Section 6: Claims Filing

Texas Medicaid Provider Procedures Manual: Vol. 1

November 2026



SECTION 6: CLAIMS FILING

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6.1 Claims Information

Providers that render services to Texas Medicaid fee-for-service and managed care clients must file the assigned claims. Texas Medicaid does not make payments to clients. Federal regulations prohibit providers from charging clients a fee for completing or filing Medicaid claim forms. Providers are not allowed to charge TMHP for filing claims. The cost of claims filing is part of the usual and customary rate for doing business. Providers cannot bill Texas Medicaid or Medicaid clients for missed appointments or failure to keep an appointment. Only claims for services rendered are considered for payment.

Medicaid providers are also required to complete and sign authorized medical transportation forms (e.g., Form H3017, Individual Transportation Participant [ITP] Service Record, or Form 3111, Verification of Travel to Healthcare Services by Mass Transit) or provide an equivalent (e.g., provider statement on official letterhead) to attest that services were provided to a client on a specific date. The client presents these forms to the provider.

Providers are not allowed to bill clients or Texas Medicaid for completing these forms.

All claims for Electronic Visit Verification (EVV) services, including fee-for-service and managed care claims, must be submitted electronically to TMHP using the appropriate electronic claims submission method. Paper claims for EVV services will not be accepted. The EVV aggregator will perform EVV claims matching and TMHP will forward the EVV claim with the EVV match code to the applicable payer for claims processing.

6.1.1 TMHP Processing Procedures

TMHP processes claims for services rendered to Texas Medicaid fee-for-service clients and carve-out services rendered to Medicaid managed care clients.

Note: *Claims for services rendered to a Medicaid managed care client must be submitted to the managed care organization (MCO) or dental plan that administers the client's managed care benefits. Only claims for those services that are carved-out of managed care can be submitted to TMHP.*

Claims for EVV services (Acute Care and Long Term Care Fee-For-Service and Long Term Support Services [LTSS] [managed care]) must be submitted to TMHP to perform the EVV claims matching process and forwarded to the applicable payer for adjudication.

Refer to: The *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*) for more information about carve-out services.

Medicaid claims are subject to the following procedures:

- TMHP verifies all required information is present.
- Claims filed under the same National Provider Identifier (NPI) and program and ready for disposition at the end of each week are paid to the provider with an explanation of each payment or denial. The explanation is called the Remittance and Status (R&S) Report, which may be received as a downloadable portable document format (PDF) version or on paper. A Health Insurance Portability and Accountability Act (HIPAA)-compliant 835 transaction file is also available for those providers who wish to import claim dispositions into a financial system.

  An R&S Report is generated for providers that have weekly claim or financial activity with or without payment. The report identifies pending, paid, denied, and adjusted claims. If no claim activity or outstanding account receivables exist during the time period, an R&S Report is not generated for the week.
- For services that are billed on a claim and have any benefit limitations for providers, the date of service determines which provider's claims are paid, denied, or recouped. Claims that have been submitted and paid may be recouped if a new claim with an earlier date of service is submitted, depending on the benefit limitations for the services rendered.

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Services that have been authorized for an extension of the benefit limitation will not be recouped. Providers can submit an appeal with medical documentation if the claim has been denied.

6.1.1.1 Fiscal Agent

TMHP acts as the state's Medicaid fiscal agent. A fiscal agent arrangement is one of two methods allowed under federal law and is used by all other states that contract with outside entities for Medicaid claims payment. Under the fiscal agent arrangement, TMHP is responsible for paying claims, and the state is responsible for covering the cost of claims.

Note: *The fiscal agent arrangement does not affect Long Term Care (LTC) and Health and Human Services Commission (HHSC) Family Planning providers.*

Provider Designations

The fiscal agent arrangement requires that providers be designated as either public or nonpublic. By definition, public providers are those that are owned or operated by a city, state, county, or other government agency or instrumentality, according to the Code of Federal Regulations. In addition, any provider or agency that performs intergovernmental transfers to the state would be considered a public provider. This includes those agencies that can certify and provide state matching funds, (i.e., other state agencies). New providers self-designate (public or private) on the provider enrollment application.

The fiscal agent:

- Rejects all claims not payable under Texas Medicaid rules and regulations.
- Suspends payments to providers according to procedures approved by HHSC.
- Notifies providers of reduction in claim amount or rejection of claim and the reason for doing so.
- Collects payments made in error, affects a current record credit to the department, and provides the department with required data relating to such error corrections.
- Prepares checks or drafts to providers, except for cases in which the department agrees that a basis exists for further review, suspension, or other irregularity within a period not to exceed 30 days of receipt and determination of proper evidence establishing the validity of claims, invoices, and statements.
- Makes provisions for payments to providers who have furnished eligible client benefits.
- Withholds payment of claim when the eligible client has another source of payment.
- Employs and assigns a physician, or physicians, and other professionals as necessary, to establish suitable standards for the audit of claims for services delivered and payment to eligible providers.
- Requires eligible providers to submit information on claim forms.

6.1.1.2 Payment Error Rate Measurement (PERM)

The Improper Payments Information Act (IPIA) of 2002 directs federal agency heads, in accordance with the Office of Management and Budget (OMB) guidance, to annually review agency programs that are susceptible to significant erroneous payments and to report the improper payment estimates to the U.S. Congress.

Every three years the CMS will assess Texas Medicaid using the PERM process to measure improper payments in Texas Medicaid and the Children's Health Insurance Program (CHIP).

CMS uses PERM to measure the accuracy of Medicaid and CHIP payments made by states for services rendered to clients. Under the PERM program, CMS will use three national contractors to measure improper payments in Medicaid and CHIP:

- The statistical contractor will provide support to the program by identifying the claims to be reviewed and by calculating each state's error rate.

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- The data documentation contractor will collect medical policies from the State and medical records from providers.
- The review contractor will perform medical and data processing reviews of the selected claims in order to identify any improper payments.

Providers are required to provide medical record documentation to support the medical reviews that the federal review contractor will conduct for Texas Medicaid fee-for-service and CHIP claims.

Note: *The federal review contractor will also conduct reviews for Primary Care Case Management (PCCM) claims that were submitted to TMHP with dates of service on or before February 29, 2012.*

Past studies have shown that the largest cause of error in medical reviews is lack of documentation or insufficient documentation. It is important that information be sent in a timely and complete manner, since a provider's failure to timely submit complete records in support of the claims filed can result in a higher payment error rate for Texas, which in turn can negatively impact the amount of federal funding received by Texas for Medicaid and CHIP.

