tests that are generally considered part of a laboratory panel (e.g., chemistries, CBCs, urinalyses [UAs]) and that are performed on the same day must be billed as a panel regardless of the method used to perform the tests (automated or manual).

Physician interpretations that are requested of a consulting pathologist and require professional reading and reporting of results may be billed to Texas Medicaid separately as a professional charge.

All providers of laboratory services must comply with the rules and regulations of CLIA. Providers not complying with CLIA cannot be reimbursed for laboratory services.

Texas Medicaid follows the Medicare categorization of tests for CLIA certificate holders.

Refer to: The CMS website at www.cms.gov/CLIA/10_Categorization_of_Tests.asp for information about procedure code and modifier QW requirements.

Subsection 2.2.5, "Automated Laboratory Tests and Laboratory Paneling," in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for claims processing instructions.

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Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)," in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 3.4.2, "Reimbursement," in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for claims processing instructions.

Subsection 2.2, "Fee-for-Service Reimbursement Methodology," in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

9.2.41.1 THSteps Laboratory Services

Refer to: Subsection 5.3.11.6, "Laboratory Test," in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

9.2.41.2 Laboratory Handling Charge

The laboratory handling charge covers the expense of obtaining and packaging the specimen and sending it to a reference laboratory.

A laboratory handling charge (procedure code 99000) may be billed if the specimen is obtained by venipuncture or catheterization *and* sent to an outside lab. The reference laboratory name and address or provider identifier must be listed in Block 32 of the CMS-1500 claim form, and Block 20 must be completed.

The provider is required to forward the client's name, address, Medicaid ID number, and diagnosis, if appropriate, with the specimen to the reference laboratory so the laboratory may bill Texas Medicaid for its services.

A provider may bill only one laboratory handling charge per client visit unless the specimen is divided and sent to different laboratories or different specimens are collected and sent to different labs. The claim must indicate the name and/or address of each laboratory to which a specimen is sent for more than one laboratory handling fee to be paid. This laboratory handling benefit does not apply to THSteps medical checkup providers who must submit specimens to the DSHS Laboratory.

9.2.41.3 Blood Counts

Texas Medicaid considers a baseline CBC appropriate for the evaluation and management of existing and suspected disease processes. CBCs should be individualized and based on client history, clinical indications, or proposed therapy and will not be reimbursed for screening purposes.

Refer to: Subsection 2.2.7, "Complete Blood Count (CBC)," in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about blood counts.

9.2.41.4 Clinical Lab Panel Implementation

Refer to: Subsection 2.2.5, "Automated Laboratory Tests and Laboratory Paneling," in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about laboratory panels.

9.2.41.5 Clinical Pathology Consultations

Clinical pathology consultations (procedure code 80500 or 80502) are a benefit of Texas Medicaid for services rendered by a consultant who is either a clinical pathologist or a geneticist. In a clinical pathology consultation, the consultant may also help the ordering physician determine whether further study is appropriate, based on test results.

Providers may be reimbursed for clinical pathology consultations when the claim indicates the following information:

- The name and address or provider identifier of the physician who requested the consultation.

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- A written narrative report describing the findings of the consultation, which will also be included in the client's medical record.

  Note: *To submit claims for interpretation, the provider must document an interaction that clearly shows that the consultant interpreted the test results and made specific recommendations to the attending physicians.*

If the claim does not include all of this information, the clinical pathology consultation will be denied.

Note: *Geneticists who provide a pathology consultation must submit claims using their acute care provider identifier.*

Routine conversations held between a consultant and attending physicians about test orders or results are not consultations. Information that can be furnished by a non-physician laboratory specialist does not qualify as a consultation service.

9.2.41.6 Cytogenetics Testing

Cytogenetics testing is a group of laboratory tests involving the study of chromosomes.

Clinical evidence supports the significance of cytogenetics evaluation in the diagnosis, prognosis, and treatment of acute leukemias and lymphomas, especially in children. The detection of the well-defined recurring genetic abnormalities often enables a correct diagnosis with important prognostic information that affects the treatment protocol.

Reimbursement for cytogenetics testing is limited to the following diagnosis codes or combination diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
C8280	C8281	C8282	C8283	C8284	C8285	C8286	C8287
C8288	C8289	C8291	C8292	C8293	C8294	C8295	C8296
C8297	C8298	C8299	C8310	C8311	C8312	C8313	C8314
C8315	C8316	C8317	C8318	C8319	C8380	C8381	C8382
C8383	C8384	C8385	C8386	C8387	C8388	C8389	C8440
C8441	C8442	C8443	C8444	C8445	C8446	C8447	C8448
C8449	C8461	C8462	C8463	C8464	C8465	C8466	C8467
C8468	C8469	C8471	C8472	C8473	C8474	C8475	C8476
C8477	C8478	C8479	C8581	C8582	C8584	C8585	C8586
C8587	C8588	C8589	C884	C888	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
E343	E83110	E8359	F70	F71	F72	F73	F78
F800	F801	F802	F804	F8089	F810	F812	F8181

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
F8189	F819	F82	F840	F88	F900	F901	F902
F908	H0589	H9325	I77810	I77811	I77812	I77819	M2600
M2601	M2602	M2603	M2604	M2605	M2606	M2607	M2609
N4601	N4611	N6482	N910	N911	N913	N914	N949
N970	N978	O010	O011	O019	O021	O0289	O09511
O09512	O09513	O09521	O09522	O09523	O350XX0	O350XX1	O350XX2
O350XX3	O350XX4	O350XX5	O350XX9	O351XX0	O351XX1	O351XX2	O351XX3
O351XX4	O351XX5	O351XX9	O352XX0	O352XX1	O352XX2	O352XX3	O352XX4
O352XX5	O352XX9	P293	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
Q211	Q212	Q213	Q214	Q218	Q219	Q220	Q221
Q222	Q223	Q224	Q225	Q228	Q230	Q231	Q232
Q233	Q234	Q238	Q240	Q241	Q242	Q243	Q244
Q245	Q246	Q248	Q249	Q250	Q251	Q252	Q253
Q254	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
Q447	Q450	Q451	Q452	Q453	Q458	Q459	Q5001

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
Q5002	Q501	Q502	Q5031	Q5032	Q5039	Q504	Q505
Q506	Q510	Q5110	Q5111	Q512	Q515	Q516	Q517
Q51811	Q51821	Q51828	Q520	Q5210	Q522	Q523	Q524
Q525	Q526	Q5270	Q5271	Q5279	Q528	Q529	Q5300
Q5301	Q5302	Q5310	Q5311	Q5312	Q5320	Q5321	Q5322
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	Q660	Q662	Q663
Q664	Q6651	Q6652	Q666	Q667	Q6681	Q6682	Q6689
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	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	Q750	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	Q796
Q798	Q799	Q800	Q801	Q802	Q803	Q804	Q808
Q820	Q821	Q822	Q823	Q824	Q825	Q828	Q830
Q831	Q832	Q833	Q838	Q840	Q841	Q842	Q843
Q844	Q845	Q846	Q848	Q849	Q8503	Q851	Q858
Q859	Q870	Q871	Q87410	Q87418	Q8742	Q8743	Q8901

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
Q8909	Q891	Q892	Q893	Q894	Q897	Q898	Q899
Q900	Q901	Q902	Q909	Q910	Q911	Q912	Q913
Q914	Q915	Q916	Q917	Q920	Q921	Q922	Q925
Q9261	Q9262	Q927	Q928	Q930	Q931	Q932	Q933
Q934	Q935	Q937	Q9381	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	R480	Z31430	Z31438	Z315	Z36	Z810	Z8279
Z8489							
Combination Diagnosis Codes (Must be submitted in pairs)							
Q6501 Q6532	Q6502 Q6531						

Cytogenetics testing may be reimbursed with the following procedure codes and limitations:

Procedure Code	Quantity Allowed
Tissue Culture Procedure Codes and Limitations	
88230	1 per day any provider
88233	1 per day any provider
88235	1 per day any provider
88237	1 per day any provider
88239	1 per day any provider
Chromosome Analysis Procedure Codes and Limitations	
88245	1 per day any provider
88248	1 per day any provider
88249	1 per day any provider
88261	1 per day any provider
88262	1 per day any provider
88263	1 per day any provider
88264	1 per day any provider
88280	5 per day any provider
88283	1 per day any provider
88285	1 per day any provider
88289	1 per day any provider
Molecular Cytogenetics Procedure Codes and Limitations	
88271	16 per provider per day
88272	10 per provider per day
88273	10 per provider per day
88274	5 per provider per day
88275	10 per provider per day

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Procedure Code	Quantity Allowed
Interpretation and Report Procedure Code	
88291	As medically necessary

9.2.41.7 Maternal Serum Alpha-Fetoprotein (MSAFP)

MSAFP may be reimbursed once per pregnancy per provider for all pregnant women eligible for Medicaid. For additional services, payment is allowed with documentation attached to the claim. Procedure code 82105 should be used for MSAFP.

9.2.42 Lung Volume Reduction Surgery (LVRS)

LVRS is a benefit for clients who are not high risk but have a presence of severe, upper-lobe emphysema (as defined by radiologist assessment of upper-lobe predominance on CT scan) or who are not high risk but have a presence of severe, non-upper-lobe emphysema with low exercise capacity.

Note: *Clients who have low exercise capacity are those whose maximal exercise capacity is at or below 25 watts for women and 40 watts for men after completion of the pre-operative therapeutic program in preparation for LVRS. Exercise capacity is measured by incremental, maximal, symptom-limited exercise with a cycle ergometer utilizing a 5- or 10-watt-per-minute ramp on 30-percent oxygen after 3 minutes of unloaded pedaling.*

LVRS must be performed in a facility that meets at least one of the following requirements:

- Certified under the Disease Specific Care Certification Program for LVRS by the Joint Commission on Accreditation of Health Care Organization
- Approved by Medicare as a lung or heart-lung transplant facility

The surgery must be both preceded and followed by a program of diagnostic and therapeutic services that are consistent with those provided in the National Emphysema Treatment Trial (NETT) and designed to maximize the client's potential to successfully undergo and recover from surgery. The program must meet all of the following requirements:

- Include a 6- to 10-week series of at least 16, and no more than 20, pre-operative sessions, each lasting a minimum of 2 hours
- Include at least 6, and no more than 10, post-operative sessions, each lasting a minimum of 2 hours, within 8 to 9 weeks after the LVRS
- Be consistent with the care plan that was developed by the treating physician following the performance of a comprehensive evaluation of the client's medical, psychosocial, and nutritional needs
- Be arranged, monitored, and performed under the coordination of the facility where the surgery takes place

Clients must have surgical clearance by a licensed cardiologist for any of the following conditions:

- Unstable angina
- Left ventricular ejection fraction (LVEF) cannot be estimated from the echocardiogram
- LVEF less than 45 percent
- Dobutamine-radionuclide cardiac scan indicates coronary artery disease or ventricular dysfunction
- Arrhythmia (more than 5 premature ventricular contractions (PVC) per minute)
- Cardiac rhythm other than sinus
- PVCs on electrocardiogram (EKG) at rest

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For clients with cardiac ejection fraction less than 45 percent, there must be no history of congestive heart failure or myocardial infarction within six months of consideration for surgery.

Clients must have surgical clearance by a licensed pulmonologist, thoracic surgeon, and anesthesiologist after completion of pre-operative rehabilitation.

Procedure codes 32491, G0302, G0303, G0304, and G0305 are limited to one per rolling year per client for any provider.

Pre-operative pulmonary rehabilitation services for preparation for LVRS (procedure codes G0302, G0303, and G0304) and post-discharge pulmonary surgery services LVRS (procedure code G0305) will be restricted to diagnosis codes J430, J431, J432, J438, and J983.

Procedure code G0305 may be reimbursed only if a claim for LVRS (procedure code 32491) has been submitted within the past 12 months.

9.2.42.1 Prior Authorization for Lung Volume Reduction Surgery

LVRS must be prior authorized and is limited to clients who have severe emphysema, disabling dyspnea, and evidence of severe air trapping. The following documentation must be submitted with the request for prior authorization:

- The client's history and physical examination is consistent with emphysema
- BMI less than 31.1 kg/m2 (men) or less than 32.3 kg/m2 (women)
- Pulmonary status that is stable with less than 20 mg prednisone (or equivalent) per day
- A radiographic high resolution computer tomography (HRCT) scan has been conducted that shows evidence of bilateral emphysema.
- The forced expiratory volume in one second (FEV1) (maximum of pre- and postbronchodilator values) is less than or equal to 45 percent of the predicted value. If the client is 70 years of age and older, FEV1 is 15 percent of the predicted value or more.
- The total lung capacity (TLC) greater than 100 percent predicted postbronchodilator
- Residual volume (RV) greater than 150 percent predicted postbronchodilator found on prerehabilitation pulmonary function study.
- Arterial blood gas level (pre-rehabilitation):
  - Partial pressure of carbon dioxide (PaCO2) less than or equal to 60 mm Hg (PaCO2 less than or equal to 55 mm Hg if one mile above sea level)
  - Partial pressure of oxygen (PaO2) greater than or equal to 45 mm Hg on room air (PaO2 greater than or equal to 30 mm Hg if one mile above sea level)
- The plasma cotinine is less than or equal to 13.7 ng/ml (if the client is not using nicotine products) or the carboxyhemoglobin is less than or equal to 2.5 percent (if the client is using nicotine products).
- Nonsmoking for four months prior to initial interview and throughout evaluation for surgery
- Successful 6-minute walk test equal to or greater than 140 meters following pre-operative rehabilitation
- Successful completion of three minute unloaded pedaling in an exercise tolerance test both before and after pre-operative rehabilitation

To complete the prior authorization process, a provider must mail or fax the request to the TMHP Special Medical Prior Authorization Unit and include documentation of medical necessity.

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- Requisition forms from the laboratory are not sufficient for verification of the personal and family history.
- Medical documentation that is submitted by the physician must verify the client's diagnosis or family history.

Prior authorization is not required for the associated preoperative pulmonary surgery services for preparation for LVRS (procedure codes G0302, G0303, and G0304) or the associated postdischarge pulmonary surgery services after LVRS (procedure code G0305).

9.2.42.1.1 Noncovered Conditions

LVRS is not a benefit in any of the following clinical circumstances:

- A client with characteristics that carry a high risk for perioperative morbidity and/or mortality
- A disease that is unsuitable for LVRS
- A medical condition or other circumstance that makes it likely that the client will be unable to complete the preoperative and postoperative pulmonary diagnostic and therapeutic program required for surgery
- The client presents with FEV1 less than or equal to 20 percent of predicted value, and either a homogeneous distribution of emphysema on the CT scan or a carbon monoxide diffusing capacity of less than or equal to 20 percent of predicted value (a high-risk group identified in October 2001 by the NETT)
- The client satisfies the criteria outlined above and has severe, non-upper-lobe emphysema with a high-exercise capacity. High-exercise capacity is defined as a maximal workload at the completion of the preoperative diagnostic and therapeutic program that is above 25 watts for women or 40 watts for men (under the measurement conditions for cycle ergometry).
- A previous LVRS (laser or excision) on the same lung
- A pleural or interstitial disease which precludes surgery
- A giant bulla (greater than 1/3 the volume of the lung in which the bulla is located)
- A clinically significant bronchiectasis
- A pulmonary nodule requiring surgery
- A previous lobectomy
- Uncontrolled hypertension (systolic greater than 200 mm Hg or diastolic greater than 110 mm Hg)
- Oxygen requirement greater than 6 liters per minute during resting to keep oxygen saturation greater than or equal to 90 percent
- A history of recurrent infections with clinically significant production of sputum
- Unplanned weight loss greater than 10 percent within 3 months before the consideration of surgery
- Pulmonary hypertension, defined as the mean pulmonary artery pressure of 35 mmHg or greater on the right heart catheterization or peak systolic pulmonary artery pressure of 45 mmHg or greater. Right heart catheterization is required to rule out pulmonary hypertension if the peak systolic pulmonary artery pressure is greater than 45 mmHg on an echocardiogram
- Resting bradycardia (less than 50 beats per minute)
- Frequent multifocal premature ventricular contractions (PVCs) of complex ventricular arrhythmia or sustained supraventricular tachycardia (SVT)
- Evidence of a systemic disease or neoplasia that is expected to compromise survival

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9.2.43 Diagnostic and Therapeutic Breast Procedures

Diagnostic, mastectomy, and breast reconstruction procedures are benefits of Texas Medicaid.

These are physician-directed services including, but not limited to diagnostic and surgical breast procedures provided by physicians in the office, outpatient, or inpatient hospital settings, and external breast prostheses provided by durable medical equipment (DME) providers in the home setting.

Categories of service include:

- Diagnostic breast procedures
- Mastectomy
- Reconstructive breast procedures
- Treatment of complications of breast reconstruction
- External breast prostheses

9.2.43.1 Diagnostic Procedures

Diagnostic breast procedures for a condition or malignancy of the breast 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 breast 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					

The following services are not benefits of Texas Medicaid:

- Mastectomy for a diagnosis of fibrocystic disease in the absence of documented risk factors.
- Cosmetic services performed primarily to improve appearance.
- Commercial or "decorative" tattooing.
- Replacement of external breast prostheses when the damage is due to abuse or neglect by the client, client's family, or the caregiver.

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9.2.43.2 Therapeutic Procedures

9.2.43.2.1 Mastectomy Procedures

Mastectomy and partial mastectomy (e.g., lumpectomy, tylectomy, quadrantectomy, and segmentectomy) are benefits 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 procedure codes for mastectomy are benefits of Texas Medicaid:

Procedure Codes						
19301	19302	19303	19304	19305	19306	19307

Procedure codes 19301, 19302, 19303, 19304, 19305, 19306, and 19307 may be reimbursed without prior authorization for services rendered to male or female clients who are 18 years of age and older.

Prior authorization is required for services rendered to clients who are 17 years of age and younger.

Procedure codes 19303, 19304, 19305, 19306, and 19307 are limited to 1 service per breast per lifetime.

9.2.43.2.2 Prophylactic Mastectomy

Prophylactic mastectomy is a benefit after a thorough assessment of a client's unique risk factors, health, and the level of concern. Prophylactic mastectomy is limited to clients who are at moderate- to high-risk for the development of breast cancer.

Moderate- to high-risk clients are those who meet one or more of the following criteria for development of breast cancer:

- Current or previous diagnosis of breast cancer
- Family history of breast cancer in mother, sister, or daughter, especially before the age of 50
- 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)
- Lobular carcinoma in situ (LCIS)
- Radiation therapy to the chest before a client reaches 30 years of age

Refer to: Subsection 2.2.6, "Breast Cancer Gene 1 and 2 (BRCA) Testing" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks)*.

Documentation that supports medical necessity for prophylactic mastectomy must include the information listed above.

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Documentation that as a candidate for prophylactic mastectomy, the client has undergone counseling regarding cancer risks. Counseling must include assessment of all of the following:

- The client's ability to understand the risks and long-term implications of the surgical procedure, and
- The client's informed choice to proceed with the surgical procedure.

9.2.43.2.3 Mastectomy for Pubertal Gynecomastia

Mastectomy for pubertal gynecomastia is a benefit with prior authorization for males who are 20 years of age and younger. Procedure code 19300 may be reimbursed for mastectomy for pubertal gynecomastia.

The following documentation must be submitted with the prior authorization request for procedure code 19300:

- The gynecomastia classification (grade II, III, or IV) as defined by the American Society of Plastic Surgeons classification.
- Evidence that puberty is near completion, as indicated by the following:
  - 95 percent of adult height based on bone age, and
  - Tanner stage V has been achieved.
- Evidence that the client has been off gynecomastia inducing drugs or other substances for a minimum of one year when this is identified as the cause of the gynecomastia.
- Evidence of resolution as supported by appropriate test results and treatment for hormonal causes, including hyperthyroidism, estrogen excess, prolactinomas, and hypogonadism, for a minimum of one year when identified as the cause of the gynecomastia.
- Evidence of a psychiatric assessment performed by a psychiatrist or psychologist.
- Client's history and treatment plan including planned surgical procedure and timelines.
- Identification of which breast or breasts, require mastectomy.

Documentation that supports medical necessity for mastectomy for pubertal gynecomastia must be maintained in the client's medical record, and must include the following:

- A complete medical and family history, including:
  - Gynecomastia classification
  - Bone age
  - Tanner stage
  - Use of any gynecomastia inducing drugs or substances and date last ingested
  - Hormonal causes of gynecomastia, treatment, and length of treatment
  - Psychiatric assessment performed by a psychiatrist or psychologist and outcome
  - Affected breast or breasts
- A thorough physical examination
- Medically indicated laboratory testing and any other testing including results

9.2.43.3 Breast Reconstruction

Breast reconstruction may be performed in a single stage or several stages. Breast reconstruction is a benefit when all of the following criteria are met:

- The client has a documented history of one or more of the following:

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  - Mastectomy
  - Congenital defect
  - Developmental abnormality
  - Trauma or injury to the chest wall
- The client meets age and gender criteria for the requested procedure.
- The physician has documented a treatment plan in the client's medical record that addresses the recommended breast reconstruction.
- Reconstruction to attain symmetry is required and may include a surgical procedure to the contralateral breast and may be either a reduction or an augmentation.

Procedure options for breast reconstruction following a mastectomy include, but are not limited to the following:

- Superficial inferior epigastric artery (SIEA) flap
- Deep inferior epigastric artery (DIEP) flap
- Transverse rectus abdominis myocutaneous (TRAM) flap
- Breast implants (saline or silicone)
- Reduction mammoplasty
- Mastopexy
- Reconstruction of the nipple or areola (small flaps)
- Tattooing to correct color defects of the skin
- Treatment for complications of breast reconstruction

Documentation that supports medical necessity for breast reconstruction, including tattooing, must include the following:

- Diagnosis resulting in the need for breast reconstruction,
- Date of mastectomy, when appropriate,
- Date of any previous breast reconstruction procedures, when appropriate,
- Treatment plan to include planned surgical procedures and timeline for completion, and
- When appropriate, identification of the complication.

All Medicaid services, including breast reconstruction after breast cancer surgery, are covered for Medicaid Breast and Cervical Cancer (MBCC) clients who are receiving active cancer treatment. "Active treatment" is defined as medical treatment following a cancer diagnosis that is intended to cure or otherwise treat a diagnosed cancer.

Active treatment may include some or all of the following:

- Surgery
- Chemotherapy
- Radiotherapy
- Medication (e.g., ongoing hormonal treatments for estrogen and progesterone breast cancer)
- Active disease surveillance for triple negative receptor breast cancer

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Reconstructive surgery (e.g., breast reconstruction) is considered "active treatment" if it is intended to permanently correct a physical condition resulting from either the diagnosed cancer or the treatment of the diagnosed cancer.

Ongoing treatment of a persistent condition resulting from a diagnosed cancer or treatment of a diagnosed cancer is not considered "active treatment" if cancer is no longer present or in need of treatment.

The following breast reconstruction procedure codes may be reimbursed without prior authorization for services rendered to clients who are 18 years of age and older:

Procedure Codes									
11970	11971	19316*	19324*	19325*	19340*	19342*	19350	19355	19357*
19361	19364	19366	19367	19368	19369	19396*	S2068		
***Procedure codes are limited to females only.**									

Prior authorization is required for services rendered to clients who are 17 years of age and younger or when the client does not meet gender or age criteria.

Procedure codes 11920, 11921, and 11922 may be reimbursed when performed as part of breast reconstruction.

Breast reconstruction claims denied for no history of previous mastectomy may be appealed with supporting documentation indicating the date of mastectomy, or the identified trauma, injury, or congenital or developmental abnormality.

9.2.43.3.1 Tattooing to Correct Color Defects of the Skin

Tattooing to correct color defects of the skin (procedure codes 11920, 11921, and 11922) are limited to two services per lifetime.

Tattooing claims denied for no history of breast reconstruction may be appealed with supporting documentation indicating the date of breast reconstruction, or the identified trauma, injury, or congenital or developmental abnormality.

9.2.43.3.2 Treatment for Complications of Breast Reconstruction

The treatment of complications related to breast reconstruction may be reimbursed using procedure codes 19328, 19330, 19370, 19371, and 19380.

Procedure codes 19328, 19330, 19370, and 19371 may be reimbursed for services rendered to female clients only.

9.2.43.3.3 External Breast Prostheses

External breast prostheses are available through a durable medical equipment (DME) provider for a female client with a history of a medically necessary mastectomy procedure.

The following procedure codes may be reimbursed for external breast prostheses services rendered to female clients of any age:

Procedure Codes									
L8000	L8001	L8002	L8010	L8015	L8020	L8030	L8031	L8032	L8035
L8039									

To be considered for reimbursement, an LT or RT modifier must be appropriately appended to the submitted diagnostic and therapeutic breast procedure codes or external breast prostheses procedure codes.

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The external breast prosthesis procedure codes are limited as follows:

Procedure Code	Limitation
L8000	4 per rolling year
L8001	4 per rolling year, per modifier
L8002	4 per rolling year
L8010	8 per rolling year
L8015	2 per rolling year
L8020	1 per 6 rolling months
L8030	per 2 rolling years
L8031	per 2 rolling years
L8032	8 per rolling year
L8035	Requires prior authorization
L8039	Requires prior authorization

Replacement of external breast prostheses may be considered at any time, through the prior authorization with documentation.

For a new or replacement external breast prosthesis procedure code outside the limitations, all of the following documentation must be submitted with the prior authorization request:

- The client's diagnosis
- Documentation of medical necessity for the requested prosthesis
- Documentation indicating the reason for recommending the requested prosthesis

When requesting a prior authorization for procedure code L8035 (custom prosthesis), all of the following documentation must be submitted with the prior authorization request:

- The client's diagnosis
- Documentation of medical necessity for the requested prosthesis
- Documentation indicating the reason for recommending the requested prosthesis

When requesting a prior authorization for procedure code L8039 (other prosthesis), all of the following documentation must be submitted with the prior authorization request:

- A clear, concise description of the breast prosthesis requested
- Reason for recommending the requested prosthesis
- A CPT or HCPCS procedure code, which is comparable to the procedure being requested
- Documentation that this breast prosthesis is not investigational or experimental
- The provider's intended fee for the requested prosthesis

9.2.43.4 Prior Authorization Requirements for Diagnostic and Therapeutic Breast Procedures

Prior authorization is not required for the following when all of the following criteria are met:

- The procedure is a mastectomy or breast reconstruction for clients who are 18 year of age or older.
- The request is for one of the following external breast prosthesis procedure codes: L8000, L8001, L8002, L8010, L8015, L8020, or L8030.
- The procedure is for partial mastectomy procedure codes 19301 and 19302 for clients of any age.

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Prior authorization is required for the following:

- Mastectomy or breast reconstruction when the client is 17 years of age or younger, or does not meet gender criteria
- Mastectomy for pubertal gynecomastia
- Procedure code 19499 (unlisted procedure)
- External breast prosthesis procedure codes L8035 (custom prosthesis) and L8039 (other prosthesis)
- Any request for new or replacement external breast prosthesis outside of the limitations

9.2.43.4.1 Unlisted Breast Procedure

All of the following documentation must be submitted for procedure code 19499 with the prior authorization request:

- A clear, concise description of the procedure to be performed
- Reason for recommending this particular procedure
- A Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) procedure code, which is comparable to the procedure being requested
- Documentation that this procedure is not investigational or experimental
- Place of service the procedure is to be performed
- The provider's intended fee for this procedure

9.2.43.4.2 Documentation Requirements

In addition to documentation requirements outlined in the "Prior Authorization Requirements" section above, the following requirements apply:

- All services are subject to retrospective review. Documentation in the client's medical record must be maintained by the physician and must support the medical necessity for the services provided.
- Services not supported by documentation are subject to recoupment.

9.2.44 Neurostimulators

Neurostimulator and neuromuscular stimulator procedures and the rental or purchase of devices and associated supplies, such as leads and form fitting conductive garments are a benefit of Texas Medicaid when medically necessary.

Neurostimulator devices are considered DME, so providers must complete both the Home Health (Title XIX) DME/Medical Supplies Physician Order Form (Title XIX Form) to prescribe the DME and the DME Certification and Receipt Form to show receipt of the DME by the client. Both forms must be maintained in the client's medical record.

Refer to: Subsection 2.2.2, "Durable Medical Equipment (DME) and Supplies," in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2, Provider Handbooks)* for more information about DME.

Rental of equipment includes all necessary accessories, supplies, adjustments, repairs, and replacement parts.

Items and/or services addressed in the sections below are either reimbursed at a maximum fee determined by HHSC or are manually priced. If an item is manually priced, the manufacturer's suggested retail pricing (MSRP) must be submitted for consideration of rental or purchase with the appropriate procedure codes. Manually priced items are reimbursed at the MSRP minus a discount (18 percent) as determined by HHSC.

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9.2.44.1 Prior Authorization for Neurostimulators

All devices and related procedures for the initial application or surgical implantation of the stimulator or neuromuscular stimulator device require prior authorization.

Requests for prior authorization must be submitted to the Special Medical Prior Authorization (SMPA) department with documentation supporting the medical necessity of the requested device. Providers may use the Special Medical Prior Authorization (SMPA) Request Form when they submit requests to the SMPA department.

To avoid unnecessary denials, the physician must provide correct and complete information including documentation for medical necessity of the equipment and/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 equipment and/or supplies. Prior authorization requests for all neurostimulators and related procedures must include the provider identifiers for both the surgeon and the facility.

A neurostimulator device that has been purchased is anticipated to last a maximum of five years and may be considered for replacement when five years have passed and/or the equipment is no longer repairable. At that time, replacement of the device will be considered. Replacement devices require prior authorization. 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 the measures to be taken to prevent reoccurrence must be submitted.

9.2.44.2 Neuromuscular Electrical Stimulation (NMES)

NMES application and the rental or purchase of devices and conductive garments are a benefit of Texas Medicaid when medically necessary and prior authorized. Prior authorization requests for NMES must include documentation of a spinal cord injury or disuse atrophy that is refractory to conventional therapy.

NMES may be reimbursed using the following procedure codes:

Procedure Codes							
64580	E0731	E0745	E0762	E0764	A4556	A4557	A4595

9.2.44.2.1 NMES Rental

The rental of a NMES device may be considered before purchase and is limited to a one-month trial period with consideration for one additional month's trial with documentation of medical necessity. Supplies are considered to be part of the rental and will not be separately reimbursed. Garments may be considered for reimbursement during the rental period when medically necessary.

9.2.44.2.2 NMES Purchase

The purchase of a NMES device is limited to once per five years, and may be reimbursed when there is documentation of successful test stimulation (during rental or other therapeutic period) that showed improvement as measured by the following:

- A demonstrated increase in range of motion.
- The client's improved ability to complete activities of daily living or perform activities outside the home.

Garments may be considered for reimbursement during the purchase period when medically necessary.

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9.2.44.2.3 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 conditions. Examples of NMES treatment for non-neurological conditions 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.

9.2.44.2.4 NMES for Walking in Clients with Spinal Cord Injury (SCI)

The type of NMES that is used to enhance the ability to walk of SCI clients 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.

The use of NMES/FES is limited to SCI clients who have completed a training program which consists of at least 32 physical therapy sessions with the device over a period of three months.

The trial period of physical therapy will enable the treating physician to properly evaluate the client's ability to use NMES/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. The goal of physical therapy must be to train SCI clients on the use of NMES/FES devices to achieve walking, not to reverse or retard muscle atrophy.

NMES/FES is a benefit for SCI clients who have all of the following characteristics:

- Clients with intact lower motor unit (L1 and below) (both muscle and peripheral nerve).
- Clients with muscle and joint stability for weight bearing at upper and lower extremities that can demonstrate balance and control to maintain an upright posture while standing independently for at least three minutes.
- Clients who demonstrate brisk muscle contraction to NMES and have sensory perception electrical stimulation sufficient for muscle contraction.
- Clients who possess high motivation, commitment, and cognitive ability to use such devices for ambulation, as established by provider interview and documentation.
- Clients who can transfer independently.
- Clients who can demonstrate hand and finger function to manipulate controls.
- Clients with at least six-month post recovery spinal cord injury and restorative surgery.
- Clients with hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis.

NMES and FES used for walking is not a benefit in SCI clients with any of the following:

- Cardiac pacemakers
- Severe scoliosis or severe osteoporosis
- Skin disease or cancer at area of stimulation
- Irreversible contracture
- Autonomic dysflexia

9.2.44.3 Transcutaneous Electrical Nerve Stimulation (TENS)

TENS involves the attachment of a transcutaneous nerve stimulator to the surface of the skin over the peripheral nerve to be stimulated.

TENS may be reimbursed for the treatment of acute postoperative pain or chronic pain that is refractory to conventional therapy.

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TENS may be reimbursed using the following procedure codes:

Procedure Codes						
64550	E0720	E0730	E0731	A4556	A4557	A4595

9.2.44.3.1 TENS Rental

Rental of a TENS device will be considered for prior authorization when there is documentation of a condition that indicates acute postoperative pain or chronic pain that is refractory to conventional therapy.

The rental of a TENS device is limited to one-month trial period with consideration for one additional month's trial with documentation of medical necessity. Supplies, such as lead wires and electrodes, are considered to be part of the rental and will not be separately reimbursed. Garments may be considered during the rental period when medically necessary.

When the TENS device is rented for a trial period rather than supplied by the provider, the combined payment made for professional services and the rental of the stimulator must not exceed the amount which would be reimbursed for the total service, including the stimulator, if furnished by the provider alone.

9.2.44.3.2 TENS Purchase

The purchase of a TENS device is limited to once every five years and may be reimbursed with prior authorization when there is documentation of the following:

- A condition that indicates chronic pain that is refractory to conventional therapy.
- A successful test stimulation (during rental or other therapeutic period) that showed improvement as measured by demonstrated increase in range of motion.
- The client's improved ability to complete activities of daily living or perform activities outside the home.

9.2.44.4 NMES and TENS Garments

The rental of the NMES/TENS garment is not covered during the trial rental period unless the client has a documented skin problem prior to the start of the trial period, and HHSC or its designee determines that use of such an item is medically necessary for the client based on the documentation submitted.

The purchase of conductive garments for NMES/TENS devices may be considered when:

- The garment has been prescribed by a physician for use in providing covered NMES/TENS treatment.
- A NMES/TENS device has been purchased for the client's use.
- 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 the treatment for chronic intractable pain without the conductive garment 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 skin problems that preclude the application of conventional electrodes, adhesive tapes, and lead wires.

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9.2.44.5 NMES and TENS Supplies

Supplies for purchased devices are limited as follows:

- If additional electrodes are required, procedure code A4556 may be considered for reimbursement at a maximum of 15 per month.
- If additional lead wires are required, procedure code A4557 may be considered for reimbursement at a maximum of 2 per month.
- Procedure code A4595 is limited to 1 per month.

Supplies are included in the rental and will not be reimbursed separately.

Supply procedure codes A4556, A4557, or A4595 may be reimbursed for clients with a purchased device and a claims history of an NMES/TENS procedure within the past 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 device may be required.

9.2.44.6 Diaphragm-Pacing Neuromuscular Stimulation

Diaphragm-pacing neuromuscular stimulation is a benefit of Texas Medicaid when medically necessary and prior authorized.

Diaphragm-pacing neuromuscular stimulation is the electrical stimulation to one or both of the phrenic nerves or to the phrenic motor point regions of the diaphragm muscles that cause contraction of one or both of the two hemidiaphragms rhythmically to produce inspiration.

Diaphragm-pacing neuromuscular stimulation may be reimbursed when billed with procedure codes 64575 and 64590.

9.2.44.6.1 Prior Authorization for Diaphragm-Pacing Neuromuscular Stimulation

The surgical implantation of the diaphragm-pacing neuromuscular stimulator and purchase of a device are considered for prior authorization when medically necessary for individuals with severe, chronic respiratory failure that requires mechanical ventilation for any of the following reasons:

- Improvement of ventilatory function in stable, non-acute members with spinal cord injury (SCI) with high quadriplegia at or above C-3
- Alveolar hypoventilation, either primary or secondary to brainstem disorder
- Amyotrophic lateral sclerosis

All of the following criteria must be met:

- The phrenic nerves are viable
- Diaphragmatic function is sufficient to accommodate chronic stimulation
- Pulmonary function is known to be adequate
- The client has normal chest anatomy, a normal level of consciousness, and has the ability to participate in and complete the training and rehabilitation associated with the use of the device

9.2.44.7 Dorsal Column Neurostimulator (DCN)

DCN involves the surgical implantation of neurostimulator electrodes within the dura mater (endodural) or the percutaneous insertion of electrodes in the epidural space. The neurostimulator system stimulates pain-inhibiting nerve fibers, masking the sensation of pain with a tingling sensation (paresthesia).

DCN implantation may be reimbursed using procedure codes 61783, 63650, 63655, or 63685.

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Conditions that may indicate chronic intractable pain include, but are not limited to, the following:

- Post-amputation "ghost" pain
- Cancer with bone metastasis
- Causalgia of upper/lower limb
- Herniated disc
- Radiculitis
- Spinal stenosis
- Spinal surgery
- Tic douloureux (trigeminal neuralgia)

9.2.44.7.1 Prior Authorization for Dorsal Column Neurostimulators

DCN electrode implantation and the purchase of devices is a benefit of Texas Medicaid when medically necessary and prior authorized.

The surgical implantation of DCN device may be considered for prior authorization for clients who have chronic intractable pain with documentation that indicates the following:

- Other treatment modalities, including pharmacological, surgical, physical, and/or psychological therapies, have been tried and 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.
- There has been evidence of pain relief during a trial period for DCN with a temporarily implanted electrode or electrodes preceding the permanent implantation.

  Note: *A trial period including device and supplies is considered part of DCN procedures and will not be separately reimbursed.*

- All the facilities, equipment, and professional and support personnel required for the proper diagnosis, treatment, training, and the client's follow-up are available.

9.2.44.8 Gastric Electrical Stimulation (GES)

GES involves electrical stimulation of the lower stomach (antrum) with a fully implantable system that consists of two unipolar intramuscular leads (thin wires) and a neurostimulator device.

GES is a benefit of Texas Medicaid when medically necessary and prior authorized for the treatment of chronic intractable nausea and vomiting that is secondary to gastroparesis that has proven to be refractory to medical management.

GES may be reimbursed with procedure codes 43647, 43881, and 64590.

GES is a benefit for Texas Medicaid clients with the following conditions:

- Organic obstruction or pseudo-obstruction
- A primary eating or swallowing disorder
- Chemical dependency
- Pregnancy

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9.2.44.8.1 Prior Authorization for GES

The surgical implantation of a GES and purchase of a device are considered for prior authorization for chronic intractable nausea and vomiting secondary to gastroparesis of diabetic or idiopathic etiology when all of the following criteria are met:

- Gastric emptying is significantly delayed as documented by standard scintigraphic imaging of solid food.
- Patient is refractory or intolerant of two out of three classes of prokinetic medications and two out of three antiemetic medications.
- The client's nutritional status is sufficiently low that all of the following criteria for total parenteral nutrition are met.
- Adequate trials of dietary adjustment, oral supplements, or tube enteral nutrition have demonstrated that the patient can receive no more than 30 percent of his/her caloric needs orally and/or by tube.
- The patient must be in a stage of wasting as indicated by all of the following:
  - Weight is significantly less than normal body weight for a patient's height and age in comparison with pre-illness weight.
  - Serum albumin is less than 3.4 grams.
  - BUN is less than 10 mg.
  - Phosphorus level is less than 2.5 mg.

9.2.44.9 Intracranial Neurostimulators

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.

Intracranial neurostimulation may be reimbursed using the following procedure codes:

Procedure Codes									
61781	61782	61850	61860	61863	61864	61867	61868	61870	61885
61886									

9.2.44.9.1 Prior Authorization for Intracranial Neurostimulators

Intracranial neurostimulation involves the stereotactic implantation of electrodes in the brain and is a benefit of Texas Medicaid when medically necessary and prior authorized.

The surgical implantation and purchase of an intracranial neurostimulation device may be considered for prior authorization for chronic intractable pain or treatment of intractable tremors.

Requests for prior authorization must include documentation of the following:

- Other treatment modalities, including pharmacological, surgical, physical, and psychological therapies, have been tried and shown to be unsatisfactory, unsuitable, or contraindicated for the client.
- The client has undergone careful screening, evaluation, and assessment by a multidisciplinary team prior to implantation.
- The client has reported pain relief with a temporarily implanted electrode preceding the permanent implantation.

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- All the facilities, equipment, and support personnel required for the proper assessment, treatment, training, and client's follow-up are available.

Prior authorization will not be given for the treatment of motor function disorders such as multiple sclerosis; however, the implantation, revision, and removal of deep brain stimulators may be reimbursed for the treatment of intractable tremors due to the following:

- Idiopathic Parkinson's disease
- Essential tremor

9.2.44.10 Pelvic Floor Stimulation

Purchase of a non-implantable pelvic floor stimulator (procedure code E0740) is a benefit of Texas Medicaid for the treatment of stress or urge incontinence in clients who have failed conservative treatment, such as Kegel exercises, behavior management, bladder training, or medication.

Purchase of the pelvic floor stimulator device is limited to once per five years. All accessories and supplies are considered part of the purchase price and are not reimbursed separately.

9.2.44.10.1 Prior Authorization for Pelvic Floor Stimulation

Prior authorization is required for the purchase of a pelvic floor stimulator device.

Documentation submitted with the prior authorization request must demonstrate that the client:

- Has a diagnosis of stress or urge incontinence.
- Has completed a six-month trial of pelvic muscles exercises with no significant clinical improvement.

9.2.44.11 Percutaneous Electrical Nerve Stimulation (PENS)

PENS is a benefit of Texas Medicaid when medically necessary and prior authorized. Devices and supplies are considered a part of the service and are not separately reimbursable.

PENS is a diagnostic procedure for the treatment of chronic pain involving the stimulation of peripheral nerves by a needle electrode inserted through the skin.

9.2.44.11.1 Prior Authorization for PENS

PENS services may be reimbursed with prior authorization for clients who meet the following criteria:

- The client has a diagnosis that indicates chronic pain, which is refractory to conventional therapy.
- Treatment with TENS has failed or is contraindicated for the client.

PENS may be reimbursed using the following procedure codes: 64553, 64555, or 64590. The revision or removal of a peripheral neurostimulator used in PENS therapy may be reimbursed without prior authorization using procedure code 64595.

9.2.44.12 Sacral Nerve Stimulators (SNS)

SNS are a benefit of Texas Medicaid when medically necessary and prior authorized. SNS implantation may be reimbursed using procedure code 64561, 64581, or 64590.

SNS involves the use of pulse generators that transmit electrical impulses to the sacral nerves through a surgically implanted wire for treatment of urinary retention, urinary frequency, and urinary/fecal incontinence.

9.2.44.12.1 Prior Authorization for SNS

The surgical implantation of SNS and purchase of a device may be considered for prior authorization with the following:

- Urinary incontinence secondary to urethral instability and/or detrusor muscle instability.

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- Chronic voiding dysfunction.
- Non-obstructive urinary retention.
- Fecal incontinence.

Additionally, the medical record of the client must have documentation of the following:

- The urinary retention, urinary frequency, and urinary/fecal incontinence are refractory to conventional therapy (documented behavioral, pharmacological, and/or surgical corrective therapy).
- The client is an appropriate surgical candidate such that implantation with anesthesia can occur.

9.2.44.13 Vagal Nerve Stimulators (VNS)

VNS are a benefit of Texas Medicaid when medically necessary and prior authorized, for the treatment of intractable partial onset seizures.

VNS involves the use of devices that deliver electrical pulses to the cervical portion of the vagus nerve by an implanted generator.

9.2.44.13.1 Prior Authorization for VNS

The surgical implantation and purchase of VNS devices may be considered for prior authorization for clients with partial onset intractable seizures when there is failure, contraindication, or intolerance to all suitable medical and pharmacological management.

The surgical implantation of VNS may be reimbursed using procedure code 61885, 61886, 64553, or 64568.

VNS are not a benefit of Texas Medicaid in the following cases:

- For the treatment of clients with an absent left vagus nerve
- For the treatment of clients with depression
- For the treatment of clients with diseases or conditions with a poor prognosis or are progressively terminal in nature

Incapacities due to intellectual disabilities or cerebral palsy may confound the assessment of benefits resulting from VNS. When a diagnosis of intellectual disabilities or cerebral palsy exists, the treating physician must document in the client's medical record how VNS will measurably benefit the client in spite of intellectual disabilities or cerebral palsy.

9.2.44.14 Prior Authorization of Neurostimulator Devices Procedure Codes

The following device procedure codes may be reimbursed with prior authorization:

Procedure Codes									
L8681	L8682	L8683	L8684	L8685	L8686	L8687	L8688	L8689	L8695

To identify the service as a VNS device, procedure code L8686 must be submitted with modifier TG. Only one similar device code may be reimbursed per date of service for any provider.

9.2.44.15 Supplies for Neurostimulators

Supply procedure codes A4290, C1883, C1897, L8680, and L8696 may be reimbursed for clients with a purchased device and a claims history of a prior neurostimulator or neuromuscular stimulator implantation within the past 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 implantable device may be required. Supplies for implantable devices

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may be considered for reimbursement on appeal with documentation of a prior neurostimulator or a neuromuscular stimulator implantation procedure for clients with a history that is more than five years or for those who have a neurostimulator that was not received through Texas Medicaid.

To identify the service as a VNS implantable electrode, procedure code L8680 must be submitted with modifier TG.

9.2.44.16 Electronic Analysis for Neurostimulators

The following procedure codes may be reimbursed without prior authorization for the electronic analysis of the implanted neurostimulator and neuromuscular stimulation:

Procedure Codes									
95970	95971	95972	95974	95975	95978	95979	95980	95981	95982

9.2.44.17 Revision or Removal of Neurostimulator Devices

The revision or removal of implantable neurostimulators may be reimbursed without prior authorization using the following procedure codes:

Procedure Codes									
43648	43882	61781	61782	61783	63661	63662	63663	63664	63688
61880	61888	64569	64570	64585	64595				

9.2.44.18 Noncovered Neurostimulator Services

The following services are not a benefit of Texas Medicaid:

- VNS is not a benefit when provided for the treatment of depression.
- Neurostimulation and neuromuscular stimulation services for indications other than those outlined above.

9.2.45 Newborn Services

The newborn period is defined as the time from birth through 28 days of life. This section addresses routine newborn care, attendance at delivery, newborn resuscitation, neonatal critical care, and intensive (noncritical) low birth weight services.

Retrospective review may be performed to ensure documentation supports the medical necessity of the service and any modifier used when billing a claim.

Modifier 25 may be used to identify a significant separately identifiable E/M provided on the same day by the same physician as a 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 Texas Medicaid upon request.

Physician standby (procedure code 99360) is not a benefit.

Note: *Some of the services addressed in this section may also be used for care beyond 28 days of life.*

Refer to: Subsection 9.2.58, "Physician Evaluation and Management (E/M) Services," in this handbook.

Subsection 2.6.5, "Cardiorespiratory (Apnea) Monitor," in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for authorization of apnea monitors through CCP.

9.2.45.1 Circumcisions for Newborns

Texas Medicaid may provide reimbursement for circumcisions billed with procedure code 54150 or procedure code 54160.

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9.2.45.2 * Hospital Visits and Routine Care

The following procedure codes may be reimbursed for neonatal care and intensive care services:

Service	Procedure Code(s)	Benefit(s) and Limitation(s)
Initial hospital E/M admission	99221 99222 99223	If the client is readmitted within the first 28 days of life, the provider must bill an initial hospital evaluation and management (E/M) admission. Reimbursed one per day, any provider.
Hospital discharge	99238 99239	Reimbursed for the client's discharge from the hospital.
Subsequent hospital and hospital consultation services	99251 99252 99253 99254 99255	Services for a client who is not critically ill and unstable but who happens to be in a critical care unit must be reported using subsequent hospital codes (99478, 99479, and 99480) or hospital consultation codes (99251, 99252, 99253, 99254, and 99255).
Initial newborn care	99460*	May be reimbursed once per lifetime, any provider.
Normal newborn care	99461*	May be reimbursed once per lifetime, any provider. Subsequent visits must be billed using an appropriate visit code based on the place of service.
Subsequent hospital care	99462	Reimbursable once per day in the hospital. Restricted to clients who are birth through seven days of age. Procedure code 99462 is not reimbursable in the birthing center.
Newborn admission and discharge, same date	99463**	May be reimbursed once per lifetime when submitted by any provider. Reimbursed for newborns who are admitted and discharged on the same day from the hospital or birthing room setting (either hospital or birthing center).
Attendance at delivery	99464	May be reimbursed once, and only on the day of delivery, when billed by a physician other than the delivering physician.
Newborn resuscitation	99465	Reimbursed for the resuscitation of the newborn.
Initial hospital care and initial intensive care	99477	Reimbursed for those neonates who require intensive observation, frequent interventions, and other intensive services. Non-time-based procedure codes must be billed daily irrespective of the time that the provider spends with the neonate or infant. Initial neonatal critical and intensive care (procedure codes 99468 and 99477) may be reimbursed once per admission, any provider. ***Note:*** *For subsequent admissions during the first 28 days of life, procedure codes 99468 and 99477 may be considered for reimbursement upon appeal.*

*** Newborn examinations billed with procedure codes 99460, 99461, and 99463 may be counted as a THSteps periodic medical checkup when all necessary components are completed and documented in the medical record.**
**** If the client is readmitted within the first 28 days of life, the provider must bill an initial hospital evaluation and management (E/M) admission (procedure code 99221, 99222, or 99223).**

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Service	Procedure Code(s)	Benefit(s) and Limitation(s)
Subsequent intensive care	99478 99479 99480	Non-time-based procedure codes must be billed daily irrespective of the time that the provider spends with the neonate or infant. Subsequent critical and intensive care (procedure codes 99469, 99478, 99479, and 99480) will be considered for reimbursement once per day, any provider. Services for a client who is not critically ill and unstable but who happens to be in a critical care unit must be reported using subsequent hospital codes (99478, 99479, and 99480) or hospital consultation codes (99251, 99252, 99253, 99254, and 99255). Procedure codes 99478, 99479, and 99480 must be billed for subsequent neonatal intensive (noncritical) services. The present body weight of the neonate or infant determines the appropriate procedure code that must be billed. When the present body weight of a neonate exceeds 5,000 grams, a subsequent hospital care service (procedure code 99231, 99232, or 99233) must be billed.
*** Newborn examinations billed with procedure codes 99460, 99461, and 99463 may be counted as a THSteps periodic medical checkup when all necessary components are completed and documented in the medical record.** **** If the client is readmitted within the first 28 days of life, the provider must bill an initial hospital evaluation and management (E/M) admission (procedure code 99221, 99222, or 99223).**		

Note: *Services for a newborn's unsuccessful resuscitation may be billed under the mother's Texas Medicaid number using procedure code 99499.*

Refer to: Section 5, "THSteps Medical" in the *Children's Services Handbook* (*Vol. 2 Provider Handbooks*).

Subsection 5.3.9, "Newborn Examination," in the *Children's Services Handbook* (*Vol. 2 Provider Handbooks*) for a list of the required components for an initial THSteps exam.

Retrospective review may be performed to ensure documentation supports the medical necessity of the service and any modifier used when billing a claim.

In the following table, procedure codes in Column A will be denied when billed with the same date of service by the same provider as a procedure code in Column B:

Column A (Denied)	Column B
99238, 99239	99460, 99461, 99463
99462	99238, 99239
36410, 96361, 99292, 99307, 99354, 99355, 99356, 99357	99468, 9469
36410, 96361, 99354, 99355, 99356, 99357, 99471, 99472	99477
36410, 96361, 99291, 99292, 99307, 99354, 99355, 99356, 99357, 99471, 99472, 99478	99478
36410, 94761, 96361, 99291, 99292, 99307, 99354, 99355, 99356, 99357, 99471, 99472, 99478, 99479	99479
36410, 96361, 99291, 99292, 99307, 99308, 99309, 99310, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99354, 99355, 99356, 99357, 99471, 99472, 99478, 99479, 99480	99480

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9.2.45.3 Newborn Hearing Screening

The newborn hearing screening procedure is a screening procedure, not diagnostic, and will not be reimbursed separately from the usual inpatient newborn delivery payment. Special investigations and examination codes are not appropriate for use with hearing screening of infants. For more information on newborn hearing screening, providers may contact:

Texas Early Hearing Detection and Intervention
PO Box 149347, MC-1918
Austin, TX. 78714-9347
1-512-458-7111, Ext. 2600
www.dshs.state.tx.us/audio

Refer to: Section 2, "Nonimplantable Hearing Aid Devices and Related Services" in the *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 5.3.11.2.3, "Hearing Screening," in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about hearing screenings.

9.2.46 Obstetrics and Prenatal Care

Medicaid reimburses prenatal care, deliveries, and postpartum care as individual services. Providers may choose one of the following options for billing maternity services:

- Providers may itemize each service individually on *one* claim form and file at the time of delivery. The filing deadline is applied to the date of delivery.
- Providers may itemize each service individually and submit claims as the services are rendered. The filing deadline is applied to each individual date of service.

Providers who only provide prenatal care and choose to submit prenatal visit charges on one claim form have the filing deadline applied to the estimated date of confinement (EDC) that must be stated in Block 24D of the CMS-1500 claim form.

Laboratory (including pregnancy tests) and radiology services provided during pregnancy must be billed separately and claims must be received by TMHP within 95 days of the date of service.

When billing for prenatal services, use modifier TH with the appropriate evaluation and management procedure code to the highest level of specificity. Failure to use modifier TH may result in recoupment of payment rendered.

Providers must bill the most appropriate new or established patient prenatal or postnatal visit procedure code. New patient codes may be used when the client has not received any professional services from the same physician or a physician of the same specialty who belongs to the same group, within the past three years.

Physicians (obstetricians, family practice physicians, and maternal-fetal medicine specialists), CNMs, and maternity service clinics (MSCs) are limited to 20 prenatal care visits per pregnancy and one postpartum care visit after discharge from the hospital. Routine pregnancies are anticipated to require around 11 visits per pregnancy, and high-risk pregnancies are anticipated to require around 20 visits per pregnancy.

More frequent visits may be necessary for high-risk pregnancies. High-risk obstetrical visits are not limited to 20 visits per pregnancy. The provider can appeal with documentation supporting a complication of pregnancy. Documentation reflecting the need for increased visits must be maintained in the physician's files and is subject to retrospective review.

Prenatal and postpartum care visits billed in an inpatient hospital (POS 3) are denied as part of another procedure when billed within the three days before delivery or the six weeks after delivery. The inpatient intrapartum and postpartum care are included in the fee for the delivery or Cesarean section and should not be billed separately.

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One postpartum care procedure code may be reimbursed per pregnancy. The claim for the postpartum visit may be submitted with either procedure code 59430 or with a delivery procedure code (59410, 59515, 59614, or 59622) that includes postpartum care. The reimbursement amount for the submitted procedure code covers all postpartum care per pregnancy regardless of the number of postpartum visits provided.

Procedure code 59430 may be reimbursed once per pregnancy following a delivery if the delivery procedure code does not include postpartum care. Since delivery procedure codes 59410, 59515, 59614, and 59622 include postpartum care, procedure code 59430 will be denied if procedure codes 59410, 59515, 59614, or 59622 were submitted by any provider for the same pregnancy.

Any other E/M office visit will not be reimbursed when billed with the same date of service, by the same provider, as any antenatal or postpartum office visit. Modifier 25 may be used to identify a significant, separately identifiable E/M service performed by the same physician on the same date of service as 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 Texas Medicaid upon request.

Delivering physicians who perform regional anesthesia or nerve block do not receive additional reimbursement because these charges are included in the reimbursement for the delivery except as outlined under subsection 9.2.6.3, "Anesthesia for Labor and Delivery" in this handbook. Medicaid may reimburse only one delivery or Cesarean section procedure code per client in a seven-month period; reimbursement includes multiple births.

Procedure code 99140 is not considered for reimbursement when submitted with diagnosis code O80 for a normal delivery or with diagnosis code O82 for a Cesarean delivery when one of these diagnosis codes is documented on the claim as the referenced diagnosis. The referenced diagnosis must indicate the complicating condition. An emergency is defined as a situation when delay in treatment of the client poses a significant health threat to a client's life, bodily organ, or body part.

Hospital admissions resulting from conditions or comorbidities complicating labor should be billed using the appropriate E/M procedure codes. These codes are not subject to the three-day pre-care period but are not payable on the date of delivery or the following six-week post-care period.

Refer to: Subsection 9.2.6, "Anesthesia," in this handbook for complete information about anesthesia for obstetrical procedures.

9.2.46.1 Amniocentesis, Cordocentesis, and Ultrasonic Guidance

Procedure code 59001 is restricted to the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
O401XX0	O401XX1	O401XX2	O401XX3	O401XX4	O401XX5	O401XX9	O402XX0
O402XX1	O402XX2	O402XX3	O402XX4	O402XX5	O402XX9	O403XX0	O403XX1
O403XX2	O403XX3	O403XX4	O403XX5	O403XX9	O409XX0	O409XX1	O409XX2
O409XX3	O409XX4	O409XX5	O409XX9				

Cordocentesis and ultrasonic guidance procedure code 76941 are benefits of Texas Medicaid when billed with one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
O353XX0	O353XX1	O353XX2	O353XX3	O353XX4	O353XX5	O353XX9	O358XX0
O360110	O360111	O360112	O360113	O360114	O360115	O360119	O360120
O360121	O360122	O360123	O360124	O360125	O360129	O360130	O360131
O360132	O360133	O360134	O360135	O360139	O360190	O360191	O360192

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
O360193	O360194	O360195	O360199	O360910	O360911	O360912	O360913
O360914	O360915	O360919	O360920	O360921	O360922	O360923	O360924
O360925	O360929	O360930	O360931	O360932	O360933	O360934	O360935
O360939	O360990	O360991	O360992	O360993	O360994	O360995	O360999
O361110	O361111	O361112	O361113	O361114	O361115	O361119	O361120
O361121	O361122	O361123	O361124	O361125	O361129	O361130	O361131
O361132	O361133	O361134	O361135	O361139	O361190	O361191	O361192
O361193	O361194	O361195	O361199	O361910	O361911	O361912	O361913
O361914	O361915	O361919	O361920	O361921	O361922	O361923	O361924
O361925	O361929	O361930	O361931	O361932	O361933	O361934	O361935
O361939	O361990	O361991	O361992	O361993	O361994	O361995	O361999
O368210	O368211	O368212	O368213	O368214	O368215	O368219	O368220
O368221	O368222	O368223	O368224	O368225	O368229	O368230	O368231
O368232	O368233	O368234	O368235	O368239	O368290	O368291	O368292
O368293	O368294	O368295	O368299	O4690	O4691	O4692	O4693

The Medical Director reviews cordocentesis requests on a case-by-case basis for diagnosis codes other than those listed above.

Cordocentesis or umbilical blood sampling is included in the global fee for procedure code 36460.

9.2.46.2 Deliveries

Texas Medicaid restricts any cesarean section, labor induction, or any delivery following labor induction to one of the following criteria:

- Gestational age of the fetus should be determined to be at least 39 weeks.
- When the delivery occurs prior to 39 weeks, maternal and/or fetal conditions must dictate medical necessity for the delivery.

Cesarean sections, labor inductions, or any deliveries following labor induction that occur prior to 39 weeks of gestation and are not considered medically necessary will be denied.

Claims that are submitted for obstetric delivery procedure codes 59409, 59410, 59514, 59515, 59612, 59614, 59620, or 59622 require one of the following modifiers:

Modifier	To Indicate
U1	Medically necessary delivery prior to 39 weeks of gestation
U2	Delivery at 39 weeks of gestation or later
U3	Non-medically necessary delivery prior to 39 weeks of gestation

Note: *Claims for deliveries that are submitted without one of the required modifiers will be denied.*

Records are subject to retrospective review. Payments made for a Cesarean section, labor induction, or any delivery following labor induction that fail to meet these criteria (as determined by review of medical documentation), will be recouped. Recoupment will apply to the obstetric delivery procedure code and the associated hospital claim.

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9.2.46.3 External Cephalic Version

External cephalic version is the external manipulation of a fetus to alter its position in the uterus to make it more favorable for delivery.

Procedure code 59412 is payable in the inpatient hospital (POS 3) or outpatient hospital (POS 5) setting when billed as an independent procedure performed by a physician at least one day before delivery.

Emergency room and subsequent hospital care visit procedure codes billed the same day as external cephalic version by the same provider are denied.

9.2.46.4 Fetal Fibronectin

Procedure code 82731 is a benefit of Texas Medicaid and may be considered for reimbursement when the fetal gestational age is 23 weeks through 34 weeks on the date the service was provided.

Fetal fibronectin is limited to threatened preterm labor using diagnosis code O4700, O4702, O4703, or O479.

9.2.46.5 Fetal Intrauterine Transfusion (FIUT)

FIUT (procedure code 36460) is limited to the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
O353XX0	O353XX1	O353XX2	O353XX3	O353XX4	O353XX5	O353XX9	O358XX0
O360110	O360111	O360112	O360113	O360114	O360115	O360119	O360120
O360121	O360122	O360123	O360124	O360125	O360129	O360130	O360131
O360132	O360133	O360134	O360135	O360139	O360190	O360191	O360192
O360193	O360194	O360195	O360199	O360910	O360911	O360912	O360913
O360914	O360915	O360919	O360920	O360921	O360922	O360923	O360924
O360925	O360929	O360930	O360931	O360932	O360933	O360934	O360935
O360939	O360990	O360991	O360992	O360993	O360994	O360995	O360999
O361110	O361111	O361112	O361113	O361114	O361115	O361119	O361120
O361121	O361122	O361123	O361124	O361125	O361129	O361130	O361131
O361132	O361133	O361134	O361135	O361139	O361190	O361191	O361192
O361193	O361194	O361195	O361199	O361910	O361911	O361912	O361913
O361914	O361915	O361919	O361920	O361921	O361922	O361923	O361924
O361925	O361929	O361930	O361931	O361932	O361933	O361934	O361935
O361939	O361990	O361991	O361992	O361993	O361994	O361995	O361999
O368210	O368211	O368212	O368213	O368214	O368215	O368219	O368220
O368221	O368222	O368223	O368224	O368225	O368229	O368230	O368231
O368232	O368233	O368234	O368235	O368239	O368290	O368291	O368292
O368293	O368294	O368295	O368299	O4690	O4691	O4692	O4693

FIUT is reimbursed as a global fee and, therefore, includes all other services provided by the same physician, including umbilical blood sampling or cordocentesis.

In addition to the physician performing the FIUT, another physician may assist with echography control. Procedure code 76941 may be reimbursed separately when billed by a different physician.

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9.2.46.6 Doppler Studies

Umbilical artery Doppler (procedure code 76820) is limited to the following indications, as supported by the American College of Obstetricians and Gynecologists (ACOG):

- Suspected intrauterine growth restriction (IUGR)
- Post-term gestation
- Diabetes mellitus
- Systemic lupus erythematosus or antiphospholipid antibody syndrome

Middle cerebral artery Doppler (procedure code 76821) is indicated, but not limited to, fetuses who are alloimmunized.

9.2.46.7 Fetal Echocardiography

Fetal echocardiography (procedure codes 76825, 76826, 76827, and 76828) may be reimbursed for the following risk factors and syndromes:

- Fetal Risk Factors
  - Extracardiac anomalies (including chromosomal and anatomic)
  - Fetal cardiac dysrhythmia (including irregular rhythm, tachycardia, and bradycardia)
  - Nonimmune hydrops fetalis
  - Suspected cardiac anomaly on ultrasound
  - Abnormal fetal situs
- Maternal Risk Factors
  - Congenital heart disease
  - Cardiac teratogen exposure (including lithium, alcohol, phenytoin, trimethadione, and isoretinoin)
  - Maternal metabolic disorders (including diabetes mellitus and phenylketonuria)
- Familial Risk Factors
  - Congenital heart disease (including previous sibling and paternal)
- Syndromes
  - Marfan's
  - Noonan's
  - Tuberous sclerosis

9.2.46.8 * Fetal Surgery

Fetal surgery procedures require prior authorization. Prior authorization requests must be submitted with a completed Special Medicaid Prior Authorization (SMPA) Request Form to the SMPA department.

9.2.46.8.1 Fetal Surgery Repairs

Procedure codes S2401, S2402, S2403, S2405, and S2409 may be prior authorized only when the hospital is a member of the North American Fetal Therapy Network (NAFTNet). The pediatric surgeon who performs these surgeries must submit documentation which includes the following:

- A clear description of the fetal malformation. The malformation must interfere with the in utero organ development and fetal survival and have potential fatal consequences before or after birth.

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- Evidence that in utero correction of the fetal congenital malformation will result in a clinical outcome that is better than what would be seen in expectant management.

9.2.46.8.2 Fetoscopic Laser Therapy

Procedure code S2411 may be considered for prior authorization when the submitted documentation indicates all of the following:

- Fetal gestational age is less than 26 weeks.
- Evidence of polyhydramnios in the recipient fetus.
- Donor fetus is oligohydramniotic.
- Evidence of abnormal blood flow documented by Doppler studies in one or both fetuses.

9.2.46.8.3 Umbilical Cord Occlusion

Procedure code 59072 may be considered for prior authorization when the submitted documentation indicates all of the following:

- A diagnosis of monoamniotic-monochorionic twins.
- There is spontaneous fetal death of one of the twins with the presence of hydrops.
- The ratio of acardiac:pump twin weight is greater than 50 percent.
- The abdominal circumference of the twin with reversed arterial perfusion is greater than or equal to the abdominal circumference of the pump twin.

9.2.46.9 * Obstetric Ultrasound

Ultrasound of the pregnant uterus is a benefit of Texas Medicaid when medically indicated. Ultrasound may be indicated for suspected genetic defects, high risk pregnancy, and fetal growth retardation.

The following procedure codes for ultrasound of the pregnant uterus are limited to a total of three per pregnancy:

Procedure Codes									
76801	76802	76805	76810	76811	76812	76813	76814	76815	76816
76817									

The limit of three obstetric ultrasounds per pregnancy does not apply to obstetric ultrasound procedures that are rendered in the emergency room, outpatient observation, or inpatient hospital setting. Obstetric ultrasounds provided in the emergency department must be submitted with modifier U6 when submitted on the professional claim form in order to be considered for payment. Obstetric ultrasounds provided in the emergency department or during a hospital observation stay must be submitted with the appropriate corresponding emergency services or hospital observation revenue code in order to be considered for payment.

The initial three claims paid for obstetric ultrasounds do not require prior authorization. Any obstetric ultrasound claims submitted with or without prior authorization for the initial three will count toward the three-per-pregnancy limit. If it is medically necessary to perform more than three obstetrical ultrasounds on a client during one pregnancy, the provider must request prior authorization with documentation of medical necessity using the Obstetric Ultrasound Prior Authorization Request on the TMHP website at www.tmhp.com.

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Documentation is required to substantiate the need to perform a transvaginal obstetric ultrasound in addition to a transabdominal examination on the same date of service. Texas Medicaid follows the ACOG indications for sonography. First trimester ultrasounds may be medically necessary for, but are not limited to, the following reasons:

- To confirm the presence of an intrauterine pregnancy
- To evaluate a suspected ectopic pregnancy
- To evaluate vaginal bleeding
- To evaluate pelvic pain
- To estimate gestational age
- To diagnose or evaluate multiple gestation
- To confirm cardiac activity
- As an adjunct to chorionic villus sampling or localization and removal of an intrauterine device
- To assess certain fetal anomalies, such as anencephaly, in clients at high risk
- To evaluate maternal pelvic or adnexal masses or uterine abnormalities
- To screen for fetal aneuploidy
- To evaluate a suspected hydatidiform mole

Second and third trimester ultrasounds may be medically necessary for the following reasons:

- To estimate fetal age
- To evaluate fetal growth
- To evaluate vaginal bleeding
- To evaluate cervical insufficiency
- To evaluate abdominal and pelvic pain
- To determine fetal presentation
- As an adjunct to amniocentesis or other procedure
- To evaluate suspected multiple gestation
- To evaluate a significant discrepancy between uterine size and clinical dates
- To evaluate a pelvic mass
- To evaluate a suspected hydatidiform mole
- As an adjunct to cervical cerclage placement
- To evaluate a suspected ectopic pregnancy
- To evaluate suspected fetal death
- To evaluate suspected uterine abnormality
- To evaluate fetal well-being
- To evaluate suspected amniotic fluid abnormalities
- To evaluate suspected placental abruption
- As an adjunct to external cephalic version
- To evaluate premature rupture of membranes or premature labor

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- To evaluate abnormal biochemical markers
- As a follow-up evaluation of a fetal anomaly
- As a follow-up evaluation of placental location for suspected placenta previa
- To evaluate clients who have a history of previous congenital anomaly
- To evaluate fetal condition in late registrants for prenatal care
- To assess findings that may increase the risk of aneuploidy
- To screen for fetal anomalies

The Obstetric Ultrasound Prior Authorization Request Form must be completed, signed, dated, and maintained in the client's medical record by the provider ordering the test, regardless of the method of request for authorization. A physician, nurse practitioner (NP), clinical nurse specialist (CNS), certified nurse midwife (CNM), or physician assistant (PA) may sign the Obstetric Ultrasound Prior Authorization Request Form. Residents may order obstetric ultrasounds; however, the attending physician must sign the authorization form and include the group or supervising provider identifier on the form.

