Texas Medicaid

Provider Procedures Manual

July 2025

Volume 2

Provider Handbooks

Children's Services Handbook

The Texas Medicaid & Healthcare Partnership (TMHP) is the claims administrator for Texas Medicaid under contract with the 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" (Vol. 1, General Information). 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 1.7, "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: The *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/resources/rate-and-code-updates/rate-changes.

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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 National Provider Identifier (NPI) 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 3.7.4.17, "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 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.

Under the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) regulation, known in Texas as Texas Health Steps (THSteps), Section 1905(r) of the Social Security Act mandates that all Medicaid-eligible beneficiaries who are birth through 20 years of age receive medically necessary services to treat, correct and ameliorate illnesses and conditions identified if the service is covered in the state's Medicaid

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plan or is an optional Medicaid service. It is the responsibility of the state to determine medical necessity on a case specific basis. No arbitrary limitations on services are allowed (e.g., one pair of eyeglasses or 10 therapy sessions per year) if determined to be medically necessary.

Services not covered under this section include:

- Experimental or investigational treatment.
- Services or items not generally accepted as effective and/or not within the normal course and duration of treatment.
- Services for the caregiver or provider convenience.

All EPSDT requirements must be adhered to for beneficiaries who receive services under managed care arrangements.

The following CCP provider sections describe the specific requirements of each area of responsibility:

- Subsection 2.6, "Clinician-Directed Care Coordination Services (CCP)" in this handbook.
- Subsection 2.11, "Medical Nutrition Counseling Services (CCP)" in this handbook.
- Subsection 2.9, "Early Childhood Intervention (ECI) Services" in this handbook.
- Subsection 2.12, "Personal Care Services (PCS) (CCP)" in this handbook.
- Subsection 2.17, "Inpatient Psychiatric Hospital or Facility (Freestanding) (CCP)" in this handbook.
- Subsection 2.18, "Inpatient Rehabilitation Facility (Freestanding) (CCP)" in this handbook.

Refer to: The *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for information about comprehensive outpatient rehabilitation facilities (CORFs) and outpatient rehabilitation facilities (ORFs).

The *Home Health Nursing and Private Duty Nursing Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about private duty nursing (PDN) services.

The *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about CCP therapy services.

The *Certified Respiratory Care Practitioner (CRCP) Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about CRCP CCP services.

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 Medicaid card states "Emergency," "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

Refer to: Subsection 1.7.19, "Children's Services Comprehensive Care Program (CCP)" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for enrollment information.

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 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: Fee-for-Service Prior Authorizations" (*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 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.

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

TMHP will consider the reimbursement of claims for services that were rendered on or after the MCO's disenrollment date only when the provider submits a request to TMHP to transfer the previously approved authorization for CCP services.

The request to TMHP must be received on or before the end date of the previously approved MCO authorization. Any requests submitted after the MCO's authorization end date will have to meet the regular submission guidelines for the specific service type.

2.2.2 Documentation Requirements

All of the requests to transfer the authorizations from the MCO to FFS must include:

- A copy of the previously approved 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 Request form, Special Medical Prior Authorization (SMPA) form, Home Health Plan of Care, or Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form, 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.

Note: *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.*

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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.

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.
- Claims for services that were paid by an MCO and then recouped must contain the recoupment EOB from the MCO for consideration of payment. The claims must meet the 95-day deadline from the recoupment disposition date.

  Note: *Letter requests for refunds will not be accepted. A recoupment EOB with a disposition date is required.*

If a request to transfer an MCO authorization is submitted after the end date of the MCO authorization or 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 CCP services, PDN, OT, PT, and ST.

All new requests for rendered services must meet the documentation requirements.

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 and meet all established submission guidelines for prior authorization.

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 "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*).

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 Autism Services

Autism services are a benefit of the Texas Health Steps-Comprehensive Care Program (THSteps-CCP) for Medicaid children or youth who are 20 years of age or younger and meet the criteria outlined in this section.

2.3.1 Autism Spectrum Disorder (ASD)

Autism spectrum disorder (ASD) is a condition characterized by restricted, repetitive patterns of behavior, interests, or activities and deficits in social communication and social interaction, with onset of symptoms occurring in early childhood.

Texas Medicaid acknowledges that research and clinical practices in interventions for ASD are an evolving and dynamic field. As such, documentation to support the medical need for ASD services, including applied behavior analysis (ABA) services, may include intervention techniques with a sound basis in discipline-specific peer-reviewed literature when available, interventions with specific applicability to the person's clinical and functional profile (including comorbid conditions), and an individualized, person-centered treatment plan that aligns with the values and preferences of the person with ASD and their family.

2.3.2 Comprehensive Diagnostic Evaluation

A comprehensive diagnostic evaluation is required to diagnose ASD. A comprehensive diagnostic evaluation is the entire process of gathering information to determine a diagnosis, which must include a reliable, valid, standardized diagnostic assessment tool(s). Each element must be conducted by appropriately trained, specialized or certified providers. Diagnosis of ASD may be made by any one of the following providers or utilizing an interdisciplinary diagnostic team approach:

- A developmental pediatrician
- A neurologist
- A psychiatrist
- A licensed psychologist
- Interdisciplinary Diagnostic Team
    - Members of an interdisciplinary diagnostic team administer the elements required for the diagnosis of ASD. Each provider must be qualified by licensure to use the reliable, valid, standardized diagnostic assessment tool(s).
    - An interdisciplinary diagnostic team may be composed of a physician or allowed diagnosing provider who may coordinate with providers specializing in autism for consultation as listed under the Interdisciplinary Diagnostic Team. Providers of the interdisciplinary diagnostic team must be qualified child specialists and have expertise in autism. The prescribing provider may use the documented results of a reliable, valid, standardized diagnostic assessment tool or combination of tools from the following disciplines:
        - Any provider listed above
        - Licensed clinical social worker
        - Licensed professional counselor
        - Licensed psychological associate
        - Licensed specialist in school psychology
        - Occupational therapist (OT)

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- Speech-language pathologist (SLP)

Note: *An allowed practitioner is an individual licensed in Texas as a physician assistant (PA), a certified nurse practitioner (NP), or clinical nurse specialist (CNS).*

The comprehensive diagnostic evaluation must include all of the following to support a diagnosis of ASD:

- Diagnostic criteria and symptom severity level according to the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
- A reliable, valid, standardized diagnostic assessment tool or combination of tools, using the most current editions or versions of the tools, as age and clinically appropriate, such as the Autism Diagnostic Observation Schedule, the Autism Diagnostic Interview-Revised (ADI-R), the Childhood Autism Rating Scale, or another validated diagnostic assessment tool, as clinically appropriate. The diagnostic assessment tool must be indicated for diagnostic purposes by the publisher.
  - Screening tools such as the Screening Tool for Autism in Toddlers and Young Children (STAT) or the Modified Checklist for Autism in Toddlers (M-CHAT-R) or M-CHAT Revised with Follow-Up (M-CHAT-R/F) may not replace the use of validated diagnostic assessment tools.
- Documentation of diagnosis must include:
  - Age of the child or youth
  - Date of the initial ASD diagnosis
  - Documentation of any known comorbid behavioral or physical health disorders
  - Documentation of trauma history

To be eligible for the ABA services outlined in this section, a diagnosis of ASD complete with diagnostic criteria and symptom severity level from the current DSM must be made or reconfirmed within 3 years of initiation or recertification of ABA services.

To be eligible for ABA services outlined in this section more than 3 years after initial ASD comprehensive diagnosis, a comprehensive re-evaluation of ASD symptom severity levels per DSM criteria must be made by qualifying diagnostic providers, as listed above. A re-evaluation consists of the same components as an initial comprehensive diagnostic evaluation.

2.3.3 Comprehensive Service Array

Texas Medicaid offers an array of medically necessary services to support individualized treatment plans for children or youth who are 20 years of age or younger with ASD.

These services may be covered benefits when matched with an individualized treatment plan tailored to the specific needs of the child or youth who are 20 years of age or younger and their caregivers and documented as medically necessary and effective. Not all services may be clinically appropriate for all people, families, or situations.

Services must be evidence-based, person-centered, delivered by personnel of appropriate training and credentialing, and oriented to functional, attainable, and measurable goals.

These services may include one or more of the following but are not limited to:

- Applied behavior analysis (ABA)
- Case management/service coordination (with parent permission)
- Early Childhood Intervention (ECI)
- Nutrition, when provided by a licensed dietitian
- Occupational therapy (OT)

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- Outpatient behavioral health services
- Physician services, including medication management
- Physical therapy (PT)
- Speech-language pathology (SLP); also called speech therapy (ST)

Nonphysician qualified health-care professionals who are enrolled in Texas Medicaid may be reimbursed up to 2 times per rolling year for participation in interdisciplinary team meetings (procedure code 99366) for the coordination of care for children or youth who are 20 years of age or younger with ASD and have a prior authorization for ABA evaluation or treatment services. The Licensed Behavior Analyst (LBA) is required to participate in interdisciplinary treatment team meetings. Interdisciplinary team meetings are not required for a child or youth for access to any service but are highly encouraged for a collaborative approach to treatment, which is considered the gold standard for care of people with ASD.

Interdisciplinary team meetings must include the LBA and at least 2 other licensed professionals meeting simultaneously with the parent or caregiver. The child or youth may optionally attend the meeting.

Additional members may attend, such as assistants, paraprofessionals, or others the family chooses, but these participants may not seek Medicaid reimbursement or count toward the required members of the interdisciplinary team meeting.

Non-Medicaid enrolled licensed professionals who work directly with the child or youth and would otherwise be eligible for reimbursement for interdisciplinary team meetings except that they are not Medicaid-enrolled may not receive Medicaid reimbursement for participation in team meetings. However, they may be considered as a participating team member for the purpose of meeting the minimum number of licensed provider participants.

Regardless of Medicaid enrollment, licensed assistants, nonclinical social workers, case managers, and paraprofessionals may not count toward the minimum number of licensed professionals present at the interdisciplinary team meeting.

Team members may include licensed Medicaid-enrolled practitioners of the following disciplines:

- Licensed clinical social worker (LCSW)
- Licensed behavior analyst (required team member)
- Licensed dietitian (LD)
- Licensed professional counselor (LPC)
- Licensed psychologist (LP)
- Occupational therapist (OT)
- Physical therapist (PT)
- Physician, physician assistant, or nurse practitioner
- Speech-language pathologist (SLP)

Note: *The physician, physician assistant, or nurse practitioner may bill a standard evaluation and management code (i.e., established patient visit) based on the counseling and coordination of care time spent in the team conference.*

To be reimbursed for the interdisciplinary team meeting (procedure code 99366), each participating licensed team member must have individually evaluated or provided direct services to the child or youth within the previous 180 days.

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For a change of provider, the new provider must follow requirements in the Change of Provider section to begin services prior to attendance at the interdisciplinary team meeting.

Team members, including the child or youth, their family, or their caregiver, may participate via remote technology, which meets standards of care for telehealth.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telehealth and technology requirements.

Medicaid-enrolled providers must designate remote delivery with modifier 95 on the claim.

Team members may include representatives from the child or youth's school, but school districts are not eligible for direct reimbursement for the interdisciplinary team meeting.

No more than one individual from the same specialty may receive Medicaid reimbursement for the team meeting.

School personnel of the same discipline as Medicaid-enrolled providers who are participating to coordinate care are not considered duplicates of the same specialty and may count toward the 3-participant licensed professional minimum.

2.3.4 Applied Behavior Analysis (ABA)

Behavior analysis is the scientific study of the principles of learning and behavior, specifically about how behavior affects, and is affected by, past and current environmental events in conjunction with biological variables.

ABA refers to the application of current, evidence-based specialized principles of the applied behavior analysis discipline by a provider, such as a licensed and certified behavior analyst (LBA), trained in this intervention.

The intent of ABA therapy is to effect meaningful changes, which are durable and generalizable, in socially significant behaviors in everyday settings. ABA focuses on treating behavior difficulties and shaping behavior patterns through environmental adaptations and consistent reinforcement and consequences across settings and situations.

Intensive behavioral intervention (IBI) is a high-intensity application of ABA therapy.

ABA services must be medically necessary to treat, correct, or ameliorate the individual's condition. A diagnosis alone is not sufficient documentation to support the medical necessity of ABA.

Physical restraint is not appropriate during any service provided to Medicaid children or youth under the Autism Services benefit except in emergency instances of threat of physical harm to the child or youth or others around them.

Physical restraint may only be implemented by a person trained in the type of restraint being implemented.

Restraint must be limited to the use of such reasonable force as is necessary to address the emergency.

Restraint must be discontinued at the point at which the emergency no longer exists.

Restraint must be implemented in such a way as to protect the health and safety of the child or youth and others.

Restraint must not deprive the child or youth of basic human necessities.

Documentation must be kept of the up-to-date training for all staff members involved and of each incident that resulted in restraint.

Use of ABA in no way precludes other medically necessary treatment interventions for ASD, such as ST, OT, and other forms of behavioral therapy, family therapy, parent-implemented models that use a developmental relationship-based approach, or medication management.

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Texas Medicaid strongly encourages, and in some circumstances requires, interdisciplinary collaboration of care.

2.3.5 Parent or Caregiver Involvement

For fidelity to the ABA treatment model for children or youth who meet eligibility requirements, an effective course of ABA typically requires active parent or caregiver participation and involvement to increase the potential for behavior changes in the specific behaviors identified as causing limitations or deficits in functional skills expected for the child or youth.

Parent or caregiver training is considered a separate component of the individualized treatment plan from the direct services provided to the child or youth, and documentation of parent progress on goals is required.

Parent or caregivers ideally must be able to participate in ABA therapy and implement ABA techniques in the home and community environment as instructed by the LBA or licensed assistant behavior analyst (LaBA) for behavior changes to prove to be durable and generalizable. Individual family circumstances are necessary criteria when designing the individualized treatment plan.

Participation by the parents or caregivers are expected, and continued authorization for ABA services will take consideration of their involvement and ability to reinforce behavior changes over time and across settings.

Exceptions to this general expectation may be considered on a case-by-case basis. For example: for children or youth in residential placement through the Department of Family and Protective Services conservatorship who have a treatment plan designed to address this limitation. In these cases, persons involved in the child or youth's care are encouraged to be involved in implementation of the therapeutic interventions in the home and community.

ABA services will not be denied solely on the basis of lack of parent or caregiver involvement; however, parent or caregiver involvement may affect the effectiveness, durability, and generalizability to natural settings of the treatment and may be considered when making determinations regarding effectiveness of the treatment requested.

2.3.5.1 Treatment Planning

Treatment planning requires that the LBA collaborate with and obtain documentation of determinations from the prescribing provider or other appropriate providers for elements of the treatment plan that are not within the LBA scope of practice.

ABA treatment plans, including group treatment, require goals that relate to the child or youth's individual functional contexts.

Functional context refers to everyday environments for behaviors or skills that allow the child or youth to achieve an outcome relevant to their health, safety, or independence.

Goals to address behaviors that result in deficits in social communication and social interaction relating to the child or youth's health, safety, or independence in functional contexts may be considered medically necessary.

Treatment plan goals (to include parent or caregiver training) may target a specific behavior interfering with activities of daily living (ADLs) use the principles of ABA (i.e., backward chaining, schedules of reinforcement, etc.) to teach parents or caregivers on supporting ADLs.

- General goals addressing ADL skill acquisition are excluded.

Functional goals must be specific to the child or youth, objectively measurable within a specified time frame, attainable in relation to the child or youth's prognosis and developmental status, both important to and relevant to the child or youth and their family, and directly related to the core symptoms of ASD as defined by the current version of DSM.

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The treatment plan may also include goals to specifically address challenging behaviors, such as aggression, in the creation of a Behavior Support Plan (BSP).

BSPs may not include the use of aversive interventions, including but not limited to the use of pain, discomfort, social humiliation, seclusion, or restraints.

The treatment plan must include separate goals specific to parent or caregiver training.

The child or youth must be able to participate in sessions as outlined in the individualized treatment plan.

This section addresses ABA services provided by Texas LBAs as well as by an LaBA or behavior technician (BT) working under the supervision of an LBA in office, home, clinic, and community settings.

All LBAs and their supervisees must provide services in a way that is consistent with the physician's orders, commonly accepted practice standards, licensing requirements, and within their scope of practice.

Services must be provided in compliance with the Texas Health Step-Comprehensive Care Program, medical standards for telehealth, and these Medicaid Autism Services requirements, which may be more restrictive than general ABA practice.

The LBA must determine whether services are clinically appropriate, effective, and not contraindicated for the child or youth, their family, or particular situation.

> ***Note:*** *Remote delivery as specified for this service will supersede that of the Telecommunication Services Handbook.*

ABA therapy addresses the behaviors associated with the core symptoms of ASD that impact attainment of individualized functional goals. It is out of scope for an ABA provider to attempt to remediate underlying or associated medical conditions that may impact progress toward individualized functional goals or to formulate a treatment plan without appropriate collaboration with other health-care disciplines, as appropriate.

LBAs and the staff they supervise are expected to have training and knowledge of typical development for children or youth who are 20 years of age or younger in order to provide medically necessary services.

When evaluating and treating children and youth with suspected or diagnosed comorbid genetic, physical, or behavioral health conditions or trauma history, the LBA is expected to coordinate with the appropriate skilled and licensed professionals. Co-occurring conditions may mimic or exacerbate ASD symptoms.

Diagnosis and treatment of physical health conditions, including developmental delays in children, would require collaboration with additional professionals.

- For example, a child or youth with a co-morbid diagnosis of a motor disorder who has treatment plan goals addressing speech or motor skill development would require coordination with an SLP, OT, or PT, as appropriate.
- For example, a child or youth with a diagnosis of a seizure disorder would require close coordination with the physician treating the condition.
- A child with a co-morbid diagnosis of a feeding disorder who has treatment plan goals addressing feeding would require coordination with the appropriate medical provider, including but not limited to a physician, dietitian, OT, or SLP, as appropriate.
- LBAs are not permitted as the sole provider of a feeding treatment plan.

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Diagnosis and treatment of co-occurring behavioral health conditions require the input of and coordination with behavioral health professionals specifically trained and educated in this scope of practice.

- For example, a child or youth with a co-morbid diagnosis of anxiety would require coordination with the appropriate behavioral health provider.

It is out of scope for an LBA to dictate the provision of other medically necessary treatments, including requiring a child or youth and their family to drop other services in order to access ABA.

The following ABA services may be authorized for eligible children or youth who have been diagnosed with ASD according to guidelines:

- An initial ABA evaluation (procedure code 97151) to include development of an individualized treatment plan and a BSP, as appropriate
- An initial 90-day course of ABA treatment with medical necessity documentation from the ABA evaluation. Treatment may include the following with documented medical necessity:
  - Provision of one-on-one ABA services delivered directly by the LBA or delivered by the supervised LaBA, BT, or both (procedure codes 97153, 97155)
  - Provision of group ABA services delivered directly by the LBA or delivered by the supervised LaBA, BT, or both (procedure codes 97154, 97158)
  - One-on-one services delivered directly to the child or youth with ASD by a BT or LaBA must be delivered in person. Use of telehealth in one-on-one, direct service delivery with the child or youth by a BT or LaBA is prohibited.
  - Providing training to family members or caregivers by the LBA or delegated supervised LaBA in accordance with the child or youth's individualized treatment plan (procedure code 97156). The child or youth with ASD is not required to be present for this family or caregiver training.
- A 90-day extension of medically necessary ABA treatment with supportive documentation of the extension from submission of an attendance log that also includes a calculation of the percentage of planned sessions completed for the child or youth and their parent or caregiver, and a progress summary
- An ABA re-evaluation (procedure code 97151), to include an attendance log that also includes a calculation of the percentage of planned sessions completed for the child or youth and their parent or caregiver
- A 180-day recertification of ABA treatment with medical necessity documentation from the ABA re-evaluation and related documents

All ABA treatment and evaluation services require a signed and dated referral from the child or youth's prescribing provider.

2.3.6 ABA Provider Requirements

2.3.6.1 Licensed Behavior Analysts (LBA)

Licensed behavior analysts (LBA) must meet all of the following requirements:

- Have a current, unrestricted state-issued license and meet all applicable Texas licensure requirements.
- If applicable, employ directly or contract with LaBAs or BTs or both.
- Have training and knowledge of typical development for children or youth who are 20 years of age or younger.

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LBAs serve as direct supervisors of the LaBAs and BTs and must ensure that the quality of the ABA services provided by LaBAs and BTs meets the minimum standards promulgated by the applicable certifying body's recommendations, rules, and regulations as well as Medicaid requirements.

LBAs are ultimately responsible for the delivery of ABA care including the treatment plan.

Direct supervision must be provided in accordance with Texas state licensure.

Only direct supervision, where the LBA directly observes the LaBA or the BT providing services with the child or youth, or the child or youth's parents or caregivers, will be reimbursed by Texas Medicaid (procedure code 97155). Indirect supervision, including but not limited to a review and discussion of case load, data collection procedures, and professional development, is not reimbursable under Texas Medicaid. See the Reimbursement and Billing Guidelines section.

ABA treatment will ideally be delivered in the primary language used at home or the primary language of the child or youth with ASD.

Translation or interpretation services, when and as required for effective service delivery, must be offered if providers are not able to deliver the treatment in the child or youth's primary language.

The LBA is responsible for provision of services within Medicaid requirements.

2.3.6.2 Licensed Assistant Behavior Analysts (LaBA)

LaBAs must have a current, unrestricted state-issued license and meet all applicable Texas licensure requirements.

A supervised LaBA working within the scope of their training, practice, and competence may assist the LBA in various roles and responsibilities as determined appropriate by the LBA and delegated to the LaBA, consistent with the Texas state licensure requirements and Medicaid requirements.

LaBAs must have training and knowledge of typical development for children or youth who are 20 years of age or younger.

LaBAs may not enroll in Texas Medicaid.

2.3.6.3 Behavior Technicians (BT)

A BT refers to a high school graduate-level paraprofessional who delivers ABA services under the supervision of an LBA or an LBA and an LaBA.

All BTs must have certification as one of the following:

- Registered Behavior Technician (RBT®)
- Board Certified Autism Technician (BCAT)
- Applied Behavior Analysis Technician (ABAT®)

Behavior technicians may not enroll in Texas Medicaid.

Behavior technicians may not use the term "therapist" or be referred to as a "therapist" in their job title when interacting with Medicaid-enrolled children or youth families, or caregivers or with professionals who also serve the child or youth, such as school staff or physicians.

BTs may not amend the treatment plan or interpret the treatment plan to family, caregivers, or professionals who also serve the child or youth, such as school staff or physicians.

A BT may not conduct the ABA assessment or establish a child or youth's ABA treatment plan.

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2.3.7 Documentation Requirements

2.3.7.1 Submission Documentation

All of the following elements must be submitted with the authorization request.

Note: *"Days" refers to calendar days unless otherwise specified.*

2.3.7.2 Documentation Required for Authorization of an ABA Initial Evaluation

The referral for ABA services must be submitted with the authorization request and must contain documentation from the diagnosing or prescribing provider of the following:

- Age of the child or youth and year of the initial ASD diagnosis
- Any co-morbid behavioral health or physical conditions, including trauma history
- Level of symptom severity as per DSM criteria under ASD
- Diagnosis of ASD or re-evaluation of ASD diagnosis must have been made within the past 3 years, including the diagnostic criteria and symptom severity level per DSM criteria. A reliable, valid, standardized diagnostic tool or combination of tools must have been a part of the initial evaluation or re-evaluation.
- A signed and dated referral from the prescribing provider for an evaluation for ABA services
  - This referral may originate from the primary care provider.
  - The referral may originate from the diagnosing provider who is a physician, or allowed practitioner.

Note: *An allowed practitioner is an individual licensed in Texas as a physician assistant (PA), a certified nurse practitioner (NP), or clinical nurse specialist (CNS).*

2.3.7.3 Documentation Required for Authorization of Initiation of Treatment with ABA

All of the following elements must be submitted with the authorization request:

- A signed and dated referral from a physician or allowed practitioner outlining the frequency and duration of treatment based on recommendations made in the ABA evaluation as well as the prescribing provider's own clinical judgement.
- The LBA must coordinate with the prescribing or other appropriate physician to document elements for initiation of ABA treatment that are not within the LBA's scope of practice.

To document medical necessity for ABA, the following elements are required in the ABA assessment documentation:

- A complete developmental history, including:
  - Relevant co-morbid conditions, including trauma history.
  - Vision and hearing or audiologic screening, as age and clinically appropriate.

Note: *If age and clinically appropriate, Texas Health Steps required screenings are acceptable. Results of further evaluations may be required if those screenings indicated deficits.*

  - One-on-one observations of the child or youth, including at least one natural setting.
  - Documentation of interviews with parents or caregivers to further identify and define lack of adaptive behaviors and presence of maladaptive behaviors, to include any linguistic or cultural factors that may impact treatment.
  - Family history.
  - Primary language used by the child or youth with ASD and their family.

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- Document whether the child or youth has a previous history of ABA. When prior history exists, include how long the child or youth has been receiving ABA services (include any gaps in treatment) and their responses to previous interventions.
- Prognosis based on evidence from the evaluation regarding the individual's capacity to make behavioral gains.
- Validated assessments of cognitive abilities and adaptive behaviors, such as the Vineland Adaptive Behavior Scales.
    - An estimate of the child or youth's cognitive abilities may be provided when a validated assessment of cognitive abilities is not possible due to the child or youth's level of ASD or behaviors or both.
    - Limited cognitive ability or other co-occurring disability does not preclude the child or youth from consideration for medically necessary ABA evaluation and treatment services provided the treatment plan is realistic for the child or youth.
- A functional behavior assessment, related to specific behaviors of concern, to be addressed in a BSP, as clinically indicated.

Individualized ABA treatment plans must include:

- Identification of specific targeted behaviors/skills related to the child or youth's health, safety, or independence that will be addressed in treatment.
- Treatment goals must directly relate to the core symptoms of ASD as defined by the DSM.
- Goals and protocols must be selected by the LBA in collaboration with the parents or caregivers, consistent with person-centered and family-centered practice.
- Functional goals must be specific to the child or youth, objectively measurable within a specified time frame, attainable in relation to the child or youth's prognosis and developmental status, both important to and relevant to the child or youth and their family, and directly related to the core symptoms of ASD as defined by the DSM.
- Baseline data for all behaviors and skills identified for intervention across settings (e.g., home, school, community) where treatment will occur.
- A BSP, if appropriate.
    - BSPs must include an operational, behavioral definition of the target behavior excesses and deficits, prevention and intervention strategies, schedules of reinforcement, and functional alternative responses.
- The planned frequency (intensity) and duration of treatment across all settings to reflect the severity of the impairments, goals of treatment, expected response to treatment, and specific individual variables, including availability of appropriately trained and certified ABA staff, that may affect the recommended treatment dosage.

    Refer to: Frequency and Duration Guidelines for ABA services section for guidelines to determine medical necessity.
- Measurable parent or caregiver goals pertaining to learning the basic behavioral principles of ABA and applicability of these behavioral interventions in the home and community.
- The planned frequency and duration of parent or caregiver training. Participation by the parents or caregivers are expected, and continued authorization for ABA services will take consideration of their participation in at least 85% of planned sessions.
    - Parent or caregiver training must be conducted by an LBA or LaBA.

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- The formal design of treatment plan must be followed by all ABA service providers, including the supervised LaBAs and/or BTs.
- If group treatment is planned, the treatment plan must include clearly defined, measurable goals for the group therapy that are specific to the individual and their targeted behaviors/skills.
- A plan to ensure maintenance and generalization of skills.
- Clearly defined, measurable, realistic discharge criteria and a transition plan across all treatment environments.
- A clear plan to coordinate care with other providers and with school services.
    - This is contingent upon a signed release of information from parent or guardian. Documentation of parent or guardian refusal to sign consent should be documented in these situations but should not preclude access to treatment.

ABA Assessments and treatment plans completed by the LBA must include:

- The child or youth's name
- Date of birth
- Date the initial ABA evaluation and treatment plan was completed
- Name of the referring prescribing provider
- Signature with date by the LBA
- Signature with date by the parent or caregiver

Initial requests for ABA will be authorized for 90 days and may be extended for an additional 90 days contingent upon submission of an attendance log and progress summary that support an extension of treatment.

2.3.7.4 Documentation Required for Authorization of 90-day Extension of Initial ABA Authorization

All of the following elements must be submitted with the authorization request:

- Attendance log for the child or youth
- Attendance log for the parent or caregiver
- Progress summary

2.3.7.5 Attendance Log and Progress Summary

Attendance logs that include a calculation of the percentage of scheduled sessions successfully completed must be maintained for the child or youth receiving treatment and for responsible parent or caregiver participation. If attendance falls below 85% of approved hours per authorization period as outlined in the individualized treatment plan and parent or caregiver education plan, additional documentation must be submitted by the LBA to substantiate need for continued ABA services at the previously approved level. All documentation must be submitted to the child or youth's health plan.

- Attendance logs will record all scheduled and completed sessions and the percent of scheduled sessions attended by child or youth and the parent or caregiver for their scheduled respective sessions.
- Attendance logs must be submitted after the first 90 days of initiating ABA treatment.
- Attendance logs must be submitted with each request for extension or recertification.

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- Children or youth and parents or caregivers are expected to have attended a minimum of 85% of their respective sessions agreed upon within the approved treatment plan to substantiate the need for continuing at the previously approved frequency and duration of ABA services.
- In cases where either the child or youth or the parent or caregiver has not met the 85% attendance expectation, the ABA provider must submit justification to continue services at the previously approved frequency to the health plan for physician review.

2.3.7.6 Progress Summary

A progress summary is made in the format of a treatment note and must be:

- Submitted after the first 90 days of initiating ABA treatment.
- Billed as procedure code 97155.
- Signed and dated by the LBA.
- Signed and dated by the parent or caregiver.

2.3.7.7 Documentation Required for Recertification for Treatment with ABA

Subsequent requests after the initial total 180-day authorization may be approved for an additional 180-day period.

Requests for recertification of ABA treatment must include:

- Documentation of the comprehensive ASD diagnosis within the 3 years prior to the date of the ABA re-evaluation.
- Attendance log that includes a calculation of the percentage of scheduled sessions that were completed.
    - For recertifications, children or youth and parents or caregivers are expected to have attended a minimum of 85% of their respective sessions agreed upon within the approved treatment plan in order to continue at the previously approved frequency and duration of ABA services. Recertification requests not meeting this requirement will require submission of additional documentation and must be sent for physician review.
- ABA re-evaluation.

2.3.7.8 ABA Re-evaluation

Re-evaluation may be performed no earlier than within the last 60 days of an authorization period.