Providers must submit the requested medical records to the data documentation contractor and HHSC within 60 calendar days of the receipt of the written notice of request. If providers have not responded within 15 days, the data documentation contractor and possibly state officials will initiate reminder calls and letters to providers. The data documentation contractor and possibly state officials will also initiate reminder calls and letters to providers after 35 days. If providers have not responded in 60 days, the data documentation contractor will submit a letter to the provider and the state PERM director indicating a "no documentation error." After the provider's submittal of requested information, the data documentation contractor may request additional information to determine proper payment. In this instance, the provider is given 15 days to provide additional documentation.

If medical records are not received within 60 calendar days, the data documentation contractor will identify the claim as a PERM error and classify all dollars associated with the claim as an overpayment. Providers will be required to reimburse the overpayment in accordance with state and federal requirements.

A provider's failure to maintain complete and correct documentation in support of claims filed or failure to provide such documentation upon request can result in the provider being sanctioned under Title 1, Texas Administrative Code (TAC) Part 15, Chapter 371. Sanction actions may include, but are not limited to, a finding of overpayment for the claims that are not sufficiently supported by the required documentation. Sanctions may include, but are not limited to, a finding of overpayment for the claims that are not sufficiently supported by the required documentation.

6.1.2 Claims Filing Instructions

This manual references paper claims when explaining filing instructions. HHSC and TMHP encourage providers to submit claims electronically. TMHP offers specifications for electronic claim formats. These specifications are available from the TMHP website and include a cross-reference of the paper claim filing requirements to the electronic format.

Providers can participate in the most efficient and effective method of submitting claims to TMHP by submitting claims through the TMHP Electronic Data Interchange (EDI) claims processing system using TexMedConnect or a third party vendor. The proceeding claim filing instructions in this manual apply to paper and electronic submitters. Although the examples of claims filing instructions refer to their inclusion on the paper claim form, claim data requirements apply to all claim submissions, regardless of the media. Claims must contain the provider's complete name, physical address including the ZIP+4 code, NPI, taxonomy code, and benefit code (if applicable) to avoid unnecessary delays in processing and payment.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on accessing the TMHP website.

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6.1.2.1 Wrong Surgery Notification

Providers are required to notify TMHP when a wrong surgery or other invasive procedure is performed on a Texas Medicaid client. Notification is mandated by Senate Bill (SB) 203, Section 3, Regular Session, 81st Texas Legislature, which covers preventable adverse events (PAE) and reimbursement for services associated with PAE.

Professional, inpatient, and outpatient hospital claims that are submitted for the wrong surgery or invasive procedure will be denied. Any corresponding procedures that are rendered to the same client, on the same dates of service (for professional and outpatient hospital claims), or the same date of surgery (for inpatient hospital claims) will be denied. Claims that have already been reimbursed will be recouped.

The law requires providers that are submitting claims for services rendered to Texas Medicaid clients to indicate whether any of the following situations apply to the claim:

- The incorrect operation or invasive procedure was performed on the correct client.
- The operation or invasive procedure was performed on the incorrect client.
- The incorrect operation or invasive procedure was performed on the incorrect body part.

Providers must notify Texas Medicaid of a wrong surgery or invasive procedure by submitting one of the following nonspecific injury, poisoning and other consequences of external causes diagnosis codes or modifiers with the procedure code for the rendered service:

Code	Description	Type of Claim
Injury, Poisoning and Other Consequences of External causes Diagnosis Codes		
Y6551	Performance of wrong procedure (operation) on correct patient	Inpatient hospital
Y6552	Performance of procedure (operation) on patient not scheduled for surgery	
Y6553	Performance of correct procedure (operation) on wrong side or body part	
Modifiers		
PA	Surgical or other invasive procedure on wrong body part	Professional or outpatient hospital
PB	Surgical or other invasive procedure on wrong patient	
PC	Wrong surgery or other invasive procedure on patient	

Professional or outpatient hospital claims must include a valid diagnosis with up to seven-digit specificity, the procedure code that identifies the service rendered, and the PA, PB, or PC modifier that describes the type of "wrong surgery" performed.

Inpatient hospital claims must be submitted with type of bill (TOB) 110 as an inpatient hospital-nonpayment claim when a "wrong surgery" is reported. If other services or procedures that are unrelated to the "wrong surgery" are provided during the same stay as the "wrong surgery," the inpatient hospital must submit a claim for the "wrong surgery" and a separate claim or claims for the unrelated services rendered during the same stay as the "wrong surgery."

The "wrong surgery" claim must include TOB 110, the appropriate diagnosis code, the surgical procedure code for the surgical service rendered, and the date of surgery. The "wrong surgery" claim will be denied.

The unrelated services rendered during the same stay as the "wrong surgery" must include TOB 111, 112, 113, 114, or 115 on a claim separate from the "wrong surgery" claim. The unrelated services that are benefits of Texas Medicaid may be reimbursed by Texas Medicaid.

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A claim that is denied for wrong surgery will have one of the following EOB codes:

EOB Code	Message
01167	Claim detail denied due to wrong surgery performed on client
01168	Claim denied due to wrong surgery performed on client
01185	Claim denied due to wrong surgery claim found in history for the same PCN and DOS
01186	Claim detail denied due to wrong surgery claim found in history for the same PCN and DOS
PCN = Patient Control Number (also known as the client's Medicaid number) DOS = Date of service	

6.1.2.2 Maximum Number of Units allowed per Claim Detail

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

6.1.2.3 Tips on Expediting Paper Claims

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

General requirements

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

Data Fields

- Print claim data within defined boxes on the claim form.
- Use black ink, but not a black marker. Do not use red ink or highlighters.
- Use all capital letters.
- Print using 10-pitch (12-point) Courier font. Do not use fonts smaller or larger than 12 points. Do not use proportional fonts, such as Arial or Times Roman.
- Use a laser printer for best results. Do not use a dot matrix printer, if possible.
- Do not use dashes or slashes in date fields.

Attachments

- Use paper clips on claims or appeals if they include attachments. Do not use glue, tape, or staples.
- Place the claim form on top when sending new claims, followed by any medical records or other attachments.
- Number the pages when sending attachments or multiple claims for the same client (e.g., 1 of 2, 2 of 2).
- Do not total the billed amount on each claim form when submitting multi-page claims for the same client.

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- Use the CMS-approved Medicare Remittance Advice Notice (MRAN) printed from Medicare Remit Easy Print (MREP) (professional services) or PC-Print (institutional services) when sending a Remittance Advice from Medicare or the paper MRAN received from Medicare or a Medicare intermediary. You may also download the TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template from the TMHP website at www.tmhp.com.
- Submit claim forms with MRANs and R&S Reports.