The form must include information related to medical necessity of the test including all of the following:

- Procedure code requested (CPT code) and quantity requested
- The trimesters during which the requested ultrasounds will be performed
- The date range during which the procedures will be performed
- Client's estimated date of confinement (EDC) at the time the request is submitted
- Diagnosis

Additional documentation to support medical necessity may include any of the following:

- Treatment history
- Treatment plan
- Medications
- Previous imaging results

When requesting retroactive authorization, providers must submit the request no later than 14 calendar days beginning the day after the study is completed.

Providers can submit requests for prior authorization or retroactive authorization by fax, online, or by mailing to:

Texas Medicaid & Healthcare Partnership
Inpatient/Outpatient Prior Authorization
12357-B Riata Trace Parkway Ste. 100
Austin, TX 78727

Reimbursement for obstetric ultrasounds may be considered on appeal when submitted with documentation that indicates any one of the following:

- Ultrasound was performed for a different pregnancy.
- The provider was unable to obtain the previous ultrasound records from a different provider.
- The provider was new to treating the client and was not aware the client had already had three obstetric ultrasounds.

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Only one appeal will be considered per client for the same provider. Providers must obtain prior authorization for any additional obstetric ultrasounds performed after the appealed service. Claims for add-on codes for multiple fetuses should be billed with modifier 76 if there is more than one additional fetus. Claims will be considered on appeal with documentation indicating the number of fetuses.

The following procedure codes must be billed together:

- Procedure code 76802 must be billed in conjunction with primary procedure code 76801.
- Procedure code 76810 must be billed in conjunction with primary procedure code 76805.
- Procedure code 76812 must be billed in conjunction with primary procedure code 76811.
- Procedure code 76814 must be billed in conjunction with primary procedure code 76813.

Note: *Add-on procedure codes (76802, 76810, 76812, and 76814) do not count toward the three-per-pregnancy limitation.*

9.2.46.10 Prenatal Surveillance

Prenatal surveillance includes fetal contraction stress test (procedure code 59020), fetal nonstress test (procedure code 59025), and fetal biophysical profile with or without nonstress testing (procedure code 76818 or 76819). According to guidelines established by ACOG, some of the conditions under which testing may be appropriate include, but are not limited to, the following maternal and pregnancy related conditions:

- Maternal Conditions
  - Antiphospholipid syndrome
  - Hyperthyroidism (poorly controlled)
  - Hemoglobinopathies (hemoglobin SS, SC, or S-thalassemia)
  - Cyanotic heart disease
  - Systemic lupus erythematosus
  - Chronic renal disease
  - Type I diabetes mellitus
  - Hypertensive disorders
- Pregnancy Related Conditions
  - Pregnancy-induced hypertension
  - Decreased fetal movement
  - Oligohydramnios
  - Polyhydramnios
  - Intrauterine growth restriction
  - Post-term pregnancy
  - Isoimmunization (moderate to severe)
  - Previous fetal demise (unexplained or recurrent risk)
  - Multiple gestations (with significant growth discrepancy)

Procedure code 59025 is payable in the office setting only and procedure code 59020 is payable in the inpatient and outpatient hospital settings only.

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Procedure codes 59020 and 59025, when billed with revenue code 729 for outpatient facilities, may be reimbursed on the same day by a different provider without appeal. However, procedure codes 59020 and 59025, billed with revenue code 729 more than once per day by the same provider, will be denied. The provider may appeal with documentation supporting the performance of the test more than once on the same day by the same provider.

Fetal biophysical profile (procedure codes 76818 and 76819) may be reimbursed separately when billed with one of the following procedure codes on the same day:

Procedure Codes							
76805	76810	76811	76812	76813	76814	76815	76816

To prevent repeat unintended or unwanted pregnancies, physicians are urged to include family planning services or referrals in the maternity care of the client. Genetic diagnosis and counseling is also available through Texas Medicaid for clients suspected of having a genetic disorder for informed reproductive decision making.

Refer to: Section 2, "Medicaid Title XIX Family Planning Services" in the *Gynecological and Reproductive Health and Family Planning Services Handbook* (*Vol. 2, Provider Handbooks*).

9.2.46.11 Tobacco Use Cessation Counseling

Tobacco use cessation counseling (procedure codes 99406 and 99407) is a benefit of Texas Medicaid for pregnant clients who are 10 through 55 years of age. Both procedure codes are restricted to diagnosis codes O99330, O99331, O99332, O99333, O99334, and O99335.

Only one procedure code, either 99406 or 99407, will be reimbursed per day, any provider. Procedure codes 99406 and 99407 will be limited to a combined total of 8 visits per rolling year, any provider.

9.2.46.12 Transabdominal Amnioinfusion

Procedure codes 59070, 59074, and 59076 are restricted to the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
O360110	O360111	O360112	O360113	O360114	O360115	O360119	O360120
O360121	O360122	O360123	O360124	O360125	O360129	O360130	O360131
O360132	O360133	O360134	O360135	O360139	O360190	O360191	O360192
O360193	O360194	O360195	O360199	O360910	O360911	O360912	O360913
O360914	O360915	O360919	O360920	O360921	O360922	O360923	O360924
O360925	O360929	O360930	O360931	O360932	O360933	O360934	O360935
O360939	O360990	O360991	O360992	O360993	O360994	O360995	O360999
O361110	O361111	O361112	O361113	O361114	O361115	O361119	O361120
O361121	O361122	O361123	O361124	O361125	O361129	O361130	O361131
O361132	O361133	O361134	O361135	O361139	O361190	O361191	O361192
O361193	O361194	O361195	O361199	O361910	O361911	O361912	O361913
O361914	O361915	O361919	O361920	O361921	O361922	O361923	O361924
O361925	O361929	O361930	O361931	O361932	O361933	O361934	O361935
O361939	O361990	O361991	O361992	O361993	O361994	O361995	O361999

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9.2.46.13 Documentation Requirements for Diagnostic Studies

Texas Medicaid requires providers to follow the documentation requirements as set forth in the Diagnostic Ultrasound section of the *Current Procedural Terminology* (CPT) manual for the diagnostic studies of the fetus, including when ultrasound is used to guide a procedure.

Documentation requirements set forth in the CPT manual include, but are not limited to, the following:

- Permanently recorded images with measurements, when measurements are clinically indicated.
- Final written report included in the client's medical record (includes written interpretation).
- Report must include description of elements that comprised a "complete" or "limited" exam, and the reasons an element could not be visualized.
- Permanently recorded images are also required for ultrasound guidance procedures of the site to be localized. In addition, description of the localization process, either separately or within the report of the procedure, when the guidance is used.

Permanently recorded images must be made available on request by HHSC.

Medical record documentation must include assessment findings that substantiate the medical necessity for each diagnostic test.

9.2.46.14 Required Screening of Pregnant Women for Syphilis, HIV, and Hepatitis B

Providers are required to perform serologic testing during pregnancy for syphilis, HIV, and hepatitis B (*Health and Safety Code* §81.090).

9.2.46.14.1 HIV Testing

An HIV test must be performed at the first prenatal care visit and during the third trimester of pregnancy.

If there is no record of a third-trimester test when a woman arrives at labor and delivery, a test must be immediately performed. The laboratory must provide the results of the test to the provider within six hours of the submission of the sample. If there is no record of a third-trimester test and no test was performed during labor and delivery, the infant must be tested within two hours of birth, and those test results must be provided to the provider within six hours of the submission of the sample.

If a pregnant woman refuses HIV testing, the attending health care provider must make a note in the client's record of the following:

- The HIV test was offered.
- The patient declined testing.
- A referral to an anonymous testing site was made.
- The patient was provided with appropriate literature.

9.2.46.14.2 Hepatitis B and Syphilis Screening

Providers and hospitals are required to screen all pregnant women for hepatitis B surface antigen (HBsAg) and syphilis at their first prenatal visit and at delivery. Pregnant women who test positive for HBsAg must be reported to DSHS (25 TAC §97.3) and appropriate prophylaxis must be administered to the infant born to that pregnant woman per DSHS and the ACIP. The Perinatal Hepatitis B Prevention Program manual, reporting forms, and information brochures are available at www.texas-perinatalhepb.org. Providers may also contact the Perinatal Hepatitis B Prevention Program Coordinator at 1-512-776-7447.

Pregnant women who are identified as being chronically infected with HBsAg should receive appropriate follow-up services.

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9.2.47 Occupational Therapy (OT) Services

Occupational therapy (OT) is a payable benefit to physicians.

Refer to: Section 4, "Therapists, Independent Practitioners, and Physicians" in the *Nursing and Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for information about occupational therapy services provided by a physician.

9.2.48 Ophthalmology

When an ophthalmologist sees a client for a minor condition that does not require a complete eye exam, such as conjunctivitis, providers are to use the appropriate office E/M code.

Providers are to use the eye exam procedure codes with a diagnosis of ophthalmological disease or injury.

Refer to: Subsection 4.3.5, "Vision Testing," in the *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*).

9.2.48.1 Corneal Transplants

Corneal transplants are benefits of Texas Medicaid. Corneal transplants are subject to global surgery fee guidelines. Procedure codes 65710, 65730, 65750, 65755, 65756, and 65757 are used for this surgery.

Bioengineered cornea transplants remain investigational at this time and are not considered for reimbursement under Texas Medicaid.

Procurement of the cornea is not reimbursed separately.

9.2.48.2 Eye Surgery by Laser

Eye surgery by laser is a benefit of Texas Medicaid when medically necessary and meets the conditions and limitations stated in this section.

Authorization is not required for eye surgery by laser.

All procedure codes in this section are subject to multiple surgery guidelines. For bilateral procedures, the following modifiers must be added to the claim to indicate that the procedures were performed on the right and left eyes:

- Modifier RT to indicate the right eye
- Modifier LT to indicate the left eye

All procedures may be reimbursed only to physicians and are limited to reimbursement once every 90 days for the same eye with the exception of infants from birth through 23 months of age. Procedures performed on infants from birth through 23 months of age are not subject to any frequency restrictions.

9.2.48.2.1 Other Eye Surgery Procedures

Anterior Segment of the Eye–The Cornea

Laser surgery to the cornea by laser-assisted in situ keratomileusis (LASIK) or photorefractive keratectomy (PRK) for the purpose of correcting nearsightedness (myopia), farsightedness (hyperopia), or astigmatism is not a benefit of Texas Medicaid.

Reimbursement for laser surgery to the cornea, procedure codes 65450, 65855, and 65860 is limited to once every 90 days for the same eye.

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Anterior Segment of the Eye–The Iris, Ciliary Body

Laser surgery to the anterior segment of the eye–the iris, ciliary body may be reimbursed only when billed with one of the following procedure codes:

Procedure Codes						
66600	66605	66710	66711	66761	66762	66770

Reimbursement for procedure codes 66600, 66605, 66710, 66711, 66761, 66762, and 66770 is limited to once every 90 days for the same eye.

Claims for iridectomy (66600, 66605, 66625, 66630, or 66635) or iridotomy (66500 or 66505) are not reimbursed when billed for the same date of service as a trabeculectomy (66170 or 66172). These claims are considered for review when filed on appeal with documentation of medical necessity. The iridectomy is considered part of a trabeculectomy. An iridectomy billed with any other eye surgery on the same day suspends for review.

An iridectomy is also considered part of certain types of cataract extractions. An iridectomy (66600 or 66605) is not reimbursed when billed for the same date of service as the cataract surgeries listed in the following table. The iridectomy is considered part of the cataract surgery. These claims are considered for review when filed on appeal with documentation of medical necessity.

Procedure Codes									
65920	66840	66850	66852	66920	66930	66940	66983	66984	66985
66986									

Posterior Segment of the Eye–Retina or Choroid

Laser surgery to the retina or choroid may be reimbursed only when billed with one of the following procedure codes:

Procedure Codes									
67105	67107	67108	67110	67112	67113	67145	67210	67220	67221
67225	67228	67229	G0186						

Procedure code 67229 is restricted to clients who are birth through 1 year of age.

When billed for the same date of service, same eye, any provider, procedure code 67031 will be denied as part of any of the following procedure codes:

Procedure Codes									
67036	67108	67110	67120	67121	67141	67142	67208	67210	67218
67227	67228								

When billed for the same date of service, same eye, any provider, only one of the following procedure codes may be reimbursed: 67220, 67221, 67225, or G0186.

When billed for the same date of service, same eye, by any provider, procedure codes 67025, 67028, 67031, 67036, 67039, 67040, and 67105 will be denied as part of 67108.

Posterior Segment of the Eye, Vitreous–Vitrectomy

Laser surgery to the vitreous may be reimbursed only when billed with one of the following procedure codes: 67031, 67039, 67040, and 67043.

Reimbursement for procedure codes 67031, 67039, 67040, and 67043 is limited to once every 90 days for the same eye.

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When billed for the same date of service, same eye, any provider procedure codes 67500 and 69990 are denied as part of 66821.

Procedure code 66821 is denied as part of 66830, 67031, and 67228.

Procedure codes 66820, 66984, 66985, and 67036 will pay according to multiple surgery guidelines when billed with procedure code 66821.

When billed for the same date of service, same eye, different provider procedure codes 66821, 67005, 67010, and 69990 will be denied as part of 67031.

When billed for the same date of service, same eye, any provider procedure code 67031 will be denied as part of any of the following procedure codes: 67036, 67108, 67110, 67120, 67121, 67208, 67218, 67227, and 67228.

9.2.48.3 Eye Surgery by Incision

The following restrictions apply to vitrectomy and cataract surgeries:

- Procedure codes 66500, 66505, 66605, 66625, 66630, and 66635 are denied as part of another procedure when billed with the following cataract surgeries: 65920, 66840, 66850, 66852, 66920, 66930, 66940, 66983, 66984, 66985, and 66986. Claims may be appealed with additional documentation to demonstrate the medical necessity.
- Procedure code 66020 is denied as part of another procedure when billed with any related eye surgery procedure code.
- Procedure code 67036 may be reimbursed when billed alone.
- Procedure code 67036 is denied as part of another procedure when billed with procedure codes 67039, 67040, 67041, 67042, 67043, or 67108.
- Procedure codes 67039 and 67040 are combined and reimbursed as procedure code 67108 when billed by the same provider for the same date of service.
- For clients who are 8 years of age and younger, the following cataract extraction and vitrectomy procedure codes, performed on the same eye, will be considered for payment per multiple surgery guidelines:

Procedure Codes									
66840	66850	66852	66920	66930	66940	66983	66984	67005	67010
67015	67025	67027	67028	67030	67031	67036	67039	67040	67041
67042	67043								

- For clients who are nine years of age and older, the following procedure codes will be paid when performed on the same eye as a cataract extraction:

Procedure Codes									
67005	67010	67015	67025	67027	67028	67030	67031	67036	67039
67040	67041	67042	67043						

- For clients who are nine years of age and older, the following procedure codes will be denied as part of the codes listed above, when performed on the same eye:

Procedure Codes							
66840	66850	66852	66920	66930	66940	66983	66984

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Reimbursement for procedure codes 67041, 67042, and 67043 is limited to once every 90 days for the same eye.

9.2.48.4 Intraocular Lens (IOL)

An IOL (V2630, V2631, and V2632) may be reimbursed only to physicians in the office setting (POS 1). Providers must submit a copy of the manufacturer's invoice for procedure code V2631 to TMHP with their claim. Reimbursement for the lens is limited to the actual acquisition cost for the lens (taking into account any discount) plus a handling fee not to exceed five percent of the acquisition cost.

Medicaid does not reimburse physicians who supply IOLs to ASCs/HASCs.

Reimbursement for the surgical procedure necessary to implant an IOL remains unchanged.

9.2.48.5 Intravitreal Drug Delivery System

Procedure codes 67027 and 67121 pertain to the procurement, implantation, and removal of an intravitreal drug delivery system (e.g., a ganciclovir implant). They are set to deny when billed concurrently.

9.2.48.6 Other Eye Surgery Limitations

The following procedure codes require modifier LT or RT to identify the eye for which the surgery is being performed:

Procedure Codes									
65205	67311	67312	67314	67316	67318	67320	67331	67332	67334
67345	67414	67800	67801	67805	67808	V2790			

In the following table, the procedure codes in Column A may be reimbursed only when at least one corresponding procedure code from Column B has been paid to the same provider for the same date of service:

Column A Procedure Codes	Column B Procedure Codes
66990	65820, 65875, 65920, 66985, 66986, 67036, 67039, 67040, 67041, 67042, 67043, or 67112
67320, 67331, 67332, 67334	67311, 67312, 67314, 67316, or 67318
67335, 67340	67311, 67312, 67314, 67316, or 67318
V2790	65780

9.2.49 Organ/Tissue Transplants

Organ/tissue transplants that include bone marrow, peripheral stem cell, heart, intestine, lung, liver, kidney, or pancreas are a benefit of Texas Medicaid.

Solid organ transplants are a benefit of Texas Medicaid when medically necessary based on safety and efficacy, as demonstrated by scientific evidence and by controlled clinical studies, in accordance with the Texas Administrative Code (TAC). Solid organ transplants are limited to clients with a critical medical condition who are expected to have a successful clinical outcome that will result in a return to improved functional independence. Benefits are not available for the following experimental or investigational services:

- Artificial and bioartificial livers
- Xenotransplantation of solid organs
- Thymus transplant

Coverage is limited to one transplant per organ system (or organ systems for combined transplants) per lifetime except for one subsequent transplant because of organ rejection.

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Solid organ transplants require prior authorization and may be reimbursed only when performed in a Medicaid-enrolled facility that is a designated children's hospital with a transplant unit or program, or certified for the procedure by the United Network for Organ Sharing (UNOS).

The facility must be in Texas, unless there are no Texas facilities certified by UNOS or designated as a Children's Hospital with a transplant unit or program for the requested procedure.

All requests for out-of-state (OOS) services, whether for pre-transplant evaluation, transportation, or post-transplant monitoring, must be sent to the medical director for prior authorization review. Texas Medicaid will consider authorizing OOS services when the following criteria are met:

- The client does not leave Texas to receive care that can be received in Texas.
- An in-state facility approved for the procedure has declined to accept the client and documentation is submitted to explain why the in-state team cannot perform the procedure.
- There is no physician provider or facility with the level of expertise required to perform the necessary procedure available in Texas, or the client has received an initial transplant at the OOS facility and requires additional transplant services due to complications or graft loss.
- There is reasonable assurance that the client meets the clinical criteria required by Texas Medicaid for transplant approval.
- The service is necessary, reasonable, and federally allowable, and the facility and physicians agree to accept Medicaid reimbursement for these services.
- The OOS facility must be certified by UNOS or designated as a Children's Hospital with a transplant unit or program.

When requesting an OOS prior authorization for a pre-transplant evaluation, the provider must submit a copy of the transplant evaluation performed by a Texas facility to support the need for an OOS solid organ pre-transplant evaluation.

When requesting an OOS prior authorization for transplant of a solid organ, the provider must submit a copy of the transplant evaluation performed by a Texas facility and a copy of the transplant evaluation performed by the OOS facility to support the need for an OOS solid organ transplant.

When requesting an OOS prior authorization for post-transplant monitoring or other post-transplant services, the provider must submit documentation that the client received the initial transplant at the same OOS facility to include complications or graft loss if present, in order to support the need for OOS solid organ post-transplant monitoring or other post-transplant services.

Expenses incurred for the procurement of a living donor's organ are not a benefit of Texas Medicaid.

Refer to: Subsection 3.2.5, "Organ and Tissue Transplant Services," in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about the transplant facility approval criteria.

Subsection 3.2.5.2, "Transplant Benefits and Limitations," in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about organ/tissue transplant program limitations.

9.2.49.1 General Prior Authorization Requirements

Solid organ transplant prior authorization requests must include all of the following:

- A complete history and physical
- A statement of the current medical conditions and status of the transplant recipient
- Documentation of how the client meets the prior authorization criteria specified for the transplant requested

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- Documentation of the absence of co-morbidities or contraindications such as the following:
  - Severe pulmonary hypertension
  - End-stage cardiac, renal, hepatic, or other organ dysfunction unrelated to the primary disorder
  - Uncontrolled HIV infection or AIDS defining illness
  - Multiple organ compromise secondary to infection, malignancy, or condition with no known cure
  - Ongoing or recurrent active infections that are not effectively treated
  - Psychiatric instability severe enough to jeopardize incentive for adherence to medical regimen
  - Active alcohol or chemical dependency that might interfere with compliance to a medical regimen
- History of compliance with other medical treatments, regimen, and plan of care

Backbench procedures do not require prior authorization but may only be reimbursed when a corresponding transplant procedure has been paid for the same date of service.

Note: *Clients who are birth through 20 years of age and who do not meet the criteria for coverage may be considered through the Comprehensive Care Program (CCP).*

Additional prior authorization criteria, if applicable, specific to each type of transplant are outlined in the following sections.

If prior authorization is not obtained for a solid organ transplant, services directly related to the transplant within the three-day preoperative and six-week postoperative period are also denied regardless of who provides the services (e.g., laboratory services, status post visits, radiology services). However, coverage for other services needed as a result of complication of the transplant or for services unrelated to the transplant may be considered when medically necessary, reasonable, and federally allowable.

Claims for transplant clients are placed on active review when the transplant was not prior authorized so that the services related to the transplant can be monitored.

9.2.49.2 Heart Transplants

9.2.49.2.1 Prior Authorization for Heart Transplants

A heart transplant to a client for primary heart dysfunction must be documented as the client being unresponsive to more conventional and/or standard therapies to be considered for coverage.

Procedure code 33945 may be considered for prior authorization with medical necessity documentation that indicates a New York Heart Association (NYHA) Class III or IV cardiac disease with one of the following medical conditions:

- Congenital heart disease
- Valvular heart disease
- Viral cardiomyopathy
- Familial and restrictive cardiomyopathy

9.2.49.3 Intestinal Transplants

An intestinal transplant may be considered for clients who are dependent on parental nutrition and have compromised venous access, have had two or more episodes of central line sepsis, or who have begun to manifest progressive parental nutrition associated liver dysfunction. Procedure codes 44135 and 44136 must be prior authorized.

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Small bowel transplantation is considered medically necessary in clients with irreversible intestinal failure including, but not limited to:

- Short bowel syndrome
- Pseudo-obstruction
- Microvillus inclusion
- Tumor

The prior authorization request must include documentation of irreversible intestinal failure with failed total parenteral nutrition (TPN) therapy. The client has experienced TPN failure if any one of the following criteria is met:

- Impending or overt liver failure due to TPN-induced liver injury. Clinical indictors include the following:
  - Increased serum bilirubin levels
  - Increased liver enzyme levels
  - Splenomegaly
  - Thrombocytopenia
  - Gastroesophageal varices
  - Coagulopathy
  - Stomal bleeding
  - Hepatic fibrosis
  - Cirrhosis
- Thrombosis of major central venous channels (subclavian, jugular, or femoral veins). Thrombosis of two or more of these vessels is considered a life-threatening complication and TPN failure.
- Frequent central line-related sepsis. Two or more episodes of central-line-induced systemic sepsis per year that require hospitalization are considered TPN failure. A single episode of central-line-related fungemia, septic shock, or acute respiratory distress syndrome is considered TPN failure.
- Frequent episodes of severe dehydration despite TPN and intravenous fluid supplement. Under certain medical conditions, such as secretory diarrhea and nonconstructable gastrointestinal tract, the loss of combined gastrointestinal and pancreatobiliary secretions exceed the maximum intravenous infusion rates that can be tolerated by the cardiopulmonary system.

Diagnoses that indicate intestinal failure include, but are not limited to, the following:

- Small bowel syndrome resulting from inadequate intestinal propulsion due to neuromuscular impairment
- Small bowel syndrome resulting from postsurgical conditions due to resections
- Intestinal cysts
- Mesenteric cysts
- Small bowel or other tumors involving small bowel
- Crohn's disease
- Mesenteric thrombosis
- Volvulus
- Short-gut syndrome in which there is liver function impairment (usually secondary to TPN)

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9.2.49.4 Kidney Transplants

9.2.49.4.1 Prior Authorization for Kidney Transplants

Procedure codes 50360 and 50365 must be prior authorized. Medical necessity documentation of one of the following is required:

- Hemodialysis or continuous ambulatory peritoneal dialysis (CAPD).
- Chronic renal failure with anticipated deterioration to end-stage renal disease.
- End-stage renal disease, evidenced by a creatinine clearance below 20 ml/min or development of symptoms of uremia.
- End-stage renal disease that requires dialysis or is expected to require dialysis within the next 12- to 18-month period.

9.2.49.4.2 Cytogam

Procedure code J0850 is reimbursable by Texas Medicaid. Cytogam is indicated for the attenuation of primary cytomegalovirus disease in seronegative kidney transplant recipients who receive a kidney from a seropositive donor. Payment of cytogam is limited to diagnosis code Z940, Z941, Z942, Z943, Z944, or Z9483. Cytogam is payable only in the office or outpatient setting.

Refer to: Subsection 3.2.5, "Organ and Tissue Transplant Services," in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about the transplant facility approval criteria.

9.2.49.5 Liver Transplants

9.2.49.5.1 Prior Authorization for Liver Transplants

For a client to be considered for coverage of a liver transplant, the medical records for the client must include documentation showing the client is unresponsive to more conventional and/or standard therapies.

Authorization of procedure codes 47133 and 47135 requires medical necessity documentation of liver disease in one of the following categories:

- Primary cholestatic liver disease
- Other cirrhosis:
  - Alcoholic
  - Hepatitis C, non-A, non-B, and Hepatitis B
- Fulminant hepatic failure
- Metabolic diseases
- Malignant neoplasms
- Benign neoplasms
- Biliary atresia

9.2.49.6 Lung Transplants

9.2.49.6.1 Prior Authorization for Lung Transplants

A lung transplant to a client must be documented as unresponsive to more conventional and/or standard therapies to be considered for coverage.

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Prior authorization of procedure codes 32851, 32852, 32853, 32854, and S2060 may be considered with medical necessity documentation of the following:

- Symptoms at rest directly related to chronic pulmonary disease and resultant severe functional limitation
- End-stage pulmonary diseases in one of these categories:
  - Obstructive lung disease
  - Restrictive lung disease
  - Cystic Fibrosis
  - Pulmonary hypertension

9.2.49.7 Pancreas Transplant

9.2.49.7.1 Prior Authorization for Pancreas Transplant

A pancreas/simultaneous kidney-pancreas transplant must be documented as the client being unresponsive to more conventional and/or standard therapies to be considered for coverage.

For prior authorization of procedure codes 48160 and 48554, medical necessity documentation must be submitted that shows the following:

- Recurrent, acute, and severe metabolic and potentially life-threatening complications requiring medical attentions such as:
  - Hypoglycemia
  - Hyperglycemia
  - Ketoacidosis
  - Failure of exogenous insulin-based management to achieve sufficient glycemic control (HbA1c of greater than 8.0) despite aggressive conventional therapy
  - Insensibility to hypoglycemia; OR
- Satisfactory kidney function (creatinine clearance greater than 40mL/min), except for kidney-pancreas transplants; and
- Type 1 diabetes with secondary diabetic complications that are progressive despite the best medical management; and
- At least two of the following secondary complications:
  - Diabetic neuropathy
  - Retinopathy
  - Gastroparesis
  - Autonomic neuropathy
  - Extremely labile (brittle) insulin-dependent diabetes mellitus

9.2.49.8 Multi-Organ Transplants

Procedure codes 33935, S2053, and S2054 may be considered for prior authorization if medical necessity documentation meets the requirements for each organ.

Procedure code S2065 may be considered for prior authorization if medical necessity documentation indicates the client meets criteria for a pancreas transplant and has end-stage renal disease that requires dialysis or is expected to require dialysis within the next 12 months.

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9.2.49.9 Nonsolid Organ Transplants

Nonsolid organ transplants covered by Texas Medicaid include allogeneic and autologous stem cell transplantation, allogeneic and autologous bone marrow transplantation, autologous islet cell transplantation, and hematopoietic progenitor cell (HPC) boost infusion.

9.2.49.9.1 Allogeneic and Autologous Bone Marrow and Stem Cell Transplantation

Stem cell transplantation is a process in which stem cells are obtained from either a client's or donor's bone marrow, peripheral blood, or umbilical cord blood for intravenous infusion. The transplant can be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy and/or radiotherapy used to treat various malignancies, and also can be used to restore function in clients having an inherited or acquired deficiency or defect.

Benefits are not available for any experimental or investigational services, supplies, or procedures.

Coverage of bone marrow and stem cell transplantation is limited to the following procedure codes: 38206, 38230, 38232, 38240, 38241, 38242, and S2142.

Texas Medicaid recognizes the following covered indications for stem cell transplants:

- Allogeneic
  - Hematological malignancy
  - Lymphatic malignancy
  - Bone marrow disorders
  - Hemoglobinopathies
  - Platelet function disorders
  - Immunodeficiency disorders
  - Inherited metabolic disorders
  - Multiple myeloma/plasma cell disorders
- Autologous
  - Hematological malignancy
  - Lymphatic malignancy
  - Germ cell tumors
  - Brain tumors
  - Small round blue cell tumors of childhood
  - Multiple myeloma/plasma cell disorders
- Indications for additional infusions
  - Infusion of stem cells for failure to graft (autologous)
  - Donor leukocyte infusion for persistent or relapsed malignant disease (allogeneic)
- Indications for re-transplantation
  - Relapse of disease
  - Failure to engraft or poor graft function

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9.2.49.9.2 Autologous Islet Cell Transplantation

Autologous islet cell transplantation associated with the complete or partial removal of the pancreas (procedure code 48160) is a benefit of Texas Medicaid only for clients with a diagnosis of chronic pancreatitis.

Allogeneic islet cell transplantation is not a benefit.

9.2.49.9.3 HPC Boost Infusion

Prior authorization is required for HPC boost infusion procedure code 38243. The prior authorization request must include documentation of a prior stem cell transplant.

Requests for more than two boost procedures per lifetime requires medical necessity review and approval by the medical director.

9.2.49.9.4 Prior Authorization for Nonsolid Organ Transplants

All nonsolid organ transplants require mandatory prior authorization and 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 Transportation Network (OPTN), the United Network for Organ Sharing (UNOS), or the National Marrow Donor Program (NMDP). Prior authorization is effective for the date span specified on the prior authorization approval letter. If the transplant has not been performed by the end of the authorization period, the physician must apply for an extension.

Documentation supplied with the prior authorization request must include the following:

- A complete history and physical.
- A statement of the client's current medical condition and the expected long-term prognosis for the client from the proposed procedure.

Each subsequent transplant must be prior authorized separately.

Peripheral or umbilical cord blood stem cell transplantation may be authorized in lieu of bone marrow transplantation (BMT), but will not be approved when performed simultaneously.

If a stem cell transplant has been prior authorized for a client who is 21 years of age or older, a maximum of 30 days of inpatient hospital services during a Title XIX spell of illness may be covered beginning with the actual first day of the transplant. This coverage is in addition to covered inpatient hospital days provided before the actual first day of the transplant. This 30-day period is considered a separate inpatient hospital admission for reimbursement purposes, but is included under one hospital stay.

Bone marrow harvesting (38230) or peripheral stem cell harvesting (38206) for autologous bone marrow or stem cell transplants are a benefit of Texas Medicaid and require prior authorization.

Autologous harvesting of stem cells (single or multiple sessions) may be reimbursed to the facility when prior authorized by HHSC or its designee and performed in the outpatient setting (POS 5). Harvesting of stem cells performed in the inpatient setting (POS 3) is included in the DRG and will not be reimbursed separately.

Physician services for the storage of stem cells are not a benefit of Texas Medicaid.

Donor expenses are included in the global fee for the transplant recipient and are not reimbursed separately. Therefore, allogeneic bone marrow or stem cell harvesting procedures are not a benefit of Texas Medicaid.

Stem cell transplants for other conditions may be considered on a case by case basis. Documentation for prior authorization must be submitted to determine whether the transplant is medically necessary and appropriate.

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9.2.49.10 Organ Procurement

The appropriate DRG reimbursement coverage to the approved institution for a prior authorized solid organ transplant procedure includes procurement of the organ and services associated with the organ procurement as specified by HHSC or its designee. Documentation of organ procurement must be maintained in the hospital medical records.

9.2.50 Orthognathic Surgery

Orthognathic surgery is a benefit of Texas Medicaid only when it is necessary for medical reasons, or when it is necessary as part of an approved plan of care in the Texas Medicaid Dental Program. Orthognathic surgery is administered and may be reimbursed as part of the medical/surgical benefit of Texas Medicaid and not as part of the Texas Medicaid Dental Program.

Treatment of malocclusion is a benefit of the Texas Medicaid Dental Program. Orthognathic surgery is a benefit when it is necessary as part of the approved dental benefit.

Maxillary and/or mandibular facial skeletal deformities are associated with clearly abnormal masticatory malocclusion.

Orthognathic surgery may be considered medically necessary for the following client conditions:

- Producing signs or symptoms of masticatory dysfunction
- Facial skeletal discrepancies associated with documented sleep apnea, airway defects, and soft tissue discrepancies
- Facial skeletal discrepancies associated with documented speech impairments
- Structural abnormalities of the jaws secondary to infection, trauma, neoplasia, or congenital anomalies

Orthognathic surgery may be considered for reimbursement when required for the client to access a dental service. Orthognathic surgery that is done primarily to improve appearance and not for reasons of medical necessity is considered cosmetic and is not a benefit of Texas Medicaid.

9.2.50.1 Prior Authorization for Orthognathic Surgery

The following orthognathic medical surgical services may be considered for reimbursement to oral and maxillofacial surgeons with prior authorization. A narrative explaining medical necessity must be provided with the authorization request.

Procedure Codes									
21010	21031	21032	21050	21060	21073	21100	21110	21120	21121
21122	21123	21125	21127	21137	21138	21139	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	29800
29804	40840	40842	40843	40844	40845				

9.2.51 Osteopathic Manipulative Treatment (OMT)

OMT, when performed by a physician (MD or DO), is a benefit of Texas Medicaid for the acute phase of the acute musculoskeletal injury or the acute phase of an acute exacerbation of a chronic musculoskeletal injury with a neurological component.

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OMT is covered when it is performed with the expectation of restoring the patient's level of function, which has been lost or reduced by injury or illness. Manipulations should be provided in accordance with an ongoing, written treatment plan that supports medical necessity. A model of documentation that supports medical necessity for the treatment plan includes the following:

- Specific modalities/procedures to be used in treatment
- Diagnosis
- Region treated
- Degree of severity
- Impairment characteristics
- Physical examination findings (X-ray or other pertinent findings)
- Specific statements of long- and short-term goals
- Reasonable estimate of when the goals will be reached (estimated duration of treatment)
- Frequency of treatment (number of times per week)
- Equipment and techniques used

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.

Reimbursement is contingent on correct documentation of the condition. The acute modifier AT must be submitted with the claim for payment to be made. Paper claims submitted without modifier AT will be denied; electronic claims will be rejected. The AT modifier is described as representing treatment provided for an acute condition or an exacerbation of a chronic condition that persists less than 180 days from the start date of therapy. If the condition persists for more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client's condition has not become chronic and the client has not reached the point of plateauing. Plateauing is defined as the point at which maximal improvement has been documented and further improvement ceases.

The following procedure codes are payable when billing for OMT to the head, cervical, thoracic, lumbar, sacral, pelvic, lower extremities, upper extremities, rib cage, abdominal, and visceral regions: 98925, 98926, 98927, 98928, and 98929.

OMT will be denied when billed on the same date of service by the same provider as any of the following procedure codes:

Procedure Codes									
00640	51701	51702	51703	62310	62311	62318	62319	64400	64402
64405	64408	64410	64412	64413	64415	64416	64417	64418	64420
64421	64425	64430	64435	64445	64446	64447	64448	64449	64450
64470	64472	64475	64476	64479	64480	64483	64484	64505	64508
64510	64517	64520	64530	96360	96365	96372	96374	96375	99201
99202	99203	99204	99205	99211	99212	99213	99214	99215	99217
99218	99219	99220	99221	99222	99223	99231	99232	99233	99234
99235	99236	99238	99239	99241	99242	99243	99244	99245	99251
99252	99253	99254	99255	99281	99282	99283	99284	99285	99291
99304	99305	99306	99307	99308	99309	99310	99315	99316	99318

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Procedure Codes									
99324	99325	99326	99327	99328	99334	99335	99336	99337	99341
99342	99343	99344	99345	99347	99348	99349	99350	99354	99356
99460	99461	99462	99463	99464	99465	99468	99469	99471	99472
99478	99479	99480							

When multiples of procedure codes 98925, 98926, 98927, 98928, and 98929 are billed on the same day by the same provider, the most inclusive code is paid and the others are denied.

An E/M or initial or subsequent care visit or consultation may be paid in addition to OMT billed on the same day if the client's condition requires a visit for a significant and separately identifiable service above and beyond the usual pre- and post-care associated with the OMT procedure, even if the visit and OMT are related to the same symptom or condition. Modifier 25 must be submitted with the E/M procedure code to identify a separate and distinct service rendered on the same day as OMT.

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 Texas Medicaid upon request.

Procedure code 97140 will be denied as part of another service if billed on the same date of service as procedure codes 98925, 98926, 98927, 98928, or 98929.

9.2.52 Pain Management

Pain management is a benefit of Texas Medicaid.

Procedure codes 62350, 62351, 62355, 62360, 62361, 62362, and 62365 billed on the same day as another surgical procedure performed by the same physician are paid according to multiple surgery guidelines.

Procedure codes 62350, 62351, 62355, 62360, 62361, 62362, and 62365 billed on the same day as an anesthesia procedure performed by the same physician are denied as included in the total anesthesia time.

Reimbursement to the physician for the surgical procedure is based on the assigned RVUs or maximum fee. Outpatient facilities are reimbursed at their reimbursement rate. Inpatient facilities are reimbursed under the assigned diagnosis-related group (DRG). No separate payment for the intrathecal pump is made.

Use the following procedure codes when billing for the implantation/revision/replacement of the pump/catheter:

Procedure Codes						
62350	62351	62355	62360	62361	62362	62365

Procedure codes 62367 and 62368 do not require prior authorization and are payable as a medical service only.

Refer to: Subsection 9.2.39.24, "Implantable Infusion Pumps," in this handbook for more information about implanted pumps.

Acute pain is defined as pain caused by occurrences such as trauma, a surgical procedure, or a medical disorder manifested by increased heart rate, increased blood pressure, increased respiratory rate, shallow respirations, agitation or restlessness, facial grimace, or splinting.

Chronic pain is defined as persistent, often lasting more than six months; symptoms are manifested similarly to that of acute pain.

Postoperative refers to the time frame immediately following a surgical procedure in which a catheter is maintained in the epidural or subarachnoid space for the duration of the infusion of pain medication.

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9.2.52.1 Epidural and Subarachnoid Infusion (Not Including Labor and Delivery)

Epidural and subarachnoid infusion for pain management is payable 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. Procedure code 01996 billed longer than 30 days requires medical necessity documentation. Cancer diagnoses are excluded from the 30-day limitation.

Procedure code 01996 is payable to CRNAs and physicians.

9.2.53 Palivizumab Injections

RSV immune globulin, intramuscular palivizumab (*Synagis*) must be obtained through the Texas VDP. Providers must obtain prior authorization through the VDP.

Providers may not bill Texas Medicaid for RSV prophylaxis that was obtained through VDP; however providers may be reimbursed for administering the drug. Providers may refer to the HHSC Texas Medicaid/CHIP Vendor Drug Program website at www.txvendordrug.com/dur/synagis.shtml for more information about obtaining palivizumab for Texas Medicaid clients.

9.2.54 Panniculectomy and Abdominoplasty

Procedure codes 15830 and 15847 are benefits of Texas Medicaid when prior authorized.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation establishing medical necessity of the service requested. This documentation must remain in the client's medical record and is subject to retrospective review.

9.2.54.1 Panniculectomy

A panniculectomy (procedure code 15830) may be reimbursed with prior authorization for one of the following conditions when the panniculus hangs to or below the level of the pubis:

- A panniculus has recurrent non-healing ulcers.
- Client is insulin dependent with recurring infection and causing the prolapse of a ventral hernia.
- Panniculus directly causes significant clinical functional impairment.

Panniculectomy is not a benefit when one of following is the primary purpose:

- To remove excess skin and fat from the middle and lower abdomen in order to contour and alter the appearance of the abdominal area to improve appearance.
- Dissatisfaction with personal body image.
- To minimize the risk of ventral hernia formation of recurrence.
- For the sole purpose of treating neck or back pain.

Panniculectomy may be prior authorized when the client meets one of the following:

- Panniculectomy is planned and there is no history of significant weight loss or gastric bypass surgery.
- Panniculectomy is planned without history of gastric bypass surgery but with significant weight loss and the panniculus hangs to or below the level of the pubis.
- Panniculectomy is planned with history of gastric bypass surgery or abdominoplasty and the client is 12 months post-surgery.

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If a panniculectomy is planned and there is no history of significant weight loss or gastric bypass surgery, or a panniculectomy is planned without history of gastric bypass surgery but with significant weight loss and the panniculus hangs to or below the level of the pubis, one of the following must be met:

- Documentation of recurrent episodes of infection or recurrent non-healing ulcers over three months that are non-responsive to treatment or appropriate medical therapy, such as oral or topical prescription.
- The client is insulin-dependent and has a serious infection control problem and the panniculus is causing the prolapse of a ventral hernia.
- Documentation by the treating physician that the panniculus directly causes significant clinical functional impairment. Clinical functional impairment may be indicated by associated musculoskeletal dysfunction or interference with activities of daily living and there is reasonable evidence to support that this surgical intervention will correct the condition.

If a panniculectomy is planned with a history of gastric bypass surgery or abdominoplasty and the client is 12 months post-surgery, the following must be met:

- Documentation that the panniculus hangs to or below the level of the pubis and the client has maintained a significant (100 pounds or more), stable weight loss for at least six months. Documentation must include the weight loss history, prior and current height, prior and current weight, and the history and physical including all previous surgeries.
- Documentation of recurrent episodes of infection or recurrent non-healing ulcers over three months that are non-responsive to treatment or appropriate medical therapy, such as oral or topical prescription. The 12-month post-gastric bypass requirement may be waived.
- The client is insulin-dependent and has a serious infection control problem and the panniculus is causing the prolapse of a ventral hernia. The 12-month post-gastric bypass requirement may be waived.
- Documentation by the treating physician that the panniculus directly causes significant clinical functional impairment. The 12-month post-gastric bypass requirement may be waived. Clinical functional impairment may be indicated by associated musculoskeletal dysfunction or interference with activities of daily living and there is reasonable evidence to support that this surgical intervention will correct the condition.

All medical record documentation pertinent to the client's evaluation and treatment must support medical necessity of the panniculectomy. Documentation may include the following:

- Office records
- Consultation reports
- Operative reports
- Other hospital records (examples: pathology report, history and physical)

Documentation to support the panniculectomy must be submitted with the request for prior authorization. In addition to medical record documentation, the provider may also submit a letter of support or an explanation to substantiate medical necessity.

This service is typically expected to be limited to once per lifetime; however, repeat panniculectomies may be considered for prior authorization upon submission of supporting documentation as outlined above.

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A panniculectomy provided as a secondary surgery may be considered for prior authorization when the panniculus interferes with a medically necessary intra-abdominal surgery (e.g., abdominal hernia repair or hysterectomy) or to facilitate an improved anatomical field in order to provide radiation treatment to the abdomen. Documentation of medical necessity must include:

- The comorbidity for the diagnosis of the primary surgery or for the nature of the condition undergoing radiation treatment.
- Documentation supporting the need for the panniculectomy as the panniculus hangs below the level of the pubis and will significantly interfere with a planned surgical procedure, or the abdominal structures identified as requiring radiation therapy will not be adequately treated due to the size of the panniculus.

A panniculectomy provided as a secondary surgery may be considered when the primary surgery was performed for an urgent condition defined as a symptom or condition that is not an emergency, but requires further diagnostic workup or treatment within 24 hours to avoid a subsequent emergent situation.

The need for the panniculectomy as a secondary surgery in conjunction with a primary urgent surgery must be supported by retrospective review of submission of all of the following documentation:

- History and physical and the operative report.
- The panniculus hangs below the level of the pubis and would have significantly interfered with the urgent primary surgical procedure.

9.2.54.2 Abdominoplasty

An abdominoplasty (procedure code 15847) is a benefit for clients who are birth through 20 years of age and may be reimbursed with prior authorization for one of the following conditions:

- Prune belly
- Diastasis recti in the presence of a true midline hernia (ventral or umbilical)

Abdominoplasty is not a benefit when one of the following is the primary purpose:

- To remove excess skin and fat and tighten abdominal wall from the middle and lower abdomen in order to contour and alter the appearance of the abdominal area to improve appearance.
- Dissatisfaction with personal body image.
- To repair diastases recti (unless prior authorization criteria has been met).

Abdominoplasty may be prior authorized when the client meets all of the following criteria:

- Documented diagnosis of prune belly (i.e., Eagle Barret syndrome) or repair of diastasis recti in the presence of a true midline hernia (ventral or umbilical).
- Documentation for reconstructive surgery that must include appropriate historical medical record documentation and may include any of the following:
  - Consultation reports
  - Operative reports or other applicable hospital records (examples: pathology report, history and physical)
  - Office records
  - Letters with pertinent information from provider (when medical records are requested, a letter of support or explanation may be helpful, but alone will not be considered sufficient documentation to make a medical necessity determination)

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- For repair of diastasis recti with a true midline hernia, documentation must also include all of the following:
  - The size of the hernia
  - Whether it is reducible, painful, or other symptoms
  - Whether there is a defect rather than just thinning of the abdominal fascia

Consideration of other abdominal diagnoses may be considered for prior authorization with the submission of additional supporting documentation that may include the following:

- Consultation reports
- Operative reports or other applicable hospital records (examples: pathology report, history and physical)
- Office records
- Letters with pertinent information from provider (when medical records are requested, a letter of support or explanation may be helpful, but alone will not be considered sufficient documentation to make a medical necessity determination)

9.2.55 Penile and Testicular Prostheses

The following services are a benefit of Texas Medicaid for male clients:

- Removal of a penile prosthesis without replacement (procedure codes 54406 and 54415).
- Insertion of testicular prosthesis for the replacement of congenitally absent testes or testes lost due to disease, injury, or surgery (procedure code 54660)—prior authorization is required.

Procedure code 54660 is a benefit for clients who are birth through 20 years of age. Insertion of a testicular prosthesis may be prior authorized with the following criteria:

- The client has lost a testicle as a result of cancer or trauma or has congenital absence of a testicle.
- The loss of the testicle has resulted in detrimental psycho-social sequelae, as evidenced by a psychiatric evaluation.

Requests for prior authorization must be submitted by the physician to the Special Medical Prior Authorization (SMPA) department using the Special Medical Prior Authorization (SMPA) Request Form. The request must be submitted with documentation that supports medical necessity.

9.2.56 Percutaneous Transluminal Coronary Interventions

Percutaneous transluminal coronary interventions are a therapeutic option for clients who have arteriosclerotic heart disease.

When any of the following procedure codes are performed on the same date of service and on the same vessel as intracoronary vessel stenting, any provider, only the stenting procedure code will be considered for reimbursement: 92973, 92982, 92984, 92995, and 92996.

Angioplasty, atherectomy, or thrombectomy performed on different coronary vessels may be reimbursed separately. When different coronary vessels are not indicated, only the stenting procedure will be paid.

9.2.57 Physical Therapy (PT) Services

Physical therapy (PT) is a payable benefit to physicians.

Refer to: Section 4, "Therapists, Independent Practitioners, and Physicians" in the *Nursing and Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for information about physical therapy services provided by a physician.

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9.2.58 Physician Evaluation and Management (E/M) Services

E/M is a benefit of Texas Medicaid. 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.

The following E/M services are benefits of Texas Medicaid:

- Domiciliary, rest home, or custodial care services
- Emergency department services
- Group clinical visits
- Home services
- Hospital services including inpatient, observation, critical care, discharge, and concurrent care services (includes consultation and prolonged services)
- Nursing facility services
- Office or other outpatient services for new and established patients (includes consultation and prolonged services)
- Preventive care visits
- Services outside of business hours

Claims submitted to TMHP by physicians for services provided during an inpatient hospital stay must be received by TMHP within 95 days of each date of service, not 95 days of the discharge date.

Inpatient claims must indicate the facility's provider identifier in Block 32 or in the appropriate field of electronic software.

9.2.58.1 Office or Other Outpatient Hospital Services

9.2.58.1.1 New and Established Patient Services

A new patient is one who has not received any professional services from a physician or from another physician of the same specialty who belongs to the same group practice, within the past three years. Providers must use procedure codes 99201, 99202, 99203, 99204, and 99205 when billing for new patient services provided in the office or an outpatient or other ambulatory facility. New patient visits are limited to one every three years, per client, per provider.

An established patient is one who has received professional services from a physician or from another physician of the same specialty within the same group practice, within the last three years. Providers must use procedure codes 99211, 99212, 99213, 99214, and 99215 when billing for established patient services provided in the office or an outpatient or other ambulatory facility.

New or established office or outpatient care visits are limited to once per day, same provider. When a new patient checkup is billed for the same date of service as a new patient acute care visit, both new patient services may be reimbursed when billed by the same provider or provider group if no other acute care visits or preventive care medical checkups have been billed in the past three years.

Modifier 25 may be used to identify a significant, separately identifiable E/M service performed by the same physician on the same day as another procedure or 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 Texas Medicaid 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.

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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.

An established patient visit that is billed with the same date of service as a new patient visit by the same provider will be denied as part of another procedure except when the established patient visit is billed with a new THSteps medical checkup.

Office visits (procedure codes 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215) provided on the same date of service as a planned procedure (minor or extensive) are included in the cost of the procedure and are not separately reimbursed.

Office visit procedure code 99211, 99212, 99213, 99214, or 99215 must be billed by the same provider with the same date of service as a group clinical visit.

Refer to: Subsection 9.2.58.4, "Group Clinical Visits," in this handbook.

Emergency department-based physicians or emergency department-based groups may not bill charges for inconvenience or after hours services (procedure code 99050, 99056, or 99060).

9.2.58.1.2 Preventive Care Visits

Preventive care services are comprehensive visits that may include counseling, anticipatory guidance, and risk-factor-reduction interventions. Documentation must indicate the anticipatory guidance rendered.

Preventive health visits for clients who are birth through 20 years of age are available through THSteps medical checkups.

Refer to: Section 5, "THSteps Medical" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 5.3.11.2.3, "Hearing Screening," in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about hearing screenings.

Adult preventive services (procedure codes 99385, 99386, 99387, 99395, 99396, and 99397) are a benefit of Texas Medicaid for clients who are 21 years of age and older. Adult preventive services are limited to one service per rolling year, any provider, and must be billed with diagnosis code Z0000, Z0001, Z01411, or Z01419.

Adult preventive services must be provided in accordance with the U.S. Preventive Services Task Force (USPSTF) recommendations with grades A or B. USPSTF recommendations, with specific age and frequency guidelines, are located on the Agency for Healthcare Research and Quality website at www.ahrq.gov/clinic/uspstfix.htm.

Laboratory, immunization, and diagnostic procedures recommended by USPSTF are covered benefits and may be billed separately, as clinically indicated, using the most appropriate diagnosis code that represents the client's condition. Diagnosis code Z0000 or Z0001 may each be used once per rolling year for each screen if no other diagnosis is appropriate for the service rendered, but no more frequently than recommended by the USPSTF.

The following USPSTF recommendations are not reimbursed separately but must be provided, when applicable, as part of the routine preventive exam:

- Counseling to prevent tobacco use and tobacco-caused disease
- Behavioral counseling in primary care to promote a healthy diet
- Behavioral interventions to promote breast feeding
- Screening for obesity in adults (with intensive counseling and interventions)
- Screening and behavioral counseling interventions in primary care to reduce alcohol misuse

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- Screening for depression

The following USPSTF recommendations are not a benefit of Texas Medicaid:

- Chemoprevention of breast cancer
- Varicella immunization

The following screenings are covered benefits in addition to USPSTF recommendations:

- Tuberculosis screening
- Prostate cancer screening; prostate specific antigen (PSA) for men who are 50 through 64 years of age

Services that exceed USPSTF recommendations are not considered part of a screening and require medical documentation to justify medical necessity of the services performed.

For clients who are 21 years of age and older, breast exams and Pap smears are available through programs related to women's health, including Texas Medicaid family planning services and Texas Women's Health Program.

Refer to: Section 2, "Medicaid Title XIX Family Planning Services" in the *Gynecological and Reproductive Health and Family Planning Services Handbook* (*Vol. 2, Provider Handbooks*).

Section 3, "Texas Women's Health Program" in the *Gynecological and Reproductive Health and Family Planning Services Handbook* (*Vol. 2, Provider Handbooks*).

9.2.58.1.3 Consultation Services

A consultation is an E/M service provided at the request of another provider for the evaluation of a specific condition or illness. The consultation must meet the following requirement:

- 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 consulting provider's medical findings.

During a consultation, the consulting provider may initiate diagnostic and therapeutic services if necessary.

The visit is not considered a consultation if any of the following applies:

- If diagnostic or therapeutic treatment is initiated during a consultation and the patient returns for follow-up care, the follow-up visit is considered an established patient visit, and must be billed as an established patient visit.
- If the purpose of the referral is to transfer care.

The medical records maintained by both the referring and consulting providers must identify the other provider and the reason for consultation.

Providers must use procedure code 99241, 99242, 99243, 99244, or 99245 when billing new or established patient consultations in the office, or in an outpatient or other ambulatory facility.

Office or outpatient consultations are limited to one consultation every six months by the same provider for the same diagnosis. Subsequent office or outpatient consultation visits during this six-month period will be denied.

9.2.58.1.4 Services Outside of Business Hours

Texas Medicaid limits reimbursement for after-hours charges (procedure codes 99050, 99056, and 99060) to office-based providers rendering services after routine office hours.

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An office-based provider may bill an after-hours charge in addition to a visit when providing medically necessary services for the care of a client with an emergent condition after the provider's posted, routine office hours. Office-based physicians may be reimbursed an inconvenience charge when either of the following exists and the reason is documented in the client's medical record:

- 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.

9.2.58.1.5 Observation Services

Hospital observation (procedure codes 99217, 99218, 99219, and 99220) are professional services provided for a period of more than 6 hours but fewer than 24 hours regardless of the hour of the initial contact, even if the client remains under physician care past midnight. Subsequent observation care, per day (procedure codes 99224, 99225, and 99226) is also a benefit of Texas Medicaid.

Inpatient hospital observation services must be submitted using the procedure code 99234, 99235, or 99236.

Observation care discharge day management procedure code 99217 must be billed to report services provided to a client upon discharge from observation status if the discharge is on a date other than the initial date of admission. The following procedure codes are denied if submitted with the same date of service as procedure code 99217:

Procedure Codes							
99211	99212	99213	99214	99215	99218	99219	99220

If an E/M service is billed by the same provider with the same date of service as a physician observation visit, the E/M service is denied if provided in any place of service other than inpatient hospital.

If a physician observation visit (procedure code 99217, 99218, 99219, 99220, 99234, 99235, or 99236) is billed by the same provider with the same date of service as prolonged services (procedure code 99354, 99355, 99356, or 99357), the prolonged services will be denied as part of another procedure on the same day.

If dialysis treatment and a physician observation visit are billed by the same provider (and same specialty other than an internist or nephrologist) with the same date of service, the dialysis treatment may be reimbursed and the physician observation visit will be denied.

9.2.58.2 Domiciliary, Rest Home, or Custodial Care Services

The following procedure codes are used to report E/M in a facility that provides room, board, and other personal assistance services:

New Patient Procedure Codes				
99324	99325	99326	99327	99328

Established Patient Procedure Codes			
99334	99335	99336	99337

Established patient visits billed on the same date of service as a new patient visit, by the same provider, will be denied as part of another procedure. Established patient visits are limited to one per day regardless of diagnosis.

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9.2.58.3 Physician Services Provided in the Emergency Department

Providers must use procedure codes 99281, 99282, 99283, 99284, and 99285 when billing emergency department services.

If an emergency department visit is billed by the same provider with the same date of service as any of the following office, outpatient consultation, or nursing facility service procedure codes, the emergency department visit may be reimbursed and the office, consultation, or nursing facility visit is denied:

Procedure Codes									
99201	99202	99203	99204	99205	99211	99212	99213	99214	99215
99241	99242	99243	99244	99245	99304	99305	99306	99307	99308
99309	99310								

Emergency department visits are denied when billed with the same date of service as an observation service (procedure code 99217) by the same provider.

Multiple emergency department visits provided by the same provider for the same client on the same day must have the times for each visit documented on the claim form. Also, more than one visit billed with the same date of service can be indicated by adding the appropriate modifier to the claim form. Medical documentation is required to support this service.

Reimbursement for physicians in the emergency department is based on Section 104 of TEFRA. TEFRA requires that Medicaid limit reimbursement for nonemergent and nonurgent physicians' services furnished in hospital outpatient settings that also are ordinarily furnished in physician offices. The emergency department procedure code that is submitted on the claim is used to determine the appropriate reimbursement for these services. The procedure code billed may include, but is not limited to, E/M, surgical or other procedure, or any other service rendered to the client in the emergency room. The procedure code must accurately reflect the services rendered by the physician in the hospital's emergency department. The reimbursement for each service is determined by multiplying the base allowable fee by 60 percent.

Refer to: Section 4, "Outpatient Hospital (Medical and Surgical Acute Care Outpatient Facility)" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for information on emergency department services by facilities (room and ancillary).

Subsection 2.2.1.1, "Non-emergent and Non-urgent Evaluation and Management (E/M) Emergency Department Visits," in Section 2, "Texas Medicaid Fee-For-Service Reimbursement" (*Vol. 1, General Information*) for more information.

9.2.58.4 Group Clinical Visits

Texas Medicaid may reimburse physicians for group clinical visits (procedure code 99078) providing clinical services and educational counseling to a group of clients with the same condition.

To be considered for reimbursement, procedure code 99078 must be billed for the same date of service by the same provider as E/M procedure code 99211, 99212, 99213, 99214, or 99215.

Group clinical visits may be reimbursed for established patients only. The client's plan of care must be determined and documented in the medical record by the physician before attending group clinical visits.

Participation of established patients in a group clinical visit is optional. Informed consent must be obtained from the client and maintained in the medical record before rendering group clinical visit services.

Clients who participate in group clinical visits and who have diseases covered under the Texas Medicaid Enhanced Care Program (congestive heart failure, chronic obstructive pulmonary disease, diabetes, coronary artery disease, and asthma) must receive a referral to the disease management program.

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Clinical providers are encouraged to coordinate care with the Texas Medicaid Enhanced Care Program for clients who are eligible for the disease management program and choose to participate in the program.

The physician leading the group clinical visit is responsible for the effectiveness and content of the information provided during the group clinical visit.

Nationally approved curriculum on asthma and diabetes, such as that available through the American Association of Diabetic Educators and Asthma Education and Prevention Programs approved by the CDC must be incorporated into the educational portion of group clinical visits.

Group clinical visits must last at least 1 hour, but no longer than 2 hours, with a minimum of 2 clients and a maximum of 20 and must include:

- An informational and instructional presentation. In order to promote self-management of the chronic disease, the group visit must include a presentation instructing and informing the client about clinical issues including how to prevent exacerbation or complications, proper use of medications and other therapeutic techniques, and living with chronic illness.
- A question and answer period. Allow time for the clients to ask questions.
- An encounter with the physician. A short (approximately 5 to 15 minutes per client), one-on-one, private, face-to-face encounter with the physician is required. This visit consists of a physical examination; the gathering, monitoring, and reviewing of laboratory and diagnostic tests; and medical decision-making, including an individual treatment plan. Documentation in the client's medical record must support the level of E/M as approved by CMS guidelines.

The documentation of the individual treatment plan retained in the client's medical record must include data collected (physical exam and lab findings), educational services provided, patient participation, referrals to the HHSC disease management program, and the beginning and ending time of the visit.

Group visits for conditions of diabetes or asthma are limited to a maximum of four per year for any provider.

9.2.58.4.1 Group Clinical Visits for Diabetes

Group clinical visits are benefits of Texas Medicaid for the management of the condition of diabetes when submitted with one of the following diagnosis codes or combination diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
E1010	E1011	E1021	E1022	E1029	E10311	E10319	E10321
E10329	E10331	E10339	E10341	E10349	E10351	E10359	E1036
E1039	E1040	E1041	E1042	E1043	E1044	E1049	E1051
E1052	E1059	E10610	E10618	E10620	E10621	E10622	E10628
E10630	E10638	E10641	E10649	E1065	E1069	E108	E109
E1101	E1121	E1122	E1129	E11311	E11319	E11321	E11329
E11331	E11339	E11341	E11349	E11351	E11359	E1136	E1139
E1140	E1141	E1142	E1143	E1144	E1149	E1151	E1152
E1159	E11610	E11641	E1169	E118	E119	E1301	E1310
E1311	E1321	E1322	E1329	E13311	E13319	E13321	E13329
E13331	E13339	E13341	E13349	E13351	E13359	E1336	E1339
E1340	E1341	E1342	E1343	E1344	E1349	E1351	E1352
E1359	E13610	E13641	E138	E139			
Combination Diagnosis Codes (Must be submitted in pairs)							

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
E1010, E1065	E1011, E10641	E1011, E1065	E1021, E1065	E1022, E1065	E1029, E1065	E10311, E1065	E10319, E1065
E10321, E1065	E10329, E1065	E10331, E1065	E1036, E1065	E1039, E1065	E10339, E1065	E10341, E1065	E10349, E1065
E10351, E1065	E10359, E1065	E1051, E1065	E1052, E1065	E1059, E1065	E10610, E1065	E1140, E1165	E1040, E1065
E1041, E1065	E1042, E1065	E1043, E1065	E1044, E1065	E1049, E1065	E1065, E1069	E1065, E108	E1100, E1165
E1101, E1165	E1121, E1165	E11311, E1165	E11319, E1165	E1136, E1165	E1139, E1165	E1151, E1165	E1165, E1169
E1165, E118	E13319, E1165	E13321, E1165	E13329, E1165	E13331, E1165	E1336, E1165	E1339, E1165	E13339, E1165
E13341, E1165	E13349, E1165	E13351, E1165	E13359, E1165				

Diabetic education must explain the following:

- What diabetes is
- Nutrition
- Exercise and physical activity
- Prevention of acute complications
- Prevention of chronic complications
- Monitoring
- Medication

9.2.58.4.2 Group Clinical Visits for Asthma

Group clinical visits are benefits of Texas Medicaid for the management of the condition of asthma when submitted with one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
J440	J441	J449	J4520	J4521	J4522	J4530	J4531
J4532	J4540	J4541	J4542	J4550	J4551	J4552	J45901
J45902	J45909	J45990	J45991	J45998			

Asthma education must consist of the following:

- What is asthma?
- What are symptoms of asthma?
- What happens during an episode of asthma?
- What exacerbates asthma?
- How is asthma controlled?
- What physical activities can people with asthma do?

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9.2.58.4.3 Group Clinical Visits for Pregnancy

Group clinical visits are benefits of Texas Medicaid for the management of the condition of pregnancy when submitted with procedure code 99078 and modifier TH, along with one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
O0901	O0902	O0903	O0911	O0912	O0913	O09211	O09212
O09213	O09291	O09292	O09293	O0931	O0932	O0933	O0941
O0942	O0943	O09511	O09512	O09513	O09521	O09522	O09523
O09611	O09612	O09613	O09621	O09622	O09623	O0971	O0972
O0973	O09811	O09812	O09813	O09821	O09822	O09823	O09891
O09892	O09893	O0991	O0992	O0993	Z331	Z3401	Z3402
Z3403	Z3481	Z3482	Z3483				

Providers are encouraged to provide a comprehensive curriculum or use materials from the Centering Pregnancy Program that will be incorporated into the educational portion of the group clinical visit.

Comprehensive curriculums will allow clinical issues to be identified to promote a healthy pregnancy. The education material may include screenings and preparations, health maintenance, counseling, and birth plans:

- Screenings and preparations may consist of the following:
  - Expected course of the pregnancy
  - Anticipated outline of the scheduled visits
  - Signs and symptoms, which should be reported to the physician as soon as possible
  - Laboratory services
  - Appropriate use of medications
  - Proper weight monitoring
  - Immunizations (e.g., hepatitis, varicella, or RhoGAM)
  - Complications of pregnancy that may occur (e.g., preeclampsia, diabetes, or edema)
- Health maintenance may consist of the following:
  - Hygiene (e.g., hot tubs or baths)
  - Sexual activity
  - Exercise
  - Nutrition and dietary needs
- Counseling may consist of the following:
  - Use of seat belts
  - Job activity
  - Air travel
  - Dental care appointments
  - Domestic abuse or violence
  - Tobacco or drug use

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- Birth planning may consist of the following:
  - What to expect during labor and delivery
  - Pain control during labor
  - Complications during delivery that may occur (e.g., Caesarean section or episiotomy)
  - Breast feeding
  - Newborn care
  - Postpartum adjustments

Group clinical visits for the management of pregnancy are restricted to female clients who are 10 through 55 years of age and are limited to a maximum of 10 visits per 270 days for any provider.

To be considered for reimbursement, procedure code 99078 with modifier TH must be billed for the same date of service by the same provider as E/M procedure code 99211, 99212, 99213, 99214, or 99215 with modifier TH.

9.2.58.5 Home Services

Home services are provided in a private residence. New patient visits will be limited to once every three years. Providers must utilize procedure codes 99341, 99342, 99343, 99344, and 99345 when billing for new patient services provided in the home setting. New patient visits are limited to one every three years.

Providers must use procedure codes 99347, 99348, 99349, and 99350 when billing established patient services provided in the home setting.

A subsequent home visit (procedure codes 99347, 99348, 99349, and 99350) billed with the same date of service as a new patient home visit (procedure codes 99344 and 99345) by the same provider will be denied as part of another procedure, regardless of the diagnosis.

Subsequent home E/M codes are limited to one per day, regardless of diagnosis.

9.2.58.6 Inpatient Hospital Services

Hospital visits are limited to one per day for the same provider.

Only one initial hospital care visit may be reimbursed to the same provider within a 30-day period for the same diagnosis. Additional initial hospital visits with the same diagnosis within a 30-day period will be denied.

A hospital care visit submitted by the same provider for the same client within three days of a new patient office, home, nursing facility, or skilled nursing facility (SNF) visit, for the same or for a similar diagnosis must be submitted as a subsequent care visit.

Refer to: Subsection 9.2.71.6, "Global Fees," in this handbook for more information about global services.

9.2.58.6.1 Hospital Admissions, Initial Visits, and Subsequent Visits

Inpatient hospital visits must be submitted using procedure codes 99221, 99222, 99223, 99231, 99232, and 99233.

If a subsequent hospital visit (procedure code 99231, 99232, or 99233) following admission is billed by the same provider with the same date of service as any of the following emergency department visits, office visits, or outpatient consultations, the subsequent hospital visit may be reimbursed and the other visits will be denied:

Procedure Code									
99281	99282	99283	99284	99285	99201	99202	99203	99204	99205

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Procedure Code									
99211	99212	99213	99214	99215	99241	99242	99243	99244	99245

Only one initial hospital care visit may be reimbursed to the same provider within a 30-day period for the same diagnosis. Additional initial hospital visits with the same diagnosis within a 30-day period will be denied.

A subsequent hospital visit (procedure code 99231, 99232, or 99233) may be reimbursed to the same provider when performed on the same day as critical care services (procedure codes 99291 and 99292).

E/M services provided in a hospital setting following a major procedure and 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.

Refer to: Subsection 9.2.45, "Newborn Services," in this handbook for information about newborn services.

9.2.58.6.2 Concurrent Care

Concurrent care exists when services are provided to a patient 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 patient in accordance with accepted standards of good medical practice. Concurrent care may be reimbursed to providers of different specialties when the services are for unrelated diagnoses involving different organ systems.

Concurrent care will be denied when billed for providers of the same specialty for the same or related diagnoses. A diagnosis will be considered related when up to six digits match the primary ICD-10-CM diagnosis code. Denied concurrent care may be appealed when accompanied by documentation of medical necessity.

Each appeal submitted for concurrent care must contain the following information:

- Documentation of the medical necessity for the physician's services (care and treatment)
- Diagnosis and indication of the severity of the client's condition (acute or critical)
- Role of the physician in the care of the client, including the name of the admitting physician
- Specialty and subspecialty of each physician and any limitations of practice

Claims appealed without clear documentation of medical necessity as described above will be denied.