A re-evaluation includes all of the following:

- All components of an initial evaluation that are within the scope of practice of an LBA.
- The LBA shall maintain documentation of all elements of the initial ABA assessment that have been conducted by or coordinated with another provider.
- An updated BSP for the child or youth, if applicable.
- Baseline, current, and interim data for all behaviors and skills identified for intervention to demonstrate degree of progress toward mastering the functional treatment goals.
- Documentation to allow reviewers to assess whether the child or youth's behavior and skills have improved to a clinically meaningful extent in at least two settings (e.g., home, community, or with different family members or peers) and to demonstrate that the LBA appropriately recorded and tracked progress and made protocol modifications as needed for effective service delivery.
- Individual considerations should be given on a case-by-case basis for those with unusual or complex circumstances that may impact functional goal achievement (e.g., children or youth in residential placement through the Department of Family and Protective Services conservatorship).

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- The child or youth's treatment plan updated and modification of the treatment protocol, as appropriate, to include clearly defined, measurable, functional goals for addressing behaviors and ensuring maintenance and generalization of acquired skills.
- Documentation of the child or youth's status using a reliable, valid standardized assessment tool.
- Discharge plan, to include fading and generalization plan.
- For children or youth with additional diagnoses/co-morbid conditions, LBAs must address the impact of those conditions on ABA progress and collaborate with other disciplines as appropriate.
- Date and time the re-evaluation and treatment plan update was completed.
- LBA signature and date.

The LBA must submit documentation attesting that:

- The family, caregiver, or responsible adult has agreed to the treatment plan, including:
  - The frequency specified on the treatment plan.
  - All places of service specified on the treatment plan.
  - That the specific goals and prioritization of the identified goals on the treatment plan align with the child or youth and their family values and preferences.
  - That the provider has access to sufficient staff to deliver the treatment plan frequency, duration, and in all places of service specified to allow accurate assessment of attendance in scheduled sessions.

2.3.7.9 Client Record Documentation

In addition to documentation requirements outlined in the Submission Documentation section, all services outlined in this section are subject to retrospective review to ensure that the documentation in the child or youth's medical record supports the medical necessity of the services provided as well as adherence to Medicaid requirements.

This documentation does not need to be submitted for the purposes of prior authorization.

2.3.7.10 Comprehensive Diagnostic Evaluation

All required elements of the comprehensive evaluation must be retained by the diagnosing provider in the child or youth's medical record.

2.3.7.11 Interdisciplinary Team Meeting

For procedure code 99366, each rendering provider must document the following:

- Start and stop time of team meeting (minimum 30 minutes)
- Date of most recent evaluation or re-evaluation
- Names, disciplines, and organizational affiliation of other attendees
- Brief narrative of reports to parents or guardians and the child or youth with ASD
- Summary of decisions made
- Action items
- Signature and date of the provider

Licensed assistants, nonclinical social workers, or paraprofessionals may not represent their supervisors at interdisciplinary team meetings.

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2.3.7.12 Consent

Formal documentation of signed consent to ABA treatment signed by the child or youth's legally authorized representative must be kept in the child or youth's file.

2.3.7.13 Treatment Note

For procedure codes 97153 (individual treatment) and 97154 (group treatment), the following documentation must be kept on file by the treating provider and be available when requested:

- Child or youth's name.
- Date of service.
- Start and stop time of each treatment session.
- Treatment plan goals addressed, and progress noted, if applicable.
- A summary of the covered ABA services attempted during the session to include the activities or interventions delivered during the session and time allotted for them.
    - This summary should include direct observation measures that record data during every treatment session to allow the LBA to graph data across time for analysis.
- Rendering ABA providers must sign each entry with full signature and credentials.
    - Additional supervisory signatures must be made in accordance with state licensure requirements and professional standards of care for the delivery of medically necessary services.

For procedure codes 97155 (individual treatment with protocol modification) and 97158 (group treatment with protocol modification) the documentation should include all required treatment note elements listed for procedure codes 97153 and 97154 as well as:

- Description of protocol modification decision points (may include supervision of BT or LaBA for procedure code 97155).
- Assessments of child or youth's progress or lack of progress.
- Treatment plan, such as updated goals.

For procedure code 97156 (parent or caregiver training and guidance, with or without the child or youth present), the following documentation in the treatment note must be kept on file by the treating provider and be available when requested:

- Child or youth's name
- Date of service
- Start and stop time of each parent or caregiver education session
- Treatment plan goals addressed, and progress noted, if applicable
- A summary of the covered parent or caregiver training during the session
- Rendering ABA providers must sign each entry with a full signature and credentials

2.3.7.14 Frequency and Duration Guidelines for ABA services

Frequency must always be commensurate with the child or youth's clinical needs and level of disability, as well as evidence-based standards of practice; it is not for the convenience of the responsible parents or caregivers or the provider.

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LBA recommendations for frequency and duration on the ABA treatment plan are expected to reflect the LBA's skilled analysis of the optimal dose-response relationship for the child or youth and their family. Therefore, the child or youth and family attendance at the recommended frequency and duration levels is critical in following evidence-based treatment recommendations. Poor or sporadic attendance may impact the effectiveness, durability, or generalizability of the treatments that are delivered.

An effective course of ABA typically requires active parent or caregiver involvement to increase the potential for durable and generalizable behavior changes in the specific behaviors identified as causing limitations or deficits in functional skills expected for the child or youth based on personal and environmental factors unique to that individual. Exceptions to this are made only as determined on a case-by-case basis.

ABA treatment (not inclusive of procedure code 97156) may be delivered at the following frequency and duration levels without requiring additional submission of documentation or review by a physician for medical necessity. Medical necessity is related to symptom severity as defined by the current version of the DSM in addition to guidelines in this section. All levels of intensity of ABA treatment services may be considered depending upon individual case consideration. The following are guidelines. The objectives of ABA therapy will vary per child or youth, and frequency and duration should be based upon the functional goals of treatment, specific needs of the child or youth, response to treatment, and availability of appropriately trained and certified ABA staff. Treatment plans in which the requested frequency exceeds the following service level guidelines will be sent for physician review to determine medical necessity.

- High frequency IBI (greater than 20 hours/week) may be considered when documentation shows two or more of the following:
  - 6 years of age or younger
  - Autism Severity Level 2 or 3 (per DSM-V criteria)
  - Goals related to elopement, aggression, or self-injury that are severely impairing
  - Within the first 2 years of initiating ABA
- Moderate frequency (6 to 20 hours/week) may be considered when documentation shows two or more of the following:
  - 12 years of age or younger
  - Autism Severity Level 2 or 3 (per DSM-V criteria)
  - Goals related to elopement, aggression, or self-injury that are moderately impairing
  - Within the first 4 years of initiating ABA therapy
- Targeted/focused frequency (5 hours or less/week or 20 hours or less/month in some other increment) may be considered when documentation shows two or more of the following:
  - 20 years of age or younger
  - Autism Severity Level 1, 2, or 3 (per DSM-V criteria)
  - Focused on specific targeted clinical issues or goals related to specific targeted skills
- Maintenance/consultative level (2-4 hours per week or less) may be considered when documentation shows all of the following:
  - Ages 1 through 20 years of age
  - Autism Severity Level 1, 2, or 3 (per DSM-V criteria)
  - Goals related to integration of specific skills into daily functioning

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- Documentation substantiates the risk for regression after completion of more intense ABA intervention

2.3.7.15 Discharge or Discontinuation Criteria

The ABA provider may discharge the child or youth from treatment, or ABA prior authorizations may be discontinued, when documentation submitted indicates one or more of the following:

- The child or youth has met ABA treatment plan goals and is no longer in need of ABA services.
- The child or youth has not made clinically significant progress toward meeting goals identified on the ABA treatment plan after successive progress review periods and repeated modifications to the treatment plan.
- Health-care services that do not demonstrate effectiveness as consistent with Medicaid autism service requirements must be modified or discontinued.
- ABA treatment plan gains are not generalizable or durable over time and do not transfer to the larger community setting after successive progress review periods and repeated modifications to the treatment plan.
- The child or youth can no longer participate in ABA services because of medical factors, family factors, or other factors that prohibit participation.
- Parent or caregiver opts to discontinue.
- Attendance falls below 85% of scheduled sessions without documentation supporting the medical necessity of continued treatment.
- The ABA providers do not appropriately collect, track, or review progress or outcomes data, or do not make appropriate treatment plan modifications for effective service delivery.

2.3.8 Exclusions

The following services are not a benefit of Texas Medicaid:

- ABA addressing academic goals
- ABA addressing goals only related to performative social norms that do not significantly impact health, safety, or independence
- Treatment other than at the maintenance or consultative level not expected to result in improvements in the child or youth's level of functioning
- Services that do not require the supervision of or specific skills and judgment of a LBA to perform
- Services that do not meet accepted standards of practice for specific and effective treatment of ASD
- Services delivered by a BT in the school setting as a shadow, or an aide, or to provide general support to the child or youth
- Equipment and supplies used during ABA services are not reimbursed separately; they are considered part of the services provided
- ABA evaluation or intervention services provided by a clinic or agency owned or partially owned by the child or youth's responsible adult (e.g., biological, adoptive, or foster parents, guardians, court-appointed managing conservators, other family members by birth or marriage)
- ABA evaluation or intervention services provided directly by the child or youth's responsible adult (e.g., biological, adoptive, or foster parents, guardians, court-appointed managing conservators, other family members by birth or marriage)
- Experimental or investigational treatment

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- Services or items not generally accepted as effective or not within the normal course and duration of treatment
- Services for the caregiver or provider convenience (e.g., as respite care or limiting treatment to a setting chosen by provider for convenience)

2.3.9 Change of Provider

If a provider or client discontinues therapy during an existing prior authorized period, and the client requests services through a new provider outside the current group, the new provider must start a new request for authorization and submit all documentation required for an initial evaluation, including the following:

- A change-of-therapy provider letter, signed by the responsible adult.
- The letter must document the date that the client ended therapy (effective date of change) with the previous provider, or the last date of service.
- The name of the new provider and previous provider.

When a client transfers to a new performing provider within the same group, the new provider must use the same evaluation and plan of care.

The authorization period will not change when the provider changes in this situation.

2.3.10 Prior Authorization/Authorization Requirements

Prior authorization is required for an ABA evaluation (procedure code 97151), an initial course of ABA treatment, and for subsequent recertifications for treatment (procedure codes 97153, 97154, 97155, 97156, 97158). Re-evaluations (procedure code 97151) for recertification of treatment require authorization.

Essential elements for prior authorization are listed in the Submission Documentation section.

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

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

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

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

The prescribing provider or the LBA may be asked for additional information to clarify or complete a request.

Retrospective review may be performed to ensure that documentation supports the medical necessity of the requested services, equipment, or supplies, as well as to determine compliance with all Medicaid requirements.

2.3.11 Submission Guidelines

2.3.11.1 Timelines and Required Items

The completed CCP Prior Authorization Request Form and submitter certification statement are required with every submission for authorization or prior authorization.

TMHP will accept the prescribing provider's signature on the CCP Prior Authorization Request Form as a statement that the client's Texas Health Steps (THSteps) screenings are current unless otherwise stated by the provider.

2.3.11.2 ABA Initial Evaluation

To request prior authorization for an ABA initial evaluation, LBAs or prescribing providers must submit the following:

- Documentation of comprehensive diagnostic evaluation or re-evaluation of diagnosis for ASD signed and dated by the diagnosing physician and dated within 3 years prior to the date that the PA request for ABA initial evaluation is received.
- A completed CCP Prior Authorization Request Form, signed and dated by a prescribing provider within 60 calendar days prior to or on the anticipated evaluation date requested.
    - The authorization for the initial ABA evaluation (procedure code 97151) is valid for 60 days from the requested evaluation date.
    - When the request for prior authorization is signed and dated after the requested evaluation date, dates of service prior to the prescribing provider's signature date will be denied.

A request for prior authorization for an ABA initial evaluation must be submitted within 60 days prior to or on the requested evaluation date.

When the request for prior authorization is submitted after the requested evaluation date, dates of service prior to the receive date will be denied.

2.3.11.3 Initial 90-day ABA Treatment

To request prior authorization for an initial 90-day ABA treatment, providers must submit the following:

- Completed ABA evaluation and treatment plan signed and dated by the LBA
    - An ABA evaluation is considered current when it is performed within 60 days prior to the start of care date on the prior authorization request form.
- A completed CCP Prior Authorization Request Form, signed and dated by a prescribing provider within 60 calendar days prior to the requested ABA treatment start date, including the requested procedure codes and maximum units requested

Providers may be authorized for units of procedure codes 97153, 97154, 97155, 97156, or 97158 for up to 90 days from the start date of service requested on the CCP Prior Authorization Request Form.

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Providers must obtain authorization within 3 business days of the start of care (SOC) date for services that have not been prior authorized. During the authorization process, providers are required to deliver the requested services from the SOC date. Requests received after the 3-business day period will be denied for services prior to the date that the request was received.

Late submissions: Requests for initial 90-day ABA treatment submitted 60 days after the completed ABA evaluation date and within 180 days after the evaluation date will require a progress summary signed and dated by the LBA.

For late submissions submitted after 180 days from the evaluation date, a re-evaluation must be completed.

2.3.11.4 ABA 90-day Treatment Extension

To request prior authorization for an ABA 90-day treatment extension, providers must submit the following:

- Attendance log that also includes a calculation of the percentage of scheduled sessions attended by the:
  - Child or youth and
  - Parent or caregiver for family education
- Progress summary signed by LBA and parent or caregiver.
- A completed CCP Prior Authorization Request Form (prescribing provider signature not necessary).

  Note: *The initial treatment plan must be signed and dated by a prescribing provider for the full 180 days. The 90-day treatment extension is to continue the same treatment frequency or submit new goals if needed.*
- A 90-day recertification request is considered timely when it is submitted within 30 days prior to the end of the current authorization period. Providers may be authorized for units of procedure codes 97153, 97154, 97155, 97156, or 97158 for up to 90 days from the initiation of services.
- A request for prior authorization that is submitted after the current authorization end date is denied for all dates of service prior to the date the request is received.

2.3.11.5 ABA Re-evaluation

To request authorization for an ABA re-evaluation, providers must submit the following:

- Completed ABA re-evaluation and treatment plan signed and dated by the LBA.
- Re-evaluations do not require prior authorization (procedure code 97151). Re-evaluation will be reviewed for authorization upon submission.
- Providers must have a signed referral from the prescribing provider for an ABA re-evaluation in the client's file.
  - A re-evaluation may occur as early as 60 days prior to the end of the current authorization period.
  - An ABA re-evaluation is considered current when it is performed within 60 days before the end of the current authorization period.

Procedure code 97151 should be listed on the CCP Prior Authorization Request Form with date span to include dates the re-evaluation was performed.

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2.3.11.6 ABA 180-day Recertification

Prior authorization for documented medically necessary recertification requests may be considered for increments up to 180 days for each request following the initial total of 180-day (two 90-day) authorization periods.

To request prior authorization for an ABA 180-day recertification, providers must submit the following:

- Attendance log that also includes a calculation of the percentage of scheduled sessions attended by the:
  - Child or youth
  - Parent or caregiver for family education
- ABA re-evaluation and treatment plan signed by LBA
  - An ABA re-evaluation is considered current when it is performed within 60 days before the current prior authorization end date.
- A completed CCP Prior Authorization Request Form, signed and dated by a prescribing provider within 60 calendar days prior to the requested ABA treatment recertification start date, including the requested procedure codes and maximum number of units.

Providers may be authorized for units of procedure codes 97153, 97154, 97155, 97156, or 97158 for up to 180 days from the start date of service requested on the CCP Prior Authorization Request Form.

Late submissions: Requests submitted 60 days after the completed ABA evaluation date and within 180 days after the evaluation will require a review of current progress summary signed and dated by the LBA.

For requests submitted more than 180 days after the re-evaluation date, a new re-evaluation must be completed.

A request for prior authorization for recertification of treatment that is submitted after the current authorization end date is denied for all dates of service after that end date and prior to the date the request is received.

A complete request must be received no earlier than 60 days before the current authorization period expires.

A gap in service is defined as not receiving ABA treatment or re-evaluation for 180 days or more. When a gap in service is identified, the provider must submit the request as an initial request and all documentation related with an initial request is required.

2.3.12 Reimbursement and Billing Guidelines

If services billed exceed the limitations outlined in this section, the claim will be denied, and may be appealed.

Autism services are reimbursed in accordance with Title 1 Texas Administrative Code § 355.

Direct treatment for the child or youth is limited to a total of 8 hours per day, inclusive of procedure codes 97153, 97154, 97155, and 97158.

The following modifiers may be required for ABA services:

Modifier	Description
HO	Licensed behavior analyst
HN	Licensed assistant behavioral analyst
HM	Behavior technician
95	Telehealth

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For clients who are 20 years of age or younger, the limitations listed below may be exceeded with evidence of medical necessity.

The following procedure codes will be authorized for a 30-day authorization period for ABA evaluation or re-evaluation:

ABA Initial Evaluation		
Procedure Code	**Limitations**	**Modifier Options**
97151	Limited to 6 hours (24 units)	HO only

ABA Re-evaluation		
Procedure Code	**Limitations**	**Modifier Options**
97151	Limited to 6 hours (24 units)	HO only

The following procedure codes may be reimbursed for ABA individual treatment:

ABA Services	
Procedure Code	**Modifier Options**
97153	No modifier required
97155	HO HN

The following procedure codes may be reimbursed for ABA group treatment services:

ABA Services	
Procedure Code	**Modifier Options**
97154	No modifier required
97158	HO HN

The following procedure codes may be reimbursed for ABA parent or caregiver, family education, and training services:

ABA Services	
Procedure Code	**Modifier Options**
97156	HO HN

The following procedure codes may be reimbursed for interdisciplinary team meetings attended by qualified nonphysician health-care providers:

Interdisciplinary Team Meeting	
Procedure Code	**Modifier Options**
99366	No modifier required

Each claim submitted with procedure code 97151 requires the following modifier:

Evaluation and Re-evaluation	
Modifier	**Description**

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Evaluation and Re-evaluation	
HO	Licensed behavior analyst

Each claim submitted with procedure codes 97155, 97156, and 97158 requires one of the following modifiers:

ABA Services	
Modifier	**Description**
HO	Licensed behavior analyst
HN	Licensed assistant behavior analyst

Claims submitted with procedure codes 97153 and 97154 may include the following modifiers for information purposes:

Behavior Technician Level Services	
Modifier	**Description**
HO	Licensed behavior analyst
HN	Licensed assistant behavior analyst
HM	Behavior technician

Reimbursement for procedure code 99366 is limited to autism diagnosis code F84 and is contingent upon prior authorization of ABA evaluation, re-evaluation, or treatment services.

Texas Medicaid will not reimburse multiple ABA providers during one ABA session with a child or youth when more than one ABA provider is present (concurrent billing).

Concurrent billing is excluded except when the family and the child or youth with ASD are receiving separate services and the child or youth is not present in the family session.

Texas Medicaid will not reimburse for ABA treatment services when the child or youth or family is not present and engaged in a therapeutic relationship.

Reimbursement for covered ABA procedure codes are for the direct service time. Pre- and post-work for the session are not reimbursed separately. Separate reimbursement for treatment planning, note documentation, report writing, or updating of charts and data sheet is prohibited (other than what is allowable under procedure code 97151).

2.3.12.1 Telehealth Service Delivery

Some service delivery to children or youth and to the parents or caregivers may be delivered remotely. It is the LBA's responsibility to ensure that remotely delivered telehealth services are within scope of practice, are not contraindicated for the child or youth, family, or particular situation, are clinically appropriate and effective, and are in compliance with Texas licensure and standards for telehealth as well as follow all Medicaid, Texas Health Steps-CCP and the Medicaid Autism Services requirements.

ABA evaluation and treatment services may only be delivered via telehealth using synchronous audio-visual technology.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telehealth and technology requirements.

The following procedure codes may be delivered via telehealth:

Procedure Codes	Required Modifier to Designate Remote Delivery
97151	95

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Procedure Codes	Required Modifier to Designate Remote Delivery
97155	95
97156	95
97158	95
99366	95

LaBAs and RBTs may not deliver any service remotely.

Reimbursable remote delivery services must include synchronous audiovisual interaction between the distant site provider and the child or youth or parent or caregiver in another location.

2.3.12.2 ABA Services

Procedure code 97151 is intended for conducting and reporting initial evaluations and treatment plans as well as re-evaluations by the LBA once every 180 days.

Procedure code 97151 is reimbursed per authorized units provided by an LBA.

Procedure code 97151 will be authorized for up to 24 units (six hours) for the initial request of ABA services to complete an initial ABA evaluation and develop a treatment plan, including data analysis and report writing.

Procedure code 97151 must be used within 30 calendar days of the first date of service for procedure code 97151 and is not reimbursable unless evaluation was submitted for authorization of payment.

Procedure code 97151 is eligible for reimbursement upon submission and approval of completed evaluation or re-evaluation.

After the initial evaluation, procedure code 97151 will be authorized for up to 24 units (six hours) for re-evaluations for every subsequent authorization.

Procedure code 97153 is intended to be used for direct one-on-one ABA services delivered per ABA treatment plan protocol to the child or youth.

Procedure code 97153 designates a service of the complexity level appropriate for the delivery by a BT.

Procedure code 97155 is used by the LBA (or as delegated to an LaBA) for direct one-on-one time with one child or youth to develop a new or modified protocol.

Procedure code 97155 may also be used to demonstrate a new or modified protocol to a BT, LaBA, and parents or caregivers with the child or youth with ASD present. The focus of this code is the skilled determination to make an addition or change to the protocol.

Procedure code 97155 may be used when directly supervising the BT or LaBA while working directly with the child or youth.

Either procedure code 97153 or 97155 may be used to request total hours of direct individual ABA treatment for the authorization period. Providers may then bill the code that reflects the treatment delivered.

Procedure code 97154 is intended to be used for direct group ABA services delivered per ABA treatment plan protocol to the child or youth.

Procedure code 97154 designates a service of the complexity level appropriate for the delivery by a BT.

A group includes at least 2 children or youth but no more than 8.

Procedure code 97158 is used by the LBA (or as delegated to an LaBA) for direct group time to develop a new or modified group treatment protocol.

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Either procedure code 97154 or 97158 may be used to request total hours of direct group ABA treatment for the authorization period. Providers may then bill the code that reflects the treatment delivered.

Procedure code 97156 is used by the LBA (or as delegated to an LaBA) for guiding the parents or caregivers (with or without the child or youth with ASD present) to use the ABA treatment plan protocols to reinforce adaptive behaviors for durability and generalizability. LBAs may delegate parent or caregiver teaching to LaBAs working under their supervision. LaBAs may not deliver services remotely via telehealth.

2.3.12.3 Method for Counting Minutes for Timed Procedure Codes in 15-Minute Units

All claims for reimbursement of procedure codes paid in 15-minute increments are based on the actual amount of billable time associated with the service. For those services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units should be rounded up or down to the nearest quarter hour.

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 zero units of service if they are seven or fewer minutes.

For example: 68 total billable minutes/15 = 4 units + 8 minutes. Because 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.

When providers are counting minutes for timed procedure codes, the time intervals for 1 through 8 units are as follows:

Units	Number of Minutes
0 units	0 minutes through 7 minutes
1 unit	8 minutes through 22 minutes
2 units	23 minutes through 37 minutes
3 units	38 minutes through 52 minutes
4 units	53 minutes through 67 minutes
5 units	68 minutes through 82 minutes
6 units	83 minutes through 97 minutes
7 units	98 minutes through 112 minutes
8 units	113 minutes through 127 minutes

2.4 Breastfeeding Support Services

Refer to: Section 3, "Breastfeeding Support Services" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for information about breastfeeding support services.

2.5 Certified Respiratory Care Practitioner Services (CCP)

Refer to: The *Certified Respiratory Care Practitioner (CRCP) Services Handbook* (*Vol. 2, Provider Handbooks*) for information about CRCP (CCP) services.

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2.6 Clinician-Directed Care Coordination Services (CCP)

2.6.1 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 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.

2.6.1.1 Non-Face-to-Face Services

2.6.1.1.1 Non-Face-to-Face Medical Conferences

Procedure code 99367 must be used when billing for medical team conferences.

2.6.1.1.2 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.

2.6.1.1.3 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.

2.6.1.1.4 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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2.6.1.1.5 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 non-face-to-face prolonged services of at least 30 minutes total duration. Prolonged services of less than 30 minutes are considered part of the physician's E/M service being provided.

Procedure codes 99358 and 99359 will be denied if billed on the same date of service as any of the following procedure codes:

Procedure Codes									
99202	99203	99204	99205	99212	99213	99214	99215	99221	99222
99223	99231	99232	99233	99234	99235	99236	99242	99243	99244
99245	99252	99253	99254	99255	99281	99282	99283	99284	99285
99304	99305	99306	99307	99308	99309	99310	99341	99342	99344
99345	99347	99348	99349	99350	99417	99418			

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.

Non-face-to-face prolonged services procedure codes 99358 and 99359 may be used when billing for completion of paperwork required by a judge to determine guardianship of a client. Required paperwork may include a certified medical examination form for clients who are birth through 20 years of age that are eligible for the Texas Health Steps program on the date of service.

2.6.1.1.6 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									
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's NPI and prior authorization number must be submitted on the claim.

2.6.1.1.7 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.

2.6.1.1.8 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 health agency (procedure codes 99374 and 99375), hospice (procedure codes 99377 and 99378), or nursing facility (procedure codes 99379 and 99380).

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.

Reimbursement for procedure codes 99374 or 99375, 99377 or 99378, and 99379 or 99380 are limited to one per client, per calendar month for any provider. Providers should bill the code that most appropriately reflects the total time spent in a calendar month performing care plan oversight.

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.

2.6.1.1.9 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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2.6.1.2 Face-to-Face Services

2.6.1.2.1 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									
99367	99374	99375	99377	99378	99379	99380			

2.6.2 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.

2.6.2.1 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

2.6.2.2 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
- NPI for the specialist or subspecialist and the clinician providing the medical home

2.6.3 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.

2.6.4 Reimbursement

Clinician-directed care coordination services are reimbursed in accordance with 1 TAC §355.8441.

2.7 Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Outpatient Rehabilitation Facilities (ORFs)

Refer to: The *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about CCP therapy services.

2.8 Durable Medical Equipment (DME) Supplier (CCP)

2.8.1 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*).

2.8.1.1 Pharmacies (CCP)

Pharmacy providers are eligible to participate in CCP. To be enrolled in CCP, the pharmacy must also be enrolled in VDP.

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 opl.tmhp.com.

Refer to: Subsection 2.1.2, "Enrollment" in this handbook for more information about CCP enrollment procedures.

Section 1.1, "About the Vendor Drug Program" in the *Outpatient Drug Services Handbook* (*Vol. 2, Provider Handbooks*) for information about this program.

Section 2, "Texas Medicaid (Title XIX) Home Health Services" for details about coverage through Texas Medicaid (Title XIX) Home Health Services.

2.8.2 Services, Benefits, and Limitations

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 serves a medical purpose, can withstand repeated use, and is appropriate and safe for use in the home.

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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.

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 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 to a wheeled mobility system 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 Request 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.

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- The specific type of supply needed.
- The length of time needed.

2.8.2.1 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.

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.

2.8.3 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.

Retrospective review may be performed to ensure documentation supports the medical necessity of the requested equipment or supplies.

A determination as to whether the equipment will be rented, purchased, 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.

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Equipment that has been purchased may be considered for replacement when loss or irreparable damage has occurred outside the warranty terms, conditions, and limitations. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent reoccurrence must be submitted with the prior authorization request.

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: Section 2.2.30, "Procedure Codes That Do Not Require Prior Authorization" for details about specific procedure codes that do not require prior authorization through Texas Medicaid (Title XIX) Home Health Services.

2.8.3.1 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.

2.8.3.2 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 to a wheeled mobility system 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.

2.8.3.3 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.

2.8.3.4 Repair to Client-Owned Equipment

Repairs to a wheeled mobility system within the first six months after delivery are considered part of the purchase price. 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.

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. When there is documented proof of abuse or neglect, requests for repairs will not be prior authorized.

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Providers are responsible for maintaining documentation in the client's medical record that specifies the repairs and supporting medical necessity.

Documentation must include all of the following:

- The date of purchase
- The serial number of the current equipment (as applicable)
- The cause of the damage or need for repairs
- What steps the client or caregiver will take to prevent further damage if repairs are due to an accident
- When requested, the cost of purchasing new equipment as opposed to repairing current equipment

Temporary replacement of client-owned respiratory equipment during the repair may be considered for prior authorization for one month using procedure code K0462.

Labor for repair of client-owned respiratory equipment may be considered for prior authorization using procedure code K0739 up to a maximum of two hours per day (maximum quantity of eight units).

Routine maintenance of rental equipment is the provider's responsibility.

2.8.3.5 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.

2.8.3.6 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 with the shipping date and delivery date as confirmation that the supplies were shipped and delivered. The dated carrier tracking document must be attached to the delivery slip or corresponding invoice, or
- If using a third-party distributor, the delivery confirmation from the third-party distributor and corresponding tracking number from the third-party distributor's carrier must be attached.

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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 either one business day before or one business day after the date of service as documented on 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.

2.8.3.7 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.

The *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*) for DME services.

2.9 Early Childhood Intervention (ECI) Services

The Texas Health and Human Services (HHS) ECI program is available statewide to all children who have been determined to be eligible for ECI services by ECI contractors. 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 HHS 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 HHS Inquiry Line at 1-877-787-8999. For additional ECI information, providers can visit the Early Childhood Intervention Services page of the HHS website at www.hhs.texas.gov. Persons who are deaf or hard of hearing may use the relay option of their choice or dial 7-1-1 to connect with Relay Texas.

2.9.1 Enrollment

The Texas HHS ECI program contracts with local non-profit entities to take referrals, determine clients' eligibility, and provide services to ECI-eligible children and their families. The non-profit entities must contract with the Texas HHS ECI program and must comply with all of the applicable federal and state laws and regulations that govern the Texas HHS ECI program.

ECI contractors are eligible to enroll as Texas Medicaid ECI providers to render services to eligible Medicaid clients. After providers meet the criteria of the Texas HHS ECI program, they must complete a Medicaid application.

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To participate in Texas Medicaid, an ECI contractor must submit a copy of the current contract award from the Texas HHS ECI program.

Refer to: Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about the procedures for enrolling as a Medicaid provider.

2.9.2 Services, Benefits, and Limitations

Prior authorization is not required for evaluations, re-evaluations, seating assessments, therapy services, SST, and TCM. The IFSP Services Pages identify the amount, duration, and scope for the provision of SRS treatment services and serves as the prior authorization for ECI services. The IFSP is retained in the client's record and is subject to retrospective review.

ECI services include targeted case management (TCM) and specialized rehabilitative services (SRS), which includes occupational therapy (OT), physical therapy (PT), speech therapy (ST), and specialized skills training (SST).

ECI SRS services may be provided in the following places of service (POS): office/facility (POS 1), home (POS 2), outpatient (POS 5 applicable only to ECI services rendered in a Prescribed Pediatric Extended Care Center [PPECC]), and other locations (POS 9). In addition to these places of service, TCM may be provided in inpatient hospital (POS 3) and outpatient hospital (POS 5).

ECI services of OT, PT, ST, SST and TCM are provided to Medicaid-eligible clients who are birth through 35 months of age and have a documented developmental delay or a medically diagnosed condition as established by HHSC (26 TAC, Part 1, Chapter 350), or an auditory or visual impairment as defined by the Texas Education Agency (19 TAC §89.1040).