6.1.3 TMHP Paper Claims Submission

All paper claims must be submitted with an NPI and taxonomy code for the billing and performing provider. All other provider fields on the claim forms require an NPI only. If an NPI and taxonomy code are not included in the billing and performing provider fields, or if an NPI is not included on all other provider identifier fields, the claim will be denied. In addition to the NPI and taxonomy code for the billing provider, claim submissions will need to include the provider benefit code (if applicable) and complete physical address with ZIP + 4 code.

Refer to: Subsection 6.4, "Claims Filing Instructions" in this section for more information.

6.1.4 Claims Filing Deadlines

For claims payment to be considered, providers must adhere to the time limits described in this section. Claims received after the following claims filing deadlines are not payable because Texas Medicaid does not provide coverage for late claims.

Exception: *Unless otherwise stated, claims must be received by TMHP within 95 days of each DOS. Appeals must be received by TMHP within 120 days of the disposition date on the R&S Report on which the claim appears. A 95-day or 120-day appeal filing deadline that falls on a weekend or a holiday is extended to the next business day following the weekend or holiday.*

Only the following holidays extend the deadlines in 2026:

Date	Holiday
January 1, 2026	New Year's Day
January 19, 2026	Martin Luther King, Jr. Day
February 16, 2026	Presidents' Day
May 25, 2026	Memorial Day
June 19, 2026	Emancipation Day
July 4, 2026	Independence Day
September 7, 2026	Labor Day
October 12, 2026*	Columbus Day
November 11, 2026	Veterans Day
November 26, 2026	Thanksgiving Day
November 27, 2026	Day after Thanksgiving
December 24, 2026	Christmas Eve Day
December 25, 2026	Christmas Day
December 26, 2026	Day after Christmas
***Federal holiday, but not a state holiday. The claims filing deadline will be extended for providers because the Post Office will not be operating on this day.**	

The following are time limits for submitting claims:

- Inpatient claims that are filed by the hospital must be received by TMHP within 95 days of the discharge date or last DOS on the claim.

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  - Hospitals that are reimbursed according to diagnosis-related group (DRG) payment methodology may submit an interim claim because the client has been in the facility 30 consecutive days or longer. A total stay claim is needed after discharge to ensure accurate calculation for potential outlier payments for clients who are 20 years of age and younger.
  - Hospitals that are reimbursed according to Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 methodology may submit interim claims before discharge and must submit an interim claim if the client remains in the hospital past the hospital's fiscal year end.
- When medical services are rendered to a Medicaid client in Texas, TMHP must receive claims within 95 days of the DOS on the claim.
- Re-enrolling providers who are assigned their previous enrollment information must submit claims so that they are received by TMHP within 95 days of the date of service.
- Providers that are enrolling in Texas Medicaid for the first time or are making a change that requires the issuance of a new taxonomy and benefit code can submit claims within 95 days from the date their taxonomy and benefit code is issued as long as claims are submitted within 365 days of the date of service.
- Providers who are revalidating an existing enrollment can continue to file claims while they are completing the revalidation process. TMHP must receive claims within 95 days of the date of service.
- TMHP must receive claims from out-of-state providers within 365 days from the DOS. The DOS is the date the service is provided or performed.
- TMHP must receive claims on behalf of an individual who has applied for Medicaid coverage but has not been assigned a Medicaid number on the DOS within 95 days from the date the eligibility was added to the TMHP eligibility file (add date) and within 365 days of the date of service or from the discharge date for inpatient claims.
- Providers should verify eligibility and add date by contacting TMHP (Automated Inquiry System [AIS], TMHP EDI's electronic eligibility verification, or TMHP Contact Center) when the number is received. Not all applicants become eligible clients. Providers that submit claims electronically within the 365-day federal filing deadline for services rendered to individuals who do not currently have a Texas Medicaid identification number will receive an electronic rejection. Providers can use the TMHP rejection report as proof of meeting the 365-day federal filing deadline and submit an administrative appeal.

Important: *Providers should keep documentation of all Texas Medicaid client eligibility verification. Documentation of client eligibility is required for the appeal process.*

- If a client becomes retroactively eligible or loses Medicaid eligibility and is later determined to be eligible, the 95-day filing deadline begins on the date that the eligibility start date was added to TMHP files (the add date). However, the 365-day federal filing deadline must still be met.
- When a service is a benefit of Medicare and Medicaid, and the client is covered by both programs, the claim must be filed with Medicare first. TMHP *must* receive Medicaid claims within 95 days of the date of Medicare disposition.

  Providers must submit a paper MRAN received from Medicare or a Medicare intermediary, the computer-generated MRANs from the CMS-approved software application MREP for professional services or PC-Print for institutional services, or the TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template with a completed claim form to TMHP.

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- When a client is eligible for Medicare Part B only, the inpatient hospital claim for services covered as Medicaid only is sent directly to TMHP and is subject to the 95-day filing deadline (from date of discharge).

  Note: *It is strongly recommended that providers who submit paper claims keep a copy of the documentation they send. It is also recommended that paper claims be sent by certified mail with a return receipt requested. This documentation, along with a detailed listing of the claims enclosed, provides proof that the claims were received by TMHP, which is particularly important if it is necessary to prove that the 95-day claims filing deadline has been met. TMHP will accept certification receipts as proof of the 95-day or 120-filing deadline. If a certified receipt is provided as proof, the certified receipt number must be indicated on the detailed listing along with the Medicaid number, billed amount, DOS, and a signed claim copy. The provider needs to keep such proof of multiple claims submissions if the provider's enrollment with TMHP is pending.*

- If the provider is attempting to obtain prior authorization for services performed or will be performed, TMHP must receive the claim according to the usual 95-day filing deadline.
- The provider bills TMHP directly within 95 days from the DOS. However, if a non-third party resource (TPR) is billed first, TMHP must receive the claim within 95 days of the claim disposition by the other entity.

  Note: *The provider submits a copy of the disposition with the claim. A non-TPR is secondary to Texas Medicaid and may only pay benefits after Texas Medicaid.*

Refer to: Subsection 8.4, "Non-TPR Sources" in "Section 8: Third Party Liability (TPL)" (*Vol. 1, General Information*) for examples of non-TPRs.

- When a service is billed to another insurance resource, the filing deadline is 95 days from the date of disposition by the other resource.
- When a service is billed to a third party and no response has been received, Medicaid providers must allow 110 days to elapse before submitting a claim to TMHP. However, the 365-day federal filing deadline requirement must still be met.
- A Compass21 (C21) process allows an HHSC Family Planning claim to be paid by Title XIX (Medicaid) if the client is eligible for Title XIX when those services are provided and billed under the HHSC Family Planning Program. In this instance, the Medicaid 95-day filing deadline is in effect and must be met or the claim will be denied.
- For claims re-submitted to TMHP with additional detail changes (i.e., quantity billed), the additional details are subject to the 95-day filing deadline.