Important: *If the attending physician requests only a consultation, the request must be clearly stated in the orders.*

All concurrent care is subject to retrospective review. Documentation of medical necessity for concurrent care must be retained by the physician as required by federal law and must include, but is not limited to, documentation of:

- The orders for concurrent care or valid reasons for the request by the attending physician.
- The name of the requesting physician by the physician rendering concurrent care.

9.2.58.6.3 Consultations

Consultations provided to hospital inpatients, residents of nursing facilities, or patients in a partial hospital setting must be billed using procedure codes 99251, 99252, 99253, 99254, and 99255.

One initial inpatient consultation (procedure code 99251, 99252, 99253, 99254, or 99255) is allowed for each hospitalization within a 30-day period. Subsequent consultations billed as initial consultations during this time period will be denied.

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Refer to: Subsection 9.2.58.1.3, "Consultation Services," in this handbook for additional criteria information.

9.2.58.6.4 Critical Care

Critical care includes the care of critically ill clients that require the constant attention of the physician. The physician must either be at bedside or immediately available to the client. The physician's full attention must be devoted to the client so that the physician cannot render E/M to any other client during the same period of time. Critical care is usually given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, neonatal intensive care unit, or the emergency department care facility. The following procedure codes are used to bill critical care services:

Procedure Code	Limitations
99291	A per day charge for the first 30 to 74 minutes of critical care (time spent by the physician does not have to be continuous on that day).
99292	A per day charge for each additional 30 minutes beyond the first 74 minutes of critical care for up to 6 units or 3 hours per day.*
99471	A per day charge for initial inpatient pediatric critical care of the critically ill client who is 29 days through 24 months of age.
99472	A per day charge for subsequent inpatient pediatric critical care of the critically ill client who is 29 days through 24 months of age.
99475	A per day charge for initial inpatient pediatric critical care of the critically ill client who is 2 years through 5 years of age.
99476	A per day charge for subsequent inpatient pediatric critical care of the critically ill client who is 2 years through 5 years of age.
*** If the number of units is not stated on the claim, a quantity of one is allowed.**	

Services for a client who is not critically ill and unstable but who was treated in a critical care unit must be reported using subsequent hospital visit codes or hospital consultation codes.

If the same provider who performed a major surgery must also perform critical care on the same day for the same client, the provider must bill the critical care with documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure.

Critical care (procedure codes 99291, 99292, 99471, 99472, 99475, and 99476) may be reimbursed only to the provider rendering the critical care service at the time of crisis. Critical care involves high-complexity decision-making to access, manipulate, and support vital system functions. While providers from various specialties may be consulted to render an opinion and assist in the management of a particular portion of the care, only the provider managing the care of the critically ill patient during a life threatening crisis may bill the critical care procedure codes.

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.

Actual time spent with the individual client must 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.

Time spent under the following circumstances may not be reported as critical care:

- Activities that occur outside of the unit or off the floor
- Activities that do not directly contribute to the treatment of the client
- While performing separately reportable procedures or services

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Critical care of less than 30 minutes total duration per day must be reported with the appropriate E/M procedure code.

If critical care that meets the initial 30-minute time requirement is provided to the same client by different physicians, the initial provider's claim may be reimbursed. The second provider's claim will be denied but may be appealed. The time spent by each physician cannot overlap; two physicians cannot bill critical care for care delivered at the same time. Supporting medical record documentation that includes the time in which the critical care was rendered must be provided by the second physician. In addition, a statement must be submitted indicating the physician was the only provider managing the care of the critically ill patient during the life threatening crisis.

If the provider's time exceeds the 74-minute threshold for procedure code 99291, procedure code 99292 may be billed 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 and is limited to 6 units per day for any provider.

Inpatient critical care services provided to infants 29 days through 24 months of age are reported with pediatric critical care procedure codes 99471 and 99472. The pediatric critical care procedure codes are reported as long as the infant or young child qualifies for critical care services during the hospital stay through 24 months of age.

Pediatric critical care (procedure codes 99471, 99472, 99475, and 99476) is a per-day charge. Only one physician can bill pediatric critical care per day. If an inpatient or outpatient E/M service is billed by the same provider with the same date of service as pediatric critical care, the E/M service is denied.

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. Critical care provided to a neonatal or pediatric client in both the outpatient and inpatient settings on the same day must be billed using the appropriate neonatal or pediatric critical care procedure code.

If critical care (procedure code 99291 or 99292) is provided to a patient at a distinctly separate time from another outpatient E/M service by the same provider, both services may be reimbursed with supporting medical record documentation.

Prolonged physician services (procedure codes 99354, 99355, 99356, and 99357) will be denied when billed by the same provider with the same date of service as critical care (procedure code 99291, 99292, 99471, 99472, 99475, or 99476).

Claims may be subject to retrospective review to ensure documentation supports the medical necessity of the service when billing the claim.

Critical care procedure codes 99291 and 99292 will be denied when submitted with the same date of service by the same provider as neonatal intensive care procedure code 99468, 99469, 99478, 99479, or 99480.

9.2.58.6.5 Hospital Discharge

Hospital discharge must be submitted using procedure code 99238 or 99239.

Discharge management billed by the same provider with the same date of service as the admission will be denied.

Discharge management billed by the same provider with the same date of service as an emergency room visit will be denied but may be reimbursed upon appeal if provided at a separate time.

Subsequent hospital visits billed by the same provider with the same date of service as discharge management will be denied.

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Initial hospital visit procedure codes 99221, 99222, and 99223 billed with the same date of service as hospital discharge day management procedure code 99238 will be denied as part of another procedure billed on the same day. Initial hospital visit procedure code 99221 billed with the same date of service as hospital discharge day management procedure code 99239 will be denied as part of another procedure billed on the same day.

9.2.58.6.6 Nursing Facility Services

Providers must use the following when billing initial nursing facility assessments, subsequent nursing facility care, and annual nursing facility assessments in a nursing facility:

Procedure Codes									
99304*	99305*	99306*	99307	99308	99309	99310	99315	99316	99318
*** Initial nursing facility assessments include all services related to an admission to the nursing facility.**									

Comprehensive initial nursing facility assessments performed by the same provider for the same diagnosis are limited to one every six months. The second initial nursing facility assessment within the six-month period will be denied.

Prolonged services in the nursing facility involving direct (face-to-face) patient contact that is beyond the usual service may be reimbursed on the same day as a nursing facility visit (procedure code 99304, 99305, 99306, 99307, 99308, 99309, or 99310).

Procedure code 99356 must be used to report the first hour of prolonged service and is limited to one per day.

Procedure code 99357 must be used to report each additional 30 minutes and is limited to a quantity of three units or one and one-half hours per day.

Prolonged physician services will not be reimbursed in addition to an emergency room visit billed on the same day.

All E/M services, regardless of setting, are considered part of the initial nursing facility care when performed by the same provider on the same day as the admission.

Subsequent nursing facility care E/M procedure codes 99307, 99308, 99309, and 99310 are limited to one per day regardless of diagnosis.

9.2.58.6.7 Observation

When a patient is admitted to the hospital as an inpatient and is discharged in less than 48 hours, the hospital may request that the physician change the admission order from inpatient status to outpatient observation status. This is an acceptable billing practice under Texas Medicaid when the physician makes the changes to the admitting order from inpatient status to outpatient observation status before the hospital submits the claim for reimbursement.

Refer to: Subsection 9.2.58.1.5, "Observation Services," in this handbook for more information about hospital observation.

9.2.58.7 Prolonged Physician Services

Prolonged services involve face-to-face patient contact and may be provided in the office, outpatient hospital, or inpatient hospital settings. The face-to-face patient contact must exceed the time threshold of the following E/M procedure codes submitted for the date of service and be beyond the usual service.

Procedure Codes									
99201	99202	99203	99204	99205	99211	99212	99213	99214	99215
99221	99222	99223	99231	99232	99233	99241	99242	99243	99244
99245	99251	99252	99253	99254	99255	99341	99342	99343	99344

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Procedure Codes				
99345	99347	99348	99349	99350

The following procedure codes must be used for prolonged physician services:

Procedure Codes	Limitation
99354 and 99356	Used in conjunction with the E/M procedure code to report the first hour of prolonged service and are limited to one per day.
99355 and 99357	Used to report each additional 30 minutes and are limited to a quantity of 3 units or 1.5 hours per day.
Note: Prolonged services that are less than 30 minutes in duration cannot not be reported separately.	

Prolonged services in the inpatient setting involving face-to-face client contact that is beyond the usual service may be reimbursed when provided on the same day as an initial hospital visit (procedure codes 99221, 99222, 99223, 99251, 99252, 99253, 99254, and 99255) or a subsequent hospital visit (99231, 99232, 99233).

Prolonged physician services are denied when billed with critical care or emergency room visits billed with the same date of service.

Prolonged physician services and physician standby services without a face-to-face contact (procedure codes 99358, 99359, and 99360) are not a benefit of Texas Medicaid.

9.2.58.8 Referrals

A *referral* is defined as the transfer of the total or specific care of a patient from one physician to another; a referral does not constitute a consultation. These services must be billed using the appropriate E/M visit code.

When a Texas Medicaid provider refers a Texas Medicaid client to another provider for additional treatment or services, the referring provider must forward notification of the client's eligibility and his provider identifier. The client must be made aware that the provider he/she is referred to does or does not participate in Texas Medicaid. Some clients not eligible for Medicaid are eligible for family planning through the DSHS Family Planning Program. These clients should be referred to contracted agency providers for family planning services.

9.2.58.8.1 Referral Requirements for Children with Disabilities

All health-care professionals are required by state and federal legislation to refer children who are 35 months of age or younger with developmental delays to early childhood intervention services provided under the authority of the Department of Assistive and Rehabilitative Services (DARS).

Refer to: Subsection 2.7, "Early Childhood Intervention (ECI) Services," in the *Children's Services Handbook (Vol. 2, Provider Handbooks).*

9.2.59 Physician Services in a Long Term Care (LTC) Nursing Facility

The Department of Aging and Disability Services (DADS) requires initial certification and recertification of Medicaid clients in nursing facilities by physicians in accordance with guidelines set forth in federal regulations. Physician visits for certification and recertification are considered medically necessary, and are reimbursable by Medicaid whether performed in the physician's office or the nursing facility.

Additional information is available on the DADS website at www.dads.state.tx.us.

9.2.60 Podiatry and Related Services

Podiatry and related services are a benefit of Texas Medicaid.

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9.2.60.1 Clubfoot Casting

Procedure code 29450 is limited to clients who are birth through 3 years of age and is payable to a physician in the management of clubfoot when a previous surgery has been performed. The physician may bill the appropriate E/M code with a casting code and be reimbursed for both. Procedure code 29750 is limited to clients who are birth through 2 years of age and is payable to a physician in addition to the initial casting or strapping procedure.

Use modifiers LT (left) and RT (right) with all procedures, as appropriate.

Casting and wedging are benefits if the client has one of the following conditions:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
M21541	M21542	M21549	Q660	Q661	Q662	Q663	Q664
Q6651	Q6652	Q666	Q667	Q6681	Q6682	Q6689	

9.2.60.2 Flat Foot Treatment

Reimbursement for treatment of deformities of the foot and lower extremity that includes flat foot as a component of the deformity may be considered when the client presents with significant pain in the foot, leg, or knee, resulting in a loss of or decrease in function, along with a secondary condition such as valgus deformity or plantar fasciitis.

Treatment of flat foot (flexible pes planus) that is solely cosmetic in nature is not a benefit of Texas Medicaid.

9.2.60.3 Routine Foot Care

Routine foot care must be medically necessary and billed with the following procedure codes. No specific diagnosis restrictions exist. The following procedures are limited to one service every six months per client, regardless of provider specialty: 11055, 11056, 11057, 11719, and G0127.

9.2.61 Prostate Surgery

A transurethral resection of the prostate (TURP) is the most common procedure performed to treat benign prostatic hyperplasia (BPH). A TURP may be billed with procedure code 52601, 52630, or 52640.

If a provider submits separate charges for any of the TURP procedure codes listed above and procedure code 52351 or 52354, the charges for procedure codes 52351 and 52354 will be denied as part of the TURP procedure.

9.2.62 Radiation Therapy

Radiation treatment management may be reimbursed by Texas Medicaid as defined in the *Current Procedure Terminology* (CPT) manual under the "Radiation Treatment Management" section.

The following radiation therapy services are limited to once per day unless documentation submitted with an appeal supports the need for the service to be provided more frequently:

- Therapeutic radiation treatment planning
- Therapeutic radiology simulation-aided field setting
- Teletherapy
- Brachytherapy isodose calculation
- Treatment devices
- Proton beam delivery/treatment
- Intracavitary radiation source application
- Interstitial radiation source application

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- Remote afterloading high intensity brachytherapy
- Radiation treatment delivery
- Localization
- Radioisotope therapy

Laboratory and diagnostic radiological services provided in the office setting may be reimbursed to physicians as a total component. Radiation treatment centers may also be reimbursed for the total component for these services in the outpatient hospital setting. Injectable medications given during the course of therapy in any setting may be reimbursed separately.

Routine follow-up care by the same physician on the day of any therapeutic radiology service will be denied. Medical services within program limitations may be reimbursed on appeal when documentation supports the medical necessity of the visit due to services unrelated to the radiation treatment or radiation treatment complication.

The professional component and the technical component will be denied when billed with the total component. The total component includes the professional and the technical components.

The professional component may be reimbursed for services rendered in the inpatient hospital setting, radiation treatment center setting, or outpatient hospital setting. Physicians billing client services rendered in the office setting or in a facility recognized by Medicaid as a radiation treatment center may be reimbursed for total components.

9.2.62.1 Brachytherapy

9.2.62.1.1 Prior Authorization for Brachytherapy

Prior authorization is not required for brachytherapy.

9.2.62.1.2 Other Limitations on Brachytherapy

Clinical brachytherapy services include admission to the hospital and daily care. Initial and subsequent hospital care will be denied as part of another service when billed with the same date of service as clinical brachytherapy services.

An office visit will be denied as part of another service when billed with the same date of service by the same provider as clinical treatment planning and clinical brachytherapy.

Normal follow-up care by the same physician will be denied as part of another service when billed with the same dates of service as any therapeutic radiology service. Any other E/M office visit will be denied as part of another service when billed with the same date of service by the same provider as the radiation treatment or radiation treatment complication.

Providers may use modifier 25 to indicate that 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 upon request.

Procedure codes 77321 and 77470 are limited to once per two calendar months.

Documentation that supports the provision of special procedures must be maintained in the client's medical record and made available upon request.

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9.2.62.2 Stereotactic Radiosurgery

9.2.62.2.1 Prior Authorization for Stereotactic Radiosurgery

The following procedure codes are a benefit of Texas Medicaid with prior authorization and documentation of medical necessity:

Procedure Codes									
32701	61781	61782	61783	61796	61797	61798	61799	61800	63620
63621	77371	77372	77373	77399	77422	77423	77520	77522	77523
77525	G0339	G0340	G6002	S8030					

Prior authorization requirements for stereotactic radiosurgery and stereotactic body radiation therapy may include, but are not limited to, diagnoses indicating one of the following medical conditions:

- Benign and malignant tumors of the central nervous system
- Vascular malformations
- Soft tissue tumors in chest, abdomen, or pelvis
- Trigeminal neuralgia refractory to medical management

Stereotactic radiosurgery and stereotactic body radiation therapy are considered investigational and not a benefit of Texas Medicaid for all other indications including, but not limited to, epilepsy, chronic pain, and pancreatic adenocarcinoma.

Prior authorization requirements for proton beam (procedure codes 77520, 77522, 77523, 77525, and S8030) and helium ion radiosurgery (procedure codes 77422 and 77423) may include, but are not limited to, diagnoses indicating one of the following medical conditions:

- 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

Prior authorization for neutron beam radiosurgery may be considered for malignant neoplasms of the salivary gland.

Prior authorization requirements for procedure code 77399 include, but are not limited to, diagnosis, documentation of medical necessity, a specific description of the procedure to be performed, and an indication that the procedure would not be covered by a more specific procedure code.

Stereotactic radiosurgery and stereotactic body radiation therapy will not be prior authorized for clients with metastatic disease and a projected life span of less than six months or for clients with widespread cerebral or extracranial metastasis that is not responsive to systemic therapy.

9.2.62.2.2 Other Limitations on Stereotactic Radiosurgery

In the following table, the procedure codes in Column A may be reimbursed when at least one corresponding procedure code from Column B has been paid to the same provider for the same date of service:

Column A Procedure Code	Column B Procedure Code
61797	61796, 61798
61799	61798

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Column A Procedure Code	Column B Procedure Code
61800	61796, 61798
63621	63620

Procedure codes 61796 and 63620 must not be billed more than once per course of treatment.

Procedure codes 61797 and 61799 must not be billed more than once per lesion, and may only be billed up to four times for the entire course of treatment, regardless of the number of lesions treated.

Procedure code 63621 may only be billed up to two times for the entire course of treatment, regardless of the number of lesions treated.

9.2.63 Radiology Services

In compliance with HHS regulations, physicians (MDs and DOs), group practices, and clinics may not bill for radiology services provided outside their offices. These services must be billed directly by the facility/provider that performs the service.

This restriction does not affect radiology services performed by physicians or under their supervision in their offices. The radiology equipment must be owned by physicians and be located in their office to allow for billing of TOS 4 (complete procedure) or TOS T with modifier TC to Texas Medicaid. If physicians are members of a clinic that owns and operates radiology facilities, they may bill for these services. However, if physicians practice independently and share space in a medical complex where radiology facilities are located, they may not bill for these services even if they own or share ownership of the facility, unless they supervise and are responsible for the operation of the facilities on a daily basis.

Providers billing for three or more of the same radiology procedures on the same day must indicate the time the procedure was performed to indicate that it is not a duplicate service. The use of modifiers 76 and 77 does not remove the requirement of indicating the times services were rendered. The original claim will be denied but can be appealed with the documentation of procedure times.

When billing for services in an inpatient or outpatient hospital setting, the radiologist may only bill the professional interpretation of procedures (modifier 26). This also applies when providing services to a client who is in an inpatient status even if the client is brought to the radiologist's office for the service. The hospital is responsible for all facility services (the technical component) even if the service is supplied by another facility/provider.

A separate charge for an X-ray interpretation billed 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 patient.

Providers other than radiologists are sometimes under agreement with facilities to provide interpretations in specific instances. Those specialties may be paid if a radiologist does not bill for the professional component of X-ray procedures.

If duplicate billings are found between radiologists and the other specialties, the radiologist may be paid, and the other provider is denied.

Abdominal flat plates (AFP) or kidneys, ureters, bladder (KUB) codes 74000, 74010, and 74020 are frequently done as preliminary X-rays before other, more complicated X-ray procedures. If a physician bills separately for an AFP or KUB and more complicated procedures, the charges are combined and the more complex procedure may be paid. If, however, the claim specifically states the AFP or KUB was done first and the results required additional X-rays, each procedure may be paid separately.

Oral preparations for X-rays are included in the charge for the X-ray procedure when billed by a physician. Separate charges for the oral preparation are denied as part of another procedure on the same day.

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Separate charges for injectable radiopharmaceuticals used in the performance of specialized X-ray procedures may be paid. If a procedure code is not indicated, an unlisted code must have a drug name, route of administration, and dosage written on the claim.

9.2.63.1 Diagnosis Requirements

Physicians enrolled and practicing as radiologists are not routinely required to send a diagnosis with their request for payment except when providing the following services:

- Arteriograms
- Venography
- Chest X-rays
- Cardiac blood pool imaging
- Echography

Radiologists are required to identify the referring provider by full name and credentials in Block 17 of the CMS-1500 claim form. Radiology procedures submitted by all other physician specialties must reference a diagnosis with every procedure billed. As with all procedures billed to Texas Medicaid, baseline screening and/or comparison studies are not a benefit.

9.2.63.2 Cardiac Blood Pool Imaging

Cardiac blood pool imaging may be reimbursed with procedure codes 78472, 78473, 78481, 78483, 78494, and 78496. Prior authorization is required for outpatient diagnostic services.

Refer to: Subsection 9.2.26.9, "Myocardial Perfusion Imaging," in this handbook for more information about myocardial perfusion imaging.

Section 3, "Radiological and physiological laboratory services" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information and authorization requirements.

9.2.63.3 Chest X-Rays

All providers including radiologists billing for chest X-rays must supply a diagnosis code.

Screening, baseline, or rule-out studies do not qualify for reimbursement.

9.2.63.4 Magnetic Resonance Angiography (MRA)

MRA is an effective diagnostic tool used to detect, diagnose, and aid the treatment of heart disorders, stroke, and blood vessel diseases.

Refer to: Section 3, "Radiological and physiological laboratory services" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information and authorization requirements.

9.2.63.5 Magnetic Resonance Imaging (MRI)

MRIs may be an effective diagnostic tool for detecting defects, diseases, and trauma.

Refer to: Section 3, "Radiological and physiological laboratory services" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information and authorization requirements.

9.2.63.6 Technetium TC 99M

Procedure codes A9500 (Sestamibi) and A9502 (Tetrofosmin) are limited to three per day when billed by the same provider.

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9.2.64 Magnetoencephalography (MEG)

Magnetoencephalography is a benefit of Texas Medicaid when medically necessary for the presurgical evaluation of clients with intractable epilepsy (i.e., refractory or drug-resistant epilepsy), brain tumors, vascular malformations of the brain, or when one or more conventional measures of localizing the seizure focus have failed to provide sufficient information.

MEG is a noninvasive method of measuring magnetic fields in the brain and is used to precisely localize both the essential functional cortex (i.e., eloquent cortex) and abnormal epileptogenic brain activity as part of a presurgical evaluation. The origin of abnormal MEG brain activity can be precisely localized (source localization) and displayed as a map or image.

The term magnetic source imaging (MSI) refers to an imaging technique that combines a MEG scan with an anatomic magnetic resonance imaging (MRI) image of the brain to map or visualize brain activity.

MEG may assist in guiding the placement of intracranial Electroencephalography (EEG) and, in some patients, avoid an unnecessary intracranial EEG. In the case of pre-surgical mapping of patients with operable lesions, MEG provides non-invasive localization of eloquent cortices (e.g., motor, sensory, language, auditory, or visual).

Physicians must provide MEG services in a comprehensive level IV epilepsy center or a physiological laboratory. A neurologist, epileptologist, or neurosurgeon must order the MEG test.

MEG is not a stand-alone test. Pre-surgical evaluation with MEG testing must include a comprehensive evaluation by the medical team.

Procedure codes 95965, 95966, and 95967 may be reimbursed for MEG services. Procedure code 95967 is an add-on code and must be submitted with procedure code 95966.

9.2.64.1 * Prior Authorization for MEG

Prior authorization is required for MEG. Prior authorization requests must be submitted using the Special Medical Prior Authorization (SMPA) form. The ordering physician must sign and date the form and submit it to the SMPA department. Requests must include documentation supporting the medical necessity of the study. The ordering physician must maintain all documentation.

Providers must include information about the MEG test facility. This information must be documented on the SMPA form.

Prior authorization requests must include a completed SMPA request form and all of the following documentation:

- Documentation of one of the following conditions: intractable epilepsy, brain tumors, or vascular malformations of the brain
- The statement of medical necessity from the ordering physician, which must support the need for MEG with identified medical conditions as applicable, including:
  - History of treatment methods used
  - Length of treatment and treatment outcomes
  - Date of onset of supporting diagnoses
  - Types of previous diagnostic testing used or considered and documentation that indicates how these tests have failed to provide the necessary information to address the client's medical needs or when one or more conventional measures of localizing the seizure focus have failed to provide sufficient information

Documentation from the ordering physician outlining how the MEG test will assist in identifying the area to be resected in instances when an MEG test is needed due to a tumor and surgery is the first option.

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Documentation that includes the name and number of medications, tried and failed, to control the client's seizure activity when the MEG request is related to intractable epilepsy.

The date of prior MEG, the results of the previous MEG tests, and supporting medical documentation outlining the medical reasons for the repeat MEG requested if the request is for a repeat MEG.

Providers may submit prior authorization requests electronically, through the provider website, fax, or by standard mail.

The provider may complete and submit the required prior authorization documentation through any approved electronic method. The provider must maintain a copy of the prior authorization request as well as all submitted documentation in the client's medical record at the performing provider's place of business, in order to complete the prior authorization process electronically.

The provider may complete and submit the required prior authorization documentation through fax or standard mail and must maintain a copy of the prior authorization request as well as all submitted documentation in the client's medical record at the performing provider's place of business, to complete the prior authorization process by paper.

Providers must include correct and complete information, such as documentation of medical necessity for the service(s) requested, in order to avoid unnecessary denials. Providers 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.

Requests for prior authorization with documentation supporting the medical necessity for the number of studies requested must be received on, or before, the requested date(s) of service.

Note: *Requests received after the services are performed will be denied for dates of service that occurred before the date the request was received.*

9.2.64.2 Documentation Requirements

In addition to documentation requirements outlined in the "Prior Authorization for MEG" section, the following requirements apply:

- All MEG 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.
- Magnetic Source Imaging procedure code S8035 is not a benefit of Texas Medicaid, but it may be used for informational purposes.

9.2.64.3 Noncovered Services

The following MEG services are not benefits of Texas Medicaid:

- MEG when used as a stand-alone test for epilepsy
- MEG used as a first-line diagnostic screening
- MEG when used for evaluation of:
  - Alzheimer's disease
  - Autism
  - Cognitive and mental disorders
  - Developmental dyslexia
  - Learning disorders
  - Migraines
  - Multiple sclerosis
  - Parkinson's disease

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- Schizophrenia
- Stroke rehabilitation
- Traumatic brain injury

Note: *This list is not all inclusive.*

9.2.65 Reduction Mammaplasties

9.2.65.1 Prior Authorization for Reduction Mammaplasty

Procedure code 19318 is the removal of breast tissue and is a benefit of Texas Medicaid when prior authorized.

For prior authorization of reduction mammaplasty, a completed "Medicaid Certificate of Medical Necessity for Reduction Mammaplasty" form signed and dated by the physician, must be submitted and include at least one of the following criteria:

- Evidence of severe neck and/or back pain with incapacitation from the pain.
- Evidence of ulnar pain or paresthesia from thoracic nerve root compression.
- Submammary dermatological conditions such as intertrigo and acne that are refractory to conventional medication.
- Shoulder grooving with ulceration due to breast size.

In addition to the above criteria, documentation must indicate:

- The minimum weight of tissue expected to be removed from each breast with consideration to height and weight is as follows:

Height and Weight Chart		
Under 5'	<140 lb	300 grams per breast
5'-5'.4"	up to 180 lb	350 grams per breast
5'.4"-5'.7"	up to 220 lb	400 grams per breast
5'.7"- and up	211 lb and up	500 grams per breast

- The client, if 40 years of age or older, has had a mammogram within the past year that was negative for cancer.

The following services are *not* a benefit of Texas Medicaid:

- Reduction mammaplasty for cosmetic purposes (such as the equalization of breast size)
- Reduction mammaplasty for gynecomastia (enlargement of breast tissue in the male)
- Augmentation mammaplasty to increase breast size

The physician is required to maintain the following documentation in the client's clinical records:

- A complete history and physical
- Pulmonary function studies results
- Past treatments, therapies, and outcomes for pain control and weight reduction

The physician is required to maintain preoperative photographs (frontal and lateral views) in the client's clinical records and must be made available to Texas Medicaid upon request.

For reimbursement purposes on a bilateral procedure, the full allowed amount will be paid to the surgeon and assistant surgeon for the first breast reduction and one half the allowed amount will be paid for the second reduction. Facilities are paid for one surgical procedure.

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When submitting for prior authorization, requests *must* be sent to TMHP Special Medical Prior Authorization. Sending requests directly to the TMHP Medical Director delays the processing of the request. Providers are to mail prior authorization requests for reduction mammaplasty to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax 1-512-514-4213

9.2.66 Renal Disease

9.2.66.1 Dialysis Patients

Physician reimbursement for supervision of patients on dialysis is based on a monthly capitation payment (MCP) calculated by Medicare. The MCP is a comprehensive payment that covers all physician services associated with the continuing medical management of a maintenance dialysis patient for treatments received in the facility. An original onset date of dialysis treatment must be included on claims for all renal dialysis procedures in all POSs except inpatient hospital. The original onset date must be the same date entered on the 2728 form sent to the Social Security office.

9.2.66.1.1 Physician Supervision of Dialysis Patients

Physician supervision of outpatient ESRD services includes services provided 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.

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

The procedure codes must be billed as described below:

- In the circumstances where the client is not on home dialysis and has had a complete assessment visit during the calendar month and ESRD-related services are provided for a full month, procedure codes 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, or 90962 must be used, 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, procedure codes 90963, 90964, 90965, or 90966 must be used, determined by the client's age.
- 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:
  - The client is seen for a partial month and is not on home dialysis and received one or more face-to-face visits but did not receive a complete assessment.
  - The client is on home dialysis and received less than a full month of services.

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- The client is a transient client.
- The 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.
- The 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 date of service must indicate each day that supervision was provided.
- Procedure codes 90967, 90968, 90969, and 90970 will be denied when billed within the same calendar month by any provider as procedure code 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, or 90966.
- Procedure codes 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, or 90966 are limited to once per calendar month by any provider, and only one service may be reimbursed per calendar month by any provider.

The following services may be provided in conjunction with physician supervision of ESRD dialysis but are considered non-routine and may be billed separately:

- Declotting of shunts when performed by the physician.
- Physician services to inpatient clients. 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 must 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, procedure code 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, or 90962 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. The appropriate inpatient evaluation and management codes must be reported for procedures provided during the hospitalization.
- Dialysis at an outpatient facility other than the usual dialysis setting for a patient of a physician who bills the MCP. The physician must bill procedure code 90967, 90968, 90969, or 90970 for each date supervision is provided. The physician may not bill for days that the client dialyzed elsewhere.
- Physician services beyond those that are related to the treatment of the patient's renal condition that cause the number of physician-patient 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.

Use procedure codes 90935, 90937, 90945, and 90947 for 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. These codes are not payable for a cursory visit by the physician; hospital visit codes must be used for a cursory visit.

The hospital procedure codes 90935, 90937, 90945, and 90947 are for complete care of the patient; hospital visits cannot be billed on the same day as these codes. However, if the physician only sees the patient when they are not dialyzing, the physician must bill the appropriate hospital visit code. The inpatient dialysis code must not be submitted for payment.

Only one of procedure code 90935, 90937, 90945, or 90947 may be reimbursed per day, any provider.

Procedure codes 90935, 90937, 90945, and 90947 may also be used for outpatient dialysis services for non-ESRD clients.

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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.

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 client 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 monthly capitation payment for physician supervision rendered to maintenance facility clients.

9.2.66.2 Laboratory Services for Dialysis Patients

Texas Medicaid may reimburse for laboratory services performed for dialysis patients.

Charges for *routine laboratory services* performed according to established frequencies are included in the facility's composite rate billed to Texas Medicaid regardless of where the tests were performed. Routine laboratory testing processed by an outside laboratory are billed to the facility and billed by a renal dialysis facility, unless they are inclusive tests.

Nonroutine laboratory services for people dialyzing in a facility and all laboratory work for people on CAPD may be billed separately from the dialysis charge.

Refer to: Subsection 6.2.9, "Laboratory and Radiology Services," in the *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*) for more information on laboratory services.

9.2.66.3 Self-Dialysis Patients

Physician reimbursement for supervision of patients on self-dialysis is made after completion of the patient's training. If the training is not completed, payment is proportionate to the amount of time spent in training. Payment for training may be made in addition to payment under the MCP for physician supervision of an in-facility maintenance dialysis patient. Use procedure codes 90989 and 90993 for dialysis training regardless of the type of training performed. These procedure codes must be billed as specified:

- When complete dialysis training is provided, bill procedure code 90989. Providers are to use modifier AT when using this procedure code. The date of service indicates the date training was completed, and the quantity is 1.
- When dialysis training is not completed, bill procedure code 90993. The date of service must list each day that a session of training was provided and the quantity must indicate the number of training sessions provided.

The amount of reimbursement of subsequent training is determined by prorating the physician's payment for initial training sessions. The amount of payment for each additional training session does not exceed $20.

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9.2.66.3.1 Physician Supervision

All physician services required to create the capacity for self-dialysis must include:

- Direction of and participation in training of dialysis patients.
- Review of family and home status and environment, and counseling and training of family members.
- Review of training progress.

9.2.66.3.2 Initial Training

The following services are included in the physician charge for supervision of a client on self-dialysis:

- Physician services rendered during a dialysis session including those backup dialyses that occur in outpatient facility settings.
- Office visits for the routine evaluation of patient progress, including the interpretation of diagnostic tests and procedures.
- Physician services rendered by the attending physician in the course of an office visit, the primary purpose of which is routine monitoring or the follow-up of complications of dialysis, including services involved in prescribing therapy for illnesses unrelated to renal disease, which may be appropriately treated without increasing the number of contacts beyond those occurring at regular monitoring sessions or visits for treatment of renal complications.
- General support services (for example, arranging for supplies).

9.2.66.3.3 Subsequent Training

No additional payment is made after the initial self-dialysis training course unless subsequent training is required for one of the following reasons:

- A change from the client's treatment machine to one the client had not been trained to use in the initial training course
- A change in setting
- A change in dialysis partner

The physician must document the reason for additional training sessions on the CMS-1500 paper claim form.

Dialysis equipment and supplies used by the client who dialyzes in the home are not benefits of Texas Medicaid, including the lease or purchase of dialysis machines and disposable supply kits.

9.2.67 Sign Language Interpreting Services

Sign language interpreting services are benefits of Texas Medicaid. Providers must use procedure code T1013 with modifier U1 for the first hour of service, and T1013 with modifier UA for each additional 15 minutes of service. Procedure code T1013 billed with modifier U1 is limited to once per day, same provider, and procedure code T1013 billed with modifier UA is limited to a quantity of 28 per day, same provider.

Sign language interpreting services are available to Medicaid clients who are deaf or hard of hearing or to a parent or guardian of a Medicaid client if the parent or guardian is deaf or hard of hearing.

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 Texas Medicaid for providing this service.

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Sign language interpreting services must be provided by an interpreter who possesses one of the following certification levels (i.e., levels A through H) issued by either the DARS, Office for Deaf and Hard of Hearing Services, Board for Evaluation of Interpreters (BEI) or the National Registry of Interpreters for the Deaf (RID).

Certification Levels:

- BEI Level I/Ii and BEI OC: B (Oral Certificate: Basic)
- BEI Basic and RID NIC (National Interpreter Certificate) Certified
- BEI Level II/IIi, RID CI (Certificate of Interpretation), RID CT (Certificate of Transliteration), RID IC (Interpretation Certificate), and RID TC (Transliteration Certificate)
- 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)
- BEI Advanced and RID NIC Advanced
- BEI IV/IVi, RID MCSC (Master Comprehensive Skills Certificate), and RID SC: L (Specialist Certificate: Legal)
- BEI V/VI
- 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 HHSC or its designee.

9.2.68 Skin Therapy

Skin therapy is a benefit of Texas Medicaid and may be reimbursed with the following procedure codes:

Procedure Codes									
15782	15783	15792	15793	17000	17003	17004	17106	17107	17108
17110	17111	17250	17260	17261	17262	17263	17264	17266	17270
17271	17272	17273	17274	17276	17280	17281	17282	17283	17284
17286	17311	17312	17313	17314	17315	17340	17999	11900	11901
96900	96910	96912	96913	96920	96921	96922	96999		

Claims for incision and drainage of acne when the diagnosis states there is infection or pustules may be paid.

Procedure codes 96900, 96910, 96912, 96913, 96920, 96921, and 96922 are covered benefits for the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone 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

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
L130	L131	L138	L139	L200	L2081	L2082	L2083
L2084	L2089	L210	L211	L218	L219	L22	L230
L231	L232	L233	L235	L236	L237	L2381	L240
L241	L242	L243	L244	L245	L246	L247	L2481
L270	L271	L272	L278	L279	L300	L301	L302
L303	L304	L305	L400	L401	L402	L403	L404
L4050	L4051	L4052	L4053	L4054	L4059	L408	L410
L411	L412	L413	L414	L415	L418	L42	L440
L560	L561	L562	L563	L564	L565	L570	L571
L572	L573	L574	L575	L580	L581	L700	L701
L702	L703	L704	L705	L708	L710	L711	L718
L730	L80						

Intralesional injection(s) may be considered for reimbursement in addition to an office visit.

Procedure codes 11900 and 11901 are covered benefits for intralesional injections for the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
B070	B081	B550	B551	B552	B559	D863	L400
L401	L402	L403	L404	L4050	L4051	L4052	L4053
L4054	L4059	L408	L410	L411	L412	L413	L414
L415	L418	L42	L440	L700	L701	L702	L703
L704	L705	L708	L710	L711	L718	L730	L732
L910	L928	T2000XA	T2000XD	T2000XS	T20011A	T20011D	T20011S
T20012A	T20012D	T20012S	T2002XA	T2002XD	T2002XS	T2003XA	T2003XD
T2003XS	T2004XA	T2004XD	T2004XS	T2005XA	T2005XD	T2005XS	T2006XA
T2006XD	T2006XS	T2007XA	T2007XD	T2007XS	T2009XA	T2009XD	T2009XS
T2010XA	T2010XD	T2010XS	T20111A	T20111D	T20111S	T20112A	T20112D
T20112S	T2012XA	T2012XD	T2012XS	T2013XA	T2013XD	T2013XS	T2014XA
T2014XD	T2014XS	T2015XA	T2015XD	T2015XS	T2016XA	T2016XD	T2016XS
T2017XA	T2017XD	T2017XS	T2019XA	T2019XD	T2019XS	T2020XA	T2020XD
T2020XS	T20211A	T20211D	T20211S	T20212A	T20212D	T20212S	T2022XA
T2022XD	T2022XS	T2023XA	T2023XD	T2023XS	T2024XA	T2024XD	T2024XS
T2025XA	T2025XD	T2025XS	T2026XA	T2026XD	T2026XS	T2027XA	T2027XD
T2027XS	T2029XA	T2029XD	T2029XS	T2030XA	T2030XD	T2030XS	T20311A
T20311D	T20311S	T20312A	T20312D	T20312S	T2032XA	T2032XD	T2032XS
T2033XA	T2033XD	T2033XS	T2034XA	T2034XD	T2034XS	T2035XA	T2035XD
T2035XS	T2036XA	T2036XD	T2036XS	T2037XA	T2037XD	T2037XS	T2039XA
T2039XD	T2039XS	T2040XA	T2040XD	T2040XS	T20411A	T20411D	T20411S
T20412A	T20412D	T20412S	T2042XA	T2042XD	T2042XS	T2043XA	T2043XD
T2043XS	T2044XA	T2044XD	T2044XS	T2045XA	T2045XD	T2045XS	T2046XA

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
T2046XD	T2046XS	T2047XA	T2047XD	T2047XS	T2049XA	T2049XD	T2049XS
T2050XA	T2050XD	T2050XS	T20511A	T20511D	T20511S	T20512A	T20512D
T20512S	T2052XA	T2052XD	T2052XS	T2053XA	T2053XD	T2053XS	T2054XA
T2054XD	T2054XS	T2055XA	T2055XD	T2055XS	T2056XA	T2056XD	T2056XS
T2057XA	T2057XD	T2057XS	T2059XA	T2059XD	T2059XS	T2060XA	T2060XD
T2060XS	T20611A	T20611D	T20611S	T20612A	T20612D	T20612S	T2062XA
T2062XD	T2062XS	T2063XA	T2063XD	T2063XS	T2064XA	T2064XD	T2064XS
T2065XA	T2065XD	T2065XS	T2066XA	T2066XD	T2066XS	T2067XA	T2067XD
T2067XS	T2069XA	T2069XD	T2069XS	T2070XA	T2070XD	T2070XS	T20711A
T20711D	T20711S	T20712A	T20712D	T20712S	T2072XA	T2072XD	T2072XS
T2073XA	T2073XD	T2073XS	T2074XA	T2074XD	T2074XS	T2075XA	T2075XD
T2075XS	T2076XA	T2076XD	T2076XS	T2077XA	T2077XD	T2077XS	T2079XA
T2079XD	T2079XS	T2100XA	T2100XD	T2100XS	T2101XA	T2101XD	T2101XS
T2102XA	T2102XD	T2102XS	T2103XA	T2103XD	T2103XS	T2104XA	T2104XD
T2104XS	T2106XA	T2106XD	T2106XS	T2107XA	T2107XD	T2107XS	T2110XA
T2110XD	T2110XS	T2111XA	T2111XD	T2111XS	T2112XA	T2112XD	T2112XS
T2113XA	T2113XD	T2113XS	T2114XA	T2114XD	T2114XS	T2116XA	T2116XD
T2116XS	T2117XA	T2117XD	T2117XS	T2119XA	T2119XD	T2119XS	T2120XA
T2120XD	T2120XS	T2121XA	T2121XD	T2121XS	T2122XA	T2122XD	T2122XS
T2123XA	T2123XD	T2123XS	T2124XA	T2124XD	T2124XS	T2126XA	T2126XD
T2126XS	T2127XA	T2127XD	T2127XS	T2130XA	T2130XD	T2130XS	T2131XA
T2131XD	T2131XS	T2132XA	T2132XD	T2132XS	T2133XA	T2133XD	T2133XS
T2134XA	T2134XD	T2134XS	T2136XA	T2136XD	T2136XS	T2137XA	T2137XD
T2137XS	T2140XA	T2140XD	T2140XS	T2141XA	T2141XD	T2141XS	T2142XA
T2142XD	T2142XS	T2143XA	T2143XD	T2143XS	T2144XA	T2144XD	T2144XS
T2146XA	T2146XD	T2146XS	T2147XA	T2147XD	T2147XS	T2150XA	T2150XD
T2150XS	T2151XA	T2151XD	T2151XS	T2152XA	T2152XD	T2152XS	T2153XA
T2153XD	T2153XS	T2154XA	T2154XD	T2154XS	T2156XA	T2156XD	T2156XS
T2157XA	T2157XD	T2157XS	T2159XA	T2159XD	T2159XS	T2160XA	T2160XD
T2160XS	T2161XA	T2161XD	T2161XS	T2162XA	T2162XD	T2162XS	T2163XA
T2163XD	T2163XS	T2164XA	T2164XD	T2164XS	T2166XA	T2166XD	T2166XS
T2167XA	T2167XD	T2167XS	T2170XA	T2170XD	T2170XS	T2171XA	T2171XD
T2171XS	T2172XA	T2172XD	T2172XS	T2173XA	T2173XD	T2173XS	T2174XA
T2174XD	T2174XS	T2176XA	T2176XD	T2176XS	T2177XA	T2177XD	T2177XS
T2200XA	T2200XD	T2200XS	T22011A	T22011D	T22011S	T22012A	T22012D
T22012S	T22021A	T22021D	T22021S	T22022A	T22022D	T22022S	T22031A
T22031D	T22031S	T22032A	T22032D	T22032S	T22041A	T22041D	T22041S
T22042A	T22042D	T22042S	T22049D	T22051A	T22051D	T22051S	T22052A
T22052D	T22052S	T22061A	T22061D	T22061S	T22062A	T22062D	T22062S
T22091A	T22091D	T22091S	T22092A	T22092D	T22092S	T2210XA	T2210XD

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
T2210XS	T22111A	T22111D	T22111S	T22112A	T22112D	T22112S	T22121A
T22121D	T22121S	T22122A	T22122D	T22122S	T22131A	T22131D	T22131S
T22132A	T22132D	T22132S	T22141A	T22141D	T22141S	T22142A	T22142D
T22142S	T22151A	T22151D	T22151S	T22152A	T22152D	T22152S	T22161A
T22161D	T22161S	T22162A	T22162D	T22162S	T22191A	T22191D	T22191S
T22192A	T22192D	T22192S	T2220XA	T2220XD	T2220XS	T22211A	T22211D
T22211S	T22212A	T22212D	T22212S	T22221A	T22221D	T22221S	T22222A
T22222D	T22222S	T22231A	T22231D	T22231S	T22232A	T22232D	T22232S
T22239D	T22241A	T22241D	T22241S	T22242A	T22242D	T22242S	T22249D
T22251A	T22251D	T22251S	T22252A	T22252D	T22252S	T22261A	T22261D
T22261S	T22262A	T22262D	T22262S	T22291A	T22291D	T22291S	T22292A
T22292D	T22292S	T2230XA	T2230XD	T2230XS	T22311A	T22311D	T22311S
T22312A	T22312D	T22312S	T22321A	T22321D	T22321S	T22322A	T22322D
T22322S	T22331A	T22331D	T22331S	T22332A	T22332D	T22332S	T22341A
T22341D	T22341S	T22342A	T22342D	T22342S	T22351A	T22351D	T22351S
T22352A	T22352D	T22352S	T22361A	T22361D	T22361S	T22362A	T22362D
T22362S	T22369D	T22391A	T22391D	T22391S	T22392A	T22392D	T22392S
T2240XA	T2240XD	T2240XS	T22411A	T22411D	T22411S	T22412A	T22412D
T22412S	T22421A	T22421D	T22421S	T22422A	T22422D	T22422S	T22431A
T22431D	T22431S	T22432A	T22432D	T22432S	T22441A	T22441D	T22441S
T22442A	T22442D	T22442S	T22451A	T22451D	T22451S	T22452A	T22452D
T22452S	T22461A	T22461D	T22461S	T22462A	T22462D	T22462S	T22491A
T22491D	T22491S	T22492A	T22492D	T22492S	T2250XA	T2250XD	T2250XS
T22511A	T22511D	T22511S	T22512A	T22512D	T22512S	T22521A	T22521D
T22521S	T22522A	T22522D	T22522S	T22531A	T22531D	T22531S	T22532A
T22532D	T22532S	T22541A	T22541D	T22541S	T22542A	T22542D	T22542S
T22551A	T22551D	T22551S	T22552A	T22552D	T22552S	T22561A	T22561D
T22561S	T22562A	T22562D	T22562S	T22591A	T22591D	T22591S	T22592A
T22592D	T22592S	T2260XA	T2260XD	T2260XS	T22611A	T22611D	T22611S
T22612A	T22612D	T22612S	T22621A	T22621D	T22621S	T22622A	T22622D
T22622S	T22631A	T22631D	T22631S	T22632A	T22632D	T22632S	T22641A
T22641D	T22641S	T22642A	T22642D	T22642S	T22649D	T22651A	T22651D
T22651S	T22652A	T22652D	T22652S	T22661A	T22661D	T22661S	T22662A
T22662D	T22662S	T22691A	T22691D	T22691S	T22692A	T22692D	T22692S
T2270XA	T2270XD	T2270XS	T22711A	T22711D	T22711S	T22712A	T22712D
T22712S	T22721A	T22721D	T22721S	T22722A	T22722D	T22722S	T22731A
T22731D	T22731S	T22732A	T22732D	T22732S	T22741A	T22741D	T22741S
T22742A	T22742D	T22742S	T22751A	T22751D	T22751S	T22752A	T22752D
T22752S	T22761A	T22761D	T22761S	T22762A	T22762D	T22762S	T22791A
T22791D	T22791S	T22792A	T22792D	T22792S	T23001A	T23001D	T23001S

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
T23002A	T23002D	T23002S	T23011A	T23011D	T23011S	T23012A	T23012D
T23012S	T23021A	T23021D	T23021S	T23022A	T23022D	T23022S	T23031A
T23031D	T23031S	T23032A	T23032D	T23032S	T23041A	T23041D	T23041S
T23042A	T23042D	T23042S	T23051A	T23051D	T23051S	T23052A	T23052D
T23052S	T23061A	T23061D	T23061S	T23062A	T23062D	T23062S	T23071A
T23071D	T23071S	T23072A	T23072D	T23072S	T23091A	T23091D	T23091S
T23092A	T23092D	T23092S	T23101A	T23101D	T23101S	T23102A	T23102D
T23102S	T23111A	T23111D	T23111S	T23112A	T23112D	T23112S	T23121A
T23121D	T23121S	T23122A	T23122D	T23122S	T23131A	T23131D	T23131S
T23132A	T23132D	T23132S	T23141A	T23141D	T23141S	T23142A	T23142D
T23142S	T23151A	T23151D	T23151S	T23152A	T23152D	T23152S	T23161A
T23161D	T23161S	T23162A	T23162D	T23162S	T23171A	T23171D	T23171S
T23172A	T23172D	T23172S	T23191A	T23191D	T23191S	T23192A	T23192D
T23192S	T23201A	T23201D	T23201S	T23202A	T23202D	T23202S	T23211A
T23211D	T23211S	T23212A	T23212D	T23212S	T23221A	T23221D	T23221S
T23222A	T23222D	T23222S	T23231A	T23231D	T23231S	T23232A	T23232D
T23232S	T23241A	T23241D	T23241S	T23242A	T23242D	T23242S	T23251A
T23251D	T23251S	T23252A	T23252D	T23252S	T23261A	T23261D	T23261S
T23262A	T23262D	T23262S	T23271A	T23271D	T23271S	T23272A	T23272D
T23272S	T23291A	T23291D	T23291S	T23292A	T23292D	T23292S	T23301A
T23301D	T23301S	T23302A	T23302D	T23302S	T23311A	T23311D	T23311S
T23312A	T23312D	T23312S	T23321A	T23321D	T23321S	T23322A	T23322D
T23322S	T23331A	T23331D	T23331S	T23332A	T23332D	T23332S	T23341A
T23341D	T23341S	T23342A	T23342D	T23342S	T23351A	T23351D	T23351S
T23352A	T23352D	T23352S	T23361A	T23361D	T23361S	T23362A	T23362D
T23362S	T23371A	T23371D	T23371S	T23372A	T23372D	T23372S	T23391A
T23391D	T23391S	T23392A	T23392D	T23392S	T23401A	T23401D	T23401S
T23402A	T23402D	T23402S	T23411A	T23411D	T23411S	T23412A	T23412D
T23412S	T23421A	T23421D	T23421S	T23422A	T23422D	T23422S	T23431A
T23431D	T23431S	T23432A	T23432D	T23432S	T23441A	T23441D	T23441S
T23442A	T23442D	T23442S	T23451A	T23451D	T23451S	T23452A	T23452D
T23452S	T23461A	T23461D	T23461S	T23462A	T23462D	T23462S	T23471A
T23471D	T23471S	T23472A	T23472D	T23472S	T23491A	T23491D	T23491S
T23492A	T23492D	T23492S	T23501A	T23501D	T23501S	T23502A	T23502D
T23502S	T23511A	T23511D	T23511S	T23512A	T23512D	T23512S	T23521A
T23521D	T23521S	T23522A	T23522D	T23522S	T23531A	T23531D	T23531S
T23532A	T23532D	T23532S	T23541A	T23541D	T23541S	T23542A	T23542D
T23542S	T23551A	T23551D	T23551S	T23552A	T23552D	T23552S	T23561A
T23561D	T23561S	T23562A	T23562D	T23562S	T23571A	T23571D	T23571S
T23572A	T23572D	T23572S	T23591A	T23591D	T23591S	T23592A	T23592D

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
T23592S	T23601A	T23601D	T23601S	T23602A	T23602D	T23602S	T23611A
T23611D	T23611S	T23612A	T23612D	T23612S	T23621A	T23621D	T23621S
T23622A	T23622D	T23622S	T23631A	T23631D	T23631S	T23632A	T23632D
T23632S	T23641A	T23641D	T23641S	T23642A	T23642D	T23642S	T23651A
T23651D	T23651S	T23652A	T23652D	T23652S	T23661A	T23661D	T23661S
T23662A	T23662D	T23662S	T23671A	T23671D	T23671S	T23672A	T23672D
T23672S	T23691A	T23691D	T23691S	T23692A	T23692D	T23692S	T23701A
T23701D	T23701S	T23702A	T23702D	T23702S	T23711A	T23711D	T23711S
T23712A	T23712D	T23712S	T23721A	T23721D	T23721S	T23722A	T23722D
T23722S	T23731A	T23731D	T23731S	T23732A	T23732D	T23732S	T23741A
T23741D	T23741S	T23742A	T23742D	T23742S	T23751A	T23751D	T23751S
T23752A	T23752D	T23752S	T23761A	T23761D	T23761S	T23762A	T23762D
T23762S	T23771A	T23771D	T23771S	T23772A	T23772D	T23772S	T23791A
T23791D	T23791S	T23792A	T23792D	T23792S	T24001A	T24001D	T24001S
T24002A	T24002D	T24002S	T24011A	T24011D	T24011S	T24012A	T24012D
T24012S	T24021A	T24021D	T24021S	T24022A	T24022D	T24022S	T24031A
T24031D	T24031S	T24032A	T24032D	T24032S	T24091A	T24091D	T24091S
T24092A	T24092D	T24092S	T24101A	T24101D	T24101S	T24102A	T24102D
T24102S	T24111A	T24111D	T24111S	T24112A	T24112D	T24112S	T24121A
T24121D	T24121S	T24122A	T24122D	T24122S	T24131A	T24131D	T24131S
T24132A	T24132D	T24132S	T24191A	T24191D	T24191S	T24192A	T24192D
T24192S	T24201A	T24201D	T24201S	T24202A	T24202D	T24202S	T24211A
T24211D	T24211S	T24212A	T24212D	T24212S	T24221A	T24221D	T24221S
T24222A	T24222D	T24222S	T24229D	T24231A	T24231D	T24231S	T24232A
T24232D	T24232S	T24291A	T24291D	T24291S	T24292A	T24292D	T24292S
T24301A	T24301D	T24301S	T24302A	T24302D	T24302S	T24311A	T24311D
T24311S	T24312A	T24312D	T24312S	T24321A	T24321D	T24321S	T24322A
T24322D	T24322S	T24331A	T24331D	T24331S	T24332A	T24332D	T24332S
T24391A	T24391D	T24391S	T24392A	T24392D	T24392S	T24401A	T24401D
T24401S	T24402A	T24402D	T24402S	T24411A	T24411D	T24411S	T24412A
T24412D	T24412S	T24421A	T24421D	T24421S	T24422A	T24422D	T24422S
T24431A	T24431D	T24431S	T24432A	T24432D	T24432S	T24491A	T24491D
T24491S	T24492A	T24492D	T24492S	T24501A	T24501D	T24501S	T24502A
T24502D	T24502S	T24511A	T24511D	T24511S	T24512A	T24512D	T24512S
T24521A	T24521D	T24521S	T24522A	T24522D	T24522S	T24531A	T24531D
T24531S	T24532A	T24532D	T24532S	T24591A	T24591D	T24591S	T24592A
T24592D	T24592S	T24601A	T24601D	T24601S	T24602A	T24602D	T24602S
T24611A	T24611D	T24611S	T24612A	T24612D	T24612S	T24621A	T24621D
T24621S	T24622A	T24622D	T24622S	T24631A	T24631D	T24631S	T24632A
T24632D	T24632S	T24691A	T24691D	T24691S	T24692A	T24692D	T24692S

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
T24701A	T24701D	T24701S	T24702A	T24702D	T24702S	T24711A	T24711D
T24711S	T24712A	T24712D	T24712S	T24721A	T24721D	T24721S	T24722A
T24722D	T24722S	T24731A	T24731D	T24731S	T24732A	T24732D	T24732S
T24791A	T24791D	T24791S	T24792A	T24792D	T24792S	T25011A	T25011D
T25011S	T25012A	T25012D	T25012S	T25021A	T25021D	T25021S	T25022A
T25022D	T25022S	T25031A	T25031D	T25031S	T25032A	T25032D	T25032S
T25091A	T25091D	T25091S	T25092A	T25092D	T25092S	T25111A	T25111D
T25111S	T25112A	T25112D	T25112S	T25121A	T25121D	T25121S	T25122A
T25122D	T25122S	T25131A	T25131D	T25131S	T25132A	T25132D	T25132S
T25191A	T25191D	T25191S	T25192A	T25192D	T25192S	T25211A	T25211D
T25211S	T25212A	T25212D	T25212S	T25221A	T25221D	T25221S	T25222A
T25222D	T25222S	T25231A	T25231D	T25231S	T25232A	T25232D	T25232S
T25291A	T25291D	T25291S	T25292A	T25292D	T25292S	T25311A	T25311D
T25311S	T25312A	T25312D	T25312S	T25321A	T25321D	T25321S	T25322A
T25322D	T25322S	T25331A	T25331D	T25331S	T25332A	T25332D	T25332S
T25391A	T25391D	T25391S	T25392A	T25392D	T25392S	T25411A	T25411D
T25411S	T25412A	T25412D	T25412S	T25421A	T25421D	T25421S	T25422A
T25422D	T25422S	T25431A	T25431D	T25431S	T25432A	T25432D	T25432S
T25491A	T25491D	T25491S	T25492A	T25492D	T25492S	T25511A	T25511D
T25511S	T25512A	T25512D	T25512S	T25521A	T25521D	T25521S	T25522A
T25522D	T25522S	T25531A	T25531D	T25531S	T25532A	T25532D	T25532S
T25591A	T25591D	T25591S	T25592A	T25592D	T25592S	T25611A	T25611D
T25611S	T25612A	T25612D	T25612S	T25621A	T25621D	T25621S	T25622A
T25622D	T25622S	T25631A	T25631D	T25631S	T25632A	T25632D	T25632S
T25711A	T25711D	T25711S	T25712A	T25712D	T25712S	T25721A	T25721D
T25721S	T25722A	T25722D	T25722S	T25731A	T25731D	T25731S	T25732A
T25732D	T25732S	T25791A	T25791D	T25791S	T25792A	T25792D	T25792S
T2601XA	T2601XD	T2601XS	T2602XA	T2602XD	T2602XS	T2611XA	T2611XD
T2611XS	T2612XA	T2612XD	T2612XS	T2621XA	T2621XD	T2621XS	T2622XA
T2622XD	T2622XS	T2631XA	T2631XD	T2631XS	T2632XA	T2632XD	T2632XS
T2641XA	T2641XD	T2641XS	T2642XA	T2642XD	T2642XS	T2651XA	T2651XD
T2651XS	T2652XA	T2652XD	T2652XS	T2661XA	T2661XD	T2661XS	T2662XA
T2662XD	T2662XS	T2671XA	T2671XD	T2671XS	T2672XA	T2672XD	T2672XS
T2681XA	T2681XD	T2681XS	T2682XA	T2682XD	T2682XS	T2691XA	T2691XD
T2691XS	T2692XA	T2692XD	T2692XS	T271XXA	T271XXD	T271XXS	T275XXA
T275XXD	T275XXS	T280XXA	T280XXD	T280XXS	T281XXA	T281XXD	T281XXS
T282XXA	T282XXD	T282XXS	T283XXA	T283XXD	T283XXS	T2840XA	T2840XD
T2840XS	T28411A	T28411D	T28411S	T28412A	T28412D	T28412S	T2849XA
T2849XD	T2849XS	T285XXA	T285XXD	T285XXS	T286XXA	T286XXD	T286XXS
T287XXA	T287XXD	T287XXS	T288XXA	T288XXD	T288XXS	T2890XA	T2890XD

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
T2890XS	T28911A	T28911D	T28911S	T28912A	T28912D	T28912S	T2899XA
T2899XD	T2899XS	T300	T304	T310	T3110	T3111	T3120
T3121	T3122	T3130	T3131	T3132	T3133	T3140	T3141
T3142	T3143	T3144	T3150	T3151	T3152	T3153	T3154
T3155	T3160	T3161	T3162	T3163	T3164	T3165	T3166
T3170	T3171	T3172	T3173	T3174	T3175	T3176	T3177
T3180	T3181	T3182	T3183	T3184	T3185	T3186	T3187
T3188	T3190	T3191	T3192	T3193	T3194	T3195	T3196
T3197	T3198	T3199	T320	T3210	T3211	T3220	T3221
T3222	T3230	T3231	T3232	T3233	T3240	T3241	T3242
T3243	T3244	T3250	T3251	T3252	T3253	T3254	T3255
T3260	T3261	T3262	T3263	T3264	T3265	T3266	T3270
T3271	T3272	T3273	T3274	T3275	T3276	T3277	T3280
T3281	T3282	T3283	T3284	T3285	T3286	T3287	T3288
T3290	T3291	T3292	T3293	T3294	T3295	T3296	T3297
T3298	T3299						

Procedure codes 15782, 15783, 15792, 15793, and 17999 require prior authorization. Requests for prior authorization must be submitted by the physician to the Special Medical Prior Authorization (SMPA) department with documentation supporting the medical necessity of the anticipated procedure. This documentation must remain in the client's medical record and is subject to retrospective review. To avoid unnecessary denials, the physician must provide correct and complete information.

Dermabrasion procedures (procedure codes 15782 and 15783) and chemical peel procedures (procedure codes 15792 and 15793) may be prior authorized with documentation that the client meets all of the following criteria:

- A diagnosis of actinic keratosis with more than three lesions.
- Failed conservative treatment or documentation that conservative treatment is contraindicated.

Prior authorization requests for procedure code 17999 must include the following documentation:

- A clear, concise description of the procedure to be performed.
- Reason for recommending the particular procedure.
- Documentation that a specific procedure code is not available for the procedure requested.
- The client's diagnosis.
- Medical records indicating prior treatment for the diagnosis and the medical necessity of the requested procedure.
- Place of service the procedure is to be performed.
- Documentation that the procedure is not investigational or experimental.
- The physician's intended fee for the procedure including a comparable procedure code.

9.2.69 Sleep Studies

Sleep study procedure code 95806 is not a benefit of Texas Medicaid.

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9.2.69.1 Actigraphy

Actigraphy (procedure code 95803) may be reimbursed in the office or outpatient hospital setting with a limit of one per day, and two per rolling year by any provider. Claims denied for more than two times per year may be appealed with documentation of medical necessity.

Actigraphy can be performed as a stand-alone procedure or as an adjunct to polysomnography or multiple sleep latency test (MSLT).

Actigraphy (procedure code 95803) must be billed with one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
F5104	F5105	F5113	G2581	G4700	G4701	G4709	G4710
G4711	G4712	G4713	G4714	G4719	G4720	G4721	G4722
G4723	G4724	G4725	G4726	G4727	G4729	G4761	

If the primary care physician performs the actigraphy, the technical component must be billed (procedure code 95803 with modifier TC).

Documentation of actigraphy must include a hard-copy printout or electronic file. Interpretation and treatment recommendations must be completed by a sleep specialist. The physician's professional interpretation and report must include inspection of the entire recording and integration of the information gathered from other professionals' analysis and observations. Documentation of the interpretation must be maintained by the interpreting physician.

Under the following conditions, actigraphy may be a useful adjunct to a detailed history, examination, and subjective sleep diary for the diagnosis and treatment of insomnia, circadian-rhythm disorders, and excessive sleepiness:

- When demonstration of multiday rest-activity patterns is necessary to diagnose, document severity, and guide the proper treatment.
- When more objective information regarding the day-to-day timing or the amount or patterns of a client's sleep is necessary for optimal clinical decision-making.
- When the severity of a sleep disturbance reported by the client or caretaker seems inconsistent with clinical impressions or laboratory findings.
- To clarify the effects of, and under some instances, compliance with pharmacologic, behavioral, phototherapeutic, or chronotherapeutic treatment.
- In symptomatic clients for whom an accurate history cannot be obtained and at least one of the following is true:
  - A polysomnographic study has already been conducted.
  - A polysomnographic study is considered unlikely to be of much diagnostic benefit.
  - A polysomnographic study is not yet clearly indicated (because of the absence of accurate historical data).
  - A polysomnographic study is not immediately available.

Actigraphy may be useful in the assessment of specific aspects of the following disorders:

- Insomnia. Assessment of sleep variability, measurement of treatment effects, and detection of sleep phase alterations in insomnia secondary to circadian rhythm disturbance.
- Restless legs syndrome or periodic limb movement disorder. Assessment of treatment effects.

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9.2.69.2 Pneumocardiograms

Pneumocardiograms (procedure code 95807) are limited to clients who are birth through 12 months of age.

Pneumocardiograms are limited to one per day, and two per rolling year by any provider. Claims denied for more than two times per year may be appealed with documentation of medical necessity.

Procedure code 95807 must be billed with one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
G4731	G4733	G4734	G4735	G4736	G4737	P282	P283
P284	P285	P2911	P2912	R063	R0681	R0902	R230
R6813							

Documentation of the complete readings associated with the pneumocardiogram and the physician's interpretation must be maintained in the client's medical record in a hard-copy printout or electronic file at the facility where the procedure is performed.

The physician's interpretation and report must include inspection and integration of the information gathered from all physiological systems and other professionals' analysis and observations.

9.2.69.3 Polysomnography

Polysomnography (procedure codes 95782, 95783, 95808, 95810, and 95811) is a benefit of Texas Medicaid.

Polysomnography is distinguished from sleep studies by the inclusion of sleep staging that includes a 1-to 4- lead electroencephalogram (EEG), electro-oculogram (EOG), and a limb or submental electro-myogram (EMG).

Additional parameters of sleep that are evaluated in polysomnography include, but are not limited to, the following:

- ECG
- Airflow (by thermistor or intra-nasal pressure monitoring)
- Respiratory effort
- Adequacy of oxygenation by oximetry or transcutaneous monitoring
- Extremity movement or motor activity
- EEG monitoring for sleep staging
- Nocturnal penile tumescence
- Esophageal pH or intraluminal pressure monitoring
- Continuous blood pressure monitoring
- Snoring
- Body positions
- Adequacy of ventilation by end-tidal or transcutaneous CO2 monitoring

For a sleep study to be reported as a polysomnography, sleep must be recorded and staged. Use the following procedure codes to bill for polysomnography studies: 95782, 95783, 95808, 95810, and 95811.

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Polysomnography (procedure codes 95782, 95783, 95808, 95810, and 95811) is limited to one per day and two per rolling year by any provider and is allowed for the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
E6601	E662	F10182	F10282	F10982	F11182	F11282	F11982
F13182	F13282	F13982	F14182	F14282	F14982	F15182	F15282
F15982	F19182	F19282	F19982	F5101	F5102	F5103	F5104
F5105	F5109	F5111	F5112	F5113	F5119	F513	F514
F515	F518	F519	G120	G121	G1221	G128	G2581
G373	G4700	G4701	G4710	G4711	G4712	G4713	G4719
G4720	G4721	G4722	G4723	G4724	G4725	G4726	G4727
G4729	G4730	G4731	G4732	G4733	G4734	G4735	G4736
G4737	G4739	G47411	G47419	G47421	G47429	G4750	G4751
G4752	G4753	G4754	G4759	G4761	G4762	G4763	G4769
G478	G479	G710	G712	G809	G8250	G901	G931
J353	J9610	J9611	J9612	N5201	N5202	N5203	N521
Q040	Q041	Q042	Q078	Q308	Q311	Q312	Q313
Q315	Q318	Q320	Q321	Q322	Q323	Q324	Q672
Q673	Q674	Q750	Q751	Q752	Q753	Q754	Q755
Q758	Q759	Q770	Q771	Q773	Q774	Q775	Q777
Q778	Q779	Q781	Q789	Q870	R0681	R0902	

Claims denied for more than two times per year may be appealed with documentation of medical necessity.

Documentation of the polysomnography testing must be maintained in the client's medical record at the sleep facility and include approximately 1,000 pages or the electronically-stored equivalent of data during a single nighttime recording. Each record must be for sleep-wake states and stages, cardiac arrhythmias, respiratory events, motor activity, oxygen desaturations, and behavioral observations.

Documentation must also include the technologist's analysis and report, the patient's subjective report, and the influence of intervention applied during the night.

Interpretation and treatment recommendations must be completed by a sleep specialist. The physician's professional interpretation and report must include inspection of the entire recording, examination of the technologist's analysis and observations, and integration of the information gathered from all physiological systems. Documentation of the interpretation must be maintained in the sleep facility and by the interpreting physician.

9.2.69.4 Multiple Sleep Latency Test (MSLT)

Multiple sleep latency test (procedure code 95805) is limited to one per day and two per rolling year by any provider, and is restricted to the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
E662	F5104	F5105	G2581	G4700	G4701	G4709	G4730
G47411	G47419	G47421	G47429	G4753	G4761		

Claims denied for more than two times per year may be appealed with documentation of medical necessity.

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Documentation of MSLT must be maintained in the client's medical record at the sleep facility and include a hard copy or electronic copy of four to five 20-minute recordings of sleep-wake states and stages spaced at two-hour intervals throughout the day, taking approximately seven to nine hours to complete. In addition, documentation must include the physiological recordings typically made during daytime testing. These typically include:

- EEG
- Electro-oculogram (EOG)
- EMG
- EKG
- Audio and video recordings made during the monitored portion of the day

Documentation must also include the technologist's analysis and report, the client's subjective report, and the influence of intervention applied during the night.

Interpretation and treatment recommendations must be completed by a sleep specialist. The physician's interpretation and report must include inspection of the entire recording, examination of the technologist's analysis and observations, and integration of the information gathered from all physiological systems. Documentation of the interpretation must be maintained in the sleep facility and by the interpreting physician.

MSLT procedure code 95805 must be performed in conjunction with polysomnography procedure code 95782, 95783, 95808, 95810, or 95811. Polysomnography must be performed on the date before MSLT. MSLT that is not performed in conjunction with polysomnography will be denied, but may be considered on appeal with documentation that explains why the polysomnography did not occur.