To the maximum extent appropriate, ECI services are delivered in the client's natural environment, as defined in 26 TAC, Part 1, Chapter 350, and are family-centered.

The interdisciplinary team must document ECI eligibility decisions in accordance with 26 TAC, Part 1, Chapter 350. The eligibility statement must be in the child's record and updated when eligibility changes or is re-determined.

All documentation of ECI services, including the plan of care specified in the Individualized Family Service Plan (IFSP) must be retained in the client's record and available upon request. The IFSP is a written plan of care for providing early childhood intervention services and other medical, health, and social services to an eligible child and the child's family when necessary to enhance the child's development.

ECI service providers are employees and subcontractors of non-profit entities that have contracts with the State of Texas for the provision of Individuals with Disabilities Education Act (IDEA) Part C Early Childhood Intervention services.

Medically necessary services may be provided by other Medicaid-enrolled providers in addition to the services provided by the ECI contractor. For example, the family may choose to receive speech therapy from the ECI contractor and physical therapy from a home health provider. Or, outpatient clinic personnel may have expertise that will enhance the services of the ECI provider resulting in ECI providers and other Medicaid-enrolled providers providing services within the same discipline.

Only the services provided to ECI enrolled children by ECI contracted entities must comply with the Medicaid medical guidelines for ECI services.

Services provided by other Medicaid-enrolled providers, including other providers of physical, occupational, and speech therapy, must comply with Medicaid medical guidelines that apply to those provider types (e.g., outpatient rehabilitation facility, home health agency).

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2.9.2.1 Physical, Occupational, and Speech Therapies and Specialized Skills Training (PT, OT, ST, and SST)

ECI services use techniques by which the ECI service provider engages the family or caregiver in activities to meet the developmental needs of the child.

ECI services are performed in accordance with 26 TAC, Part 1, Chapter 350.

To the maximum extent possible, ECI services are provided in the client's natural environment, as defined in 34 CFR Part 303, unless the IFSP team determines the identified outcomes cannot be achieved in a natural environment. Natural environments are defined as settings that are natural or typical for the same-aged infant or toddler without a disability, and may include the home and community settings such as daycare, playgrounds, stores, and restaurants.

Justification for providing services in other settings (e.g., office, clinic, Prescribed Pediatric Extended Care Center (PPECC)) must be documented in the client's record.

PT, OT, ST, and SST are benefits for clients with an acute or a chronic condition when documented on the IFSP. Documentation on the IFSP is evidence that services are developed and recommended by the child's interdisciplinary team, including the parents and a licensed practitioner of the healing arts (as defined in 26 TAC, Part 1, Chapter 350).

PT, OT, ST, and SST must be performed and delivered as identified in the IFSP.

Missed visits may be rescheduled within the authorization period as long as the total number of visits or units provided does not exceed the amount authorized in the client's IFSP. The ECI contractor must document the reason for visits outside of the weekly or monthly frequency in the client's record.

A single identified need and treatment goal (outcome on the IFSP) may be addressed by more than one discipline.

More than one discipline can evaluate a child at the same time to facilitate compliance with the federal requirement for multidisciplinary evaluation (34 CFR, Part 303).

A client may receive a combination of PT, OT, ST, or SST with any other IFSP service when the IFSP indicates necessity for co-visits or co-treatment (i.e., two or more services to be provided at the same time).

PT, OT, ST, and SST may be delivered to a client individually or in a group setting according to 26 TAC, Part 1, Chapter 350 and when documented in the IFSP.

Documentation of each PT, OT, ST, and SST contact must be entered into the child's record in accordance with 26 TAC, Part 1, Chapter 350.

2.9.2.2 Telehealth Synchronous Audiovisual Services

Telehealth services may be provided using synchronous audiovisual technologies if clinically appropriate and safe, as determined by the provider, and agreed to by the client receiving services.

Whenever possible, HHSC encourages face-to-face interaction, such as an in-person visit, as well as the use of synchronous audiovisual technology over synchronous telephone (audio-only) technology of telehealth services.

Providers must defer to the needs of the client receiving services, allowing the mode of service delivery to be accessible, person- and family-centered, and primarily driven by the client in service's choice and not provider convenience.

Services delivered by synchronous audiovisual technology will require participation of a parent or caregiver to assist with the treatment.

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Therapy assistants may deliver services and receive supervision using synchronous audiovisual technology in accordance with each discipline's rules. Providers should refer to state practice rules and national guidelines regarding supervision requirements for each discipline.

Note: *Telehealth services must adhere to documentation, privacy, informed consent, and security requirements as outlined in the Telecommunication Services Handbook (Vol. 2, provider handbooks).*

The following procedure codes may be provided through telehealth delivery using synchronous audio-visual technology:

Services	Procedure Codes
Specialized skills training (SST)	T1027
Targeted case management (TCM)	T1017
Physical therapy (PT) evaluations and reevaluations	97161, 97162, 97163, 97164
Occupational therapy (OT) evaluations and reevaluations	97165, 97166, 97167, 97168
PT and OT treatments	97110, 97112, 97150, 97530, 97535
Speech therapy (ST) evaluations and reevaluations	92521, 92522, 92523, 92524, 92610, S9152
ST treatments	92507, 92508, 92526

Providers must use modifier 95 to indicate remote delivery. Providers are reminded to use the required modifiers GP, GO, and GN on all claims except evaluation and re-evaluation procedures for physical, occupational, or speech therapy treatment.

2.9.2.2.1 Telehealth Exclusions

The following procedure codes are in-person only and will not be reimbursed if provided through telehealth delivery:

Procedure Codes									
97012	97014	97016	97018	97022	97024	97026	97028	97032	97033
97034	97035	97036	97113	97124	97140	97542	97760	97761	97763

Any PT, OT, ST, and SST services delivered through synchronous telephone (audio-only) technology is not a benefit.

During a Declaration of State of Disaster, HHSC may issue direction to providers regarding the use of a telehealth service to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law. A Declaration of State of Disaster is when an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

2.9.2.3 Physical, Occupational, and Speech Therapy (PT, OT, and ST)

Physical and occupational therapy treatment services require orders from a referring provider once a year.

Speech therapy treatment services do not require an order from a referring provider.

Therapy goals for acute or chronic conditions include, but are not limited to the following:

- Improving function
- Maintaining function

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- Slowing the deterioration of function

2.9.2.3.1 Physical Therapy (PT)

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 performed in accordance with 42 CFR 440.110.

A PT evaluation, re-evaluation, or seating assessment may be performed without an order from a referring provider as allowed by 22 TAC Part 16, Chapter 322, §322.1(a)(2)(A).

PT services must be provided by one of the following:

- A licensed physical therapist who meets the requirements of 42 CFR 440.110(a)
- A licensed physical therapy assistant (PTA) 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 law

2.9.2.3.2 Occupational Therapy (OT)

OT includes services that address the functional needs of a child 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 performed in accordance with 42 CFR 440.110.

An OT evaluation, re-evaluation, or seating assessment may be performed without an order from a referring provider as allowed by §454.213 of the Texas Occupations Code.

OT services must be provided by one of the following:

- A licensed occupational therapist who meets the requirements of 42 CFR 440.110(b)
- A licensed or licensed and certified occupational therapist assistant (OTA) 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 law

2.9.2.3.3 Speech Therapy (ST)

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 in accordance with 42 CFR 440.110 and §401.001(6) of the Texas Occupations Code.

A ST evaluation, re-evaluation, and treatment service may be performed without a physician order as allowed by Chapter 401 of the Texas Occupations Code.

ST services must be provided by one of the following:

- A licensed speech-language pathologist (SLP) who meets the requirements of 42 CFR 440.110(c) and all other applicable state and federal law
- A licensed assistant in SLP 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

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2.9.2.4 Physical Therapy, Occupational Therapy, and Speech Therapy Procedure Codes

Clients who are eligible for ongoing PT, OT, and ST through the ECI program may request additional therapy under the Early & Periodic Screening, Diagnosis, & Treatment (EPSDT) benefit of Medicaid (also known as Texas Health Steps) when medically necessary.

Refer to: Section 5, "Children's Therapy Services Clients birth through 20 years of age" in the *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for information about physical, occupational, and speech therapy procedure codes outside of the ECI benefit that are not defined in this section.

2.9.2.4.1 Evaluation and Re-evaluation Procedure Codes

The following encounter-based evaluation and re-evaluation procedure codes for PT, OT, and ST are benefits of Texas Medicaid:

Procedure Codes	Description
97165, 97166, or 97167	OT Evaluation
97168	OT Re-evaluation
97161, 97162, or 97163	PT Evaluation
97164	PT Re-Evaluation
92521, 92522, 92523, or 92524	ST Evaluation
S9152	ST Re-Evaluation
92610	ST Evaluation swallowing function

2.9.2.4.2 Time-Based Procedure Codes

The following time-based PT and OT treatment procedure codes may be a benefit of Texas Medicaid and must be billed in 15-minute increments (units).

Procedure Codes									
97032	97033	97034	97035	97036	97110	97112	97113	97116	97124
97140	97530	97535	97542	97750	97760	97761	97763		

2.9.2.4.3 Untimed PT and OT Procedure Codes

The following untimed PT and OT treatment procedure codes representing supervised modalities are limited to one encounter each, per date of service per discipline, must be delivered on the same day as one or more time-based codes listed above, and are subject to the CMS NCCI relationships.

Procedure Codes							
97012	97014	97016	97018	97022	97024	97026	97028

The following PT and OT group therapy code may be reimbursed as an untimed procedure code, payable per encounter, and reimbursed once per date of service per discipline.

Procedure Codes
97150

2.9.2.4.4 Encounter-Based Speech Therapy Procedure Codes

The following speech therapy individual treatment codes must be billed per encounter and are limited to once per day per provider. Only one ST treatment procedure code 92507 or 92526 may be reimbursed per date of service.

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Procedure Codes	
92507	92526

The following ST group treatment code may be reimbursed as an untimed procedure code, payable per encounter, and reimbursed once per date of service.

Procedure Codes
92508

2.9.2.4.5 Modifier Requirements for PT, OT, or ST Services

The following modifiers must be submitted for PT, OT, and ST treatment services. Services delivered using synchronous audiovisual technology must also be billed with modifier 95 to indicate remote delivery:

Modifier	Description
GO	Services delivered under an outpatient occupational therapy plan of care
GP	Services delivered under an outpatient physical therapy plan of care
GN	Services delivered under an outpatient speech therapy plan of care
UB	Services delivered by a therapy assistant under supervision of a licensed therapist
U5	Services delivered by a licensed therapist or a physician

Modifier UB or U5 is required on all claims for therapy treatment procedure codes to designate whether treatment was provided by a licensed therapist or a licensed assistant.

Modifier U3 is not used by an ECI contractor for co-visits or co-treatment services.

Modifier	Description
U3	Not used by an ECI contractor

2.9.2.4.6 Seating Assessments

Seating assessments are reimbursed in 15-minute increments (units) and must be billed with the following procedure code:

Procedure Codes
97542

The PT completing the assessment must submit procedure code 97542 with modifiers GP and UC in order to bill for the seating assessment.

Modifier	Description
GP	Services delivered under an outpatient physical therapy plan of care
UC	Assessment performed by an OT or PT

The OT completing the assessment must submit procedure code 97542 with modifiers GO and UC in order to bill for the seating assessment:

Modifier	Description
GO	Services delivered under an outpatient occupational therapy plan of care
UC	Assessment performed by an OT or PT

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2.9.2.4.7 Specialized Skills Training (SST) Services

SST services are rehabilitative services to promote 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.

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.
- Skills training and anticipatory guidance for family members, or other significant caregivers, to ensure effective treatment and to enhance the client's development.

SST services do not require an order from a referring provider. The ECI contractor ensures that SST services are provided by a certified early intervention specialist. SST services must be provided by an early intervention specialist who meets the criteria established in 26 TAC Part 1, Chapter 350.

SST services must be submitted with the following procedure codes and modifiers, and they must be billed in 15-minute increments:

Procedure Code	Description	Modifier
T1027	Individual setting	U1
T1027	Group setting	

SST services delivered using synchronous audiovisual technology must also be billed using modifier 95 to indicate remote delivery.

2.9.2.4.8 Reimbursement Guidelines for PT, OT, ST, and SST

Claims may be submitted to Medicaid when the interaction is directly with the client and the client's parent(s) as defined in 20 U.S.C. §1401, or the client and the routine caregiver(s) as defined in 26 TAC, Part 1, Chapter 350.

ECI services must be billed under the ECI contractor's NPI and benefit code of EC1 as the insured's policy group when submitting claims.

Refer to: "Section 6: Claims Filing" (*Vol. 1, General Information*) for more information about benefit codes.

Physical therapy, occupational therapy, and speech-language pathology evaluations are performed for the purposes of initial determination of need for rehabilitative services and annually to verify the child's ongoing need for rehabilitative services. To ensure there are no gaps in rehabilitative services, the annual evaluation should occur prior to the child's annual IFSP meeting.

Physical, occupational, and speech therapy evaluation and re-evaluation services are benefits through the ECI Medicaid benefit and do not require an order from a referring provider.

Physical therapy, occupational therapy, and speech-language pathology re-evaluations may be performed periodically during the child's annual enrollment in ECI services, and without a physician's order, to determine if changes to the IFSP are necessary.

Evaluations, re-evaluations, and seating assessments are not required to be listed on the IFSP Service Pages. A physical or occupational therapist may provide a seating assessment that is required to order a wheeled mobility system. A seating assessment does not require an order from a referring provider.

Refer to: Subsection 2.2.17, "Mobility Aids" in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*) for information about mobility aids.

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Reimbursement is available to two or more of the ECI contractor's service providers when the client receives a combination of any Medicaid-covered service identified on the IFSP and the IFSP indicates necessity for co-visits or co-treatments (i.e., two or more services to be provided at the same time). For example, the child may receive both PT and ST at the same time. Another example, the child may receive counseling and SST at the same time.

Reimbursement is available to two or more of the ECI contractor's service providers when they are conducting an evaluation at the same time.

When an evaluation and treatment service within the same discipline occur on the same day, only the evaluation will pay.

When a re-evaluation and treatment service within the same discipline occur the same day, only the treatment will pay.

PT, OT, and ST equipment and supplies used during therapy visits are not reimbursed separately.

Reimbursement under Medicaid benefit guidelines applies to only the services provided to ECI enrolled children by ECI contracted entities.

Reimbursement for services provided to ECI enrolled children by other Medicaid-enrolled providers (e.g., home health, CORF) is available under the Medicaid medical policies that apply to those provider types.

2.9.2.5 Targeted Case Management (TCM)

TCM services are provided to assist an eligible client and his or her family in gaining access to the rights and procedural safeguards under Part C of IDEA, and to needed medical, social, educational, developmental, and other appropriate services.

TCM services are performed in accordance with the ECI Medicaid benefit guidelines and 26 TAC, Part 1, Chapter 350.

TCM services do not require an order from a referring provider, but must be delivered by a qualified ECI contractor. The ECI contractor ensures that TCM services are provided by the assigned Service Coordinator who meets the criteria established in 26 TAC Part 1, Chapter 350.

TCM is provided in the natural environment (including office, home, daycare, and other community locations), outpatient, PPECC, and inpatient hospital setting.

The documentation for each TCM contact must be in accordance with 26 TAC, Part 1, Chapter 350. The place of service is the location of the service coordinator at the time of service delivery.

TCM services must be submitted with the following procedure codes and modifiers, and they must be billed in 15-minute increments:

Procedure Code	Description	Modifier
T1017	Face-to-face interaction	U1
T1017	Telephone interaction	

TCM services may be delivered face-to-face or by telephone.

TCM services (procedure code T1017) may also be delivered using a synchronous telephone (audio-only) platform. TCM services delivered using a synchronous telephone (audio-only) platform are subject to the restrictions outlined in the *Telecommunication Services Handbook (Vol. 2, Provider Handbooks)*.

TCM services delivered using synchronous audiovisual technology must also be billed using modifier 95 to indicate remote delivery.

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TCM services delivered using synchronous audio-only (including telephone) technology must also be billed with modifier 93.

2.9.2.5.1 Guidelines for TCM Services

Claims may be submitted to Texas Medicaid when the interaction is directly with the client or the client's parent(s) as defined in 20 United States Code (U.S.C.) §1401), or other routine caregiver(s) as defined in 26 TAC, Part 1, Chapter 350.

Contacts may be made with other individuals when directly related to identifying the eligible client's needs, helping the eligible client access services, identifying needs and support to assist the eligible client in obtaining services, providing the service coordinator with useful feedback, and alerting the service coordinator to changes in the eligible client's needs. These contacts must be documented in the client's record, but are not submitted as claims to Medicaid if they took place outside of the presence of the client or the client's parent or routine caregivers.

2.9.2.6 Guidelines for ECI Services Performed in a Prescribed Pediatric Extended Care Center (PPECC)

When ECI services are rendered in a PPECC, the place of service will be outpatient hospital (used for a PPECC). The PPECC's NPI must appear on the claim, in addition to the ECI contractor's NPI. The ECI contractor and PPECC must have a written agreement for the provision of ECI services at the PPECC. The written agreement must address responsibilities of both parties, and how the parties will coordinate related to the client's IFSP or plan of care, which includes documentation of coordination with the PPECC. The written agreement must be maintained in the client's record.

2.9.3 Claims Filing and Reimbursement

2.9.3.1 Claims Information

Claims for SST and TCM services that have been rendered by an ECI contractor must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Contractors 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*) 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.

2.9.3.1.1 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

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Units	Number of 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

2.9.3.1.2 Managed Care Clients

If the child is enrolled in a Medicaid managed care organization (MCO), claims for PT, OT, and ST are submitted to the MCO.

TCM services are carved-out of Medicaid managed care and must be billed to TMHP for payment consideration.

SST services are carved-out of Medicaid managed care and claims must be billed to TMHP for payment consideration.

2.9.3.2 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.

2.10 Health and Behavior Assessment and Intervention

2.10.1 Services, Benefits, and Limitations

Health and Behavior Assessment and Intervention (HBAI) services are a benefit of Texas Medicaid for persons 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 physician, PA, NP, or CNS who is treating the person receiving services. Co-location is defined as the provision of services in the same office or building complex in which the client's physician, PA, or APRN has their practice.

In many cases, the treating physician, PA, NP, or CNS will be the person's primary care provider; however, a specialist seeing a person regularly may function in a similar role to a primary care provider and may also make HBAI referrals to a co-located LPHA.

HBAI 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 person receiving services meets the following criteria:

- The person 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 person is alert, oriented, and, depending on the person's age, has the capacity to understand and to respond meaningfully during the evaluation.

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- The person 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 family of the person receiving services are a benefit when the family member directly participates in the overall care of the person receiving services.

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 person receiving services. 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						
96156	96158	96159	96164	96165	96167	96168

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) LCSW, 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 (99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, or 99215). The physician, NP, CNS, or PA may bill the HBAI procedure codes for an LPHA that is in the medical practice.

Refer to: Section 9.2.60, "Physician Evaluation and Management (E/M) Services" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information.

Section 4, "Outpatient Mental Health Services" in the *Behavioral Health and Case Management Services Handbook (Vol. 2, Provider Handbooks)* for more information about delegated psychological services and the appropriate use of modifiers by psychologists and LMFTs.

HBAI services are limited to a total of three units per day, by any provider, as follows:

- The initial 30 minutes of health behavior intervention (procedure codes 96158, 96164, and 96167) is limited to one unit per day.
- Each additional 15 minutes of health behavior intervention (procedure codes 96159, 96165, and 96168) is limited to two units per day.

Procedure codes 96167 and 96168 which include the family of the person receiving services, are a benefit when the family member directly participates in the overall care of the person receiving services.

An in-person evaluation is defined as a patient evaluation conducted by a provider who is at the same physical location as the person receiving services. 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
96156	Limited to a maximum of 2 per client, per rolling 180 days, any provider
96158, 96164, 96167	Limited to a maximum of 8 per client, per rolling 180 days, any provider

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Procedure Codes	Limitations
96159, 96165, 96168	Limited to a maximum of 14 per client, per rolling 180 days, any provider

Rural Health Clinics and Federally Qualified Health Centers may be reimbursed for in-person evaluation visits based on encounter rates.

Documentation must be maintained in the person's medical record that details the change in the mental or medical status warranting reassessment of the person's capacity to understand and cooperate with the medical interventions that are necessary to the client's health and well-being.

Persons receiving services must be referred for psychiatric evaluation or psychotherapy 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 HBAI assessment, if the person is receiving behavioral health services from another health-care provider, the HBAI provider should coordinate with the external behavioral health provider and establish the most appropriate course of treatment for the person.

Refer to: Section 4, "Outpatient Mental Health Services" for more information about behavioral health services beyond the acute care limitations outlined in this section.

Subsection 3.4, "Services, Benefits, Limitations, and Prior Authorization - Inpatient Psychiatric Services" in the *Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks).*

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 person receiving services may receive another episode of HBAI services with the same medical diagnosis if there is a newly identified behavioral health issue. The person may have two episodes of HBAI services 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 person receiving services should be referred for those additional services that would meet the person's biopsychosocial needs.

2.10.2 Telemedicine and Telehealth

Providers must defer to the needs of the person receiving services, allowing the mode of service delivery to be accessible, person- and family-centered, and primarily driven by the person's choice and not provider convenience.

Providers must provide HBAI services to Medicaid eligible persons in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. In addition, providers must deliver, to include delivery by telemedicine or telehealth, HBAI services in full accordance with all applicable licensure and certification requirements.

During a Declaration of State of Disaster, the Health and Human Services Commission (HHSC) may issue direction to providers regarding the use of a telemedicine or telehealth service to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law. A Declaration of State of Disaster is when an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

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Synchronous Audiovisual Technology

HBAI services may be provided by synchronous audiovisual technology if clinically appropriate and safe, as determined by the provider, and agreed to by the person receiving services. HBAI services provided by synchronous audiovisual technology must be billed using modifier 95.

The following HBAI services may be provided by synchronous audiovisual technology:

Procedure Codes						
96156	96158	96159	96164	96165	96167	96168

Synchronous Telephone (Audio-Only) Technology

HBAI services may be provided by synchronous telephone (audio-only) technology if clinically appropriate and safe, as determined by the provider, and agreed to by the person receiving services. Whenever possible, HHSC encourages face-to-face interaction, such as an in-person visit, as well as the use of synchronous audiovisual technology over synchronous telephone (audio-only) technology of telemedicine and telehealth services. Therefore, providers must document in the person's medical record the reason(s) for why services were delivered by synchronous telephone (audio-only) technology. HBAI services provided by synchronous telephone (audio-only) technology must be billed using modifier FQ.

The following HBAI services may be provided by synchronous telephone (audio-only) technology:

Procedure Codes						
96156	96158	96159	96164	96165	96167	96168

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telemedicine and telehealth to include informed consent, and privacy and security requirements.

2.10.3 Documentation Requirements for Telemedicine and Telehealth

Documentation requirements for a telemedicine or telehealth service are the same as for an in-person visit and must accurately reflect the services rendered. Documentation must identify the means of delivery when provided by telemedicine or telehealth.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telemedicine and telehealth documentation requirements including requirements for informed consent.

2.10.4 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.

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)

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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 person receiving services 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 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.

2.10.5 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.

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.

2.10.6 Reimbursement

Providers may refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com for reimbursement rates.

2.11 Medical Nutrition Counseling Services (CCP)

2.11.1 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 Department of Licensing and Regulation (TDLR) 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.

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2.11.2 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
- 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.

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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 data 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.

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 TDLR, 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.

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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
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

2.11.3 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

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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.

2.11.4 Telehealth Services

Certain telehealth services may be provided for medical nutrition therapy and nutrition counseling services clients if clinically appropriate and safe, as determined by the provider, and agreed to by the person receiving services. Whenever possible, HHSC encourages face-to-face interactions, such as an in-person visit, as well as the use of synchronous audiovisual technology over synchronous telephone (audio-only) technology of telehealth services. Therefore, providers must document in the person's medical record the reason(s) that services were delivered by synchronous telephone (audio-only) technology.

The following medical nutrition therapy services are authorized for telehealth delivery using synchronous audiovisual and synchronous telephone (audio-only) technologies, when noted:

Procedure Codes						
97802	97803	97804				

The procedure codes in the table above may be delivered by synchronous telephone (audio-only) technology only during certain PHE or natural disasters.

Medical nutrition counseling services (procedure code S9470) are authorized for telehealth delivery using synchronous audiovisual and synchronous telephone (audio-only) technologies, when noted.

Medical nutrition counseling services (procedure code S9470) may be delivered by synchronous telephone (audio-only) technology only during certain PHE or natural disasters.

Services provided by synchronous audio-visual technology must be billed using modifier 95.

Services delivered using audio-only technologies must be billed using modifier 93.

Documentation requirements for a telehealth service are the same as for an in-person visit and must accurately reflect the services rendered. Documentation must identify the means of delivery when provided.

During a Declaration of State of Disaster, the Texas Health and Human Services Commission (HHSC) may issue direction to providers regarding the use of telehealth services to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law. A Declaration of State of Disaster is when an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for information on restrictions for services delivered by synchronous telephone (audio-only) technologies.

2.11.5 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.

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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.

Medical Nutrition Counseling (CCP Only) on the TMHP website at www.tmhp.com for a claim form example.

2.11.6 Reimbursement

Dietitian services are reimbursed in accordance with 1 TAC §355.8441.

2.12 Personal Care Services (PCS) (CCP)

2.12.1 Enrollment

CCP providers that want to participate in the delivery of PCS to Medicaid clients must be enrolled with TMHP and have the appropriate HHSC licensure or certification. All PCS providers must have an NPI.

Providers that are currently contracted with HHSC 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 HHSC 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 HHSC 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 an NPI 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.

2.12.2 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

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(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 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

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- 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])
- 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 following table. 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**	

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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.

2.12.2.1 Place of Service

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.

2.12.2.2 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

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- 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)

Clients who are enrolled in a HHSC 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 HHSC 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.

2.12.2.2.1 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

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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.

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.

2.12.2.2.2 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.

2.12.2.3 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*

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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.

- 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.*

2.12.3 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.

PCS may be authorized in the same day as PPECC, if medically necessary. However, they must be rendered in a home setting, before or after PPECC services.

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 new assessment is required when a client's physician orders services in a PPECC. 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.

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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.

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.*

2.12.3.1 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.

2.12.3.2 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.

2.12.4 Coordination with PPECC Provider

When a DSHS case manager is notified by the client, client's responsible adult, or client's physician that PPECC services have been initiated, revised, or recertified, the DSHS case manager must conduct a PCS reassessment, and submit all documentation required for a revision, modification, or denial of the

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original PCS authorization request, including a Physician's Statement of Need if there is a change in client condition. The new authorization request must be submitted within ten (10) business days of notification.

DSHS case managers must provide documentation to support medical necessity if PCS service hours do not decrease when PPECC services are initiated.

DSHS case managers must also document coordination with the PPECC provider, maintaining documentation that the client or the client's responsible adult has participated in the development of the plan of care.

When a client receives both PCS and PPECC in a single day, and decides to receive fewer hours of service in a PPECC (i.e., shifts more services to the home setting), or terminates PPECC services, the PCS case manager must conduct a reassessment, and submit all documentation required for a revision, modification, or denial of the original PCS authorization request, including a Physician's Statement of Need if there is a change in condition within ten (10) business days of notification by the client, client's responsible adult, or client's physician.

Similarly, if the client decides to receive fewer hours of PCS services in the home, and increase PPECC hours, the DSHS case manager must conduct a reassessment, and submit all documentation required for an modification of the authorization request, within ten (10) business days of notification by the client, client's responsible adult, or client's physician.

Note: *Coordination requirements may be different in a Medicaid managed care environment.*

PCS services rendered in a client's home may be billed before or after PPECC services on the same day, but not at the same time as PPECC services. PCS services required while a client is in a PPECC are considered part of the PPECC billable rate.

2.12.5 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.

2.12.5.1 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, STAR Kids, and STAR+PLUS are not carved out and must be submitted to the client's MCO for payment consideration.

2.12.5.2 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

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2.12.6 Reimbursement

Providers of PCS are reimbursed in accordance with 1 TAC §355.8441.

2.13 Community First Choice (CFC) Services

2.13.1 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 HHSC 1915(c) waiver or through a managed care organization (MCO), providers must refer to HHSC or the MCO for information about benefits, limitations, prior authorization, reimbursement, and specific claim processing procedures.*

2.13.2 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.

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.

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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.
- 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.

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- 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.
- 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

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- 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 following additional habilitation needs:

- 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;
- 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.

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CFC is considered for reimbursement when billed with procedure code T1019 in conjunction with the appropriate modifier listed in the following table. 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.
- 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.

2.13.2.1 Place of Service

CFC may be provided in the following settings:

- Client's home;
- Client's school;

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- 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.

2.13.3 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.

2.13.4 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.

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.

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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.

2.13.4.1 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.

2.13.4.2 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.
- 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.

2.13.5 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.

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2.13.5.1 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.

2.14 Private Duty Nursing (PDN)(CCP)

Refer to: The *Home Health Nursing and Private Duty Nursing Services Handbook* (*Vol. 2, Provider Handbooks*) for information about private duty nursing (PDN) (CCP) services.

2.15 Prescribed Pediatric Extended Care Centers (PPECC) (CCP)

PPECC services may be a benefit of the Texas Health Steps (THSteps) Comprehensive Care Program (CCP) for Medicaid clients who are:

- 20 years of age and younger;
- THSteps - CCP eligible;
- Medically or technologically dependent;

  Note: *The term "medically dependent or technologically dependent client" does not include a minor or occasional medical condition that does not require continuous nursing care, including asthma or diabetes, or a condition that requires an epinephrine injection.*

- Have an acute or chronic condition;
- Require ongoing skilled nursing care beyond the level of skilled nursing visits normally authorized under Texas Medicaid Home Health Skilled Nursing (HHSN) and Home Health Aide (HHA) services;
- Meet the medical necessity criteria for admission to a PPECC detailed in the "Prior Authorization and Documentation Requirements" section, and have a physician's order prescribing PPECC services; and
- Have chosen to receive PPECC services.

A PPECC does not provide emergency services. PPECCs must follow the safety provisions in state PPECC licensure requirements, including the adoption and enforcement of policies and procedures for a client's medical emergency. PPECCs must call for emergency transport to the nearest hospital when emergency services are needed by a PPECC client.

2.15.1 Services, Benefits, and Limitations

PPECC services are provided in a non-residential facility licensed by HHSC. PPECCs serve four or more medically dependent or technologically dependent clients who are 20 years of age or younger and who require ongoing skilled nursing prescribed by the client's physician to avert death or further disability or require the routine use of a medical device to compensate for a deficit in life-sustaining body function.