  Note: *In accordance with federal regulations, all claims must be initially filed with TMHP within 365 days of the DOS, regardless of provider enrollment status or retroactive eligibility.*

Refer to: Subsection 6.1.2, "Claims Filing Instructions" in this section.

Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for information on the provider enrollment process.

Subsection 7.1, "Appeal Methods" in "Section 7: Appeals" (*Vol. 1, General Information*) for information on the process for submitting appeals.

Subsection 6.1.4.3, "Exceptions to the 95-Day Filing Deadline" in this section.

Subsection A.12.3, "Automated Inquiry System (AIS)" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*) to learn how to retrieve client eligibility information by telephone.

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Refer to: "Section 8: Third Party Liability (TPL)" (*Vol. 1, General Information*).

Subsection 4.1.10, "Eligibility Verification" in "Section 4: Client Eligibility" (*Vol. 1, General Information*).

Subsection 6.11.6, "Provider Inquiries—Status of Claims" in this section.

6.1.4.1 Claims for Clients with Retroactive Eligibility

Claims for clients who receive retroactive eligibility must be submitted within 95 days of the date that the client's eligibility was added to the TMHP eligibility file (add date) and within 365 days of the DOS.

Title 42 of the Code of Federal Regulations (42 CFR), at 447.45 (d) (1), states "The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service." The 12-month filing deadline applies to all claims. Claims not submitted within 365 days (12 months) from the date of service cannot be considered for payment.

Retroactive eligibility does not constitute an exception to the federal filing deadline. Even if the patient's Medicaid eligibility determination is delayed, the provider must still submit the claim within 365 days of the date of service. A claim that is not submitted within 365 days of the date of service will not be considered for payment.

If a client is not yet eligible for Medicaid, providers must submit the claim using either 999999999 or 000000000 as the recipient identification number. Although TMHP will deny the claim, providers should retain the denial or electronic rejection report for proof of timely filing, especially if the eligibility determination occurs more than 365 days after the date of service. Claims denied for recipient ineligibility may be resubmitted when the patient becomes eligible for the retroactive date(s) of service. Texas Medicaid may then consider the claim for payment because the initial claim was submitted within the 365-day federal filing deadline and the denial was not the result of an error by the provider.

If the 365-day federal filing deadline requirement has passed, providers must submit the following to TMHP within 95 days from the add date:

- A completed claim form.
- One of the following dated within 365 days from the date of service:
  - A page from an R&S Report documenting a denial of the claim.
  - An electronic rejection report of the claim that includes the Medicaid recipient's name and date of service.

Providers that have submitted their claims electronically can provide proof of timely filing by submitting a copy of an electronic claims report that includes the following information:

- Client name or Medicaid identification number (PCN)
- DOS
- Total charges
- Batch identification number (Batch ID) (in correct format)

Note: *Only reports that were accepted or rejected by TMHP will be honored. The claim filed (client name or PCN, DOS and total charges) should match the information on the batch report.*

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6.1.4.2 Claims for Newly Enrolled Providers

Claims submitted by newly enrolled providers must be received within 95 days of the date that enrollment is complete and within 365 days of the date of service. Providers with a pending application should submit any claims that are nearing the 365-day deadline from the date of service. Claims will be rejected by TMHP until enrollment is complete. Providers can use the TMHP rejection report as proof of meeting the 365-day deadline and submit an appeal.

Note: *Claims can be submitted for dates of service on or after the provider's effective date of enrollment. Providers can find the effective date for their enrollment in their Welcome Letter in PEMS.*

Refer to: Subsection 1.1.9.7, "Copy of License, Temporary License, or Certification" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

All claims for services rendered to Texas Medicaid clients who do not have Medicare benefits are subject to a filing deadline from the date of service of:

- 95 days for in-state providers.
- 365 days for out-of-state providers.

TMHP cannot issue a prior authorization before Medicaid enrollment is complete. Upon notice of Medicaid enrollment, the provider must contact the appropriate TMHP Authorization Department before providing services that require a prior authorization number to Medicaid clients. Regular prior authorization procedures are followed after the TMHP Prior Authorization Department has been contacted.

Retroactive authorizations will not be issued unless the regular authorization procedures for the requested services allow for authorizations to be obtained after services are provided. For these services, providers have 95 days from the add date of the client's retroactive eligibility in TMHP's system to obtain authorization for services that have already been performed. Providers should refer to the specific manual section for details on authorization requirements, claims filing, and timeframe guidelines for authorization request submissions.

Providers who have not completed enrollment and have general claim submission questions may refer to this section for assistance with claim submission. If additional general information is needed, providers may call the TMHP Contact Center at 800-925-9126 to obtain information. Due to HIPAA privacy guidelines, specific client and claim information cannot be provided.

Providers who have completed enrollment and have questions about submitting claims may call the same number and select the option to speak with a TMHP Contact Center representative.

6.1.4.3 Exceptions to the 95-Day Filing Deadline

TMHP is not responsible for appeals about exceptions to the 95-day filing deadline. These appeals must be submitted to the HHSC Claims Administrator Operations Management. TAC allows HHSC to consider exceptions to the 95-day filing deadline under special circumstances.

6.1.4.4 Appeal Time Limits

All appeals of denied claims and requests for adjustments on paid claims must be received by TMHP within 120 days from the date of disposition, the date of the R&S Report on which that claim appears. If the 120-day appeal deadline falls on a weekend or holiday, the deadline will be extended to the next business day.

Refer to: Subsection 6.1.2, "Claims Filing Instructions" in this section.

Hospitals appealing final technical denials, admission denials, DRG changes, continued-stay denials, or cost/day outlier denials refer to "Section 7: Appeals" (*Vol. 1, General Information*) for complete appeal information.

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6.1.4.5 Claims with Incomplete Information and Zero Paid Claims

Claims listed on the R&S Report with $0 allowed and $0 paid may be resubmitted as electronic appeals. Previously, these claims were only accepted as paper claims and were not accepted as electronic appeals. Appeals may be submitted through a third party biller or through TexMedConnect.