9.2.69.5 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 American Academy of Sleep Medicine (AASM) practice parameters and clinical guidelines.

Home sleep study testing is a benefit of Texas Medicaid 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 Texas Medicaid 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.

9.2.69.6 Sleep Facility Restrictions for Polysomnography and Multiple Sleep Latency Testing

Sleep facilities that perform services for Medicaid clients must be accredited with the AASM or the Joint Commission of Accreditation of Healthcare Organizations (JCAHO). Sleep facilities must maintain documentation with proof that the facility is accredited. Documentation is subject to retrospective review. Sleep facilities that perform services for Texas Medicaid clients must also follow current AASM practice parameters and clinical guidelines.

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Physicians who provide supervision in sleep facilities must be board-certified or board-eligible, as outlined in the AASM guidelines.

Sleep facility technicians, technologists, and trainees 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.

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 a 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 provided.*

- A polysomnographic technologist provides comprehensive evaluation and treatment of sleep disorders under the general supervision of the clinical director (MD or DO).
- A polysomnographic technician provides comprehensive polysomnographic testing and analysis and associated interventions under the general supervision of a polysomnographic technologist or clinical director (MD or DO).
- 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.

The sleep facility must have one or more supervising physicians who are responsible for the direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of equipment used to perform tests, and the qualifications of the nonphysician staff who use the equipment.

Services provided without the required level of supervision are not considered medically appropriate and will be recouped upon retrospective record review.

Claims denied for more than two times per year may be appealed with documentation of medical necessity.

Documentation of MSLT must be maintained in the client's medical record at the sleep facility and include a hard copy or electronic copy of four to five, 20-minute recordings of sleep-wake states and stages spaced at two-hour intervals throughout the day, taking approximately seven to nine hours to complete. In addition, documentation must include the physiological recordings typically made during daytime testing. These typically include:

- EEG
- Electro-oculogram (EOG)
- EMG
- EKG
- Audio and video recordings made during the monitored portion of the day

Documentation must also include the technologist's analysis and report, the client's subjective report, and the influence of intervention applied during the night.

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Interpretation and treatment recommendations must be completed by a sleep specialist. The physician's interpretation and report must include inspection of the entire recording, examination of the technologist's analysis and observations, and integration of the information gathered from all physiological systems. Documentation of the interpretation must be maintained in the sleep facility and by the interpreting physician.

MSLT procedure code 95805 must be performed in conjunction with polysomnography procedure code 95808, 95810, or 95811. Polysomnography must be performed on the date before MSLT. MSLT that is not performed in conjunction with polysomnography will be denied, but may be considered on appeal with documentation that explains why the polysomnography did not occur.

9.2.70 Speech Therapy (ST) Services

Speech therapy (ST) is a payable benefit to physicians.

Refer to: Section 4, "Therapists, Independent Practitioners, and Physicians" in the *Nursing and Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for information about speech therapy services provided by a physician.

9.2.71 Surgery Billing Guidelines

9.2.71.1 Primary Surgeon

A primary surgeon may be reimbursed for services provided in the inpatient hospital, outpatient hospital setting, and ASC/HASC Center.

A surgeon billing for a surgery and an assistant surgery fee on the same day may be reimbursed if two separate procedures are performed.

Refer to: Subsection 9.2.71.7, "Multiple Surgeries," in this handbook.

9.2.71.2 Anesthesia Administered by Surgeon

If the physician bills for a surgical procedure and anesthesia for the same procedure, the surgery is paid and the anesthesia is denied as part of the surgical procedure. The exception to this policy is an epidural during labor and delivery.

Refer to: Subsection 9.2.6, "Anesthesia," in this handbook.

9.2.71.3 Assistant Surgeon

Assistant surgeons may be reimbursed 16 percent of the TMRM fee for the surgical procedures performed.

Medicaid follows the TEFRA regulations for assistant surgeons in teaching hospitals. TEFRA states that an assistant surgeon will not be paid in a hospital classified by Medicare as a teaching facility with an approved graduate training program in the performing physician's specialty. Medicaid may consider reimbursement for an assistant surgeon at a teaching hospital classified by Medicare as a teaching facility with approved graduate training program if one of the following situations is present and documented on the claim:

- No qualified resident was available. (Modifier 82 may be used to document this exception.)
- There were exceptional medical circumstances such as an emergency or life-threatening situation requiring immediate attention (modifiers 80 and KX).
- The primary surgeon has a policy of never, without exception, involving a resident in the preoperative, operative, or postoperative care of a patient (modifiers 80 and KX).
- The surgical procedure was complex and required a team of physicians (modifiers 80 and KX).

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Use of these modifiers is not required but expedites claims processing. Therefore, it is *recommended* that these modifiers be used in conjunction with the procedure code rather than a narrative statement when these specific circumstances exist.

All claims for assistant surgeon services must include in Block 32 of the CMS-1500 paper claim form the name, address, and provider identifier of the hospital in which the surgery was performed. If the physician seeks an exception to this TEFRA regulation based on unavailability of a qualified resident, the following certification statement must appear on or 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."

Surgical procedures that do not ordinarily require the services of an assistant, as identified by Medicare, are denied when billed as an assistant surgery. One assistant surgeon is reimbursed for surgical procedures when appropriate.

Use modifier AS when the physician assistant is not enrolled as an individual provider and provides assistance at surgery. The claim must include the PA's name and license number. Only procedures currently allowed for assistant surgeons are payable.

PAs actively enrolled as a Medicaid provider with an assigned provider identifier may bill assistant surgery services on a separate claim form using the PA's individual provider identifier and modifiers U7 and 80.

9.2.71.4 Bilateral Procedures

When a bilateral procedure is performed and an appropriate bilateral code is not available, a unilateral code must be used. The unilateral code must be billed twice with a quantity of 1 for each code. For all procedures, use modifiers LT (left) and RT (right) as appropriate. For example, bilateral application of short leg cast is billed as follows:

Procedure Code	Modifier
29405	LT
29405	RT

9.2.71.5 Cosurgery

Cosurgery (two surgeons) may be reimbursed when the skills of two surgeons (usually with different skills) are required in the management of a specific surgical procedure. Cosurgery is for a surgery where the two surgeons' separate contributions to the successful outcome of the procedure are considered to be of equal importance.

Note: *No additional reimbursement will be made for an assistant surgeon.*

Cosurgeons may be reimbursed for surgical procedure codes that are billed with modifier 62 if the CMS fee schedule indicates that the procedure allows for cosurgeons. Claims will not suspend for manual review of the documentation of medical necessity. Reimbursement will be calculated at 62.5 percent of the amount allowed for the intraoperative portion of the surgical procedure's fee.

No cosurgery payment is made for claims submitted without modifier 62. In instances where the surgeons do not use modifier 62, the first claim received at TMHP for the service is considered that of the primary surgeon, and the subsequent claim is denied as a previously paid service.

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9.2.71.6 Global Fees

Texas Medicaid uses global surgical periods to determine reimbursement for services that are related to 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

Texas Medicaid adheres 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, any associated services that are provided on the same day of the surgery, and any associated services that are provided for up to 10 days following the date of the surgical procedure.
- 90-day Global Period-Reimbursement includes the surgical procedure, preoperative services that are provided on the day before the surgical procedure, any associated services that are provided on the same day of the surgery, and any associated services that are provided for up to 90 days following the date of the surgical procedure.

Procedure codes that are designated as "Carrier Discretion" will have their global periods determined by HHSC.

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.

Modifiers

For services that are rendered in the preoperative, intraoperative, or postoperative period to be correctly reimbursed, providers must use the appropriate modifiers from the following table. Failure to use the appropriate modifier may result in recoupment.

Modifiers Related to Surgical Fees					
24	25	54	55	56	57
58	62	76	77	78	79

For services that are billed with modifier 54, 55, or 56, medical record documentation must be maintained by both the surgeon and the physician who provides preoperative or postoperative care. Reimbursement for claims associated with modifier 54, 55, or 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.

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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, 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.

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

Preoperative Services

Preoperative physician E/M services (such as office or hospital visits) that are directly related to the planned surgical procedure and provided during the preoperative limitation period will be denied if they are billed by the surgeon or anesthesiologist who was involved in the surgical procedure.

Reimbursement will be considered when the E/M services are performed for distinct reasons that are unrelated to the procedure. E/M services that meet the definition of a significant, separately identifiable service 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 Texas Medicaid 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 the 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 billed with modifier 57. The client's medical record must clearly indicate when the initial decision to perform the procedure was made.

Intraoperative Services

Physicians who perform a surgical procedure with a 10- or 90-day global period but do not render postoperative services must bill the surgical procedure code with modifier 54. Modifier 54 indicates that the surgeon provided the surgical care only. Documentation in the medical record must support the transfer of care and must indicate that an agreement has been made with another physician to provide the postoperative management.

Postoperative services

Postoperative services that are directly related to the surgical procedure are included in the global surgical fee and are not reimbursed separately. Postoperative services include, but are not limited to, all of the following:

- Postoperative follow-up visits (any place of service)
- Postoperative pain management
- Miscellaneous services, including:
  - Dressing changes
  - Local incision care

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- 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 the 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 the postoperative care until after the client has been seen during a face-to-face follow-up visit.*

When a 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 assuming in-hospital postoperative care must bill subsequent care procedure code 99231, 99232, or 99233.
- When the transfer of care occurs after hospital discharge, 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.

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 any 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).*

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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. The submitted documentation must substantiate the reasons for providing E/M services.

- Modifier 24 may be billed with modifier 25 if a significant, separately identifiable E/M service that was performed on the day of a procedure falls within the postoperative period of another unrelated procedure.
- Modifier 24 may be billed with modifier 57 if an E/M service that was performed within the postoperative period of another unrelated procedure results in the decision to perform major surgery.

Return Trips to the Operating Room

Return trips to the operating room for a repeat surgical procedure on the same part of the body may be considered for reimbursement when billed with modifiers 76 and 77. Billing with modifier 76 or 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 must 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.

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- 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.

9.2.71.7 Multiple Surgeries

Medicaid payment for multiple surgeries is based on the following guidelines:

- When two surgical procedures are performed on the same day at the same operative session, the primary procedure (such as the higher paying procedure) is paid at the full TMRM allowance. Secondary procedures performed on the same day are paid at half of the TMRM allowance when medically justified.
- Surgical procedures performed at different operative sessions on the same day are paid at the full TMRM allowance for each primary procedure at each session.
- Vaginal deliveries followed by tubal ligations are considered different operative sessions and are paid at full allowance for each primary procedure at a different session (i.e., both vaginal delivery and tubal ligation are paid at full allowance).
- Procedure code 58611 performed in conjunction with a Cesarean section is reimbursed at full allowance in cases where the allowance already represents half of the primary procedure.
- When a surgical procedure and a biopsy on the same organ or structure is done on the same day, the charges will be reviewed and reimbursement will be made only for the service with the higher of the allowed amounts.

9.2.71.8 Office Procedures

CMS has identified certain surgical procedures that are more appropriately performed in the office setting rather than as outpatient hospital, ASC/HASC procedures. The following list of surgical procedure codes should be billed in POS 1 (physician's office). The medical necessity and/or special circumstances that dictate that these surgical procedures be performed in a POS other than the office must be documented on the claim. These surgical procedures are evaluated on a retrospective basis that may cause recoupment and/or adjustment of the original claim payment. This list is not all inclusive.

Procedure Codes		
Excision benign lesions	**Excision malignant lesions**	**Manipulation (urethral)**
11400	11600	53600
11401	11601	53601
11402	11602	53620
11403	11603	53621
11404	11604	53660
11420	11620	53661
11421	11621	
11422	11622	
11423	11623	
11440	11624	
11441	11640	
11442	11641	

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Procedure Codes		
11443	11642	
11444	11643	
	11644	
Simple repairs	**Endoscopy**	**Biopsy (tongue)**
28010	31505	41100
28011		
Lesions (penile)	**Lesions (eyelid)**	
54060	67801	

9.2.71.9 Orthopedic Hardware

Reimbursement for the orthopedic hardware (e.g., buried wire, pin, screw, metal band, nail, rod, or plate) is part of the surgeon's global fee or the facility's payment group. The hardware is not reimbursed separately to either the surgeon or the facility.

The removal of orthopedic hardware is not payable to the same provider who inserted it, if removed within the global operative care period of the original insertion.

Services for removal of orthopedic hardware may be reimbursed separately after the global post operative care period.

9.2.71.10 Second Opinions

Texas Medicaid benefits include payment to physicians when eligible clients request second opinions about specific problems. The claim must be coded with the appropriate office or hospital visit codes, and the notation "Client Initiated Second Opinion" should be identified in Block 24D of the CMS-1500 paper claim form.

Refer to: Subsection 9.2.58.1.3, "Consultation Services," in this handbook.

9.2.71.11 Supplies, Trays, and Drugs

Payment to physicians for supplies is not allowed under Texas Medicaid. All supplies, including anesthetizing agents, inhalants, surgical trays, or dressings are included in the surgical payment on the day of surgery when the surgery is performed in the office or home setting.

Reimbursement for office visits includes overhead for supplies. If any of these items are submitted separately, they are denied as included in the surgical fee. If the supplies are submitted with a place of service (POS) other than the office, these supplies are denied as services that must be billed by the hospital, or as services that are included in nursing facility charges.

Silver nitrate applicators, used to treat granulated tissue around gastrostomy tubes and tracheostomies, are considered part of the office/hospital visit. Silver nitrate applicators are not a benefit for home use.

9.2.72 Telemedicine Services

Telemedicine services are a benefit of Texas Medicaid.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for information about telemedicine services.

9.2.73 Therapeutic Apheresis

The following conditions must be met for therapeutic apheresis:

- To perform the medical services, including all nonphysician services, and to respond to medical emergencies at all times during client care, direct supervision by a physician is required.

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- Each client must be under the care of a physician.

Procedure codes 36511, 36512, 36513, 36514, 36515, and 36516 are limited to the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
C880	C882	C883	C888	C9000	C9002	C9010	C9011
C9012	C9020	C9021	C9022	C9030	C9031	C9032	C9100
C9101	C9102	C9110	C9111	C9112	C9130	C9131	C9132
C9140	C9141	C9142	C9150	C9151	C9152	C9160	C9161
C9162	C9190	C9191	C9192	C91A0	C91A1	C91A2	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
C9332	C9391	C9392	C93Z0	C93Z1	C93Z2	C9400	C9401
C9402	C9420	C9421	C9422	C9430	C9431	C9432	C9440
C9441	C9442	C9480	C9481	C9482	C9500	C9501	C9502
C9510	C9511	C9512	C9590	C9591	C9592	D45	D472
D473	D474	D5700	D5701	D5702	D571	D5720	D57211
D57212	D57219	D57412	D5780	D57811	D57812	D57819	D588
D589	D590	D591	D592	D593	D594	D599	D6182
D65	D682	D68311	D6851	D6852	D6859	D6861	D6862
D6869	D688	D690	D691	D692	D693	D6941	D6942
D6949	D696	D698	D699	D72828	D732	D740	D748
D749	D750	D751	D7589	D759	D761	D762	D763
D77	D890	D892	E0842	E0942	E1042	E1142	E780
G603	G610	G6181	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	K767	K7689
K77	K8041	K8043	K8045	K8047	K8061	K8063	K8065
K8081	L100	L101	L102	L103	L104	L105	L1081
L1089	L109	L900	L940	L941	L943	M05011	M05012
M05021	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	M083	M08411	M08412	M08421	M08422

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
M08431	M08432	M08441	M08442	M08451	M08452	M08461	M08462
M08471	M08472	M0848	M08832	M08841	M08842	M08851	M08852
M08861	M08931	M08932	M08941	M08942	M08951	M08952	M08961
M08962	M310	M311	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	N010
N011	N012	N013	N014	N015	N016	N017	N018
N032	N034	N035	N037	N040	N042	N044	N045
N047	N048	N049	N052	N054	N055	N058	N059
N08	N171	N172	T8690	T8691	T8692	T8693	T8699

Procedure codes 36515 and 36516 may be considered for reimbursement when billed for the low density lipoprotein (LDL) apheresis (such as *Liposorber* LA 15) or the protein A immunoadsorption (such as *Prosorba*) columns.

The protein A immunoadsorption column is indicated for use in either of the following cases:

- Clients who have a platelet count of less than 100,000 mm3.
- Adult clients who have signs and symptoms of moderate to severe rheumatoid arthritis with long-standing disease who have failed, or are intolerant to, DMARDs.

The LDL apheresis column is indicated for use in clients who have severe familial hypercholesterolemia whose cholesterol levels remain elevated despite a strict diet and ineffective or untolerated maximum drug therapy. Coverage is considered for the following high-risk population, for whom diet has been ineffective and maximum drug therapy has either been ineffective or not tolerated:

- Functional hypercholesterolemia homozygotes with LDL-C > 500 mg/dL.
- Functional hypercholesterolemia heterozygotes with LDL-C > 300 mg/dL.
- Functional hypercholesterolemia heterozygotes with LDL-C > 200 mg/dL and documented coronary heart disease.

Baseline LDL-C levels are to be obtained after the client has had, at a minimum, a six-month trial on an American Heart Association (AHA) Step II diet or equivalent and maximum tolerated combination drug therapy designed to reduce LDL-C. Baseline lipid levels are to be obtained during a two- to four-week period and should be within 10 percent of each other, indicating a stable condition.

Therapeutic apheresis using the LDL apheresis column may be reimbursed for diagnosis code E780.

Apheresis services represents one 30-minute time interval of personal physician involvement in the apheresis. Apheresis is limited to three 30-minute time intervals per procedure. The actual time must be reflected on the claim, or a unit of 1, 2, or 3 must be indicated. If the time (or unit) is not indicated, payment is based on one 30-minute time interval.

Apheresis is denied for all other diagnosis codes. Other diagnosis codes can be reviewed by the TMHP Medical Director or designee on appeal with documentation of medical necessity.

Laboratory work before and during the apheresis procedure is covered when apheresis is performed in the outpatient setting (POS 5). Laboratory work billed in conjunction with apheresis performed in the inpatient setting (POS 3) is included in the DRG reimbursement and is not paid separately.

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9.2.74 Therapeutic Phlebotomy

Therapeutic phlebotomy is a treatment whereby a prescribed amount of blood is withdrawn for medical reasons. Conditions that cause an elevation of the red blood cell volume or disorders that cause the body to accumulate too much iron may be treated by therapeutic phlebotomy.

Therapeutic phlebotomy is a benefit of Texas Medicaid and may be billed using procedure code 99195. This procedure code should be used only for the therapeutic form of phlebotomy and not for diagnostic reasons.

Reimbursement of therapeutic phlebotomy is limited to the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
D45	D649	D750	D751	E800	E801	E8020	E8021
E8029	E8310	E83110	E83118	E8319	P611		

Therapeutic phlebotomy will autodeny for all other diagnosis codes.

9.2.75 Therapeutic Radiopharmaceuticals

Therapeutic radiopharmaceuticals, when used for therapeutic treatment, are a benefit of Texas Medicaid.

The following procedure codes may be submitted for therapeutic radiopharmaceuticals:

Procedure Codes									
79403	A9542	A9543	A9544	A9545	A9563	A9564	A9600	A9699	G3001

9.2.75.1 Prior Authorization for Therapeutic Radiopharmaceuticals

Prior authorization is not required for therapeutic radiopharmaceuticals except for tositumomab or ibritumomab tiuxetan.

Tositumomab or ibritumomab tiuxetan may be prior authorized when all of the following criteria are met:

- Client has a diagnosis of either a low-grade follicular or transformed B-cell non-Hodgkin's lymphoma.
- Client has failed, relapsed, or become refractory to conventional chemotherapy and the following is documented:
  - Marrow involvement is less than 26 percent.
  - Platelet count is 100,000 cell/mm3 or greater.
  - Neutrophil count is 1,500 cell/mm3 or greater.
- Client has failed a trial of rituximab.

Prior authorization must be submitted through Special Medical Prior Authorization department.

Only one tositumomab or ibritumomab tiuxetan (procedure codes A9542, A9543, A9544, and A9545) may be prior authorized and reimbursed once per lifetime, any provider with one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
C8259	C8399	C8499	C84A9	C84Z9	C8519	C8529	C8589
C8599							

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9.2.75.2 Other Limitations on Therapeutic Radiopharmaceuticals

Strontium-89 chloride (procedure code A9600) may be reimbursed when submitted with diagnosis code C7951 or C7952.

Strontium-89 chloride is limited to a total of 10 mci intravenously injected every 90 days, any provider, and may be reimbursed one per day same provider.

Sodium phosphate P-32, therapeutic (procedure code A9563) may be reimbursed when submitted with the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
C7951	C7952	C9110	C9112	C9192	C91Z2	C9292	C92Z2
C9512	C9592	D45					

Chromic phosphate P-32 suspension (procedure code A9564) may be reimbursed when submitted with diagnosis codes C782 and C786.

An appropriate modifier may be used when billing for services more than once per day, same provider.

9.2.76 Urethral Dilation

If urethral dilation (procedure code 53600, 53601, 53605, 53620, 53621, 53660, 53661, or 53665) is billed on the same date of service by the same provider as procedure code 52000, the charges will be combined and processed as procedure code 52281.

Urethral dilation will be denied when billed on the same date of service by the same provider as any other cystoscopy.

9.2.77 Ventilation Assist and Management for the Inpatient

Use the following procedure codes and guidelines for reimbursement of ventilation assist and management: 94002 and 94003. Procedure codes 94002 and 94003 may be reimbursed only when the client is in observation or inpatient status. Respiratory care billed in any other POS will be denied.

Use the ventilation assist and management subsequent code (procedure code 94003) when respiratory support must be established for a patient in the postoperative period in the hospital (POS 3). Subsequent days of ventilation assistance are payable when documentation indicates a respiratory problem.

When the use of a ventilator is required as part of a major surgery, initial ventilation assist and management will be denied. It should be billed as ventilation assist and management subsequent procedure code 94003.

Procedure codes 94002 and 94003 apply only to hospital care for critically ill patients. They do not apply to routine recovery room ventilation services. Separate support service charges billed on the same day as ventilatory support are denied (for example, arterial or venous punctures; interpretations of arterial blood gases; or pulmonary function tests and management of the hemodynamic functions of the patient).

Use ventilation assist and management and initiation of pressure or volume preset ventilators for assisted or controlled breathing–first day (procedure coed 94002) when respiratory support must be established for a patient. It is a *one-time charge* per hospitalization that may be paid when the claim documents that a respiratory problem exists (for example, respiratory distress, asphyxia). After the first day, use subsequent days (procedure code 94003).

9.2.78 Wearable Cardiac Defibrillator (WCD)

A WCD (procedure codes 93292, 93745, and K0606) are a benefit of Texas Medicaid.

The rental of a WCD (procedure code K0606) is limited to once per month and must be submitted with modifier RR.

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Modifier 25 may be used to identify a significant separately identifiable evaluation and management service performed (for example, different diagnosis) on the same day as the initial set up of a WCD by the same provider for the same client. 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 Texas Medicaid upon request.

Procedure code 93292 will be denied as part of procedure code 93745 when submitted on the same date of service by any provider.

Procedure codes 93000, 93005, 93010, 93040, 93041, and 93042 will be denied as part of procedure code 93745 when submitted on the same date of service by any provider.

9.2.78.1 * Prior Authorization for WCD

Prior authorization is required for the rental of WCD (procedure code K0606).

The WCD may be prior authorized for clients at high-risk of sudden cardiac arrest who meets one of the following criteria:

- Has completed electrophysiologic studies to determine the type of arrhythmia present and confirm that a wearable cardiac defibrillator is the best course of treatment.
- Is contraindicated for an implantable cardiac defibrillator (ICD) at the current time, such as with a systemic infection.
- Is waiting for ICD implantation.
- Is waiting for ICD implantation and is undergoing treatment for a systemic infection.
- Has had an ICD explantation due to pocket infection.
- Is waiting for heart transplantation.
- Has self-limiting arrhythmias from iatrogenic (drug loading with potentially pro-arrhythmic medications) or other causes.
- Has a familial or inherited condition with a high risk of life-threatening ventricular tachyarrhythmias, such as long QT syndrome or hypertrophic cardiomyopathy.
- Has had either documented prior myocardial infarction or dilated cardiomyopathy and a measured left ventricular ejection fraction (LVEF) less than or equal to 35 percent.
- Has received a documented diagnosis of any one of the following conditions:
  - Clinically inducible hemodynamically significant ventricular tachycardia (HSVT) or ventricular fibrillation (VF), where drug treatment has been ineffective, or the side effects of the medication used to treat the arrhythmia are intolerable.
  - Inducible VT or VF despite endocardial ablation or surgical excision when drug therapy has failed.
  - VF or syncopal ventricular tachycardia.
  - Specific ST-T wave changes, borderline CPK-MB isoenzymes, and dangerous ventricular arrhythmias are exhibited in a postmyocardial infarction patient.
  - VT caused by ischemic heart disease not associated with an acute myocardial infarction, and where drug therapy or surgical therapy has failed.
  - Recurrent syncope of undetermined etiology in a patient with HSVT or VF induced by EPS in whom no effective or tolerated drug is available or appropriate. Symptoms must be linked to HSVT or VF.

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- Recurrent syncope of undetermined etiology with positive EPS studies where ventricular arrhythmia is documented as the cause.
- Palliative treatment for VT or VF in clients awaiting heart transplant.

The WCD is contraindicated in clients with an active ICD and should not be used in clients who meet the following criteria:

- Have a vision or hearing problem that may interfere with the perception of alarms or messages from the WCD.
- Is taking medications that would interfere with responding to the alarms or message from the WCD by depressing buttons.
- Is unwilling or unable to wear the device continuously, except when bathing or showering.
- Is pregnant or breastfeeding.
- Is of childbearing age and is not attempting to prevent pregnancy.

The WCD is considered investigational and not medically necessary for all other indications, including but not limited to, the following:

- Clients with drug-refractory class IV congestive heart failure who is not candidates for heart transplantation.
- Clients who have a history of psychiatric disorders that interfere with the necessary care and follow-up.
- Clients in whom a reversible triggering factor for VT/VF can be definitely identified, such as ventricular tachyarrhythmias in evolving acute myocardial infarction or electrolyte abnormalities.
- Clients with terminal illnesses.

A completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form (Title XIX Form) prescribing the DME and/or medical supplies must be signed and dated by the prescribing physician familiar with the client prior to requesting authorization.

- The completed Title XIX Form must be maintained by the requesting provider and the prescribing physician. The original signature copy must be kept in the physician's medical record for the client.
- The completed Title XIX Form must include the procedure codes and quantities requested for the services.

To complete the prior authorization process the provider must submit the completed Title XIX Form by fax to the Home Health Unit at 1-512-514-4209 or in writing to the following address:

Texas Medicaid & Healthcare Partnership
Home Health Services
PO Box 202977
Austin, TX 78720-2977

When a WCD is not covered as a home health service, it may be considered for reimbursement through the CCP for clients who are 20 years of age and younger. All of the following criteria must be met for CCP reimbursement for a WCD:

- The client is eligible for CCP benefits.
- The documentation submitted with the request supports the determination of medical necessity based on the criteria listed in the policy.
- Federal financial participation is available.
- The client's cardiac status would be compromised without the requested equipment.

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- The requested equipment is safe in the home setting.

Rental of an automatic external defibrillator, with integrated electrocardiogram analysis, garment type (procedure code K0606) may be prior authorized (initially for up to three months) with documentation supporting the medical necessity and appropriateness of the device.

The provider may be reimbursed only for the length of time the device is used even though the authorization for the rental may be for a longer period of time.

The rental of the device includes the monitor, electrode belt (four sensors or electrodes and three treatment pads), garment, two rechargeable batteries, a battery charger and modem.

The purchase of a replacement battery (procedure code K0607), the purchase of a garment (procedure code K0608), and electrodes (procedure code K0609) will be considered part of the rental.

Prior authorization extensions for WCDs beyond the initial three-month rental may be considered by the medical director when documentation supports continued medical necessity for the device. Providers must submit new documentation to support continued medical necessity for an extension of the rental to be considered.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation for medical necessity of the device. 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 WCD.

Retrospective review may be performed to ensure documentation supports the medical necessity of the service when billing the claim.

9.2.79 Wound Care Management

Wound care management includes the care of acute and chronic wounds, which include, but are not limited to, open ulcers (venous pressure or diabetic ulcers), fistulas, or erosion of skin related to cancer. Acute and chronic wounds are defined as the following:

- Acute wounds: Wounds taking less than 30 days for complete healing
- Chronic wounds: Wounds taking more than 30 days for complete healing

Wound care includes the following:

- Optimization of nutritional status
- Debridement by any means to remove devitalized tissue
- Maintenance of a clean, moist bed of granulation tissue
- Necessary treatment to resolve any infection that may be present

For clients with an ulcer, wound care may include the following:

- Frequent repositioning of a client who has a pressure ulcer
- Off-loading pressure and good glucose control for a client who has a diabetic ulcer
- Establishment of adequate circulation for a client who has an arterial ulcer
- Use of a compression system for clients who have a venous ulcer

Wound care management includes first- and second-line therapies. First-line wound care is used for acute wounds. If the wound does not improve with first-line treatment, adjunctive second-line therapy may be used. Measurable signs of improved healing include the following:

- A decrease in wound size, either in surface area or volume
- A decrease in amount of exudate

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- A decrease in amount of necrotic tissue

Wound care must be performed by a licensed health professional who is qualified to safely and effectively provide the medically necessary care. Providers are expected to exercise their clinical judgment to render the most appropriate care in accordance with their scope of practice as designated by their regulatory and governing boards.

The following services are not a benefit of Texas Medicaid:

- 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

9.2.79.1 First-Line Wound Care Therapy

First-line wound care therapy includes the following:

- Cleansing, antibiotics, and pressure off-loading
- Compression
- Debridement
- Dressing
- Whirlpool for burns

9.2.79.1.1 Cleansing, Antibiotics, and Pressure Off-loading

Wound cleansing helps to create an optimal healing environment and decreases the potential for infection by loosening and removing cellular debris and residual topical agents from previous dressings.

Wound cleansing agents may include normal saline, commercial wound cleansers, providone iodine, hydrogen peroxide, or sodium hydrochlorite. Cleansing solutions and methods vary based on effectiveness and individual client needs.

Systemic or topical antibiotics may be used to prevent or treat wound infections and to aid in the healing of wounds.

Pressure off-loading devices, such as pillows, boots, mattresses, and protectors, may also be used as part of first-line wound care therapy to prevent or relieve pressure on the wound.

9.2.79.1.2 Compression

Compression performed as a part of wound care management is a benefit and may be reimbursed when billed with procedure code 29580.

9.2.79.1.3 Debridement

Wound debridement includes the pre-debridement wound assessment, the debridement, and the post-procedure instructions provided to the client on the date of service.

Selective debridement consists of the following:

- Conservative sharp debridement
- High-pressure lavage to selected areas

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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							

The procedure code submitted on the claim (and authorization request, if applicable) 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.

Prior authorization is required for non-emergent wound debridement procedure codes 11042, 11043, and 11044. A request for prior authorization must be submitted to TMHP with the Special Medical Prior Authorization (SMPA) Request Form before the procedure is performed. Providers must retain a copy of the signed and dated form in the client's medical record at the provider's place of business. The requesting provider may be asked for additional information to clarify or complete a request for the equipment/supply requested.

Requests for prior authorization for wound debridement procedure codes 11042, 11043, and 11044 must include the following documentation:

- Location of the wound
- Characteristics of the wound, including:
  - Dimensions (diameter and depth)
  - Drainage (amount and type)
  - Related signs and symptoms (swelling, pain, inflammation)
  - Presence of necrotic tissue/slough
- Wound care treatment plan

For procedure codes 11043 and 11044, at least one of the following conditions must be present and documented:

- Stage III or IV wounds
- Venous or arterial insufficiency ulcers
- Dehisced wounds or wounds with exposed hardware or bone
- Neuropathic ulcers
- Complications of surgically created or traumatic wound where accelerated granulation therapy is necessary but cannot be achieved by other available topical wound treatment

Wound debridement procedure codes 11042, 11043, and 11044 are not appropriate and will not be approved for the following:

- Washing bacteria or fungal debris from the feet

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- 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

Retroactive authorization is required for wound debridement procedure codes 11042, 11043, and 11044 that are performed on an urgent or emergent basis. The provider must submit a request for retroactive authorization within 14 calendar days, beginning the day after the procedure is performed.

9.2.79.1.4 Dressings and Metabolically Active Skin Equivalents

Wound dressings may include wet and dry dressings.

Dressings applied to the wound are considered part of the service for wound debridement. Metabolically active skin equivalents used in wound care may be considered separate benefits, in addition to the wound debridement procedure. The following procedure codes are a benefit for metabolically active skin equivalents provided in the office setting:

Procedure Codes									
C9250	Q4100	Q4101	Q4102	Q4103	Q4104	Q4105	Q4106	Q4107	Q4108
Q4110	Q4111	Q4112	Q4113	Q4114	Q4115	Q4116	Q4119	Q4120	Q4121
Q4122	Q4123	Q4124	Q4126	Q4127	Q4128	Q4129	Q4130	Q4131	Q4134
Q4135	Q4136	Q4137	Q4138	Q4140	Q4142	Q4143	Q4146	Q4147	Q4148
Q4149									

The client's medical record must include documentation that wound treatments with metabolically active skin equivalents or skins substitutes are accompanied by appropriate adjunctive measures, and must identify the adjunctive therapies being provided to the client as part of the wound treatment regimen.

Prior authorization is required for unspecified skin substitute procedure code Q4100. When requesting prior authorization for procedure code Q4100, providers must submit the Special Medical Prior Authorization (SMPA) Request Form and the following information with the request:

- The client's diagnosis
- Characteristics of the wound, including:
  - Location
  - Dimensions (diameter and depth)
  - Drainage (amount and type)
  - Related signs and symptoms (swelling, pain, inflammation)
  - Presence of necrotic tissue/slough
- Medical records that indicate prior treatment for the diagnosis, the medical necessity of the requested skin substitute, and the wound care treatment plan
- A clear, concise description of the skin substitute to be applied and the reason for recommending this particular item
- A CPT or HCPCS procedure code that is comparable to the requested procedure

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- Documentation that demonstrates that the requested procedure is not investigational or experimental
- The place of service in which the requested procedure will be performed
- The physician's intended fee for the requested procedure

9.2.79.1.5 Whirlpool for Burns

Whirlpool may be a benefit when used as first-line wound care therapy for the treatment of burn wounds.

9.2.79.2 Second-Line Wound Care Therapy

Second-line wound care therapy is limited to chronic Stage III or IV wounds and may be covered 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 medial condition.

Second-line wound care therapy includes the following:

- Whirlpool
- Irrigation, including pulsatile jet irrigation

9.2.79.2.1 Whirlpool

Whirlpool is a nonselective hydrotherapy used in the second-line treatment of chronic wounds that may be used in combination with other therapeutic treatments. Whirlpool generates water movement, which produces massage of body areas that impacts surface circulation and loosens nonviable tissue.

9.2.79.2.2 Pulsatile-Jet Irrigation

Pulsatile-jet irrigation is a benefit for the treatment of Stage III or IV wounds when other forms of treatment have failed. Removal of devitalized tissue using pulsatile-jet irrigation may be reimbursed when claims are submitted for procedure code 97597 or 97598.

9.2.79.3 Documentation Requirements

For all wound care management services, documentation that supports the medical necessity of the service must be maintained in the client's medical records, including the following information:

- Accurate diagnostic information that pertains to the underlying diagnosis and condition as well as any other medical diagnoses and conditions, which include the client's overall health status.
- Appropriate medical history related to the current wound, including the following:
  - Wound measurements, which includes length, width, and depth, any tunneling and/or undermining
  - Wound color, drainage (type and amount), and odor, if present
  - The prescribed wound care regimen, which includes frequency, duration, and supplies needed
  - Treatment for infection, if present
  - All previous wound care therapy regimens, if appropriate
  - The client's use of a pressure reducing support surface, mattress, and/or cushion, when appropriate

Documentation maintained in the client's medical record must support the level of debridement service provided.

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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.

9.3 Doctor of Dentistry Practicing as a Limited Physician

This section outlines the guidelines for the Doctor of Dentistry practicing as a limited physician. The THSteps dental program is not addressed in these guidelines.

Services by a dentist (DDS or DMD) are covered by Texas Medicaid in accordance with the Omnibus Budget Reconciliation Act (OBRA) of 1987 (public law 100-203), if the services are furnished within the dentist's scope of practice as defined by Texas state law and would be covered under Texas Medicaid when provided by a licensed physician (MD or DO).

Dentist (DDS or DMD) who want to participate as a dentist-physician in Texas Medicaid must be separately enrolled as a Doctor of Dentistry practicing as a limited physician even if they are enrolled in the THSteps Dental Program.

Dual licensure (MD, DO, and DDS) is not required for a dentist to enroll as a limited physician. Medicare enrollment is required for a dentist to enroll as a limited physician.

9.3.1 Prior Authorization for General Dental Services Due to Life-Threatening Medical Condition

Reimbursement for general dental services by any provider, irrespective of the medical or dental qualifications of the provider, is not a Medicaid benefit for Medicaid clients who are 21 years of age and older (who do not reside in an ICF-IID facility).

The TMHP Medical Director or designee may allow an exception for a dental condition causally related to a life-threatening medical condition. *Mandatory prior authorization is required* and the dental diagnoses *must* be secondary to a life-threatening medical condition.

Examples of dental procedures that may be authorized for a *general dentist* who is enrolled as a *limited physician* are:

- Extractions.
- Alveolectomies (in limited situations).
- Incision and drainage.
- Curettement.

Examples of dental procedures that may be authorized for an *oral and maxillofacial surgeon* who is enrolled as a *limited physician* are:

- Extractions.
- Alveolectomies (in limited situations).
- Incision and drainage.
- Curettement maxillofacial surgeries to correct defects caused by accident or trauma.
- Surgical corrections of craniofacial dysostosis.

Note: *Therapeutic procedures such as restorations, dentures, and bridges are not a benefit of the program and will not be authorized.*

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9.3.1.1 Guidelines for Requesting Mandatory Prior Authorization

The *limited physician* dentist must request the mandatory prior authorization, and the request must include:

- A treatment plan that clearly outlines the dental condition as related to the life-threatening medical condition.
- Narrative describing the current medical problem, client status, and medical need for requested services.
- The client name and Medicaid number.
- The *limited physician* dentist's provider identifier.
- The name and address of the facility.
- CPT procedure codes.
- The history and physical.
- The *limited physician* dentist's signature.

Note: *The "limited physician" dentist who will perform the procedure(s) must submit the request for prior authorization.*

All supporting documentation must be included with the request for authorization. Providers are to send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax: 1-512-514-4213

9.3.2 Benefits and Limitations

Dental procedure codes and their corresponding CPT procedures may not be billed on the same date of service by any provider.

Cosmetic procedures are not a benefit of Texas Medicaid. Certain procedure codes, including, but not limited to, the procedure codes in the following table, may be considered cosmetic and are not a benefit except when the procedure is performed as a result of trauma or injury for the purpose of:

- Reconstructing tissues/body structures.
- Repairing damaged tissues.

Procedure Codes									
11950	11951	11952	11954	11970	15780	15781	15786	15787	15788
15789	15838	15876	21089	21497	41820	41821	41828	61501	Q3031

9.3.2.1 Additional Payable Procedure Codes

The following procedure codes are a benefit when prior authorized and the dentist is qualified and licensed to perform the procedures:

Procedure Codes									
Surgery									
10021	10022	10060	10061	10120	10121	10140	10160	10180	11000
11001	11010	11011	11012	11042	11043	11044	11045	11046	11047

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Procedure Codes									
11100	11101	11200	11201	11305	11306	11307	11308	11310	11311
11312	11313	11420	11421	11422	11423	11424	11426	11440	11441
11442	11443	11444	11446	11620	11621	11622	11623	11624	11626
11640	11641	11642	11643	11644	11646	11900	11901	11950	11951
11952	11954	11960	11970	11971	12001	12002	12004	12005	12006
12007	12011	12013	12014	12015	12016	12017	12018	12020	12021
12031	12032	12034	12035	12036	12037	12051	12052	12053	12054
12055	12056	12057	13120	13121	13122	13131	13132	13133	13151
13152	13153	13160	14020	14021	14040	14041	14060	14061	14301
14302	15004	15005	15115	15116	15120	15121	15135	15136	15155
15156	15157	15240	15241	15260	15261	15275	15276	15277	15278
15574	15576	15620	15630	15732	15740	15750	15756	15757	15758
15760	15770	15780	15781	15782	15783	15786	15787	15788	15789
15792	15793	15819	15820	15821	15822	15823	15838	15850	15851
15852	15876	16020	16025	16030	17000	17003	17004	17106	17107
17108	17110	17111	17250	17270	17271	17272	17273	17274	17276
17280	17281	17282	17283	17284	17286	20005	20100	20200	20205
20220	20240	20520	20525	20550	20551	20552	20600	20604	20605
20606	20615	20650	20660	20661	20670	20680	20690	20692	20693
20694	20696	20697	20900	20902	20910	20912	20920	20922	20926
20955	20956	20957	20962	20969	20970	20972	20973	20999	21010
21011	21012	21013	21014	21015	21016	21025	21026	21029	21030
21031	21032	21034	21040	21044	21045	21046	21047	21048	21049
21050	21060	21070	21073	21076	21079	21080	21081	21082	21083
21085	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	21310	21315	21320	21325	21330	21335	21336	21337	21338
21339	21340	21343	21344	21345	21346	21347	21348	21355	21356
21360	21365	21366	21385	21386	21387	21390	21395	21400	21401
21406	21407	21408	21421	21422	21423	21431	21432	21433	21435
21436	21440	21445	21450	21451	21452	21453	21454	21461	21462
21465	21470	21480	21485	21490	21495	21497	21499	21501	21550
21552	21554	21555	21556	21558	21685	29800	29804	29999	30000
30020	30120	30124	30125	30150	30160	30200	30300	30310	30400
30410	30420	30430	30435	30450	30460	30462	30465	30520	30580

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Procedure Codes									
30600	30620	30630	30801	30802	30901	30903	30905	30906	30930
30999	31020	31030	31032	31080	31081	31084	31085	31086	31087
31225	31230	31600	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	41135	41140	41145	41150	41153
41155	41250	41251	41252	41500	41510	41520	41599	41800	41805
41806	41820	41821	41822	41823	41825	41826	41827	41828	41830
41850	41870	41872	41874	41899	42000	42100	42104	42106	42107
42120	42140	42145	42160	42180	42182	42200	42205	42210	42215
42220	42225	42226	42227	42235	42260	42280	42281	42299	42300
42305	42310	42320	42330	42335	42340	42400	42405	42408	42409
42410	42415	42420	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	42842	42844
42845	42890	42892	42894	42900	42950	42960	42961	42962	42970
42999	61501	61559	61575	61576	61580	61581	61584	61586	61590
61592	62147	64400	64402	64600	64612	64722	64736	64738	64740
67900	67914	67915	67916	67917	67921	67922	67923	67924	67930
67935	67950	67961	92511						
Injections/Medications									
90284	96360	96361	96369	96370	96372	96374	J0120	J0171	J0280
J0290	J0295	J0330	J0360	J0475	J0558	J0561	J0670	J0690	J0692
J0694	J0696	J0697	J0698	J0702	J0710	J0715	J0720	J0744	J0780
J0945	J1020	J1030	J1040	J1094	J1100	J1165	J1170	J1200	J1364
J1459	J1557	J1559	J1561	J1566	J1568	J1569	J1572	J1599	J1630
J1631	J1700	J1710	J1720	J1730	J1790	J1800	J1810	J1840	J1850
J1885	J1890	J1940	J1990	J2010	J2060	J2175	J2180	J2360	J2370
J2400	J2410	J2460	J2510	J2515	J2540	J2550	J2560	J2650	J2690
J2700	J2765	J2770	J2800	J2810	J2920	J2930	J2970	J3000	J3010
J3260	J3301	J3302	J3303	J3310	J3320	J3360	J3370	J3410	J3430
J3480	J3485	J3490	J3520	S0021					
Pathology									
88305	88331	88332							

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9.3.2.2 Immune Globulin by a Doctor of Dentistry as a Limited Physician

A Doctor of Dentistry Practicing as a Limited Physician may be reimbursed for immune globulin injection procedure code J1571 when billed with one of the following diagnosis codes:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
D611	D612	D613	D619	D804	D805	D838	D8982
D8989	G7000	N19	Z205	Z206	Z20828		

9.3.2.3 Radiographs by a Doctor of Dentistry Practicing as a Limited Physician

When a Doctor of Dentistry Practicing as a Limited Physician uses appropriate radiograph equipment to produce required radiographs, the following procedure codes are eligible for reimbursement:

Procedure Codes									
70100	70110	70120	70130	70140	70150	70160	70190	70200	70250
70260	70300	70310	70320	70328	70332	70336	70350	70355	70370
70371	70380	70390	73100	70450	70460	70470	70480	70481	70482
70486	70487	70488	70490	70491	70492				

9.3.2.4 Dental Anesthesia by a Doctor of Dentistry Practicing as a Limited Physician

A Doctor of Dentistry Practicing as a Limited Physician who is licensed by the Texas State Board of Dental Examiners (TSBDE) practicing in Texas, who has obtained an Anesthesia Permit from the TSBDE in accordance with Title 22 TAC §§110.1 through 110.9, may be reimbursed for anesthesia services on clients having dental/oral and maxillofacial surgical procedures in the dental office or hospital in accordance with all applicable rules for physician administration and supervision of anesthesia services.

Dentists providing sedation/anesthesia services must have the appropriate permit from TSBDE for the level of sedation/anesthesia provided.

The following anesthesia services are payable to dentists as physician services:

Procedure Codes									
00100	00102	00160	00162	00164	00170	00190	00192	00300	99100
99116	99135	99140							

9.4 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including physician services. Physician services are subject to retrospective review and recoupment if documentation does not support the service billed.

9.5 Claims Filing and Reimbursement

9.5.1 Claims Information

Claims for physician and doctor 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 them.

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 and itemized statements are not accepted as claim supplements.

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Physicians who submit a claim using the physician's own provider identifier for services provided by an NP, CNS, PA, or CNM 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 NP or CNS
- U7 – Services were provided by a physician assistant
- SB – Services were provided by a CNM

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions," in Section 6, "Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

9.5.2 National Drug Codes (NDC)

Refer to: Subsection 6.3.4, "National Drug Code (NDC)," in Section 6, "Claims Filing" (*Vol. 1, General Information*).

9.5.3 Reimbursement

Texas Medicaid rates for physicians and other practitioners are calculated in accordance with TAC §355.8085. Providers can refer to the online fee lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Physicians may be reimbursed 92 percent of the established reimbursement rate for services provided by an NP, CNS, PA, or CNM 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, X-ray services, and injections provided by an NP, CNS, PA, or CNM.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Section 104 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 requires that Medicare/Medicaid limit reimbursement for those physician services furnished in outpatient hospital settings (e.g., clinics and emergency situations) that are ordinarily furnished in physician offices.

Reimbursement for these services will be 60 percent of the Texas Medicaid rate for the service furnished in the physician's office. The following table identifies the services applicable to the 60-percent limitation when furnished in outpatient hospital settings:

Procedure Codes									
99201	99202	99203	99204	99205	99211	99212	99213	99214	99215
99281	99282	99283							

These procedures are designated with note code "1" in the current physician fee schedule, which is available at www.tmhp.com. The following list shows the services excluded from the 60-percent limitation:

- Services furnished in rural health clinics (RHCs).

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- Surgical services that are covered ambulatory surgical center (ASC)/hospital-based ambulatory surgical center (HASC) 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 could reasonably be expected to result in one of the following:
  - Serious jeopardy to the client's health.
  - Serious impairment to bodily functions.
  - Serious dysfunction of any bodily organ or part.

Because of TEFRA, Texas Medicaid reimbursement for a payable nonemergency office service that is performed in the outpatient department of a hospital is limited to 60 percent of Texas Medicaid rate for that service. If the condition qualifies as an emergency or if the client is critically ill or critically injured, the 60 percent professional service reimbursement limit does not apply.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology," in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

Subsection 2.2.1.1, "Non-emergent and Non-urgent Evaluation and Management (E/M) Emergency Department Visits," in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about conditions that are excluded from the 60-percent limitation.

Subsection 9.2.6, "Anesthesia," in this handbook for information on anesthesia services that are reimbursed according to relative value units (RVUs).

9.5.3.1 Affordable Care Act of 2010 (ACA) Rate Increase for Primary Care Services

To qualify for the Affordable Care Act of 2010 (ACA) rate increase for primary care services, a physician must have a specialty designated of general internal medicine, family practice, or pediatrics and must attest to one of the following:

- The provider has a certification recognized by the American Board of Allergy and Immunology (ABAI), American Board of Medical Specialties (ABMS), American Board of Physician Specialties (ABPS), or American Osteopathic Association (AOA) and meets the requirements as required by federal and state regulation to receive the increased payment.
- The provider does not have a certification recognized by the ABAI, ABMS, ABPS, or AOA, but at least 60 percent of the provider's Medicaid billings for the previous calendar year (or for the previous calendar month if the provider has been enrolled in Medicaid for less than one year) were for the evaluation and management (E/M) and vaccine administration procedure codes as published in the final federal and state regulations and the provider meets the requirement to receive payment.

  Note: *New providers with no history of Medicaid billings can attest that 60 percent of their Medicaid billing will be for primary care services.*

Providers can attest using the Texas Medicaid Attestation for ACA Primary Care Services Rate Increases form. ABAI-certified allergists must indicate "ABAI-allergy" in the "List subspecialties" field of the attestation form.

Important: *By signing the form, providers attest that they qualify for the rate increase, and that the increase will be applied to paid claims for primary care services on or after the effective date. Payment of the rate increase may be subject to retrospective review and recoupment if it is*

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determined at a later time that the provider did not qualify for the ACA primary care services rate increase. Federal regulations require states to conduct an annual audit of provider attestations.

Non-physician practitioners who are under the supervision of a provider who has self-attested, are not required to submit a separate provider attestation form. Increased payment may be available to the supervising physician when the following conditions are met:

- The non-physician practitioner renders services under the personal supervision of a provider who has self-attested to meeting the requirements.
- Services are billed under the qualifying provider's provider identification number.

10 Physician Assistant

10.1 Enrollment

To enroll in Texas Medicaid, a PA must be licensed and recognized as a PA by the Texas Physician Assistant Board. Texas Medicaid accepts a signed letter of certification from the Texas Physician Assistant Board as acceptable documentation of appropriate licensure and certification for enrollment. The PA must identify their supervising physician in the appropriate field of the enrollment application.

Providers cannot be enrolled if their license is due to expire within 30 days.

Enrollment as an individual provider is optional. PAs currently treating clients and billing under the supervising physician's provider identifier may continue this billing arrangement.

All PA services must be delivered according to protocols developed jointly within the scope of practice and state law governing PAs.

All providers of laboratory services must comply with the rules and regulations of CLIA. Providers not complying with CLIA are not reimbursed for laboratory services.

PAs may enroll as providers of THSteps medical checkups.

Refer to: Subsection 1.1, "Provider Enrollment and Reenrollment," in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)," in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 5.2, "Enrollment," in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about enrolling as a THSteps provider.

10.2 Services, Benefits, Limitations, and Prior Authorization

Services performed by PAs are covered if the services meet the following criteria:

- Are within the scope of practice for PAs, as defined by Texas state law
- Are consistent with rules and regulations promulgated by the Texas Medical Board or other appropriate state licensing authority
- Are covered by Texas Medicaid when provided by a licensed physician (MD or DO)
- Are reasonable and medically necessary as determined by HHSC or its designee

Services provided to Medicaid clients must be documented in the client's medical record to include the following:

- Services provided

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- Date of service
- Pertinent information about the client's condition supporting the need for service
- The individual practitioner of the service

PAs who are employed or remunerated by a physician, hospital, facility, or other provider must not bill Texas Medicaid 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.

Laboratory (including pregnancy tests) and radiology services provided during pregnancy must be billed separately from antepartum care visits and claims must be received within 95 days from the date of service.

Note: *Payment to providers for supplies is not a benefit of Texas Medicaid. Costs of supplies are included in the reimbursement for office visits.*

Refer to: Section 2, "Medicaid Title XIX Family Planning Services" in the *Gynecological and Reproductive Health and Family Planning Services Handbook* (*Vol. 2, Provider Handbooks*).

Section 9, "Physician" in this handbook.

Section 5, "THSteps Medical" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

10.2.1 Prior Authorization

Services performed by a PA are subject to the same prior authorization guidelines as services performed by other provider types.

10.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including PA services. PA services are subject to retrospective review and recoupment if documentation does not support the service billed.

10.4 Claims Filing and Reimbursement

10.4.1 Claims Information

Claims for PA services must include modifier U7 on the claim details to indicate that the client was treated by a PA.

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

When completing a CMS-1500 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: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions," in "Section 6: Claims Filing" (*Vol.1, General Information*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

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10.4.2 Reimbursement

According to 1 TAC §355.8093, the Medicaid rate for PAs is 92 percent of the rate paid to a physician (MD or DO) for the same professional service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections.

Note: *PA providers who are enrolled in Texas Medicaid as THSteps providers also receive 92 percent of the rate paid to a physician for THSteps services when a claim is submitted with their THSteps provider identifier as the billing provider.*

PAs who bill Medicaid directly for services they perform must use their individual provider identifier. If the services were performed by the PA but billed by a physician or physician group, the billing provider is the physician or physician group. 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. This 92 percent reimbursement rate does not apply to laboratory services, X-ray services, or injections provided by a PA.

Providers can refer to the online fee lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com. To request a hard copy, call the TMHP Contact Center at 1-800-925-9126.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Refer to: Subsection 1.1, "Provider Enrollment and Reenrollment," in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on how to obtain electronic fee schedules from the TMHP website.

11 Claims Resources

Resource	Location
Appendix D: Acronym Dictionary	Appendix D (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	"Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5 (*Vol. 1, General Information*)
Family Planning Claim Form Examples	Section 9, "Claim Form Examples", *Gynecological and Reproductive Health and Family Planning Services Handbook* (*Vol. 2, Provider Handbooks*)
Appendix A: State, Federal, and TMHP Contact Information	Appendix A (*Vol. 1, General Information*)
TMHP Electronic Claims Submission	Subsection 6.2 (*Vol. 1, General Information*)
Section 3: TMHP Electronic Data Interchange (EDI)	Section 3 (*Vol. 1, General Information*)

12 Contact TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.

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13 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Abortion Certification Statements Form
DME Certification and Receipt Form
Hospital Report (Newborn Child or Children) (Form 7484)
Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information
Medicaid Certificate of Medical Necessity for Reduction Mammaplasty
Non-emergency Ambulance Exception Form
Non-emergency Ambulance Prior Authorization Request
Obstetric Ultrasound Prior Authorization Request Instructions
Obstetric Ultrasound Prior Authorization Request
Special Medical Prior Authorization (SMPA) Request Form
Sterilization Consent Form Instructions
Sterilization Consent Form (English)
Sterilization Consent Form (Spanish)
THSteps Dental Mandatory Prior Authorization Request Form
THSteps Dental Criteria for Dental Therapy Under General Anesthesia

14 Claim Form Examples

The following linked claim form examples can also be found on the Claim Form Examples page of the Provider section of the TMHP website at www.tmhp.com:

Claim Form Examples
Anesthesia
Certified Nurse-Midwife (CNM)
Certified Registered Nurse Anesthetist (CRNA)
Chiropractic Services
Dental (Doctor of Dentistry)
Dialysis Training
Genetics
Radiation Therapy
Surgery

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MEDICAL TRANSPORTATION PROGRAM HANDBOOK

TEXAS MEDICAID PROVIDER PROCEDURES MANUAL: VOL. 2

APRIL 2016

TEXAS
Health and Human
Services Commission

MEDICAL TRANSPORTATION PROGRAM HANDBOOK

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1 General Information

The Medical Transportation Program (MTP), under the direction of the Texas Health and Human Services Commission (HHSC), arranges transportation and travel-related services for eligible Medicaid, Children with Special Health Care Needs (CSHCN) Services Program, and Transportation for Indigent Cancer Patients (TICP) clients who have no other means of transportation. MTP is responsible for the prior authorization of all MTP services.

MTP provides for the following general services:

- Mass transit (intercity and intracity): Passes or tickets for client transport within a city and from city to city. Air travel is also an allowable service.
- Demand response transportation: Common carriers such as taxi, wheelchair van, and other transportation according to contractual requirements.
- Mileage reimbursement for enrolled individual transportation provider (ITP): The enrolled ITP can be the responsible party, family member, friend, neighbor, or client.
- Meals: Contracted vendors (e.g., hospital cafeteria).
- Lodging: Contracted hotels and motels.
- Advanced funds: Financial services contractor.
- Attendant: Responsible party, parent/guardian, etc., who accompanies the client to a health-care service.

Under the contract between Texas Medicaid & Healthcare Partnership (TMHP) and MTP, TMHP is responsible for enrollment of providers and processing of MTP provider claims.

MTP contracts with various provider types to arrange transportation and travel-related services for eligible MTP clients and their attendants.

There are three MTP provider types that enroll directly with TMHP:

- ITPs
- Lodging providers
- Meal providers

All other transportation providers arrange enrollment through MTP (e.g., transportation service area providers, client services providers).

1.1 Contacting MTP

If health-care providers have MTP-eligible clients who express difficulty accessing health-care services, advise the clients or their advocates to call the statewide MTP toll-free number at 1-877-633-8747 to request transportation services. MTP clients in the Houston/Beaumont area can call 1-855-687-4786 to request services. Clients in the Dallas/Ft. Worth area can call 1-877-687-3255 to request services. For transportation services within the county where the client lives, clients or their advocates must call the MTP office at least 2 business days before the scheduled appointment. For clients who need to travel beyond the county where they live, clients or their advocates must call the MTP office at least 5 business days before the scheduled appointment.

The client must provide the following information to the intake operator at the time of the call:

- Client name, address, and, if available, the telephone number
- Medicaid, TICP or CSHCN Services Program client identification number (if applicable) or Social Security number, and date of birth

- Name, address, and telephone number of health-care provider and/or referring health-care provider
- Purpose and date of trip and time of appointment
- Affirmation that other means of transportation are unavailable
- Special needs, including wheelchair lift or attendant(s)
- Medical necessity verified by the Health Care Provider's Statement of Need, if applicable
- Affirmation that advance funds are needed in order for the recipient to access health-care services

Note: *Clients must reimburse the department for any advance funds, and any portion thereof, that are not used for the specific prior authorized service.*

2 Individual Transportation Provider (ITP)

ITPs are individuals who volunteer to use their personal vehicle to drive themselves, a friend, or a family member safely to the doctor, dentist, or drug store.

2.1 Enrollment for ITPs

ITPs must follow all rules for enrollment that other providers follow when enrolling with TMHP.

To initiate the enrollment process, the MTP client must contact MTP to request a ride from an individual who is a potential ITP. This request is the first step in the enrollment process for the ITP.

After the client's call, MTP sends the potential ITP's information to TMHP, and TMHP mails the potential ITP an enrollment package. The ITP must fill out the Individual Transportation Provider Enrollment Application and mail it to TMHP with all requested documentation.

The provider must identify the MTP clients they will be transporting and whether they are related to the client. The application packet also includes an Electronic Funds Transfer (EFT) Agreement form that authorizes TMHP to deposit payments directly into a bank account, which results in faster payments.

After the ITP application has been processed, the ITP will receive a letter from TMHP that includes the Atypical Provider Identifier (API) and the Texas Provider Identifier (TPI) to be used when the ITP submits claim forms for mileage reimbursement.

2.2 Prior Authorization for ITPs

Once an ITP is enrolled with TMHP and a client calls MTP to request a ride, MTP will mail a preprinted ITP Service Record (Form H3017) to the MTP client. The H3017 is the form the provider must mail to TMHP to be reimbursed for the ride.

Important: *Only claims that are authorized by MTP will be considered for payment. All claims must be prior authorized to be paid.*

Refer to: Section 5, "Prior Authorization" in this handbook.

2.3 Claims Filing for ITPs

To file a claim, an ITP completes the H3017 form that was sent to the Medicaid client and mails is to TMHP at the following address:

Texas Medicaid & Healthcare Partnership
Claims
PO Box 200555
Austin, TX 78720-0555

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The H3017 includes the following transportation details:

- Date of the ride
- Number of miles authorized
- Prior authorization number
- MTP client's name
- ITP's name.

The H3017 claim form must be signed by the doctor, dentist, or drug store representative that rendered services to the MTP client. This signature stands as proof that the ride authorized by MTP was taken. The ITP must also sign the claim form and include the API and TPI that was assigned to them by TMHP. If any of this required information is missing, the claim will be denied.

The provider must mail the completed claim form to TMHP after the client's authorized ride, but no later than 95 days from the date of the ride. Any claims received by TMHP more than 95 days after the date of the ride will be denied.

An ITP may not charge an MTP client a fee for completing claim forms. TMHP also cannot be charged for the filing of claim forms.

3 Lodging Provider

Lodging providers are businesses that have entered into an enrollment contract to provide hotel/lodging facilities for MTP clients' attendant(s) when authorized by MTP.

3.1 Enrollment for Lodging Providers

Lodging providers must be enrolled with TMHP as an MTP provider to receive reimbursement for claims.

Lodging providers enroll in MTP in one of two ways:

- Providers can download and fill out a paper Lodging Provider Enrollment Application and mail it to TMHP.
- Providers can complete the enrollment process through the Provider Enrollment on the Portal (PEP) application on the TMHP website at www.tmhp.com.

The provider must complete and return the entire provider enrollment application including the Lodging Provider Rate Information Sheet and the Internal Revenue Service (IRS) W-9 Tax Identification form. The enrollment packet contains an EFT form that authorizes direct deposit payments for faster reimbursement; however, completion of the EFT form is not a requirement for enrollment.

Lodging providers can download an application for MTP by visiting the MTP Lodging page on the TMHP website at www.tmhp.com/Pages/MTP/MTP_lodging.aspx.

3.2 Prior Authorization for Lodging Providers

An MTP client must contact MTP to request a lodging stay to initiate the claims process for lodging providers.

When MTP authorizes a request from the client for a lodging stay, the lodging provider will be sent the approved authorization and information including the client's name and the date of stay. Each approved authorization is for one overnight stay and will have a unique authorization number.

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Each overnight stay must be authorized by MTP, and a separate claim form must be submitted to TMHP for each individual overnight stay. It is the lodging provider's responsibility to obtain the MTP client's signature on each authorization form before it is submitted to TMHP.

Refer to: Section 5, "Prior Authorization" in this handbook.

3.3 Claims Filing for Lodging Providers

There are two ways for lodging providers to submit claims to TMHP, including:

- *By paper* using the CMS-1500 paper claim form.

  Refer to: Subsection 6.6, "Paper Claims" in this handbook.

- *Electronically*, using TMHP electronic data interchange (EDI) or the TexMedConnect functionality through the TMHP website.

  Refer to: Subsection 6.5, "Electronic Claims" in this handbook.

Lodging providers may not charge an MTP client a fee for completing claim forms. TMHP also cannot be charged for the filing of claim forms.

4 Meals Provider

4.1 Enrollment for Meals Providers

Meal providers can enroll with TMHP in one of two ways:

- Download and fill out a paper Meal Provider Enrollment Application and mail it to TMHP.
- Complete the enrollment process through the PEP application on the TMHP website at www.tmhp.com.

Meals providers can download an application for MTP by visiting the MTP Meals page on the TMHP website at www.tmhp.com/Pages/MTP/MTP_meals.aspx.

The provider must complete and return the IRS W-9 Tax Identification Form as part of the enrollment process. The enrollment packet contains an EFT form that authorizes direct deposit payments for faster reimbursement; however, completion of the EFT form is not a requirement for enrollment.

4.2 Prior Authorization for Meals Providers

An MTP client must contact MTP to request meal services to initiate the claims process for meal providers.

Upon authorization of meal services, MTP will send an authorization form directly to the MTP client. This form will include the MTP client's name, the attendant's name, and the date of the authorized meal(s). The MTP client's attendant must present this authorization form to the meal provider for meals to be received by the client.

Important: *Only claims for authorized meal services are considered for payment.*

One authorization covers all authorized meals for a single day. Each day of meals must be authorized by MTP and will be assigned a unique authorization number.

Refer to: Section 5, "Prior Authorization" in this handbook.

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4.3 Claims Filing for Meals Providers

Providers must submit a separate claim form to TMHP for each unique authorization number (or day of meals).

There are two ways for providers to submit claims to TMHP:

- *By paper* using the CMS-1500 paper claim form.

  Refer to: Subsection 6.6, "Paper Claims" in this handbook.

- *Electronically*, using TMHP electronic data interchange (EDI) or the TexMedConnect functionality through the TMHP website.

  Refer to: Subsection 6.5, "Electronic Claims" in this handbook.

Meals providers may not charge an MTP client a fee for completing claim forms. TMHP also cannot be charged for the filing of claim forms.

5 Prior Authorization

All MTP services must be prior authorized by MTP, which issues all prior authorizations for transportation services. The eligible MTP client must contact MTP to obtain an authorization. Claims that are submitted without proper prior authorization will be denied.

5.1 Retention of Prior Authorization Documents

MTP prior authorization documents relating to Medicaid services or benefits provided to clients who are 20 years of age and younger must not be destroyed until the provider receives notice from HHSC. Examples of such documents include but are not limited to:

- Correspondence with HHSC/MTP;
- Invoices
- Receipts
- Contacts with clients who are class members

5.2 Definition of Prior Authorization Documents

The term "prior authorization document" is broad and includes, but is not limited to, the following:

- Paper records
- Electronic files in any format
- Database entries
- The original *and* any drafts or non-identical copies of any document
- Exhibits or attachments to documents
- Handwritten documents
- Emails
- Drawings, graphs, charts
- Electronic or videotape recordings
- Computer disks
- Other forms of computer memory storage

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5.3 Copies of Prior Authorization Documents

Providers are not required to retain multiple *exact* copies of a document. For example:

- An exact electronic copy (e.g., scanned computer image, microfiche) may be retained instead of a paper copy.
- If the last in a chain of emails is retained, it is not necessary to retain each of the individual emails included in the chain, as long as the email that is retained reflects all of the earlier emails.

However, a document containing any substantive editorial comment, margin notes, underlining, etc., is *not* an exact copy and becomes a new original that must be retained.

5.4 Storage of Prior Authorization Document Storage

Relevant information and documents should be stored in a way that is protected from unintentional disclosure or destruction.

6 Claims Filing

This section contains instructions for completion of Medicaid-required claim forms. When filing a claim, providers should review the instructions carefully and complete all requested information. A correctly completed claim form is processed faster.

Texas Medicaid cannot make payments to clients, so the provider who performs the service must file an assigned claim. Federal regulations prohibit providers from charging clients a fee for completing or filing Medicaid claim forms. Providers are not allowed to charge TMHP for filing claims. The cost of claims filing is part of the usual and customary rate for doing business. Providers cannot bill Texas Medicaid or Medicaid clients for missed appointments or failure to keep an appointment. Only claims for services rendered are considered for payment.

Medicaid providers are also required to complete and sign authorized medical transportation forms (e.g., Form 3103, Individual Driver Registrant (IDR) Service Record, or Form 3111, Verification of Travel to Healthcare Services by Mass Transit) or provide an equivalent (e.g., provider statement on official letterhead) to attest that services were provided to a client on a specific date. The client presents these forms to the provider.

Providers are not allowed to bill clients or Texas Medicaid for completing these forms.

Medicaid claims are subject to the following procedures:

- TMHP verifies all required information is present.
- Claims filed under the same provider identifier and program and ready for disposition at the end of each week are paid to the provider with an explanation of each payment or denial. The explanation is called the Remittance and Status (R&S) Report, which may be received as a downloadable portable document format (PDF) version or on paper. A Health Insurance Portability and Accountability Act (HIPAA)-compliant 835 transaction file is also available for those providers who wish to import claim dispositions into a financial system.

An R&S Report is generated for providers that have weekly claim or financial activity with or without payment. The report identifies pending, paid, denied, and adjusted claims. If no claim activity or outstanding account receivables exist during the time period, an R&S Report is not generated for the week.

Providers can participate in the most efficient and effective method of submitting claims to TMHP by submitting claims through the TMHP Electronic Data Interchange (EDI) claims processing system using TexMedConnect or a third party vendor. Claims must contain the provider's complete name, address, and provider identifier to avoid unnecessary delays in processing and payment.

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6.1 Claims Filing Deadlines

All claims for services rendered to eligible MTP clients are subject to a filing deadline from the DOS of:

- 95 days for in-state providers
- 365 days for out-of-state providers

Claims submitted by newly-enrolled MTP providers must be received within 95 days of the date the atypical provider identifier (API) is issued, and within 365 days of the date of service (DOS). Providers with a pending application should submit any claims that are nearing the 365-day deadline from the DOS. TMHP will reject all claims until an API is issued. MTP providers can use the TMHP rejection report or Return to Provider (RTP) letters as proof of meeting the 365- day deadline and submit an appeal.