Services must be included in a PPECC plan of care (POC) and are limited to no more than 12 hours in a 24-hour period. PPECC services may not be provided overnight. PPECC services are intended as an alternative to private duty nursing (PDN). Clients who are eligible to receive PDN services may also receive PPECC services. A client may choose to receive all authorized PPECC and PDN service hours through PPECC services only, PDN services only, or a combination of both PPECC and PDN services. If a client chooses to receive both PPECC and PDN services, the client must not receive service hours in addition to what was initially authorized for PPECC and PDN unless additional hours are medically necessary.

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PPECCs must comply with:

- Medicaid program rules, as well as PPECC licensing statute and rules;
- Mandatory reporting of suspected abuse and neglect of children;
- Texas Medicaid provider participation requirements; and
- The requirements of the TMPPM.

Clients who receive PPECC services through THSteps-CCP require ongoing medical supervision by the ordering physician who has a therapeutic relationship with and ongoing clinical knowledge of the client. An in-person evaluation must be performed each year by the ordering physician for each client. A physician order is required for each authorization period including initial, revisions, and recertification. A physician in a relationship with a PPECC (employed by or contracted with a PPECC) cannot provide the physician's order, unless the physician is the client's treating physician and has examined the client outside of the PPECC setting.

The following services may be rendered at a PPECC, but are not considered part of the PPECC services covered by Texas Medicaid, and must be billed separately by Medicaid-enrolled service providers:

- Speech, physical, and occupational therapies
- Certified respiratory care practitioner services
- Early intervention services provided through the Early Childhood Intervention (ECI) program, which are subject to ECI policies.

When the client's POC indicates that therapy services are required while the client is at the PPECC, clients must be provided a choice in speech, occupational, and physical therapy providers, as well as certified respiratory care providers. PPECC providers must coordinate care with the therapy providers to ensure the client receives therapy services as required in the PPECC setting.

Clients from birth through 36 months of age must be given the option of receiving ECI services in addition to their PPECC services. The PPECC providers must coordinate care with the client's ECI service coordinator.

ECI services rendered in a PPECC are provided by entities that are contracted with the state to provide early intervention services.

When therapy services (occupational, speech, and/or physical therapy), or certified respiratory care services are rendered in a PPECC, they may be provided by:

- Medicaid-enrolled providers contracted with or employed by the PPECC or Medicaid-enrolled providers not employed by or contracted with the PPECC.
- Independent therapists
- Home health therapists
- Certified respiratory care providers

Refer to: The *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about CCP therapy services.

The *Certified Respiratory Care Practitioner (CRCP) Services Handbook* (*Vol. 2, Provider Handbooks*) for information about CRCP (CCP) services.

An admission authorized under this section is not intended to supplant the right of a client to access PDN, personal care services (PCS), HHSN, HHA, and therapies (physical, occupational, and speech), as well as certified respiratory care practitioner services and ECI services rendered in the client's residence when medically necessary.

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PPECC providers must collaborate and coordinate care with the client's existing service providers, including physicians, therapists, certified respiratory care practitioners, and home health agencies rendering services such as PDN and/or HHSN, HHA services, PCS, hospice, and other providers who render medically necessary services. The PPECC must ensure the provision of the following basic services:

- The development, implementation, and monitoring of a comprehensive POC in collaboration with the client or the client's responsible adult that addresses the client's medical, nursing, psychosocial, therapeutic, and developmental services, including the following prescribed services:
  - Skilled nursing
  - PCS to assist with activities of daily living or instrumental activities of daily living while in the PPECC
  - Functional developmental services
  - Nutritional and dietary services, including nutritional counseling

    Note: *Nutritional services must comply with standards in HHSC licensure rules related to nutritional counseling and dietary services.*
  - Occupational, physical and speech therapy
  - Respiratory care
  - Psychosocial services
  - Physician's oversight of services
- The POC must also include the following, as applicable:
  - Training for the client's responsible adult associated with caring for a medically or technologically dependent client.
  - Specification whether the client is stable to receive transportation services provided by the PPECC as determined by the client's ordering physician.
  - If the client's ordering physician determines the client is stable, the client's ordering physician, in collaboration with the PPECC, must specify the type of provider—registered nurse (RN), licensed vocational nurse (LVN) or direct care staff—who must be on board the PPECC transport vehicle to assist the client during transportation to and from the PPECC.
    - Transportation must be provided by a PPECC when the client's ordering physician has determined that the client is stable, and the client or the client's responsible adult wants the client to receive transportation services to and from the PPECC.
    - When a PPECC provides transportation to a PPECC client, an RN, LVN, or direct care staff employed by the PPECC must be on board the transport vehicle as determined by the client's ordering physician, in collaboration with the PPECC.
    - The client does not need to be accompanied by the client's responsible adult when a PPECC provides transportation.
    - When a client's ordering physician has determined a client is stable to receive PPECC transportation and the client or the client's responsible adult wants the client to receive transportation services, the client must be able to utilize transportation services offered by the PPECC with the assistance of a PPECC nurse or direct care staff to and from the PPECC, rather than a non-emergency ambulance.

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- A non-emergency ambulance may not be utilized for transport to and from a PPECC.

Note: *A client or a client's responsible adult may decline a PPECC's transportation services entirely, on a specific date or for part of a day, and choose to be transported by other means, including their responsible adult. A client or a client's responsible adult's decision to utilize or not utilize PPECC transportation services does not preclude a PPECC from being eligible for reimbursement of non-transportation services.*

- Direct care staff, defined in licensure regulations, works under the supervision of an RN and provides direct care to a client
- PPECC services must be:
  - Individualized, specific, and consistent with symptoms or confirmed diagnosis of the condition, illness or injury under treatment, not in excess of the client's needs;
  - Consistent with generally accepted professional medical standards as determined by the Medicaid program and may not be experimental or investigational;
  - Reflective of the level of service that can be safely and effectively furnished;
  - Furnished in a manner not primarily intended for the convenience of the client, the client's responsible adult, or the provider.

Note: *The fact that a client's ordering physician has prescribed, recommended, or approved medical care, goods or services does not, in itself, make such care or services medically necessary or a covered service.*

2.15.1.1 Prior Authorization and Documentation Requirements

Prior authorization is required for PPECC services, excluding PPECC transportation. All requests for PPECC services must be based on the client's current medical needs. Texas Medicaid defines medically necessary THSteps services as health care, diagnostic services, treatments, and other measures necessary to correct or ameliorate any disability, physical or mental illness, or chronic conditions.

Documentation of medical necessity is required for PPECC services. PPECC services are considered medically necessary when a client meets all of the following admission criteria:

- Eligible for THSteps-CCP;
- 20 years of age or younger;
- Requires ongoing skilled nursing care and supervision beyond the level of skilled nursing visits normally authorized under Texas Medicaid HHSN and HHA services, skillful observations, judgments, and therapeutic interventions all or part of the day to correct or ameliorate health status;
- Considered to be a medically dependent or technologically dependent client in accordance with Texas Health and Safety Code chapter 248A;
- Stable for outpatient medical services, and does not present significant risk to other clients or personnel at the PPECC;
- Requires ongoing and frequent skilled interventions to maintain or ameliorate health status, and delayed skilled intervention is expected to result in:
  - Deterioration of a chronic condition;
  - Loss of function;
  - Imminent risk to health status due to medical fragility; or
  - Risk of death.

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- Has a physician's order prescribing PPECC services signed and dated by an ordering physician who has personally examined the client in person within 30 calendar days prior to admission and reviewed all appropriate medical records;
- The physician may waive the examination when:
  - A diagnosis has already been established by the physician;
  - The client is under the continuing care and medical supervision of the physician; and
  - The physician has stated in writing that an examination of the client 30 calendar days prior to admission is not medically necessary.
- If a physician waives an examination, the physician must examine the client in person within 365 calendar days after the date of the client's last examination and the physician and PPECC must maintain documentation of the waived examination in the client's medical record
- Has consent for the client's admission to the PPECC signed and dated by the client or the client's responsible adult. Admission must be voluntary and based on the preference for PPECC services in place of PDN by the client or client's responsible adult in both managed care and non-managed care service delivery systems.
- Resides with the responsible adult and does not reside in any 24-hour inpatient facility, including the following:
  - General acute hospital
  - Skilled nursing facility
  - Intermediate care facility
  - Special care facility, including sub-acute units or facilities for the treatment of AIDS.

The PPECC will hold interdisciplinary conferences when PPECC services are initiated, recertified, or revised, and at least every 90 calendar days. Interdisciplinary conferences should include the client's responsible adult and the following, as applicable:

- The client's Department of Family and Protective Services case worker
- The client's therapy provider(s)
- Hospice provider

Note: *For clients who receive their PPECC services through a Medicaid managed care organization (MCO), the MCO service coordinator and/or service manager should be included in interdisciplinary conferences.*

When the sole purpose of PPECC services is to train and educate the client's responsible adult or the client (e.g., how to administer total parenteral nutrition (TPN) or how to manage a chronic condition), PPECC services will not be approved.

Training in a home setting for certain services such as how to administer TPN may be considered through intermittent HHSN visits.

Refer to: The *Home Health Nursing and Private Duty Nursing Services Handbook* (*Vol. 2, Provider Handbooks*) for more details on training and education for the client or the client's responsible adult on TPN administration in a home setting.

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2.15.1.1.1 Initial Authorization Requests

Initial requests may be prior authorized for a maximum of 90 calendar days. Requests for the prior authorization, including all required documentation, must be submitted to the claims administrator by electronic portal, fax, or mail no later than 3 business days following the start of care (SOC). Requests received after the 3 business day period allowed will be denied for dates of service (DOS) that occurred before the date the request is received.

When PPECC services are authorized, the authorized period begins on the day of the week that prior authorization starts. For example, if service hours are authorized on a weekly basis, the period would begin from the day of the week the prior authorization period begins and continue for 7 calendar days. PPECC services may be authorized based on the client's individual needs. Services may be authorized as hours per day, hours per week or days per week.

Consistent with PPECC licensure requirements, an initial comprehensive nursing assessment must be completed, signed, and dated by the PPECC RN no earlier than 3 business days before the SOC at the PPECC and no later than the day the client is admitted to the center. The initial comprehensive nursing assessment must be performed by a PPECC RN and cannot be delegated. The initial comprehensive nursing assessment is used to establish the POC and must support medical necessity for the client to receive ongoing skilled nursing care. The comprehensive nursing assessment must include the elements outlined in the "Documentation Requirements" section.

> ***Note:*** *The PPECC provider may be asked to submit additional documentation to support medical necessity as defined in this section.*

A written order prescribing PPECC services signed and dated by the client's ordering physician must be in place by the SOC. The physician order as detailed in the "Documentation Requirements" section must be maintained in the client's medical record.

Initial prior authorization requests for PPECC services must include all the following documentation:

- A completed CCP Prior Authorization Request form signed and dated by the ordering physician.
- A completed Prescribed Pediatric Extended Care Center (PPECC) Plan of Care form signed and dated by the ordering physician, and the PPECC RN completing the POC. A PPECC may also submit the POC on their own form, but the POC must contain all required elements listed in the "Documentation Requirements" section. A written or verbal physician approval of the POC from the ordering physician must be in place by the SOC. If the PPECC has a verbal approval of the POC at the time the prior authorization request is submitted, the dated documentation of this POC verbal approval must be submitted with the POC, followed by the physician-signed and dated POC within 14 calendar days from the receipt of the authorization request by the claims administrator.

  > ***Note:*** *For authorization purposes only, a physician signature on the PPECC POC serves as the physician order. However, the physician order as detailed in the "Documentation Requirements" section must be maintained in the client's medical record.*

- A completed Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form, as detailed in the "Documentation Requirements" section, signed, and dated by the ordering physician, RN completing the comprehensive nursing assessment, and client or client's responsible adult.
- Signed and dated consent of the client or client's responsible adult documenting their choice for PPECC services. The signed consent must include an acknowledgment by the client or the client's responsible adult that they have been informed that their PDN service hours might be reduced as a result of accepting PPECC services. Signed and dated consent to share the client's personal health information with the client's other providers to ensure coordination of care must also be obtained.

  > ***Note:*** *A client or client's responsible adult signature on the Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form meets the client consent requirements.*

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The ordering physician, PPECC RN, and client or client responsible adult signatures on the initial prior authorization request forms must be current. Current is defined as signed and dated within the 30 calendar day period before the SOC. Prior authorization request forms received with signatures dated after the SOC will be denied for DOS prior to the latest signed and dated documentation.

Note: *The client or client's responsible adult signature is not required on the CCP Prior Authorization Request form or the PPECC Plan of Care form.*

When initial prior authorization requests are submitted with a verbal approval of the POC, to be current, the ordering physician's dated signature on the POC must be within the fourteen (14) calendar day period following the receipt of the authorization request by the claims administrator. If the POC is not received with a dated physician signature within fourteen (14) calendar days of the receipt of the authorization request by the claims administrator, the prior authorization will be considered incomplete and will be denied.

When initial prior authorization requests are submitted with a verbal approval of the POC, all other required documentation forms must still be signed and dated within the 30 calendar day period before the SOC. If the other required documentation forms are received with dated signatures after the SOC, DOS prior to the latest signed and dated documentation will be denied.

Requests for authorizations of PPECC services should always be commensurate with the client's medical needs.

The length of the authorization is determined on an individual basis and is based on the goals and timelines identified by the physician, provider, and client or client's responsible adult. PPECC services will not be authorized for more than 90 calendar days from the SOC for an initial authorization.

Note: *Clients enrolled in a Medicaid managed care health plan may receive services from a PPECC. Authorization must be received from the health plan.*

2.15.1.1.2 Recertification

A recertification is a new authorization period that may be approved for up to a maximum of 180 calendar days when the client meets medical necessity criteria. Recertification requests may be submitted by electronic portal, fax, or mail. The client or the client's responsible adult, physician, and PPECC provider must agree in writing that the recertification is appropriate each certification period.

An updated comprehensive nursing assessment as outlined in the "Documentation Requirements" section must be performed by the PPECC RN no more than 30 calendar days before the current authorization period expires. If there is no change in the client's condition, the POC must document medical necessity to support continued PPECC services.

A recertification request must be submitted to the claims administrator no more than 30 calendar days before a current authorization period will expire. Requests received after the current authorization period expires will be denied for DOS that occurred before the date the request is received.

A written order prescribing PPECC services signed and dated by the client's ordering physician must be in place by the recertification SOC. The physician order as detailed in the "Documentation Requirements" section must be maintained in the client's medical record.

Recertification prior authorization requests for PPECC services must include all the following documentation:

- A completed CCP Prior Authorization Request form signed and dated by the ordering physician within 30 calendar days prior to the recertification SOC date.

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- A completed Prescribed Pediatric Extended Care Center (PPECC) Plan of Care form signed and dated by the ordering physician and the PPECC RN who completed the POC within 30 calendar days prior to the recertification SOC date. A PPECC may also submit the POC on their own form, but the POC must contain all required elements listed in the "Documentation Requirements" section.
    - The PPECC provider is responsible for ensuring that the ordering physician reviews and signs the POC within 30 calendar days prior to the expiration of the authorization period and this documentation must be maintained in the client's record.

    Note: *For authorization purposes only, a physician signature on the PPECC POC serves as the physician order. However, the physician order as detailed in the "Documentation Requirements" section must be maintained in the client's record.*

- A completed Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form, as detailed in the "Documentation Requirements" section, signed and dated by the ordering physician, RN who completed the comprehensive nursing assessment, and client or client's responsible adult within 30 calendar days prior to the recertification SOC date.
- Signed and dated consent of the client or client's responsible adult documenting their choice for PPECC services. The signed consent must include an acknowledgment by the client or the client's responsible adult that they have been informed that their PDN service hours might be reduced as a result of accepting PPECC services. Signed and dated consent to share the client's personal health information with the client's other providers to ensure coordination of care must also be obtained.

    Note: *A client or client's responsible adult signature on the Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form meets the client consent requirements.*

The PPECC provider may request a revision of a recertification at any time during the recertification period. Revisions must follow the instructions outlined in "Revisions to the Plan of Care" in this section. The PPECC provider must notify the claims administrator and the client's ordering physician at any time during a recertification period if the client's condition changes, the authorized services are not commensurate with the client's medical needs, and the client requires additional hours of ongoing skilled nursing services. The submission of a revision authorization request with physician signatures on required documentation meets the notification requirement.

2.15.1.1.3 Revisions to the Plan of Care

The PPECC provider may request a revision to the POC at any time during an authorization period. Requests for changes in the service hours during a current authorization period should be submitted if there is a change in the client's condition, or the authorized services are not commensurate with the client's medical needs and additional authorized hours are medically necessary.

Revisions during a current authorization period must fall within that authorization period. If the revision is requested beyond the existing authorization period, the provider must request a recertification authorization and submit all required documentation for a recertification.

Note: *Schedule changes that do not affect overall authorized ongoing skilled nursing hours do not require a revision authorization request, but must be documented in the client's medical record.*

Requests for revisions must be submitted to the claims administrator as soon as the PPECC identifies the need for a revision. Revision requests may be submitted by electronic portal, fax, or mail.

Requests for revisions must be submitted within 3 business days of the revised SOC date. Requests received after the 3 business days will be denied for DOS that occurred before the request is received.

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When a client's condition changes during the course of the authorization period that impacts the amount or duration of services, an updated comprehensive nursing assessment, as outlined in the "Documentation Requirements" section, performed by a PPECC RN is required. An updated comprehensive nursing assessment is not necessary if there is not a change in the client's condition.

The PPECC provider must notify the claims administrator and the client's ordering physician at any time during an authorization period if the client's condition changes, the authorized services are not commensurate with the client's medical needs, and the client requires additional hours of ongoing skilled nursing services. Submission of a revision authorization request, with physician signatures on required documentation, meets the notification requirement.

A written or verbal order prescribing PPECC services from the ordering physician must be in place by the revised SOC. If the PPECC obtains a verbal order from the ordering physician, the PPECC must maintain dated documentation of this verbal order in the client's medical record, and the PPECC must obtain a written, signed, and dated order within the fourteen (14) calendar day period following the receipt of the verbal order. The physician order as detailed in the "Documentation Requirements" section must be maintained in the client's medical record.

Revision prior authorization requests for PPECC services must include all the following documentation:

- A completed CCP Prior Authorization Request form signed and dated by the ordering physician.
- An updated Prescribed Pediatric Extended Care Center (PPECC) Plan of Care form signed and dated by the ordering physician and the PPECC RN who completed the POC. A PPECC may also submit the POC on their own form, but the POC must contain all required elements listed in the "Documentation Requirements" section. A written or verbal physician approval of the POC from the ordering physician must be in place by the revised SOC. If the PPECC has a verbal approval of the POC at the time the prior authorization request is submitted, the dated documentation of this POC verbal approval must be submitted with the POC, followed by the physician signed and dated POC within 14 calendar days from the receipt of the authorization request by the claims administrator.

  Note: *For authorization purposes only, a physician signature on the PPECC POC serves as the physician order. However, the physician order as detailed in the "Documentation Requirements" section must be maintained in the client's medical record.*

- An updated Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form, as detailed in the "Documentation Requirements" section, signed and dated by the ordering physician, RN who completed the comprehensive nursing assessment, and client or client's responsible adult.
- Signed and dated consent of the client or client's responsible adult documenting their choice for PPECC services. The signed consent must include an acknowledgment by the client or the client's responsible adult that they have been informed that their PDN service hours might be reduced as a result of accepting PPECC services. Signed and dated consent to share the client's personal health information with the client's other providers to ensure coordination of care must also be obtained.

  Note: *A client or client's responsible adult signature on the Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form meets the client consent requirements.*

- The ordering physician, PPECC RN, and client or client responsible adult signatures on the revision prior authorization request forms must be current. Current is defined as signed and dated within the 30 calendar day period before the revised SOC. Revision prior authorization request forms received with signatures dated after the revised SOC will be denied for DOS prior to the latest signed and dated documentation.

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- When revision prior authorization requests are submitted with a verbal approval of the POC, to be current, the ordering physician's dated signature on the POC must be within the fourteen (14) calendar day period following the receipt of the authorization request by the claims administrator. If the POC is not received with a dated physician signature within fourteen (14) calendar days of the receipt of the authorization request by the claims administrator, the prior authorization will be considered incomplete and will be denied.
- When revision prior authorization requests are submitted with a verbal approval of the POC, all other required documentation forms must still be signed and dated within the 30 calendar day period before the revised SOC. If the other required documentation forms are received with dated signatures after the revised SOC, DOS prior to the latest signed and dated documentation will be denied.

2.15.1.1.4 Coordination with Private Duty Nursing (PDN)

When a client or client's physician notifies the PPECC that the client also receives PDN from a Medicaid-enrolled PDN provider, the PPECC must coordinate services with the PDN provider. Both PDN and PPECC services are considered ongoing skilled nursing. A client has a choice of PDN, PPECC, or a combination of both PDN and PPECC for ongoing skilled nursing where PPECC services are available. Skilled nursing services are authorized for a set number of hours based on the client's medical necessity at the time of the prior authorization request. Skilled nursing hours are not expected to increase when the client utilizes a combination of both PPECC and PDN services, unless there is a documented change in medical condition, or the authorized hours are not commensurate to the client's medical needs and additional hours are medically necessary.

PPECC and PDN providers must collaborate in developing their respective 24-hour flow charts found in the Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers each time a client's authorization for ongoing skilled nursing is initiated, recertified, and revised.

Both providers must maintain documentation that the client or the client's responsible adult has participated in the development of the POC (e.g., the completed PPECC POC and Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers, with the client's or client's responsible adult's signature on the Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers.)

Both providers must discuss with the client or the client's responsible adult how care will be coordinated between the two providers.

When a new service is initiated for ongoing skilled nursing services, and the client wants to receive both PDN and PPECC services, the claims administrator will compare the Nursing Addendum's 24-hour daily care flow sheets and medical necessity documentation (e.g., authorization requests). Upon subsequent approval of PDN or PPECC services, the provider who submitted the initial prior authorization request that established the number of authorized skilled nursing hours will have their authorized hours reduced to prevent duplication. (E.g., if the client currently has PDN, and then adds PPECC services, the PDN hours will be reduced.)

When hours are reduced, the PDN or PPECC provider affected by the reduction will be notified by the claims administrator when the reduction is effective, and the revised amount of authorized hours. A revision request from the provider affected by the reduction, with documentation of medical necessity is required only if there is a change in the client's medical condition or the client's medical needs are not commensurate with authorized hours and additional ongoing skilled nursing hours are medically necessary. No action is required from the provider affected by the reduction if additional hours are not medically necessary.

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2.15.1.1.5 Client Receives both PPECC and PDN Services and Shifts Services from One to the Other

A client receiving both PPECC and PDN services may choose to shift approved hours from one ongoing skilled nursing provider to another.

The receiving provider (PPECC or PDN provider who will gain hours in the shift) must submit all required documentation for a revision.

The sending provider (PPECC or PDN provider who will lose hours in the shift) will receive a notice from the claims administrator with revised (decreased) hours and the effective date of the reduction. The sending provider does not need to take any action unless there is a change in the client's medical condition, or the authorized hours are not commensurate with the client's medical needs, and additional ongoing skilled nursing hours are medically necessary. If there is a medical need for additional ongoing skilled nursing hours, the sending provider may submit a revision request.

The total combined hours between PPECC and PDN services are not expected to increase without client medical necessity for additional hours (e.g., change in client condition or authorized hours are not commensurate with the client's medical needs).

2.15.1.1.6 PPECC Provider Change During an Existing Authorization Period

If a provider or client discontinues PPECC services during an existing prior authorized period and the client requests services through a new PPECC provider, the new PPECC provider must follow all of the processes and submit documentation required for an initial request, as well as the following:

A change of provider letter signed and dated by the client or the client's responsible adult documenting the date the client ended PPECC services (effective date of the change) with the previous provider, the names of the previous and new providers, and an explanation of why providers were changed.

When the new provider submits an authorization request, including all required documentation for an initial request, it will be authorized for no more than 90 calendar days regardless of the number of provider changes a client chooses to make.

2.15.1.1.7 Termination of Authorizations

Authorization for PPECC services will be terminated when:

- The client is no longer eligible for THSteps-CCP.
- The client no longer meets the medical necessity criteria for PPECC services.
- The place of service cannot ensure the health and safety of the client.
- The client or the client's responsible adult refuses to comply with the service plan and compliance is necessary to assure 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.
- After receiving PPECC services, the client opts to decline PPECC services and receive their services at home. The home health agency or independent provider offering ongoing skilled nursing (e.g., PDN) must submit or update all required authorization documentation to the claims administrator.

2.15.1.1.8 Appeal of Authorization Decisions

Providers may appeal denials or modifications of requested PPECC services with documentation to support the medical necessity of the requested PPECC services.

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Appeals must be submitted to the claims administrator's CCP department 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 claims administrators will go back no more than three (3) business days for initial, or revision requests; and no more than 7 calendar days for recertification requests.

The client or the client's responsible adult will be notified of any denial or modification of requested services and will be given information about how to appeal the claims administrator's decision or request a fair hearing.

PPECC services may be denied when:

- The client does not meet medical necessity criteria for admission.
- The client does not have an ordering physician.
- The client is 21 years of age or older.
- The client's needs are not beyond the scope of services available through Texas Medicaid HHSN and/or HHA services because the needs can be met on a part-time or intermittent basis through a visiting nurse.
- The services are primarily intended to provide respite care or child care.
- The services are provided for the sole purpose of responsible adult training.
- The prior authorization request is submitted with documentation of a verbal physician approval of the POC, and the physician signed and dated POC is not received by the claims administrator within 14 calendar days of the receipt of the authorization request by the claims administrator.
- The prior authorization request is submitted late.
- The request is incomplete.
- The information in the request is inconsistent.
- The requested services are not ongoing skilled nursing services.
- There is a duplication of services.

Appeals to prior authorization requests must be submitted for processing to the Claims Administrator Prior Authorization Department (fee-for-service clients).

Note: *Clients enrolled in a Medicaid managed care health plan may receive services from a PPECC. Prior authorization requests for these clients must be submitted solely to the client's MCO.*

2.15.1.1.9 Documentation Requirements

In addition to the requirements outlined in the "Prior Authorization and Documentation Requirements" section, the following documentation requirements apply. Services not supported by documentation are subject to recoupment.

All services and documentation outlined in this section 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.

PPECCs must maintain documentation in the client's medical record, including but not limited to the following:

- Written orders from the ordering physician that prescribe PPECC services. If the PPECC obtains a verbal order for a revision request from the ordering physician, dated documentation of this verbal order must also be maintained in the client's medical record. The physician's order must include the following:

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- Client's name, date of birth, gender, and Medicaid number
- Provider name, NPI, address, and phone number
- Date the client was last seen by the physician
- Description of current medical diagnosis or condition
- Nursing services
- Medication administration, if applicable
- Dietary needs, if applicable
- Permitted activities, if applicable
- Therapies, if applicable
- Determination of whether the client is stable enough to receive PPECC transportation services and, if the client is determined to be stable, the provider type that must be on board: RN, LVN, or direct care staff, if applicable.
- Other services, if applicable
- Approval of the client's admission to the PPECC

- A completed CCP Prior Authorization Request form signed and dated by the ordering physician.
- A completed PPECC Plan of Care form must be signed and dated by the ordering physician and the PPECC RN completing the POC. If the PPECC obtains verbal approval of the POC from the ordering physician, the PPECC must maintain dated documentation of this verbal approval of the POC in the client's medical record. The POC using either the PPECC POC form or a PPECC-developed form, must include the following components:
  - The client's name, date of birth, and Medicaid number
  - The PPECC's name, National Provider Identifier (NPI), taxonomy, address, hours of operation, phone number, and fax number
  - The ordering physician's name, NPI and phone number
  - The PDN provider's name, NPI, address, phone number and fax number, if applicable
  - Date the client was last seen by the ordering physician
  - Date the PPECC comprehensive nursing assessment was completed and the name, title, and credentials of the RN who completed the comprehensive nursing assessment
  - The requested SOC date and requested end date for PPECC services
  - The client's scheduled days and hours of attendance for PPECC services
  - List of services the client receives in the home and school settings. [e.g., ECI, therapies, School Health and Related Services (SHARS), PCS, PDN, therapies, HHSN, HHA, case management services, hospice, and Medicaid waiver programs such as Medically Dependent Children's Program (MDCP), Home and Community-Based Services (HCS), Deaf-Blind Multiples Disabilities (DBMD), Texas Home Living (TxHL), and Community Living Assistance and Support Services (CLASS)]

    Note: *Services provided under these programs will not prevent a client from obtaining medically necessary services.*

  - All pertinent diagnoses and known allergies
  - Nursing services to be provided, including amount, duration, and frequency
  - The client's prognosis

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- The client's mental status
- Rehabilitation potential
- The equipment and/or supplies required
- Therapies (occupational, physical, speech, and respiratory care), including how those therapies are accessed, amount, duration, and frequency. Therapies provided in the PPECC, as well as outside the PPECC (e.g., school based), must be documented.
- Nutritional requirements, including type, method of administration, and frequency
- Medications, including the dose, route, and frequency and any medication-related allergies if known
- Treatments, including amount and frequency
- Wound care orders and measurements
- Safety measures to protect against injury
- Prior and current functional or medical limitations
- Permitted activities
- Functional developmental services and psychosocial services, including amount, duration, and frequency
- Other prescribed services, including amount, duration, and frequency
- The determination from the client's ordering physician whether the client is stable to receive PPECC transportation. The description of the type of provider-RN, LVN, or direct care staff-who must be present on board the PPECC vehicle to assist the client if the client is determined stable.
- Responsible adult training needs
- Name and phone number of the responsible adult when the client is a minor
- Client's emergency contact name and phone number
- Confirmation that a signed contingency plan is in place in circumstances when PPECC services are not available (e.g., fire, flood, windstorm, or electrical malfunctions) and for emergencies that occur while the client is in the care of the PPECC
- Confirmation of a discharge plan, including instructions for timely discharge or referral
- RN who completed the POC signature and date of signature
- Ordering physician signature and date of signature

- The PPECC comprehensive nursing assessment. The comprehensive nursing assessment must be performed by a PPECC RN and cannot be delegated. The comprehensive nursing assessment must include:
  - Complexity and intensity of the client's care
  - Stability and predictability of the client's condition
  - Frequency of the client's need for skilled nursing services
  - Identified medical, nursing, psychosocial, therapeutic, nutritional, dietary, functional, educational, and developmental needs and goals, and any training needs for the client or the client's responsible adult
  - Description of wounds, if present

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- The client's equipment needs and 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, equipment, and supplies required by the client
- The comprehension level of the client's responsible adult; and
- Receptivity to training and ability level of the responsible adult

- The completed Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form signed and dated by the ordering physician, RN who completed the comprehensive nursing assessment, and the client or client's responsible adult. The Nursing Addendum form must include the following components:
  - The client's name and Medicaid number
  - The requested SOC date and requested end date for PPECC services
  - A nursing care plan summary, including a current problem list
  - A current summary and rationale page
  - A 24-hour daily care flow sheet
  - An acknowledgments page that includes the signed and dated signature of the client or the client's responsible adult, the RN who completed the POC, and the ordering physician

  Note: *For further details on completing PPECC prior authorization forms, refer to the Instructions for Completing Prescribed Pediatric Extended Care Center Prior Authorization Forms.*

  - The signed and dated consent of the client or the client's responsible adult documenting:
    - The client or client's responsible adult choice for PPECC services.
    - Acknowledgment that the client or client's responsible adult have been informed that their PDN service hours might be reduced as a result of accepting PPECC services.
    - Consent to share the client's personal health information with the client's other providers to ensure coordination of care.
    - The client or the client's responsible adult has been informed about how care will be coordinated between the client's providers.
    - The client or the client's responsible adult has been involved in the development of the POC.