Zero-paid claims that are still within the 95-day filing deadline should be submitted as new day claims, which are processed faster than appeals. Electronic appeal for these claims must be submitted within the 120-day appeal deadline. Electronic claims can be resubmitted past the 95-day deadline as new day claims if the following fields have not changed:

- NPIs
- Client Medicaid number
- Dates of service
- Total billed amount

Claims that are past the 95-day filing deadline and require changes to the fields listed above must be appealed on paper, with a copy of the R&S report. All other appeal guidelines remain unchanged.

Important: *Initial zero-paid claims and appeal submissions must meet the 95-day deadline and 120-day appeal deadline outlined in subsection 6.1.4, "Claims Filing Deadlines" in this section.*

6.1.4.6 Claims Filing Reminders

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

The provider should allow TMHP 45 days to receive a Medicare-paid claim automatically transmitted for payment of deductible or coinsurance.

Electronic billers should notify TMHP about missing claims when:

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

Certain claims, including those that were submitted for newborn services or that might be covered under Medicare, are suspended for review so that other state agencies can verify information. This review may take longer than 60 days.

These suspended claims will appear on the provider's R&S Report under "The following claims are being processed" with a message indicating that the client's eligibility is being investigated. Providers must wait until the claim is finalized and appears under "Paid or Denied" or "Adjustment to Claims" on the R&S Report before appealing the claim. If the claim does not appear on the R&S Report, providers must resubmit the claim to TMHP to ensure compliance with filing and appeal deadlines.

6.1.5 HHSC Payment Deadline

Payment deadline rules, as defined by HHSC, affect all providers with the exception of LTC and the HHSC Family Planning Program. The HHSC payment deadline rules for the fiscal agent arrangement ensure that state and federal financial requirements are met.

TMHP is required to finalize and pay claims within 24 months of:

- Each date of service on a claim.
- Discharge date for inpatient claims.

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Texas Medicaid and Children with Special Health Care Needs (CSHCN) Service Program payments, excluding crossovers, cannot be made after 24 months. Claims and appeals that are submitted after the designated payment deadlines are denied.

Note: *Providers may appeal HHSC Office of Inspector General (OIG) initiated claims adjustments (recoupments) after the 24-month deadline but must do so within 120 days from the date of the recoupment. Refer to subsection 7.1.5, "Paper Appeals" in "Section 7: Appeals" (Vol. 1, General Information) for instructions. All appeals of OIG recoupments must be submitted by paper, no electronic or telephone appeals will be accepted.*

6.1.6 Filing Deadline Calendars

The most current filing deadline calendars are available on the TMHP website at www.tmhp.com:

- Filing Deadline Calendar for 2025
- Filing Deadline Calendar for 2026

6.2 TMHP Electronic Claims Submission

TMHP uses the HIPAA-compliant American National Standards Institute (ANSI) ASC X12 5010 file format through a Secure File Transfer Protocol (SFTP) connection for maximum security.

Claims may be submitted electronically to TMHP through TexMedConnect on the TMHP website at www.tmhp.com or through billing agents who interface directly with the TMHP EDI Gateway.

Providers must retain all claim and file transmission records. They may be required to submit them for pending research on missing claims or appeals.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*).

6.2.1 Benefit and Taxonomy Codes

Providers must submit the Benefit Code field (when applicable), Address field, and Taxonomy Code Field and all other required fields. These fields must be completed before submitting electronic claims.

Taxonomy codes do not affect pricing or the level of pricing, but rather are used to crosswalk the NPI to the billing provider. It is critical that the taxonomy code selected as the primary or secondary taxonomy code during a provider's enrollment with TMHP is included on all electronic transactions.

Billing providers that are not associated with a group are required to submit a taxonomy code on all electronic claims. Claims submitted without a taxonomy code may be rejected.

Medicare does not require a taxonomy code for Part B claims. Therefore, some claims submitted to TMHP from Medicare for payment of deductible or coinsurance may not include the taxonomy code needed for accurate processing by TMHP.

6.2.2 Electronic Claim Acceptance

Providers should verify that their electronic claims were accepted by Texas Medicaid for payment consideration by referring to their Claim Response report, which is in the 27S batch response file (e.g., file name E085LDS1.27S). Providers should also check their Accepted and Rejected reports in the rej and acc batch response files (e.g., E085LDS1.REJ and E085LDS1.ACC) for additional information. Only claims that have been accepted on the Claim Response report (27S file) will be considered for payment and made available for claim status inquiry. Claims that are rejected must be corrected and resubmitted for payment consideration.

Refer to: Subsection 3.2, "Electronic Billing" in "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*), visit www.tmhp.com, or call the EDI Help Desk at 888-863-3638 for more information about electronic claims submissions.

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6.2.3 Electronic Rejections

The most common reasons for electronic professional claim rejections are:

- *Client information does not match.* Client information does not match the PCN on the TMHP eligibility file. The name, date of birth, sex, and nine-digit Medicaid identification number must be an exact match with the client's identification number on TMHP's eligibility record. If using TexMedConnect, send an interactive eligibility request to obtain an exact match with TMHP's record. If not using TexMedConnect, verify through the TMHP website or call AIS at 800-925-9126 to verify client information. A lack of complete client eligibility information causes a rejection and possibly delayed payment. To prevent delays when submitting claims electronically:
  - Always include the first and last name of the client on the claim in the appropriate fields.
  - Always enter the client's complete, valid nine-digit Medicaid number. Valid Medicaid numbers begin with 1, 2, 3, 4, 5, 6 or 7. CSHCN Services Program client numbers begin with a 9.
  - When submitting claims for newborns, use the guidelines in the following section.
- *Referring/Ordering Physician field blank or invalid.* The referring physician's NPI must be present when billing for consultations, laboratory, or radiology. Consult the software vendor for this field's location on the electronic claims entry form.
- *Performing Physician ID field blank or invalid.* When the billing NPI is a *group* practice, the performing NPI for the physician who performed the service must be entered. Consult the software vendor for this field's location on the electronic claim form.
- *Facility Provider field blank or invalid.* When place of service (POS) is anywhere other than home or office, the facility's NPI must be present. If the NPI is not known, enter the name and address of the facility. Consult the software vendor for this field's location on the electronic claims entry form.
- *Invalid Type of Service or Invalid Type of Service/Procedure code combination.* In certain cases some procedure codes will require a modifier to denote the procedure's type of service (TOS).

  Note: *The C21 claims processing system can accept only 40 characters (including spaces) in the Comments section of electronic submissions for ambulance and dental claims. If providers include more than 40 characters in that field, C21 will accept only the first 40 characters; the other characters will not be imported into C21. Providers must ensure that all of the information that is required for the claim to process appropriately is included in the first 40 characters.*

Refer to: Subsection 6.2.5, "Modifier Requirements for TOS Assignment" in this section for TMHP EDI modifier information.