6.2 Auditing of Claims

Reimbursement may be recouped when the medical record does not document that the level of service provided accurately matches the level of service claimed. Furthermore, the level of service provided and documented must be medically necessary based on the clinical situation and needs of the patient.

HHSC and TMHP routinely perform retrospective reviews of all providers. HHSC ultimately is responsible for Texas Medicaid utilization review activities. This review includes 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.

6.3 Important Codes for All MTP Providers

MTP providers must use the following codes when submitting claims:

- Benefit Code = MTP
- Provider Type = MT
- Diagnosis Code = Z753
- Place of Service = 09 for paper claims, 99 for TexMedConnect claims
- Type of Service = 9

The following table shows additional codes that TMHP recommends for filing MTP claims. The codes are based on transportation provider type:

MTP Provider Description	Provider Specialty	Taxonomy Code	Recommended Procedure Code	Modifier Codes
Client Financial Services (CFS)	T1	347E00000X	A0170	
Individual Transportation Provider (ITP)	T4	347C00000X	S0215	

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MTP Provider Description	Provider Specialty	Taxonomy Code	Recommended Procedure Code	Modifier Codes	
Lodging	T6	177F00000X	A0180	U1	Single occupancy
				U2	One-bedroom suite
				U3	Executive/concierge
				U4	King bedroom rate
				U5	Double occupancy room
				U6	Two bedroom suite
				U7	Additional person charge
				U8	Other
				U9	Lodging taxes
Meals	T8	174200000X	A0190		
Transportation Service Area Provider (TSAP)	T0	343800000X	A0100	U1	In-county
				U2	Out of county
				U3	Reduced rate in-county
				U4	Reduced rate out of county

6.4 Delegation of Signature Authority

A provider that delegate signatory authority to a member of the office staff or to a billing service *remains responsible* for the accuracy of all information on a claim submitted for payment. A provider's employees or a billing service and its employees are equally responsible for any false billings in which they participated or directed.

If the claim is prepared by a billing service or printed by data processing equipment, it is permissible to print "Signature on File" in place of the provider's signature. When claims are prepared by a billing service, the billing service must obtain and keep a letter on file that is signed by the provider authorizing claim submission.

6.5 Electronic Claims

6.5.1 TMHP Electronic Data Interchange (EDI)

Providers are encouraged to submit claims using electronic methods. 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 HIPAA-compliant American National Standards Institute (ANSI) ASC X12 4010A1 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 at www.tmhp.com, TexMedConnect, vendor software, and billing agents. Providers may also submit claims using paper forms. Version 2001 0805 3 MTP Claim Filing.

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6.5.2 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:

- An internet service provider (ISP)
- Microsoft Internet Explorer®
- Google Chrome®
- Mozilla Firefox®

A broadband connection is recommended but not required. Providers that use TexMedConnect can find the online instruction manual on the home page and on the EDI page of the TMHP website at www.tmhp.com.

6.5.3 Vendor Software

Providers that do not use TexMedConnect may use vendor software to create, submit, and retrieve data files. Providers can use software from any vendor listed on the EDI Submitter List, which is located on the EDI Vendor Testing web page of the TMHP website at www.tmhp.com. There are hundreds of software vendors that have a wide assortment of services and 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 details on 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 with TMHP.

Providers must setup their software or billing agent services to access the TMHP EDI Gateway. Providers who 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. Providers that use a billing agent do not need a submitter ID.

Providers may receive an ER&S Report by completing the Electronic Remittance and Status (ER&S) Agreement and submitting it to the EDI Help Desk after setting up access to the TMHP EDI Gateway. 4 Version 2001 0805 MTP Claim Filing.

6.5.4 Third Party Vendor Implementation

TMHP requires all software vendors and billing agents to complete EDI testing before access to the production server is allowed. 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 editesting.tmhp.com and use the TMHP Support link. An EDIFECS account will be created for the vendor to begin testing EDI formats once they have enrolled for testing. After the successful completion of EDIFECS testing and the submission of a Trading Partner Agreement, vendors must then 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 software vendor or billing agent will be added to the EDI Submitter List. Providers and billing agents may then order production submitter IDs for use with the vendor's software. Companion guides and vendor specifications are available in the EDI section of the TMHP website at www.tmhp.com.

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6.6 Paper Claims

MTP providers can also file claims using the CMS-1500 paper claim form. Providers obtain copies of the CMS-1500 paper claim form from a vendor of their choice; TMHP does not supply them.

Providers must submit paper claims to TMHP at the following address:

Texas Medicaid & Healthcare Partnership
Claims
PO Box 200555
Austin, TX 78720-0555

6.6.1 Tips on Expediting Paper Claims

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

6.6.1.1 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. Version 2001 0805 5 MTP Claim Filing

6.6.1.2 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 10-pitch (12-point) Courier font, 10 point. Don't use fonts smaller or larger than 12 points. Don't use proportional fonts, such as Arial or Times Roman.
- Use a laser printer for best results. Don't use a dot matrix printer, if possible.
- Don't use dashes or slashes in date fields.

6.6.1.3 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 multi-page claims for the same client.

  Note: *It is strongly recommended that providers who submit paper claims keep a copy of the documentation they send.*

- All paper claims must be submitted with a TPI and NPI.

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- Modifiers describe and qualify the services provided by Texas Medicaid. A modifier is placed after the five-digit procedure code.

6.6.1.4 Attachments to Claims

To expedite claims processing, providers must supply all information on the claim form itself and limit attachments to those required by TMHP or necessary to supply information to properly adjudicate the claim.

6.6.2 CMS-1500 Instruction Table

The table below describes what information must be entered in each of the block numbers of the CMS-1500 claim form. Providers obtain copies of the CMS-1500 paper claim form from a vendor of their choice; TMHP does not supply them.

Block numbers not referenced in the table may be left blank. They are not required for TMHP to process MTP claims.

CMS 1500 - Required MTP Information		
Block No	Description	Guidelines
1a	Insured's ID No. (for program checked above, include all letters)	Enter the patient's MPCN (10-digit) patient number from the MTP authorization form.
2	Patient's name	Enter the patients last name, first name, and middle initial as printed on the MTP authorization form.
		If the insured uses a last name suffix (e.g., Jr, Sr) enter it after the last name and before the first name.
21	Diagnosis or nature of illness or injury	The ICD-10-CM diagnosis codes recommended for MTP claims are Z753.
23	Prior authorization number	Enter the Prior Authorization Number issued by MTP.
24a	Date(s) of service	Enter the date of service for each MTP authorization provided in a MM/ DD/YYYY format.
24b	Place of service	The recommended POS code for MTP paper claims is 09. For electronic filing using TexMedConnect, the POS code is 99.
24d	Fully describe procedures, medical services, or supplies furnished for each date given	"The recommended procedure code for TSAP claims is A0100 The recommended procedure code for CFS claims is A0170"
24e	Diagnosis pointer	The recommended diagnosis codes are Z753 for all MTP claims.
24f	Charges	Indicate the charges for the service listed
24g	Days or units	Enter the number of services performed (such as the quantity billed) per MTP.
27	Accept assignment	Required
		All providers of the Texas Medicaid must accept assignment to receive payment by checking Yes.
28	Total charge	Enter the total charges.

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CMS 1500 - Required MTP Information		
Block No	Description	Guidelines
31	Signature of physician or supplier	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.
33	Billing provider info & PH #	Enter the billing provider's name, street, city, state, ZIP+4 code, and telephone number.
33A	NPI	Enter your API
33B	Other ID #	Enter your TPI number

7 Claim Form Examples

The following linked claim form examples can also be found on the Claim Form Examples page of the Provider section of the TMHP website at www.tmhp.com:

Claim Form Examples
Lodging Provider Paper Claim Form Example
Meals Provider Paper Claim Form Example

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Nursing and Therapy Services Handbook

Texas Medicaid Provider Procedures Manual: Vol. 2

April 2016

TEXAS
Health and Human
Services Commission

NURSING AND THERAPY SERVICES HANDBOOK

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1 General Information

This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, refer to the *Medicaid Managed Care Handbook*.

Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in Section 8, "Carve-Out Services" in the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

The information in this handbook is intended for nursing and therapy services. Nursing services include home health skilled nursing visits and home health aide services. Therapy services include occupational therapy (OT), physical therapy (PT), speech therapy (ST), and certified respiratory care practitioners (CRCP) services. The Handbook provides information about Texas Medicaid's benefits, policies, and procedures applicable to these therapies.

This section does not apply to Comprehensive Outpatient Rehabilitation Facility (CORF), Outpatient Rehabilitation Facility (ORF), or Inpatient Rehabilitation Facility (Freestanding) services provided through the Comprehensive Care Program (CCP).

Refer to: Subsection 2.5, "Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Outpatient Rehabilitation Facilities (ORFs)" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information.

Subsection 2.16, "Inpatient Rehabilitation Facility (Freestanding) (CCP)" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information.

Important: *All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: Section 1: Provider Enrollment and Responsibilities (*Vol. 1, General Information*) for more information about enrollment procedures.

Subsection 2.14, "Therapy Services (CCP)" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about providing OT, PT, and ST services.

2 Certified Respiratory Care Practitioner (CRCP) Services

2.1 Enrollment

To enroll in Texas Medicaid, a CRCP must be certified by the Department of State Health Services (DSHS) to practice under the Texas Occupations Code, Chapter 604. For CRCPs, Medicare certification is not a prerequisite for Medicaid enrollment. A provider cannot be enrolled if his license is due to expire within 30 days; a current license must be submitted. CRCPs must enroll as individual providers and comply with all applicable federal, state, and local laws and regulations.

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2.2 Services, Benefits, Limitations, and Prior Authorization

Respiratory therapy services provided by a Texas Medicaid provider enrolled as a CRCP may be reimbursed when services are reasonable, medically necessary, and prescribed by the client's physician. These services are for all age groups and do not require the client to be homebound.

CRCP services are a benefit of Texas Medicaid with prior authorization when provided in the home setting for ventilator-dependent clients. Providers must use procedure code 99504 when billing for in-home respiratory services.

Benefits include, but are not limited to, the following:

- Respiratory therapy services and treatments prescribed by a physician who is familiar with the client's medical history and care, and who has medically determined that in-home care is safe and feasible for the client.
- Education of the client, the appropriate family members, and support people about the in-home respiratory care (must include the use and maintenance of required supplies, equipment, and techniques appropriate to the situation).

2.2.1 * Prior Authorization

Prior authorization is required for in-home CRCP services (procedure code 99504).

To avoid unnecessary denials, the provider must submit correct and complete information including documentation of medical necessity for the service requested. The prescribing physician and provider 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 service.

Prior authorization requests for traditional Medicaid clients must be submitted by the physician or the CRCP to the Special Medical Prior Authorization (SMPA) Department by approved electronic method using the SMPA Request Form.

When required, the requests must include the physician's signature and the date signed. Without this information, requests will be considered incomplete.

The SMPA Request Form must be submitted with the following documentation supporting medical necessity for the requested procedure:

- The client is on a ventilator at least six hours per day.
- The client has been ventilator-dependent for at least 30 consecutive days or more as an inpatient in one or more hospitals, skilled nursing facilities (SNF), or intermediate care facilities (ICF).
- The respiratory therapy services are in lieu of respiratory services requiring the client to remain in an inpatient care setting.
- Identification of the adequate support services in place that allow the client to be cared for at home.
- The respiratory services and goals for the services that will be provided by the CRCP.
- The frequency and number of home visits requested by the CRCP.
- The client's wish to be cared for at home.
- Documentation supporting why the respiratory therapy visits included in the Home Health durable medical equipment (DME) rental of a ventilator, or the monthly respiratory therapy visit included in the Ventilator Service Agreement authorized to a Home Health DME provider would not meet the client's medical needs.

Note: *For clients who are birth through 20 years of age, CRCP services that do not meet the criteria above, may be considered through the Comprehensive Care Program (CCP) when prior authorized and billed with procedure code 99503.*

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The prior authorization request may be authorized for up to a 12-month period. Prior authorization requests for more than 24 visits in a 12-month period will be referred for the medical director to review and a determination will be based on the individual client's medical needs.

Retrospective review may be performed to ensure documentation supports the medical necessity of the service when billing the claim for procedure codes 99503 or 99504.

Refer to: Special Medical Prior Authorization (SMPA) Request Form on the TMHP website at www.tmhp.com.

2.3 Documentation Requirements

All supporting documentation must be included with the request for prior authorization. Providers should send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-A Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax: 1-512-514-4213

2.4 Claims Filing and Reimbursement

2.4.1 Claims Information

CRCP services must be submitted to the Texas Medicaid & Healthcare Partnership (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: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Electronic billers must submit the prior authorization number (PAN) on the electronic claim form. Providers should consult the software vendor for the location of this field in the software.

2.4.2 Reimbursement

Respiratory therapy services provided by a participating CRCP are reimbursed the lesser of the provider's billed charges or the rate calculated in accordance with 1 TAC §355.8089.

Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

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Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

The professional service may be billed by the CRCP for services provided in the client's home (procedure code 99504). The professional service will be allowed once per day up to a limit of 24 visits per year. The recommended frequency for CRCP services is as follows: 7 visits during the first week, a total of 6 visits during the second through fourth weeks, and 11 monthly visits for the second through the 12th month.

Providers will not be reimbursed for procedure codes 99503 and 99504 on the same date of service, any provider.

Disposable respiratory supplies and respiratory equipment rental or purchase are a home health services benefit and are not reimbursed to the certified respiratory therapist.

Refer to: Subsection 2.2, "Services, Benefits, Limitations and Prior Authorization" in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2, Provider Handbooks)* for DME or medical supplies prior authorization information.

3 Home Health Nursing and Therapy Services

3.1 Enrollment

To enroll in Texas Medicaid as a provider of home health services, Home Health Services and Home and Community Support Services Agency (HCSSA) providers must complete the Texas Medicaid Provider Enrollment Application. Medicare certification is required for providers that are licensed as a Licensed and Certified Home Health Agency. Providers that are licensed as a Licensed Home Health Agency are not required to enroll in Medicare as a prerequisite to enrollment with Texas Medicaid.

Licensed and Certified Home Health agencies that are enrolled as Medicaid providers can provide personal care services (PCS) using their existing provider identifier. PCS for clients who are 20 years of age and younger will be provided by the Texas Health and Human Services Commission (HHSC) under the PCS benefit.

Refer to: Subsection 2.11, "Personal Care Services (PCS) (CCP)" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

To provide CCP services, HCSSA providers must follow the enrollment procedures in subsection 5.2, "Enrollment" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

Providers may download the Texas Medicaid Provider Enrollment Application at www.tmhp.com or request a paper application form by contacting TMHP directly at 1-800-925-9126.

Providers may also obtain the application by writing to the following address:

Texas Medicaid & Healthcare Partnership
Provider Enrollment
PO Box 200795
Austin, TX 78720-0795
1-800-925-9126
Fax: 1-512-514-4214

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Providers may request prior authorization for home-health services by contacting:

Texas Medicaid & Healthcare Partnership
Home Health Services
PO Box 202977
Austin, TX 78720-2977
1-800-925-8957
Fax: 1-512-514-4209

3.1.1 Change of Address and Telephone Number

A current physical and mailing address and telephone number must be on file for the agency/company to receive reimbursement checks, Medicaid provider procedures manuals, and all other TMHP correspondence. Promptly send all address and telephone number changes to:

Texas Medicaid & Healthcare Partnership
Provider Enrollment
PO Box 200795
Austin, TX 78720-0795
1-800-925-9126
Fax: 1-512-514-4214

3.1.2 Pending Agency Certification

Home health agencies submitting claims before the enrollment process is complete or without prior authorization for services issued by the TMHP Home Health Services Prior Authorization Department will not be reimbursed. The effective date of enrollment is when all Texas Medicaid provider enrollment forms are received and approved by TMHP.

Upon the receipt of notice of Texas Medicaid enrollment, the agency must contact the TMHP Home Health Services Prior Authorization Department before serving a Texas Medicaid client for services that require a prior authorization number. Prior authorization cannot be issued before Texas Medicaid enrollment is complete. Regular prior authorization procedures are followed at that time.

Home health agencies that provide laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers who do not comply with CLIA will not be reimbursed for laboratory services.

Refer to: Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

3.1.3 Home Health Skilled Nursing and Home Health Aide (HHA) Services Provider Responsibilities

Providers must be licensed home health agencies, enrolled in Texas Medicaid, and must comply with all applicable federal, state, and local laws and regulations and Texas Medicaid policies and procedures. All providers must maintain written policies and procedures:

- That meet the standards of the Texas Family Code, Chapter 32 for obtaining consent for the medical treatment of clients in the absence of the primary caregiver.
- For obtaining physician signatures for all telephone orders within 14 calendar days of receipt of the order.

Providers must only accept clients on the basis of a reasonable expectation that the client's needs can be adequately met in the place of service (POS). The essential elements of safe and effective home health SN or HHA services include a trained parent, guardian, or caregiver, a primary physician, competent providers, and an environment that supports the client's health and safety needs.

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Necessary primary and back-up utility, communication, and fire safety systems must be available.

Note: *A parent or guardian, primary caregiver, or alternate caregiver may not provide SN or HHA services to their family member even if he or she is an enrolled provider or employed by an enrolled provider.*

3.2 Services, Benefits, Limitations, and Prior Authorization

3.2.1 Home Health

Prior authorization must be obtained for all professional services (SN, HHA, OT, PT, most DME, and some medical supply services). Prior authorization requests for SN, HHA, DME and some medical supply services must be submitted within three business days of the start of care (SOC), and within five business days for PT and OT services.

The benefit period for home health professional services is up to 60 days with a current plan of care (POC). This extended prior authorization period begins on the date that clients receive their first prior authorized home health service. Texas Medicaid allows prior authorization of additional visits that have been determined to be medically necessary and have been prior authorized by TMHP Home Health Services Prior Authorization Department. These records and claims must be retained for a minimum of five years from the date of service (DOS) or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.

3.2.1.1 Client Eligibility

It is the provider's responsibility to determine the type of coverage (Medicare, Medicaid, or private insurance) that the client is eligible to receive. To verify client Medicaid eligibility and retroactive eligibility, the home health agency, DME, or medical supplier must contact the Automated Inquiry System (AIS) at 1-800-925-9126 or the TMHP Electronic Data Interchange (EDI) Help Desk at 1-888-863-3638. Home health clients do not need to be homebound to qualify for services.

The Medicaid client must be eligible on the DOS and must meet all of the following requirements to qualify for Home Health Services:

- Have a medical need for home health professional services, DME, or medical supplies that is documented in the client's POC and considered a benefit under Home Health Services
- Receive services that meet the client's existing medical needs and can be safely provided in the client's home
- Receive prior authorization from TMHP for most home health professional services, DME, or medical supplies

Refer to: "Automated Inquiry System (AIS)" in "Preliminary Information" (*Vol. 1, General Information*).

Note: *Texas Health Steps (THSteps)-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit may receive those services through CCP.*

3.2.1.2 Prior Authorization Requests for Clients with Retroactive Eligibility

Retroactive eligibility occurs when the effective date of a client's Medicaid coverage is before the date the client's Medicaid eligibility is added to TMHP's eligibility file, which is called the "add date."

For clients with retroactive eligibility, prior authorization requests must be submitted after the client's add date and before a claim is submitted to TMHP.

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For services provided to fee-for-service Medicaid clients during the client's retroactive eligibility period, i.e., the period from the effective date to the add date, prior authorization must be obtained within 95 days from the client's add date and before a claim for those services is submitted to TMHP. For services provided on or after the client's add date, the provider must obtain prior authorization within 3 business days of the date of service.

The provider is responsible for verifying eligibility. The provider is strongly encouraged to access AIS or TexMedConnect to verify eligibility frequently while providing services to the client. If services are discontinued before the client's add date, the provider must still obtain prior authorization within 95 days of the add date to be able to submit claims.

Refer to: Section 4: Client Eligibility (*Vol.1, General Information*).

3.2.1.3 Client Evaluation

When a home health agency receives a referral to provide home health nursing and therapy services for a client who is eligible for Texas Medicaid, the agency-employed registered nurse (RN) must evaluate the client in the home before calling TMHP for prior authorization. A home evaluation by the agency-employed RN is required for SN, HHA, OT, PT, DME, or medical supplies requested on a Home Health Services POC. It is expected that appropriate referrals will be made between home health agencies and DME suppliers for care. It is recommended that DME suppliers keep open communication with the client's physician to ensure the client's medical record is current.

This evaluation must include assessment of the following:

- Medical necessity for Home Health Services, DME, or medical supplies requested
- Client safety
- Appropriateness of care in the home setting
- Capable caregiver available if clients are unable to perform their own care or monitor their own medical condition

Following the RN's assessment/evaluation of the client in the home setting for Home Health Services needs, the agency-employed RN who completed the home evaluation must contact TMHP for prior authorization within three business days of the SOC.

3.2.2 Benefits

Home Health Services include SN, HHA, OT, PT, DME, and medical supplies that are provided to eligible Medicaid clients at their place of residence.

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit may receive those services through CCP.*

Refer to: Subsection 2.14, "Therapy Services (CCP)" and subsection 2.13, "Private Duty Nursing (PDN)(CCP)" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information on nursing and therapy benefits for clients who are 20 years of age and younger.

The *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2, Provider Handbooks)*.

An SN or HHA visit may be reimbursed for up to a maximum of 2.5 hours per visit. A combined total of three SN or HHA visits may be reimbursed per date of service. When services are provided to more than one client in the same setting, only the units directly provided to each client at distinct, separate time periods will be reimbursed. Provider documentation must support that the services were delivered at distinct, separate time periods. Total Home Health Services billed for all clients cannot exceed the individual provider's total number of hours spent at the POS.

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One SN visit as needed (PRN) may be reimbursed every 30 days outside of the prior authorized visits when SN visits have been prior authorized for the particular client. For reimbursement purposes, home health SN and HHA services are always billed as POS 2 (home) regardless of the setting in which the services are actually provided. SN and HHA services provided in the day care or school setting will not be reimbursed.

OT and PT services must be billed one visit per day, per therapy.

The quantity billed must be identified and each procedure code must be listed as separate line items on the claim.

Procedural modifiers are required when billing SN, HHA, OT, and PT visits.

Modifier	Visit Service Category
U2	SN or HHA second visit per day
U3	SN or HHA third visit per day
GO	OT
GP	PT

Note: *The U2 and U3 modifiers are only required if a PRN SN visit is the second or third SN or HHA visit performed on the same date of service.*

3.2.3 Home Health Skilled Nursing Services

Home health SN services are a benefit of Texas Medicaid 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 has an end-point. SN visits may be provided on consecutive days. SN visits are intended to provide SN care to promote independence and support the client living at home. Home Health Services must be provided by a licensed and certified home health agency enrolled in Texas Medicaid.

Note: *Nursing visits for the primary purpose of assessing a client's care needs to develop a POC are considered administrative and not billable. These visit costs are reflected on the cost report.*

An acute condition is a condition or exacerbation that is anticipated to improve and reach resolution within 60 days. An intermittent basis is an SN visit that is provided for less than eight hours per visit and less frequently than daily. Intermittent visits may be delivered in interval visits up to 2.5 hours per visit, not to exceed a combined total of three visits per day. A part-time basis is an SN visit that is provided less than eight hours per day for any number of days per week. Part-time visits may be continuous up to 7.5 hours per day (not to exceed a combined total of three 2.5 hour visits).

SN visits are considered medically necessary for clients who require the following:

- Skillful observations and judgment to improve health status, skilled assessment, or skilled treatments and procedures
- Individualized, intermittent, acute skilled care
- Skilled interventions to improve health status, and if skilled intervention is delayed, it is expected to result in the deterioration of a chronic condition or one of the following:
  - Loss of function
  - Imminent risk to health status due to medical fragility, or risk of death

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When documentation does not support medical necessity for home health SN visits, providers may be directed to possible alternative services based on the client's age and needs.

Note: *For Medicaid clients who are 20 years of age or younger, home health skilled nursing services are available when the client requires nursing services for an acute condition, acute exacerbation of a chronic condition, or a chronic condition that can be treated on an intermittent or part-time basis.*

3.2.3.1 SN Visits

SN visits (procedure codes G0299 and G0300) are limited to SN procedures performed by an RN or licensed vocational nurse (LVN) licensed to perform these services under the Texas Nursing Practice Act and include direct SN care, and parent or guardian, caregiver training, and education as well as SN observation, assessment, and evaluation by an RN, provided a primary physician specifically requests that a nurse visit the client for this purpose, and the physician's order reflects the medical necessity for the visit.

For all clients, SN visits may be provided in the following locations:

- Home of the client, parent, guardian, or caregiver
- Foster homes
- Independent living arrangements

The cost of incidental medical supplies used during an SN or HHA visit may be added to the charge of the visit ($10 maximum for medical supplies is included in G0299 or G0300 visit code).

3.2.3.1.1 SN Care

SN care consists of those services that must, under state law, be performed by an RN or LVN, and meet the criteria for SN services specified in the Title 42 Code of Federal Regulations (CFR) §§ 409.32, 409.33, and 409.44. In determining whether a service requires the skill of a licensed nurse, consideration must be given to the inherent complexity of the service, the condition of the client, and the accepted standards of medical and nursing practice.

The fact that the SN service can be, or is taught to the client or to the client's family or friends does not negate the skilled aspect of the service when the service is performed by a nurse. If the service could be performed by the average nonmedical person, the absence of a competent person to perform it does not cause it to be an SN service. If the nature of a service is such that it can safely and effectively be performed by the average nonmedical person without direct supervision of a licensed nurse, the service cannot be regarded as an SN service.

Some services are classified as SN services on the basis of complexity alone (e.g., intravenous and intramuscular injections or insertion of catheters), and if reasonable and necessary to the treatment of the client's illness or injury, would be covered on that basis. However, in some cases, the client's condition may cause a service that would ordinarily be considered unskilled to be considered an SN service. This may occur when the client's condition is such that the service can be safely and effectively provided only by a nurse.

A service which, by its nature, requires the skills of a nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the client, the client's family, or other caregivers. Where the client needs the SN care and there is no one trained, able and willing to provide it, the services of a nurse would be reasonable and necessary to the treatment of the illness or injury.

SN services 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

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accepted standards of medical and nursing practice. A client's overall medical condition is a valid factor in deciding whether skilled services are needed. A client's diagnosis should never be the sole factor in deciding whether the service the client needs is either skilled or not skilled.

The determination of whether the services are reasonable and necessary should be made in consideration of the primary 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.

SN care must be provided on a part-time or intermittent basis.

3.2.3.1.2 Professional Nursing

Professional nursing provided by an RN, as defined in the Texas Nursing Practice Act, means the performance of an act that requires substantial specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of professional nursing. The term does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures.

Professional nursing involves:

- The observation, assessment, intervention, evaluation, rehabilitation, care and counsel, or health teachings of a person who is ill, injured, infirm, or experiencing a change in normal health processes.
- The maintenance of health or prevention of illness.
- The administration of a medication or treatment as ordered by a physician, podiatrist, or dentist.
- The supervision of delegated nursing tasks or teaching of nursing.
- The administration, supervision, and evaluation of nursing practices, policies, and procedures.
- The performance of an act delegated by a physician.
- Development of the nursing care plan.

3.2.3.1.3 Vocational Nursing

Vocational nursing, as defined in the Texas Nursing Practice Act, means a directed scope of nursing practice, including the performance of an act that requires specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of vocational nursing. The term does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures.

Vocational nursing involves:

- Collecting data and performing focused nursing assessments of the health status of an individual
- Participating in the planning of the nursing care needs of an individual
- Participating in the development and modification of the nursing care plan
- Participating in health teaching and counseling to promote, attain, and maintain the optimum health level of an individual

Vocational nursing also involves assisting in the evaluation of an individual's response to a nursing intervention and the identification of an individual's needs and engaging in other acts that require education and training, as prescribed by board rules and policies, commensurate with the nurse's experience, continuing education, and demonstrated competency.

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3.2.4 Home Health Aide Services

HHA visits (procedure code G0156) are a benefit of Texas Medicaid 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. HHA visits will not be considered unless the client also requires SN or therapy services. HHA visits may be provided on consecutive days. HHA visits are intended to provide personal care under the supervision of an RN, occupational therapist, or physical therapist employed by the home health agency to promote independence and support the client living at home.

An acute condition is considered a condition or exacerbation that is anticipated to improve and reach resolution within 60 days. An intermittent basis is considered an HHA visit provided for less than eight hours per visit and less frequently than daily. Intermittent visits may be delivered in interval visits up to 2.5 hours per visit, not to exceed a combined total of three visits per day. A part-time basis is considered an HHA visit provided less than eight hours per day for any number of days per week. Part-time visits may be continuous up to 7.5 hours per day (not to exceed a combined total of three 2.5 hour visits).

HHA visits are considered medically necessary for clients who require the following:

- Skillful observations and judgment to improve health status, skilled assessment, or skilled treatments or procedures
- Individualized, intermittent, acute skilled care
- Skilled interventions to improve health status, and if skilled intervention is delayed, it is expected to result in the deterioration of a chronic condition or one of the following:
  - Loss of function
  - Imminent risk to health status due to medical fragility, or risk of death
- General supervision of nursing care provided by an HHA over whom the RN, occupational therapist, or physical therapist is administratively or professionally responsible

When documentation does not support medical necessity for HHA visits, providers may be directed to possible alternative services based on the client's age and needs.

3.2.4.1 HHA Visits

HHA visits are intended to provide hands-on personal care, performance of simple procedures as an extension of therapy or nursing services, assistance in ambulation or exercises, and assistance in administering medications that are ordinarily self-administered.

Any HHA services offered by a home health agency must be provided by a qualified HHA under the supervision of a qualified licensed individual (RN, occupational therapist, or physical therapist) employed by the home health agency.

For all clients, HHA visits may be provided in the following locations:

- Home of the client, parent, guardian, or caregiver
- Foster homes
- Independent living arrangements

The duties of an HHA during a visit include, but are not limited to the following:

- Ambulation
- Assistance with medication that is ordinarily self-administered
- Assisting with nutrition and fluid intake
- Completing appropriate documentation
- Exercise

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- Household services essential to the client's health care at home
- Obtaining and recording the client's vital signs (temperature, pulse, respirations, and blood pressure)
- Observation, reporting, and documentation of the client's status, and the care or service furnished
- Personal care (hygiene and grooming), including, but not limited to the following:
  - Sponge, tub, or shower bath
  - Shampoo, sink, tub, or bed bath
  - Nail and skin care
  - Oral hygiene
- Positioning
- Range of motion
- Reporting changes in the client's condition and needs
- Safe transfer
- Toileting and elimination care

3.2.4.2 Supervision of HHA

Supervision, as defined by the Texas Nursing Practice Act, is the process of directing, guiding, and influencing the outcome of an individual's performance of an activity. An RN, occupational therapist, or physical therapist must provide the HHA written instructions for all the tasks delegated to the HHA. An occupational therapist or physical therapist may prepare the written instructions if the client is receiving only HHA visits, which do not include delegated SN tasks, in addition to the therapy services.

The requirements for HHA supervision are as follows:

- When only HHA visits are provided, an RN must make a supervisory visit to the client's residence at least once every 60 days. The supervisory visit must occur when the HHA is providing care to the client.
- When SN, OT, or PT visits are provided in addition to an HHA visit, an RN must make a supervisory visit to the client's residence at least every two weeks. The supervisory visit must occur when the HHA is providing care to the client.
- When only OT or PT visits are provided in addition to HHA visits, the appropriate therapist may make the supervisory visit in place of an RN. The supervisory visit must occur when the HHA is providing care to the client.
- Documentation of HHA supervision must be maintained in the client's medical record.

3.2.5 DME and Medical Supplies Submitted with a Plan of Care (POC)

The cost of incidental medical supplies used during an SN or HHA visit may be added to the charge of the visit ($10 maximum for medical supplies and included in G0299 or G0300 visit code). Medical supplies left at the home for the client to use must be billed with the provider identifier enrolled as a DME supplier after prior authorization has been granted by the TMHP Home Health Services Prior Authorization Department.

Refer to: Subsection 2.2, "Services, Benefits, Limitations and Prior Authorization" in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*) for DME or medical supplies prior authorization information.

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When the Home Health Services POC is used to submit a prior authorization for DME or medical supplies that will be used in conjunction with the professional services provided by the agency, such as SN, HHA, OT, or PT, the home health agency's DME provider identifier must be submitted on the POC, and all of the requested DME and medical supplies must be listed in the "Supplies" section of the POC. The POC does not require a physician's signature before prior authorization of professional services, DME, or medical supplies is requested but does require the assessing RNs dated signature. The POC must be signed and dated by a primary physician familiar with the client prior to submitting a claim for services and no later than 30 days from the SOC date.

If the home health agency uses the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form, the agency must complete Section A. A primary physician familiar with the client must complete Section B, sign, and date it prior to submission to TMHP for prior authorization of the requested DME or medical supplies.

The following information is required to consider these medical supplies for prior authorization:

- Item description
- Procedure code
- Quantity of each medical supply requested
- Manufacturer's suggested retail price (MSRP) for items that do not have a maximum fee assigned

Refer to: Subsection 2.2, "Services, Benefits, Limitations and Prior Authorization" in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2, Provider Handbooks)* for DME or medical supplies prior authorization information.

3.2.6 Medication Administration Limitations

Nursing visits for the purpose of administering medications are not a benefit if one of the following conditions exists:

- The medication is not considered medically necessary to the treatment of the individual's illness or is not approved by the Food and Drug Administration (FDA) or is being used for indications not approved by the FDA.
- The administration of medication exceeds the therapeutic frequency or duration by accepted standards of medical practice.
- A medical reason does not prohibit the administration of the medication by mouth.
- The client, a primary caregiver, a family member, or neighbor have been taught or can be taught to administer subcutaneous (SQ/SC), intramuscular (IM), and intravenous (IV) injections and has demonstrated competency.
- The medication is a chemotherapeutic agent or blood product SQ/SC, IM, and IV injections.

3.2.7 Occupational Therapy (OT) Services

As stated in 1 TAC §354.1039, to be payable as a Home Health Services benefit, OT services must be:

- Provided by an occupational therapist or an OT assistant who is currently registered and licensed by the Executive Council of Physical Therapy and Occupational Therapy Examiners
- For the evaluation and function-oriented treatment of individuals whose ability to function in life roles is impaired by recent or current physical illness, injury, or condition

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- For specific goal-directed activities to achieve a functional level of mobility and communication to prevent further dysfunction within a reasonable length of time based on the therapist's evaluation, physician's assessment, and POC

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit will receive those services through CCP.*

Refer to: Subsection 2.14, "Therapy Services (CCP)" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for OT benefits for clients who are 20 years of age and younger and Section 4, "Therapists, Independent Practitioners, and Physicians" in this handbook for OT benefits provided by a physician.

3.2.8 Physical Therapy (PT) Services

As stated in 1 TAC §354.1039, in order to be payable as a Home Health Services benefit, PT services must be:

- Provided by a physical therapist or PT assistant who is currently licensed by the Executive Council of Physical Therapy and Occupational Therapy Examiners.
- For the treatment of an acute musculoskeletal or neuromuscular condition or an acute exacerbation of a chronic musculoskeletal or neuromuscular condition.
- Expected to improve the client's condition in a reasonable and generally predictable period of time, based on the physician's assessment of the client's restorative potential after any necessary consultation with the therapist.
- Provided only until the client has reached the maximum level of improvement. Repetitive services designed to maintain function when the maximum level of improvement has been reached are not a benefit. Additionally, services related to activities for the general good and welfare of clients, such as general exercises to promote overall fitness and flexibility, and activities to provide diversion or general motivation are not reimbursed.

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit may receive those services through CCP.*

Refer to: Subsection 2.14, "Therapy Services (CCP)" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for PT benefits for clients who are 20 years of age and younger.

Section 4, "Therapists, Independent Practitioners, and Physicians" in this handbook for PT benefits provided by a physician.

3.2.9 Occupational Group Therapy and Physical Group Therapy

Group therapy consists of simultaneous treatment of 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.

3.2.9.1 Group Therapy Guidelines

The following guidelines must be followed in order to meet the Texas Medicaid criteria for group therapy:

- Physician prescription for group therapy. ECI providers are excluded from this requirement.
- 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.

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- 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.

Texas Medicaid 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.

3.2.9.2 Group Therapy Documentation Requirements

The following documentation must be maintained in the client's medical record:

- Physician prescription for group therapy. ECI providers are excluded from this requirement.
- Individualized treatment plan that includes frequency and duration of the prescribed group therapy and individualized treatment goals.

Documentation for each 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 techniques 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.

When physical or occupational group therapy is administered, providers must bill procedure code 97150 for each member of the group.

Note: *There is an exception to these requirements for Early Childhood Intervention (ECI) Services. The group therapy guidelines for ECI services are outlined in Section 2.7, "Early Childhood Intervention (ECI) Services" in the Children's Services Handbook.*

3.2.10 Prior Authorization

To initiate a new prior authorization request, or request an extension of an existing prior authorization, home health services providers are required to submit the request online using the TMHP secure provider portal or on paper by faxing or mailing TMHP the appropriate paper prior authorization form.

The following prior authorization requests can be submitted on the TMHP website at www.tmhp.com:

- Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form
- Home Health Services POC

Refer to: Subsection 5.5.1, "Prior Authorization Requests Through the TMHP Website" in Section 5, "Prior Authorization" (*Vol. 1, General Information*) for more information, including mandatory documentation requirements.

Providers can still call the Home Health Inquiry and Prior Authorization telephone number to inquire about the status of home health prior authorization requests that have been initially submitted to TMHP online or by fax or mail.

The Home Health Inquiry and Prior Authorization telephone number is 1-800-925-8957.

If a client's primary coverage is private insurance and Medicaid is secondary, prior authorization is required for Medicaid reimbursement. If the primary coverage is Medicare, Medicare approves the service, and Medicaid is secondary, prior authorization is not required. If Medicare denied the service, then Medicaid prior authorization is required. Contact TMHP within 30 days of the date of Medicare's

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final disposition. The medicare remittance advice notice (MRAN) containing Medicare's final disposition must accompany the prior authorization request. If the service is a Medicaid-only service, prior authorization is required within three business days of the SOC date.

The provider is responsible for determining if eligibility is effective by using AIS or an electronic eligibility inquiry through the TMHP EDI gateway.

The provider must contact the TMHP Home Health Services Prior Authorization Department within three business days of the SOC for professional services or the DOS for DME or medical supplies to obtain prior authorization following the RN's assessment/evaluation of the client in the home setting. When contacting TMHP by telephone for prior authorization, the nurse who made the initial assessment visit in the client's home must make this call to answer questions about the client's condition as it relates to the medical necessity.

If inadequate or incomplete information is provided or medical necessity is lacking, the provider will be requested to furnish additional documentation as required to make a decision on the request. Because it often must be obtained from the client's primary physician, providers have two weeks to submit the requested documentation. If the additional documentation is received within the two-week period, prior authorization can be considered for the original date of contact. If the additional documentation is received more than two weeks from the request for the documentation, prior authorization is not considered before the date the additional documentation is received. It is the home health agency's responsibility to contact the primary physician to obtain the requested additional documentation.

The Home Health Prior Authorization Checklist is a useful resource for home health agency providers completing the prior authorization process. This optional form offers the nurse a detailed account of the client's needs when completed.

Refer to: Subsection 2.2.2, "Durable Medical Equipment (DME) and Supplies" in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*) for DME or medical supplies prior authorization.

Home Health Prior Authorization Checklist on the TMHP website at www.tmhp.com.

Client eligibility for Medicaid is for one month at a time. Providers should verify eligibility every month. Prior authorization does not guarantee payment.

3.2.10.1 Home Health SN and HHA Services Prior Authorization Requirements

SN and HHA services require prior authorization. Requests must be submitted in writing, by fax or mail. Providers must obtain prior authorization within three business days of the SOC date for an initial prior authorization. For extension of the prior authorization providers must obtain prior authorization within seven business days of the new SOC date. During the prior authorization process, providers are required to deliver the requested services from the SOC date, which is the date agreed to by the primary physician, the RN, the home health agency, and the client, parent, guardian, or caregiver. The SOC date must be documented on the POC.

Prior authorization of SN or HHA visits requires that a client's primary physician complete the following steps:

- Provide specific, written, dated orders for SN or HHA visits or recertification that identifies that the prescribed visits are medically necessary as defined in subsection 3.2.3, "Home Health Skilled Nursing Services" and subsection 3.2.4, "Home Health Aide Services" in this handbook.
- Maintain documentation in the client's medical record that supports the medical necessity of the prescribed visits.
- Maintain documentation in the client's medical record that demonstrates that the client's medical condition is sufficiently stable to permit safe delivery of the prescribed visits as described in the client's Home Health Services POC.

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- Establish a medical POC that is maintained in the client's medical record.
- Provide continuing care and medical supervision.
- Review and approve the client's Home Health Services POC once every 60 days or more frequently if the primary physician determines it to be necessary, including but not limited to a change in the client's condition.

Providers who request prior authorization for SN or HHA services must submit the following documentation:

- A completed client assessment
- A completed Texas Medicaid Home Health Services POC that must:
  - Be signed and dated by the assessing RN
  - Signed and dated by the primary physician or submitted with the signed and dated physician's orders

All signatures and dates must be current, unaltered, original, and handwritten; computerized or stamped signatures or dates will not be accepted. All documentation, including all written and verbal orders, and all physician-signed POCs, must be maintained by the ordering physician. The home health agency must keep the original, signed copy of the POC in the client's medical record.

Requests must be based on the medical needs of the client. Documentation must support the quantity and frequency of intermittent or part-time SN and HHA visits that will safely meet the client's needs. The amount and duration of SN and HHA visits requested will be evaluated by the claims administrator. The home health agency must ensure the requested services are supported by the client assessment, POC, and the physician's orders.

If a client is already receiving authorized SN visits, instructions to the client or caregiver in the self-administration of prescribed injections (IM, SQ, or IV), including, but not limited to, Factor 8 and intra-venous immunoglobulin (IVIg), are considered part of the existing authorized SN home visits. Additional nursing visits for instruction and initial supervision of the client or caregiver will not be allowed.

Instruction and initial supervision must be provided by an RN who is appropriately trained in the administration of the drug or product being administered, and the client and caregiver must be involved in the decision to self-administer the medication.

In order to qualify for self-administration of prescribed injections, the client must be medically stable, and the client or caregiver who is administering the injectable medication (IM, SQ, or IV) must:

- Have a history of compliance with other medications.
- Have a simple drug regimen.
- Have the ability to read and understand directions on the medication label.
- Demonstrate knowledge of the administration technique, maintenance of the required supplies and equipment, and storage requirements.

The length of the prior authorization is determined on an individual basis and is based on the goals and timelines identified by the primary physician, home health agency, RN, and client, parent, guardian, or caregiver. SN and HHA visits will be prior authorized for no more than 60 days at a time.

As a client's problems are resolved and goals are met, a client's condition is expected to become more stable, and the client's needs for SN and HHA services may decrease.

Private duty nursing (PDN) and SN should not be routinely performed on the same date during the same time period. PDN and SN will not be considered for reimbursement when the services are performed on the same date during the same time period without prior authorization approval.

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Both the intermittent SN visit and the PDN services provided during the same time period may be recouped if the documentation does not support the medical necessity of each service provided.

3.2.10.1.1 Routine Laboratory Specimens

SN visits to obtain routine laboratory specimens may be considered when the only alternative to obtain the specimen is to transport the client by ambulance.

3.2.10.1.2 Home Phototherapy

SN visits to address hyperbilirubinemia will not be considered for prior authorization if the client has an open prior authorization for home phototherapy. Home phototherapy is reimbursed as a daily global fee and includes coverage of SN visits for parent or caregiver teaching, client monitoring, and obtaining customary and routine laboratory specimens.

3.2.10.1.3 Prothrombin Time/Internationalized Normalized Ration (TP/INR) Home Testing Device

SN visits will not be authorized for setting up a TP/INR home testing device or training clients to use it.

3.2.10.1.4 Total Parenteral Nutrition (TPN)

SN visits to address TPN must:

- Be provided by an RN appropriately trained in the administration of TPN.
- Include education of the client or caregiver regarding the in-home administration of TPN before administration initially begins.
- Include the use and maintenance of required medical supplies and DME.
- Occur at least once every month to monitor the client's status and to provide ongoing education to the client and caregiver regarding the administration of TPN.

For clients receiving PDN who also require TPN administration education, intermittent SN visits may be considered for separate prior authorization when:

- The PDN provider is not an RN appropriately trained in the administration of TPN, and the PDN provider is not able to perform the function.
- There is documentation to support the medical need for an additional skilled nurse to perform TPN.

For clients receiving PDN who also require TPN administration education, the SN services may be prior authorized only for the client/caregiver training in TPN administration.

The nurse providing the intermittent SN visit for TPN services will only be reimbursed for time spent delivering client and family instruction and for direct client TPN services. The services delivered must be documented in the client's medical record.

If the SN visit for TPN education occurs during a time period when the PDN provider is caring for the client, both the PDN provider and the nurse educator must document in the client's medical record the skilled services individually provided, including, but not limited to, the following:

- The start and stop time of each nursing provider's specialized tasks
- The client condition that requires the performance of skilled PDN tasks during the SN visit for TPN education
- The skilled services that each provided during that time period

Up to a maximum combined total of three SN and HHA visits may be prior authorized per day.

When documentation does not support medical necessity for home health SN and HHA visits, providers may be directed to possible alternative services based on the client's age and needs.

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A prior authorization for SN and HHA visits is no longer valid when:

- The client is no longer eligible for Medicaid.
- The client no longer meets the medical necessity criteria for SN or HHA services.
- The place of service cannot provide for the health and safety of the client.
- The client, parent, guardian, or caregiver refuses to comply with the primary physician's plan of treatment and compliance is necessary to ensure the health and safety of the client.
- The client changes providers and the change of notification is submitted to the claims administrator in writing with a prior authorization request from the new provider.

An SN or HHA visit may be prior authorized to provide services to more than one client over the span of the day as long as each client's care is based on an individualized POC and each client's needs and POC do not overlap with another client's needs and POC. Settings in which an SN or HHA provider may provide services in a provider-client ratio greater than 1:1 include, but are not limited to, homes with more than one client receiving Home Health Services, foster homes, and independent living arrangements.

Refer to: Subsection 2.13, "Private Duty Nursing (PDN)(CCP)" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for information about PDN.

3.2.10.2 Canceling a Prior Authorization

The client has the right to choose their home health agency provider and to change providers. If the client changes providers, TMHP must receive a change of provider letter with a new POC or Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form. 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 original provider of the change and the effective date. Prior authorization for the new provider can only be issued up to three business days before the date TMHP receives the change of provider letter and the new Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

3.2.10.3 Home Health SN and HHA Services That Will Not Be Prior Authorized

SN visits requested primarily to provide the following will not be prior authorized:

- Respite care
- Child care
- Activities of daily living for the client
- Housekeeping services
- Routine post-operative disease, treatment, or medication teaching after a physician visit
- Routine disease, treatment, or medication teaching after a physician visit
- Individualized, comprehensive case management beyond the service coordination required by the Texas Nursing Practice Act
- SN visits will not be approved for the sole purpose of instructing the client on the use of the subcutaneous injection port device. Any necessary instruction must be performed as part of the office visit with the primary physician.

HHA visits requested primarily to provide the following will not be prior authorized:

- Housekeeping services
- Services provided to a client residing in a hospital, SN facility, or intermediate care facility

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Certain facilities are required by licensure to meet all the medical needs of the client. SN or HHA visits will not be prior authorized for clients receiving care in any of the following facilities:

- Hospitals
- SN facilities
- Intermediate care facilities for individuals with intellectual disabilities (ICF-IID)
- Special care facilities, including but not limited to, sub-acute units and facilities for the treatment of acquired immunodeficiency syndrome (AIDS)

3.2.10.4 OT and PT Prior Authorization Requirements

Additional information is available on the TMHP website at www.tmhp.com. For requests that are submitted on or after April 1, 2014, providers must follow all guidelines that became effective January 1, 2014.

Prior authorization requests for occupational or physical therapy services, provided through a home health agency for an acute condition or an exacerbation of a chronic condition, must be obtained by contacting the TMHP Home Health Department.

The date and time that therapy began and ended must be documented and maintained in the client's medical record.

The submitted POC must include all information as shown on the Texas Medicaid Home Health POC form. The Home Health POC form is recommended but not required. The Medicare POC (485/486) will not be accepted.

Prior authorization for individual therapy services will be considered when all of the following criteria are met:

- The client has an acute condition or acute exacerbation of a chronic medical condition resulting in a significant decrease in functional ability that will benefit from therapy services that can be performed in a home setting.
- Documentation supports treatment goals and outcomes for the specific therapy disciplines requested.
- Services do not duplicate those that are provided concurrently by any other therapy.
- Services are within the provider's scope of practice, as defined by state law.

A nursing POC that addresses the OT or PT services must be completed, signed, and dated by the RN who performed the client's admission home assessment prior to the RN requesting authorization and must include:

- Diagnosis codes
- Treatment goals
- Duration of need
- Frequency
- Requested dates of service

To complete the prior authorization process by paper, the provider must complete and submit the prior authorization requirements documentation through fax or mail. The provider 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.

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To complete the prior authorization process electronically, the provider must complete and submit the prior authorization requirements documentation through any approved electronic method. The provider 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 must provide correct and complete information, including documentation of medical necessity for the services requested. The physician 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.

In addition to the nursing POC, home health agencies must provide the following information at the time each request for OT or PT is made:

- The requested OT or PT procedure codes with the appropriate GO or GP modifier
- OT or PT evaluation or re-evaluation results
- An initial or subsequent therapy treatment plan to include occupational or physical goals and dates of service requested

Prior authorization may be granted for a period not to exceed 60 days. A prior authorization request may be extended for an additional 60 days when requests are submitted with supporting documentation. Subsequent prior authorization requests may be granted for an additional 60 days, not to exceed a total of 180 days, when submitted with documentation.

Requests are not accepted from, nor are authorizations granted directly to the occupational therapist, physical therapist, OT assistant, or PT assistant.

If a client discontinues therapy with a provider, and a new provider begins therapy during an existing authorization period, submission of a new POC and documentation of the last therapy visit with the previous provider is required, along with a letter from the client, parent, or guardian stating the date therapy ended with the previous provider.

Group therapy procedures involve constant attendance of the physician, occupational therapist, or physical therapist, but by definition do not require one-on-one client contact by the physician, occupational therapist, or physical therapist. Procedure code 97150 may be submitted for each member of the group.

3.2.10.4.1 Initial Prior Authorization Requests

The initial request for prior authorization must be received no more than five business days from the date the therapy treatments are initiated. Initial prior authorization requests that are received after the five business-day period will be denied for dates of service that occurred before the date that the request was received.

The following supporting documentation must be submitted for an initial prior authorization request:

- A completed Home Health Services Plan of Care (POC) form. The request form must be signed and dated by the ordering physician. If the prior authorization form is not signed and dated by the physician, the form must be accompanied by a written order or prescription that is signed and dated by the physician, or a documented verbal order from the physician that includes the date the verbal order was received.

  Note: *A verbal order is considered current when the date received is on, or no more than, 60 rolling days before the start of therapy. A written order or prescription is considered current when it is signed and dated on, or no more than, 60 rolling days before the start of therapy.*
  A request received without a physician's signature, documented verbal order, or written prescription will not be processed and will be returned to the provider.

  Prior authorization requests that were submitted to the TMHP Prior Authorization

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Department using the previously published Request for Outpatient Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization form will be considered on a case-by-case basis.

- A current therapy evaluation that documents the client's age at the time of the evaluation for each therapy discipline.

  Note: *A therapy evaluation submitted with an initial request for prior authorization is current when it is performed within 60 rolling days before the initiation of therapy services.*

- A client-specific, comprehensive treatment plan that is established by the ordering physician or therapist to be followed during treatment in the home setting and includes all of the following:
  - Date and signature of the licensed therapist
  - Diagnosis
  - Treatment goals for the therapy discipline and associated disciplines requested that are related to the client's individual needs
  - A description of the specific therapy disciplines being prescribed
  - Duration and frequency of therapy
  - Date of onset of the illness, injury, or exacerbation requiring the home health services
  - Requested dates of service

3.2.10.4.2 Subsequent Prior Authorization Requests

A prior authorization request for subsequent services must be received no more than 30 days before the current authorization expires. Prior authorization requests for subsequent services received after the current authorization expires will be denied for dates of service that occurred before the date the submitted request was received.

Prior authorization requests for subsequent services may be considered for increments up to 60 days for each request with documentation that supports medical necessity and includes all of the following:

- A new, completed Home Health Plan of Care (POC) form, signed and dated by the ordering physician. If the prior authorization form is not signed and dated by the physician, the form must be accompanied by a written order of prescription that is signed and dated by the physician, or a documented verbal order from the physician that includes the date the verbal order was received.

  Note: *A verbal order is considered current when the date received is on, or no more than, 60 rolling days before the start of therapy. A written order or prescription is considered current when it is signed and dated on, or no more than, 60 rolling days before the start of therapy. A request received without a physician's signature, documented verbal order, or written prescription will not be processed and will be returned to the provider.*

- A current therapy evaluation or re-evaluation for each therapy discipline documenting the client's age at the time of evaluation or re-evaluation

  Note: *A therapy evaluation or re-evaluation for subsequent services is current when performed within 30 days before the prior authorization request is received.*

  For example:
  - If an authorization period ends on July 31, 2014, TMHP must receive the prior authorization request for subsequent services between July 1, 2014, and July 31, 2014.
  - The therapy evaluation or re-evaluation for subsequent services can be performed up to 30 days before the date TMHP receives the prior authorization request.
  - If TMHP receives the prior authorization request for subsequent services on July 1, 2014, the evaluation or re-evaluation can be performed June 1, through July 1, 2014.

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- If TMHP receives the prior authorization request for subsequent services on July 31, 2014, the evaluation or re-evaluation can be performed July 1, 2014, through July 31, 2014.

An updated client-specific comprehensive treatment plan established by the ordering physician or therapist to be followed during treatment in the home health setting must include all of the following:

- Date and signature of the licensed therapist
- Diagnosis(es)
- Updated treatment goals that are related to the client's individual needs for the therapy discipline and associated disciplines requested
- A description of the specific therapy disciplines that are being prescribed
- Duration and frequency of therapy
- Date of onset of the illness, injury, or exacerbation that requires the home health services
- A brief summary of the outcomes of the previous treatment as it relates to the client's debilitating condition
- Requested dates of service

3.2.10.4.3 Revisions to Existing Prior Authorization Requests

A prior authorization request for revisions to services may be considered up to the end of the current approved prior authorization.

Requests for revisions to an existing prior authorization must be received no later than five business days from the date that the revised therapy treatments are initiated.

Requests for revisions that are received after the five business-day period will be denied for dates of service that occurred before the date that the request was received.

If a provider or client discontinues therapy during an existing prior authorized period and the client requests services through a new provider, the new provider must submit all of the following:

- A new therapy request form
- A new evaluation with required documentation
- A change-of-provider letter signed and dated by the client or responsible adult documenting the date 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 length of the original authorization with the new provider. The original authorized period will apply to services that are performed by the new provider.

3.2.10.4.4 Physical Therapy and Occupational Therapy Frequency Levels

Physical therapy and occupational therapy services may be provided at one of the following levels commensurate with the client's medical condition, life stage, and therapy needs that are identified in the documentation submitted:

- **High Frequency:** Therapy provided three or more times a week may be considered when documentation supports all of the following:
  - Client has a medical condition that is rapidly changing
  - Client has a potential for rapid progress or rapid decline or loss of functional skill

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  - The client's therapy plan and home program require frequent modification by the licensed therapist
  - The client requires a high frequency of intervention for a limited duration (60 days or fewer) to recover function lost due to surgery, illness, or trauma
- **Moderate Frequency:** Therapy provided two times a week may be considered when documentation supports one or more of the following:
  - The client is making functional progress toward goals
  - The client is in a critical period to restore function or is at risk of regression
  - The licensed therapist needs to adjust the client's therapy plan and home program weekly or more often than weekly, based on the client's progress and medical needs
  - The client has complex needs requiring on-going education of the responsible adult
- **Low Frequency:** Therapy provided one time per week may be considered when the documentation supports one or more of the following:
  - The client is making progress toward the client's goals, but the progress has slowed, or the client may be at risk of deterioration due to the client's medical condition
  - The licensed therapist is required to adjust the client's therapy plan and home program weekly based on the client's progress.

As a client's condition improves and goals are met, it is anticipated that the therapy will decrease to a lesser frequency level.

3.2.10.5 Medicare and Medicaid Prior Authorization

Qualified Medicare Beneficiaries (QMB) are not eligible for Medicaid benefits. Providers should not submit prior authorization requests to the TMHP Home Health Services Prior Authorization Department for these clients.

For eligible Medicare and Medicaid clients, Medicare is the primary insurance and providers must contact Medicare first for prior authorization and reimbursement. Home health service prior authorizations may be given for HHA services, certain medical supplies, or DME suitable for use in the home in one of the following instances:

- When an eligible Medicaid client (enrolled in Medicare) does not qualify for Home Health Services under Medicare because SN care, OT, or PT are not a part of the client's care.
- When the medical supplies and DME are not a benefit of Medicare Part B and are a home health services benefit.

Federal and state laws require the use of Medicaid funds for the payment of most medical services only after all reasonable measures have been made to use a client's third party resources or other insurance.

> ***Note:*** *If the client has Medicare Part B coverage, contact Medicare for prior authorization requirements and reimbursement. If the service is a Part B benefit, do not contact TMHP for prior authorization.*

To ensure that Medicare benefits are used first in accordance with Texas Medicaid regulations, the following procedures apply when requesting Medicaid prior authorization and payment of Home Health Services for clients:

- Contact TMHP for prior authorization of Medicaid services (based on medical necessity and home health services benefits) within 30 days of the date on the MRAN. Fax a copy of the original MRAN and the Medicare appeal review letter to the TMHP Home Health Services Prior Authorization Department for prior authorization.

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- An MRAN is not required when a client is eligible for Medicare/Medicaid and needs HHA visits only. However, a skilled supervisory nursing visit must be made on the same day as the initial HHA visit and at least every 60 days (on the same day an HHA visit is made) thereafter as long as no skilled need exists. An SN supervisory visit is reimbursable, but an SN visit made for the primary purpose of assessing a client's nursing care is not. The SOC date will be the date of the first requested Medicare Home Health Services visit as listed on the original MRAN.

  Note: *Claims for State of Texas Access Reform (STAR)+PLUS MQMB clients (those with Medicare and Medicaid) should always be submitted to TMHP as noted on these pages. The STAR+PLUS health plan is not responsible for these services if Medicare denies the service as not a benefit.*

  For Medicaid qualified Medicare beneficiary (MQMB) clients, do not submit prior authorization requests to TMHP if the Medicare denial reason states "not medically necessary." Medicaid will only consider prior authorization requests if the Medicare denial states "not a benefit" of Medicare.

- When the client is 65 years of age or older or appears otherwise eligible for Medicare (e.g., a person who is blind or disabled), but has no Part A or Part B Medicare, the TMHP Home Health Services Prior Authorization Department uses regular prior authorization procedures. In this situation, the claim is held for a midyear status determined by HHSC. The maximum length of time a claim may be held in a "pending status" for Medicare determination is 120 days. After the waiting period, the claim is paid or denied. If denied, the EOB code on the R&S report indicates that Medicare is to be billed.

Refer to: Subsection 3.2.3, "Home Health Skilled Nursing Services" in this handbook.

Home health providers should follow these guidelines:

- Clients who are 64 years of age and younger without Medicare Part A or B:
  - If the agency erroneously submits an SOC notice to Medicare and does not contact TMHP for prior authorization, TMHP does not assume responsibility for any services provided before contacting TMHP. The SOC date is no more than three business days before the date the agency contacts TMHP. Visits made before this date are not considered a benefit of Texas Medicaid.
- Clients who are 65 years of age and older without Medicare Part A or Part B and clients with Medicare Part A or B regardless of age:
  - In filing home health claims, home health providers may be required to obtain Medicare denials before TMHP can approve coverage. When TMHP receives a Medicare denial, the SOC is determined by the date the agency requested coverage from Medicare. If necessary, the 95-day claims filing deadline is waived for these claims, provided TMHP receives notice of the Medicare denial within 30 days of the date on the MRAN containing Medicare's final disposition.
  - If the agency receives the MRAN and continues to visit the client without contacting TMHP by telephone, mail, or fax within 30 days of the date on the MRAN, TMHP will provide coverage only for services provided from the initial date of contact with TMHP. The SOC date is determined accordingly. TMHP must have the MRAN before considering the request for prior authorization.

TMHP will not prior authorize or reimburse the difference between the Medicare payment and the retail price for Medicare Part B eligible clients.

Refer to: Subsection 4.12, "Third Party Liability (TPL)" in Section 4, "Client Eligibility" (*Vol. 1, General Information*).

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3.2.10.6 Procedure Codes that Must be Included with the Prior Authorization Request

The following procedure codes are not automatically included in the prior authorization requests for PT and OT services unless requested:

PT and OT Procedure Codes That Require Separate Prior Authorization for Home Health									
97012	97014	97016	97018	97022	97024	97026	97028	97032	97033
97035	97150	97535	97537	97542	97799				

Prior authorization requests for any of the procedure codes listed above must include documentation of:

- The frequency of therapy for the procedure code
- The total amount of time in units or visits requested for the procedure code
- The therapeutic activities for which the procedure code will be used
- The specific, measurable short-term and long-term goals for the procedure code
- The appropriate modifier for the type of therapy being requested

3.2.11 Limitations and Exclusions

Payment cannot be made for any service, medical supply, or DME for which federal financial participation (FFP) is not available.

Refer to: Subsection 2.1, "CCP Overview" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) to find which of these items are a benefit for CCP clients who are 20 years of age and younger and who are eligible to receive THSteps services.

Home Health Service benefits do not include the following:

- Aids for daily living, such as toothpaste, spoons, forks, knives, and reachers
- Allergy injections
- Any services, including medical supplies or DME, furnished to a client who is a resident of a public institution or a client in a hospital, SN facility, or intermediate care facility
- Any services, including medical supplies, furnished to a client before the effective date of Medicaid eligibility as certified by HHSC or after the date of termination of Medicaid eligibility
- Any services, including medical supplies, furnished without prior authorization by TMHP, except as listed
- Application of a modality to one or more areas; hot or cold packs
- Developmental therapy
- Inpatient rehabilitation
- Nursing visits to administer long-term SQ/SC, IM, oral, or topical medications, such as insulin, vitamin B12, or deferoxamine, or to set up medications such as prefill insulin syringes or medication boxes, on a long-term basis
- PDN services
- Personal protective equipment (such as gloves, masks, gowns, and sharps containers) for use by a health-care provider, including but not limited to an RN, LVN, or attendant in the home setting.
- Respite care (caregiver relief)
- Services that are not medically necessary, including, but not limited to:

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  - Massage therapy that is the sole therapy or is not part of a therapeutic plan of care to address an acute condition
  - Hippotherapy
  - Treatment solely for the instruction of other agency or professional personnel in the client's physical or occupational therapy program
  - Training in non-essential tasks (e.g., homemaking, gardening, recreational activities, cooking, driving, assistance with finances, scheduling)
  - Maintenance therapy, including passive range of motion and exercises, which are not directed towards restoration of a specific loss of function
  - Emotional support, adjustment to extended hospitalization or disability, and behavioral readjustment
  - Therapy prescribed primarily as an adjunct to psychotherapy
- ST provided in the home
- Visits made primarily for performing housekeeping services are not considered a benefit of Texas Medicaid. These requests should be referred to in-home and family support service at HHSC

Any therapy services that exceed 180 rolling days from the start of therapy are not considered to be acute and will not be covered.

Refer to: Subsection 1.11, "Texas Medicaid Limitations and Exclusions" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

Subsection 2.7, "Early Childhood Intervention (ECI) Services" in the *Children's Services Handbook (Vol. 2, Provider Handbooks)*.

Subsection 2.16, "Inpatient Rehabilitation Facility (Freestanding) (CCP)" in the *Children's Services Handbook (Vol. 2, Provider Handbooks)*.

3.3 Documentation Requirements

All documentation, including that which supports medical necessity, and the comprehensive treatment plan related to the therapy services that were prior authorized and provided, must be maintained in the client's medical record and made available upon request.

For each therapy discipline provided, the documentation maintained in the client's medical record must identify the therapy provider's name and must include all of the following:

- Date of service
- Start time of the therapy
- Stop time of the therapy
- Total minutes of therapy
- Specific therapy performed
- Client's response to the therapy

3.3.1 Written POC

A Home Health Services POC is required for SN, HHA, OT, or PT services. The POC is not required as an attachment with the claim, but a signed and dated POC must be maintained by the provider and primary physician in the client's medical record. The client's primary physician must recommend, sign, and date a POC. The POC must be initiated by the RN in a clear and legible format.

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The POC must contain the following information:

- Activities permitted
- All pertinent diagnoses
- Available caregiver
- Client's Medicaid number
- Date the client was last seen by the primary physician. The client must be seen by a primary physician within 30 days of the initial SOC and at least once every six months thereafter unless the client's condition changes. The primary physician visit may be waived when a diagnosis has already been established by the primary physician and the recipient is under the continuing care and medical supervision of the primary physician. Any waiver must be based on the primary physician's written statement that an additional evaluation visit is not medically necessary. The original must be maintained by the primary physician and a copy must be maintained in the primary provider's files
- DME or medical supplies required
- Instructions for timely discharge or referral
- List of all community or state agency services the client receives in the home (e.g., Primary Home Care (PHC), PCS, community-based alternative [CBA], Medically Dependent Children's Program [MDCP])
- Medications including the dose, route, and frequency
- Mental status
- Nutritional requirements
- Physician's license number
- Prior and current functional limitations
- Prognosis
- Provider Medicaid number
- Rehabilitation potential
- Safety measures to protect against injury
- SOC date for Home Health Services
- Treatments, including amount, duration, and frequency
- Types of services including amount, duration, and frequency
- Wound care orders and measurements

Primary physicians that order OT or PT services must include the ICD-10-CM diagnosis codes for an acute or exacerbated event when OT and PT is being requested and the following documentation is included with the request:

- Specific procedures and modalities to be used
- Amount, frequency, and duration of therapy needed
- Physical and occupational therapy and goals
- Name of therapist who participated in developing the POC

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The primary physician and home health agency personnel (SN, HHA, OT, or PT) must review the POC as often as the severity of the client's condition requires or at least once every 60 days. This signed and dated documentation must be maintained in the client's medical record and must include the primary physician and requesting provider information. This applies to all written and verbal orders, and POCs.

Verbal physician orders may be given only to people authorized to receive them under state and federal law. They must be written, signed, and dated by the RN or qualified therapist who is responsible for furnishing or supervising the ordered service and placed in the client's medical record. The physician who gave the verbal order must sign the written copy of the verbal order within two weeks or per agency policy if less than two weeks. The original verbal order (without the physician's signature) and a copy of the verbal order that has been signed by the physician must be maintained in the client's medical record.

The type and frequency of visits, DME, or medical supplies must appear on the POC *before* the primary physician signs the POC and must not be added after the primary physician has signed the POC. If any change in the POC occurs during a prior authorization period (e.g., additional visits, DME, or medical supplies), the home health agency must contact the TMHP Home Health Services Prior Authorization Department for prior authorization and maintain a completed, revised POC that has been signed and dated by the primary physician.

Coverage periods do not necessarily coincide with calendar weeks or months but instead cover a number of services to be scheduled between a start and end date that is issued for the prior authorization.

Providers may request the frequency of physical, occupational, or speech therapy services either by week or by month, but not both.

A week includes the day of the week on which the prior authorization period begins and continues for seven days. For example, if the prior authorization starts on a Thursday, the prior authorization week runs Thursday through Wednesday. The number of therapy services authorized for a week must be provided within the prior authorized week.

A month includes the day of the month on which the prior authorization period begins and continues for 30 days. The number of therapy services authorized for a month must be provided within the prior authorized month.

Services billed in excess of those authorized for the prior authorization week or month are subject to recoupment.

Refer to: Home Health Plan of Care (POC) on the TMHP website at www.tmhp.com.

Subsection 3.2.8, "Physical Therapy (PT) Services" in this handbook.

3.3.1.1 Physician Supervision-POC

For the Home Health Services POC to be valid, the primary physician must sign and date it, and indicate when the services will begin. The home health agency must update and maintain the POC at least every 60 days or as necessitated by a change in the client's condition.

Medicare Form 485 is not accepted as a POC. The Home Health Services POC is the only acceptable form for prior authorization through Texas Medicaid.

3.3.2 Home Health SN and HHA Services Assessments and Reassessments

When a provider has received a referral and has physician orders for SN or HHA services, the provider must have an RN perform an initial client assessment in the client's home. A client can be referred to a home health agency for SN or HHA services by the client, the client's primary physician, or the client's family.