  Note: *A client or client's responsible adult signature on the Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers meets the client consent requirements.*

- Confirmation of PDN provider notification, including the date the notification was provided when a client is receiving PDN services.
- Notes from interdisciplinary team meetings.
- Documentation of all discrepancies between the weekly service hours scheduled and the service hours provided. Examples include but are not limited to, doctor's appointments; the PPECC was closed one day for unforeseen reasons; the client was hospitalized; or the client's responsible adult was ill and could not provide services that they would normally provide.
- For each day that PPECC services are provided, the PPECC must maintain the following documentation:
  - A daily attendance log that includes:
    - The date of attendance.
    - The name of the client.

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- The signature of the responsible adult and the time when the PPECC assumes responsibility for the care of the client, which is the time the client boards the PPECC transport vehicle or the time the client is brought to the PPECC by a responsible adult.
- The signature of the responsible adult and the time when the responsible adult assumes responsibility for the care of the client, which is the time the client is taken off the PPECC transport vehicle at their return destination or the time the client is picked up from the PPECC by a responsible adult.
- The name of the PPECC staff member riding in the PPECC transport vehicle when PPECC transportation services are used and whether the staff member is an RN, LVN, or direct care staff.
- The name of the specific person or persons (e.g., nursing, direct care staff, therapist) providing services,
- Date of service,
- Type of services performed, and
- The start and end times of services performed.

- When a PPECC provides transportation for a PPECC client, an RN, LVN, or direct care staff, as determined by the client's ordering physician in collaboration with the PPECC, must be on board the PPECC transport vehicle to assist the client during transportation. The PPECC must ensure that the driver and the RN, LVN, or direct care staff member on board the PPECC transport vehicle maintain a daily transportation log that must include:
  - The driver's name.
  - The name of the PPECC staff member and whether the staff member is an RN, LVN, or direct care staff member.
  - The date of service.
  - The name of the client.
  - The time that the client is put on the transport vehicle to deliver the client to the PPECC.
  - The time that the client arrives at the PPECC.
  - The time that the client is put on the transport vehicle to return to their responsible adult or authorized adult.
  - The time that the client arrives at their return destination and the name of the person to whom the client was released.
  - The reason that the transport time was longer than one hour for a client who is in transport longer than one hour traveling to the PPECC or longer than one hour traveling to their return destination.

To complete a prior authorization process by paper, the provider must complete and submit the prior authorization 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 PPECC's place of business.

To complete a prior authorization process electronically, the provider must complete and submit the prior authorization 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 PPECC's place of business.

The PPECC provider may use any reliable method to record times, dates, and signatures provided that it is accurate and allows for an auditable review of the records, including electronic census, time-stamp, scanning, and signature records.

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The PPECC provider must keep these records in case of an audit or monitoring.

The PPECC must coordinate the following with the client or the client's responsible adult:

- The client's transportation schedule
- The pick-up and drop-off locations (such as home or school)
- The authorized persons to whom the client may be released

A responsible adult must be provided daily a written, one-page summary of services provided to the client for each day that the client is in the PPECC's care.

The PPECC must maintain documentation in the client's medical record of the notification provided to the client or the client's responsible adult of an intent to transfer or discharge the client as follows:

- A copy of the written notification provided
- Personal contact with the client or the client's responsible adult
- Notification to the provider of the date of transfer or discharge.

PPECC service providers must provide written notice to clients of their intent to voluntarily terminate PPECC services at least fifteen (15) calendar days prior to terminating services, except in situations of a potential threat to the provider's personal safety.

The PPECC and the therapy provider must have a written agreement regarding the provision of therapy services when therapy services (occupational, speech, physical, and respiratory care) are provided at the PPECC. The written agreement must address the responsibilities of both parties and how the parties will coordinate related to the client's POC.

The PPECC and hospice provider must have a written agreement for each client regarding the provision of hospice services when hospice is provided at the PPECC. The written agreement must address the responsibilities of both parties and how the parties will coordinate related to the client's POC. The written agreement must be kept in the client's medical record.

The ordering physician must also maintain a copy of the signed and dated physician order and signed and dated POC in the client's medical record.

2.15.1.1.10 Exclusions

The services that are not covered by the PPECC benefit include the following:

- Baby food or formula.
- PPECC services to clients related to the PPECC owner by blood, marriage or adoption.
- Services that are intended to provide mainly respite care or child care and do not directly relate to the client's medical needs or disability.
- PPECC services rendered to a client who does not meet the definition of a medically or technologically dependent minor.
- Services covered separately by Texas Medicaid, such as:
- Speech, occupational, physical, respiratory therapy services, and ECI services.
- Durable medical equipment (DME), medical supplies, nutritional products provided to the client by Medicaid's DME and medical supply service providers.
- PDN, HHSN, and HHA services provided in the home setting when medically needed in addition to the PPECC services authorized.
- Services that are the legal responsibility of a local school district.
- Individualized comprehensive case management beyond required service coordination.

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2.15.1.1.11 Claims Filing and Reimbursement

PPECC services may be reimbursed when billed with procedure codes T1025, T1026, or T2002.

Services begin when the PPECC assumes responsibility for the care of the client (i.e., the point the client boards the PPECC transportation, or when the client is brought to the PPECC by a responsible adult) and ends when the care is relinquished to the client's responsible adult.

Providers must use appropriate procedure codes for the PPECC services performed. Procedure codes T1025 and T2002 are limited to once per day.

The PPECC per diem procedure code (T1025) and hourly procedure code (T1026) may not be billed on the same day.

Procedure code T1026 is allowed on an hourly basis, up to four hours. Services beyond four hours must be billed using procedure code T1025. At a minimum, four hours and fifteen minutes of services must be provided before procedure code T1025 may be billed.

For procedure code T1026, a minimum of 15 minutes of service is required to round up to a full hour after the first hour.

Procedure code T2002 is not allowed without a PPECC service on the same day, same provider.

PPECC per diem procedure code T1025 and hourly procedure code T1026 may be billed without nonemergency transportation procedure code T2002 on the same date of service.

Therapy services are billed separately by Medicaid-enrolled licensed therapists, including ECI providers, and are subject to prior authorization and policies governing Physical, Occupational, and Speech Therapy - Children (Acute and Chronic), or ECI services, as applicable.

If hospice services are rendered in a PPECC setting, they must be billed separately by Medicaid-enrolled hospice providers, and are subject to prior authorization and policies governing hospice reimbursement.

The following services may be billed on the same day as PPECC services, but they may not be billed simultaneously with PPECC services. These services may be billed before or after PPECC services:

- Private Duty Nursing
- Home Health Skilled Nursing
- Home Health Aide services
- Personal Care Services

PCS services provided in a PPECC are considered part of the PPECC billable rate.

PPECC services may be reimbursed only to a licensed PPECC.

> ***Note:*** *Texas Medicaid will not reimburse PPECC services that duplicate services that are the legal responsibility of the school districts. The school district, through the SHARS program, is required to meet the client's skilled nursing 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 claims administrator.*

Parental accompaniment is not required for PPECC reimbursement.

Non-emergency ambulance service providers will not be reimbursed for transportation to and from a PPECC.

PPECC services are subject to retrospective review and possible recoupment when the medical record does not document the provision of PPECC services is medically necessary based on the client's medical needs at the time PPECC services were rendered. The PPECC provider must explain all discrepancies between the service hours approved and the service hours provided. For example: The parents withdrew

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their client from a PPECC and released the provider from all responsibility for the service hours; the PPECC was closed one day for unforeseen reasons; the client was hospitalized; or the responsible adult was ill and could not provide services that he or she would normally provide.

Payment will not be rendered for services that are not prior authorized.

2.16 Therapy Services (CCP)

Refer to: Section 5, "Children's Therapy Services Clients birth through 20 years of age" for information about CCP therapy services.

2.17 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 Hospital Services Handbook* (*Vol. 2, Provider Handbooks*).

2.18 Inpatient Rehabilitation Facility (Freestanding) (CCP)

2.18.1 Enrollment

Note: *Rehabilitation provided at an acute care facility is covered through Texas Medicaid fee-for-service.*

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.

2.18.1.1 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 access the HHSC Medicaid Provider Agreement through the Provider Enrollment and Management System (PEMS).

2.18.2 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.

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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.

2.18.2.1 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.

2.18.3 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.
- 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 Request 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:

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- 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.

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.

2.18.4 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.

2.18.5 Reimbursement

Reimbursement for care provided in the freestanding inpatient rehabilitation facility is made under the Texas Diagnosis-Related Group (DRG) Payment System.

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Refer to: Subsection 3.7.4.4.1, "Day Outliers" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for reimbursement information.

2.18.5.1 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 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: *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.*

All dental providers must refer to the Current Dental Terminology (CDT) book for recording services provided and when reporting procedures on a paper or electronic claim submission form.

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.*

Refer to: The *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*) or to the HHSC website at www.hhs.texas.gov/services/health/medicaid-chip, for additional information about children's Medicaid dental Services.

Under the Early Periodic Screening Diagnostic, and Treatment (EPSDT) regulation, known in Texas as Texas Health Steps (THSteps), Section 1905(r) of the Social Security Act mandates that all Medicaid eligible beneficiaries who are birth through 20 years of age receive medically necessary services to treat, correct, and ameliorate illnesses and conditions identified if the service is covered in the state's Medicaid plan or is an optional Medicaid service. It is the responsibility of the state to determine medical necessity on a case-specific basis. No arbitrary limitations on services are allowed (e.g., one pair of eyeglasses or 10 therapy sessions per year) if determined to be medically necessary.

Services not covered under this section include:

- Experimental or investigational treatment.
- Services or items not generally accepted as effective and/or not within the normal course and duration of treatment.
- Services for the caregiver or provider convenience.

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All EPSDT requirements must be adhered to for beneficiaries who receive services under managed care arrangements.

3.1 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 through the Provider Enrollment and Management System (PEMS).

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).

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.

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)

Dentists (D.D.S., D.M.D.) who want to provide the three levels of orthodontic services must be enrolled as a dentist or orthodontist provider for THSteps and must have at least one of the following qualifications listed below for the relevant level of service.

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THSteps dental providers may perform and be reimbursed for level I or level II orthodontic services if they have attested to at least one of the following requirements:

- Completion of a dental pediatric specialty residency or
- 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 may perform and be reimbursed for level I, level II, or level III orthodontic services and must be in compliance 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.

3.1.1 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 Medicaid card or Medicaid Eligibility Verification Form (Forms H1027 and H1027-A-C) states any of the following:

- Emergency
- Presumptive eligibility (PE)
- Qualified Medicare beneficiary (QMB)
- Healthy Texas Women (HTW) program

3.1.2 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 3.2, "Services, Benefits, Limitations, and Prior Authorization" in this handbook.

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3.1.3 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 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.

3.1.4 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 Medicaid.
- Enroll as a limited physician.

3.1.5 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.

3.1.6 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.
- The provider did not use sterile procedures; the facility or equipment were not clean.

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- 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.

3.2 Services, Benefits, Limitations, and Prior Authorization

3.2.1 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, HHSC, 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.

3.2.1.1 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.

3.2.1.2 Parental Accompaniment

Clients who are 14 years of age and younger must be accompanied to Texas Health Steps dental checkups and visits by the client's parent, legal guardian, or another adult who is authorized by the parent or legal guardian. The authorized adult can be the client's relative. The individual accompanying the client must wait for the client while the appointment takes place. For additional information and exceptions, see "D.5 Parental Accompaniment" in this handbook.

3.2.2 Substitute Dentist

In accordance with TAC §§354.1121 and 354.1221, related to Medicaid billing for the services of substitute dentists, dentists who are temporarily absent from their practice are allowed to submit claims for reimbursement of Medicaid services rendered to their Medicaid clients by a substitute dentist.

Dentists may bill for the services of a substitute dentist pursuant to 42 CFR §447.10.

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

- Dentists who take a leave of absence for no more than 90 days may bill for the services of a substitute dentist who renders services on an occasional basis when the primary dentist is unavailable to provide services. Services must be rendered at the practice location of the dentist who has taken the leave of absence. A locum tenens arrangement is not allowed for dentists.
- This arrangement is limited to no more than 90 consecutive days. Under this temporary basis, the primary dentist (who is the billing agent dentist) may not submit a claim for services furnished by a substitute dentist to address long-term vacancies in a dental practice. The billing agent dentist may submit claims for the services of a substitute dentist for longer than 90 consecutive days if the dentist has been called or ordered to active duty as a member of a reserve component of the Armed Forces. Medicaid and CSHCN accepts claims from the billing agent dentist for services provided by the substitute dentist for the duration of the billing agent dentist's active duty as a member of a reserve component of the Armed Forces.
- Providers billing for services provided by a substitute dentist must bill with modifier U5 in Block 19 of the American Dental Association (ADA) claim form.
- The billing agent dentist may recover no more than the actual administrative cost of submitting the claim on behalf of the substitute dentist. This cost is not reimbursable by Medicaid or CSHCN.
- The billing agent dentist must bill substitute dentist services on a different claim form from his or her own services. The billing agent dentist services cannot be billed on the same claim form as substitute dentist services.
- The substitute dentist must be licensed to practice in the state of Texas, must be enrolled in Texas Medicaid, and must not be on the Texas Medicaid provider exclusion list.
- The dentist who is temporarily absent from the practice must be indicated on the claim as the billing agent dentist, and his or her name, address, and NPI must appear in Blocks 53, 54, and 56 of the ADA claim form.
- The substitute dentist's NPI number must be documented in Block 35 of the ADA claim form. Electronic submissions do not require a provider signature.

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

3.2.3 Texas Health Steps Dental Checkups

Texas Health Steps dental checkups include an oral evaluation, prophylaxis, topical fluoride, and appropriate radiographs.

The Texas Health Steps dental periodicity schedule for preventative and diagnostic procedures does not apply to clients living in an intermediate care facility for individuals with intellectual or developmental disabilities (ICF-IID) who are 21 years of age and older.

3.2.3.1 Exception-to-Periodicity Oral Evaluation, Dental Checkup, and Emergency or Trauma Related Services

Oral evaluations and dental checkups allow for the early diagnosis and treatment of dental problems. Oral evaluations and dental checkups might be needed at more frequent intervals than noted in the periodicity schedule.

If needed, a dental checkup or oral evaluation can still be reimbursed when the service falls outside the periodicity schedule. The rules for such exceptions are outlined below.

3.2.3.2 Exception-to-Periodicity Oral Evaluation

A Texas Health Steps exception-to-periodicity oral evaluation is limited to dental procedure code D0120.

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An exception-to-periodicity oral evaluation is allowed when the service is:

- Medically necessary and based on risk factors and health needs for clients birth through 6 months of age.
- Mandated service required to meet federal or state exam requirements for Head Start, daycare, foster care or preadoption.

Providers must include all appropriate procedure codes on the dental claim submission form. Additionally, dental providers must include modifier SC or 32 to identify the reason for the exception.

3.2.3.3 Exception-to-Periodicity Dental Checkup

A Texas Health Steps exception-to-periodicity dental checkup is allowed when the client will not be available for the next periodically due dental checkup. This includes clients whose parents are migrant or seasonal workers.

Providers must include all appropriate procedure codes on the dental claim submission form. Additionally, dental providers must include modifier SC to identify the reason for the exception.

3.2.3.4 Exception-to-Periodicity Emergency or Trauma Related Oral Evaluation

A Texas Health Steps exception-to-periodicity emergency or trauma related oral evaluation is limited to dental procedure code D0140.

A Texas Health Steps exception-to-periodicity emergency or trauma related dental service is allowed when the service is:

- Required for immediate treatment and any follow-up treatment.
- Required for therapeutic services needed to complete a case for clients who are 5 months of age and younger, when initiated as emergency services, trauma, or early childhood caries.

When submitting a claim for emergency or trauma related dental services, the provider must include:

- "Trauma" or "Emergency" in Block 30 "Description" field.
- The original date of treatment or incident in Block 35, "Remark" field.
- Completion of Block 45, "Treatment Resulting from" field, if applicable.

Providers must include all appropriate procedure codes on the dental claim submission form. Additionally, dental providers must include modifier ET to identify the reason for the exception.

Refer to: Subsection 6.7, "American Dental Association (ADA) Dental Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

3.2.3.5 Documentation

The client's dental medical record must include documentation for the exception-to-periodicity Texas Health Steps oral evaluation, dental checkup or exception-to periodicity emergency or trauma related service for medical necessity.

Dental services are subject to retrospective review and recoupment if documentation does not support the services submitted for payment.

3.2.3.6 Reimbursement

Providers must include the appropriate procedure code and one of the modifiers to identify the reason for the exception must be included on the ADA dental claim submission form. Procedure codes must be included in Block 29. Modifiers must be included in Block 19:

Procedure Code	Modifier to Identify Exemption	Modifier Description
D0120	32	Mandated Service

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Procedure Code	Modifier to Identify Exemption	Modifier Description
D0120	SC	Medically Necessary Service
D0140, D9110	ET	Emergency - Trauma Related Services

3.2.3.7 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. Denied when submitted within six months of D0150 by the same 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 and twice per day for any provider. 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 Texas Health Steps staff to perform this procedure. Procedure codes D0120, D0150, D0160, D0170, D0180, 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. Denied when submitted for the same date of service as D8070 or D8080 by the same 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 by the same provider. Denied when submitted for the same DOS as D0145 by any provider. A Birth–20
D0180*	Used for periodontal evaluation. Denied when submitted for the same DOS as D0120, D0140, 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.

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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 are submitted for reimbursement on the same claim, for the same date of service, by the same provider.

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)
- Texas Health Steps (THSteps)

Procedure Code	Limitations
Radiographs/Diagnostic Imaging (Including Interpretation)	
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 panoramic 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. Will be denied when submitted on an emergency claim. 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
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
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. Denied when submitted for the same DOS as D0210 by any provider. A 1–20
D0273	Limited to one service per day by the same provider. Denied when submitted for the same DOS as D0210 by any provider. A 1–20
D0274	Limited to one service per day by the same provider. Denied when submitted for the same DOS as D0210 by any provider. A 2–20
D0277	Limited to one service per day by the same provider. Denied when submitted for the same DOS as D0330 by the same provider. Denied when submitted for the same DOS as D0210 by any provider. A 2–20
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 panoramic radiographic image (D0330) with four bitewing radiographic images (D0274) may be considered equivalent to a comprehensive intraoral series of radiographic images (D0210), and the submitted amount for either combination is equivalent to the maximum fee. Denied when submitted with procedure codes D8070 and D8080. A 3–20
D0340*	Limited to one service per day by the same provider. Not reimbursable separately when a crossbite therapy workup is performed. Denied when submitted with procedure codes D8070 and D8080. A 1–20, N, CCP
D0350*	Limited to one service per day by the same provider. Not reimbursable separately when a crossbite therapy workup is performed. Denied when submitted with procedure codes D8070 and D8080. 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
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.

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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
D0470*	Not reimbursable separately when crown, fixed prosthodontics, diagnostic workup, or crossbite therapy workup is performed. Procedure code D0470 is limited to once per lifetime, any provider. Denied when submitted with procedure codes D8070 and D8080. 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
Case Management	
D9994*	A benefit of Texas Health Steps when anticipatory guidance is provided during a first dental home visit. Denied if not submitted with procedure code D0145 on the same day by the same provider. A 6-35 months
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	

3.2.3.8 Preventive Services

Reimbursement for dental services exceeding the stated benefit limitations may be considered when medically necessary. Providers must submit documentation supporting medical necessity when submitting the claim. The documentation must also be kept in the client's medical record.

Procedure Code	Limitations
Dental Prophylaxis	
D1110*	Limited to one prophylaxis per client, any 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
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
D1120*	Limited to one prophylaxis per client, any provider, per six-month period (includes oral health instructions). Limited to once every six months, any provider for clients who are 35 months of age or older. If submitted on emergency claim, procedure code will be denied. Denied when submitted for the same DOS as any D4000 series periodontal procedure code. May be performed every 60 days when provided on the same date of service as procedure code D0145 by the same provider. A 6 months–12 years
Topical Fluoride Treatment (Office Procedure)	
D1206	Limited to once every six months, by any provider for clients who are 35 months of age or older. If submitted on emergency claim, procedure code will be denied. Denied when submitted for the same DOS as any D4000 series periodontal procedure code. May be performed every 60 days when provided on the same date of service as procedure code D0145 by the same provider. A 6 months–20 years, N, CCP
D1208	Limited to once every six months, by any provider. 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–20 years, N, CCP
Other Preventive Services	
D1310	Denied as part of all preventative, therapeutic, orthodontic, and diagnostic dental procedures. A client requiring more involved nutrition counseling may be referred to a THSteps medical provider. The THSteps medical provider may then refer the client to a THSteps-enrolled, licensed dietitian for further nutrition counseling.
D1320	A client requiring tobacco counseling may be referred to a THSteps primary care provider. Tobacco counseling is considered inclusive of all preventive, therapeutic, orthodontic, and diagnostic dental procedures.
D1330	Requires documentation of the type of instructions, number of appointments, and content of instructions. This procedure is a benefit of the THSteps Dental Program when the services are above and beyond routine brushing and flossing instruction and requires that additional time and expertise have been directed toward the client's care. Procedure code D1330 is limited to the office setting. Denied when billed for the same DOS as dental prophylaxis (D1110 or D1120) or topical fluoride treatments (D1206 or D1208) by any 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 primary teeth (Tooth Identification (TID) A, B, I, J, K, L, S, and T) or permanent teeth (TID 1-5, 12-21, 28-32). TID and Surface Identification (SID) must be indicated 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. Limited to once per lifetime, per TID, any provider. Procedure code D1351 will be denied if billed on the same date of service for the same permanent TID as procedure code D1352, by any provider. If submitted on emergency claim, procedure code will be denied. 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
D1352	Limited to once per lifetime, per TID, any provider. Reimbursement will be considered on a per-tooth basis, regardless of the number of surfaces sealed. TID and SID must be indicated on the claim form. Payable for only posterior permanent teeth (TID 2-5, 12-15, 18-21, 28-31). Denied if a moderate or high caries risk assessment (procedure code D0602 or D0603) has not been submitted, by any provider, within 180 days prior. Denied when submitted for the same DOS as any D4000 series periodontal procedure code. A 5–20
D1354	Application of caries arresting medicament is limited to once per lifetime per TID (A-T and 3, 14, 19, and 30) by any provider in the office setting. Denied if billed on the same date of service for the same TID as procedure code D1351 or D1352 by any provider. Procedure code D1354 will be denied if billed within six months of procedure codes D9222 or 00170 with the modifier U3 by any provider. A 0–6 ***Note:*** *Silver diamine fluoride is the only material providers may use for procedure code D1354.*
D9994*	A benefit of Texas Health Steps when anticipatory guidance is provided during a first dental home visit. Denied if not submitted with procedure code D0145 on the same day by the same provider. A 6-35 months
Space Maintainers (Passive Appliances)	
Space maintainers are designed to prevent tooth movement and are a benefit of Texas Medicaid in the following situations: • After premature loss of a deciduous primary first and/or second molar(s) (TID: A, B, I, and J) for clients who are 1 through 12 years of age (procedure codes D1510 and D1516) • After premature loss of a deciduous primary first and/or second molar(s) (TID: K, L, S, and T) for clients who are 1 through 12 years of age (procedure codes D1510 and D1517) • After premature loss of a deciduous primary second molar (TID: A, J, K, and T) for clients who are 3 through 7 years of age (procedure code D1575) Removal of a fixed space maintainer (procedure code D1556, D1557, or D1558) is not payable to the provider or dental group practice that originally placed the device. Procedure codes D1510, D1520, D1553, D1556, and D1575 are limited to once per lifetime, per quadrant, by any provider. Procedure codes D1551 and D1552 are limited to once per lifetime, by the same provider. Procedure codes D1516, D1517, D1526, and D1527 are limited to once per lifetime, per tooth ID, same procedure code, by any provider. Procedure code D1553 will be denied if procedure code D1510 was reimbursed within the previous rolling year, same quadrant, by the same provider. Procedure code D1551 will be denied if procedure code D1516 was reimbursed within the previous rolling year, by the same provider. Procedure code D1552 will be denied if procedure code D1517 was reimbursed within the previous rolling year, by the same provider.	
Space Maintainers (Passive Appliances) continued	
D1510*	A 1–12 (TIDs #A, B, I, J, K, L, S, T), MTID
D1516*	A 1–12 (TIDs #A, B, I, J), 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

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Procedure Code	Limitations
D1517*	A 1–12 (TIDs #K, L, S, T), MTID
D1520*	A 1–12 (TIDs #A, B, I, J, K, L, S, T), MTID A 1–12 (TIDs #3, 14, 19, 30), MTID
D1526*	A 1–12 (TIDs #A, B, I, J), MTID A 1–12 (TIDs #3, 14), MTID
D1527*	A 1–12 (TIDs #K, L, S, T), MTID A 1–12 (TIDs #19, 30), MTID
D1551	A 1–12 (TIDs #A, B, I, J,), MTID
D1552	A 1–12 (TIDs #K, L, S, T), MTID
D1553	A 1–12 (TIDs #A, B, I, J, K, L, S, T), MTID
D1556	A 1-20 (TIDs #A, B, I, J, K, L, S, T), MTID A 1-20 (TIDs #3, 14, 19, 30), MTID
D1557	A 1-20 (TIDs #A, B, I, J,), MTID A 1-20 (TIDs #3, 14), MTID
D1558	A 1-20 (TIDs #K, L, S, T), MTID A 1-20 (TIDs #19, 30), MTID
D1575	A 3-7 (TIDs #A, J, K, T), 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

3.2.3.9 Therapeutic Services

Medicaid reimbursement is contingent on compliance with the following limitations:

- Documentation requirements

Refer to: Subsection 3.3, "Documentation Requirements" in this handbook.

- 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.
- 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 3.3, "Documentation Requirements" in this handbook.

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3.2.4 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).

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 with the notation "CCP" beginning in subsection 3.2.3.7, "Diagnostic Services" in this handbook.

3.2.5 Children's Medicaid Dental Plan Choices

Children's Medicaid dental services benefits are administered by three dental managed care organizations (i.e., dental plans) across the state of Texas.

Medicaid Managed Care Dental Plan Provider Services	
DentaQuest	1-800-685-9971
MCNA Dental	1-855-776-6262
United Healthcare Dental	1-800-527-1764

Note: *Services provided to Medicaid managed care clients must be provided by their main dentist.*

3.2.6 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.

3.2.7 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 HHSC.

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 3.2.15, "Medicaid Dental Benefits, Limitations, and Fee Schedule" in this handbook.

3.2.7.1 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

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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.
- Only the treatment required to address documented medical necessity that meets professionally recognized standards of health care.

3.2.7.2 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
P.O. Box 2906
Milwaukee, WI 53201-2906
Fax: 262-834-3589

3.2.8 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."

3.2.9 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 or legal guardians 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:

- Oral examination
- Caries risk assessment

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The following services may be reimbursed separately when provided during an FDH visit:

- Oral evaluation for a client who is 3 years of age or younger (procedure code D0145)
- Dental case management and patient education to improve oral health literacy (procedure code D9994) when providing dental anticipatory guidance
- Dental prophylaxis (procedure code D1120) if appropriate
- Topical fluoride application using fluoride varnish (procedure code D1206) if appropriate

Caries susceptibility tests are considered part of dental evaluation procedures and are not reimbursed separately.

Clients who are from 6 through 35 months of age may be seen for dental checkups by a certified First Dental Home provider.

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 Texas Health Steps dental 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, 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 one service per day and ten services per client lifetime with at least 60 days between visits by any provider.

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3.2.10 Teledentistry Services

Teledentistry services may be reimbursed by Texas Medicaid. When provided as a teledentistry service procedure code D0120 or D0140, must be billed with teledentistry procedure code D9995.

Teledentistry refers to the use of communication technology by a dentist to provide dental care services to a patient at a different physical location than the office setting.

Texas Health Steps dental providers must follow the rules and regulations of the Texas Dental Practice Act and Texas Board of Dental Examiners (TSBDE) in regard to the practice of teledentistry and the permissible work that may be delegated to a licensed dental hygienist or dental assistant.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information on Medicaid services provided through telecommunications.

Dental services delivered using teledentistry must meet the same standard of care as the same dental health service or procedure provided in an in-person setting.

For dental services delivered through a dental maintenance organization (DMO), providers must refer to the individual DMO benefit package for information on teledentistry services.

The service must be delivered using only synchronous real-time audiovisual technologies.

The client or parent/guardian must agree to receiving the teledentistry service.

Services provided through teledentistry outside of the frequency specified in the periodicity schedule may be reimbursed when medically necessary and criteria for procedure code D0120 or D0140 are met.

A periodic oral evaluation (procedure code D0120) may be delivered as a teledentistry service when the following criteria are met:

- The client must be 3 years through 20 years of age.
- The teledentistry platform must be operated at the patient site by a dental hygienist trained in its operation.

A limited problem-focused oral evaluation (procedure code D0140) may be delivered as a teledentistry service when the following criteria are met:

- The client must be birth through 20 years of age.
- The teledentistry platform must be operated at the patient site by a dental assistant or hygienist trained in its operation.

Synchronous Teledentistry

Real-time encounter procedure code D9995 must be included on the claim form when procedure code D0120 or D0140 is provided as a teledentistry service. Procedure code D9995 is not separately reimbursable.

When procedure code D0120 or D0140 is provided as a teledentistry service, additional documentation in the client's dental record must indicate that the service was provided using synchronous real-time audiovisual technologies. The documentation must include the following:

- The name and credentials of the dental health care professional
- The location of the dentist at the time of service

3.2.11 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

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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.*

3.2.12 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.

3.2.12.1 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 TexMedConnect, the Medicaid Client Portal for Providers, 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 3.2.24.4, "Premature Termination of Comprehensive Orthodontic Treatment" in this handbook.

3.2.13 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/Counseling, and Oral Treatment for Infants, Children, and Adolescents" 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.

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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.

3.2.13.1 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 TexMedConnect, the Medicaid Client Portal for Providers, 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.