6.2.3.1 Newborn Claim Hints

The following are to be used for newborns:

- If the mother's name is "Jane Jones," use "Boy Jane Jones" for a male child and "Girl Jane Jones" for a female child.
- Enter "Boy Jane" or "Girl Jane" in first name field and "Jones" in last name field. *Always* use "boy" or "girl" first and then the mother's full name. An exact match must be submitted for the claim to process.
- Do not use "NBM" for newborn male or "NBF" for newborn female.

The following are the most common reasons for electronic hospital UB-04 CMS-1450 claim rejections:

- *Admit hour outside allowable range* (such as 24 hours).
- *Billed amount blank.*

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- *Health coverage ID blank or invalid.* This number *must* be the valid nine-digit Medicaid client number. *Incorrect data* includes: a number less than nine digits; PENDING; 999999999; and Unknown.
- *Referring physician information on outpatient claim is blank* when laboratory/radiology services are ordered or a surgical procedure is performed. The referring physician's NPI is required in Fields 78–79. Consult the software vendor for the location of this field on the electronic claims entry form.

6.2.4 TMHP EDI Batch Numbers, Julian Dates

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

- *JJJ – Julian date.* The three J characters represent the Julian date that the file was received by the TMHP EDI Gateway. The first character (J) is displayed as a letter, where I = 0, J = 1, K = 2, and L = 3. The last two characters (JJ) are displayed as numbers. All three characters (JJJ) together represent the Julian date. For example, a Julian date of 143 would be J43.
- *Y – Year.* The Y character represents the last digit of the calendar year when the TMHP EDI Gateway receives the file. For example, a "2" in this position indicates the year 2012.
- *SSSS* = The unique 4-character sequence number assigned by EDI to the batch filed.

6.2.5 Modifier Requirements for TOS Assignment

Modifiers for TOS assignment are not required for Texas Health Steps (THSteps) Dental claims (claim type 021) and Inpatient Hospital claims (claim type 040). Additionally, procedures submitted by specific provider types such as genetics, eyeglass, and THSteps medical checkup are assigned the appropriate TOS based on the provider type or specific procedure code, and will not require modifiers.

Most procedure codes do not require a modifier for TOS assignment, but modifiers are required for some services submitted on professional claims (claim type 020) and outpatient hospital claims (claim type 023). Services that require a modifier for TOS assignment are listed in the following sections.

6.2.5.1 Assistant Surgery

For assistant surgical procedures, use one of the following modifiers: 80, 81, 82, and AS. Using these modifiers results in TOS 8 being assigned to the procedure.

6.2.5.2 Anesthesia

For anesthesia procedures, use one of the following modifiers: AA, AD, QK, QS, QX, QY, and QZ. Using these modifiers results in TOS 7 being assigned to the procedure.

6.2.5.3 Interpretations

For interpretations or professional components of laboratory, radiology, or radiation therapy procedures, use modifier 26. Using modifier 26 results in TOS I being assigned to the procedure.

Note: *Procedure codes that only have a TOS I are not required to use modifier 26.*

6.2.5.4 Technical Components

For technical components of laboratory, radiology, or radiation therapy procedures, use modifier TC. Using this modifier results in TOS T being assigned to the procedure.

Exception: *Outpatient hospitals do not include the TC modifier when they provide technical components of lab and radiology services. These services automatically have TOS 4 or 5 assigned and are subject to the facility's interim reimbursement rate or the clinical lab rate.*

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6.2.6 Electronic Visit Verification (EVV)

All claims for Electronic Visit Verification (EVV) services, including fee-for-service and managed care claims, must be submitted electronically to TMHP using the appropriate electronic claims submission method. Paper claims for EVV services will not be accepted. The EVV aggregator will perform EVV claims matching and TMHP will forward the EVV claim with the EVV match code to the applicable payer for claims processing.

6.3 Coding

Electronic billers must code all claims. TMHP encourages all providers to code their paper claims. Claims are processed fast and accurately if providers furnish appropriate information. By coding claims, providers ensure precise and concise representation of the services provided and are assured reimbursement based on the correct code. If providers code claims, a narrative description is not required and does not need to be included unless the code is a not an otherwise classified code.

Important: *Claims for anesthesia must have the CPT anesthesia procedure code narrative descriptions or CPT surgical codes; if these codes are not included, the claim will be denied.*

The carrier for the Texas Medicare Program has coding manuals available for physicians and suppliers with codes not available in CPT. To order a CPT Coding Manual, write to the following address:

American Medical Association
Book and Pamphlet Fulfillment
PO Box 2964
Milwaukee, WI 53201

6.3.1 Diagnosis Coding

Texas Medicaid requires providers to provide *International Classification of Diseases, Tenth Revision, Clinical Modification* (ICD-10-CM) diagnosis codes on their claims. The *only* diagnosis coding structure accepted by Texas Medicaid is the ICD-10-CM. Diagnosis codes must be to the highest level of specificity available. In most cases a written description of the diagnosis is not required.

All diagnosis codes that are submitted on a claim must be appropriate for the age of the client as identified in the ICD-10-CM description of the diagnosis code. Claims that are denied because one or more of the diagnosis codes submitted on the claim are not appropriate for the age of the client may be appealed with the correct diagnosis code or documentation of medical necessity to justify the use of the diagnosis code.

Diagnosis codes in the following categories are not valid as primary or referenced diagnosis:

- Nonspecific injury, poisoning and other consequences of external causes
- Diagnosis in the International Classification of Diseases for Oncology, 3rd Edition (ICD-O-3)
- Factors influencing health status and contact with health services, unless otherwise directed in this manual.
- External causes of morbidity

6.3.1.1 Place of Service (POS) Coding

The POS identifies where services are performed. Indicate the POS by using the appropriate code for each service identified on the claim.

Important: *Attention ambulance providers: POS 41 and 42 are accepted by Texas Medicaid for ambulance claims processing. The two-digit origin and destination codes are still required for claims processing.*

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Use the following codes for POS identification where services are performed:

POS	2-Digit Numeric Codes	1-Digit Numeric Codes
Office	02, 10, 11, 15, 17, 20, 49, 50, 60, 65, 71, 72	1
Home	12, 27	2
Inpatient hospital	21, 51, 52, 56, 61	3
Outpatient hospital	19, 22, 23, 24, 55, 57, 58, 62	5
Birthing center	25	7
Other location	01, 03, 04, 05, 06, 07, 08, 16, 18, 26, 34, 41, 42, 53, 99	9
Skilled nursing facility or intermediate care facility for individuals with an intellectual disability or related conditions	13, 31, 32, 54	4
Extended care facility (rest home, domiciliary or custodial care, nursing facility boarding home)	14, 33	8
Independent lab	81	6
Destination of ambulance	Indicate destination using above codes	Indicate destination using above codes

Note: *Family planning and THSteps medical services performed in a rural health clinic (RHC) are billed using national POS code 72.*

6.3.2 Type of Service (TOS)

The TOS identifies the specific field or specialty of services provided.