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The client assessment or reassessment should include, but is not limited to, the following:

- Whether the setting can support the health and safety needs of the client and is adequate to accommodate the use, maintenance, and cleaning of all medical devices, DME, and medical supplies required by the client
- Comprehension level of client, parent, guardian, or caregiver
- Receptivity to training and ability level of the client, parent, guardian, or caregiver
- A nursing assessment of medical necessity for the requested visits which includes:
  - 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
  - Cardiac status

The initial assessment and any reassessments that are required because of changes in the client's condition that occur during the course of the authorization period must be performed by an RN and must document medical necessity to support the requested service. If there is no change in the client's condition, the reassessment must document medical necessity to support continued and ongoing SN or HHA visits beyond the initial 60-day prior authorization period.

Note: *Nursing visits for the primary purpose of assessing a client's care needs to develop a POC are considered administrative and not billable. These visit costs are reflected on the cost report.*

3.4 Claims Filing and Reimbursement

3.4.1 Claims Information

Providers must use only type of bill (TOB) 321 in Form Locator (FL) 4 of the UB-04 CMS-1450. Other TOBs are invalid and will result in a claim denial. Home Health Services must be submitted to TMHP in an approved electronic format or on a CMS-1500 or a UB-04 CMS-1450 paper claim form. Submit home health DME and medical supplies to TMHP in an approved electronic format, or on a CMS-1500 or on a UB-04 CMS-1450 paper claim form. Providers may purchase CMS-1500 or UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply them.

When completing a CMS-1500 or a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as TMHP does not key information from attachments.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

Section 6.5, "CMS-1500 Paper Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

Outpatient claims must have the appropriate revenue code and, if appropriate, the corresponding Healthcare Common Procedure Coding System (HCPCS) code or narrative description. The prior authorization number must appear on the CMS-1500 paper claim form in Block 23 and in Block 63 of

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the UB-04 CMS-1450 paper claim form. The certification dates or the revised request date on the POC must coincide with the DOS on the claim. Prior authorization does not waive the 95-day filing deadline requirement.

Home health service claims should not be submitted for payment until Medicaid certification is received and a prior authorization number is assigned.

3.4.2 Reimbursement

The reimbursement methodology for professional services delivered by home health agencies is a statewide visit rate calculated in accordance with 1 TAC §355.8021(a).

Home health agencies are reimbursed for DME and medical supplies in accordance with 1 TAC §355.8021. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com. Providers may also request a hard copy of the fee schedule by contacting the TMHP Contact Center at 1-800-925-9126. DME and medical supplies, other than nutritional products, that have no established fee are subject to manual pricing at the documented MSRP less 18 percent or the provider's documented invoice cost.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

For reimbursement, providers should note the following:

- The client's primary physician must request professional, SN, and HHA services through a home health agency, and sign and date the POC.
- Claims are approved or denied according to eligibility, prior authorization status, and medical appropriateness.
- Claims must represent a numerical quantity of one-month for medical supplies according to the billing requirements.
- SN, HHA, OT, and PT services must be provided through a Medicaid-enrolled home health agency. These services must be billed using the home health agency's provider identifier. File these services on a UB-04 CMS-1450 claim form.
- OT and PT are always billed as POS 2 (home) and may be prior authorized to be provided in the home of the client or the home of the caregiver/guardian.
- DME or medical supplies must be provided by either a Medicaid enrolled home health agency's Medicaid/DME supply provider or an independently-enrolled Medicaid/DME supply provider. Both must enroll and bill using the provider identifier enrolled as a DME supplier. File these services on a CMS-1500 claim form.

Note: *Medical social services and speech-language pathology services are available to clients who are 20 years of age and younger and are not a home health services benefit. These services may be considered a benefit for clients who qualify for CCP.*

Texas Medicaid does not reimburse separately for associated DME charges, including but not limited to, battery disposal fees or state taxes. Reimbursement for any associated charges is included in the reimbursement for a specific piece of equipment.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

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3.4.3 Prohibition of Medicaid Payment to Home Health Agencies Based on Ownership

Medicaid denies Home Health Services claims when TMHP records indicate that the physician ordering treatment has a significant ownership interest in, or a significant financial or contractual relationship with, the nongovernmental home health agency billing for the services. Federal regulation Title 42 CFR §424.22 (d) states that "a physician who has a significant financial or contractual relationship with, or a significant ownership in a nongovernmental home health agency may not certify or recertify the need for Home Health Services care services and may not establish or review a plan of treatment."

A physician is considered to have a significant ownership interest in a home health agency if either of the following conditions apply:

- The physician has a direct or indirect ownership of five percent or more in the capital, stock, or profits of the home health agency.
- The physician has an ownership of five percent or more of any mortgage, deed of trust, or other obligation that is secured by the agency, if that interest equals five percent or more of the agency's assets.

A physician is considered to have a significant financial or contractual relationship with a home health agency if any of the following conditions apply:

- The physician receives any compensation as an officer or director of the home health agency.
- The physician has indirect business transactions, such as contracts, agreements, purchase orders, or leases to obtain services, medical supplies, DME, space, and salaried employment with the home health agency.
- The physician has direct or indirect business transactions with the home health agency that, in any fiscal year, amount to more than $25,000 or five percent of the agency's total operating expenses, whichever is less.

When providing CCP services and general Home Health Services, the provider must file these on two separate UB-04 CMS-1450 paper claim forms with the appropriate prior authorization number, and should send them to the appropriate address. Claims denied because of an ownership conflict will continue to be denied unless the home health agency submits documentation indicating that the ordering physician no longer has a significant ownership interest in, or a significant financial or contractual relationship with the home health agency providing services. Documentation should be sent to TMHP Provider Enrollment at the address indicated in the "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*).

3.4.4 Claims Filing for OT Services

Providers must use the codes listed under subsection 3.4.8, "OT Procedure Codes" in this handbook to submit claims for Title XIX OT services that are provided through a home health agency. Indicate modifier AT (indicating the service procedure is an acute treatment) on each OT procedure code. OT services must be billed on a UB-04 CMS-1450 claim form.

3.4.5 Claims Filing for PT Services

Providers must use the procedure codes listed in subsection 3.4.9, "PT Procedure Codes" in this handbook to submit claims for Title XIX PT services provided through a home health agency. Indicate modifier AT (indicating the service procedure is an acute treatment) on each PT procedure code. PT services must be billed on a UB-04 CMS-1450 claim form.

Refer to: Subsection 2.14, "Therapy Services (CCP)" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for CCP OT and PT services.

Subsection 6.3.5, "Modifiers" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

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3.4.6 OT Limitations

The AT modifier indicates an acute service and must be billed with the appropriate OT procedure codes identifying the therapy service provided. OT services billed without the AT modifier will be denied.

In addition to the AT modifier, the GO modifier must also be billed with all OT procedure codes except evaluation and re-evaluation procedure codes 97003 and 97004.

Providers must use procedure code 97003 when billing for OT evaluations. OT evaluations are payable once in 180 rolling days to any provider. Providers must use procedure code 97004 when billing for OT re-evaluations. OT re-evaluations are payable when documentation supports a change in the client's status or with a request for extension of services, or with a change in provider.

An evaluation or re-evaluation performed on the same date of service as therapy from a different therapy discipline must be performed at distinctly separate times to be considered for reimbursement.

A client may receive therapy in more than one distinct therapy discipline in one day when:

- Therapy is rendered at different times
- Reimbursement in any one distinct therapy type does not exceed one evaluation or one re-evaluation

If a therapy evaluation or re-evaluation procedure code and therapy procedure codes for the same discipline are billed for the same date of service by any provider, the like therapy evaluation or re-evaluation will be denied. OT evaluations (procedure code 97003) or re-evaluations (procedure code 97004) will be denied as part of the following OT procedure codes billed with modifier GO.

Procedure Codes									
97012	97014	97016	97018	97022	97024	97026	97028	97032	97033
97035	97039	97110	97112	97116	97124	97139	97140	97150	97530
97535	97537	97542	97799						

3.4.7 PT Limitations

The AT modifier indicates an acute service and must be billed with the appropriate PT procedure codes identifying the therapy service provided. PT services billed without the AT modifier will be denied.

In addition to the AT modifier, the GP modifier must also be billed with all PT procedure codes except evaluation and re-evaluation procedure codes 97001 and 97002.

Providers must use procedure code 97001 when billing for PT evaluations. PT evaluations are payable once every 180 rolling days for any provider. Providers must use procedure code 97002 when billing for PT re-evaluations. PT re-evaluations are payable when documentation supports a change in the client's status or with a request for extension of services, or with a change of provider.

An evaluation or re-evaluation performed on the same date of service as therapy from a different therapy discipline must be performed at distinctly separate times to be considered for reimbursement.

A client may receive therapy in more than one distinct therapy discipline in one day when:

- Therapy is rendered at different times.
- Reimbursement in any one distinct therapy type does not exceed one evaluation or one re-evaluation.

If a therapy evaluation or re-evaluation procedure code and therapy procedure codes for the same discipline are billed for the same date of service by any provider, the like therapy evaluation or re-evaluation will be denied. PT evaluations (procedure code 97001) or re-evaluations (procedure code 97002) will be denied as part of the following PT procedure codes billed with modifier GP.

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Procedure Codes									
97012	97014	97016	97018	97022	97024	97026	97028	97032	97033
97035	97039	97110	97112	97116	97124	97139	97140	97150	97530
97535	97537	97542	97799						

3.4.8 OT Procedure Codes

OT services may be reimbursed using the following procedure codes:

Procedure Codes									
97003	97004	97012	97014	97016	97018	97022	97024	97026	97028
97032	97033	97035	97039	97110	97112	97116	97124	97139	97140
97150	97530	97535	97537	97542	97799				

OT services are billed one visit per day, per therapy, and are reimbursed at the statewide visit rate available on the TMHP web site at www.tmhp.com.

The documentation retained in the client's file must include the billable start time, billable stop time, total billable minutes, and activity that was performed.

3.4.9 PT Procedure Codes

PT services may be reimbursed using the following procedure codes:

Procedure Codes									
97001	97002	97012	97014	97016	97018	97022	97024	97026	97028
97032	97033	97035	97039	97110	97112	97116	97124	97139	97140
97150	97530	97535	97537	97542	97799				

PT services are billed one visit per day, per therapy, and are reimbursed at the statewide visit rate available on the TMHP web site at www.tmhp.com.

The documentation retained in the client's file must include the billable start time, billable stop time, total billable minutes, and activity that was performed.

4 Therapists, Independent Practitioners, and Physicians

4.1 Enrollment

To enroll in Texas Medicaid, licensed therapists and physicians must be enrolled in Medicare.

Refer to: Subsection 9.1.1, "Physicians and Doctors" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about physician enrollment requirements.

If providers are currently enrolled with Texas Medicaid or plan to provide regular acute care services to clients with Medicaid coverage, enrollment in CCP is not necessary. All non-CCP therapy services must be billed with the current provider identifier.

Providers cannot be enrolled if their license is due to expire within 30 days of applying. A current license must be submitted.

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4.2 Services, Benefits, Limitations, and Prior Authorization

OT, PT, and ST are benefits of Texas Medicaid for an acute condition or an exacerbation of a chronic condition when all of the following criteria are met:

- Treatments are expected to significantly improve the client's condition in a reasonable and generally predictable period of time, based on the physician's assessment of the client's restorative potential.
- Treatments are directed towards restoration of or compensation for lost function.
- 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.

PT, OT, and ST services are a benefit for 180 rolling days from the first date of therapy services. If the client's condition persists for more than 180 rolling days from the start of the therapy services, the condition is considered chronic.

Therapy may be performed by a licensed occupational therapist, physical therapist, speech therapist, or one of the following under the supervision of a licensed therapist: licensed therapy assistant or licensed speech-language pathology intern.

Services performed by an OT aide, OT orderly, OT student, OT technician, PT aide, PT orderly, PT student, PT technician, SLP aide, SLP orderly, SLP student, or SLP technician are not benefits of Texas Medicaid.

Therapy services performed by an unlicensed provider are subject to retrospective review and recoupment.

OT, PT, and ST that is not a benefit of traditional Medicaid may be covered:

- In the physician's office, or Medicaid-enrolled private therapist's office for a chronic condition.
- Through the SHARS program.
- In an outpatient rehabilitation or free-standing rehabilitation facility.
- In a licensed hospital.

OT, PT, and ST services that are not benefits of traditional Medicaid may be benefits under CCP.

Professional services for selective wound debridement (procedure codes 97597 and 97598) may 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 Medicaid-enrolled supervising physician or qualified non-physician provider.

Refer to: Subsection 2.14, "Therapy Services (CCP)" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for therapy benefits for clients who are 20 years of age and younger.

4.2.1 OT Services

Payment for OT is limited to the treatment of disease for individuals whose ability to function in life roles is impaired. OT can be provided by a physician or occupational therapist and may include physical agents such as massage, electricity, traction, or exercises as forms of therapy. Examples of what may be considered acute are as follows:

- A new injury
- Therapy before or after surgery
- Acute exacerbations of conditions

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OT is considered acute for 180 calendar days from the first date (onset) of therapy for a specific condition. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client's condition has not become chronic and the client has not reached the point of plateauing.

A client may receive therapy in more than one distinct therapy discipline on the same date of service when the therapy is rendered at different times.

An evaluation or re-evaluation that is performed on the same date of service as a therapy from a different therapy discipline must be performed at distinctly separate times to be considered for reimbursement.

Claims for OT services must include modifier GO to be considered for reimbursement. Modifier AT must also be submitted with all claims for therapy procedure codes for acute conditions or the claims will be denied. Modifiers are not required for evaluations or re-evaluations.

Reimbursement for OT procedure codes is based on the actual amount of billable time associated with the service. Services for which the unit of service is 15 minutes (1 unit = 15 minutes) must 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 divided by 15 equals 4 units plus 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 identified in the following table:

Units	Number of Minutes
0 units	0 minutes through 7 minutes
1 unit	8 minutes through 22 minutes
2 units	23 minutes through 37 minutes
3 units	38 minutes through 52 minutes
4 units	53 minutes through 67 minutes
5 units	68 minutes through 82 minutes
6 units	83 minutes through 97 minutes
7 units	98 minutes through 112 minutes
8 units	113 minutes through 127 minutes

The following procedure codes may be reimbursed in 15-minute increments for a combined maximum of four units (one hour) per day, per therapy type:

Procedure Codes									
97032	97033	97034	97035	97036	97039	97110	97112	97113	97116
97124	97139	97140	97530	97750	97799				

If the therapy services billed exceed four units a day, the claim will be denied and may be appealed. On appeal the provider must document the prior authorization period week for the date of service appealed.

The appeal must include an attestation that the provider has billed all therapy services for the week in question.

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Occupational group therapy procedures involve constant attendance of the physician or therapist, but by definition do not require one-on-one client contact by the physician or therapist. When billing for occupational group therapy, procedure code 97150 must be used for each member of the group.

Procedure codes 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028, and 97150 are limited to one per day, per therapy type.

Procedure codes 97535, 97537, and 97542 are only payable for clients who are 20 years of age and younger in an outpatient rehabilitation setting or through CCP.

Evaluation procedure code 97003 is reimbursed once in 180 rolling days to any provider. Re-evaluation procedure code 97004 is payable when documentation supports a change in the client's status, a request for extension of services, or a change of provider.

OT evaluations or re-evaluations (procedure code 97003 or 97004) will be denied when any of the procedure codes in the following table are billed with modifier GO by any provider on the same date of service:

Procedure Codes									
97012	97014	97016	97018	97022	97024	97026	97028	97032	97033
97034	97035	97036	97039	97110	97112	97113	97116	97124	97139
97140	97150	97530	97750	97799					

The documentation retained in the client's file must include the billable start time, billable stop time, total billable minutes, and activity that was performed.

4.2.2 PT Services

Payment for PT is limited to acute disorders of the musculoskeletal and neuromuscular systems. PT can be provided by a physician or physical therapist and may include physical agents such as massage, electricity, traction, or exercises in the treatment of disease. Examples of what may be considered acute are as follows:

- A new injury
- Therapy before or after surgery
- Acute exacerbations of conditions
- Interventions that result in a change in a client's condition, such as a newly implanted pump to administer an antispasmodic
- Botulinum toxin type A injections

PT is considered acute for 180 calendar days from the first date (onset) of therapy for a specific condition. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client's condition has not become chronic and the client has not reached the point of plateauing.

A client may receive therapy in more than one distinct therapy discipline on the same date of service when the therapy is rendered at different times.

An evaluation or re-evaluation performed on the same date of service as a therapy from a different therapy discipline must be performed at distinctly separate times to be considered for reimbursement.

Claims for PT services must include modifier GP to be considered for reimbursement. Modifier AT must also be submitted with all claims for therapy procedure codes for acute conditions or the claims will be denied. Modifiers are not required for evaluations or re-evaluations.

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Reimbursement for PT procedure codes is based on the actual amount of billable time associated with the service. Services for which the unit of service is 15 minutes (1 unit = 15 minutes) must 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.

Refer to: Subsection 4.2.1, "OT Services" in this handbook for an example of the 15-minute conversion table.

The following procedure codes may be reimbursed in 15-minute increments for a combined maximum of four units (one hour) per day, per therapy type:

Procedure Codes									
97032	97033	97034	97035	97036	97039	97110	97112	97113	97116
97124	97139	97140	97530	97750	97799				

If the therapy services billed exceed four units a day, the claim will be denied, and may be appealed.

On appeal, the provider must document the prior authorization period week for the date of service appealed. The appeal must also include an attestation that the provider has billed all therapy services for the week in question.

Physical group therapy procedures involve constant attendance of the physician or therapist, but by definition do not require one-on-one client contact by the physician or therapist. When billing for physical group therapy, procedure code 97150 must be used for each member of the group.

Procedure codes 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028, and 97150 are limited to one per day, per therapy type.

Procedure codes 97535, 97537, and 97542 are only payable for clients who are 20 years of age and younger in an outpatient rehabilitation setting or through CCP.

Evaluation procedure code 97001 is payable once per 180 rolling days, any provider. Re-evaluation procedure code 97002 is payable when documentation supports a change in the client's status, a request for extension of services, or a change of provider.

PT evaluations or re-evaluations (procedure code 97001 or 97002) will be denied when any of the procedure codes in the following table are billed with modifier GP by any provider on the same date of service:

Procedure Codes									
97012	97014	97016	97018	97022	97024	97026	97028	97032	97033
97034	97035	97036	97039	97110	97112	97113	97116	97124	97139
97140	97150	97530	97750	97799					

The documentation retained in the client's file must include the billable start time, billable stop time, total billable minutes, and activity that was performed.

4.2.3 ST Services

ST is limited to treatment of conditions of the head or neck which affect speech production. ST may be provided by a physician or speech-language pathologist (SLP). Examples of what may be considered acute are as follows:

- Stroke or Cerebral vascular accident (CVA)
- Neoplasms of the head or neck

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- Open or closed head trauma

ST is considered acute for 180 calendar days from the first date (onset) of therapy for a specific condition. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client's condition has not become chronic and the client has not reached the point of plateauing.

A client may receive therapy in more than one distinct therapy discipline on the same date of service when the therapy is rendered at different times.

An evaluation or re-evaluation performed on the same date as a therapy from a different therapy discipline must be performed at distinctly separate times to be considered for reimbursement.

ST evaluations are performed before the initiation of speech therapy. The speech therapy may be performed by an SLP if the SLP is on staff at the hospital or under the personal supervision of a physician.

Claims for ST services must include modifier GN to be considered for reimbursement. Modifier AT must also be submitted with all claims for therapy procedure codes for acute conditions or the claims will be denied. Modifiers are not required for evaluations or re-evaluations.

Reimbursement for ST procedure codes is based on the actual amount of billable time associated with the service. Services for which the unit of service is 15 minutes (1 unit = 15 minutes) must 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.

Refer to: Subsection 4.2.1, "OT Services" in this handbook for an example of the 15-minute conversion table.

Procedure codes 92526 and 92610 may be reimbursed for the treatment and evaluation of swallowing dysfunctions and oral functions for feeding.

Procedure codes 92507, 92508, and 92526 may be reimbursed in 15-minute increments, and are limited to four units (one hour) per day.

Speech group therapy procedures involve constant attendance of the physician or therapist, but by definition do not require one-on-one client contact by the physician or therapist.

If reassessment is necessary within the 180-day period, payment will be considered for procedure code S9152 when documentation supports a change in the client's status, a request for extension of services, or a change of provider.

ST evaluations or re-evaluations (procedure code 92521, 92522, 92523, 92524, or S9152) will be denied when billed on the same date of service, any provider as procedure codes 92507 and 92508 with modifier GN.

The documentation retained in the client's file must include the billable start time, billable stop time, total billable minutes, and activity that was performed.

Refer to: Subsection 3.2.1.3, "Auditory Rehabilitation" in the *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*) for information about aural rehabilitation services.

4.2.4 Therapy in a Nursing Facility

Separate payment cannot be made to therapists, independent practitioners, or physicians who provide therapy services to a resident of a nursing facility. These services must be made available to nursing facility residents as needed and must be provided directly by the staff of the facility or furnished by the facility through arrangements with outside qualified resources as part of the daily care. Nursing facilities should refrain from admitting clients who need goal-directed therapy if the facility is unable to provide these services.

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4.2.5 Group Therapy Definition

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.

4.2.5.1 Group Therapy Guidelines

In order to meet Texas Medicaid 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: *Texas Medicaid 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.*

4.2.6 Authorization Requirements

PT, OT, and ST evaluations or re-evaluations do not require prior authorization when provided within the limits of the provider's practice. PT, OT, and ST services performed within the office or outpatient setting do require prior authorization.

The physician must maintain documentation of medical necessity, including the treatment plan and therapy evaluation or re-evaluation, in the client's medical record. The provider requesting the therapy may be asked for additional information to clarify or complete a request for therapy. The date, time, and duration of services provided must be documented and maintained in the client's medical record.

Prior authorization for individual therapy services may be considered when all of the following criteria are met:

- The client has an acute condition or an acute exacerbation of a chronic medical condition resulting in a significant decrease in functional ability that will benefit from services that can be performed in the office or outpatient setting
- Documentation must support treatment goals and outcomes for 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

Therapy procedure codes that may be authorized in 15-minute units will be limited to a combined maximum of four units (one hour) per day, per therapy type. Additional services may be considered without prior authorization.

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4.2.6.1 Procedure Codes that Must be Included with the Prior Authorization Request

The following procedure codes are not included in PT, OT, and ST prior authorizations unless requested:

PT and OT Procedure Codes That Require Separate Prior Authorization for Acute Services									
97012	97014	97016	97018	97022	97024	97026	97028	97033	97034
97035	97799								

ST Procedure Code That Requires Separate Prior Authorization
97535

Note: *Procedure code 97535 is used for ST services for training for augmentative communication devices (ACD).*

Prior authorization requests for any of the procedure codes listed above must include documentation of:

- The frequency of therapy for the procedure code
- The total amount of time in units or visits requested for the procedure code
- The therapeutic activities for which the procedure code will be used
- The specific, measurable short-term and long-term goals for the procedure code
- The appropriate modifier for the type of therapy being requested

4.2.6.2 Initial Prior Authorization Request for Therapy Services

The initial request for authorization must be received no later than five business days from the date the therapy treatments are initiated. Requests received after the five business-day period will be denied for dates of service that occurred before the date that the request was received.

Therapy services may be initiated upon the receipt of the physician's order. Therapy services initiated before the date of the physician order will not be approved.

Prior authorization may be given for a service period not to exceed 90 days per event for acute care services only. An additional 90-day period may be requested with documentation submitted through prior authorization.

Subsequent prior authorizations beyond 180 days will not be authorized, as treatment for chronic conditions is not a benefit. Prior authorizations may be approved for a time period less than the established maximum.

Supporting Documentation for Initial Prior Authorization Requests

Supporting documentation must be submitted for an initial request and must include all of the following:

- A completed Request for Outpatient Physical, Occupational, or Speech Therapy (PT, OT, ST) Special Medical Prior Authorization Form. The request form must be signed and dated by the ordering physician. The following also applies:
  - If the prior authorization form is not signed and dated by the physician, the form must be accompanied by a written order or prescription signed and dated by the physician, or a documented verbal order from the physician that includes the date the verbal order was received
  - A verbal order is considered current when the verbal order is received on, or no more than, 60 rolling days before the start of therapy

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  - A written order or prescription is considered current when it is signed and dated on, or no more than, 60 days before the start of therapy
  - A request received without a physician's signature or documented verbal order or written prescription will not be processed and will be returned to the provider
- A current therapy evaluation for each therapy discipline documenting the client's age at the time of the evaluation (A therapy evaluation is current when performed within 60 rolling days before the initiation of therapy services)
- A client-specific comprehensive treatment plan established by the ordering physician or therapist to be followed during treatment in the office or outpatient setting must include all of the following:
  - Date and signature of the licensed therapist
  - Diagnosis(es)
  - Treatment goals for the therapy discipline and associated disciplines requested related to the client's individual needs
  - A description of the specific therapy disciplines being prescribed
  - Duration and frequency of therapy
  - Date of onset of the illness or injury or exacerbation requiring the office or outpatient services
  - Requested dates of service

4.2.6.3 Subsequent Prior Authorization Requests for Therapy Services

A prior authorization request for subsequent services must be received no more than 30 days before the current authorization expires. Prior authorization requests for subsequent services received after the current authorization expires will be denied for dates of service that occurred before the date the submitted request was received.

Prior authorization requests for subsequent services may be considered for increments up to 90 days for each request with documentation supporting medical necessity that includes all of the following:

- A new, completed Request for Outpatient Physical, Occupational, or Speech Therapy (PT, OT, ST) Special Medical Prior Authorization Form. The request form must be signed and dated by the ordering physician.
- If the prior authorization form is not signed and dated by the physician, the form must be accompanied by a written order or prescription signed and dated by the physician, or a documented verbal order from the physician that includes the date the verbal order was received. A verbal order is considered current when the verbal order is received on, or no more than, 60 rolling days before the start of therapy.
- A written order or prescription is considered current when it is signed and dated on, or no more than, 60 rolling days before the start of therapy. A request received without a physician's signature, documented verbal order, or written prescription will not be processed and will be returned to the provider.
- A current therapy evaluation or re-evaluation for each therapy discipline documenting the client's age at the time of the evaluation or re-evaluation.

A therapy evaluation or re-evaluation for subsequent services is current when performed within 30 days before the prior authorization request is received. For example:

- If an authorization period ends on July 31, 2014, TMHP must receive the prior authorization request for subsequent services between July 1, 2014, and July 31, 2014.The therapy evaluation or re-evaluation for subsequent services can be performed up to 30 days before the date TMHP receives the prior authorization request.

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- If TMHP receives the prior authorization request for subsequent services on July 1, 2014, the evaluation or re-evaluation can be performed June 1, through July 1, 2014.
- If TMHP receives the prior authorization request for subsequent services on July 31, 2014, the evaluation or re-evaluation can be performed July 1, 2014, through July 31, 2014.

Updated Treatment Plan or Prior Authorization Revisions

An updated client-specific comprehensive treatment plan established by the ordering physician or therapist to be followed during treatment in the office or outpatient setting must include all of the following:

- Date and signature of the licensed therapist
- Diagnosis(es)
- Updated treatment goals for the therapy discipline and associated disciplines requested related to the client's individual needs
- A description of the specific therapy disciplines being prescribed
- Duration and frequency of therapy
- Date of onset of the illness, injury, or exacerbation requiring the office or outpatient hospital services
- A brief summary of the outcomes of the previous treatment relative to the client's debilitating condition
- Requested dates of service

Requests for revisions of prior authorization must be received no later than five business days from the date the revised therapy treatments are initiated. Requests for revisions received after the five business-day period will be denied for dates of service that occurred before the date the request was received. A prior authorization request for revisions to services may be considered up to the end of the current approved prior authorization.

Discontinuation of Therapy or Change in Provider

If a provider or client discontinues therapy during an existing prior authorized period and the client requests services through a new provider, the new provider must submit all of the following:

- A new therapy request form
- A new evaluation with required documentation
- A change of provider letter signed and dated by the client or responsible adult documenting the date 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

The change of provider letter should be submitted with the provider's initial request for services to avoid a delay in processing the request. A change of provider during an authorization period will not extend the authorization period. Regardless of the number of provider changes, clients may not receive therapy services beyond the limitations outlined in this policy.

Speech Therapy Services Frequency Levels

PT, OT, and ST services may be provided at one of the following levels commensurate with the client's medical condition, life stage, and therapy needs identified in the documentation submitted. As the client's condition improves and goals are met, it is anticipated that the therapist will decrease the frequency to a lesser level.

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High Frequency: Three or more times per week may be considered when documentation supports all of the following:

- The client has a medical condition that is rapidly changing.
- The client has a potential for rapid progress, rapid decline, or loss of functional skill.
- The client's therapy plan and home program require frequent modification by the licensed therapist.
- The client requires a high frequency of intervention for a limited duration (60 days or fewer) to recover function lost due to surgery, illness, or trauma.

Moderate Frequency: Two times per week may be considered when documentation supports one or more of the following:

- The client is making functional progress toward goals.
- The client is in a critical period to restore function or is at risk of regression.
- The licensed therapist needs to adjust the client's therapy plan and home program weekly, or more often than weekly, based on the client's progress and medical needs.
- The client has complex medical needs requiring on-going education of the responsible adult.

Low Frequency: One time per week may be considered when the documentation supports one or more of the following:

- The client is making progress toward the client's goals, but the progress has slowed, or the client may be at risk of deterioration due to the client's medical condition.
- The licensed therapist is required to make weekly adjustments to the client's therapy plan and home program based on the client's progress.

4.2.7 Noncovered Services

The following services are not a benefit of Texas Medicaid:

- Therapy services that exceed 180 rolling days from the start of therapy are not considered to be acute and will not be covered
- Application of a modality to one or more areas; hot or cold packs
- Services that are not considered medically necessary. Examples include, but are not limited to the following:
  - Massage therapy that is the sole therapy or is not part of a therapeutic POC to address an acute condition
  - Hippotherapy
  - Treatment solely for the instruction of other agency or professional personnel in the client's OT, PT, and ST program
  - Separate reimbursement for VitalStim therapy for dysphagia
  - Training in nonessential tasks (e.g., homemaking, gardening, recreational activities, cooking, driving, assistance with finances, and scheduling)
  - Maintenance therapy, including passive range of motion and exercises that are not directed towards restoration of a specific loss of function
  - Emotional support, adjustment to extended hospitalization, or disability behavioral readjustment

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- Therapy prescribed primary as an adjunct to psychotherapy

Note: *Therapy that exceeds 180 days may be considered for prior authorization for clients who are birth through 20 years of age through CCP.*

4.2.8 Rehabilitative Services

Rehabilitative Services is a program administered by TMHP to nursing facility clients who need rehabilitation. These services must be prior authorized through TMHP before the therapy is provided and reimbursed by TMHP. Covered services include OT, PT, and ST to clients who are eligible for Texas Medicaid, with an acute onset of an illness or injury, with the expectation that function will be improved measurably. For all rehabilitative services inquiries, call Rehabilitative Services at 1-800-792-1109.

Refer to: Subsection 2.16, "Inpatient Rehabilitation Facility (Freestanding) (CCP)" in the *Children's Services Handbook (Vol. 2, Provider Handbooks)* for more information.

4.3 Documentation Requirements

Therapy must be provided under the current written orders of a physician and based on medical necessity. A prescription is considered current when it is signed and dated on or no later than 60 days before the start of therapy. Therapy may be performed by auxiliary personnel under the direct supervision of the physician or the licensed, independently practicing therapist.

All documentation, including that which supports medical necessity, and a comprehensive treatment plan related to the therapy services prior authorized and provided must be maintained in the client's medical record and made available upon request. For each therapy discipline provided, the documentation maintained in the client's medical record must identify the therapy provider's name and must include all of the following:

- Date of service
- Start time of the therapy
- Stop time of the therapy
- Total minutes of therapy
- Specific therapy performed
- Client's response to therapy

To complete the prior authorization process by paper, the provider must complete and submit the prior authorization requirements documentation through fax or mail, 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 complete the prior authorization process electronically, the provider must complete and submit the prior authorization requirements documentation through any approved electronic 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 must provide correct and complete information, including documentation of medical necessity for the services requested. The physician 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.

If a client discontinues therapy with a provider and a new provider begins therapy, submission of a new plan of care and documentation of the last therapy visit with the previous provider is required, along with a letter from the client, parent, or guardian stating the date therapy ended with the previous provider.

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4.3.1 Group Therapy Documentation Requirements

The following documentation must be maintained in the client's medical record:

- Physician prescription for group therapy

  Note: *Physician prescription for group therapy is not required in the medical record of Early Childhood Intervention clients.*

- 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 techniques 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.

When physical or occupational group therapy is administered, providers must bill procedure code 97150 for each member of the group.

Note: *There is an exception to these requirements for ECI services. The group therapy guidelines for ECI services are found in the current Texas Medicaid Provider Procedures Manual, Children's Services Handbook, Subsection 2.7.2, "Services, Benefits, Limitations, and Prior Authorization".*

4.4 Claims Filing and Reimbursement

4.4.1 Claims Information

The Medicaid rates for therapists, independent practitioners, and physicians are calculated in accordance with 1 TAC §355.8081 and §355.8085.

Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

Subsection 2.7, "Medicare Crossover Claim Reimbursement" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for additional information about Medicare coinsurance and deductible payments.

Therapy 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. Claims may be filed electronically in a CMS-1500 format as long as the nine-digit prior authorization number is reflected in the equivalent electronic field.

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Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Subsection 6.4, "Claims Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

5 Claims Resources

Providers may refer to the following sections or forms when filing claims:

Resource	Location
Appendix A: State, Federal, and TMHP Contact Information	Appendix A (*Vol. 1, General Information*)
Appendix D: Acronym Dictionary	Appendix D (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	"Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5 (*Vol. 1, General Information*)
Section 3: TMHP Electronic Data Interchange (EDI)	Section 3 (*Vol. 1, General Information*)
TMHP Electronic Claims Submission	Subsection 6.2 (*Vol. 1, General Information*)
UB-04 CMS-1450 Paper Claim Filing Instructions	Subsection 6.6 (*Vol. 1, General Information*)

6 Contact TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday–Friday from 7 a.m. to 7 p.m., Central Time.

7 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Home Health Plan of Care (POC) Instructions
Home Health Plan of Care (POC)
Home Health Prior Authorization Checklist
Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions
Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form
Special Medical Prior Authorization (SMPA) Request Form

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8 Claim Form Examples

The following linked claim form examples can also be found on the Claim Form Examples page of the Provider section of the TMHP website at www.tmhp.com:

Claim Form Examples
Certified Respiratory Care Practitioner (CRCP)
Home Health Services Skilled Nursing Visit
Home Health Services Skilled Nursing Visit and Physical Therapy
Physical Therapist

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Radiology and Laboratory Services Handbook

Texas Medicaid Provider Procedures Manual: Vol. 2

April 2016

TEXAS
Health and Human
Services Commission

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1 General Information

This information is intended for Texas Medicaid independent (freestanding) laboratories, radiological laboratories, and physiological laboratories.The handbook provides information about Texas Medicaid's benefits, policies, and procedures applicable to these providers.

Important: *All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: Section 1: Provider Enrollment and Responsibilities (*Vol. 1, General Information*).

1.1 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

According to 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: Subsection 3.7.3.8, "Payment Window Reimbursement Guidelines"of the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about the payment window reimbursement guidelines.

2 Independent Laboratory

The requirements in this section apply to all providers who bill laboratory services.

2.1 Enrollment

Providers must meet the following requirements and submit a complete application in order to enroll as independent (freestanding) laboratory providers:

- The provider must be actively enrolled in Medicare as an independent laboratory.
- The independent laboratory must be independent from a physician's office or hospital.
- The independent laboratory must meet staff, equipment, and testing capability standards for certification by the Health and Human Services Commission (HHSC).

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2.1.1 Clinical Laboratory Improvement Amendments (CLIA)

CLIA regulations set standards that are 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.

The regulations concern all laboratory testing that is used for the assessment of human health or the diagnosis, prevention, or treatment of disease. Under CLIA 88, all clinical laboratory providers (including those located in physicians' offices), regardless of location, size, or type of laboratory, must meet certain standards based on the complexity of the tests they perform.

Providers must hold the appropriate CLIA certificates to perform certain tests as indicated in this handbook.

Refer to: The Centers for Medicare & Medicaid Services (CMS) website at www.cms.gov for the CLIA rules and regulations. The regulations are found at Title 42 Code of Federal Regulations, Part 493.

2.1.2 CLIA Requirements

To be eligible for reimbursement by Medicare and Medicaid, all providers that perform laboratory tests must do the following:

- Pay the applicable fee to 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 Licensing and Certification Division
  HHSC
  1100 West 49th Street
  Austin, TX 78756

- Notify the Texas Medicaid & Healthcare Partnership (TMHP) of the assigned CLIA number at the following address:

  Texas Medicaid & Healthcare Partnership
  Provider Enrollment
  PO Box 200795
  Austin, TX 78720-0795

TMHP monitors claims that are submitted by clinical laboratory providers to verify that the clinical laboratory has a CLIA number on file. If the provider does not have a CLIA number on file with TMHP, the laboratory services claims may be denied.

2.2 Services, Benefits, Limitations, and Prior Authorization

Texas Medicaid only covers professional and technical services that an independent laboratory is certified by CLIA to perform.

Provider documentation must be maintained in the client's medical record and must delineate the medical need for administering the laboratory test.

The physician is responsible for providing to the performing laboratory the clinical diagnosis code that is associated with the individual test so that the performing laboratory may bill Texas Medicaid directly for the analysis of the specimen.

Refer to: The Current Procedural Terminology (CPT) manual for information regarding examples of laboratory codes. Correct use of CPT coding requires using the most specific laboratory code that matches the services provided, based on the code's description.

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2.2.1 CLIA Certificates

Texas Medicaid follows the Medicare categorization of tests for CLIA certificate holders.

Refer to: The CMS website at www.cms.gov/CLIA/10_Categorization_of_Tests.asp for additional information.

2.2.2 Laboratory Handling Fees and Reference Laboratories

2.2.2.1 Independent Laboratory Providers

An independent laboratory provider may be reimbursed for tests performed in the laboratory and for laboratory handling fees for tests that are forwarded to another laboratory (i.e., reference laboratory).

An independent laboratory that forwards a specimen to another laboratory without performing any tests on that specimen may not bill for any laboratory tests.

An independent laboratory may only bill Texas Medicaid for tests referred to another independent or hospital laboratory if it performs at least one test that it is certified by CLIA to perform, and forwards a portion of the same specimen to the other laboratory to have one or more tests performed. The referring laboratory may then bill for tests it has performed on the specimen. When billing, the following information must be on the claim:

- Block 20: "Yes" box must be checked.
- Block 32: The name, address, and ZIP Code of the reference laboratory (i.e., the laboratory to which the specimen was referred).
- Block 24-J: The provider number of the reference laboratory must be included next to each procedure to be performed by the reference laboratory.

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 if the specimen is collected by routine venipuncture or catheterization.

2.2.2.2 Physician Providers

A physician may bill only one laboratory handling charge (procedure code 99000) per client visit when the specimen is collected by drawing a blood sample through venipuncture or collecting a urine specimen by catheterization, unless the specimen is divided and sent to different laboratories or there are different specimens collected and sent to different laboratories.

The claim must indicate the name and address of each laboratory where a specimen is sent for more than one laboratory handling charge to be paid.

Refer to: Subsection 9.2.41, "Laboratory Services" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information about laboratory services reimbursed to physician providers.

2.2.2.3 Outpatient Hospital Providers

An outpatient hospital may be reimbursed for a laboratory handling charge (procedure code 99001) for each independent laboratory to where it sends specimens when the laboratory handling charge is not being billed through other methods.

2.2.2.4 Family Planning Laboratory Tests

Family planning agencies must use procedure code 99000 with a family planning diagnosis code to bill their laboratory handling charges for laboratory specimens sent out; modifier FP must be omitted. Providers may refer to the appropriate section in the provider manual for instructions for billing family planning services. As with procedure code 99000, only one handling fee may be charged for each laboratory to where the agency sends specimens, regardless of the number of specimens taken.

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When family planning test specimens, such as Pap smears, are collected, providers must direct the laboratory to indicate that the claim for the test is to be billed as a family planning service.

Refer to: Subsection 3.3, "Services, Benefits, Limitations, and Prior Authorization" in the *Gynecological and Reproductive Health and Family Planning Services Handbook* (*Vol. 2, Provider Handbooks*) for the complete list of family planning diagnosis codes.

2.2.3 Nonclinical Laboratory Procedures

The reimbursement for nonclinical laboratory procedure codes can be found on the appropriate Texas Medicaid fee schedules on the TMHP website at www.tmhp.com.

2.2.4 Clinical Laboratory Procedures

The reimbursement for clinical laboratory procedures can be found on the appropriate Texas Medicaid fee schedule. Fee schedules are available on the TMHP website at www.tmhp.com.

2.2.4.1 Repeat Procedures

Modifier 91 should be used for repeat clinical diagnostic tests 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 and services must be documented on appeal.

Providers may appeal claims that have been denied for documentation of time. Most procedure codes that initially required modifier 91 will 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.

2.2.5 Automated Laboratory Tests and Laboratory Paneling

The 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. The Texas Medicaid allowable fee 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.

2.2.5.1 Fee Calculations for Automated Tests and Laboratory Panels

Automated test and laboratory panel procedure codes may be reimbursed according to the appropriate ATP level payment based on the total number of automated tests that are performed on the same day for the same client.

Refer to: The "Clinical Laboratory, Automated Test Panels - Insert" Texas Medicaid fee schedule on the TMHP website at www.tmhp.com for the ATP level payment for automated test and lab panel procedure codes.

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ATP Level Pricing

The amount that is allowed for each automated test and lab panel procedure code that is billed with the same date of service for the same client will be a percentage of the total ATP level payment. To calculate the automated test pricing, the following information is necessary:

- The number of automated tests that are billed for the client for the same date of service (including individual automated tests and all automated tests that are represented by the laboratory panels.) Procedure codes that are duplicated between panels are not counted more than once.
- The ATP pricing fee that corresponds to the number of automated tests that are billed for the client for the same date of service.
- The total billed amount for all automated test and laboratory panel procedure codes that are billed for the client for the same date of service.

The automated test pricing may be calculated as follows:

Step 1

A percentage for each automated test or lab panel detail is derived from dividing the billed amount (B/A) for each procedure by the total billed amount (TB/A) for all automated test and laboratory panel procedure codes with the same date of service for the same client.

Example:

Automated Test	B/A	Percentage
Detail 1 Automated Test	= $50.00	= 29%
Detail 2 Automated Test	= $25.00	= 14%
Detail 3 Lab Panel	= $100.00	= 57%
Detail 4 Clinical Lab Test	= $20.00	= 0%
	TB/A = $175.00	

Note: *The TB/A is for automated test and laboratory panel procedure codes (details 1, 2, and 3 only). Detail 4 is not included in the calculations for the automated tests because it is a clinical lab procedure code and may be reimbursed as indicated on the fee schedule.*

Calculations:

Detail 1	= 50.0 0 / 175.00	= .285714285714…	= 29%
Detail 2	= 25.00 / 175.00	= .142857142857…	= 14%
Detail 3	= 100.00 / 175.00	= .571428571428…	= 57%

Step 2

The detail allowed amount for each automated test (AT) procedure code will be the calculated percentage of the ATP level payment.

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Example:

Automated Test	Number of Automated Tests	Allowed Amount
Detail 1 Automated Test	= 1	= $3.10
Detail 2 Automated Test	= 1	= $1.55
Detail 3 Lab Panel	= 4	= $6.19
Detail 4 Clinical Lab Test	= 0	= Fee Schedule
	ATP = 6 = $10.84	

Note: *The total number of automated tests includes the individual automated test procedure codes and the number of automated tests that are represented by each panel procedure code that is billed. Automated tests that are duplicated between panels are not counted more than once.*

Calculations:

Detail 1	= 29% of 10.84	= (.285714285714…)X(10.84)	= $3.10
Detail 2	= 14% of 10.84	= (.142857142857…)X(10.84)	= $1.55
Detail 3	= 57% of 10.84	= (.571428571428…)X(10.84)	= $6.19
			$10.84

Note: *If a clinical laboratory procedure code is included in a panel, the fee schedule rate for the clinical laboratory procedure is added to the ATP rate, and the resulting sum is divided among the automated test and laboratory panel procedure codes that are billed for the date of service.*

The total allowed amount for all laboratory services that are billed for the client for the same date of service will represent the ATP level pricing combined with any clinical laboratory test fee schedule pricing.

2.2.6 Breast Cancer Gene 1 and 2 (BRCA) Testing

Breast Cancer Gene 1 and 2 (BRCA) testing services are benefits of Texas Medicaid when billed with the following procedure codes:

Procedure Codes									
81162	81211	81212	81213	81214	81215	81216	81217		

Breast cancer gene 1, early onset (BRCA1) and breast cancer gene 2, susceptibility protein (BRCA2) are tumor repressor genes responsible for keeping breast cells from growing too rapidly or in an uncontrolled way. Mutations within the gene interrupt this regulatory function and increase the risk of breast and ovarian cancer, have been linked to other types of cancer such as pancreatic and prostate, and can be inherited from a person's mother or father.

Note: *Coverage of BRCA mutation analysis testing, including large rearrangement gene mutation analysis testing, are based on the National Comprehensive Cancer Network (NCCN) guidelines.*

Interpretation of gene mutation analysis results is not separately reimbursable. Interpretation is part of the physician E/M service.

BRCA gene mutation analysis testing must be ordered based on familial medical history and the availability of previous familial gene mutation analysis testing results and only if the test results will affect treatment decisions or provide prognostic information.

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Unaffected male or females with a family history of breast cancer, including diagnosis of ductal carcinoma in situ (DCIS), should only be considered for testing when the appropriate affected family member is unavailable. Clinical judgment should be used to determine if the client has a reasonable likelihood of a mutation, considering the client's current age and the age of the unaffected female relatives who link the client with the affected relatives.

It is mandatory that a client who is at risk for BRCA1, BRCA2, or BRCA large rearrangement genetic mutation receive genetic counseling before and after BRCA gene mutation testing.

BRCA gene mutation analysis testing (procedure codes 81162, 81211, 81212, 81213, 81214, 81215, 81216, and 81217) is limited to once per lifetime. Additional testing services may be considered for BRCA1 and BRCA2 comprehensive sequencing gene mutation analysis testing (procedure code 81211) on a case-by-case basis with prior authorization.

Note: *Additional BRCA large rearrangement gene mutation analysis testing is not a benefit.*

2.2.6.1 Genetic Counseling

Genetic counseling must be provided by a trained genetic counselor, nurse specialist in genetics, or other medical provider possessing expertise in genetic counseling that is not affiliated with the genetic testing laboratory for clients before and after BRCA gene mutation testing.

Both pre- and post-test counseling must provide the depth of content and time for the client to make an informed testing decision. The genetic counseling must be nondirective, and information about the purpose and nature of the tests must be provided to the client.

Pre-test genetic counseling must include:

- The risks and benefits of the specific genetic testing.
- The limitations of the specific genetic testing to be performed and the limitations of interpreting test results for an unaffected individual.

2.2.6.2 Documentation

Providers must maintain the following gene mutation analysis testing documentation in the client's medical record:

- The appropriateness of the genetic testing
- The client's specific high-risk criteria
- The benefit of the specific genetic testing to be performed
- Pre-testing genetic counseling, including all of the following:
  - Pre-test counseling date with the name and qualifications of the counseling professional
  - The risks, benefits, and limitations discussed with the client
  - The client's ability to understand the risks, benefits, and limitations and the client's informed choice to proceed with the specific gene mutation analysis testing as evidenced by the client's signature on a consent form specific to the genetic mutation testing to be performed.
- The client's BRCA1 and BRCA2 comprehensive gene mutation analysis testing results to support medical necessity for BRCA large rearrangement gene mutation analysis testing
- The client's BRCA large rearrangement gene mutation analysis testing results
- Post-testing genetic counseling, including all the following:
  - Post-test counseling date with the name and qualifications of the counseling professional
  - The client's ability to understand the results of the gene mutation analysis testing and the appropriate medical treatment resulting from the test results.

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- The client's treatment plan and any treatment plan changes based on interpretation of the test results

The medical record is subject to retrospective review.

2.2.6.3 * Prior Authorization for BRCA Testing

Prior authorization is not required for BRCA large rearrangement gene mutation analysis testing (procedure code 81213) when submitted with a negative test result for procedure code 81211.

Prior authorization is required for initial BRCA testing (procedure codes 81211, 81212, 81214, 81215, 81216, and 81217). The prior authorization request must include documentation that indicates that the client meets one or more of the criteria below:

- An individual (male or female) from a family with a known deleterious BRCA1/BRCA2 mutation
- A female with a personal history of breast cancer, including invasive or ductal carcinoma in situ (DCIS), diagnosed at age 45 years or younger
- A female with a personal history of breast cancer, including DCIS, diagnosed at any age and of an ethnicity associated with higher mutation frequency, such as: Ashkenazi Jewish, Icelandic, Swedish, or Hungarian descent
- A female with a personal history of epithelial ovarian cancer, including fallopian tube and primary peritoneal cancers, diagnosed at any age
- A male with a personal history of breast cancer, including DCIS, diagnosed at any age
- A female with a personal history of breast cancer, including DCIS, diagnosed at age 50 years or younger, and has one of the following:
  - An additional primary (2 primary sites, including bilateral or clearly separate ipsilateral) tumors occurring either synchronously or asynchronously
  - At least one close blood relative with breast cancer at any age
  - An unknown or limited family history
- A female with a personal history of breast cancer, including DCIS, diagnosed at age 60 years or younger with triple negative breast cancer
- A female with a personal history of breast cancer, including DCIS, diagnosed at any age, and has one of the following:
  - At least one close blood relative with breast cancer diagnosed at age 50 years or younger
  - At least two close blood relatives with breast cancer at any age
  - At least one close blood relative with epithelial ovarian cancer, including fallopian tube and primary peritoneal cancers
  - At least two close blood relatives with pancreatic cancer or prostate cancer (Gleason score 7 or greater) at any age
  - A close male blood relative with breast cancer at any age
- A male or female with a personal history of pancreatic cancer or prostate cancer (Gleason score 7 or greater) at any age regardless of ancestry with at least two close blood relatives with one of the following:
  - Breast cancer
  - Ovarian cancer, including fallopian tube and primary peritoneal cancers
  - Prostate cancer (Gleason score 7 or greater)

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    - Pancreatic cancer
- A male or female with a personal history of pancreatic cancer at any age and of an ethnicity associated with higher mutation frequency, such as Ashkenazi Jewish, Icelandic, Swedish, or Hungarian descent and one or more close blood relatives with pancreatic cancer
- A male or female with a family history of breast or ovarian cancer, including DCIS with one of the following:
    - At least one first or second degree blood relative meeting any of the criteria above; or
    - At least one third degree blood relative who has breast cancer, including DCIS, or ovarian cancer, including fallopian tube and primary peritoneal cancers, and at least two close blood relatives with one of the following:
        - Breast cancer, including DCIS, of which at least one with breast cancer was diagnosed at 50 years of age or younger
        - Ovarian cancer, including fallopian tube and primary peritoneal cancers

Note: *The term "close blood relative" includes first-degree male or female relatives (e.g., parents, siblings), second-degree relatives (e.g., aunts, uncles, grandparents), and third-degree relatives (e.g., first cousins, great grandparents), from the same side of the family as the client.*

Prior authorization for additional BRCA testing may be considered on a case-by-case basis by Medical Director review when testing criteria for these studies are met for clients who:

- Have previously been tested for BRCA1 and BRCA2 comprehensive sequencing gene mutation analysis testing and received negative results. Documentation of negative results for BRCA1 and BRCA2 comprehensive sequencing gene mutation analysis testing are required for medically necessary BRCA large rearrangement gene mutation analysis testing.
- Results are not available and every reasonable effort has been made to obtain the results. Documentation of the specific efforts to obtain results from the client's genetic testing physician or the testing laboratory must be included with the prior authorization request.
- BRCA1 and BRCA2 comprehensive sequencing or founder gene mutation analysis testing was obtained and interpreted before BRCA large rearrangement gene mutation analysis testing (procedure code 81213) was available.

A completed Hereditary Breast and Ovarian Cancer (HBOC) Genetic Testing Prior Authorization Request Form that has been signed and dated by the referring provider must be submitted.

A provider's signature on a submitted document indicates that the provider certifies, to the best of the provider's knowledge, the information in the document is true, accurate, and complete.

For comprehensive sequencing, the physician must indicate one of the following on the prior authorization request form:

- The client's familial genetic history that supports medical necessity for the requested BRCA1 and BRCA2 comprehensive sequencing, founder gene mutation analysis, or known familial variant gene mutation analysis testing.
- Every reasonable effort was made to obtain the client's familial genetic history and have been unable to obtain BRCA1 and BRCA2 comprehensive sequencing gene mutation analysis testing results for the affected family member(s). Documentation of the specific efforts made to obtain the client's familial genetic history must be submitted with the request.

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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. Medical documentation that is submitted by the physician must verify the client's diagnosis or family history. Requisition forms from the laboratory are not sufficient for the establishment of a client's personal and family history.

To complete the prior authorization process, the provider must mail or fax the request to the TMHP Special Medical Prior Authorization Unit and include documentation of medical necessity.

A request for retroactive authorization must be submitted no later than seven calendar days beginning the day after the lab draw is performed.

2.2.7 Complete Blood Count (CBC)

A CBC and its components may be reimbursed by Texas Medicaid without prior authorization. The medical necessity for all laboratory services must be documented in the client's medical record, and the services must be referenced to an appropriate diagnosis code.

Texas Medicaid considers a baseline CBC appropriate for the evaluation and management of existing and suspected disease processes. CBC tests should be individualized and based on client history, clinical indications, or proposed therapy, and will not be reimbursed for screening purposes.

When related CBC procedure codes are billed for the same date of service by the same provider, the first procedure code will be reimbursed and all other procedure codes will be denied.

Reticulocyte procedure codes may be reimbursed in addition to the CBC, hemogram, differential analysis, and platelet procedure codes indicated above.

Refer to: The appropriate Texas Medicaid fee schedule on the TMHP website at www.tmhp.com for CBC procedure codes that may be reimbursed.

2.2.8 Drug Testing and Therapeutic Drug Assays

The following procedure codes for therapeutic drug assays may be reimbursed by Texas Medicaid:

Procedure Codes									
80150	80155	80156	80157	80158	80159	80162	80163	80164	80165
80168	80169	80170	80171	80173	80175	80176	80177	80178*	80180
80183	80184	80185	80186	80188	80190	80192	80194	80195	80197
80198	80199	80200	80201	80202	80203	80299	80300	80301	80302
80303	80304	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
* CLIA Waived test									

Note: *The procedure codes above do not require prior authorization.*

Providers are encouraged to reference the American Board of Internal Medicine (ABIM) Foundation's "Choosing Wisely" lists to determine appropriateness of laboratory tests.

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2.2.9 Evocative and Suppression Testing

The following procedure codes for evocative and suppression testing may be reimbursed by Texas Medicaid:

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							

Note: *The procedure codes above do not require prior authorization.*

Providers are encouraged to reference the American Board of Internal Medicine (ABIM) Foundation's "Choosing Wisely" lists to determine appropriateness of laboratory tests.

2.2.10 Genetic Testing for Colorectal Cancer

Genetic testing is provided to clients who have a first- or second-degree relative who has or has had colorectal cancer in order to determine if the client may have increased risk for developing colorectal cancer.

Note: *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.*

Interpretation of gene mutation analysis results are part of the evaluation and management service and will not be reimbursed separately.

Genetic test results, when informative, may influence clinical management decisions. The documentation that is maintained in the client's medical record must reflect that the client 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. The testing must be medically necessary and supported by documentation with a clear rationale for testing, which must be retained in the client's medical record and made available upon request.

2.2.10.1 Documentation Requirements

Providers must maintain the following documentation in the client's medical record for genetic testing for colorectal cancer:

- Documentation of formal pre-test counseling, including assessment of the client's ability to understand the risks and limitations of the test.
- The client's informed choice to proceed with the genetic testing for colorectal cancer.

The provider must order the test based on the familial medical history and the availability of previous family testing results. The medical record is subject to retrospective review.

Refer to: The appropriate Texas Medicaid fee schedule on the TMHP website at www.tmhp.com for genetic testing procedure codes that may be reimbursed.

2.2.10.2 * Authorization Requirements

Prior authorization is required for gene mutation analysis. Prior authorized services may be reimbursed once per lifetime when billed by any provider. Additional services will not be prior authorized.

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Prior authorization requests may be considered for Familial Adenomatous Polyposis (FAP) testing for clients of any age with well defined hereditary cancer syndromes and for which either a positive or negative result will change medical care. The client for whom the request is made must have more than 20 polyps or a first-degree relative with FAP and a documented mutation.

Note: *Clients who are seven years of age or younger must have clear rationale for testing and documentation of medical necessity from the client's medical record must be submitted with the prior authorization request.*

Prior authorization requests may be considered for Hereditary Nonpolyposis Colorectal Cancer (HNPCC) testing for clients of any age. Testing for HNPCC is used to determine whether an individual has an increased risk for colorectal cancer or other HNPCC-associated cancers. Results of the test may influence clinical management decisions. The request must include one or more of the following criteria for testing:

- The client has three or more family members (at least one must be a first-degree relative) who have colorectal cancer, and FAP has been ruled out. Two successive generations were affected, and one or more of the relatives was diagnosed with colorectal cancer at 50 years of age or younger.
- The client has had two HNPCC cancers.
- The client has colorectal cancer and a first-degree relative who also has colorectal cancer or HNPCC extracolonic cancer at 50 years of age or younger or colorectal adenoma at 40 years of age or younger.
- The client has had colorectal cancer or endometrial cancer at 50 years of age or younger.
- The client has had right-sided colorectal cancer with an undifferentiated pattern on histology at 50 years of age or younger.
- The client has had signet-cell type colorectal cancer at 50 years of age or younger.
- The client has had colorectal adenoma at 40 years of age or younger.
- The client is an asymptomatic individual with a first- or second-degree relative with a documented HNPCC mutation.

Note: *Clients who are 20 years of age or younger must have clear rationale for testing and documentation of medical necessity from the client's medical record must be submitted with the prior authorization request.*

A provider's signature, including the prescribing provider's, on a submitted document indicates that the provider certifies, to the best of the provider's knowledge, the information in the document is true, accurate, and complete.

Requisition forms from the laboratory are not sufficient for verification of the personal and family history.

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. Medical documentation that is submitted by the physician must verify the client's diagnosis or family history.

Guidelines for MLH1 and MLH2 mutation testing are based on guidelines established by the American College of Medical Genetics and the American Gastroenterological Association.

A request for retroactive authorization must be submitted no later than seven calendar days beginning the day after the lab draw is performed.

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2.2.11 Hematology and Coagulation

The following hematology and coagulation procedure codes may be reimbursed by Texas Medicaid:

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
85460	85461	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									

Note: *The procedure codes above do not require prior authorization.*

The following procedure codes are limited to one per day by the same provider:

Procedure Codes						
85027	85347	85397	85520	85576	85610	85730

Procedure codes 85460 and 85461 may be reimbursed for female clients who are 10 through 55 years of age.

Procedure code 85004 will deny if billed on the same day by the same provider as procedure code 85007.

Procedure code 85660 is limited to once per lifetime, 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 client's medical records.

Providers are encouraged to reference the American Board of Internal Medicine (ABIM) Foundation's "Choosing Wisely" lists to determine appropriateness of laboratory tests.

2.2.12 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 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.
- Individuals who have virological failure during antiretroviral therapy, laboratory results showing HIV RNA levels greater than 500 and less than 1,000 copies/ml.

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- HIV-infected pregnant women before initiation of therapy.
- HIV-infected pregnant women entering pregnancy with HIV RNA levels at or below 400 copies/ml while the women are on therapy.

Documentation must be maintained in the client's medical record to support medical necessity for the HIV drug-resistance testing. Specific documentation requirements are dependent on the rationale for the testing. 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 that support all of the following:

- Acute HIV infection, with identification of the specific viral strain
- Virological failure during antiretroviral therapy with HIV RNA levels greater than 500 and less than 1,000 copies/ml
- Positive pregnancy results in an HIV positive female client
- HIV RNA levels of 400 copies/ml or less during pregnancy

HIV drug-resistance testing is not recommended when one of the following criteria is met:

- The drug regimen has been discontinued for more than four weeks
- The viral load is less than 500 copies/ml

Refer to: Subsection C.1.1, "Routine HIV Testing Procedure Codes" in Appendix C, "HIV/AIDS" (*Vol. 1, General Information*) for additional information about HIV testing laboratory procedures.

2.2.13 Iron Studies

Iron studies are used in the evaluation of disorders of iron metabolism and are primarily indicated for the workup of iron deficiency and iron overload.

Ferritin, iron, iron binding capacity, transferrin, and iron stain-peripheral blood (procedure codes 82728, 83540, 83550, 84466, and 85536) lab tests may be reimbursed when they are billed with one of the following diagnosis codes or combination diagnosis codes:

Diagnosis Codes							
Single Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
D460	D461	D4620	D4621	D4622	D464	D469	D46A
D46B	D46C	D46Z	D471	D473	D479	D47Z1	D47Z9
D500	D501	D508	D509	D510	D511	D512	D513
D518	D519	D520	D521	D528	D529	D530	D531
D532	D538	D539	D560	D561	D562	D563	D564
D568	D569	D5700	D5701	D5702	D571	D5720	D57211
D57212	D57219	D5740	D57411	D57412	D57419	D5780	D57811
D57812	D57819	D582	D588	D589	D598	D599	D630
D631	D638	D640	D641	D642	D643	D649	D732
D7381	E0801	E0810	E0811	E0821	E0822	E0829	E08311
E08319	E08321	E08329	E08331	E08339	E08341	E08349	E08351
E08359	E0836	E0839	E0840	E0841	E0842	E0843	E0844
E0849	E0851	E0859	E08610	E08618	E08620	E08621	E08622
E08628	E08630	E08638	E08641	E08649	E0865	E0869	E088

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Diagnosis Codes							
E089	E0901	E0910	E0911	E0940	E0941	E0942	E0943
E0944	E0949	E0951	E0959	E09610	E09618	E09620	E09621
E09622	E09628	E09630	E09638	E09641	E09649	E0965	E0969
E098	E099	E1010	E1011	E1021	E1022	E1029	E10311
E10319	E10321	E10329	E10331	E10339	E10341	E10349	E10351
E10359	E1036	E1039	E1040	E1041	E1042	E1043	E1044
E1049	E1051	E1052	E1059	E10610	E10618	E10620	E10621
E10622	E10628	E10630	E10638	E10641	E10649	E1065	E1069
E108	E109	E1101	E1121	E1122	E1129	E11311	E11319
E11321	E11329	E11331	E11339	E11341	E11349	E11351	E11359
E1136	E1139	E1140	E1141	E1142	E1143	E1144	E1149
E1151	E1152	E1159	E11610	E11618	E11620	E11621	E11622
E11628	E11630	E11638	E11641	E11649	E1165	E1169	E118
E119	E1301	E1310	E1311	E1321	E1322	E1329	E13311
E13319	E13321	E13329	E13331	E13339	E13341	E13349	E13351
E13359	E1336	E1339	E1340	E1341	E1342	E1343	E1344
E1349	E1351	E1352	E1359	E13610	E13620	E13621	E13622
E13628	E13630	E13638	E13641	E13649	E1365	E1369	E138
E139	E290	E291	E298	E299	E8310	E83110	E83111
E83118	E8319	G2589	G259	G26	I420	I425	I428
I43	I440	I441	I442	I4430	I4439	I444	I445
I4460	I4469	I447	I450	I4510	I4519	I452	I453
I454	I455	I456	I4581	I4589	I459	I470	I471
I472	I479	I480	I481	I482	I483	I484	I4891
I4892	I4901	I4902	I491	I493	I4940	I4949	I495
I498	I499	I501	I5020	I5021	I5022	I5023	I5030
I5031	I5032	I5033	I5040	I5041	I5042	I5043	I509
I781	K7011	K7031	K7151	K730	K738	K739	K740
K741	K7460	K7469	K754	K7581	K760	K7689	K769
L649	L659	L818	L819	L989	M1310	M13111	M13112
M13121	M13122	M13131	M13132	M13141	M13142	M13151	M13152
M13161	M13162	M13171	M13172	M13811	M13812	M13821	M13822
M13831	M13832	M13841	M13842	M13851	M13852	M13861	M13862
M13871	M13872	M1388	M1389	M150	M151	M152	M153
M154	M158	M160	M1611	M1612	M162	M1631	M1632
M164	M1651	M1652	M166	M167	M170	M1711	M1712
M172	M1731	M1732	M174	M175	M1811	M1812	M182
M19011	M19012	M19021	M19022	M19031	M19032	M19041	M19042
M19071	M19072	M19111	M19112	M19121	M19122	M19131	M19132
M19141	M19142	M19171	M19172	M19211	M19212	M19221	M19222

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Diagnosis Codes							
M19231	M19232	M19241	M19242	M19271	M19272	M1990	M1991
M1992	M1993	N500	N5201	N5202	N5203	N521	N5231
N5232	N5233	N5234	N5239	N529	N910	N911	N912
N913	N914	N915	R001	R160	R161	R162	R180
R188	R740	R7871	R7879	R7889	R790	R7989	R799
Combination Diagnosis Codes (Must be submitted in pairs)							
E0801 E0865	E0810 E0865	E0821 E0865	E08311 E0865	E08319 E0865	E0836 E0865	E0840 E0865	E0851 E0865
E0865 E08311	E0865 E08319	E0865 E08321	E0865 E08329	E0865 E08331	E0865 E08339	E0865 E08341	E0865 E08349
E0865 E08351	E0865 E08359	E0865 E0836	E0865 E0839	E0865 E0840	E0865 E0841	E0865 E0842	E0865 E0843
E0865 E0844	E0865 E0849	E0865 E0851	E0865 E0852	E0865 E0859	E0865 E0869	E0865 E088	E0865 E0901
E0865 E0910	E0865 E0921	E0865 E09311	E0865 E09319	E0865 E0936	E0865 E0940	E0865 E0951	E0865 E0969
E0865 E098	E0865 E1310	E0865 E1365	E0865 E138	E1010 E1065	E1011 E1065	E1011 E10641	E1021 E1065
E10311 E1065	E10319 E1065	E1036 E1065	E1039 E1065	E1040 E1065	E1051 E1065	E1065 E1069	E1065 E108
E1065 E1022	E1065 E1029	E1065 E10321	E1065 E10329	E1065 E10331	E1065 E10339	E1065 E10341	E1065 E10349
E1065 E10351	E1065 E10359	E1065 E1041	E1065 E1042	E1065 E1043	E1065 E1044	E1065 E1049	E1065 E10610
E1065 E1052	E1065 E1059	E1100 E1165	E1101 E1165	E1121 E1165	E11311 E1165	E11319 E1165	E1136 E1165
E1139 E1165	E1140 E1165	E1151 E1165	E1165 E11321	E1165 E11329	E1165 E11331	E1165 E11339	E1165 E11341
E1165 E11349	E1165 E11351	E1165 E11359	E1165 E1169	E1165 E118	E1321 E0865		

Procedure code 83550 will be denied if it is billed with the same date of service by the same provider as procedure code 84466. All other iron studies may be reimbursed if they are billed with the same date of service by the same provider.

Modifier 91 may be used if a repeat procedure on the same day by the same provider is medically necessary.

Refer to: The appropriate Texas Medicaid fee schedule on the TMHP website at www.tmhp.com for iron studies procedure codes that may be reimbursed.

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2.2.14 Microbiology

The following microbiology procedure codes may be reimbursed by Texas Medicaid:

Procedure Codes									
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
87277	87278	87279	87280	87281	87283	87285	87290	87299	87300
87301	87305	87320	87324	87327	87328	87329	87332	87335	87336
87337	87338	87340	87341	87350	87380	87385	87389	87390	87391
87400	87420	87425	87427	87430	87449*	87450	87451	87470	87471
87472	87475	87476	87477	87480	87481	87482	87485	87486	87487
87490	87491	87492	87493	87495	87496	87497	87498	87500	87501
87502	87503+	87505	87506	87507	87510	87511	87512	87515	87516
87517	87520	87521	87522	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	87580	87581	87582	87590	87591	87592	87623	87624	87625
87631	87632	87633	87640	87641	87650	87651	87652	87653	87660
87661	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			
*** CLIA Waived test** **+ Add-on code**									

Note: *The procedure codes above do not require prior authorization.*

The following procedure codes are limited to one per day by the same provider:

Procedure Codes									
87015	87046	87071	87075	87076	87077	87081	87088	87101	87102
87106	87107	87140	87147	87149	87150	87152	87153	87181	87184
87185	87186	87188	87190	87206	87209	87210	87252	87254	87300
87798	87801	87809	87899	87904					

Providers are encouraged to reference the American Board of Internal Medicine (ABIM) Foundation's "Choosing Wisely" lists to determine appropriateness of laboratory tests.