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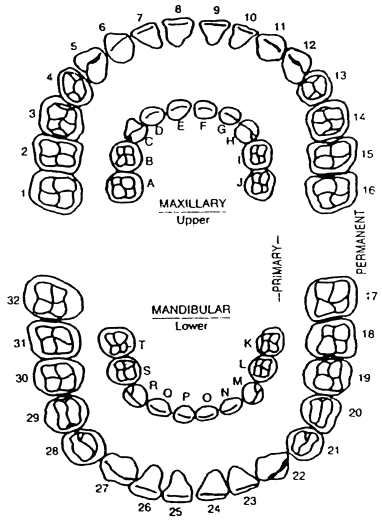
3.2.14 Tooth Identification (TID) and Surface Identification (SID) Systems

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	

3.2.14.1 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

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3.2.15 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 3.3, "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)
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

3.2.16 Restorative Services

Procedure Code	
Amalgam Restorations—Direct (Including Polishing)	
Procedure codes D2140, D2150, D2160, and D2161 are benefits for clients who are 21 years of age or older residing in an ICF-IID facility.	
D2140*	A Birth–20, PXR
D2150*	A Birth–20, PXR
D2160*	A 1–20, PXR
D2161*	A 1–20, 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	
Resin-Based Composite Restorations—Direct	
Resin restoration includes composites or glass ionomer. Procedure codes D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394 are benefits for clients who are 21 years of age or older residing in an ICF-IID facility.	
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 onlays or permanent crowns. Procedure codes D2542, D2543, D2544, and D2662 through D2664 are payable once per client, per tooth every ten years. Additional onlays may be considered with prior authorization and documentation of medical necessity.	
D2510	A 13–20, N, PPXR, CCP
D2520	A 13–20, N, PPXR, CCP
D2530	A 13–20, N, PPXR, CCP
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
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	
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) 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. Additional crowns and onlays may be considered with prior authorization and documentation of medical necessity.	
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
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. Denied if billed with the following procedure codes within one rolling year, same TID, same provider: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663 or D2664.
D2915	A 4–20
D2920	A 1–20, 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	
D2930*	A Birth–20, PXR
D2931*	A 1–20, PXR. A benefit for clients who are 21 years of age and older residing in an ICF-IID facility.
D2932*	A 1–20, PXR (TID #C-H, M-R, and 1-32), all permanent teeth. A benefit for clients who are 21 years of age and older residing in an ICF-IID facility.
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	Limited to two times per lifetime for permanent teeth, same TID, any provider. Additional services will be considered with documentation of medical necessity. 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
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	

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

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

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Procedure Codes									
D2394									

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

Procedure Codes									
D2140	D2150	D2160	D2161	D2330	D2331	D2332	D2335	D2390	D2930
D2932	D2933	D2934							

Total reimbursement for direct restorations on primary teeth cannot exceed the total dollar amount for a prefabricated stainless steel crown on a primary tooth (procedure code D2930) per TID, per date of service.

Total reimbursement for direct restorations on permanent teeth cannot exceed the total dollar amount for a prefabricated stainless steel crown on a permanent tooth (procedure code D2931) per TID, per date of service. This limitation does not apply to procedure code D2335 for primary or permanent teeth.

3.2.16.1 Direct Restorations and Other Restorative Services

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

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

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

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

Procedure Codes								
D2140	D2150	D2160	D2161	D2330	D2331	D2332	D2335	D2390

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

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

3.2.17 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

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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.

Direct pulp caps (procedure code D3110) and indirect pulp caps (procedure code D3120) are a benefit for permanent teeth only (TID 1-32).

Direct pulp caps may be reimbursed when billed with the following procedure codes for the same tooth ID on the same date of service by the same provider.

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

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

Procedure Code	**Limitations**
Pulp Capping	
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. Limited to once per lifetime, per primary tooth (TIDs A-T). Re-treatment claims for an incomplete pulpotomy performed by a dentist not associated with the original treating dentist or dental group will be considered for reimbursement upon appeal. Documentation of medical necessity and the incomplete initial pulpotomy must be submitted with the appeal. The appeal must include a written narrative and pre- and post-treatment X-rays, which will be reviewed by a Texas licensed dentist. ***Note:*** *The identified, original treating dentist or dental group will not be considered for reimbursement.*
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

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
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	

3.2.18 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 on the same claim, for the same date of service, by the same provider.

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.

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

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

Claims for preventive dental procedure codes D1110, D1120, D1206, D1208, D1351, and D1352 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.

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- 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
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	Limited to once per quadrant, per day, same provider. A 13–20, N, FMX, PXR, PC, CCP
D4261	Limited to once per quadrant, per day, same provider. 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
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
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, same provider. 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	
D4341*	Prior authorization is required. Denied when submitted on the same date of service as D4355. Denied when submitted for the same DOS as other D4000 series codes. A 13–20, FMX, PC, N, CCP
D4342	Prior authorization is required. Denied when submitted on the same date of service as D4355. Denied when submitted for the same DOS as other D4000 series codes. A 13–20, PC, FMX, N
D4355*	Denied when submitted for the same DOS as other D4000 series codes. Not payable within 90 days of D4910. 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 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

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3.2.19 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
Adjustments to Dentures	
D5410	A 3–20, PXR
D5411	A 3–20, PXR
D5421	A 6–20, PXR
D5422	A 6–20, PXR
Repairs to Complete Dentures	
D5511	Cost of repairs cannot exceed replacement costs. A 3–20, PXR
D5512	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.	
D5611*	A 3-20, PXR
D5612*	A 3-20, 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, and D5640. A 6–20
D5671*	Will be denied as part of procedure codes D5212, D5214, 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	
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
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
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

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
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
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

Any maxillary denture rebase or reline (procedure codes D5710, D5720, D5730, D5740, D5750, and D5760) will be denied when performed within one rolling year of a maxillary full or partial denture (procedure codes D5110, D5130, D5211 and D5213), any provider.

Any mandibular denture rebase or reline (procedure codes D5711, D5721, D5731, D5741, D5751, and D5761) will be denied when performed within one rolling year of a mandibular full or partial denture (procedure codes D5120, D5140, D5212, and D5214), any provider.

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For an existing full or partial maxillary denture, only one denture rebase or reline procedure (procedure code D5710, D5720, D5730, D5740, D5750 or D5760) may be reimbursed every three rolling years, same provider.

For an existing full or partial mandibular denture, only one denture rebase or reline procedure (procedure code D5711, D5721, D5731, D5741, D5751 or D5761) may be reimbursed every three rolling years, same provider.

3.2.20 Prosthodontic (Fixed) Services

Prosthodontic procedure codes require prior authorization.

Refer to: Subsection 3.2.29, "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).
- 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
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
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
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	

3.2.21 Oral and Maxillofacial Surgery Services

All oral surgery procedures include local anesthesia and visits for routine postoperative care. Suturing is included in oral surgery procedures unrelated to trauma and is not separately reimbursable.

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
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
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. Procedure code D7280 will be denied unless billed with an authorized procedure code D7283 for the same tooth, on the same day, by the same provider.
D7282	Permanent TIDs #1–32 only; may not be paid for the same DOS as D7280. A 4–20
D7283	Requires prior authorization. A 1–20; TIDs #2-15 and 18-31. To obtain prior authorization, the following items must be submitted: a prior authorization request form, a copy of an authorized Medicaid orthodontic treatment plan, and a current panoramic radiograph to determine medical necessity.
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

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
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	
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

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 Repair Procedures	
D7955	A 1–20
D7961	A 12-20. N, PXR
D7962	A 1-20. N, PHO
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

3.2.22 Adjunctive General Services

Procedure Code	Limitations
Unclassified Treatment	
D9110*	Subsection 3.2.22.1, "Benefit Limitations for Adjunctive General Services" in this handbook for benefit limitations. 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. Each claim submitted for payment must be marked as "Emergency" in the Description field, Block 30, and the original date of treatment or incident must be referenced in the "Remarks" field, Block 35. The appropriate box must be checked in the "Treatment Resulting From" field, Block 45, if applicable, and modifier ET must be used to indicate an emergency. Documentation to support the emergency and the treatment performed must be maintained in the client's dental medical record. Subsection 3.2.27, "Emergency or Trauma Related Services for All THSteps Clients and Clients Who Are 5 Months of Age and Younger" in this handbook
D9120	A 13-20, N, PXR
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, on the same day, any provider. 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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Procedure Code	Limitations
D9211*	Denied if submitted with D9248, on the same day, any provider. A 1–20, N, CCP
D9212*	Denied if submitted with D9248, on the same day, any provider. A 1–20, N, CCP
D9222	Primary procedure code indicating first 15 minutes of deep sedation/general anesthesia. Limited to once per six calendar months, any provider. Prior authorization is required for clients who are six years of age or younger. Providers who do not have proof of anesthesiology residency on file with TMHP will still be eligible for reimbursement. A 1–20
D9223	Prior authorization is required. Add on procedure code indicating additional 15 minute increments of deep sedation/general anesthesia. Limited to two hours and forty five minutes per day, and once per six calendar months, any provider. Denied if submitted with D9248. Providers who do not have 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, on the same day, any provider. A 1–20.
D9239	Primary procedure code indicating first 15 minutes of intravenous moderate (conscious) sedation. Limited to 15 minutes per day, same provider. Denied if submitted with D9222, on the same day, any provider. A 1-20
D9243	Add-on procedure code indicating additional 15 minute increments of intravenous moderate (conscious) sedation. Limited to one hour and fifteen minutes per day, same provider. Must be billed with procedure code D9239. Denied if submitted with D9248. A 1–20
D9248*	May be submitted twice within a 12-month period. Denied if submitted with D9222, D9239, D9420, and D9920, any provider. Additional services may be considered with prior authorization and documentation of medical necessity. 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	Limited to twice per rolling year, per client, any provider. Documentation supporting the medical necessity of a dental hospital call, including any medical, physical, (e.g.,traumatic event), mental or behavioral disability, and a description of the service performed that requires a hospital call must be retained in the client's dental record and will be subject to retrospective review. Charts are subject to retrospective review. 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
D9440	Visits for routine postoperative care are included in all therapeutic and oral surgery fees. A 1–20, N
Drugs	
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
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. The *Outpatient Drug Services Handbook* (*Vol. 2, Provider Handbooks*).	
D9610	May not be submitted with code D9248. A 1–20, N
D9612	Prior authorization is required. Limited to two times per rolling year, any provider. A 13-20, N, PXR
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. Not to be used for bases, liners, or adhesives under or with restorations. Limited to once per six months, any provider. 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. A 1–20
D9930*	Prior authorization is required. A 1–20, N
D9944	A 16-20, N, CCP
D9950	A 13–20, N, CCP
D9951	Full mouth procedure. Limited to once every three rolling years, per client, any provider. A 13–20, N, CCP
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	

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3.2.22.1 Benefit Limitations for Adjunctive General Services

Procedure code D9110 is a benefit for the following:

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

Procedure code D9110 is not a benefit for the following:

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

3.2.23 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.
- Providers must have a Level 4 permit and an anesthesiology residency recognized by the American Dental Board of Anesthesiology to bill the enhanced rate for procedure codes D9222 and 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.

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3.2.23.1 Anesthesia Permit Levels

The following table shows the levels of anesthesia permits that are issued by the TSBDE:

Permit Level	Description of Level	Permit Privileges
Nitrous oxide/oxygen inhalation conscious sedation		Stand-alone permit
Level 1	Minimal sedation	Stand-alone permit
Level 2	Moderate enteral	Automatically qualifies for Level 1 and Level 2 permit privileges
Level 3	Moderate parenteral	Automatically qualifies for Level 1, Level 2, and Level 3 permit privileges
Level 4	Deep sedation/general anesthesia	Automatically qualifies for Level 1, Level 2, Level 3, and Level 4 permit privileges

All providers must have the appropriate anesthesia permit when proceeding with the procedure codes in the table below. 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
D9222	Level 4
D9223	Level 4
D9230	Stand-alone permit for nitrous oxide/oxygen inhalation conscious sedation or Level 1
D9239	Level 3
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.

3.2.23.2 Method for Counting Minutes for Timed Procedure Codes

All claims for reimbursement of procedure codes paid in 15-minute increments are based on the actual amount of billable time associated with the service. For those services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units should be rounded up or down to the nearest quarter hour.

Time intervals for 1 through 12 units are as follows:

Units	Number of Minutes
0 units	0 minutes through 7 minutes
1 unit	8 minutes through 22 minutes
2 units	23 minutes through 37 minutes
3 units	38 minutes through 52 minutes
4 units	53 minutes through 67 minutes
5 units	68 minutes through 82 minutes
6 units	83 minutes through 97 minutes

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Units	Number of Minutes
7 units	98 minutes through 112 minutes
8 units	113 minutes through 127 minutes
9 units	128 minutes through 142 minutes
10 units	143 minutes through 157 minutes
11 units	158 minutes through 172 minutes
12 units	173 minutes through 187 minutes

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

3.2.24 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.
- 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 3.2.13.1, "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.

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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.*

3.2.25 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
- Post-head trauma injury involving the oral cavity
- Skeletal anomalies involving the oral cavity

A severe handicapping malocclusion is defined by Texas Medicaid as an occlusion that is severely functionally compromised and is described in detail in levels I, II, and III.

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:

- 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, clients who are 14 years of age and younger must be accompanied to Texas Health Steps dental checkups and visits by the client's parent, legal guardian, or another adult who is authorized by the parent or legal guardian. The authorized adult can be the client's relative. The individual accompanying the client must wait for the client while the appointment takes place.

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.

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- 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.

Texas Medicaid recognizes three orthodontic service levels for severe handicapping malocclusion. Each service level requires a different amount of time for treatment.

Level I Orthodontic Services

Level I orthodontic services are dedicated to resolution of early signs of handicapping malocclusion in the early mixed dentition, which may significantly impact the health of the developing dentition, alveolar bone, and symmetrical growth of the skeletal framework.

Mixed dentition is defined by Texas Medicaid as a presence of the maxillary and mandibular permanent molars, and the maxillary and mandibular incisors fully erupted, and deciduous teeth.

Exceptions for cases of mixed dentition may be considered when the treatment plan includes extractions of the remaining primary teeth or in the case of a cleft palate.

Evidence of one of the following conditions should be clearly visible and submitted in the supporting documentation:

- An anterior crossbite that is associated with clinically apparent severe gingival inflammation and/or gingival recession or severe enamel wear
- A posterior crossbite with an associated midline deviation and asymmetric closure pattern
- Dental crossbites other than those described above will not be eligible for treatment in level I. However, special orthodontic appliances are a benefit for minor treatment to control harmful habits.

Procedure codes D8210 and D8220 may be reimbursed for level I orthodontic services.

Level II Orthodontic Services

Level II orthodontic services are dedicated to the resolution of handicapping malocclusion in the transitional dentition, which is the final phase of the transition from primary to adolescent dentition during which the succedaneous permanent teeth are emerging or about to emerge.

Providers must use the appropriate procedure code that is applicable for banding when billing for level II orthodontic services.

Procedure codes D8010, D8020, and D8070 may be reimbursed for level II orthodontic services.

Level III Orthodontic Services

Level III orthodontic services are dedicated to resolution of handicapping malocclusion in the adolescent dentition, which is indicated by the complete eruption of the permanent dentition with the possible exception of the full eruption of the second molars.

Procedure code D8080 may be reimbursed for level III orthodontic services.

Completion or Premature Termination of Orthodontic Services

The completion of orthodontic services includes the construction of both maxillary and mandibular retainers in addition to the removal of all bands, brackets, and appliances.

Premature termination of orthodontic services includes all the following:

- The removal of brackets and arch wires
- The use of other special orthodontic appliances

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- The fabrication of special orthodontic appliances
- The delivery of orthodontic retainers

Procedure code D8680 may be reimbursed for the completion or premature termination of orthodontic services.

3.2.25.1 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, D0150, or D0160).

3.2.25.2 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.

ADA CDT 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).

3.2.25.3 Orthodontic Procedure Codes and Limitations

When submitting claims for orthodontic procedures, use the following procedure codes:

Procedure Code	Limitations
Orthodontic Services	
D0330*, D0340*, D0350*, D0470*, and D8660	Denied when submitted with procedure codes D8070 and D8080.
D7280	A 1-20
D7997*	Not payable to the dentist who placed the appliance. Includes removal of arch bar and premature removal of braces. A 1-20
Limited Orthodontic Treatment	
D8010*	Replaces D8050. Limited to one per lifetime, any provider.
D8020*	Replaces D8060. Limited to one per lifetime, any provider.
Comprehensive Orthodontic Treatment	
D8070	Limited to one per lifetime, any provider.
D8080*	Limited to one per lifetime, any provider.
Minor Treatment to Control Harmful Habits	
D8210*	Limited to once per arch, per lifetime, any provider.
D8220*	Limited to once per arch, per lifetime, any provider.
Other Orthodontic Services	
*** = Services payable to an FQHC for a client encounter.**	

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Procedure Code	Limitations
D8660*	Denied when submitted for the same DOS as D0145 by any provider. Denied when submitted for the same DOS as D0120, D0150, or D0160 by the same provider. Denied when submitted with procedure codes D8070 and D8080.
D8670*	Limited to one service per calendar month, same provider.
D8680*	One retainer per arch per lifetime, any provider. May be replaced once because of loss or breakage (prior authorization is required).
D8999	
*** = Services payable to an FQHC for a client encounter.**	

The diagnostic workup is considered part of the pre-orthodontic visit (procedure code D8660). Reimbursement for the pre-orthodontic visit (procedure code D8660) may be considered when all bands, brackets, and appliances have been placed and active treatment has been initiated.

The orthodontic diagnostic workup procedures are considered part of the services provided under procedure codes D8210 and D8220 and are not reimbursed separately.

Panoramic radiographic images (procedure code D0330), cephalometric radiographic images (procedure code D0340), oral or facial photographic images obtained intraorally or extraorally (procedure code D0350), and diagnostic models (procedure code D0470) will be denied when billed with procedure code D8210 or D8220.

The orthodontic diagnostic workup procedures are considered part of the services provided under procedure codes D8010 or D8020 and are not reimbursed separately. Panoramic radiographic images (procedure code D0330), cephalometric radiographic images (procedure code D0340), oral or facial photographic images obtained intraorally or extraorally (procedure code D0350), and diagnostic models (procedure code D0470) will be denied when billed with procedure code D8010 or D8020.

Procedure code D0160 will be denied when submitted on the same date of service as procedure code D8080.

Cleft or craniofacial cases are eligible for more than one level of orthodontic services (level II and level III) per lifetime.

Procedure codes D8660 and D8670 may be reimbursed for additional comprehensive orthodontic services.

The length of treatment depends on the level of orthodontic services that the client receives as indicated below:

- Level I allows up to 10 monthly visits that are expected to be completed within 12 months unless an exception is authorized.
- Level II allows up to 22 monthly visits that are expected to be completed within 24 months unless an exception is authorized.
- Level III allows up to 22 monthly visits that are expected to be completed within 36 months unless an exception is authorized.

3.2.26 Submitting Local Codes for Orthodontic Procedures

To ensure appropriate claims processing, the local code reflecting the specific service is required on the claim.

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For electronic submissions other than TexMedConnect submissions, providers must follow the steps below to ensure the correct local code is accurately applied to the appropriate claim detail:

1) Submit the DPC prefix in the first three bytes of NTE02 at the 2400 loop. Submit the DPC prefix only once.
2) Submit the remarks code (local code) in bytes 4–8, based on the order of the claim detail. Do not enter any spaces or punctuation between remarks codes unless to designate that the detail is not billed with procedure code D8210 or D8220.

   Example: *For a claim with three details, where details 1 and 3 are submitted with procedure code D8210 and detail 2 is not, enter the following information in the NTE02 at the 2400 loop: DPC1014D 1046D (The space shows that detail 2 needs no local code.)*

   Example: *If all three details require a local code, enter DPC and the appropriate local codes in sequence without any spaces between the codes: DPC1024D1055D1056D (The absence of spaces indicates that local codes are needed for all three details.)*

To submit using TexMedConnect, enter the local code into the Remarks Code field located under the Details header. The Remarks Code field is the field following the Procedure Code field. TexMedConnect submitters are not required to enter the DPC prefix because it is automatically placed in the appropriate field on the TexMedConnect electronic claim.

For paper claim submissions, providers must enter the local code in the Remarks section of the claim form.

Failure to follow the above steps does not cause the claim to be denied; however, manual intervention is required to process the claim, and a delay of payment may be the result.

Orthodontic procedure codes that were local codes used for prior authorization and reimbursement have been converted to Current Dental Terminology (CDT) (national) procedure codes.

The following procedures are not included in comprehensive treatment:

CDT Procedure Code	Remarks Code	Description
D8660	Z2009	Initial orthodontic visit
D8670	Z2013	Orthodontic adjustments, per month
D7997*	Z2016	Premature appliance removal, per arch
***May only be paid to a provider not billing for comprehensive treatment.**		

Procedure code D8080 is a comprehensive code and includes a diagnostic workup as well as all upper and lower orthodontic appliances (braces) necessary to treat the client.

CDT Procedure Code	Remarks Code	Description
D8080	Z2009 *or* Z2011 *or* Z2012	Diagnostic workup, approved *or* Orthodontic appliance, upper (braces) *or* Orthodontic appliance, lower (braces)

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When a diagnostic workup is not approved, individual components may be considered for separate reimbursement. Use the following procedure codes:

CDT Procedure Code	Remarks Code	Description
D0330	Z2010	Diagnostic workup, not approved
D0340	Z2010	Diagnostic workup, not approved
D0350	Z2010	Diagnostic workup, not approved
D0470	Z2010	Diagnostic workup, not approved

Procedure code D8680 includes all retainers necessary to treat the client. Use the following remarks codes according to the services provided:

Remarks Code	Description
1033D	Mandibular, fixed, 2x4 retainer
1034D	Mandibular, fixed, 3x3 retainer
1035D	Mandibular, fixed, 4x4 retainer
Z2014	Orthodontic retainer, upper
Z2015	Orthodontic retainer, lower

Procedure code D8010 includes a crossbite workup and removable appliance. Use the following remarks codes according to the services provided:

Remarks Code	Description
8110D	Crossbite therapy, removable appliance
Z2018	Crossbite, workup

Procedure code D8020 includes a crossbite workup and the fixed appliance. Use the following remarks codes according to the services provided:

Remarks Code	Description
8120D	Crossbite therapy, fixed appliance
Z2018	Crossbite, workup

The orthodontic diagnostic workup procedures are considered inclusive procedures. Procedure codes D0330, D0340, D0350, and D0470 are denied when billed with a diagnostic workup procedure.

The following tables display the special fixed and removable orthodontic appliances. Under the current provisions of the Health Insurance Portability and Accountability Act (HIPAA), all fixed appliances are designated as procedure code D8220, and all removable appliances are designated as procedure code D8210. These are entered as a line item on the paper American Dental Association (ADA) Dental Claim Form with the appropriate fee. However, the remarks codes (former local procedure codes), as appropriate and listed below, also need to be entered on the authorization request form and in the Remarks field of the dental claim form (paper and electronic) to ensure correct authorization, accurate records, and reimbursement. *Failure to bill the correct procedure codes may result in claim processing delays.*

Note: *Prior authorization must be requested using both the CDT procedure code and the remarks codes for orthodontia services.*

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Use the following remarks codes in the Remarks field for fixed appliances (procedure code D8220):

Remarks Code	Fixed Appliances Description
1000D	Appliance for horizontal projections
1001D	Appliance for recurved springs
1002D	Arch wires for crossbite correction, for total treatment
1003D	Banded maxillary expansion appliance
1008D	Bonded expansion device
1012D	Crib
1015D	Distalizing appliance with springs
1016D	Expansion device
1018D	Fixed expansion device
1019D	Fixed lingual arch
1020D	Fixed mandibular holding arch
1021D	Fixed rapid palatal expander
1025D	Herbst appliance, fixed or removable
1026D	Interocclusal cast cap surgical splints
1028D	Jasper jumpers
1029D	Lingual appliance with hooks
1030D	Mandibular anterior bridge
1031D	Mandibular bihelix, similar to a quad helix for mandibular expansion to attempt nonextraction treatment
1036D	Mandibular lingual, 6x6, arch wire
1042D	Maxillary lingual arch with spurs
1043D	Maxillary and mandibular distalizing appliance
1044D	Maxillary quad helix with finger springs
1045D	Maxillary and mandibular retainer with pontics
1049D	Modified quad helix appliance
1050D	Modified quad helix appliance, with appliance
1051D	Nance stent
1052D	Nasal stent
1057D	Palatal bar
1058D	Post surgical retainer
1059D	Quad helix appliance held with transpalatal arch horizontal projections
1060D	Quad helix maintainer
1061D	Rapid palatal expander (RPE), i.e., quad helix, haas, or menne
1068D	Stapled palatal expansion appliance
1072D	Thumb sucking appliance, requires submission of models
1076D	Transpalatal arch

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Remarks Code	Fixed Appliances Description
1077D	Two bands with transpalatal arch and horizontal projections forward
1078D	W-appliance

Use the following remarks codes in the Remarks field for removable appliances (procedure code D8210):

Remarks Code	Removable Appliances Description
1004D	Bite plate/bite plane
1005D	Bionator
1006D	Bite block
1007D	Bite plate with push springs
1010D	Chateau appliance (face mask, palatal expander, and hawley)
1011D	Coffin spring appliance
1013D	Dental obturator, definitive (obturator)
1014D	Dental obturator, surgical (obturator, surgical stayplate, immediate temporary obturator)
1017D	Face mask (protraction mask)
1022D	Frankel appliance
1023D	Functional appliance for reduction of anterior open bite and crossbite
1024D	Head gear (face bow)
1027D	Intrusion arch
1032D	Mandibular lip bumper
1037D	Mandibular removable expander with bite plane (crozat)
1038D	Mandibular ricketts rest position splint
1039D	Mandibular splint
1040D	Maxillary anterior bridge
1041D	Maxillary bite-opening appliance with anterior springs
1046D	Maxillary Schwarz
1047D	Maxillary splint
1048D	Mobile intraoral arch (MIA), similar to a bihelix for nonextraction treatment
1053D	Occlusal orthotic device
1054D	Orthopedic appliance
1055D	Other mandibular utilities
1056D	Other maxillary utilities
1062D	Removal bite plane
1063D	Removable mandibular retainer
1064D	Removable maxillary retainer
1065D	Removable prosthesis

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Remarks Code	Removable Appliances Description
1066D	Sagittal appliance, 2-way
1067D	Sagittal appliance, 3-way
1069D	Surgical arch wires
1070D	Surgical splints (surgical stent/wafer)
1071D	Surgical stabilizing appliance
1073D	Tongue thrust appliance, requires submission of models
1074D	Tooth positioner, full maxillary and mandibular
1075D	Tooth positioner with arch

The following procedure codes are used to bill orthodontic services:

ADA Procedure Codes									
D7997	D8010	D8020	D8070	D8080	D8210	D8220	D8660	D8670	D8680
D8999									

3.2.27 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.*

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Refer to: Subsection 6.7, "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 9.4, "Doctor of Dentistry Practicing as a Limited Physician" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 3.2.15, "Medicaid Dental Benefits, Limitations, and Fee Schedule" in this handbook.

3.2.28 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 9.4, "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.

3.2.28.1 Long Term Care (LTC) Emergency Dental Services

HHSC 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 HHSC. For information, providers should contact the appropriate LTC facility or HHSC at 1-800-252-9240.

3.2.28.2 Laboratory Requirements

Dental laboratories must be registered with TSBDE laboratories, and technicians must not be under restrictions imposed by TSBDE or a court.

3.2.29 Mandatory Prior Authorization

Mandatory prior authorization is required for consideration of reimbursement to dental providers who render the following services:

- Orthodontia
- Endodontic endosseous implants
- Fixed prosthetic services
- Removable prosthodontics (procedure codes D5951, D5952, D5953, D5954, D5955, D5958, D5959, and D5960)
- Dental general anesthesia
- All inlays/onlays or permanent crowns
- Procedure code D4276
- Nonsurgical periodontal service (procedure codes D4341 and D4342)
- Procedure code D7272
- Procedure code D7283
- Procedure code D7472

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- 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, endodontic endosseous 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.
- 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 9.4, "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.

3.2.29.1 Cone Beam Imaging

Prior authorization is required for procedure code D0367.

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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

3.2.29.2 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 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.

3.2.29.2.1 Dental Therapy Under General Anesthesia

Providers must comply with TSBDE Rules and Regulations, Title 22 TAC, Part 5, Chapter 110, §§110.6 –110.10. 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.

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

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

Dental general anesthesia using procedure code D9222, D9223, or 00170 with modifier U3 is limited to once per six calendar months per client, by any provider. Add-on procedure code D9223 must be billed in conjunction with primary procedure code D9222, same provider.

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Each distinct dental procedure code to be performed that requires prior authorization must be listed on the Texas Health Steps Dental Mandatory Prior Authorization Request Form. Repetitive dental procedure codes must be listed to indicate the total quantity to be performed.

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

- A completed Criteria for Dental Therapy Under General Anesthesia form
- A completed THSteps Dental Mandatory Prior Authorization Request Form
- The location of where the procedure(s) will be performed (office, inpatient hospital, or outpatient hospital)
- A narrative unique to the client, detailing the reasons for the proposed level of sedation (indicate procedure code D9222, D9223, or 00170). The narrative must include a history of prior treatment, information about failed attempts at other levels of sedation, behavior in the dental chair, proposed restorative treatment (tooth ID and surfaces), urgent need to provide comprehensive dental treatment based on extent of diagnosed dental caries, and any relevant medical condition(s).
- Diagnostic quality radiographs or photographs

  Note: *When appropriate radiographs or photographs cannot be taken prior to general anesthesia, the narrative must support the reasons for an inability to perform diagnostic services. For special cases that receive authorization, diagnostic quality radiographs or photographs will be required for payment and will be reviewed by the TMHP dental director.*

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

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

A copy of the Criteria for Dental Therapy Under General Anesthesia form must be maintained in the client's dental record. The client's dental record must be available for review by representatives of the Health and Human Services Commission (HHSC) or its designee.

Prior authorization is required for medically necessary dental general anesthesia that exceeds once per six months, per client, any 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 may be performed in an office, inpatient, or outpatient facility.

Surgical services related to THSteps dental services requiring general anesthesia must be coded as follows:

- Procedure code 00170 with modifier U3 is for the anesthesiologist or certified registered nurse anesthetist (CRNA) to use on the claim form.
- Procedure code G0330 may be reimbursed for facility services in the outpatient hospital setting to ASCs and Hospital-based Ambulatory Surgical Centers (HASCs) for dental rehabilitation procedure(s) performed on a client who requires monitored anesthesia (e.g., general, intravenous sedation and the use of an operating room).
- An appropriate diagnosis code must be used on the claim form.

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- Modifier U3 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.

The dental provider must include dental procedure codes and modifiers on the Texas Health Steps Dental Mandatory Prior Authorization Request Form for prior authorization to be considered for any Texas Health Steps dental services.

3.2.29.3 Orthodontic Services

Prior authorization is required for all levels of orthodontic services. Prior authorization includes the number of monthly visits and expected completion time according to the corresponding treatment level.

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.

Level I Orthodontic Services

The following documentation must be submitted with the prior authorization request for level I orthodontic services (procedure code D8210 or D8220):

- Radiographs (X-rays)
- Photographs
- Treatment plan

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- Narrative of medical necessity

The completion of level I orthodontic services does not disqualify future level II or level III orthodontic services.

Level I orthodontic services will not be prior authorized if there is an indication that the client will qualify for level II or level III orthodontic services in the future.