To determine the TOS payable for each procedure code, providers may refer to the online fee lookup (OFL) or the static fee schedules, both are available on the TMHP website at www.tmhp.com.

Refer to: Subsection 6.2.5, "Modifier Requirements for TOS Assignment" in this section for TMHP EDI modifier information.

6.3.2.1 TOS Table

Important: *TOS codes are not used for claim submissions, but they do appear on R&S Reports.*

TOS	Description
0	Blood
1	Medical Services
2	Surgery
3	Consultations
4	Radiology (total component)
5	Laboratory (total component)
6	Radiation Therapy (total component)
7	Anesthesia
8	Assistant surgery

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TOS	Description
9	Other medical items or services
C	Home health services
D	TB clinic
E	Eyeglasses
F	Ambulatory surgical center (ASC)/hospital-based ambulatory surgical center (HASC)
G	Genetics
I	Professional component for radiology, laboratory, or radiation therapy
J	DME purchase new
L	DME rental
R	Hearing aid
S	THSteps medical
T	Technical component for radiology, laboratory, or radiation therapy
W	THSteps dental

6.3.3 Procedure Coding

Texas Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS provides health-care providers and third-party payers a common coding structure that uses codes designed around a five-character numeric or alphanumeric base. The procedure codes are updated annually and quarterly.

HCPCS consists of two levels of codes:

- Level I—Current Procedural Terminology (CPT®) Professional Edition
  - Numeric, five digits
  - Makes up 80 percent of HCPCS
  - Maintained by AMA, which updates it annually
  - Updates by the AMA are coordinated with CMS before modifications are distributed to third-party payers
  - Anesthesia codes from CPT
- Level II—HCPCS
  - Approved and released by CMS
  - Codes for both physician and non-physician services not contained in CPT (for example, ambulance, DME, prosthetics, and some medical codes)
  - Maintained and updated by the CMS Maintenance Task Force
  - Alphanumeric, a single alpha character (A through V) followed by four digits
  - The single alpha character represents one of the following:

Alpha	Description
A	Supplies, ambulance, administrative, miscellaneous
B	Enteral and parenteral therapy
E	DME and oxygen

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Alpha	Description
G	Procedures/professional (temporary)
H	Rehab and behavioral health services
J	Drugs (administered other than orally)
K	Durable Medical Equipment Regional Carriers (DMERC)
L	Orthotic and prosthetic procedures
M	Medical
P	Laboratory
Q	Temporary procedures
R	Radiology
S	Private payer
T	State Medicaid agency
V	Vision and hearing services

6.3.3.1 HCPCS Updates

TMHP updates HCPCS codes on both an annual and quarterly basis. Major updates are made annually and minor updates are made quarterly.

Most of the procedure codes that do not replace a discontinued procedure code must go through the rate hearing process. HHSC conducts public rate hearings to provide an opportunity for the provider community to comment on the Medicaid proposed payment rate, as required by Chapter 32 of the Human Resources Code, §32.0282, and Title 1 of the Texas Administrative Code, §355.201.

6.3.3.1.1 Annual HCPCS

Annual HCPCS updates apply additions, changes, and deletions that include the program and coding changes related to the annual HCPCS, Current Dental Terminology (CDT), and CPT updates. These updates ensure that the coding structure is up-to-date by using the latest edition of the CPT and the nationally established HCPCS codes that are released by CMS.

6.3.3.1.2 Quarterly HCPCS

Quarterly HCPCS updates apply HCPCS additions, changes, and deletions that are released by CMS.

6.3.3.1.3 Rate Hearings for New HCPCS Codes

HHSC holds rate hearings for new HCPCS codes on a regular basis. Rate hearings are announced on the HHSC website at www.hhs.texas.gov/providers/medicaid-business-resources/texas-medicaid-chip-rate-analysis.

Claims for services that are provided before the rates are adopted through the rate hearing process are denied as pending a rate hearing (EOB 02008) until the applicable reimbursement rate is adopted. The client cannot be billed for these services.

Providers are responsible for meeting the initial 95-day filing deadline. Providers must submit the procedure codes that are most appropriate for the services provided, even if the procedure codes have not yet completed the rate hearing process and are denied by Texas Medicaid as pending a rate hearing.

Once the reimbursement rates are established in the rate hearing and applied, TMHP automatically reprocesses affected claims. Providers are not required to appeal the claims unless they are denied for other reasons after the claims reprocessing is complete.

Refer to: Subsection 5.11, "Guidelines for Procedures Awaiting Rate Hearing" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for more information about the authorization guidelines for procedure codes that are awaiting a rate hearing.

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6.3.4 National Drug Code (NDC)

The NDC is an 11-digit number on the package or container from which the medication is administered. All Texas Medicaid fee-for-service and Family Planning providers must submit an NDC for professional or outpatient claims submitted with physician-administered prescription drug procedure.

N4 must be entered before the NDC on claims.

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

The valid units of measurement codes are:

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

Note: *Unit quantities are required.*

6.3.4.1 Paper Claim Submissions

UB-04 CMS 1450

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

CMS-1500

Block No.	Description	Guidelines
24A	Dates of service	In the shaded area, enter the: • NDC qualifier of N4 (e.g., N4) • The 11-digit NDC number on the package or vial from which the medication was administered. Do not enter hyphens or spaces within this number (e.g., 00409231231). ***Example:*** *N400409231231*

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Block No.	Description	Guidelines
24D	Procedures, services, or supplies	In the shaded area, enter the NDC quantity of units administered (up to 12 digits, including the decimal point.). A decimal point must be used for fractions of a unit (e.g., 0.025).
24G	Days or units	In the shaded area, enter the NDC unit of measurement code. There are 5 allowed values: F2, GR, ML, UN, or ME.

2017 Claim Form

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

National Drug Unit

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

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

6.3.4.2 NDC Requirements for Dual Eligible Clients

The 11-digit NDC, NDC quantity, and NDC Unit of measure information is required on all professional and outpatient clinician-administered drug claims for dual-eligible clients. These drug claims are submitted to Medicare, which will cross over to Medicaid for consideration of coinsurance and deductible liabilities.