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2.2.15 Organ or Disease-Oriented Panels

The following organ or disease-oriented panel procedure codes may be reimbursed by Texas Medicaid:

Procedure Codes									
80047	80048	80050	80051	80053	80055	80061	80069	80074	80076
80081									

Note: *The procedure codes above do not require prior authorization.*

Procedure codes 80055 and 80081 are limited to female clients who are 10 through 55 years of age. Only one service for procedure code 80055 or one service for procedure code 80081 will be reimbursed per pregnancy to the same provider.

Procedure code 80061 is limited to once per rolling year, by any provider, when performed as part of a preventative care medical checkup.

The reimbursement for the complete panel procedure code represents the total payment for all automated laboratory tests that are covered under that panel combined; including any other automated tests billed for the client for the same date of service (DOS). The Texas Medicaid allowable fee 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 DOS.

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 may be billed.

Providers are encouraged to reference the American Board of Internal Medicine (ABIM) Foundation's "Choosing Wisely" lists to determine appropriateness of laboratory tests.

2.2.16 Urinalysis

Urinalysis laboratory tests may be reimbursed without prior authorization.

Refer to: The appropriate Texas Medicaid fee schedule on the TMHP website at www.tmhp.com for urinalysis procedure codes that may be reimbursed.

When related urinalysis procedure codes are billed for the same date of service by the same provider, the first procedure code will be reimbursed and all other procedure codes will be denied. Claims will be denied with an explanation directing the provider to appeal with a copy of their Remittance and Status (R&S) Report and the appropriate comprehensive procedure code if they are not satisfied with their reimbursement.

Example: *If a provider bills procedure codes 81002 and 81015 for the same date of service, the first procedure code billed may be reimbursed and the second procedure code billed will be denied. The provider will be directed to appeal the claim with the more inclusive procedure code (in this example, procedure code 81000).*

Procedure code 84578 may be reimbursed for the same date of service as procedure code 81000, 81001, 81002, 81003, 81005, or 81020.

2.2.17 Additional Laboratory Services

2.2.17.1 Colorectal Cancer Screening

Refer to: Subsection 4.2.8, "Colorectal Cancer Screening" in the *Hospital Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 9.2.15.2, "Colorectal Cancer Screening" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

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2.2.17.2 Cytopathology Studies

Refer to: Subsection 9.2.26.4, "Cytopathology Studies—Other Than Gynecological" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 5.15, "Pap Smear (Cytopathology Studies)" in the *Gynecological and Reproductive Health and Family Planning Services Handbook* (*Vol. 2, Provider Handbooks*).

2.2.17.3 Helicobacter pylori Testing

Refer to: Subsection 9.2.26.8, "Helicobacter Pylori (H. pylori)" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

2.2.17.4 Laboratory Services for Clients on Dialysis

Refer to: Subsection 6.2.9, "Laboratory and Radiology Services" in the *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*).

2.2.17.5 Prognostic Breast and Gynecological Cancer Studies

Refer to: Subsection 6.2.9, "Laboratory and Radiology Services" in the *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*).

2.2.17.6 THSteps Outpatient Laboratory Services

Refer to: Subsection 5.3.11.6, "Laboratory Test" in the *Children's Services Handbook* (*Vol.2, Provider Handbooks*).

2.2.17.7 Authorization Requirements

Prior authorization is not required for most laboratory services. Providers may refer to the specific sections for those services that require authorizations.

2.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including independent laboratory services. Independent laboratory services are subject to retrospective review and recoupment if documentation does not support the service billed.

Independent laboratory documentation must include the physician's signed and dated order for the laboratory tests. The specific tests ordered by the physician must be listed on the order. The test results must also be included in the documentation.

2.4 Claims Filing and Reimbursement

2.4.1 Claims Information

When family planning test specimens, such as Pap smears, are collected, providers must direct the laboratory to indicate that the claim for the test is to be billed as a family planning service using a family planning diagnosis code.

Refer to: Section 2.2, "Services, Benefits, Limitations, and Prior Authorization" in the *Gynecological and Reproductive Health and Family Planning Services Handbook* (*Vol. 2 Provider Handbooks*) for information about Medicaid Title XIX Family Planning Services.

Section 3.3, "Services, Benefits, Limitations, and Prior Authorization" in the *Gynecological and Reproductive Health and Family Planning Services Handbook* (*Vol. 2 Provider Handbooks*) for information about the Texas Women's Health Program.

A National Provider Identifier (NPI) is required for all claims. In addition, for paper claims, the Texas Provider Identifier (TPI) is required for the billing and performing provider only. NPI-only is required for all other fields.

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Providers must submit independent laboratory services to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers must purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 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: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

2.4.1.1 Electronic Filing for Laboratory Providers

Referring provider information is always required on laboratory claims. Failure to submit this data will result in a claim rejection on the TMHP Electronic Data Interchange (EDI).

When the place of service is 6, and the billing provider identifier belongs to a laboratory, there is no need to submit the same provider identifier in the facility ID field. This notation causes the claim to suspend processing unnecessarily, and may cause a delay in the disposition of the claim. For questions about the electronic fields, contact the commercial software vendor or the TMHP EDI Help Desk at 1-888-863-3638.

2.4.2 Reimbursement

The Medicaid rates for independent laboratories are calculated in accordance with 1 TAC §355.8081 and §355.8610, and the Deficit Reduction Act (DEFRA) of 1984. By federal law, Medicaid payments for clinical laboratory services cannot exceed the Medicare payment for that service.

As the result of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, independent laboratories are not directly reimbursed by Texas Medicaid when providing tests to clients who are registered as hospital inpatients. Hospital reimbursements (i.e., inpatient DRG reimbursement) include payment for all pathology and laboratory services, including those sent to referral laboratories. Hospital-based and referral laboratory providers 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. These services are not billable to Medicaid-covered clients.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" (*Vol. 1, General Information*).

Texas Medicaid pays up to the amount allowed for the total component for the same procedure, same client, same date of service, any provider.

- Providers who perform 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 TMHP has already made payment for the technical or interpretation component for the same procedure, same dates of service, same client, any provider, the claim for the total component will be denied as previously paid to another provider. The

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same is true if a total component has already been paid and claims are received for the individual components. Texas Medicaid implemented mandated rate reductions for certain services. The Online Fee Lookup (OFL) and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

2.4.2.1 National Correct Coding Initiative (NCCI) and Medically Unlikely Edit (MUE) Guidelines

The Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes included in the *Texas Medicaid Provider Procedures Manual* and the *Texas Medicaid Bulletin* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals and bulletins. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

3 Radiological and physiological laboratory services

3.1 Enrollment

To enroll in Texas Medicaid, physiological laboratory, portable X-ray supplier, independent diagnostic testing facility (IDTF), and radiological laboratory providers must be actively enrolled in Medicare.

3.1.1 Enrollment Criteria for Mammography Providers

All mammography providers, including those providing stereotactic biopsies, must be certified by the Bureau of Radiation Control (BRC).

Additionally, the Department of State Health Services (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 a mammography certification issued by DSHS is recognized by the FDA. TMHP will also accept mammography certification issued by the FDA. The certificate will contain the BRC certification number, dates of issue and expiration, type of service, and Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program provider identifiers.

Providers must check the expiration date of their mammography certification and submit an updated mammography certification prior to the expiration date. The certifications may be mailed or faxed to:

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

3.2 Services, Benefits, Limitations, and Prior Authorization

The following high-technology radiology services may be reimbursed by Texas Medicaid with prior authorization:

- Cardiac nuclear imagining
- Computed tomography (CT)
- Computed tomography angiography (CTA)
- Functional MRI (fMRI)
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)

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- Positron emission tomography (PET) scan imaging

Note: *Providers and facilities are required to use the lowest possible radiation dose that is consistent with acceptable image quality for cardiac nuclear imaging, CT, and PET examinations of all clients. It is recommended that providers and facilities use national standards such as those established by the American College of Radiology in their ACR Practice Guidelines and Technical Standards manual.*

Radiology interpretations in any place of service will be denied if they are billed by the attending physician. Services that are billed by the attending physician are included in the facility fee and are not reimbursed separately.

Note: *The 3-dimensional (3-D) obstetric ultrasound is not a benefit of Texas Medicaid.*

Refer to: PA section for exceptions to prior authorization.

3.2.1 Cardiac Nuclear Imaging

Cardiac nuclear imaging is a benefit of Texas Medicaid and may be reimbursed using the following procedure codes:

Procedure Codes									
78414	78428	78451	78452	78453	78454	78466	78468	78472	78473
78481	78483	78494	78496						

The cardiac nuclear imaging study may be reimbursed separately from the diagnostic radiopharmaceutical.

Refer to: The online fee lookup (OFL) or the applicable fee schedules on the TMHP website at www.tmhp.com to review the diagnostic radiopharmaceuticals that are reimbursed by Texas Medicaid.

3.2.1.1 Authorization Requirements

Authorization is required for cardiac nuclear imagining.

Refer to: Subsection 3.2.6, "Authorization Requirements for CT, CTA, MRI, fMRI, MRA, PET, and Cardiac Nuclear Imaging Services" in this handbook.

3.2.2 Computed Tomography and Magnetic Resonance Imaging

CT, CTA, MRI, fMRI, and MRA services are benefits of Texas Medicaid.

The following procedure codes may be reimbursed with prior authorization for CT, CTA, MRI, fMRI, and MRA radiology services:

Procedure Codes									
70336	70450	70460	70470	70480	70481	70482	70486	70487	70488
70490	70491	70492	70496	70498	70540	70542	70543	70544	70545
70546	70547	70548	70549	70551	70552	70553	70554	70555	71250
71260	71270	71275	71550	71551	71552	71555	72125	72126	72127
72128	72129	72130	72131	72132	72133	72141	72142	72146	72147
72148	72149	72156	72157	72158	72159	72191	72192	72193	72194
72195	72196	72197	72198	73200	73201	73202	73206	73218	73219
73220	73221	73222	73223	73225	73700	73701	73702	73706	73718
73719	73720	73721	73722	73723	73725	74150	74160	74170	74174
74175	74176	74177	74178	74181	74182	74183	74185	75557	75559

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Procedure Codes									
75561	75563	75565	75571	75572	75573	75574	75635	76376	76377
76380	76390	76497	76498	77011	77058	77059	77084		

Texas Medicaid may reimburse the total component for procedure codes 76497 and 76498 when the service is rendered in the office and outpatient hospital setting by radiation treatment center providers.

The professional component may be reimbursed when the service is rendered in the office, inpatient hospital, or outpatient hospital setting by physician providers.

The technical component will be a benefit when rendered in the office setting by physician, radiation treatment center, portable X-ray supplier, radiological laboratory, and physiological laboratory providers.

Procedure codes 76497 and 76498 will be a benefit when rendered in the outpatient hospital setting by radiation treatment center providers.

The following revenue codes must be billed with the most appropriate corresponding procedure code for CT, CTA, MRI, fMRI, and MRA radiology services rendered by outpatient hospital providers:

Revenue Codes							
350	351	352	359	610	611	612	619

The addition of post 3-D reconstruction (procedure codes 76376 and 76377) CT, CTA, MRI, and MRA studies must be prior authorized. No additional payment will be made in absence of prior authorization.

3.2.2.1 Functional MRI (fMRI)

Texas Medicaid considers fMRI medically necessary when it is being used as 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, which might potentially be put at risk during the proposed surgery.

Neurofunctional testing procedure code 96020 must be reported in conjunction with brain fMRI procedure code 70555. Procedure code 96020 is informational and will not be reimbursed separately.

3.2.2.2 Intraoperative MRI (iMRI)

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

Only one iMRI procedure code may be billed per operative session. Procedure codes 70557, 70558, and 70559 must not be billed in conjunction with procedure code 61751, 77021, or 77022.

Intraoperative MRI procedure codes 70557, 70558, and 70559 that are billed with modifier 26 may be reimbursed to physician providers for interpretation.

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

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3.2.2.3 Authorization Requirements and Flexibility

Authorization is required for CT, CTA, MRI, fMRI, and MRA procedures.

Note: *Intraoperative MRI (iMRI) does not require prior authorization.*

Refer to: Subsection 3.2.6, "Authorization Requirements for CT, CTA, MRI, fMRI, MRA, PET, and Cardiac Nuclear Imaging Services" in this handbook.

If the ordering physician or radiologist determines that a CT, CTA, MRI, fMRI, or MRA procedure that is different from the authorized procedure is required or that additional procedures are required, the following will apply:

- The procedure performed is less complex than the procedure authorized but of the same modality (e.g., an MRI with contrast is prior authorized and the actual procedure performed is an MRI without contrast). Full reimbursement is allowed for the billed procedure.
- The authorized procedure is performed and an additional higher-level procedure of the same modality is deemed medically necessary within the same authorization period. A separate authorization is required. The additional procedure must be prior authorized separately and submitted on a separate claim.
- The procedure billed is more complex than the procedure authorized but of the same modality. No authorization update will result in reimbursement according to the rate of the lesser authorized code. For full reimbursement of the more complex procedure, the authorization requires an update.

The following table includes the recognized relationships for authorization flexibility:

Level 1 (High)	Level 2 (Moderate)	Level 3 (Low)
70470	70460	70450
70482	70481	70480
70488	70487	70486
70492	70491	70490
70543	70542	70540
70546	70545	70544
70549	70548	70547
70553	70552	70551
71270	71260	71250
71552	71551	71550
72127	72126	72125
72130	72129	72128
72133	72132	72131
72156	72142	72141
72157	72147	72146
72158	72149	72148
72194	72193	72192
72197	72196	72195
73202	73201	73200
73220	73219	73218
73223	73222	73221
73702	73701	73700

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Level 1 (High)	Level 2 (Moderate)	Level 3 (Low)
73720	73719	73718
73723	73722	73721
74170	74160	74150
74178	74177	74176
74183	74182	74181
75559	75557	
75563	75561	

3.2.3 Positron Emission Tomography (PET) Scan Imaging

PET scan imaging services are benefits of Texas Medicaid and may be reimbursed using the following procedure codes:

Procedure Codes						
78608	78811	78812	78813	78814	78815	78816

Procedure codes 78459, 78491, and 78492 are not reimbursed by Texas Medicaid.

The PET scan procedure may be reimbursed separately from the diagnostic radiopharmaceutical.

Refer to: The online fee lookup (OFL) or the applicable fee schedules on the TMHP website at www.tmhp.com to review the diagnostic radiopharmaceuticals that are reimbursed by Texas Medicaid.

3.2.3.1 Authorization Requirements

Prior authorization is required for PET imaging services.

Refer to: Subsection 3.2.6, "Authorization Requirements for CT, CTA, MRI, fMRI, MRA, PET, and Cardiac Nuclear Imaging Services" in this handbook.

3.2.4 Radiology/Diagnostic Imaging Policy

Radiography and fluoroscopy radiology/diagnostic imaging may be reimbursed by Texas Medicaid using the following procedure codes:

Procedure Codes				
74775	75956	75957	75958	75959

Procedure code 74775 may be reimbursed for services rendered to clients who are 20 years of age and younger.

The procedure code in Column A must be billed with the procedure codes in Column B by the same provider with the same date of service to be reimbursed:

Column A	Column B
75956	33880
75957	33881
75958	33883 or 33884
33884	33883
75959	33886

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Texas Medicaid may reimburse the professional interpretation component only when the physician bills procedure codes 75956, 75957, 75958, or 75959. The professional and technical service may be reimbursed to the inpatient hospital through the DRG reimbursement.

3.2.4.1 Authorization Requirements

Prior authorization is not required for the radiology/diagnostic imaging procedure codes in this section.

3.2.5 Physician-Performed Radiology Services

Refer to: Subsection 9.2.63, "Radiology Services" in *Medial and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 1, Provider Handbooks*).

3.2.6 Authorization Requirements for CT, CTA, MRI, fMRI, MRA, PET, and Cardiac Nuclear Imaging Services

Prior authorization is not required for emergency department services, outpatient observation services, or inpatient hospital radiology services.

Prior authorization is required for outpatient nonemergent services (i.e., those that are planned or scheduled). Prior authorization must be obtained before the service is rendered.

The following table summarizes the authorization requirements for CT, CTA, MRI, fMRI, MRA, PET, and cardiac nuclear imaging services:

Condition	Authorization Requirements
Emergency department visit	Authorization is not required for emergency department radiology services that are rendered during an emergency department visit. • For professional claims, the appropriate radiology procedure code must be billed with modifier U6. • The facility may be reimbursed using the appropriate, corresponding emergency services revenue code.
Outpatient observation	Authorization is not required for radiology services rendered during outpatient observation. • For professional claims, the appropriate radiology procedure code must be billed with modifier U6. • The facility may be reimbursed using the appropriate, corresponding outpatient observation revenue code.
Nonemergent condition: planned or scheduled radiology service	Texas Medicaid defines a nonemergent condition as a symptom or condition that is neither acute nor severe and can be diagnosed and treated immediately, or that allows adequate time to schedule an office visit for a history, physical, or diagnostic studies prior to diagnosis and treatment. Prior authorization is required for outpatient nonemergent (i.e., those studies that are planned or scheduled) CT, CTA, MRI, fMRI, MRA, PET scan, and cardiac nuclear imagining services.

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Condition	Authorization Requirements
	Important: *The authorization number must be on the claim when it is submitted to TMHP for reimbursement. Only one authorization is allowed per claim. For the most accurate and efficient claims processing, TMHP recommends that the procedure code that is submitted on the claim match the procedure code that is authorized. Providers are encouraged to contact TMHP and update the prior authorization if the ordering physician or radiologist changes the actual procedure that is performed. Providers have 14 calendar days after the day on which the study was completed to update the prior authorization.* Additional or alternate studies identified and ordered by the radiologist at the time of a prior-authorized study meet the definition of urgent condition and require retroactive authorization. ***Refer to:*** Subsection 3.2.6.1, "Retroactive Authorization" in this handbook.
Outpatient urgent condition	Retroactive authorization is required for unplanned radiology procedures performed during other planned or scheduled outpatient visits or procedures. Texas Medicaid defines an urgent condition as a symptom or condition that is not an emergency, but requires further diagnostic work-up or treatment within 24 hours to avoid a subsequent emergent situation. ***Refer to:*** Subsection 3.2.6.1, "Retroactive Authorization" in this handbook. ***Note:*** *Additional or alternate studies identified and ordered by the radiologist at the time of a prior-authorized study meet the definition of urgent condition and require retroactive authorization.*
Outpatient emergent condition	Retroactive authorization is required for unplanned radiology procedures performed during other planned or scheduled outpatient visits or procedures. Texas Medicaid defines an emergent condition as a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, or symptoms of substance abuse) 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 at least one of the following: • Placing the recipient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy • Serious impairment to bodily functions • Serious dysfunction to any bodily organ or part The physician must determine that a medical emergency, which imminently threatens life or limb exists and that the medical emergency requires advanced diagnostic imaging. ***Refer to:*** Subsection 3.2.6.1, "Retroactive Authorization" in this handbook.

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Condition	Authorization Requirements
Inpatient hospital	Authorization is not required for inpatient hospital radiology services.

Prior authorization of nonemergent services is considered on an individual basis, adhering to standard clinical evidence-based guidelines. Documentation must support medical necessity for the service and must be maintained in the client's medical record, both by the ordering physician (i.e., the physician who orders the study) and the performing facility.

Nationally-accepted guidelines and radiology protocols based on medical literature are used in the authorization processes for urgent, emergent, and nonemergent services. These include, but are not limited to:

- American College of Radiology (specifically, their Appropriateness Criteria)
- American Academy of Neurology
- American Academy of Orthopedic Surgeons
- American College of Cardiology
- American Heart Association
- National Comprehensive Cancer Care Network

Refer to: Subsection 3.2.2.3, "Authorization Requirements and Flexibility" in this handbook for information about authorization flexibility for CT, CTA, MRI, fMRI, and MRA procedures.

3.2.6.1 Retroactive Authorization

A request for retroactive authorization for an emergent or urgent CT, MR, PET, or cardiac nuclear imaging service must be submitted no later than 14 calendar days after the day on which the study was completed.

Retroactive authorization of urgent or emergent services is considered on an individual basis, adhering to standard clinical evidence-based guidelines. Documentation must support medical necessity for the study and must be maintained in the client's medical record, both by the ordering physician (i.e., the physician ordering the study) and the performing facility.

Retroactive authorization for outpatient urgent services is considered when all of the following criteria are met:

- The physician who renders the imaging service determines, during the provision of prior-authorized services, that additional or alternate procedures are medically indicated.
- The urgent condition requires additional or alternate advanced diagnostic imaging.

Retroactive authorization for outpatient emergent services is considered when all of the following criteria are met:

- The physician determines that a medical emergency that imminently threatens life or limb exists.
- The medical emergency requires advanced diagnostic imaging.

Retroactive authorization is not required when a prior-authorized CT or MR procedure is changed by the ordering physician or radiologist to a lesser procedure of the same modality (e.g., MRI with contrast is authorized and the actual procedure performed is MRI without contrast).

3.2.6.2 * Request Form and Documentation

Regardless of method of submission, the ordering physician must complete and retain the Radiology Prior Authorization Request Form with an original signature in the client's medical record.

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Providers must submit the form with the request information related to the medical necessity for the service, including all of the following:

- Diagnosis
- Treatment history
- Treatment plan
- Medications that the client is currently taking
- Previous imaging results

Providers may also be asked to provide additional documentation as necessary during the authorization process.

Section 1 of the Radiology Prior Authorization Request Form must be completed, signed, and dated by the ordering physician before requesting prior authorization, regardless of the method of request for authorization.

Section 2 of the Radiology Prior Authorization Request Form must be completed, signed, and dated by the physician who performs the service prior to requesting retroactive authorization for urgent or emergent studies.

Residents, physician assistants (PAs), and nurse practitioners (NPs) may order radiological procedures; however, the ordering or referring clinician must sign the authorization form and provide the group or supervising provider's provider identifier.

The Radiology Decision Support Tool is provided by eviCore as a resource for providers. eviCore uses the evidence-based guidelines to authorize advanced imaging services for TMHP, and these guidelines help providers determine the most appropriate treatment option for the client related to advanced imaging services. The documents include the recognized clinical guidelines for CT, CTA, MR, MRA, PET, and cardiac nuclear imaging studies.

Refer to: Section 3, "Inpatient Hospital (Medical/Surgical Acute Care Inpatient Facility)" in *Hospital Services Handbook* (*Vol. 2, Provider Handbooks*).

Section 9, "Physician" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information on MRI and contrast material.

The Radiology Prior Auth Services page of the TMHP website at www.tmhp.com for the Radiology Decision Support Tool.

3.2.6.3 Methods of Submission

Authorization requests for CT, CTA, MRI, fMRI, MRA, PET, and cardiac nuclear imaging studies for Texas Medicaid clients must be submitted to eviCore. eviCore is the TMHP subcontractor for high-tech radiology services. Providers can submit authorizations to eviCore:

- Online at www.tmhp.com, on the Radiology Prior Auth Services page, or on the eviCore website at www.medsolutionsonline.com
- By telephone to 1-800-572-2116
- By fax to 1-800-572-2119
- By mail to:

Texas Medicaid & Healthcare Partnership
730 Cool Springs Blvd, Suite 800
Franklin, TN 37067

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All prior authorization requests for outpatient urgent or emergent radiology services should be made by telephone in order to ensure a timely response. Requests for retroactive authorization may be submitted online using the eviCore prior authorization portal, or by telephone, fax, or mail.

Requests for authorization that are submitted by fax or mail must be submitted using the Radiology Prior Authorization Request Form.

3.2.7 Additional Radiology and Physiological Laboratory Services

3.2.7.1 Ambulatory Electroencephalogram

Refer to: Section 9.2.26.2, "Ambulatory Electroencephalogram (Ambulatory EEG)" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

3.2.7.2 Brachytherapy

Refer to: Subsection 9.2.62.1, "Brachytherapy" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

3.2.7.3 Diagnostic Doppler Sonography

Refer to: Subsection 9.2.46.6, "Doppler Studies" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

3.2.7.4 Electrocardiograms

Refer to: Subsection 9.2.26.6, "Electrocardiogram (ECG)" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

3.2.7.5 Electromyography (EMG and Nerve Conduction Studies (NCS))

Refer to: Subsection 9.2.26.7, "Esophageal pH Probe Monitoring" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information.

Subsection 4.2.10, "Electrodiagnostic (EDX) Testing" in *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*).

3.2.7.6 Esophageal pH Probe Monitoring

Refer to: Subsection 9.2.26.7, "Esophageal pH Probe Monitoring" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

3.2.7.7 Mammography Services

The following procedure codes will be denied if the provider does not have a BRC mammography certification on file:

Procedure Codes					
77057	77056	77055	77054	77053	77032

Refer to: Subsection 9.2.15.5, "Prognostic Breast and Gynecological Cancer Studies" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information about mammography services.

3.2.7.8 Nonsurgical Vision Services

Refer to: Subsection 4.3.5.4, "Ophthalmic Ultrasound" in *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*).

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3.2.7.9 Obstetric Services

Refer to: Subsection 9.2.46.9, "* Obstetric Ultrasound" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

3.2.7.10 Radiation Therapy Services

Refer to: Subsection 9.2.62, "Radiation Therapy" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about radiation therapy, including brachytherapy and stereotactic radiosurgery.

3.2.7.11 Screening and Diagnostic Studies of the Breast

Refer to: Subsection 9.2.15.4, "Mammography (Screening and Diagnostic Studies of the Breast)" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

3.2.7.12 Sleep Studies

Refer to: Subsection 9.2.69, "Sleep Studies" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

3.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including radiological and physiological laboratory services. Radiological and physiological laboratory services are subject to retrospective review and recoupment if documentation does not support the service billed.

3.4 Claims Filing and Reimbursement

3.4.1 Claims Information

Claims for radiological and physiological laboratory services and portable X-ray supplier services must include the referring or ordering provider. Radiological and physiological laboratory services and portable X-ray supplier services must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 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: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

3.4.1.1 Diagnosis Requirements

A diagnosis is not required with a provider's request for payment except when providing the following services:

- Ambulatory Electroencephalogram (A/EEG)
- Arteriogram
- Cardiac nuclear imaging

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- Chest X-ray
- Computed tomography imaging (CT)
- Echography
- Electrocardiogram (ECG)
- Functional MRI (fMRI)
- Magnetic resonance angiography (MRA)
- Magnetic resonance imaging (MRI)
- Mammographies, noninvasive diagnostic studies
- Positron emission tomography (PET) scan
- Polysomnographies
- Venographies

Claims for all services provided to clients who are eligible for "Emergency Care Only" must have a diagnosis to be considered for reimbursement. As with all procedures billed to Texas Medicaid, most baseline screening or comparison studies are not a benefit.

Refer to: Section 9, "Physician" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information on these services.

3.4.1.2 Modifier Requirements for Type of Service Assignment

For the radiology, physiological lab, and X-ray procedures in this chapter, providers must bill modifier 26 for the interpretation component or modifier TC for the technical component. No modifier is necessary for the total component.

Refer to: Subsection 6.2.5, "Modifier Requirements for TOS Assignment" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

Subsection 6.3.2, "Type of Service (TOS)" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

3.4.2 Reimbursement

Radiological and physiological laboratory and portable X-ray supplier providers are reimbursed in accordance with 1 TAC §355.8081 and §355.8085. Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

Texas Medicaid pays only up to the amount allowed for the total component for the same procedure submitted for reimbursement by the same provider for the same client with the same date of service. Providers who perform the technical service and the interpretation must bill the total component. Providers who perform only the technical service must bill the technical component, and those who perform only the interpretation must bill the interpretation component. The total component and the technical or interpretation component for the same procedure are not reimbursed separately when billed by any provider with the same date of service; the first claim may be reimbursed and the additional claim(s) will be denied. Claims are considered for reimbursement based on the order in which they are received.

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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 with the same date of service for the same client, regardless of 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.

Radiology and physiological laboratory and portable X-ray services are not payable when the client is in an inpatient setting. The reimbursement for these services are included in the diagnosis-related group (DRG) payment.

Imaging services submitted by outpatient hospital providers may be reimbursed a flat fee.

Imaging services procedure codes can be found on the TMHP fee schedule website titled, "Hospital Outpatient Imaging Services."

Texas Medicaid implemented mandated rate reductions for certain services. The Online Fee Lookup (OFL) and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

3.4.2.1 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* and the *Texas Medicaid Bulletin* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals and bulletins. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

4 Claims Resources

Resource	Location
Appendix D: Acronym Dictionary	Appendix F (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	"Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5 (*Vol. 1, General Information*)
Appendix A: State, Federal, and TMHP Contact Information	Appendix A (*Vol. 1, General Information*)
TMHP Electronic Claims Submission	Subsection 6.2 (*Vol. 1, General Information*)
Section 3: TMHP Electronic Data Interchange (EDI)	Section 3 (*Vol. 1, General Information*)

5 Contact TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.

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6 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Radiology Prior Authorization Request Form

7 Claim Form Examples

The following linked claim form examples can also be found on the Claim Form Examples page of the Provider section of the TMHP website at www.tmhp.com:

Claim Form Examples
Independent Laboratory
Office Visit with Lab and Radiology
Radiological/Physiological Laboratory and Portable X-Ray Supplier

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Telecommunication Services Handbook

Texas Medicaid Provider Procedures Manual: Vol. 2

April 2016

TEXAS
Health and Human
Services Commission

TELECOMMUNICATION SERVICES HANDBOOK

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1 General Information

This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, refer to the *Medicaid Managed Care Handbook*.

Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in Section 8, "Carve-Out Services" in the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

The information in this handbook is intended for home health agencies, hospitals, nurse practitioners (NP), clinical nurse specialists (CNS), certified nurse midwives (CNM), licensed professional counselors (LPC), licensed marriage and family therapists (LMFT), licensed clinical social workers (LCSW), physicians, physician assistants (PA), psychologists, licensed psychological associates, provisionally licensed psychologists, and licensed dieticians.

Important: *All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: Section 1: Provider Enrollment and Responsibilities (*Vol. 1, General Information*).

2 Enrollment

Providers may provide telecommunication services for Texas Medicaid clients under the provider's Texas Medicaid provider identifier. No additional enrollment is required to provide telemedicine or telehealth services.

Home health agency and hospital providers who wish to provide telemonitoring services must notify the Texas Medicaid & Healthcare Partnership (TMHP) as follows:

- Current providers must use the Provider Information Management System (PIMS) to indicate that they provide telemonitoring services.
- Newly enrolling or re-enrolling home health agency or outpatient hospital providers must indicate whether they provide telemonitoring services during the enrollment process.

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Refer to: Subsection 3.1, "Provider Enrollment" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about CNM provider enrollment.

Subsection 8.1, "Enrollment" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about NP and CNS provider enrollment.

Subsection 9.1, "Enrollment" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about physician provider enrollment.

Subsection 10.1, "Enrollment" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about PA provider enrollment.

Subsection 4.1, "Enrollment" in the *Behavioral Health, Rehabilitation, and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*) for information about LPC, LMFT, and LCSW provider enrollment.

Subsection 6.1, "Enrollment" in the *Behavioral Health, Rehabilitation, and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*) for information about psychologist and licensed psychological associate provider enrollment.

Subsection 2.9.1, "Enrollment" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for information about licensed dietician enrollment.

3 Services, Benefits, Limitations, and Prior Authorization

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. 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.

Use of telemedicine and telehealth services within Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) or State Supported Living Centers is subject to the policy established by the Department of State Health Services (DSHS) and the Texas Department of Aging and Disability Services (DADS) established policies.

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.

Providers may not disclose any medical information revealed by the client or discovered by a provider in connection with the treatment of the client through telemedicine or telehealth without proper authorization from the patient.

All confidentiality and Health Insurance Portability and Accountability Act (HIPAA) standards apply to telemedicine and telehealth transmissions.

Refer to: Subsection 1.6.4, "Release of Confidential Information" in Section 1: Provider Enrollment and Responsibilities (*Vol.1, General Information*) for more information about confidentiality standards.

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3.1 Telemedicine Services

Telemedicine is defined as a health-care service that is either initiated by a physician who is licensed to practice medicine in Texas or provided by a health professional who is acting under physician delegation and supervision. Telemedicine is provided for the purpose of the following:

- Client assessment by a health professional
- Diagnosis, consultation, or treatment by a physician
- Transfer of medical data that requires the use of advanced telecommunications technology, other than telephone or facsimile technology, including the following:
  - Compressed digital interactive video, audio, or data transmission.
  - Clinical data transmission using computer imaging by way of still-image capture and store-and-forward.
  - Other technology that facilitates access to health-care services or medical specialty expertise.

3.1.1 Distant Site

A distant site is the location of the provider rendering the service. Distant-site telemedicine benefits include services that are performed by the following providers, who must be enrolled as a Texas Medicaid provider:

- Physician
- CNS
- NP
- PA
- CNM

The following procedure codes, when billed with the GT modifier, are a benefit for distant-site telemedicine providers:

Procedure Codes									
90791	90792	90832	90833	90834	90836	90837	90838	90951	90952
90954	90955	90957	90958	90960	90961	99201	99202	99203	99204
99205	99211	99212	99213	99214	99215	99241	99242	99243	99244
99245	99251	99252	99253	99254	99255	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, and 90838 are add-on codes and must be billed with a primary E/M procedure code in order to be reimbursed.

3.1.2 Patient Site

A patient site is where the client is physically located while the service is rendered. The patient-site must be one of the following:

- *Established medical site*—A location where clients will present to seek medical care. There must be a patient-site presenter and sufficient technology and medical equipment to allow for an adequate physical evaluation, as appropriate for the client's presenting complaint. A defined physician-client relationship is required. A client's private home is not considered an established medical site.
- *State mental health facility*—A hospital with an inpatient component funded or operated by DSHS.

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- *State-supported living center*—A state-supported and structured residential facility operated by DADS to provide individuals with intellectual and developmental disabilities a variety of services, including medical treatment, specialized therapy, and training in the acquisition of personal, social, and vocation skills, as defined in Health and Safety Code 431.002(17).

Patient-site providers that are enrolled in Texas Medicaid may only be reimbursed for the facility fee using procedure code Q3014. Procedure code Q3014 is payable to NP, CNS, PA, physicians, and outpatient hospital providers. 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 introduces the client to the distant-site provider for examination and performs any tasks and activities that are delegated by the distant-site provider. A patient-site provider must be at least one of the following:

- An individual who is licensed or certified in Texas to perform health-care services and who presents or is delegated tasks and activities only within the scope of the individual's licensure or certification
- A qualified mental health professional-community services (QMHP-CS) as defined in Title 25 Texas Administrative Code (TAC) 412.303

The patient-site presenter must maintain the records created at the distant site unless the distant-site provider maintains the records in an electronic-health-record format.

3.2 Telehealth Services

Telehealth is defined as health services, other than telemedicine, that:

- Are delivered by licensed or certified health professionals who are acting within the scope of their license or certification.
- Require the use of advanced telecommunications technology, other than telephone or facsimile technology, including the following:
  - Compressed digital interactive video, audio, or data transmission.
  - Clinical data transmission using computer imaging by way of still-image capture and store-and-forward.
  - Other technology that facilitates access to health care services or medical specialty expertise.

Before receiving a telehealth service, the client must receive an in-person evaluation for the same diagnosis or condition. An in-person evaluation is a client evaluation that is conducted by a provider who is at the same physical location as the client.

Exception: *Clients who have a mental health diagnosis or condition may receive a telehealth service without an in-person evaluation if the purpose of the initial telehealth appointment is to screen and refer the client for additional services. The referral must be documented in the medical record.*

To continue receiving telehealth services, the client must have had an in-person evaluation by a person who is qualified to determine a need for services at least once in the 12 months before the telehealth service.

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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

3.2.1 Distant Site

A distant site is the location of the provider rendering the service. Distant-site telehealth benefits include services that are performed by the following providers, who must be enrolled as a Texas Medicaid provider:

- Licensed professional counselor
- LMFT
- LCSW
- Psychologist
- Licensed psychological associate
- Provisionally licensed psychologist
- Licensed dietician

The following procedure codes, when billed with the GT modifier, are a benefit for distant-site telehealth providers:

Procedure Codes							
90791	90832	90834	90837	97802	97803	97804	G0459
S9470							

Note: Procedure codes for behavioral health services are subject to the benefits and limitations outlined in Section 4, "Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), and Licensed Professional Counselor (LPC)" and Section 6, "Physician, Psychologist, and Licensed Psychological Associate (LPA) Providers" of the *Behavioral Health, Rehabilitation, and Case Management Services Handbook (Vol. 2, Provider Handbooks).*

3.2.2 Patient Site

A patient site is where the client is physically located while the service is rendered. The patient-site must be one of the following:

- *Established 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.
- *State mental health facility*—A hospital with an inpatient component funded or operated by DSHS.
- *State-supported living center*—A state-supported and structured residential facility operated by DADS to provide individuals with intellectual and developmental disabilities a variety of services, including medical treatment, specialized therapy, and training in the acquisition of personal, social, and vocation skills, as defined at Health and Safety Code 431.002(17).

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.

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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 at least 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 himself/herself or to others.

The patient-site presenter must maintain the records created at the distant site unless the distant-site provider maintains the records in an electronic-health-record format.

3.3 Telemonitoring Services

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 HIPAA.

Data parameters are established as ordered by a physician's plan of care.

Data must be reviewed by a registered nurse (RN), NP, CNS, or PA, who is responsible for reporting data to the prescribing physician in the event of a measurement outside the established parameters.

Online evaluation and management for home telemonitoring services (procedure code 99444) is a benefit in the office or outpatient hospital setting when services are provided by an NP, CNS, PA, or physician provider. Procedure code 99444 is limited to once per seven days and is denied if it is submitted within the postoperative period of a previously completed procedure or within seven days of a related evaluation and management service by the same provider.

Scheduled periodic reporting of the client data to the physician is required, even when there have been no readings outside the parameters established in the physician's orders. Telemonitoring providers must be available 24 hours a day, 7 days a week. Although transmissions are generally at scheduled times, they can occur any time of the day or any day of the week, according to the client's plan of care.

The physician who orders home telemonitoring services has a responsibility to ensure the following:

- The client has a choice of home telemonitoring providers.
- The client has the right to discontinue home telemonitoring services at any time.

Although Texas Medicaid supports the use of home telemonitoring, clients are not required to use this service.

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3.3.1 Facility Services

The provision and maintenance of home telemonitoring equipment is the responsibility of the home health agency or the hospital. The initial setup and installation (procedure code 99090) of the equipment in the client's home is a benefit when services are provided by a home health agency or an outpatient hospital. Hospital providers must submit revenue code 780 or 789 with procedure code 99090.

Procedure code 99090 is limited to once per episode of care even if monitoring parameters are added after initial setup and installation. A claim for a subsequent set up and installation is not reimbursed unless there is a documented new episode of care or unless the provider submits documentation of extenuating circumstances that require another installation of telemonitoring equipment.

Daily home monitoring (procedure code 99090 with modifier GQ) is a benefit when services are provided by a home health agency or an outpatient hospital. The home health agency or hospital may submit a claim for the daily rate each day the telemonitoring equipment is used to monitor and manage the client's care. Hospital providers must submit revenue code 780 or 789 with the procedure code for daily home monitoring.

Procedure code 99090 with modifier GQ is limited to once per day, regardless of the number of transmissions, for the length of the prior authorization period.

3.4 Prior Authorization

Prior authorization is not required for telemedicine or telehealth services; however, it may be required for the individual procedure codes billed.

3.4.1 Prior Authorization of Telemonitoring Services

Procedure code 99090 with or without modifier GQ requires prior authorization. Home telemonitoring services may be approved for up to 60 days per prior authorization request. If additional home telemonitoring services are needed, the home health agency or hospital must request prior authorization before the current prior authorization period ends.

Requests for additional home telemonitoring services that are received after the current prior authorization expires will be denied for dates of service that occurred before the date the submitted request was received.

To be eligible for home telemonitoring services, clients who are diagnosed with diabetes or hypertension must exhibit two or more of the following risk factors:

- Two or more hospitalizations in the previous 12-month period
- Frequent or recurrent emergency department visits
- A documented history of poor adherence to ordered medication regimens
- Documented history of falls in the previous 6-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

A completed Home Telemonitoring Services Prior Authorization Request form must be submitted to request home telemonitoring services.

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If the prior authorization form is not signed and dated by the physician, the form must be accompanied by a written order or prescription that is signed and dated by the physician, or a documented verbal order from the physician that includes the date that the verbal order was received. The verbal order may be documented on a plan of care or treatment plan.

Note: *A verbal order is considered current when the date received is on, or no more than, 30 days before the start of home telemonitoring services. A written order or prescription is considered current when it is signed and dated on, or no more than, 30 days before the start of home telemonitoring services.*

A request received without a physician's signature, documented verbal order, or written prescription will not be processed and will be returned to the provider.

The request must include the physician-ordered frequency of the clinical data transmission and the client's diagnoses and risk factors that qualify the client for home telemonitoring services.

Providers can also request prior authorization online through the secure TMHP provider portal. The initial request for prior authorization must be received no more than three business days from the date that the home telemonitoring services are initiated. Requests that are received after the three business-day period will be denied for dates of service that occurred before the date that the request was received.

3.5 Documentation Requirements

Documentation for a telecommunication service must be the same as for a comparable in-person service.

3.5.1 Documentation Requirements for Telemonitoring Providers

The home health agency or hospital must maintain documentation of all of the following in the client's medical record:

- The telemonitoring equipment meets all of the following requirements:
  - Capable of monitoring any data parameters included in the plan of care
  - Food and Drug Administration (FDA) Class II hospital-grade medical device
  - Capable of measuring and transmitting client glucose or blood pressure data
- The provider's staff is qualified to install the needed telemonitoring equipment and to monitor the client data, which will be transmitted according to the client's care plan.
- Clinical data will be provided to the client's primary care physician or his/her designee.
- Services are not duplicated under the disease management programs described in Texas Human Resources Code, Section 32.057.
- Monitoring of the client's clinical data is not duplicated by any other provider.
- Written protocols, policies, and procedures on the provision of home telemonitoring services are available to HHSC 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

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- Synchronization and verification of patient profile data
- The client is able to operate the equipment or has a willing and able person to assist in completing electronic transmission of data. (Not required if the equipment does not require active participation from the client.)

4 Claims Filing and Reimbursement

4.1 Claims Information

Claims for 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 and itemized statements are not accepted as claim supplements.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6: Claims Filing (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" and subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in Section 6: Claims Filing (*Vol. 1, General Information*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

4.1.1 Telemonitoring Services

Providers may submit claims for home telemonitoring services that were provided to Medicaid Qualified Medicare Beneficiary (MQMB) clients directly to TMHP without first submitting a claim to Medicare.

Home telemonitoring services are not a benefit of Medicare, so the requirement that claims for MQMB clients be submitted to Medicare first does not apply. Since claims for home telemonitoring services are not submitted to Medicare first, they are subject to the standard 95-day claim-filing deadline from the date of service.

4.2 Reimbursement

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

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in Section 2: Texas Medicaid Fee-for-Service Reimbursement (*Vol. 1, General Information*) for more information about reimbursement.

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5 Claims Resources

Resource	Location
Appendix A: State, Federal, and TMHP Contact Information	Appendix A (*Vol. 1, General Information*)
Appendix D: Acronym Dictionary	Appendix D (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	"Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5 (*Vol. 1, General Information*)
Section 3: TMHP Electronic Data Interchange (EDI)	Section 3 (*Vol. 1, General Information*)
TMHP Electronic Claims Submission	Subsection 6.2 (*Vol. 1, General Information*)
UB-04 CMS-1450 Paper Claim Filing Instructions	Subsection 6.6 (*Vol. 1, General Information*)

6 Contact TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday–Friday from 7 a.m. to 7 p.m., Central Time.

7 Forms

The following linked form can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Form
Home Telemonitoring Services Prior Authorization Request

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Vision and Hearing Services Handbook

Texas Medicaid Provider Procedures Manual: Vol. 2

April 2016

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1 General Information

The information in this handbook is intended for optometrists (doctors of optometry), ophthalmologists, and opticians who render services related to the eye and vision and for hearing aid professionals (fitters and dispensers, physicians, and audiologists) who provide hearing evaluations or fitting and dispensing services. The handbook provides information about Texas Medicaid's benefits, policies, and procedures applicable to these providers.

Important: *All providers are required to read and comply with Subsection 4.1, "Enrollment". In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide healthcare services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver healthcare items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: Section 1: Provider Enrollment and Responsibilities (*Vol. 1, General Information*).

This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, refer to the *Medicaid Managed Care Handbook* (*Vol.2, Provider Handbooks*).

Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in Section 8, "Carve-Out Services" in the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

1.1 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 3.7.3.8, "Payment Window Reimbursement Guidelines" of the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about the payment window reimbursement guidelines.

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2 Nonimplantable Hearing Aid Devices and Related Services

2.1 Enrollment

To enroll in Texas Medicaid, hearing aid professionals (physicians, audiologists, and hearing aid fitters and dispensers) who provide hearing evaluations or fitting and dispensing services must be licensed by the licensing board of their profession to practice in the state where the service is performed. Hearing aid providers are eligible to enroll as individuals and facilities. Audiologists are eligible to enroll as individuals and groups. Audiologists may enroll as both audiologists and as hearing aid fitters and dispensers by completing an enrollment application for each type of provider (i.e., select "Audiologist" on one application and "Hearing Aid" on the other application).

Providers cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

2.1.1 School Districts, State Agencies, and Inpatient Facilities

To be reimbursed for audiology and audiometry evaluation and diagnostic services for suspected and confirmed hearing loss (other than audiology evaluation and therapy services reimbursed to School Health and Related Services [SHARS] providers), audiologists employed by or contracted with school districts, state agencies, and inpatient hospitals must enroll as individual practitioners or group practitioners by choosing "Audiologist" on the enrollment application.

To be reimbursed for hearing aid devices and accessories, and fitting and dispensing visits and revisits, audiologists and hearing aid fitters and dispensers employed by or contracted with school districts, state agencies, and inpatient hospitals must enroll as individual practitioners or facilities by choosing "Hearing Aid" on the enrollment application.

Appropriately-licensed providers who want to provide both audiology services and hearing aid fitting and dispensing services must complete applications for audiologist and for hearing aid fitter and dispenser for each program for which they want to enroll.

Note: *A SHARS Texas Provider Identifier (TPI) cannot be used to bill for these services.*

2.2 Services, Benefits, Limitations, and Prior Authorization

The Texas Medicaid 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.

Note: *Hearing-related services that are medically necessary because of a medical condition that cannot be improved or ameliorated using a nonimplantable hearing aid device are not considered part of the Texas Medicaid hearing services benefit. Providers may refer to the other* Texas Medicaid Provider Procedures Manual *Handbooks for benefit and limitation information about other hearing-related services.*

Texas Medicaid clients of any age are eligible to receive medically necessary hearing aid devices and services through the hearing services benefit outlined in the following sections. The Texas Medicaid hearing services benefit includes a broad range of hearing services for clients of all ages and reimburses providers who are appropriately enrolled with Texas Medicaid in accordance with their licensure and scope of practice. Prior authorization is not necessary for benefits within program limitations unless specifically addressed in the sections below.

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The following hearing services are benefits of Texas Medicaid to appropriately-enrolled audiologists, hearing aid fitters and dispensers, and physicians according to their licensure, scope of practice, and enrollment as indicated:

- Audiologists and physicians may be reimbursed for audiology and audiometry evaluation and diagnostic services for suspected and confirmed hearing loss.
- Hearing aid fitters and dispensers may be reimbursed for hearing aid devices and accessories and fitting and dispensing visits and revisits.
- Physicians may be reimbursed for physician otology and otorhinolaryngology (ENT) services.

Texas Medicaid clients whose jobs are contingent on their possessing a hearing aid or who appear to have vocational potential and who need a hearing aid may be referred to the Texas Department of Assistive and Rehabilitative Services (DARS) for hearing aids.

2.2.1 Limitations and Required Forms

All services provided to Texas Medicaid clients must be medically necessary. Unless otherwise specified, services may be reimbursed without prior authorization within the set limitations. In addition to services that always require prior authorization, providers may request prior authorization for medically necessary services that exceed benefit limitations.

Required forms, which are indicated in the specific sections below, are not required to be submitted with the claim, but the forms must be completed and maintained in the client's medical record and made available upon request by the Texas Health and Human Services Commission (HHSC) or the Texas Medicaid & Healthcare Partnership (TMHP) for retrospective review.

2.2.2 Hearing Screenings

Hearing screening 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 Medicaid-enrolled physician, and the screening is provided by a Medicaid-enrolled provider licensed to perform these services.

Routine newborn hearing screenings and Texas Health Steps (THSteps) medical checkup hearing screenings are benefits for Texas Medicaid clients, and are included in the reimbursement for the routine service or visit.

2.2.2.1 Routine Hearing Screenings

Routine hearing screenings that are required as part of the newborn hospital stay and as part of a THSteps medical checkup are included in the Texas Medicaid hearing services benefit. These routine screenings are not reimbursed to audiologists, hearing aid fitters and dispensers, or physicians.

Newborn Hearing Screen

The newborn hearing screening is included in the reimbursement to the hospital for the newborn hospital stay and is not reimbursed separately. A newborn hearing screening must be offered to each newborn by the facility where the birth occurs, through a program mandated by the Texas State Legislature and certified by the Texas Department of State Health Services (DSHS). The screening is covered as part of the newborn delivery. An infant born outside a birthing facility and not admitted to a birthing facility shall be referred to a facility that provides newborn hearing screening. If a facility is not required by legislative mandate to perform newborn hearing screening, a referral must be made to a facility that offers the screening.

Refer to: Subsection 5.3.9, "Newborn Examination" in Children's Services Handbook (Vol. 2, Provider Handbooks) for more information about the newborn hearing screening.

THSteps Medical Checkup Hearing Screen

Hearing screening is a required component of the THSteps medical checkup, and a standardized audiometric hearing screening is required at specific ages according to the periodicity schedule.

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Refer to: The THSteps Medical Checkups Periodicity Schedule including the footnotes, which is available on the DSHS website at www.dshs.state.tx.us/thsteps/providers.shtm, for coverage criteria when performed as part of a THSteps medical checkup.

Subsection 5.3.11.2.3, "Hearing Screening" in *Children's Services Handbook* (*Vol. 2, Provider Handbooks)* for more information on THSteps checkup hearing screening.

2.2.2.2 Additional Hearing Screenings

A hearing screening requested outside of a routine newborn or THSteps medical checkup may be reimbursed as medically necessary without prior authorization using procedure code 92551.

Further diagnostic testing may also be reimbursed using the appropriate procedure code as indicated in subsection 2.2.3, "Audiology and Audiometry Evaluation and Diagnostic Services" in this handbook

2.2.2.3 Abnormal Hearing Screening Results

If the screening returns abnormal results, the client must be referred to a Texas Medicaid-enrolled provider who is a licensed audiologist or physician who provides audiology services. Clients who are 20 years of age or younger and have abnormal screening results must be referred to a Texas Medicaid-enrolled provider who is an audiologist or physician who is experienced with the pediatric population and who offers auditory services.

The referring physician who performs the screening must complete the Physician's Examination Report, which is maintained in the client's medical record. A new Physician's Examination Report must be completed whenever there is a change in the client's hearing or a new hearing aid is needed. Retrospective review may be performed to ensure documentation supports the medical necessity of the service.

In addition to being referred to an appropriate provider for further testing, clients who are 35 months of age and younger and have suspected 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 was referred to an appropriate provider for further testing.

Refer to: Subsection 2.7, "Early Childhood Intervention (ECI) Services" in Children's Services Handbook (Vol. 2, Providers Handbooks) for more information about ECI.

2.2.3 Audiology and Audiometry Evaluation and Diagnostic Services

Audiometry is a benefit of Texas Medicaid for clients of any age. Physicians must recommend hearing evaluations based on examination of the client. Only physicians or licensed audiologists will be reimbursed for hearing evaluations. Hearing aid fitters and dispensers are not reimbursed for hearing evaluations.

Important: *The date of service for audiology and audiometry evaluations and diagnostic services is the date the service is rendered to the client. The date of service that is billed on the claim must match the date of service that is documented in the client's medical record.*

The following audiometry procedure codes are benefits of Texas Medicaid for a basic comprehensive audiometry survey:

Procedure Codes						
92550	92551	92552	92553	92555	92556	92557

The following additional procedure codes may be benefits for audiometric testing:

Procedure Codes									
92558	92563	92565	92567	92568	92570	92571	92572	92575	92576

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Procedure Codes								
92578	92579	92582	92583	92584	92585	92586	92587	92588

Refer to: The appropriate Texas Medicaid fee schedule on the TMHP web site at www.tmhp.com for procedure codes that may be reimbursed to individual types of providers.

Auditory brainstem response (ABR) and otoacoustic emissions (OAE) are benefits for clients of any ages when performed to identify and diagnose hearing loss and for newborns when performed for the purpose of a newborn hearing screening.

Note: *ABR and OAE tests performed as part of the newborn hearing screen are reimbursed as part of the hospital visit and are not reimbursed separately.*

2.2.3.1 Otological Examinations

Otological examinations are a benefit when medically necessary and provided by a Medicaid-enrolled physician licensed to perform this service.

Procedure codes 92504 and 92505 are benefits for otological examinations.

An otological examination may also include physician evaluation and management (E/M) services provided to diagnose or treat medical conditions.

Refer to: Subsection 9.2.58.4, "Group Clinical Visits" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about medically necessary physician E/M services.

2.2.3.2 Vestibular Evaluations

Vestibular evaluations are a benefit when medically necessary and provided by a Medicaid-enrolled physician or nonphysician provider licensed to perform this service.

The following procedure codes for vestibular evaluations are benefits:

Procedure Codes									
92531	92532	92533	92534	92537	92538	92540	92541	92542	92544
92545	92546	92547							

2.2.3.3 Forms and Documentation

Providers of hearing evaluations must have a report in the client's record. Providers must include in the report hearing evaluation test data. The Hearing Evaluation, Fitting, and Dispensing Report (Form 3503) must be completed by the physician or audiologist who conducts the diagnostic testing. The provider who signs the report must maintain it in the client's file. The report includes audiometric assessment results of the hearing evaluation and must provide objective documentation that amplification improves communication ability. Retrospective review may be performed to ensure documentation supports the medical necessity of the service.

For physician diagnostic hearing services (procedure codes 92502, 92504, 92540, 95940, and 95941), providers must maintain documentation of medical necessity in the client's medical record. Retrospective review may be performed to ensure that the documentation supports medical necessity for the service.

2.2.3.4 Prior Authorization

Hearing screening and testing services do not require prior authorization. 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.

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2.2.3.5 Limitations

Newborn hearing screenings provided during the birth admission are considered part of the newborn delivery payment to the facility and are not reimbursed as separate procedures.

An otological examination is a benefit of Texas Medicaid when medically necessary and provided by a Medicaid-enrolled physician licensed to perform this service.

An otological examination may also include physician E/M services provided to diagnose or treat medical conditions.

Refer to: Subsection 9.2.58.4, "Group Clinical Visits" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about medically necessary physician E/M services.

Audiometry survey procedure codes and evoked potential and otoacoustic emissions screening procedure codes may be reimbursed once per day.

Procedure code 92568 may be reimbursed when billed with one of the following diagnosis codes:

Diagnosis Codes							
D333	G510	G511	G518	G519	H8001	H8002	H8003
H8011	H8012	H8013	H8021	H8022	H8023	H8081	H8082
H8083	H8091	H8092	H8093	H8101	H8102	H8103	H8111
H8112	H8113	H8121	H8122	H8123	H81311	H81312	H81313
H81319	H81391	H81392	H81393	H8141	H8142	H8143	H818X1
H818X2	H818X3	H8191	H8192	H8193	H8301	H8302	H8303
H8311	H8312	H8313	H832X1	H832X2	H832X3	H838X1	H838X2
H838X3	H838X9	H8391	H8392	H8393	H900	H9011	H9012
H902	H903	H9041	H9042	H905	H906	H9071	H9072
H908	H9101	H9102	H9103	H9121	H9122	H9123	H918X1
H918X2	H918X3	H9191	H9192	H9193	H9311	H9312	H9313
H93211	H93212	H93213	H93221	H93222	H93223	H93231	H93232
H93233	H93241	H93242	H93243	H93291	H93292	H93293	H933X1
H933X2	H933X3	H933X9	Q179	R42			

Providers may bill only one of the pure tone audiometry procedure codes (92551, 92252, and 92553) per day, any provider.

Procedure codes 92553 and 92556 are not reimbursed on the same day by any provider. If these procedure codes are billed for the same date of service, they are denied with instructions to bill with the more appropriate, comprehensive audiometry procedure code 92557.

Tympanometry

Tympanometry (procedure code 92567) must be limited to selected individual cases where its use demonstrably adds to the provider's ability to establish a diagnosis and provide appropriate treatment. Tympanometry is limited to three services per rolling year when billed by any provider and is based on medical necessity, which must be documented in the client's medical record.

Electrical Testing

Electrical testing may be reimbursed for services rendered to clients of any age.

Electrical testing (procedure code 92547) must be billed with the same date of service by the same provider as procedure code 92541, 92542, 92544, 92545, or 92546.

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Vestibular Evaluation

Vestibular evaluation is a benefit of Texas Medicaid when medically necessary and provided by a provider who is licensed to provide this service.

Hearing pathway tests such as audiometry, ABR, and electrocochleography (ECoG) can also be used for the same purpose and are frequently combined with vestibular tests.

ABR and OAE Hearing Screening Services

Evoked response testing (procedure codes 92558, 92585, 92586, 92587, and 92588) is considered a bilateral procedure. If separate charges are billed for left- and right-sided tests of the same type, the tests are combined and reimbursed as a quantity of one. An electroencephalogram (EEG) may be reimbursed for the same date of service as evoked response testing by any provider.

Procedure code 92591 may be reimbursed as often as is medically necessary.

Texas Medicaid may reimburse physicians for ear and throat examination procedure codes 92502, 92504, and 92540. Audiologists will not be reimbursed for these services.

Refer to: Subsection 9.2.58, "Physician Evaluation and Management (E/M) Services" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information about these services.

Procedure codes 95940 and 95941 may be reimbursed in addition to each evoked potential test. Procedure codes 95940 and 95941 are limited to a maximum of 2 hours per day, per client, any provider, without documentation of medical necessity. Procedure codes 95940 and 95941 cannot be reported by the surgeon or anesthesiologist.

2.2.3.6 SHARS Audiology Services

Audiology evaluation and therapy services procedure codes 92507, 92508, 92521, 92522, 92523, 92524, and 92620 may be reimbursed to school districts and state agencies that are enrolled with Texas Medicaid as SHARS providers.

Refer to: Section 3, "School Health and Related Services (SHARS)" in *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about SHARS services.

Other hearing evaluation, diagnostic, and hearing aid services may be reimbursed to appropriately-enrolled audiologists, hearing aid fitters and dispensers, and physicians as outlined in this section.

2.2.3.7 Noncovered Services

Texas Medicaid does not reimburse for a hearing screening completed for day care, Head Start, or school unless it is part of an acute-care visit in a clinic setting. Separate procedure codes must not be billed for these services.

2.2.4 Hearing Aid Devices and Accessories (Nonimplantable)

Texas Medicaid may reimburse hearing aid fitters and dispensers for the following devices and accessories:

Service	Limitation
Hearing aid devices	**Limitation:** • For clients who are 20 years of age and younger, 1 hearing aid device per ear may be reimbursed every 5 years from the month it is dispensed. • For clients who are 21 years of age and older, if the client has at least a 35 dB hearing loss in both ears, 1 hearing aid device may be reimbursed every 5 years from the month it is dispensed. Either the left or the right may be reimbursed, but not both in the same 5 year period.

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Service	Limitation
	Refer to: Subsection 2.2.4.1, "Forms and Documentation" in this handbook for additional medical necessity criteria. Replacement hearing aid devices that are required within the same 5-year period must be prior authorized. Repairs or modifications may be reimbursed without prior authorization once per year after the 1-year warranty period has lapsed if the requested repair or modification is a better alternative than a new purchase. **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. ***Note:*** *During the warranty period, Texas Medicaid may reimburse providers for a replacement hearing aid and replacement hearing aid batteries. Texas Medicaid 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 for clients who are 20 years of age and younger with prior authorization. ***Note:*** *Hearing aid accessories include, but are not limited to, chin straps, clips, boots, and headbands.* **Procedure code:** V5267 **Date of service:** The date of service is the date the client successfully completes the 30-day trial period and accepts the hearing aid device or the date the client receives the replacement accessory item.
Ear impression	**Limitation:** 1 each per hearing aid device as follows: • For one impression, bill a quantity of 1. • For two impressions, bill a quantity of 2. **Procedure codes:** V5275 **Date of service:** The date of service for the ear impression is the date the ear impression is taken.
Ear mold	**Limitation:** As medically necessary for clients who are 20 years of age and younger. For clients who are 21 years of age and older: • 3 ear molds per rolling year for custom ear molds • 4 ear molds per rolling month for disposable ear molds Ear molds must be billed using the appropriate LT or RT modifier. Replacement ear molds may be reimbursed as often as is medically necessary without prior authorization. Documentation of medical necessity must be maintained in the client's medical record. **Procedure codes:** V5264 and V5265 **Date of service:** The date of service for the ear mold is the date the ear mold is taken.

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Service	Limitation
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 Texas Medicaid. ***Note:*** *If a hearing aid has not been reimbursed by Texas Medicaid in the last 5 years, the replacement batteries may be reimbursed on appeal with a statement that documents medical necessity.* **Procedure code:** V5266 **Date of service:** The date of service is the date the client receives the replacement batteries.

The following monaural procedure codes may be reimbursed for medically necessary hearing aid devices and replacements that are rendered to clients of any age 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	V5244	V5245	V5246	V5247	V5254	V5255	V5256	V5257
V5298									

Procedure codes V5170 and V5180 may be reimbursed for monaural hearing aids that are rendered to clients who are 20 years of age and younger only.

The following binaural procedure codes may be reimbursed for medically necessary hearing aid devices and replacements that are rendered to clients who are 20 years of age and younger:

Procedure Codes									
V5100	V5210	V5220	V5249	V5250	V5251	V5252	V5253	V5258	V5259
V5260	V5261	V5298							

Binaural hearing aid procedure codes must be submitted with a quantity of 1 per procedure code. Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com for reimbursement rates.

Refer to: Section 2.4.2, "Reimbursement" in this handbook for more information about manual pricing.

2.2.4.1 Forms and Documentation

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 dB or greater for the pure tone average of 500, 1000, 1500, and 2000 Hz, or a spondee threshold in the better ear of 35 dB or greater when pure tone thresholds cannot be established
- 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 who are 21 years of age and older must meet the medical necessity criteria outlined above and have at least a 35 dB hearing loss in both ears to qualify for the purchase of a monaural hearing aid device.

Clients who are 20 years of age and younger must meet the medical necessity criteria outlined above and have at least a 35 dB hearing loss in both ears to qualify for the purchase of binaural hearing aid devices.

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Claims for non-implantable hearing aid devices must be submitted with a manufacturer invoice showing 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 reflects the actual price the provider paid for the hearing aid device.

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.*

Refer to: Subsection 6.3.1.1, "Place of Service (POS) Coding" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for more information about coding place of service for other locations.

2.2.4.2 Prior Authorization

Prior authorization is not required for medically necessary hearing aid devices and supplies that are provided within the limitations outlined in the table above.

Prior authorization is required for the following:

- ***Replacement hearing aid devices that are required within the same 5-year period.*** A replacement hearing aid device may be considered for prior authorization when loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and measures to be taken to prevent reoccurrence must be submitted with the prior authorization request. 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 for clients who are birth through 20 years of age.*** Requests for prior authorization for children's 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 client is birth through 20 years of age and 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 Texas Medicaid but that are medically necessary for clients who are birth through 20 years of age (using procedure code V5298).***

  The prior authorization request must include:

  - The medical necessity for the requested hearing aid device.
  - The name of the manufacturer.
  - The model number, serial number, and the dates that the warranty is in effect for the requested hearing aid.
- Additional medically necessary repairs or modifications beyond 1 per year.
  For additional repairs or modifications, requests for prior authorization must include documentation that supports the need for the requested repair.

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.

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Prior authorization requests must be submitted to the TMHP Special Medical Prior Authorization (SMPA) Department with documentation that supports medical necessity for the requested device, service, or supply. Authorization may be submitted on the TMHP website at www.tmhp.com or by fax to 1-512-514-4213.

Important: *For clients who are birth through 20 years of age, if the authorization request is denied because it does not meet benefit criteria, the TMHP SMPA Department will refer the request to the TMHP Comprehensive Care Program (CCP) Department for consideration under CCP. The provider is not required to complete additional forms or request referral to the TMHP CCP Department.*

Providers may use the form of their choice to submit the required information to the TMHP SMPA Department. No specific request form is required.

Refer to: Section 6: Claims Filing (*Vol 1, General Information*) for more information about the authorizations and claims filing processes.

2.2.4.3 * Limitations

The following services and supplies must be provided to Texas Medicaid clients if a nonimplantable hearing aid device is medically necessary:

- An individual client assessment to identify the appropriate type of device
- The fitting/implantation of the device
- The re-assessment to determine whether the device allows for adequate hearing
- Expendable supplies that are necessary to keep the device functioning properly, such as batteries and accessories

A hearing aid dispensed through Texas Medicaid 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.

Providers must dispense each hearing aid reimbursed through Texas Medicaid with all necessary hearing aid accessories and supplies, including a 1-month supply of batteries. The reimbursement for monaural and binaural procedure codes includes the required hearing aid package as follows, and no separate reimbursement will be made for these items:

- Acquisition cost of the hearing aid (the actual cost or net cost of the hearing aid after any discounts or rebates have been deducted)
- Manufacturer's postage and handling charges, including shipping insurance
- All necessary hearing aid accessories or supplies
- Instructions for care and use
- A 1-month supply of batteries

Note: *TMHP does not supply the hearing aid devices, supplies, and accessories. Providers must purchase equipment directly from manufacturers and vendors of their choice and submit claims to TMHP for reimbursement using the appropriate procedure codes.*

Procedure code V5298 may be reimbursed with prior authorization for hearing aid devices that are not currently a benefit of Texas Medicaid but that are medically necessary for clients who are birth through 20 years of age.

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Services for residents in a skilled nursing facility (SNF), intermediate care facility (ICF), or extended care facility (ECF) must be ordered by the attending physician. The order must be on the client's chart, must state the condition that necessitates the hearing aid services, and must be signed by the attending physician.

2.2.5 Hearing Aid Services

The following additional hearing aid related procedures are benefits for services that are rendered to clients of any age:

Procedure Codes							
92590	92592	92594	V5010	V5011	V5264	V5265	V5275

The following additional hearing aid related procedures are benefits for services that are rendered to clients who are 20 years of age and younger only:

Procedure Codes		
92591	92593	92595

Texas Medicaid may reimburse hearing aid fitters and dispensers for the following services:

Service	Limitation
Hearing test for sensitivity	**Limitation:** As often as is medically necessary **Procedure code:** 92564 (SISI hearing test)
Fitting and dispensing visits	**Limitation:** 1 fitting per hearing aid procedure code per 5 rolling year period, regardless of the number of times a device is returned as unacceptable during a 30-day trial period **Procedure code:** V5011 **Limitation:** 1 dispensing fee each time a hearing aid is dispensed and a new 30-day trial period begins **Procedure codes:** V5090 and V5241 (for clients of any age) and V5110, V5160, V5200, and V5240 (for clients who are 20 years of age and younger) The dispensing fee may be reimbursed separately from the fitting of the hearing aid. The post-fitting check is included in the reimbursement for the dispensing procedure and is not reimbursed separately.
Revisit(s)	**Limitation:** 2 per calendar year when billed by any provider **Procedure codes:** 92592 (first and second revisits for monaural fittings for clients of any age) and 92593 (first and second revisits for binaural fittings for clients who are 20 years of age and younger) ***Note:*** *Services for Texas Medicaid clients who are 21 years of age and older and who received 2 hearing aid devices (binaural) on or before October 1, 2012, may be reimbursed to the client's treating physician or audiologist using procedure codes 99211 and 99212.* Hearing aid revisits are limited to a total of two per calendar year by any provider.

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2.2.5.1 Forms and Documentation

The forms and documentation required for the fitting and dispensing visits are as follows:

- Physician Examination Report
- Hearing Evaluation, Fitting, and Dispensing Report (Form 3503)
- Client acknowledgement statement (created by the provider)
- 30-day trial period certification statement (created by the provider)
- Additional necessary documentation

Physician's Examination Report—The referring physician who performs the screening must complete the Physician's Examination Report, which is maintained in the client's medical record.