Level II Orthodontic Services

The following documentation must be submitted with the prior authorization request for level II orthodontic services (procedure codes D8010, D8020, and D8070):

- Digital diagnostic models or other type of 3D diagnostic images
- Radiographs (X-rays)
- Cephalometric radiographic image with tracings
- Photographs
- Treatment plan
- Narrative of medical necessity

Evidence of four of the following conditions must be submitted in the supporting documentation:

- Full cusp class II malocclusion with the distal buccal cusp of the maxillary first molar occluding in the mesial buccal groove of the mandibular first molar
- Full cusp class III malocclusion with the maxillary first molar occluding in the embrasure distal to the mandibular first molar or on the distal incline of the mandibular molar distal buccal cusp
- Overbite measurement of more than 5 mm
- Overjet measurement of more than 8 mm
- More than four congenitally absent teeth, including at least one anterior tooth
- Anterior crowding of more than 6 mm in the mandibular arch
- Anterior crossbite of at least two of the four maxillary incisors
- Generalized spacing in both arches of more than 6 mm in each arch
- Early impacted maxillary canine or mandibular canines, supported by radiographs indicating a severe mesial angulation of the erupting canine and the crown of the canine superimposed on and crossing the image of the maxillary lateral incisor

Level III Orthodontic Services

The following documentation must be submitted with the prior authorization request for level III orthodontic services (procedure code D8080):

- Digital diagnostic models or other type of 3D diagnostic images
- Radiographs (X-rays)
- Cephalometric radiographic image with tracings
- Photographs
- Treatment plan
- Narrative of medical necessity

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Evidence of four of the following conditions must be submitted in the supporting documentation:

- Full cusp class II malocclusion with the distal buccal cusp of the maxillary first molar occluding in the mesial buccal groove of the mandibular first molar
- Full cusp class III malocclusion with the maxillary first molar occluding in the embrasure distal to the mandibular first molar or on the distal incline of the mandibular molar distal buccal cusp
- Anterior tooth impaction: unerupted with radiographic evidence to support a diagnosis of impaction (lack of eruptive space, angularly malposed, and totally imbedded in the bone) as compared to ectopically erupted anterior teeth that may be malposed but have erupted into the oral cavity and are not a qualifying element
- Anterior crowding of more than 6 mm in the mandibular arch
- Anterior open bite demonstrating that all maxillary and mandibular incisors have no occlusal contact and are separated by a measurement more than 6 mm
- Posterior open bite should demonstrate a vertical separation by a measurement more than 5 mm for several posterior teeth, not to be confused with the delayed natural eruption of a few teeth
- Posterior crossbite with an associated midline deviation and mandibular shift, a Brodie bite with a mandibular arch totally encumbered by an overlapping buccally occluding maxillary arch, or a posterior maxillary arch totally lingually malpositioned to the mandibular arch
- Anterior crossbite should include more than two incisors in crossbite and demonstrate gingival inflammation, gingival recession, or severe enamel wear
- Overbite of more than 5 mm
- Overjet of more than 8 mm

Additional Services

There may be exceptional circumstances that require additional treatment time, including but not limited to cases of craniofacial anomalies and cleft palate. Prior authorization for additional services will be reviewed and evaluated on an individual basis for medical necessity.

Prior authorization requests for additional services (procedure code D8670) must include the following:

- The reason for the additional monthly visits and the number of visits requested
- The name of the additional appliance in the case of a cleft palate treatment plan, if needed
- Recent radiographs (X-rays) showing the progress made to date
- Current photographs
- Current treatment plan

Additional treatment months may be considered for one of the following circumstances:

- The client is a child of a migrant farm worker.
- The client's orthodontic services were delayed because the client was temporarily in state custodial care (foster care).

Completion of All Levels of Orthodontic Services

Prior authorization is required for the completion of treatment (last payment) and must be reviewed for proof of the completion of the case.

A prior authorization request for the completion of level II or level III (procedure code D8680) services must include the following:

- A post-treatment panoramic radiographic image

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- Photographs
- A signed statement from the treating provider that the treatment is complete

3.2.29.3.1 Premature Termination of Orthodontic Services

Prior authorization for the premature termination of orthodontic services (procedure code D8680) is required.

The prior authorization must include all of the following for consideration:

- A release form (or a copy) that must be signed by the parent or legal guardian or by the client if they are 18 years of age or older or an emancipated minor.
- Documentation of one of the following:
  - The client is uncooperative or noncompliant.
  - The client requested the removal of orthodontic appliances.
  - The client requested the removal of appliances due to exceptional circumstances, such as incarceration.
  - The client has mental health complications with a recommendation from the treating physician.
  - The client is in a foster care placement.
  - The client is a child of a migrant farm worker and intends to complete treatment later if Medicaid eligibility for orthodontic services continues.

3.2.29.3.2 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
- 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.

3.2.29.3.3 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.

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3.2.30 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 following table:

Correspondence	Address
ADA dental claim forms	Texas Medicaid & Healthcare Partnership PO Box 200555 Austin, TX 78720-0555
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

3.3 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.

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- 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.
- 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.

3.3.1 General Anesthesia

When proceeding with Level 4 sedation/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 client's dental record as a stand alone form

3.4 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.

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Refer to: 25 TAC, §33.72 for more information about utilization review.

3.5 Claims Filing and Reimbursement

3.5.1 Reimbursement

The Medicaid rates for dentists are calculated as access-based fees in accordance with 1 TAC §§355.455(b), 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/resources/rate-and-code-updates.

3.5.2 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*).

3.5.3 Third Party Liability

Refer to: "Section 8: Third Party Liability (TPL)" (*Vol. 1, General Information*).

3.5.4 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/publications/cdt/ada-dental-claim-form.

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 NPI 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 NPI is issued, and within 365 days of the DOS.

Providers should submit claims to Texas Medicaid for their usual and customary fees.

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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 3.2.7.2, "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.

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 1.7.12, "Billing Clients" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

3.5.5 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 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 7.1.5, "Paper Appeals" in "Section 7: Appeals" (*Vol. 1, General Information*).

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.*

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 7.1.5, "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.

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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 received. The provider is urged to retain copies of multiple claim submissions if the NPI is pending.

   Note: *Claims submitted by newly-enrolled providers must be received within 95 days of the date the new NPI 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
12365-A Riata Trace Parkway
Austin, TX 78727-6418

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.

3.5.6 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.

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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 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 *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 NPIs.

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 NPI 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 NPI.

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.
- 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.

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- 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.
- Prior authorization is required for clients who are 7 through 20 years of age that are in need of general anesthesia and do not meet the Criteria for Dental Therapy Under General Anesthesia requirements (22 point threshold). Prior authorization is required for medically necessary dental general anesthesia that exceeds once per six months, per client, any provider. The dentist providing therapeutic services under general anesthesia is responsible for obtaining prior authorization for both services.
- General anesthesia (provided in the dentist office, ambulatory service clinic, and inpatient/outpatient hospital settings) does not require prior authorization for clients who are 7 through 20 years of age, 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 1.7.12.1, "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.

4 THSteps Medical

4.1 THSteps Medical and Dental Administrative Information

4.1.1 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.texas.gov/contact-us.

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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.

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.

4.1.2 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 this handbook.
- Requirements for Reporting Abuse or Neglect, as outlined in subsection 1.7.1, "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" in this handbook for more information.

4.1.3 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.

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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 follow-up regarding family and client needs. For more information about eligibility and client referral, see subsection 3.1.1, "Eligibility" in the *Behavioral Health and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*) or subsection 3.1.2, "Referral Process" in the *Behavioral Health 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 Texas Health Steps 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

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is available in Section 2, "Medicaid Title XIX Family Planning Services". 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 Health and Human Services Office of the Ombudsman at 1-877-787-8999 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.
- *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 , "Table of Contents" for more information about referrals.

4.1.4 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 4.3.11, "THSteps Medical Checkups Periodicity Schedule" in this handbook on the THSteps Periodicity Schedule.

Subsection 4.3.12, "Mandated Components" in this handbook for additional information on checkup components.

4.1.5 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.

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4.2 Enrollment

4.2.1 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.

Refer to: Subsection 1.1, "Provider Enrollment" 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, must be enrolled in Texas Medicaid, but do not have to be enrolled as a THSteps provider:

- A federal qualified health center (FQHC)
- A rural health clinic (RHC)

The following provider types may provide THSteps preventive services within his or her scope of practice and must be enrolled in Texas Medicaid 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 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.

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4.2.1.1 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 RN's as well as other medical disciplines. Required THSteps online education modules are available on the RN Information page of the THSteps website. The RN or the RN's employer must maintain documentation that the required modules were completed.

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 4.2.1, "THSteps Medical Provider Enrollment" in this handbook for more information about enrollment procedures.

4.3 Services, Benefits, Limitations, and Prior Authorization

4.3.1 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.

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 TexMedConnect, the Medicaid Client Portal for Providers, 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 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.

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 4.3.6, "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.

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Refer to: Subsection 4.3.7, "Exception-to-Periodicity Checkups" in this handbook for additional details about billing for a checkup performed as an exception-to-periodicity checkup.

4.3.2 Prior Authorization

Prior authorization is not required for preventive care medical checkups.

4.3.3 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.

4.3.4 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.

4.3.5 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.

4.3.6 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.

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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, mental health screening for adolescents, postpartum depression screening, tuberculin skin test (TST), developmental and autism screening, vaccine administration, and oral evaluation and flouride varnish (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 4.3.12.1.3, "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.hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/texas-health-steps/medical-providers.

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
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, required condition indicators, and the resulting referral status for medical checkups. Condition indicators must be used in addition to a provider type modifier at each THSteps checkup. A condition indicator must be submitted on the claim with the periodic medical checkup procedure code. Condition indicators are required whether a referral was made or not. If a referral is made, then providers must use the Y referral status. If no referral is made, then providers must use the N referral status.

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Procedure Codes	Condition Indicators	Referral Status
99381, 99382, 99383, 99384, and 99385 (new client preventive visit) -or- 99391, 99392, 99393, 99394, and 99395 (Established client preventive visit)	NU (not used)	N (no referral given)
99381, 99382, 99383, 99384, and 99385 (new client preventive visit) -or- 99391, 99392, 99393, 99394, and 99395 (established client preventive visit)	S2 (under treatment) or ST* (new services requested)	Y (yes THSteps or EPSDT referral was given to the client)
*** 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 following table:

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.

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, mental health screening for adolescents, postpartum depression screening, TST, blood lead test, and OEFV. When

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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)" for information related to billing.

Section 7, "Rural Health Clinic" 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 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 NPI 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 for a claim form example.

THSteps Preventive Visit Checkup with Immunization and Vaccine Administration on the TMHP website at www.tmhp.com for a claim form example.

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4.3.7 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.*

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.

4.3.8 Medical Checkups During a Declaration of State Disaster

During a Declaration of State Disaster, Health and Human Services Commission (HHSC) may issue direction to providers regarding the use of telemedicine or telehealth services to include the use of synchronous telephone (audio-only) platform to provide coverage of services outside of the allowances

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described herein. A Declaration of State of Disaster is when an executive order or proclamation by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

The following limitations apply to all THSteps preventive medical checkups and exception-to-periodicity checkups during a Declaration of State Disaster when HHSC issues direction regarding the use of synchronous audiovisual and synchronous telephone (audio-only) technologies:

- Clients who are 2 years through 20 years of age may receive a THSteps medical checkup or exception-to-periodicity checkup using synchronous audiovisual or synchronous telephone (audio-only) technologies.
- Clients from birth through 2 years of age may not receive a THSteps checkup or exception-to-periodicity checkup using synchronous audiovisual or synchronous telephone (audio-only) technologies.
- Clients from birth through 24 months of age must receive in-person checkups.

A medical checkup provided using synchronous audiovisual or synchronous telephone (audio-only) technologies must be completed according to the age-specific checkup requirements listed on the THSteps Periodicity Schedule.

Synchronous audiovisual delivery for medical checkups is preferred over synchronous telephone (audio-only) delivery.

An in-person THSteps follow-up visit must be completed within six months of the synchronous audiovisual or synchronous telephone (audio-only) checkup in order for the checkup to be considered a complete THSteps checkup.

When HHSC issues direction, the following THSteps medical checkup services are authorized for delivery using synchronous audiovisual or synchronous telephone (audio-only) technologies during a Declaration of State Disaster:

Procedure Codes									
99382*	99383	99384	99385	99392*	99393	99394	99395		
*** Limited to checkups for clients who are over 24 months of age and who received their 24-month checkup in-person.**									

Medical checkups and exception-to-periodicity checkups provided using synchronous audiovisual or synchronous telephone (audio-only) technologies are limited to checkups for clients who are over 24 months of age for the following procedure codes:

Procedure Codes									
99382	99383	99384	99385	99392	99393	99394	99395		

Medical checkups for clients who are 2 years of age or younger must be completed in-person and may not be completed using synchronous audiovisual or synchronous telephone (audio-only) technologies (procedure codes 99381, 99382, 99391 and 99392).

THSteps providers should use their clinical judgement regarding which checkup components may be appropriate for completion using synchronous audiovisual or synchronous telephone (audio-only) technologies.

THSteps providers are encouraged to ensure that clients receiving a medical checkup using synchronous audiovisual or synchronous telephone (audio-only) technologies receive age-appropriate vaccines and laboratory screenings in a timely manner.

Medical checkup services using synchronous audiovisual or synchronous telephone (audio-only) technologies should only be provided if agreed to by the client or parent/guardian.

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Refer to: The *Telecommunication Services Handbook (Vol. 2, Provider Handbooks)* for more information on restrictions for services delivered by synchronous telephone (audio-only) technologies.

4.3.8.1 THSteps Required Follow-up Visit

An in-person follow-up visit (procedure code 99211) is required for all clients who receive an initial synchronous audiovisual or synchronous telephone (audio-only) checkup.

The in-person follow-up visit (procedure code 99211) is required within six months of the synchronous audiovisual or synchronous telephone (audio-only) checkup.

All age-appropriate checkup components noted on the THSteps Periodicity Schedule that are not completed during the synchronous audiovisual or synchronous telephone (audio-only) checkup must be completed at the in-person follow-up visit (procedure code 99211).

4.3.8.2 Documentation Requirements

Documentation in the client's medical record for synchronous audiovisual or synchronous telephone (audio-only) checkups must meet all documentation requirements for an in-person checkup and include all the following:

- Whether the checkup was completed using synchronous audiovisual or synchronous telephone (audio-only) technology
- All checkup components that were not completed at the time of the synchronous audiovisual or synchronous telephone (audio-only) checkup, the reason that the component(s) were not completed and a plan to complete the components
- For the required in-person THSteps follow-up visit: documentation must indicate that the visit is related to a previously provided synchronous audiovisual or synchronous telephone (audio-only) checkup or exception-to-periodicity checkup
- For the required in-person THSteps follow-up visit: documentation should include all age-appropriate checkup components completed during the follow-up visit
- All anticipatory guidance and information on the next scheduled medical checkup or follow-up visit

4.3.8.3 Reimbursement

THSteps checkups billed as a synchronous audiovisual or synchronous telephone (audio-only) checkup (procedure codes 99381, 99391, 99382, or 99392) for children who are 24 months of age or younger will be denied.

THSteps checkups and exception-to-periodicity checkups delivered using synchronous audiovisual technology must be billed with modifier 95.

THSteps checkups and exception-to-periodicity checkups delivered using synchronous telephone (audio-only) technology must be billed with modifier 93.

Checkups billed as exception-to-periodicity checkups must also include the appropriate exception-to-periodicity checkup modifier (23, 32, or SC).

Records are subject to retrospective review, and incomplete checkups are subject to recoupment.

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4.3.9 Medical Checkup Follow-up Visit

Use procedure code 99211 with the NPI 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.

Refer to: Subsection 9.2.56.1.1, "New and Established Patient Services" in the Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks) for information about established patient E/M services.

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.

4.3.10 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 NPI 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.*

A newborn hearing screening is included in the reimbursement to the hospital for the newborn hospital stay and is not reimbursed separately. The screening is covered as part of the newborn delivery. A newborn hearing screening must be offered to each newborn by the facility where the birth occurs,

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through a program mandated by the Texas Legislature and certified by the Department of State Health Services (DSHS). If a facility is not required by legislative mandate to perform newborn hearing screenings, a referral must be made to a facility that offers the screening.

If an infant is not born in a birthing facility and is not admitted to a birthing facility, the infant must be referred to a facility that provides newborn hearing screening.

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 9.2.47, "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.

4.3.11 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 HHSC website at www.hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/texas-health-steps/medical-providers.

4.3.12 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
- Health education including anticipatory guidance
- Dental referral

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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.hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/texas-health-steps/forms.

The provider must offer checkups in accordance with the Texas Health Steps Medical Checkup Periodicity Schedule (periodicity schedule), found at www.onlineordersff.com/images/pdfs/26027.pdf, to ensure the preventive health screenings occur at age appropriate points in the client's life. The periodicity schedule specifies screening procedures that are required at each stage of development. There are 11 checkups before 3 years of age (excluding the newborn exam) and then annual checkups from 3 through 20 years of age.

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

4.3.12.1 Comprehensive Health and Developmental History

4.3.12.1.1 Nutritional Screening

Dietary practices must be evaluated at each checkup to identify and address nutritional issues or concerns.

4.3.12.1.2 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 THSteps medical services, developmental screening (procedure code 96110) and autism screening (procedure code 96110 with modifier U6) are 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 "Required Screening Ages and Recommended Tools" table. Providers must use one of the validated, standardized tools listed in the table 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.

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Providers may be reimbursed separately when using one of the required screening tools listed in the following table 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), Parents' Evaluation of Development Status (PEDS) or Survey of Well-being of Young Children (SWYC)	N/A
18 months	ASQ, PEDS or SWYC	Modified Checklist for Autism in Toddlers (M-CHAT) or M-CHAT Revised with Follow-Up (M-CHAT R/F)
24 months	ASQ, PEDS or SWYC	M-CHAT or M-CHAT R/F
3 years	ASQ, Ages and Stages Questionnaire: Social-Emotional (ASQ:SE), PEDS or SWYC	N/A
4 years	ASQ, ASQ:SE, PEDS or SWYC	N/A

If a developmental 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 Screening and Testing and Aphasia Assessment" 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 HHS 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.

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4.3.12.1.3 Mental Health Screening

Mental health screening for behavioral, social, and emotional development is required at each THSteps checkup. Comparable to the American Academy of Pediatrics (AAP) Recommendations for Preventive Health Care guidelines, THSteps allows clients who are 12 through 18 years of age to receive a mental health screening using one of THSteps recognized mental health screening tools.

The following validated, standardized mental health screening tools are recognized by THSteps for mental health screening in adolescents who are 12 through 18 years of age:

- Pediatric Symptom Checklist (PSC-17)
- Pediatric Symptom Checklist (PSC-35)
- Pediatric Symptom Checklist for Youth (Y-PSC)
- Patient Health Questionnaire (PHQ-9)
- Patient Health Questionnaire (PHQ-9) Modified for Adolescents (PHQ-A [depression screen])
- Car, Relax, Alone, Forget, Family, and Trouble Checklist (CRAFFT)
- Patient Health Questionnaire (PHQ-A [anxiety, eating problems, mood problems and substance use])
- Rapid Assessment for Adolescent Preventive Services (RAAPS)

A mental health screening must be submitted with procedure code 96160 for a screening tool completed by the adolescent, or procedure code 96161 for a screening tool completed by the parent or caregiver on behalf of the adolescent. When claims with procedure code 96160 or 96161 are submitted for mental health screenings, one of the validated, standardized mental health screening tools recognized by THSteps must be used.

Only one procedure code (96160 or 96161) may be reimbursed for the mental health screening per client per calendar year based on the description of the procedure code and the service rendered. Procedure codes 96160 and 96161 will not be reimbursed for the same client for any date of service.

Procedure code 96160 or 96161 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 calendar year, any provider.

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.

4.3.12.1.4 Postpartum Depression Screening

Postpartum depression screening is a benefit of Texas Medicaid. Procedure codes G8431 and G8510 may be reimbursed when billing for postpartum depression screening in the office setting.

THSteps medical providers may receive separate reimbursement for postpartum depression screening, in addition to the infant's Texas Health Steps medical checkup or follow-up visit. The reimbursement amount for procedure codes G8431 and G8510 covers all postpartum depression screenings provided during the infant's medical checkup or follow-up visit.

Postpartum depression screening must be submitted under the infant's Medicaid client number and will be restricted to clients who are 12 months of age and younger.

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Procedure codes G8431 and G8510 must be submitted on the same claim, for the same date of service, by the same provider as one of the following THSteps medical checkup or follow-up visit procedure codes:

Procedure Codes				
99211	99381	99382	99391	99392

Only one procedure code, either G8431 or G8510, may be reimbursed per provider in the 12 months following the infant's birth.

Postpartum Depression Screening and Referral Services

The American Academy of Pediatrics (AAP) recommends the infant's provider screen mothers for postpartum depression. Postpartum depression is the most common form of postpartum mood disturbance. Screening mothers for postpartum depression is appropriate for the general postpartum population and is recommended within the first few months following birth, up to the infant's first birthday.

Postpartum depression meets the same clinical criteria as major depressive disorder, with the main difference being onset during pregnancy or after delivery.

While postpartum depression is the most common form of postpartum mood disturbance, providers should be aware that other mood disorders that may arise during the postpartum period include anxiety and panic disorders, obsessive-compulsive disorder, and postpartum psychosis.

Postpartum psychosis is a much more severe form of postpartum depression accompanied by psychotic features. Postpartum psychosis is rare, typically develops in the first few days to weeks after delivery, and is a psychiatric emergency requiring immediate medical attention.

In addition to postpartum psychosis, immediate or emergent medical attention may be necessary when the risk of imminent harm or danger is present.

Screening Guidelines

Screening using a validated tool is required. At a minimum, screening should occur at least once during the postpartum period. Validated tools may include the following:

- Edinburgh Postnatal Depression Scale
- Postpartum Depression Screening Scale
- Patient Health Questionnaire 9

Screening alone is inadequate for improving clinical outcomes. A positive screening for postpartum depression requires the THSteps provider to develop a referral plan with the mother.

Positive Screenings: Referrals and Follow-Up

THSteps providers must discuss the screening results with the mother, discuss the possibility of depression, and the impact depression may have on the mother, family, and health of the infant.

The THSteps provider and mother should discuss the mother's options so the provider can refer her to an appropriate provider. Screening and referral is not contingent upon the mother's Medicaid eligibility. When needed, referrals should be made regardless of the funding source, including referral to local mental health authorities and local behavioral health authorities.

THSteps providers should refer the mother to a provider who can perform further evaluation and determine an appropriate course of treatment. Appropriate providers include, but are not limited to:

- Mental health clinicians
- The mother's primary care provider

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- Obstetricians and gynecologists
- Family physicians
- Community resources such as Local Mental Health Authorities (LMHAs)

Note: *Referral to an emergency center may be necessary when the risk for imminent harm or danger is present, such as mothers who report suicidal thoughts or thoughts of harming herself or the baby.*

Resources should be provided for support in the interim until the mother is able to access care.

Scheduling a return visit for the infant sooner than the next scheduled visit may be appropriate in some cases.

Prior Authorization Requirements

Screening for postpartum mood disorders at the checkup or follow up visit does not require prior authorization.

Note: *While recommended, screening for postpartum depression at the THSteps visit is not a compulsory requirement of the infant visit.*

Documentation Requirements

Documentation in the infant's record must include the name of the screening tool used and date the screening was completed.

If the mother screens positive for depression, at a minimum, the provider must note that a referral plan was discussed with the mother and a referral to a provider was made.

Providers may give the mother a copy of the completed screening tool to take with her to referral appointments.

Documentation should also include any health education or anticipatory guidance provided, along with the time period recommended for the infant's next appointment.

4.3.12.1.5 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 HHSC website at www.hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/health-services-providers/thsteps/ths-tb-questionnaire.pdf.

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 an NPI 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.texas.gov/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."

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4.3.12.2 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, which are recommended for clients from birth to 2 years of age.
- The Centers for Disease Control and Prevention (CDC) growth charts, which 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.

4.3.12.2.1 Oral Health Screening

Oral health screening is a part of the medical checkup physical examination.

4.3.12.2.2 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.

4.3.12.2.3 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 §§ 37.501–37.507.

A newborn hearing screening must be completed at the birthing facility. Automated auditory brainstem response (AABR) or transient evoke or distortion product otoacoustic emissions (OAE) may be performed.

Screening Results

Birthing facilities must report all newborn hearing screening results to DSHS within five business days using the web-based Texas Early Hearing Detection and Intervention (TEHDI) Management Information System (MIS) if written parental consent is obtained. Documented written consent must be maintained in the infant's medical record.

Birthing facilities must provide written newborn hearing screening results to the parent or caregiver as well as the newborn's primary care provider or medical home.

Primary care providers and medical homes (Texas Health Steps [THSteps] providers) must obtain a copy of the newborn hearing screening results within the TEHDI MIS if not provided by the birthing facility. The primary care provider or medical home must review all newborn hearing screening results with the parent or caregiver at the first checkup and determine if any additional follow-up is necessary.

> ***Note:*** *The primary care provider or medical home is responsible for managing and coordinating care for the child. Refer to the American Academy of Pediatrics Position Statement at https://publications.aap.org/pediatrics/article/129/5/996/73753/Home-Care-of-Children-and-Youth-With-Complex. Additional information related to TEHDI and Early Hearing Detection & Intervention Action Center (EHDI) can also be found at https://publications.aap.org/pediatrics/article/120/4/898/71218/Year-2007-Position-Statement-Principles.*

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Newborns who pass the newborn hearing screening must have their hearing monitored per the THSteps periodicity schedule. The primary care provider or medical home may opt to use the following tools to monitor developmental milestone benchmarks in newborns that pass their newborn hearing screening:

- TEHDI: A Roadmap for Families (English)
- Hearing Checklist for Parents (English)
- Hearing Checklist for Parents (Spanish)

Newborns who do not pass the initial screen must be rescreened a second time in the birthing facility before discharge.

Outpatient Rescreening

Newborns who do not pass the second screen in the birthing facility must be referred to a Medicaid-enrolled provider for an outpatient follow-up rescreen. The rescreen provider must have access to AABR or OAE screening and must be experienced with the pediatric population under age three.

Newborns who do not receive a referral from the birthing facility, after not passing the second screen in the birthing facility, must be referred by their primary care provider or medical home to a Medicaid-enrolled provider for an outpatient follow-up rescreen, unless their primary care provider or medical home is adequately equipped to provide the service. The optimal time frame for the outpatient follow-up rescreen is when the infant is between 10 and 30 days old.

Outpatient follow-up rescreens must be completed by AABR or OAE screening. Results must be reported as soon as possible to the DSHS TEHDI MIS, as well as the infant's primary care provider or medical home.

Newborns who pass the outpatient rescreen must have their hearing monitored by their primary care provider or medical home per the THSteps periodicity schedule.

Diagnostic Audiological Evaluation

Newborns who do not pass the outpatient rescreen must be referred to a Medicaid-enrolled audiologist for a diagnostic audiological evaluation using the Texas Pediatric Protocol for Evaluation. Referrals should be made upon consultation with the primary care provider or medical home.

> ***Note:*** *Additional information about the Texas Pediatric Protocol for Evaluation is available at www.dshs.texas.gov/texas-early-hearing-detection-intervention-tehdi*

Unless the newborn or infant has been hospitalized since birth, the diagnostic audiological evaluation must be completed no later than the third month after birth, or upon referral by the primary care provider or medical home.

Diagnostic audiological evaluations completed by audiologists using the Texas Pediatric Protocol for Evaluation must include a diagnostic auditory brainstem response (ABR) and, if not previously done, a diagnostic OAE to determine cochlear involvement.

Audiologists will use equipment norms for newborns, preferably ones 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 appropriate to fit the individual.

> ***Note:*** *Additional information about technologies that have been evaluated by an independent investigator and DSHS, and have been found to meet the requirements for conducting newborn hearing screening is available at www.dshs.texas.gov/texas-early-hearing-detection-intervention-tehdi.*

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Evaluation Results

Audiologists must report all diagnostic results to DSHS TEHDI MIS and provide written hearing screening results to the primary care provider or medical home.

The newborn or infant will be fitted for hearing aids by the audiologist when appropriate and should receive continued audiological assessments and monitoring as needed.

ECI Referrals

Newborns or infants not passing the outpatient rescreen must also be referred by the primary care provider or medical home to ECI for provision of services. The referral should be made within the TEHDI MIS.

Newborns or infants, as required by federal law under the Individuals with Disabilities in Education Act (IDEA), may be referred to ECI twice under the following circumstances:

- Upon suspicion that the child is deaf or hard of hearing, for service coordination and possible confirmation of eligibility for ECI services
- Upon confirmation that the child is deaf or hard of hearing, for a referral to other Local Education Agency for auditory impairment services

Late Onset Hearing Loss

When one or more risk factors for late onset hearing loss has been identified and the newborn or infant passed their hearing screen, the outcome will not be "normal hearing" but will be "in process." Noting the infant as "in process" allows all health-care providers in the care of the infant to be aware of the presence of risk factors to determine the frequency of risk monitoring to identify audiological issues as soon as possible. This determination depends on the type and number of the following risks identified:

- Craniofacial anomalies
- Exchange transfusion for elevated bilirubin
- Family history of deafness
- NICU > 5 days
- Apgar 0-4 at 1 minute
- Apgar 0-6 at 5 minutes
- Bacterial meningitis
- Birth weight < 1500g
- Congenital infection
- Head injury
- Neurodegenerative disorder
- Other postnatal infection
- Otitis media > 3 months (middle ear infection)
- Ototoxic medications administered
- Parental concern regarding hearing status
- Persistent pulmonary hypertension of the newborn associated with mechanical ventilation

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- Syndrome

Note: *Information about risk factors for late onset hearing loss and a risk monitoring periodicity schedule is available in Chapter 3, "Tracking, Reporting, & Follow-Up," in The NCHAM E-Book on the National Center for Hearing Assessment and Management (NCHAM) website at http://infanthearing.org.*

Hearing screening must be performed at each checkup for clients who are birth through 20 years of age. Audiometric screening must be performed at specific ages indicated on the periodicity schedule. Subjective screening through provider observation or informant report is required 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.

4.3.12.2.4 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.

4.3.12.3 Immunizations

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. Local and public health departments that are not otherwise enrolled as a provider that is authorized to receive reimbursement for vaccine administration fees should enroll as a Comprehensive Care Program (CCP) provider. Providers may not charge Texas Medicaid for the cost of the vaccines obtained from TVFC; however the administration fee, not to exceed $13.75, is considered for reimbursement.

For additional information about immunizations, providers can refer to the THSteps online educational module "Immunization" at www.txhealthsteps.com.

Refer to: Section 4.5, "Vaccine Services" in this handbook.

"Immunizations" in this handbook.

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.

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

Refer to: "Immunizations" in this handbook.

The DSHS website for TVFC provider enrollment information at www.dshs.texas.gov/immunizations/providers/overview.

The THSteps online education module "Immunizations," located on the THSteps website at txhealth-steps.com, for more information about immunizations.

4.3.12.4 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.hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/texas-health-steps/forms.

4.3.12.5 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,

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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.

4.3.12.6 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.

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 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.

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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 the following procedure codes 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 ^QW Modifier**									

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.

4.3.12.6.1 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.texas.gov/lab/MRS_forms.shtm.

4.3.12.6.2 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.texas.gov/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 78714-9347
1-512-776-7661 or 1-888-963-7111, Ext. 7661
Fax: 1-512-776-7672

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4.3.12.6.3 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 Medicaid 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.texas.gov/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.*

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

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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.texas.gov/lab/MRS_forms.shtm and fax the completed form to 1-512-776-7672.

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.

4.3.12.6.4 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

4.3.12.6.5 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.texas.gov/lab/remoteData.shtm or call 1-888-963-7111, Ext. 6030.

4.3.12.6.6 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.texas.gov, or visiting the DSHS website at www.dshs.texas.gov/lab/mrs_labtests_toc.shtm.

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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.texas.gov/blood-lead-surveillance-group/for-providers#environment. 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 3.5 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.

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.texas.gov/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 Branch's website at www.dshs.texas.gov/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. For waived tests, providers must use modifier QW as indicated on the CMS website.

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.texas.gov/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.

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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.texas.gov/newborn/screened_disorders.shtm.

Additional information about newborn screening, is available on the Newborn Screening Program website at www.dshs.texas.gov/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 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.texas.gov/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.*

4.3.12.6.7 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

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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.

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.

4.3.12.6.8 Zika Virus Testing

Refer to: Subsection 2.2.13.1, "Zika Virus Testing" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for information about Zika virus testing.

4.3.13 Non-mandated Components

4.3.13.1 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 (procedure codes 99381, 99382, 99391, and 99392) 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 Texas Health Steps Dental 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

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- 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 primary care provider must complete the intermediate oral evaluation but can delegate all other components.*

4.4 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.

4.4.1 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.

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- 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 for a claim form example.

THSteps Preventive Visit Checkup with Immunization and Vaccine Administration on the TMHP website at www.tmhp.com for a claim form example.

4.5 Vaccine Services

Vaccines and vaccine administration as recommended by the Advisory Committee on Immunization Practices (ACIP) are benefits of Texas Medicaid.

Immunization is the process by which a client becomes immune or resistant to an infectious disease, typically by vaccination.

Vaccination is the action of introducing a vaccine into the body.

A vaccine stimulates a client's immune system to produce immunity to a disease, thereby providing protection from that disease.

Vaccines may be administered orally, nasally, or via subcutaneous or intramuscular injection.

The following are categories of vaccines:

- Live, attenuated
- Inactivated
- Toxoid
- Subunit
- Conjugate
- Messenger RNA (mRNA)

Providers must follow current ACIP general usage recommendations and adhere to the National Vaccine Advisory Committee's (NVAC) Standards for Adult Immunization Practice and Standards for Pediatric Immunization Practice; however, in the event of conflict, providers are required to follow more specific Texas Vaccines for Children (TVFC) guidelines.

Providers must provide the current vaccine information statements (VISs) produced by the Centers for Disease Control and Prevention (CDC) to clients. VISs explain the benefits and risks of the vaccine(s) administered.

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4.5.1 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. Local and public health departments that are not otherwise enrolled as a provider that is authorized to receive reimbursement for vaccine administration fees should enroll as a Comprehensive Care Program (CCP) provider. Providers may not charge Texas Medicaid for the cost of the vaccines obtained from TVFC; however the administration fee, not to exceed $13.75, is considered for reimbursement.

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.

4.5.1.1 TVFC Distributed Vaccines

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.

4.5.2 Vaccine Adverse Event Reporting System (VAERS)

The National Childhood Vaccine Injury Act (NCVIA) requires health-care providers to report to VAERS:

- Any adverse event reaction listed by the vaccine manufacturer as a contraindication to subsequent doses of the vaccine.
- Any reaction listed in the VAERS Table of Reportable Events that occurs within the specified time period after vaccination.

VAERS encourages providers to report vaccine administration errors and any adverse event that occurs after the administration of any vaccine licensed in the United States even if it is clear whether a vaccine caused the adverse event.

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 vaers.hhs.gov/reportevent.html.

For additional information about NCVIA, providers can refer to www.dshs.texas.gov/immunizations/data/vaccine-adverse-event-reporting.

4.5.2.1 Vaccine Reporting to Department of State Health Services (DSHS)

Administered vaccines must be reported to DSHS. DSHS submits all vaccines reported with consent to a centralized repository of immunization histories. This lifespan registry is known in Texas as ImmTrac2.

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4.5.2.2 Rabies Vaccine Availability and Animal Bite Reporting

Providers that determine a client requires the rabies vaccination series may obtain the biologicals directly from the manufacturer or through one of the Texas Department of State Health Services (DSHS) depots around the state.

Animal bites to people must be reported as soon as possible to the designated Local Rabies Control Authority (LRCA).

Refer to: Subsection 9.2.38, "Postexposure Prophylaxis for Rabies" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol.2, Provider Handbooks)* for additional information about rabies vaccination.

4.5.3 Documentation Requirements

Providers must document the following information for every vaccine administered to a client in the client's medical record:

- Vaccine given
- Date the vaccine was administered (day, month, year format)
- Name of the vaccine manufacturer
- Vaccine lot number
- Signature and title of the person administering the vaccine
- Organization name and address
- Publication date of the VIS issues to the client, parent, or guardian

If a vaccine is given outside of ACIP's recommended routine immunization schedules for children or adults, the reason for the vaccination must be included in the client's medical record. Reasons for vaccinating outside the routine schedule may include but are not limited to:

- Pregnancy
- An impaired immune system
- Suspected exposure to a disease
- Occupation
- Travel

These records are subject to retrospective review to determine appropriate utilization and reimbursement for this service.

4.5.4 Vaccine Reimbursement

Vaccines and vaccine administration are reimbursed at a fee determined by HHSC.

Each vaccine and its administration must be submitted on the same claim in the following sequence: the vaccine procedure code immediately followed by the applicable vaccine administration procedure code(s).

All of the vaccine administration procedure codes that correspond to a single vaccine procedure code must be submitted on the same claim as the vaccine procedure code.

Vaccines for clients who are birth through 18 years of age are available through TVFC and administered at a site that is eligible for TVFC enrollment will not be reimbursed through Texas Medicaid.

Providers may not bill clients who are birth through 18 years of age for vaccines available through TVFC.

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Preventive Health Visits

If a vaccine is administered as part of a preventive health visit, including but not limited to a THSteps preventive care medical checkup, then the age-appropriate diagnosis code for the preventive health visit must be submitted on the claim. Diagnosis code Z23 may also be included on the claim as secondary.

For a vaccine administration at a visit for which the administration is the only purpose of a visit (i.e. the vaccine administration is not part of a preventive health visit), provider should submit the appropriate vaccine diagnosis code Z23.

Vaccine 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

Vaccines should be obtained through TVFC for clients who are birth through 18 years of age. Provider purchased vaccines are not reimbursed separately unless they meet the definition of "not available" as defined in this section. A vaccine may be defined as "not available" in one or more of the following situations:

- TVFC, based on their federal resolution (distribution guidelines), does not distribute a Texas Health and Human Services Commission (HHSC)-approved vaccine that has an ACIP-recommended use.
- ACIP approves a new vaccine with established guidelines, but the vaccine has not yet been negotiated or added to a TVFC contract.
- TVFC has not established funding for a new vaccine.
- TVFC reports to HHSC that there is an insufficient supply of a vaccine due to national supply or distribution issues.

Vaccines that meet the definition of "not available" as defined in this section may be reimbursed through the Comprehensive Care Program (CCP).

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

The state will notify providers if a vaccine meets the definition of "not available" and when the provider's privately purchased vaccine can be billed with the modifier U1.

Modifier U1 may not be used for failure to enroll in TVFC, maintain sufficient TVFC vaccine inventory, or clients who are 19 through 20 years of age.

Vaccines for clients who are 19 years through 20 years of age may be reimbursed through THSteps when provided as part of a THSteps preventive care medical checkup, or CCP when provided as part of an acute medical visit outside of a THSteps preventive care medical checkup. Providers must bill acute care services under their existing NPI.

Vaccines for clients who are 21 years of age or older may be reimbursed through traditional Texas Medicaid when the vaccine is medically necessary.

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Reimbursement for each vaccine is limited to one per client per day, by any provider.

The following vaccine procedure codes are a benefit of Texas Medicaid and distributed by TVFC (Does not include COVID-19 and influenza vaccines):

Procedure Codes	Age Range	Number of Recognized Components
90619	2 years of age or older	1
90620	10 years of age or older	1
90621	10 years of age or older	1
90623	10 years through 23 years of age	1
90632	18 years of age or older	1
90633	Birth through 18 years of age	2
90636	19 years of age or older	2
90647	6 weeks through 18 years of age	1
90648	6 weeks of age or older	1
90651	9 years through 45 years of age	1
90670	2 months of age or older	1
90671	6 weeks of age or older	1
90677	2 months of age or older	1
90678	10 years of age or older	1
90680	Birth through 8 months of age	1
90681	Birth through 8 months of age	1
90696	4 years through 6 years of age	4
90697	Birth through 4 years of age	6
90698	Birth through 5 years of age	5
90700	Birth through 6 years of age	3
90702	Birth through 6 years of age	2
90707	1 year of age or older	3
90710	1 year through 12 years of age	4
90713	2 months of age or older	1
90714	7 years of age or older	2
90715	7 years of age or older	3
90716	1 year of age or older	1
90723	6 weeks through 6 years of age	5
90732	2 years of age or older	1
90734	2 months through 55 years of age	1
90743	11 years through 17 years of age	1
90744	Birth through 17 years of age	1
90746	18 years of age or older	1

Note: *A component refers to all antigens in a vaccine that prevent disease(s) caused by one organism. Combination vaccines are those that contain multiple vaccine components.*

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COVID-19 Vaccines

The following vaccine procedure codes are a benefit of Texas Medicaid for COVID-19:

Procedure Codes	Age Range
91320	12 years of age or older
91322	12 years of age or older

Because the ACIP frequently reviews the composition of COVID-19 vaccines and makes updates to their recommendations, providers should refer to the CDC website for current recommendations.

Providers should refer to the TVFC website for the most up-to-date list of COVID-19 vaccines that TVFC is distributing for clients who are birth through 18 years of age.

Procedure code 90480 must be used in conjunction with one of the vaccine procedure codes listed above for reimbursement of COVID-19 vaccine administration.

COVID-19 vaccine counseling (procedure code G0315) may be reimbursed for clients who are birth through 20 years of age.

Procedure code G0315 will be denied if billed on the same day by the same provider as procedure code 90480.

Procedure code G0315 is limited to once per day, by the same provider, and three per rolling year by any provider.

Influenza Vaccines

The following vaccine procedure codes are a benefit of Texas Medicaid for influenza:

Procedure Codes	Age Range
90655	6 months through 35 months of age
90656	6 months of age or older
90657	6 months through 35 months of age
90658	6 months of age or older
90660	2 years through 49 years of age
90661	6 months of age or older
90672	2 years through 49 years of age
90673	18 years of age or older
90674	6 months of age or older
90682	18 years of age or older
90685	6 months through 35 months of age
90686	6 months of age or older
90687	6 months through 35 months of age
90688	6 months of age or older
90756	6 months of age or older

Because the ACIP reviews the composition of influenza vaccines annually and frequently makes updates to their recommendations, providers should refer to the CDC website for current recommendations.

Providers should refer to the TVFC website for the most up-to-date list of the influenza vaccines that TVFC is distributing for clients who are birth through 18 years of age for the current flu season.

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Peak influenza activity generally occurs from October of one year through February of the next year, although activity can last through May. This time period is commonly referred to as "flu season."

The first time a client who is 6 months of age through 8 years of age receives the influenza vaccine, he/she should receive a second dose of the vaccine during the same flu season at least 4 weeks after the first dose. If the client turns 9 years old between the first and second doses, he/she should still receive the second dose.

Excepting the scenario described in the previous line, clients who are 9 years of age or older should only receive one dose of the influenza vaccine per flu season, even if it is their first time receiving the influenza vaccine.

The following vaccine procedure codes are a benefit of Texas Medicaid and are not distributed by TVFC:

Procedure Codes	Age Range	Number of Recognized Components
90476	19 years through 50 years of age	1
90477	19 years through 50 years of age	1
90581	19 years through 65 years of age	1
90585	All ages	1
90586	All ages	1
90589	19 years of age or older	1
90611	18 years of age or older	1
90625	19 years through 64 years of age	1
90626	19 years of age or older	1
90627	19 years of age or older	1
90675	All ages	1
90684	19 years of age or older	1
90690	19 years of age or older	1
90691	19 years of age or older	1
90717	19 years of age or older	1
90738	19 years of age or older	1
90739	18 years of age or older	1
90740	20 years of age or older	1
90747	20 years of age or older	1
90758	18 years of age or older	2
90759	18 years of age or older	1
J9030	All ages	1

Vaccine Administration

Vaccine administration for clients who are birth through 20 years of age may be reimbursed through THSteps when provided as part of a THSteps preventive care medical checkup or CCP when provided as part of an acute medical visit outside of a THSteps preventive care medical checkup. Providers must bill acute care services under their existing NPI.

Vaccine administration for clients who are 21 years of age or older may be reimbursed through traditional Texas Medicaid when the vaccine is medically necessary.

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The specific diagnosis necessitating the vaccine and toxoid is required when billing with the following administration procedure codes in combination with an appropriate vaccine procedure code:

Procedure Codes									
90460	90461	90471	90472	90473	90474	90480	M0201		

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 for services rendered to clients of any age when counseling is not provided for the immunization administered.

Each vaccine and its administration must be submitted on the claim in the following sequence: the vaccine procedure code immediately followed by the applicable vaccine administration procedure code(s). All of the vaccine administration procedure codes that correspond to a single vaccine procedure code must be submitted on the same claim as the vaccine procedure code.

Each vaccine 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, the second administration of the vaccine will be denied.

Procedure code 90480 is a benefit for clients who are 6 months of age or older. Procedure code 90480 includes counseling and may only be reported with a COVID-19 vaccine procedure code.

Procedure code M0201 is a benefit for clients of any age. Procedure code M0201 may be reported, in addition to the vaccine and vaccine administration procedure codes when a pneumococcal, influenza, hepatitis B, and/or COVID-19 vaccine is administered inside a client's home.

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 procedure codes 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.

The necessary counseling that is conducted by a physician or other qualified health-care professional must be documented in the client's medical record.

Procedure code 90461 may not be billed by TVFC providers when administering TVFC-eligible vaccines under the TVFC program.

Administration Without Counseling

Procedure codes 90471, 90472, 90473, and 90474 may be reimbursed per vaccine based on the route of administration.

4.5.5 Respiratory Syncytial Virus (RSV)

RSV monoclonal antibodies (nirsevimab, procedure codes 90380 and 90381) may be administered to clients who are birth through 19 months of age.

Administration of nirsevimab (procedure codes 96380 and 96381) are limited to two per lifetime.

The administration of palivizumab may be denied if billed after the administration of nirsevimab.

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4.5.6 Exclusions

Vaccines that are not approved by the U.S. Food and Drug Administration, and are not recommended by the ACIP are not benefits of Texas Medicaid.

4.5.7 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 for a claim form example.

THSteps Preventive Visit Checkup with Immunization and Vaccine Administration on the TMHP website at www.tmhp.com for a claim form example.

4.5.8 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.texas.gov/immunize.

Refer to: "Appendix B. Immunizations" in this handbook.

The DSHS website for TVFC provider enrollment information at www.dshs.texas.gov/immunization-unit/texas-vaccines-children-program-immunizations-unit.

The THSteps online education module "Immunizations," located on the THSteps website at https://www.txhealthsteps.com/, for more information about immunizations.

4.6 Claims Filing and Reimbursement

Providers may refer to Volume 1 for general information about claims filing and reimbursement.

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.

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4.6.1 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, and the provider chooses to bill the other insurance, 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 $13.75 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 NPI and benefit code EP1 (exception: FQHC providers do not use benefit code EP1)
- The appropriate Texas Health Steps medical checkup procedure code (all ages) with diagnosis code Z0000, Z0001, Z00110, Z00111, Z00121, or Z00129. Diagnosis code Z23 may also be included.
    - The condition indicator codes, which must be placed in 24C (ST, S2, or NU only to identify a checkup resulting in a referral)
    - The provider type modifiers
    - The exception-to-periodicity modifier, when applicable

Refer to: Subsection 4.3.6, "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.

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4.6.2 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.

5 Claims Resources

Refer to the following sections or forms when filing claims:

Resource	Location
Acronym Dictionary	"Appendix C: Acronym Dictionary" (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	Subsection A.10, "TMHP Telephone and Fax Communication" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
State, federal, and TMHP contact information	"Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
TMHP electronic claims submission information	Subsection 6.2, "TMHP Electronic Claims Submission" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
TMHP Electronic Data Interchange (EDI) information	"Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*)

6 Contact TMHP

For a complete list of TMHP communications, refer to subsection A.10, "TMHP Telephone and Fax Communication" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*).

6.1 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.

6.2 TMHP Website

Additional information about Medicaid enrollment, general customer service, and provider education/training is available on the TMHP website at www.tmhp.com.

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6.3 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).

6.3.1 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

6.4 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.

6.4.1 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.

6.5 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.hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/texas-health-steps 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.

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
CCP Prior Authorization Request Form Instructions
CCP Prior Authorization Request for Non-Face-to-Face Clinician-Directed Care Coordination Services

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Forms
CCP Prior Authorization Request Form
CCP Prior Authorization Private Duty Nursing 6-Month Authorization
Criteria for Dental Therapy Under General Anesthesia
DME Certification and Receipt Form
Home Health Plan of Care (POC)
Home Health Plan of Care (POC) Instructions
Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Center
THSteps Dental Mandatory Prior Authorization Request Form
THSteps Referral Form Instructions
THSteps Referral Form
Specialist or Subspecialist Telephone Consultation Form for Non-Face-to-Face Clinician-Directed Care Coordination Services–Comprehensive Care Program (CCP)

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
Acute Care Visit on the Same Day as a THSteps Preventive Visit Checkup
Diagnosis and Treatment (Referral from THSteps Checkup)
Durable Medical Equipment (CCP Only)
Inpatient Rehabilitation Facility (Freestanding) (CCP Only)
Medical Checkup Follow-up Visit with Immunization Administration
Medical Checkup Follow-up Visit with TB Skin Test (TST)
Medical Nutrition Counseling (CCP Only)
Orthotic and Prosthetic Services (CCP Only)
Postpartum Depression Screening During an Infant THSteps Checkup
Private Duty Nurses (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, "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.hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/texas-health-steps/forms. 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.texas.gov/lead/providers.shtm.

Links to growth charts may be found on the THSteps website at www.hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/texas-health-steps/forms.

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* (4th edition), located at www.brightfutures.org or the Guidelines for Adolescent Preventive Services (GAP) Implementation Materials located at brightfutures.aap.org/materials-and-tools/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.texas.gov/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.texas.gov/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.hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/texas-health-steps/forms.

"Frequently Asked Questions About TB" on the DSHS website at www.dshs.texas.gov/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.texas.gov/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 (NCVIA) requires health-care providers to report to VAERS:

- Any adverse event listed by the vaccine manufacturer as a contraindication to subsequent doses of the vaccine.
- Any reaction listed in the VAERS Table of Reportable Events that occurs within the specified time period after vaccination.

VAERS encourages providers to report vaccine administration errors and any adverse event that occurs after the administration of any vaccine licensed in the United States even if it is clear whether a vaccine caused the adverse event.

A copy of the Reportable Events Table can be obtained by calling VAERS at 1-800-822-7967 or by downloading it from vaers.hhs.gov/resources/infoproviders.html.

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 ImmTrac2.*

Refer to: Subsection B.3.6, "How to Report Immunization Records to ImmTrac2, the Texas Immunization Registry" in this handbook.

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.

Refer to: Section 4, "THSteps Medical" in this handbook.

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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/hcp/imz-schedules/child-schedule-vaccines.html.

Refer to: Recommended Childhood and Adolescent Immunization Schedule on the THSteps 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. Local and public health departments that are not otherwise enrolled as a provider that is authorized to receive reimbursement for vaccine administration fees should enroll as a Comprehensive Care Program (CCP) provider. 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	90480	M0201

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.

Procedure codes 90471, 90472, 90473, and 90474 are benefits for services rendered to clients of any age when counseling is not provided for the immunization administered.

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Procedure code 90480 is a benefit for clients who are 6 months of age or older. Procedure code 90480 includes counseling and may only be reported with a COVID-19 vaccine procedure code.

Procedure code M0201 is a benefit for clients of any age. Procedure code M0201 may be reported, in addition to the vaccine and vaccine administration procedure codes when a pneumococcal, influenza, hepatitis B, and/or COVID-19 vaccine is administered inside a client's home.

Refer to: Subsection 4.3.12.3, "Immunizations" in this handbook for appropriate diagnosis codes for immunization administration.

B.3.3 Immunizations (Vaccine/Toxoids)

The following vaccine procedure codes are a benefit of Texas Medicaid and distributed by TVFC (Does not include COVID-19 and influenza vaccines):

Procedure Codes	Age Range	Number of Recognized Components
90619	2 years of age or older	1
90620	10 years of age or older	1
90621	10 years of age or older	1
90623	10 years through 23 years of age	1
90632	18 years of age or older	1
90633	Birth through 18 years of age	2
90636	19 years of age or older	2
90647	6 weeks through 18 years of age	1
90648	6 weeks of age or older	1
90651	9 years through 45 years of age	1
90670	2 months of age or older	1
90671	6 weeks of age or older	1
90677	2 months of age or older	1
90678	10 years of age or older	1
90680	Birth through 8 months of age	1
90681	Birth through 8 months of age	1
90696	4 years through 6 years of age	4
90697	Birth through 4 years of age	6
90698	Birth through 5 years of age	5
90700	Birth through 6 years of age	3
90702	Birth through 6 years of age	2
90707	1 year of age or older	3
90710	1 year through 12 years of age	4
90713	2 months of age or older	1
90714	7 years of age or older	2
90715	7 years of age or older	3
90716	1 year of age or older	1
90723	6 weeks through 6 years of age	5
90732	2 years of age or older	1
90734	2 months through 55 years of age	1

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Procedure Codes	Age Range	Number of Recognized Components
90743	11 years through 17 years of age	1
90744	Birth through 17 years of age	1
90746	18 years of age or older	1

Note: *A component refers to all antigens in a vaccine that prevent disease(s) caused by one organism. Combination vaccines are those that contain multiple vaccine components.*

COVID-19 Vaccines

The following vaccine procedure codes are a benefit of Texas Medicaid for COVID-19:

Procedure Codes	Age Range
91320	12 years of age or older
91322	12 years of age or older

Because the ACIP frequently reviews the composition of COVID-19 vaccines and makes updates to their recommendations, providers should refer to the CDC website for current recommendations.

Providers should refer to the TVFC website for the most up-to-date list of COVID-19 vaccines that TVFC is distributing for clients who are birth through 18 years of age.

Procedure code 90480 must be used in conjunction with one of the vaccine procedure codes listed above for reimbursement of COVID-19 vaccine administration.

COVID-19 vaccine counseling (procedure code G0315) may be reimbursed for clients who are birth through 20 years of age.

Procedure code G0315 will be denied if billed on the same day by the same provider as procedure code 90480.

Procedure code G0315 is limited to once per day, by the same provider, and three per rolling year by any provider.

Influenza Vaccines

The following vaccine procedure codes are a benefit of Texas Medicaid for influenza:

Procedure Codes	Age Range
90655	6 months through 35 months of age
90656	6 months of age or older
90657	6 months through 35 months of age
90658	6 months of age or older
90660	2 years through 49 years of age
90661	6 months of age or older
90672	2 years through 49 years of age
90673	18 years of age or older
90674	6 months of age or older
90682	18 years of age or older
90685	6 months through 35 months of age
90686	6 months of age or older

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Procedure Codes	Age Range
90687	6 months through 35 months of age
90688	6 months of age or older
90756	6 months of age or older

Refer to: Subsection 4.5.4, "Vaccine Reimbursement" in this handbook for additional information about influenza.

The following vaccine procedure codes are a benefit of Texas Medicaid and are not distributed by TVFC:

Procedure Codes	Age Range	Number of Recognized Components
90476	19 years through 50 years of age	1
90477	19 years through 50 years of age	1
90581	19 years through 65 years of age	1
90585	All ages	1
90586	All ages	1
90589	19 years of age or older	1
90611	18 years of age or older	1
90625	19 years through 64 years of age	1
90626	19 years of age or older	1
90627	19 years of age or older	1
90675	All ages	1
90684	19 years of age or older	1
90690	19 years of age or older	1
90691	19 years of age or older	1
90717	19 years of age or older	1
90738	19 years of age or older	1
90739	18 years of age or older	1
90740	20 years of age or older	1
90747	20 years of age or older	1
90758	18 years of age or older	2
90759	18 years of age or older	1
J9030	All ages	1

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.

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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 inventory, or for clients who are 19 through 20 years of age.

B.3.4 Respiratory Syncytial Virus (RSV)

Respiratory syncytial virus (RSV) monoclonal antibodies and their administration may be submitted with the following procedure codes:

Monoclonal Antibody Procedure Codes	Administration Procedure Codes	Age Range
90380	96380	Birth through 19 months of age
90381	96381	Birth through 19 months of age

B.3.5 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.)

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- 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.

B.3.6 How to Report Immunization Records to ImmTrac2, 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 ImmTrac2, 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 ImmTrac2, providers must first register for registry participation and access.

ImmTrac2 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.

ImmTrac2 offers two methods for reporting immunizations to DSHS: direct internet entry into ImmTrac2's internet application and electronic data transfer (import).

B.3.6.1 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 ImmTrac2 web application after administering vaccines to the patient.

B.3.6.2 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 ImmTrac2. Providers may still have access to the ImmTrac2 web application to access and review their clients' immunization histories before administering any vaccines.

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Regardless of reporting option selected, all providers must first register for ImmTrac2 access and receive login credentials from ImmTrac2 Customer Support. To register for ImmTrac2 access, providers may obtain and complete an ImmTrac2 Registration Packet (for providers and schools) from immtrac.dshs.texas.gov/TXPRD/enrollProviderEntry.do?action=newOrg or request it from ImmTrac2 Customer Support at 1-800-348-9158.

B.3.6.3 Obtaining Parental Consent for Registry Participation

Before including a client's immunization information in ImmTrac2, 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 ImmTrac2 participation during the birth certificate registration process. Written parental consent for ImmTrac2 participation applies to all past, present, and future immunizations. Texas law also permits a parent, managing conservator, or guardian to withdraw consent for ImmTrac2 participation at any time.

Providers may offer parents the opportunity to grant consent for their child's participation in ImmTrac2 using the pre-filled, ImmTrac2-generated Immunization Registry (ImmTrac2) Consent Form or the manual version (#C-7) of this form, also available from the ImmTrac2 application. Providers should retain the consent form and affirm parental consent through ImmTrac2 to establish the client's ImmTrac2 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 ImmTrac2 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.texas.gov/immunizations/what-we-do/programs.

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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 https://www.dshs.texas.gov/blood-lead-surveillance-group/for-providers 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 Branch's website at www.dshs.texas.gov/lead.

C.2 Symptoms of Lead Poisoning

Children who have EBLLs in the range of 3.5–45µg/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 3.5 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 handbook 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 3.5 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 3.5 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 4.3.12.6.6, "Required Laboratory Tests Related to Medical Checkups" in this handbook.

Subsection 4.3.10, "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.texas.gov/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.4.1.1 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							
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.4.1.2 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.4.1.3 Prior Authorization

Prior Authorization is not required for ELI services.

C.4.2 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 https://www.dshs.texas.gov/blood-lead-surveillance-group/for-providers/forms.*

C.4.3 Claims Filing and Reimbursement

C.4.3.1 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" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims.

C.4.3.2 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.4.3.3 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.texas.gov/lead.

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The following table lists materials available to providers for download:

Lead Poisoning Prevention Materials	
1-26	Protect Your Children From Lead Poisoning (English and Spanish)
1-307	Keep Lead at Bay (English and Spanish)
1-308	Consuming Lead-Free (English and Spanish)
1-311	How Lead Affects Your Child's Health (English and Spanish)
1-313	Getting a Good Specimen (Poster)
1-315	A Guide for Cleaning Lead-Safe (English and Spanish)
09-13410	Pica and Pregnancy (English and Spanish)
Pb-101	Request for Environmental Investigation
Pb-102	Follow-up of Initial Elevated Blood Lead Level
Pb-103	Elevated Blood Lead Level Investigation Questionnaire
Pb-104	Physician Checklist for Parent Education Topics
Pb-109	Reference for Blood Lead Retesting 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 HHS 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 HHS ECI website at https://www.hhs.texas.gov/sites/default/files/documents/services/disability/eci/eci-referral-form-icd-10.pdf. Providers may also refer families for services by calling their local ECI program or the Health and Human Services Office of the Ombudsman at 1-877-787-8999, select a language, and then select Option 3. The Ombudsman staff will ask for your ZIP code, county, or city and provide the name and number of the local ECI program. Callers that are deaf or hard of hearing may use the relay option of their choice or dial 7-1-1 to connect with Relay Texas.

To facilitate referrals for ECI services an optional form is available on the HHS ECI website at https://www.hhs.texas.gov/services/disability/early-childhood-intervention-services/make-a-referral-eci.

For additional ECI information, providers can visit the HHS ECI website at www.hhs.texas.gov/services/disability/early-childhood-intervention-services. Persons who are deaf or hard of hearing may use the relay option of their choice or dial 7-1-1 to connect with Relay Texas.

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, legal guardian, or other authorized adult during medical and dental checkups and dental treatment. The authorized adult can be the client's relative. DSHS implemented this requirement through rules found in 25 TAC §33.2 (Definitions) and 25 TAC §33.6 (THSteps Provider Responsibilities).

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The DSHS rules require that the parent, legal guardian, or authorized adult accompany the client to the checkup, and that the parent, legal guardian, or authorized adult must wait for the client while the checkup, treatment, or service takes place.

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) and 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.texas.gov/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 1.7, "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).

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- Call the DFPS Texas Abuse Hotline if:
  - You believe your situation requires action in less than 24 hours.
  - You prefer to remain anonymous.
  - 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.texas.gov/tehdi 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).

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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:

- 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 or by using the ECI program search web page at citysearch.hhsc.state.tx.us.
- The physician/medical home monitors the child. See the *Journal of Early Hearing Detection and Intervention 2019 Position Statement* at "Year 2019 JCIH Position Statement" (usu.edu).
- 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 HHS 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 publications.aap.org/pediatrics/article/120/4/898/71218/Year-2007-Position-Statement-Principles-and?autologincheck=redirected.
- Deaf education and other special education services available from birth through 20 years of age when determined by an individualized education program.

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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