Hearing Evaluation, Fitting, and Dispensing Report (Form 3503)—The Hearing Evaluation, Fitting, and Dispensing Report (Form 3503) must be completed by the fitter/dispenser that conducts the fitting and dispensing visit. The provider who signs the report must maintain it in the client's file. The report includes audiometric assessment results of the hearing evaluation and must provide objective documentation to support improved communication ability with amplification. Retrospective review may be performed to ensure documentation supports the medical necessity of the device, service, or supply.

Client Acknowledgement Statement (created by the provider)—At the time the hearing aid device and supplies are dispensed, the client must sign a client acknowledgement statement to verify the client was evaluated and offered an appropriate hearing aid that meets the client's hearing need. The acknowledgement statement must include language that indicates the client is responsible for paying any hearing aid rental fees if charged. The provider must obtain the signed acknowledgment statement before dispensing the hearing aid device and supplies and must keep the signed acknowledgment statement in the client's file. Retrospective review may be performed to ensure documentation supports the medical necessity of the device, service, or supply.

30-Day Trial Period Certification Statement (created by the provider)—Fitters and Dispensers must inform clients in writing of the trial period lasting 30 consecutive days. The statement, which must be created by the provider and signed by the client, must contain the start and end dates of the trial period, all charges and fees associated with the trial period, an acknowledgment that the client accepts responsibility for any assessed rental fees, and 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.

After at least 30 days and the successful completion of the trial period, the provider must update the statement to indicate that the trial was successful and the client accepted the dispensed hearing aid device. The updated statement must be maintained in the client's file. Retrospective review may be performed to ensure documentation supports the medical necessity of the device, service, or supply.

For hearing aids that are dispensed in a provider's office, if a client fails to return by the end date of the trial period, the provider must contact the client. After 3 attempts have been made, if the client does not return to the provider's office, the provider must document all attempts to contact the client and must 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. This requirement does not apply for services that are rendered to clients who receive hearing aids in other places of service (i.e., nursing homes)

2.2.5.2 Prior Authorization

Prior authorization is not required for fitting and dispensing visits and revisits.

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2.2.5.3 Limitations

The following hearing aid visits may be reimbursed by Texas Medicaid:

- 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.

Providers must allow each Texas Medicaid client a 30-consecutive-day trial period that begins with the dispensing date. This trial period gives the client time to determine whether the hearing aid device meets the client's needs. If the client is not satisfied with the purchased hearing aid, the client may return it to the provider, who must accept it. If the device is returned within 30 days of the date it was dispensed, the provider may charge the client a rental fee not to exceed $2 per day. This fee is not a benefit of Texas Medicaid and will not be reimbursed. The client is responsible for paying the hearing aid rental fees if the provider chooses to charge a fee for the rental of returned hearing aid devices.

During the trial period, providers may dispense additional hearing aids as medically necessary until either the client is satisfied with the results of the hearing aid or the provider determines that the client cannot benefit from the dispensing of another hearing aid. The dispensing date of each additional hearing aid starts a new trial period.

The licensed audiologist or fitter/dispenser must perform a post-fitting check of the hearing aid within 5 weeks of the initial fitting.

The first and second revisits are available if additional visits are required after the post-fitting check.

- ***First revisit.*** The first revisit must include a hearing aid check.
- ***Second revisit.*** The second revisit is available as needed after the post-fitting check and first revisit. The second revisit must include either a real ear measurement or aided sound field testing according to the guidelines specified for the hearing evaluation. If the aided sound field test scores suggest a decrease in hearing acuity, the provider must include puretone and speech audiometry readings from the first evaluation.

Home visit hearing evaluations and fittings are permitted only with the physician's written recommendation.

Services for residents in an SNF, ICF, or ECF must be ordered by the attending physician. The order must be on the client's chart, must state the condition that necessitates the hearing aid services, and must be signed by the attending physician.

2.3 Documentation Requirements

All services, including hearing services, require documentation to support the medical necessity of the service rendered. Hearing services are subject to retrospective review and recoupment if documentation does not support the service billed.

Required forms for nonimplantable hearing devices and services, which are indicated in the specific sections above, are not submitted with the claim to TMHP, but the forms must be completed and maintained in the client's medical record and made available upon request by HHSC or TMHP for retrospective review.

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2.4 Claims Filing and Reimbursement

2.4.1 Claims Filing

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.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

Subsection 1.6.9, "Billing Clients" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Subsection 6.1, "Claims Information" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Providers must file all claims electronically or on the appropriate Centers for Medicare & Medicaid Services (CMS) paper claim form after providing the services.

Exception: *Claims for non-implantable hearing aid devices must be submitted on the CMS-1500 paper claim form because electronic claim submissions do not allow for the submission of attachments.*

Claims must include the following information:

- The most appropriate *International Classification of Diseases,* Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis code that represents the purpose for the service.
- The most appropriate Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) procedure code(s) that represent the service(s) provided.
- The appropriate information as indicated on the provider enrollment letter (Electronic claims must also include the most appropriate attested taxonomy code.)

Note: *For Texas Medicaid managed care clients, all hearing aid benefits and otology, and audiometry services are administered by the client's Medicaid managed care organization (MCO).*

2.4.1.1 Non-implantable Hearing Aid Devices

To be reimbursed for a non-implantable hearing aid device, providers must submit documentation with the paper claim showing their cost for the hearing aid device. The Texas Health and Human Services Commission (HHSC) requires providers to submit non-implantable hearing aid claims using the CMS-1500 paper claim form because electronic claim submissions do not allow for the submission of attachments.

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Providers must use the net acquisition cost as the amount billed on the claim. The net acquisition cost 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.

The documentation submitted with the claim must be a manufacturer invoice showing 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 reflects the actual price the provider paid for the hearing aid device.

2.4.1.2 Third Party Liability

Standard third party liability (TPL) rules apply to all hearing services claims.

Refer to: Subsection 4.12, "Third Party Liability (TPL)" in Section 4, "Client Eligibility" (*Vol. 1, General Information*).

2.4.2 Reimbursement

Hearing aid devices and all hearing and audiological services are reimbursed in accordance with 1 TAC §355.8141. To be reimbursed for both audiology services and hearing aid fitting and dispensing services, audiologists must enroll with Texas Medicaid as audiologists and also as hearing aid fitters and dispensers. Audiology services must be billed using the audiologist provider number and benefit code (for electronic claims only) as indicated on the provider enrollment letter that indicates "Audiologist," and hearing aid and 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."

Requested items that are not represented by a specific procedure code must be prior authorized and are priced manually during the authorization process. Manually priced items for clients who are birth through 20 years of age require prior authorization that must be obtained through the TMHP SMPA Department. The reimbursement will be determined based on either the MSRP less 18 percent or based on the provider's documented invoice cost if there is no MSRP available.

Manually priced items are indicated with "Note Code 5" in the Texas Medicaid fee schedule.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Providers may refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

2.4.2.1 National Correct Coding Initiative (NCCI) and Medically Unlikely Edit (MUE) Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

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3 Implantable Hearing Devices and Related Services

3.1 Enrollment

To enroll in Texas Medicaid, hearing services professionals who provide implantable hearing devices and services must be appropriately enrolled according to their licensure and scope of practice.

Providers cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

3.2 Services, Benefits, Limitations and Prior Authorization

Implantable hearing devices, including the cochlear implant device, the auditory brainstem implant (ABI), and the bone anchored hearing aid (BAHA), are benefits of Texas Medicaid for clients of all ages.

The following services and supplies must be provided to Texas Medicaid clients if an implantable hearing aid device is medically necessary:

- An individual client assessment to identify the appropriate type of device
- The fitting of the device
- The reassessment to determine whether the device allows for adequate hearing
- Expendable supplies that are necessary to keep the device functioning properly, such as batteries and accessories

3.2.1 Cochlear Implants

The following procedure codes may be reimbursed for the cochlear implant device, separate components, and services:

Procedure Codes									
69930	L7368	L8499	L8614	L8615	L8616	L8617	L8618	L8619	L8621
L8622	L8623	L8624	L8627	L8628	L8629				

The following procedure codes may be reimbursed for diagnostic analysis of the cochlear implant:

Procedure Codes			
92601	92602	92603	92604

3.2.1.1 Prior Authorization

Prior authorization is required for the following:

- Cochlear implant surgery, device, and replacement parts
- Sound processor repair or replacement
- Battery recharger unit
- Replacement batteries beyond the limitations outlined in the sections below

Requests for prior authorization must be submitted by the provider to the SMPA Department with documentation supporting the medical necessity for the requested device, service, or supply.

> ***Note:*** *Requests for clients who are 20 years of age or younger who do not meet the medical necessity criteria may be considered through Comprehensive Care Program (CCP).*

Documentation submitted for review must indicate who will be providing the cochlear implant device (i.e., the facility or the Durable Medical Equipment (DME) or medical supplier). The supplier's provider number must be included on the prior authorization request.

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Prior authorization for a unilateral or bilateral cochlear implant may be granted for clients who are 12 months of age and older with documentation of all of the following criteria:

- Cognitive ability to use auditory cues and written documentation of agreement by the client or the client's parent or guardian that the client will participate in a program of post-implantation auditory rehabilitation. This documentation must be maintained in the client's medical record.
- Postlingual deafness or prelingual deafness.
- Freedom from middle-ear infection, an accessible cochlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system.
- No contraindications to surgery.
- Inability to derive benefit from appropriately fitted hearing aid devices.
- Documentation of poor speech discrimination and a recommendation for cochlear implant candidacy and the most appropriate ICD-10-CM diagnoses for severe-to-profound bilateral sensorineural hearing loss.

The initial lithium ion battery recharger unit, additional medically necessary units, and additional replacement batteries beyond the limitations indicated in the following sections may be reimbursed with prior authorization. Documentation must be submitted with the prior authorization request to support medical necessity for the request.

Refer to: Subsection 3.2.4, "Sound Processor Replacement and Repair" in this handbook for more information about sound processor repair or replacement.

3.2.1.2 Limitations

Surgery

Procedure code 69930 with the appropriate modifier LT or RT may be reimbursed for unilateral cochlear implantation. Procedure code 69930 with modifier 50 may be reimbursed for bilateral cochlear implantation performed simultaneously.

Device and Components

Procedure codes L8627, L8628, and L8629 for the cochlear implant device and components may be reimbursed for clients who are 12 months of age and older as follows:

- The device must be approved by the Food and Drug Administration (FDA) and be age-appropriate for the client.
- One per day may be reimbursed with prior authorization.

The cochlear implant device and the surgery to implant the device may be reimbursed separately.

Replacement Batteries and Related Items

Replacement batteries and related items for the cochlear implant device include non-rechargeable batteries, rechargeable batteries, and recharger units as follows:

Procedure Code	Prior Authorization	Limitation
L8621 (Zink air non-rechargeable)	Not required	Maximum of 50 per month
L8622 (Alkaline non-rechargeable)	Not required	Maximum of 31 per month
L8623 (Lithium ion rechargeable)	Not required	2 batteries per calendar year
L8624 (Lithium ion rechargeable)	Not required	2 batteries per calendar year
L7368 (Battery recharger unit for lithium ion rechargeable batteries)	Required	1 replacement unit every 5 rolling years

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Replacement batteries for clients with bilateral cochlear implants and two sound processors may be reimbursed when billed with the applicable battery procedure code and the appropriate LT or RT modifier.

Replacement batteries for the cochlear device are limited to clients with a previously paid cochlear implant procedure, device, or supply. Replacement batteries for clients who did not receive the cochlear implant through Texas Medicaid will be considered for reimbursement on appeal with a physician's statement documenting medical necessity.

Additional batteries and lithium ion battery recharger units beyond these limitations may be reimbursed with prior authorization.

3.2.1.3 Auditory Rehabilitation

Auditory rehabilitation is a benefit of Texas Medicaid when it is medically necessary for clients who have received a surgically implanted hearing device, or who have prelingual or postlingual hearing loss when the treating physician has determined that auditory rehabilitation would be beneficial.

The following procedure codes may be reimbursed for auditory rehabilitation:

Procedure Codes			
92626	92627	92630	92633

One auditory rehabilitation evaluation and 12 visits per six rolling months may be reimbursed without prior authorization. Additional visits during a six rolling month period for clients who are 12 months of age through 20 years of age require prior authorization.

Procedure code 92627 is an add-on procedure, and must be billed with the primary procedure code 92626 to be considered for reimbursement.

Note: *Additional therapy services may be a benefit through the Texas Medicaid speech therapy benefit.*

Refer to: Subsection 2.5.5, "Speech Therapy (ST)" in the *Children's Services Handbook (Vol. 2, Provider Handbooks) and* subsection 4.2.3, "ST Services" in the *Nursing and Therapy Services Handbook (Vol. 2, Provider Handbooks)* for information about the speech therapy benefit.

Frequency modulated (FM) systems are not benefits of Texas Medicaid.

3.2.2 Auditory Brainstem Implant (ABI)

The following procedure codes may be reimbursed for the ABI, related components, and services:

Procedure Codes					
92640	L8499	L8614	L8621	L8622	S2235

3.2.2.1 Prior Authorization

The following implantable hearing devices and services require prior authorization:

- ABI surgery, device, and replacement parts
- Sound processor repair or replacement
- Replacement batteries beyond the limitations outlined in the sections below

Requests for prior authorization must be submitted to the SMPA Department with documentation supporting the medical necessity for the requested device, service, or supply.

Prior authorization requests and claims for ABI is limited to clients with a condition of neurofibromatosis, type II or schwannomatosis.

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Refer to: Subsection 2.2.1, "Limitations and Required Forms" in this handbook for additional information about replacement batteries.

Subsection 3.2.4, "Sound Processor Replacement and Repair" in this handbook for more information about sound processor repair or replacement.

3.2.2.2 Limitations

ABI is a benefit for clients who are 12 years of age and older.

Diagnostic analysis of the ABI (procedure code 92640) is limited to 2 hours per day when billed by any provider.

3.2.3 Bone-Anchored Hearing Aid (BAHA)

The following procedure codes must be submitted for the BAHA and related components:

Procedure Codes								
69714	69715	69717	69718	L8690	L8691	L8692	L8693	V5266

3.2.3.1 Prior Authorization

The following implantable hearing devices and services require prior authorization:

- BAHA implant surgery, device, and replacement parts
- Sound processor repair or replacement

Requests for prior authorization must be submitted to the SMPA Department with documentation supporting the medical necessity for the requested device, service, or supply.

Prior authorization requests may be granted for clients who are 5 years of age and older with all of the following:

- Documentation of previous attempts at hearing aid devices and why these devices are inadequate or have failed
- Documentation of scores on hearing tests for bone conduction thresholds and on maximum speech discrimination
- Documentation of audiological testing showing good inner ear function
- Documentation of a multidisciplinary assessment including physical, cognitive, communicative, and behavioral limitations describing the client's auditory disability and expected benefit with use of the BAHA implant
- Documentation of an appropriate diagnosis.

Benefit-eligible conditions may include, but are not limited to the following:

- Conductive hearing loss
- Sensorineural hearing loss
- Other anomalies of external ear with impairment of hearing
- Anomalies of skull and face bones

Refer to: Subsection 3.2.4, "Sound Processor Replacement and Repair" in this handbook for more information about sound processor repair or replacement.

3.2.3.2 Limitations

BAHAs are a benefit for clients who are 5 years of age and older.

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Replacement batteries for the BAHA (procedure code V5266) do not require prior authorization. The replacement batteries are limited to clients with a previously paid hearing device. Replacement batteries for clients who did not receive the hearing device through Texas Medicaid will be considered for reimbursement on appeal with a physician's statement documenting the medical necessity.

Procedure codes L8691, L8692, and L8693 will be denied as part of another service when billed by any provider with the same date of service as procedure code L8690.

Procedure code L8692 for the BAHA device and components may be reimbursed once per day with prior authorization.

Bilateral BAHA procedures are not benefits of Texas Medicaid.

3.2.4 Sound Processor Replacement and Repair

3.2.4.1 Prior Authorization

Replacement and repair of a sound processor require prior authorization.

Documentation by the provider must explain the need for the replacement of the sound processor. The processor must be used for a minimum of 12 months before replacement of the unit will be considered.

The prior authorization request must include evidence of the purchase, such as the manufacturer's warranty.

Repair of a sound processor will be considered for prior authorization with documentation of medical necessity for the requested repair. Repair of a sound processor will be manually priced at the time the prior authorization is reviewed and granted. If the actual cost of the repair differs from the prior authorized fee, the provider must contact the SMPA Department to update the authorization before filing a claim for the repair services.

3.2.4.2 Limitations

Procedure code L8499 with modifier RB may be reimbursed for sound processor repair.

Repair or replacement of a sound processor is not a benefit during the manufacturer's warranty period.

3.2.5 Electromagnetic Bone Conduction Hearing Device - Removal Only

The removal of the electromagnetic bone conduction hearing aid may be reimbursed by Texas Medicaid using procedure code 69711.

The removal or repair of an electromagnetic bone conduction hearing device is limited to two procedures per lifetime when billed by any provider.

The implantation of the device is not a benefit of Texas Medicaid.

3.3 Documentation Requirements

All implantable hearing aid services require documentation to support the medical necessity of the service rendered. Hearing services are subject to retrospective review and recoupment if documentation does not support the service billed.

3.4 Claims Filing and Reimbursement

3.4.1 Claims Filing

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.

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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: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

Subsection 1.6.9, "Billing Clients" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

Section 3: TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Subsection 6.1, "Claims Information" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Note: *For Texas Medicaid managed care clients, all implantable hearing devices and services are administered by the client's Medicaid MCO.*

3.4.1.1 Third Party Liability

Standard TPL rules apply to all hearing services claims.

Refer to: Subsection 4.12, "Third Party Liability (TPL)" in Section 4, "Client Eligibility" (*Vol. 1, General Information*).

3.4.2 Reimbursement

Implantable hearing aids and related services are reimbursed in accordance with 1 TAC §355.8141.

Implantable hearing aids and related services are reimbursed at the lesser of the billed charges or the published Texas Medicaid fee. Unless otherwise indicated, providers may not make additional charges to the client for covered services; such charges constitute a breach of the Texas Medicaid contract.

Requested items that are not represented by a specific procedure code must be prior authorized and are priced manually during the authorization process. Manually priced items for clients who are birth through 20 years of age require prior authorization that must be obtained through the TMHP SMPA Department. The reimbursement will be determined based on either the MSRP less 18 percent or based on the provider's documented invoice cost. Manually priced items are indicated with "MP" in the reimbursement rate table at the end of this article.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Providers may refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

3.4.2.1 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

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4 Vision Care Professionals

4.1 Enrollment

To enroll in Texas Medicaid, optometrists (doctors of optometry [ODs]) and ophthalmologists must be licensed by the licensing board of their profession to practice in the state where the service is performed, at the time the service is performed, and be enrolled as Medicare providers.

An optometrist or ophthalmologist cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

4.2 Provider Responsibilities

Suppliers of eyewear must comply with all Medicaid provider responsibilities and adhere to the following guidelines:

- Do not delay the ordering of eyewear or the dispensing of eyeglasses to the client while payment is pending from TMHP.
- Deliver the eyewear in a reasonable amount of time (usually two or three weeks from the date the order is placed by the client).
- Obtain the required eligibility information from the client's Your Texas Benefits Medicaid card.
- Refer to the Your Texas Benefits Medicaid card website at www.YourTexasBenefitsCard.com to determine whether eyeglasses have been reimbursed by Texas Medicaid within the last 24 months. Providers are advised to ask clients if they have recently received vision care services that may not appear on the Your Texas Benefits Medicaid card website because of the delay in updating form information.
- Submit claims for eyewear services as soon as possible so the client's record indicates that eyewear or eyeglasses have been dispensed.
- Have the client, parent, or guardian sign and date the Vision Care Eyeglass Patient (Medicaid Client) Certification Form and retain it in their records. When a client chooses an eyeglass or contact lens option beyond the program limitations, or if nonprosthetic eyeglasses or contact lenses are replaced because of loss or destruction, the client must acknowledge their choice and his/her liability for the cost difference by signing the Vision Care Eyeglass Patient (Medicaid Client) Certification Form. The form must remain in the provider's records.
- Do not charge a Medicaid client more than a patient not enrolled in Texas Medicaid for noncovered services (e.g., tints, oversized lenses, or frames).
- Keep invoices on file for a minimum of five years.
- Submit claims using the date eyeglasses were ordered as the date of service (DOS) (the start of the 95-day filing period), not the date the eyewear was dispensed.

4.3 Services, Benefits, Limitations, and Prior Authorization

Examination and treatment of eye conditions, including prescribing and dispensing of medically necessary eyeglasses or contact lenses, are benefits of Texas Medicaid and may be reimbursed to optometrist, ophthalmologist, and optician providers as is within the scope of practice for each.

The following services are included in other services and will not be considered for separate reimbursement:

- Vision screening conducted to meet State screening requirements, such as the DSHS School Vision and Hearing Screening Program.

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- Expenses for medical supplies, equipment, and other items that are not specifically made-to-order for the client are considered to have been incurred on the date the item is delivered.

Ophthalmologist and Optometrist

Examination and treatment services rendered by an ophthalmologist or optometrist are not limited to the procedure codes included in this handbook.

Refer to: The Texas Medicaid fee schedules on the TMHP web site at www.tmhp.com for a complete list of procedure codes that may be reimbursed by Texas Medicaid.

Optician

Services rendered by an optician are limited to fitting and dispensing of medically necessary eyeglasses and contact lenses.

Note: *In accordance with the Omnibus Reconciliation Act of 1986, Section 9336, a Doctor of Optometry is considered a physician, with respect to the provision of any item or service the optometrist is authorized to perform by state law or regulation.*

4.3.1 Services Performed in Long-Term Care Facilities

Ophthalmological, optometric, and eyeglass or contact lens services provided in a skilled or intermediate care facility may be reimbursed when the client's attending physician has ordered the service and the signed order is included in the client's medical record at the nursing facility.

The ordering physician's name and provider identifier must be documented on the claim when ophthalmological, optometric, or eyeglasses or contact lenses services are performed in a skilled or intermediate care facility.

4.3.2 Services Performed in Federally Qualified Healthcare Centers (FQHC)

Vision services rendered by FQHC providers may be reimbursed based on an all-inclusive rate per visit.

Refer to: Subsection 2.2, "Services, Benefits, Limitations, and Prior Authorization" in *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*) for information about vision services that may be reimbursed to FQHC providers.

4.3.3 THSteps Medical Checkup Vision Screening

A vision screening must be completed during each THSteps medical checkup with standardized screenings performed at specific ages, as listed in the THSteps Periodicity Schedule. Providers may perform a vision screening during an acute care visit with the appropriate screening tools or refer at-risk infants and children to an optometrist or ophthalmologist who is experienced with the pediatric population and who can perform further testing, diagnosis, and treatment.

Refer to: Subsection 5.3.11.2.4, "Vision Screening" in *Children's Services Handbook (Vol. 2, Provider Handbooks)* for information about THSteps medical checkup vision screenings.

4.3.3.1 Vision Screening Outside of a THSteps Preventive Care Medical Checkup

Vision screening for clients who are birth through 20 years of age may be completed at any primary care provider's office visit upon the following:

- Request from a parent
- Referral from a school vision screening program
- Referral from a school nurse

Clients who are birth through 20 years of age must be screened for eye abnormalities by history, observation, and physical exam. Clients who are identified as high risk must be referred to an appropriate Medicaid-enrolled optometrist or ophthalmologist.

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4.3.4 Noncovered Services

The following services and supplies are not a benefit of Texas Medicaid:

- Artificial eyes for clients who are 21 years of age and older.

  Note: *Artificial eyes for clients who are birth through 20 years may be considered under Texas Health Steps-Comprehensive Care Program (THSteps-CCP).*

- Eyeglasses for residents of institutions where the reimbursement formula and vendor reimbursement include this service.
- Eyeglasses or contact lenses prescribed or dispensed to clients at a hospital or nursing facility without documented orders of the attending physician in the client's medical records.
- Low vision aids.

  Note: *Clients may be referred to DARS for low vision aids.*

- Optional eyeglass features that are requested by the client but that do not increase visual acuity (e.g., lens tint, industrial hardening, and decorative accessories or lettering).
- Plano sunglasses.
- Extended color vision examination (procedure code 92283), dark adaptation examination (procedure code 92284), and vision screening (procedure codes 99172 or 99173).
- Spectacle (eyeglass) fitting services when billed separately.

Clients may be billed for noncovered frames and other items beyond Medicaid benefits. Providers must have the client sign and date the Vision Care Eyeglass Patient (Medicaid Client) Certification Form and retain it in the provider's records. The client payment amount is not considered other insurance and must not be entered as a credit amount in the electronic field.

Example: *Texas Medicaid may reimburse providers a total of $27.93 for eyeglass frames that are within the provider's selection for Medicaid reimbursement plus the allowed cost per lens. If the client chooses a pair of frames (such as $200 frames) that are outside of the provider's selections for Medicaid reimbursement and if the client chooses other items or services that are not a benefit of Texas Medicaid (such as tinted lenses for an extra $10 charge), the client is responsible for and may be billed for the balance of the cost of the frames ($172.07) and the other items that are not a benefit of Medicaid ($10 for tinted lenses).*

The provider may withhold the noncovered eyewear, contacts, or eyeglasses until the client pays for those items. If the client fails to pay for the noncovered items or has not returned for finished eyewear within a reasonable length of time (two to three months), the provider may return any reusable items to stock. Any payment made by TMHP for frames or lenses must be refunded to Texas Medicaid. If a client requests eyewear that is beyond program benefits (for example, scratch-resistant coating), Medicaid allows reimbursement up to the maximum fee. The provider may charge the client the difference between the Medicaid payment and the customary charge for the eyewear requested, when the client has been shown the complete selection of Medicaid-covered eyewear and when the following conditions are met:

- The client rejects the Medicaid-covered eyewear and wants eyewear that complies with Texas Medicaid specifications, but is not included in the selection of Medicaid-covered eyewear.

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- The client indicates a willingness to pay the difference between the Medicaid payment and the actual charge. The provider must have the client sign the Vision Care Eyeglass Patient (Medicaid Client) Certification Form and retain it in the provider's records.

Note: *A client who has been determined by their provider to have a vision impairment that may require intensive or comprehensive vision impaired related services should be referred to the DARS Division for Blind Services for evaluation and any appropriate resources.*

4.3.5 Vision Testing

Vision testing and examination and treatment of eye conditions are benefits of Texas Medicaid and may be reimbursed to ophthalmologist or optometrist providers.

Eye examinations with refraction testing may be reimbursed using the following procedure codes:

Procedure Codes	
S0620	S0621

Medical evaluation and examination may be reimbursed using the following procedure codes:

Procedure Codes				
92002	92004	92012	92014	92015

Procedure codes 92002, 92004, 92012, and 92014 are limited to one service per day by any provider.

Refer to: Subsection 9.2.58.1.1, "New and Established Patient Services" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about new patient and established patient E/M services.

Vision testing procedure codes are subject to the CMS NCCI relationships. Claims that are submitted by physicians with the same specialty who are in the same group practice are processed as if they were the same provider. Providers should refer to the *Current Procedural Terminology (CPT) Manual* for additional information about intermediate and comprehensive ophthalmological services.

4.3.5.1 Routine Vision Testing

Procedure codes S0620 and S0621 may be reimbursed for routine vision testing with refraction when they are billed with diagnosis code Z0100 or Z0101.

Procedure codes S0620 and S0621 will be denied if billed with the same date of service as procedure code 92020.

Clients who are birth through 20 years of age are eligible for a routine eye examination with refraction testing for the purpose of obtaining eyeglasses or contact lenses once every 12 months. The limitation for refraction testing can be exceeded for clients who are birth through 20 years of age only when:

- The parent, teacher, or school nurse requests the refraction testing and it is medically necessary.
- There is a significant change in vision, and documentation supports a diopter (d) change of 0.5d or greater in the sphere, cylinder, prism measurements, or axis changes.

Clients who are 21 years of age and older are eligible for a routine eye examination with refraction testing for the purpose of obtaining eyeglasses or contact lenses once every 24 months. The limitation for refraction testing can be exceeded for clients who are 21 years of age and older only when there is a significant change in vision, and documentation supports a diopter change of 0.5d or more in the sphere, cylinder, prism measurements, or axis changes.

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4.3.5.2 Medically Necessary Eye Examinations

An eye examination with or without refraction (procedure code 92002, 92004, 92012, 92014, or 92015) may be reimbursed for medical evaluations and examinations of the eye. Procedure codes 92002, 92004, 92012, 92014, and 92015 will not be reimbursed for routine exams.

Documentation in the client's medical record must support the medical necessity of the service performed.

Procedure codes 92002, 92004, 92012, 92014, and 92015 may be reimbursed as often as is medically necessary to ophthalmologist or optometrist providers for medically necessary eye examinations without refraction.

Procedure code 92015 may be reimbursed to ophthalmologist or optometrist providers for refraction in addition to the eye examination procedure code 92002, 92004, 92012, or 92014. A refractive state (procedure code 92015) will be denied as part of another service if it is billed with the same date of service by the same provider as procedure code S0620 or S0621.

4.3.5.3 Ophthalmological Examination and Evaluation with General Anesthesia

An ophthalmological examination and evaluation under general anesthesia (procedure codes 92018 and 92019) performed by an ophthalmologist may be medically necessary when a client has significant injury or cannot otherwise tolerate the procedure while conscious.

Procedure codes 92018 and 92019 may be reimbursed once per service, per day, when billed by any provider.

4.3.5.4 Ophthalmic Ultrasound

Ophthalmic ultrasound is an ultrasonic diagnostic test that uses high frequency sound waves that are used to provide additional information about the interior of the eye and surrounding areas. The following procedure codes may be reimbursed for ophthalmic ultrasound services:

Procedure Codes								
76510	76511	76512	76513	76514	76516	76519	76529	76999

Procedure codes 76510, 76511, 76512, 76513, 76516, and 76519 are limited to two services per calendar year by any provider.

Procedure code 76999 requires prior authorization.

Procedure code 76514 may be reimbursed once per lifetime or as medically necessary as indicated when billed with one of the diagnosis codes in the following table:

Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
Once Per Lifetime							
H40001	H40002	H40003	H40011	H40012	H40013	H40021	H40022
H40023	H40031	H40032	H40033	H40041	H40042	H40043	H40051
H40052	H40053	H40061	H40062	H40063	H4010X0	H4010X1	H4010X2
H4010X3	H4010X4	H4011X0	H4011X1	H4011X2	H4011X3	H4011X4	H401210
H401211	H401212	H401213	H401214	H401220	H401221	H401222	H401223
H401224	H401230	H401231	H401232	H401233	H401234	H401310	H401311
H401312	H401313	H401314	H401320	H401321	H401322	H401323	H401324
H401330	H401331	H401332	H401333	H401334	H40141	H40142	H40143
H401510	H401511	H401512	H401513	H401514	H401520	H401521	H401522
H401523	H401524	H401530	H401531	H401532	H401533	H401534	H4020X0

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Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
H4020X1	H4020X2	H4020X3	H4020X4	H40211	H40212	H40213	H402210
H402211	H402212	H402213	H402214	H402220	H402221	H402222	H402223
H402224	H402230	H402231	H402232	H402233	H402234	H402290	H40231
H40232	H40233	H40241	H40242	H40243	H4031X0	H4031X1	H4031X2
H4031X3	H4031X4	H4032X0	H4032X1	H4032X2	H4032X3	H4032X4	H4033X0
H4033X1	H4033X2	H4033X3	H4033X4	H4041X0	H4041X1	H4041X2	H4041X3
H4041X4	H4042X0	H4042X1	H4042X2	H4042X3	H4042X4	H4043X0	H4043X1
H4043X2	H4043X3	H4043X4	H4051X0	H4051X1	H4051X2	H4051X3	H4051X4
H4052X0	H4052X1	H4052X2	H4052X3	H4052X4	H4053X0	H4053X1	H4053X2
H4053X3	H4053X4	H4061X0	H4061X1	H4061X2	H4061X3	H4061X4	H4062X0
H4062X1	H4062X2	H4062X3	H4062X4	H4063X0	H4063X1	H4063X2	H4063X3
H4063X4	H40811	H40812	H40813	H40821	H40822	H40823	H40831
H40832	H40833	H4089	H409	H42	H44511	H44512	H44513
Q150							
As Medically Necessary							
A1859	H1701	H1702	H1703	H1711	H1712	H1713	H17811
H17812	H17813	H17821	H17822	H17823	H1789	H179	H18001
H18002	H18003	H18011	H18012	H18013	H18021	H18022	H18023
H18031	H18032	H18033	H18041	H18042	H18043	H18051	H18052
H18053	H18061	H18062	H18063	H1811	H1812	H1813	H1820
H18211	H18212	H18213	H18221	H18222	H18223	H18231	H18232
H18233	H1830	H18311	H18312	H18313	H18321	H18322	H18323
H18331	H18332	H18333	H1840	H18411	H18412	H18413	H18421
H18422	H18423	H1843	H18441	H18442	H18443	H18451	H18452
H18453	H18461	H18462	H18463	H1849	H1850	H1851	H1852
H1853	H1854	H1855	H1859	H18601	H18602	H18603	H18611
H18612	H18613	H18621	H18622	H18623	H1870	H18711	H18712
H18713	H18791	H18792	H18793	H18831	H18832	H18833	H21551
H21552	H21553	H4040X4	H4041X0	H4041X1	H4041X2	H4041X3	H4041X4
H4042X0	H4042X1	H4042X2	H4042X3	H4042X4	H4043X0	H4043X1	H4043X2
H4043X3	H4043X4	H4720	H47211	H47212	H47213	H4722	H47231
H47232	H47233	H47291	H47292	H47293	H5201	H5202	H5203
Q133	Q134	Q150	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

Procedure code 76999 may be reimbursed with prior authorization.

Ophthalmic ultrasounds may be reimbursed when they are billed with the same date of service by the same provider as an eye examination visit or consultation.

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Ophthalmic ultrasounds (procedure codes 76514 and 76516) are limited to one service, per day, by any provider. Procedure codes 92002, 92004, 92012, 92014, and 92015 will not be reimbursed for routine exams.

Procedure code 76519 may be reimbursed as follows:

- The professional interpretation component may be reimbursed when procedure code 76519 is billed with modifier LT or RT to identify the eye on which the service was performed.
- The technical component may be reimbursed once when the service is performed on one or both eyes on the same date of service by any provider.
- The total component may be reimbursed along with an additional professional service when the service is performed on both eyes on the same date of service by the any provider. The claim for the additional interpretation component must include modifier LT or RT.

Ophthalmic ultrasound procedure codes are subject to CMS NCCI relationships, except for procedure code 76511, which will be denied when it is billed with the same date of service by the same provider as procedure code 76506.

Refer to: The CMS NCCI web page for the published correct coding guidelines and specific applicable code combinations.

Prior Authorization Requirements

Procedure code 76999 requires prior authorization. The provider must submit the following documentation with the request:

- A clear, concise description of the ophthalmic ultrasound being performed.
- A procedure code that is comparable to the ophthalmic ultrasound being requested or the provider's intended fee for performing the ophthalmic ultrasound.

Note: *Services and procedures that are investigational or experimental are not a benefit of Texas Medicaid.*

4.3.5.5 Corneal Topography

Procedure code 92025 may be reimbursed for corneal topography. Procedure code 92025 is considered medically necessary to diagnose, monitor, and treat various visual conditions such as, but not limited to the following:

- Corneal abrasion
- Corneal irregularities
- Corneal disease
- Corneal injury
- Keratoconus

Corneal topography may be reimbursed when it is billed with the same date of service by the same provider as an eye examination visit or consultation.

Corneal topography (procedure code 92025) is limited to one service, per day, by any provider and two services per calendar year.

4.3.5.6 Gonioscopy

A gonioscopy consists of an eye examination to look at the front part of the eye (anterior chamber) between the cornea and the iris. A microscope (slit lamp) is used to look inside the eye.

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Procedure code 92020 may be reimbursed for gonioscopy when billed with one of the diagnosis codes in the following table:

Diagnosis Codes							
H40001	H40002	H40003	H40011	H40012	H40013	H40021	H40022
H40023	H40031	H40032	H40033	H40041	H40042	H40043	H40051
H40052	H40053	H40061	H40062	H40063	H4010x0	H4010x1	H4010x2
H4010x3	H4010x4	H4011x0	H4011x1	H4011x2	H4011x3	H4011x4	H401210
H401211	H401212	H401213	H401214	H401220	H401221	H401222	H401223
H401224	H401230	H401231	H401232	H401233	H401234	H401310	H401311
H401312	H401313	H401314	H401320	H401321	H401322	H401323	H401324
H401330	H401331	H401332	H401333	H401334	H40141	H40142	H40143
H401510	H401511	H401512	H401513	H401514	H401520	H401521	H401522
H401523	H401524	H401530	H401531	H401532	H401533	H401534	H4020x0
H4020x1	H4020x2	H4020x3	H4020x4	H40211	H40212	H40213	H402210
H402211	H402212	H402213	H402214	H402220	H402221	H402222	H402223
H402224	H402230	H402231	H402232	H402233	H402234	H402290	H40231
H40232	H40233	H40241	H40242	H40243	H4031x0	H4031x1	H4031x2
H4031x3	H4031x4	H4032x0	H4032x1	H4032x2	H4032x3	H4032x4	H4033x0
H4033x1	H4033x2	H4033x3	H4033x4	H4041x0	H4041x1	H4041x2	H4041x3
H4041x4	H4042x0	H4042x1	H4042x2	H4042x3	H4042x4	H4043x0	H4043x1
H4043x2	H4043x3	H4043x4	H4051x0	H4051x1	H4051x2	H4051x3	H4051x4
H4052x0	H4052x1	H4052x2	H4052x3	H4052x4	H4053x0	H4053x1	H4053x2
H4053x3	H4053x4	H4061x0	H4061x1	H4061x2	H4061x3	H4061x4	H4062x0
H4062x1	H4062x2	H4062x3	H4062x4	H4063x0	H4063x1	H4063x2	H4063x3
H4063x4	H40811	H40812	H40813	H40821	H40822	H40823	H4089
H409	H42	Q150					

4.3.5.7 Sensorimotor Examination

A sensorimotor examination is an evaluation of the function of the ocular neuro-muscular system. This exam includes interpretation and reporting of multiple ocular deviation measurements and includes, but is not limited to, visual motor integration, reversal frequency (letters and numbers), motor speed and precision, visual memory, and visualization to test eye movement and control, focusing ability, eye teaming ability, depth perception, and visual perception skills.

Sensorimotor examination (procedure code 92060) may be reimbursed once per day and twice per calendar year by any provider. Procedure code 92060 may be reimbursed in addition as an eye examination visit.

4.3.5.8 Orthoptic or Pleoptic Training

Orthoptics, a component of vision training or vision therapy, are exercises designed to improve the function of the eye muscles with an emphasis on binocular vision and eye movements. Pleoptics are exercises designed to improve impaired vision when there is no evidence of organic eye diseases.

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Procedure code 92065 may be reimbursed for orthoptic or pleoptic training when it is billed with one of the following diagnosis codes:

Diagnosis Codes							
H50011	H50012	H50021	H50022	H50031	H50032	H50041	H50042
H5005	H5006	H5007	H5008	H50111	H50112	H50121	H50122
H50131	H50132	H50141	H50142	H5015	H5016	H5017	H5018
H5021	H5022	H50311	H50312	H5032	H50331	H50332	H5034
H50411	H50412	H5042	H5043	H5051	H5052	H5053	H5054
H5055	H50611	H50612	H5069	H50811	H50812	H5089	H5111
H5112	H518	H53011	H53012	H53013	H53021	H53022	H53023
H53031	H53032	H53033	H5501	H5502	H5503	H5504	H5509
H5581	H5589						

Orthoptic or pleoptic training may be reimbursed one service per day for up to 6 services when it is billed with one of the diagnosis codes in the above diagnosis table. Up to an additional 6 services may be reimbursed with prior authorization for a total of 12 services per lifetime.

The provider must attest that current therapy has resulted in an improvement with presenting symptomatology over the course of treatment, including, but not limited to:

- Blurred vision
- Double vision
- Amblyopia
- Accommodation or near point of convergence measurements

Note: *Orthoptic or pleoptic training services over the 12 per lifetime limit may be considered with prior authorization through CCP for clients who are birth through 20 years of age. Documentation for medical necessity must be submitted with the prior authorization request.*

Procedure code 92065 may be reimbursed in addition to an eye examination visit.

4.3.5.9 Special Ophthalmological Services

The following procedure codes may be reimbursed for special ophthalmological services:

Procedure Codes							
92081	92082	92083	92100*	92132	92133	92134	92136
*Total component only							

Procedure codes 92081, 92082, and 92083 may be reimbursed once per day and twice per calendar year by any provider of any combination.

Procedure codes 92100, 92132, 92133, and 92134 may be reimbursed once per day and twice per calendar year by any provider.

Procedure code 92136 may be reimbursed twice per calendar year by any provider as follows:

- The professional interpretation component may be reimbursed when billed with modifier LT or RT to identify the eye on which the service was performed.
- The technical component may be reimbursed once when the service is performed on one or both eyes on the same date of service by any provider.

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- The total component may be reimbursed along with an additional professional service when the service is performed on both eyes on the same date of service by the any provider.

4.3.5.10 Ophthalmoscopy and Extended Ophthalmoscopy

Ophthalmoscopy and extended ophthalmoscopy may be reimbursed using the following procedure codes:

Procedure Codes						
92225*	92226*	92230*	92235	92240	92250	92260*
* Total component only						

Ophthalmoscopy and fluorescein angioscopy or angiography (procedure codes 92225, 92226, 92230, and 92235) and indocyanine-green angiography (procedure code 92240) are considered unilateral procedures and may be reimbursed for a quantity of two if both the left and right eyes are evaluated. If two services are billed for the same date of service, one may be reimbursed at the full rate, and the other may be reimbursed at half rate.

Procedure codes 92225, 92226, 92230, 92230, 92235, and 92240 are limited to one service per eye per day and two services per eye per calendar year when billed by any provider.

Procedure codes 92225, 92226, 92230, 92235, and 92240 must be billed with modifier LT or RT to identify the eye on which the service was performed.

Procedure codes 92250 and 92260 are limited to one service per day and two services per calender year by any provider.

Ophthalmoscopy, angioscopy, and angiography procedure codes are subject to CMS NCCI relationships.

Fundus photography (procedure code 92250) is considered medically necessary when a clinical condition exists that is subject to change in extent, appearance or size and where such change would directly affect the management of client care. These conditions include, but are not limited to the following:

- Macular degeneration
- Glaucoma
- Hypertension
- Neoplasms of the retina
- Choroid (benign or malignant)
- Retinal hemorrhages
- Ischemia
- Retinal detachment
- Choroid disturbances
- Diabetic retinopathy
- Assessment of recently performed retinal laser surgery

Note: *Fundus photography performed for a routine screen of a normal eye, in the absence of a clinical condition, that is subject to change in extent, appearance or size is not a benefit of Texas Medicaid.*

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4.3.5.11 Other Specialized Vision Services

The following procedure codes may be reimbursed by Texas Medicaid when the services are medically necessary:

Procedure Codes							
92227*	92228	92265	92270	92275	92285	92286	92287
*Total component only							

Procedure codes 92227, 92228, 92265, 92270, 92275, 92285, 92286, and 92287 may each be reimbursed once per day and twice per calendar year by any provider.

External ocular photography (procedure code 92285) may be reimbursed once per day, when it is billed by any provider.

For other professional services, fitting services are included in the reimbursement for prosthetic eyeglasses or contact lenses.

4.3.6 Nonprosthetic Eyeglasses or Contact Lenses

Nonprosthetic eyeglasses or contact lenses are lenses that are medically necessary to correct defects in vision when the eye's organic lens is present. Providers may refer to TAC §354.1015 for more information.

Nonprosthetic eyeglasses or contact lenses may be reimbursed for clients of any age when there is no other option available to correct or ameliorate a visual defect. Contact lenses require prior authorization with documentation of medical necessity. Prescribing and dispensing medically necessary eyeglasses or contact lenses are benefits of Texas Medicaid as follows:

- Nonprosthetic eyeglasses or contact lenses may be reimbursed once every 24 months. Additional services within the 24-month period may be considered when documentation in the client's medical record supports medical necessity that includes a diopter change of 0.5d or more in the sphere, cylinder, prism measurements, or axis changes. A new 24 month benefit period for eyewear begins with the placement of the new nonprosthetic eyewear.
- Replacement of nonprosthetic eyeglasses or contact lenses because of loss or destruction is a benefit of Texas Medicaid for clients who are birth through 20 years of age. If the eyeglasses or contact lenses are lost or destroyed, the provider must have the client sign the Vision Care Eyeglass Patient (Medicaid Client) Certification Form and the signed form must be maintained in the client's medical record.
- For clients who have had insertion of an intraocular lens (IOL), one pair of eyeglasses or contact lenses may be reimbursed. Additional eyeglasses or contact lenses may be considered when documentation in the client's medical record supports medical necessity that includes a diopter change of 0.5d or more in the sphere, cylinder, prism measurements, or axis changes.

Note: *Because the IOL is considered the prosthetic device, the eyeglasses or contact lenses, and any replacements, are considered nonprosthetic.*

Refer to: Subsection 4.3.5.1, "Routine Vision Testing" in this handbook for information about vision testing for the purposes of prescribing eyewear.

The prescription for eyeglasses must be given to the client upon request. A provider may not withhold a prescription for eyeglasses from a client even if Medicaid reimbursement for the eye examination has not been received.

To be considered by Texas Medicaid, the eyeglasses or contact lenses must be:

- Medically necessary.
- Prescribed by a doctor of medicine, optometry, or osteopathy.

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- Prescribed to significantly improve vision or correct a medical condition.
- In compliance with eyeglass program specifications for frames and lenses as stated in TAC Rule 354.1017, Specifications for Eyewear and Rule 363.503, Specifications for Eyewear.

Note: *Contact lenses require prior authorization unless provided in a medical emergency.*

4.3.6.1 Eyeglass Lenses and Frames

The following eyeglass lens procedure codes may be billed with frame procedure codes V2020 and V2025 for reimbursement of a pair of eyeglasses:

Procedure Codes									
Single Vision Lenses									
V2100	V2101	V2102	V2103	V2104	V2105	V2106	V2107	V2108	V2109
V2110	V2111	V2112	V2113	V2114	V2115	V2118	V2121		
Bifocal Lenses									
V2200	V2201	V2202	V2203	V2204	V2205	V2206	V2207	V2208	V2209
V2210	V2211	V2212	V2213	V2214	V2215	V2218	V2219	V2220	V2221
Trifocal Lenses									
V2300	V2301	V2302	V2303	V2304	V2305	V2306	V2307	V2308	V2309
V2310	V2311	V2312	V2313	V2314	V2315	V2318	V2319	V2320	V2321

For the purpose of Texas Medicaid, high-powered lenses are lenses with a sphere greater than 7.00d or a cylinder greater than 4.00d.

Providers must bill a quantity of two when billing for bilateral lenses with the same prescription.

The following procedure codes may be reimbursed for add-on services:

Add-On Procedure Codes									
V2410	V2430	V2700	V2710*	V2715*	V2718*	V2730	V2755	V2770	V2780
*** Procedure codes for prism correction: prism, slab off, ground in, Fresnell, press-on**									

Add-on procedure codes will not be reimbursed unless they are billed with the appropriate lens procedure code by the same provider for the same date of service.

The fitting of eyeglasses (procedure codes 92340, 92341, 92342, and 92370) is considered part of the dispensing procedure and is not separately reimbursed.

Polycarbonate Lens

Polycarbonate lenses (procedure code V2784) may be reimbursed for clients with a medical or physical condition such as, but not limited to the following:

- Cerebral palsy
- Multiple sclerosis
- Muscular dystrophy
- Epilepsy
- Autism
- Down's syndrome
- Brain trauma

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- Balance disorders
- Parkinson's disease
- Seizure disorder
- Motor ataxia
- Marfan's syndrome
- Ocular prostheses
- Amblyopia

In addition to the medical or physical conditions identified above, polycarbonate lenses also may be reimbursed when the client meets the following criteria:

- Lens power in at least one meridian of -5.25/+4.00 diopters or more and the eyeglasses are not functional in regular standard glass or plastic lens materials due to weight, thickness or aberration
- Monocular vision with functional vision in one eye
- Retinal detachment or risk for retinal detachment (e.g., lattice degeneration, history of retinal detachment in the family, posterior vitreous detachment)

Procedure code V2784 may be reimbursed when it is billed with one of the following diagnosis codes or combination diagnosis codes:

Diagnosis Codes							
Single Diagnosis Codes (Submitted as stand-alone diagnosis codes)							
F840	F843	F845	F848	F849	F951	G20	G2111
G2119	G213	G214	G218	G3183	G3184	G35	G40001
G40009	G40019	G40101	G40109	G40111	G40119	G40201	G40209
G40211	G40219	G40301	G40309	G40311	G40401	G40409	G40411
G40419	G40501	G40509	G40801	G40802	G40803	G40804	G40813
G4089	G40901	G40909	G40911	G40919	G40A01	G40A09	G40A11
G40A19	G40B01	G40B09	G40B11	G40B19	G710	G7111	G7112
G7113	G7114	G7119	G712	G713	G718	G720	G722
G723	G7241	G7249	G7281	G7289	G729	G737	G800
G801	G802	G804	G808	G809	H33001	H33002	H33003
H33011	H33012	H33013	H33021	H33022	H33023	H33031	H33032
H33033	H33041	H33042	H33043	H33051	H33052	H33053	H33191
H33192	H33193	H3321	H3322	H3323	H33301	H33302	H33303
H33311	H33312	H33313	H33321	H33322	H33323	H33331	H33332
H33333	H3341	H3342	H3343	H338	H53001	H53002	H53003
H53011	H53012	H53013	H53021	H53022	H53023	H53031	H53032
H53033	H5441	H5442	H5451	H5452	H8101	H8102	H8103
H8109	H8110	H8111	H8112	H8113	H8120	H8121	H8122
H8123	H81311	H81312	H81313	H81319	H81391	H81392	H81393
H81399	H8301	H8302	H8303	H8309	H8311	H8312	H8313
H8319	H832X1	H832X2	H832X3	H832X9	P100	P101	P104
P108	P524	P526	P528	Q8740	Q87410	Q87418	Q8742

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Diagnosis Codes							
Q8743	Q900	Q901	Q902	Q909	S06890A	S06890D	S06890S
S06891A	S06891D	S06891S	S06892A	S06892D	S06892S	S06893A	S06893D
S06893S	S06894A	S06894D	S06894S	S06895A	S06895D	S06895S	S06896A
S06896D	S06896S	S06899A	S06899D	S06899S	S069X0A	S069X0D	S069X0S
S069X1A	S069X1D	S069X1S	S069X2A	S069X2D	S069X2S	S069X3A	S069X3D
S069X3S	S069X4A	S069X4D	S069X4S	S069X5A	S069X5D	S069X5S	S069X6A
S069X6D	S069X6S	S069X9A	S069X9D	S069X9S	T8521XA	T8521XD	T8521XS
T8522XA	T8522XD	T8522XS	T8529XA	T8529XD	T8529XS	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	T8579XA	T8579XD	T8579XS				
Combination Diagnosis Codes (Must be submitted in pairs)							
S06890A S0190XA	S06891A S0190XA	S06892A S0190XA	S06893A S0190XA	S06894A S0190XA	S06895A S0190XA	S06896A S0190XA	S06899A S0190XA

For lens power in at least one meridian of -5.25/+4.00 diopters or more, and the eyeglasses are not functional in regular standard glass or plastic lens material due to weight, thickness or aberration, providers must submit one of the following lens procedure codes:

Procedure Codes									
V2101	V2102	V2105	V2106	V2107	V2108	V2109	V2110	V2111	V2112
V2113	V2114	V2201	V2202	V2205	V2206	V2207	V2208	V2209	V2210
V2211	V2212	V2213	V2214	V2301	V2302	V2306	V2307	V2308	V2309
V2310	V2311	V2312	V2313	V2314					

For diagnoses not listed in the above table or for lens power other than those listed in this section, providers must submit documentation of medical necessity. If documentation is not submitted with the claim, the polycarbonate lenses will be denied.

Undeliverable Eyeglasses

The provider may be reimbursed for the lenses based on the services furnished and the materials used up to the time the provider learned that the eyeglasses were undeliverable due to any of the following:

- The client cancels an order for eyeglasses prior to their completion and delivery.
- The prescription changes prior to completion and delivery of the eyeglasses.
- The client dies prior to completion and delivery of the eyeglasses.

Reimbursement will not be made for the frames.

4.3.6.2 Contact Lenses

Prior authorization is required for all contact lenses. The following procedure codes may be reimbursed for prosthetic and nonprosthetic contact lenses:

Procedure Codes									
V2500	V2501	V2502	V2510	V2511	V2512	V2513	V2520	V2521	V2522

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Procedure Codes			
V2523	V2530	V2531	V2599

The following procedure codes may be reimbursed for the fitting or modification of a contact lens:

Procedure Codes									
92310	92311	92312	92313	92314	92315	92316	92317	92325	92326

Contact Fitting for Corneal Bandage

A contact lens fitting for the placement of a corneal bandage lens may be medically necessary for eye protection and pain control due to a disease process or an injury. Procedure codes 92071 and 92072 may be reimbursed for the fitting of the corneal bandage for treatment and management.

Procedure code 92071 is limited to once per eye by any provider. Modifier LT or RT must be included on the claim to identify the eye on which the service was performed. When procedure code 92071 is performed on both eyes on 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 is limited to one service per lifetime by the same provider.

Procedure code 92072 will be denied if billed on the same date of service by the same provider as procedure code 92071.

Prior Authorization Requirements

Nonprosthetic contact lenses and corneal plano bandage lenses must be prior authorized. The following documentation must be submitted with a request for nonprosthetic contact lenses and must be signed and dated by the prescribing physician or optometrist:

- Diagnosis causing the refractive error (such as keratoconus)
- Include the current and new prescriptions supporting a change of 0.5d or more in the sphere, cylinder, or prism measurements
- Indicate which eyes to be treated
- Specify the procedure codes requested
- Include a brief statement addressing the medical necessity for vision correction by contact lens(es) and specify why eyeglasses are inappropriate or contraindicated for this client

For the contact fitting of the corneal bandage lens (procedure code 92071 or 92072), nonprosthetic contact lenses for nonemergency placement require prior authorization that must be obtained before the lenses are dispensed. Documentation submitted with the request must include the information listed above.

Nonprosthetic contact lenses for emergency placement do not require prior authorization. The emergency condition necessitating a corneal bandage must be documented on the claim.

Additional nonprosthetic contact lenses may be considered more frequently than the limitations outlined in this handbook when documentation in the client's medical record supports medical necessity for a diopter change of 0.5d or more in the sphere, cylinder, prism measurements, or axis changes.

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4.3.6.3 Dispensing Requirements

Providers must be able to dispense standard size frames at no cost to the eligible client. The following criteria must be met for the dispensed frames:

- Providers must offer each client who is 20 years of age or younger a choice of six styles in three colors for each type of frame: metal, zylonite, or combination of metal and zylonite.
- Providers must offer each client who is 21 years of age or older a choice of three styles in three colors for each type of frame: metal, zylonite, or combination of metal and zylonite.

When a client chooses eyeglass or contact lens options that are beyond program limitations, the client must acknowledge their choice and his or her liability for the cost difference by signing the Vision Care Eyeglass Patient (Medicaid Client) Certification Form.

Dispensing of contact lenses include 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.

Dispensing of eyeglasses includes the design, verification, fitting, adjustment, sale, and delivery to the client of (1) fabricated and finished spectacle lenses, (2) frames, or (3) other ophthalmic devices, prescribed by and dispensed in accordance with a prescription from a licensed physician or optometrist.

4.3.6.4 Repair

The eyeglass supplier is required to perform minor repairs on request (without charge) on eyeglasses that they have dispensed regardless of the client's age. Minor repairs are those that cost $2 or less. The minor repairs are included in the reimbursement for the eyeglasses and are not reimbursed separately.

For clients who are birth through 20 years of age, repairs that cost $2 or more may be reimbursed using procedure code V2799. The following criteria apply:

- The cost of repair supplies cannot exceed the cost of replacement eyeglasses.
- All repair supplies must be new and at least equivalent to the original item.
- The provider must maintain in the client's medical record an itemized list of repairs and the replacement cost to determine whether criteria are met for repair.

For clients who are 21 years of age and older, repair of nonprosthetic eyeglasses or contact lenses is not a benefit when the actual cost of materials exceeds $2.

The provider must make the client's medical record available for review upon request.

4.3.6.5 Nonprosthetic Replacement

Clients who are birth through 20 years of age may obtain replacement nonprosthetic eyeglasses if the first pair is lost or destroyed. There are no limitations on the number of replacements a client who is birth through 20 years of age may receive. If the eyewear is lost or destroyed, the provider must have the client sign the Vision Care Eyeglass Patient (Medicaid Client) Certification Form. Claims for replacement lenses must be submitted with the RB modifier to ensure accurate processing. Prior authorization is not required for the replacement of nonprosthetic eyeglasses.

Replacement of eyeglasses or contact lenses is also allowed with a change in axis. A new prescription must have at least one of the following changes:

- 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.

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- A cylinder axis change of at least 5 degrees for a cylinder power of 2.00 diopters or greater.

Note: *Replacement glasses will not be reimbursed for a cylinder power of 0.12-0.37 diopters with a change in axis.*

Prior authorization is required for replacement of non-prosthetic contact lenses.

If the client is diagnosed with aphakia, procedure code 92326 may be reimbursed for the replacement of a contact lens.

4.3.6.6 Medicare Coverage for Nonprosthetic Eyewear

Eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses because of refractive errors are not a benefit of Medicare. These services must be filed directly to Texas Medicaid when performed for a Medicaid Qualified Medicare Beneficiary (MQMB) client. Medicare coverage is limited to eye examinations for treatment of eye disease or injury and for a diagnosis of aphakia. When performing an eye examination with refraction for an MQMB client diagnosed with aphakia or disease or injury to the eye, the following procedures must be followed:

- Procedure code 92015 must be used to bill Texas Medicaid for the refractive portion of the examination and is payable with a diagnosis of aphakia or ocular disease only.
- The medical portion of the eye examination (procedure code 92002, 92004, 92012, or 92014) is covered by Medicare and must be billed to Medicare first. Medicare forwards this portion of the examination automatically to TMHP for deductible and coinsurance payment consideration according to current guidelines.

Refer to: Subsection 2.7, "Medicare Crossover Claim Reimbursement" in Section 2, "Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about current coinsurance and deductible payment guidelines.

Important: *Providers performing eye exams for refractive errors on Medicaid Qualified Medicare Beneficiary (MQMB) clients must bill TMHP. Do not send the refraction (procedure code 92015) to Medicare first. Texas Medicaid will not waive the 95-day filing deadline if the claim is billed to Medicare in error, nor will Medicare transfer the refraction to Texas Medicaid for payment.*

Medicare allows payment of one pair of conventional eyewear (contact lens or glasses) for clients who have had cataract surgery with insertion of an IOL. Medicare considers the IOL the prosthetic device. Texas Medicaid providers must bill Medicare for the conventional (nonprosthetic) eyewear provided following an IOL insertion and bill Texas Medicaid for any replacements of the conventional (nonprosthetic) eyewear using the procedure codes in subsection 4.3.6, "Nonprosthetic Eyeglasses or Contact Lenses" in this handbook.

4.3.7 Vision Services for Prosthetic Eyewear

Prosthetic eyeglasses or contact lenses are lenses that replace the eye's organic lens when it is absent due to congenital or acquired aphakia. Aphakia may be the result of a congenital abnormality or defect or an acquired condition as a result of trauma or cataract removal without intraocular lens (IOL) insertion.

Prosthetic eyeglasses or contact lenses may be provided based on medical necessity. Eye examinations and prosthetic eyewear may be reimbursed as follows:

- Eye examinations for aphakia (including congenital aphakia) and disease or injury to the eye may be reimbursed as often as is medically necessary.
- One pair of permanent prosthetic eyeglasses or contact lenses is a benefit during a client's lifetime.

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- Replacement of prosthetic eyeglasses or contact lenses may be reimbursed for clients of any age due to loss or destruction of the eyewear or due to a significant change in visual acuity with a diopter change of 0.5d or more in the sphere, cylinder, prism measurements, or axis changes. The provider must maintain in the client's medical record documentation that supports the medical necessity for the replacement eyeglasses or contact lenses.

Prosthetic contact lenses may be provided, with prior authorization, for clients of any age with congenital or acquired aphakia.

Note: *Fitting services are included in the reimbursement for prosthetic eyeglasses or contact lenses.*

Providers must use modifier VP with a diagnosis code of aphakia when billing for prosthetic eyeglasses or contact lenses.

Refer to: Subsection 4.3.6, "Nonprosthetic Eyeglasses or Contact Lenses" in this handbook for the eyeglass lens, frame, and contact lens procedure codes and dispensing requirements that apply to prosthetic and nonprosthetic eyewear.

The date of cataract surgery is not required on the claim for conventional eyeglasses or contact lenses after surgery, or prosthetic eyeglasses or contact lenses after cataract surgery without IOL insertion.

4.3.7.1 Eyeglasses or Contact Lenses Following Cataract Surgery

Temporary eyeglasses or contact lenses after cataract surgery may be reimbursed when they are billed with the appropriate lens and frame procedure codes and diagnosis code Z961.

Temporary eyeglasses or contact lenses may be reimbursed for up to 4 months after surgery until the client is ready for conventional eyeglasses or contact lenses, when it is medically necessary. The date of surgery is used to determine the convalescence period for temporary eyeglasses or contact lenses. Temporary eyeglasses or contact lenses will be denied if they are dispensed more than 4 months after the date of surgery.

Temporary eyeglasses or contact lenses may be reimbursed as often as is medically necessary during the postsurgical convalescence period.

4.3.7.2 Repair

The eyeglass supplier is required to perform minor repairs on request (without charge) on eyeglasses that they have dispensed regardless of the client's age. Minor repairs are those that cost $2 or less. The minor repairs are included in the reimbursement for the eyeglasses and are not reimbursed separately.

Repairs that cost $2 or more may be reimbursed using procedure code V2799. The following criteria apply:

- The cost of repair supplies cannot exceed the cost of replacement eyeglasses.
- All repair supplies must be new and at least equivalent to the original item.
- The provider must maintain in the client's medical record an itemized list of repairs and the replacement cost to determine whether criteria are met for repair.

The provider must make the client's medical record available for review upon request.

4.3.7.3 Prosthetic Replacement

Replacement prosthetic eyeglasses or contact lenses may be reimbursed as often as is medically necessary if the replacement is due to loss, destruction, or a significant change in visual acuity.

Replacement of eyeglasses or contact lenses is also allowed with a change in axis. A new prescription must have at least one of the following changes:

- 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.

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- 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: *Replacement glasses will not be reimbursed for a cylinder power of 0.12-0.37 diopters with a change in axis.*

The appropriate eyeglass and frame or contact lens procedure codes must be billed with modifier RB to indicate replacement.

Refer to: Subsection 4.3.6, "Nonprosthetic Eyeglasses or Contact Lenses" in this handbook for the eyeglass lens, frame, and contact lens procedure codes and dispensing requirements that apply to nonprosthetic eyewear.

4.3.7.4 Intraocular Lens (IOL) and Additional Eyewear

Intraocular lenses are benefits of Texas Medicaid. If conventional eyewear is medically necessary in addition to the IOL, the IOL is considered the prosthetic device, and the eyewear and any replacements are considered nonprosthetic.

Refer to: Subsection 9.2.48.4, "Intraocular Lens (IOL)" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information about IOL benefits.

Subsection 4.3.6, "Nonprosthetic Eyeglasses or Contact Lenses" in this handbook for more information about nonprosthetic eyewear.

4.3.7.5 Artificial Eyes

For clients who are birth through 20 years of age, artificial eyes may be considered under CCP.

4.3.7.6 Ultraviolet (U-V) Protection

Procedure code V2755 may be reimbursed for U-V protection when billed with one of the following diagnosis codes:

Diagnosis Codes							
H2701	H2702	H2703	H27111	H27112	H27113	H27121	H27122
H27123	H27131	H27132	H27133	Q123	Z961		

UV lens procedure code V2755 will be denied when billed with the same date of service by the same provider as polycarbonate lens procedure code V2784.

UV and polycarbonate lens procedure codes are subject to CMS NCCI relationships.

Refer to: The CMS NCCI web page for the published correct coding guidelines and specific applicable code combinations.

4.3.8 Surgical Vision Services

Refer to: Subsection 9.2.39.12, "Fluocinolone Acetonide (Retisert)" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information about fluocinolone acetonide benefits.

Subsection 9.2.48, "Ophthalmology" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information about surgical vision services.

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4.3.9 * Prior Authorization

Prior authorization is required for the following:

- Orthoptic or pleoptic training beyond the maximum limits outlined in subsection 4.3.5.8, "Orthoptic or Pleoptic Training" in this handbook
- The unlisted ultrasound procedure
- All contact lenses, except corneal bandage lens(es) for emergency placement

A completed Special Medical Prior Authorization (SMPA) Request Form must be submitted by fax or mail to the Special Medical Prior Authorization department. The form must be signed and dated by a physician familiar with the client before requesting prior authorization. The completed Special Medical Prior Authorization (SMPA) Request Form must include the procedure codes and numerical quantities for services requested. The completed, signed, and dated Special Medical Prior Authorization (SMPA) Request Form must be maintained by the provider and the prescribing physician in the client's medical record.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation for medical necessity of the vision service 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 vision service.

4.4 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including vision services. Vision services are subject to retrospective review and recoupment if documentation does not support the service billed.

The client must sign and date the Vision Care Eyeglass Patient (Medicaid Client) Certification Form, and the provider must retain it in the provider's records.

When a client chooses an eyeglasses or contact lens option beyond the program limitations, or nonprosthetic eyeglasses or contact lenses are replaced because of loss or destruction the client must acknowledge their choice and liability for the cost difference by signing the Vision Care Eyeglass Patient (Medicaid Client) Certification Form and retain it in the provider's records.

The current and previous prescriptions must be documented in the client's medical record.

The provider must make the client's medical record available for review upon request by the following:

- HHSC
- Office of the Attorney General
- TMHP

4.5 Claims Filing and Reimbursement

4.5.1 Claims Filing

Vision care service claims 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.

When submitting the client's old and new prescriptions to show an axis change or a diopter change of.5 or more, enter the new prescription in Block 24D, line 5, and the old prescription in Block 24D, line 6 of the CMS-1500 paper claim form.

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Claims for eye examination services require a diagnosis. Claims for eye examinations that lack a diagnosis are listed as an incomplete claim on the Remittance and Status (R&S) report and must be resubmitted for payment consideration. Electronic claims that lack a diagnosis will be rejected. A letter with the reason for rejection and instructions for resubmission will be mailed the following business day.

When the eye exam limitation is exceeded for clients who are 20 years of age and younger, identify one of the following situations in Block 19 of the CMS-1500 paper claim form:

- A school nurse, teacher, or parent requests the eye examination.
- The eye examination is medically necessary.

4.5.2 Reimbursement

Providers must reflect the highest level of specificity for vision related diagnosis on claims or other documentation. Professional services by an optometrist for contact lenses and prosthetic eyewear are reimbursed in accordance with 1 TAC, §§355.8001, 355.8081, and 355.8085.

FQHCs are paid an all-inclusive rate per visit for payable services in accordance with 1 TAC, §355.8261.

Suppliers of nonprosthetic lenses and frames are reimbursed the lesser of their billed amount or of the established maximum allowable fee in accordance with 1 TAC, §355.8001. See the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

Vision Services on the TMHP website at www.tmhp.com for a claim form example.

The nonsurgical vision procedure codes included in this handbook may be subject to the CMS NCCI relationships.

Refer to: The CMS website at www.cms.gov for more information about NCCI relationships.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

4.5.2.1 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

If applicable and consistent with CMS billing guidelines, procedure codes must be billed with modifier LT (left side) or RT (right side) to identify the eye on which the service was performed.

5 Claims Resources

Refer to the following sections and forms when filing claims:

Resource	Location
Appendix D: Acronym Dictionary	Appendix D (*Vol. 1, General Information*)

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Resource	Location
Automated Inquiry System (AIS)	"Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5 (*Vol. 1, General Information*)
Appendix A: State, Federal, and TMHP Contact Information	Appendix A (*Vol. 1, General Information*)
Section 3: TMHP Electronic Data Interchange (EDI)	Section 3 (*Vol. 1, General Information*)
TMHP Electronic Claims Submission	Subsection 6.2 (*Vol. 1, General Information*)

6 Contact TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.

7 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Hearing Evaluation, Fitting, and Dispensing Report (Form 3503)
Physician's Examination Report
Vision Care Eyeglass Patient (Medicaid Client) Certification Form
Vision Care Eyeglass Patient (Medicaid Client) Certification Form (Spanish)

8 Claim Form Examples

The following linked claim form examples can also be found on the Claim Form Examples page of the Provider section of the TMHP website at www.tmhp.com:

Claim Form Examples
Hearing Aid Assessments
Vision Services

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