Important: *Claims which cross over without this required information may be denied due to missing, incomplete, or invalid NDC information. This information applies to all Medicaid providers who serve Medicare-Medicaid dual-eligible clients.*

Providers may refer to subsection 6.3.4, "National Drug Code (NDC)" in this section for more information on NDC requirements. The Texas NDC-to-HCPCS Crosswalk identifies relationships between HCPCS codes.

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6.3.4.3 Drug Rebate Program

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

CMS maintains a list of participating manufacturers and their rebate-eligible drug products, which is updated quarterly on the CMS website. TMHP will republish this list quarterly in a more accessible format.

When providers submit claims for clinician-administered drug procedure codes, they must include the National Drug Code (NDC) of the administered drug as indicated on the drug packaging. While 340B purchased claims are not eligible for drug rebates, NDCs are required to receive federal funding to pay the claim.

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

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

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

> ***Note:*** *Texas Medicaid managed care organizations (MCOs) have their own policies and procedures regarding clinician-administered drugs. Providers must contact the client's MCO for benefit and limitation information.*

Providers can find a complete, downloadable list of procedure codes and the corresponding descriptions on the Vendor Drug Program website at www.txvendordrug.com.

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

6.3.5 Modifiers

Modifiers describe and qualify the services provided by Texas Medicaid. A modifier is placed after the five-digit procedure code. Up to two modifiers may apply per service. Examples of frequently used modifiers are listed in the following table. Refer to the service-specific sections for additional modifier requirements.

Modifier	Special Instructions/Notes (if applicable)
340B Drug Rebate Program	
U8	All eligible organizations and covered entities that are enrolled in the federal 340B Drug Pricing Program to purchase 340B discounted drugs must use modifier U8 when submitting claims for 340B clinician-administered drugs. Non-compliance with this new requirement to use modifier U8 on all claims submitted for 340B clinician-administered drugs may jeopardize a covered entity's 340B status with the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA). Providers can refer to the HRSA website at www.hrsa.gov/opa/index.html for more information about the 340B Drug Pricing Program.
Ambulance	
ET	Use for all emergency transport services.
GY	Use to indicate that no medical necessity existed for a transport.
+ Modifier is required for accurate claims processing. *** Description is defined by the state.**	

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Modifier	Special Instructions/Notes (if applicable)
Surgeons	
53	Use for physician reporting of a discontinued procedure. For outpatient/ASC reporting of a discontinued procedure, see modifier 73 and 74.
54+	Surgeon who performs the surgical procedure only must bill the surgical code with modifier 54 and is reimbursed 70% of the global fee.
55+	Provider who performs the postoperative care only must bill the surgical code with modifier 55 and is reimbursed 20% of the global fee.
56+	Providers who perform the preoperative care only must bill the surgical code with modifier 56 and is reimbursed 10 percent of the global fee.
58+	Staged or related procedure or services by the same physician during the postoperative period.
62+	Cosurgery. Two surgeons perform the specific procedure(s).
76+	Use modifier 76 or 77 for transplant procedures if it is a second transplant of the same organ.
77+	Use modifier 76 or 77 for transplant procedures if it is a second transplant of the same organ.
78+	Return to the operating room for a related procedure during the postoperative period.
79+	Unrelated procedure or service by the same physician during the postoperative period.
Assistant Surgeons	
80 *and* KX+	Use modifier 80 and KX together to indicate an assistant surgeon in a teaching facility: • In a case involving exceptional medical circumstances such as emergency or life-threatening situations requiring immediate attention. • When the primary surgeon has a policy of never, without exception, involving a resident in the preoperative, operative, or postoperative care of one of his or her patients. • In a case involving a complex surgical procedure that qualifies for more than one physician.
AS	Use when the physician assistant is not enrolled as an individual provider and provides assistance at surgery.
Sterilizations	
PM	Use to indicate post-menopausal.
PS	Use to indicate previously sterilized.
Excision of Lesions/Masses	
KX+	Use modifier KX if the excision/destruction is due to one of the following signs or symptoms: inflamed, infected, bleeding, irritated, growing, limiting motion or function. Use of this modifier is subject to retrospective review.
Injections	
AT	Use to indicate acute conditions.
JA	Administered intravenously.
JB	Administered subcutaneously.

+ Modifier is required for accurate claims processing.
*** Description is defined by the state.**

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Modifier	Special Instructions/Notes (if applicable)
KX+	Use modifier KX to indicate the injection was due to: • Oral route contraindicated or an acceptable oral equivalent is not available. • Injectable medication is the accepted treatment of choice. Oral medication regimens have proven ineffective or are not available. • Patient has a temperature over 102 degrees (documented on the claim) and a high level of antibiotic is needed quickly. • Injection is medically necessary into joints, bursae, tendon sheaths, or trigger points to treat an acute condition or the acute flare up of a chronic condition.
Visits	
76+	Use to indicate the repeated non-clinical procedure.
FP+	Use to indicate that the service was part of an annual family planning examination.
TH+	Use with external causes of injury and poisoning (E Codes) procedures and morphology of neoplasms (M Codes) procedures to specify antepartum or postpartum care.
25	Use to describe circumstances in which an office visit was provided at the same time as other separately identifiable services. Refer to the CMS NCCI website for additional information.
Anesthesia	
One of the following modifier combinations must be used by anesthesiologists directing non-CRNA qualified professionals.	
AA and U1	Use to indicate that the anesthesia services were performed personally by the anesthesiologist.
AD and U1 (Emergency circumstances only)	Use when directing five or more concurrent procedures provided by non-CRNA qualified professionals. Used in emergency circumstances only and limited to 6 units (90 minutes) per case for each occurrence requiring five or more concurrent procedures.
QK an U1	Use when directing two, three, or four concurrent procedures provided by non-CRNA qualified professionals.
QY and U1	Use when directing one procedure provided by a non-CRNA qualified professional.
One of the following modifier combinations must be used by anesthesiologists directing CRNAs.	
AD and U2 (Emergency circumstances only)	Use when directing five or more concurrent procedures involving CRNA (s). Used in emergency circumstances only and limited to 6 units (90 minutes) per case for each occurrence requiring five or more concurrent procedures.
QK and U2	Use when directing two, three, or four concurrent procedures involving CRNAs.
QY and U2	Use when directing one procedure by a CRNA.
One of the following modifier combinations must be used by CRNAs.	
QX and U2	Use to indicate the anesthesia was medically directed by the anesthesiologist.
QZ and U1	Use to indicate the anesthesia was directed by the surgeon.
DME	
For DME, use one of the following modifiers:	
NU	For DME purchase new
RR	For DME rental- monthly
+ Modifier is required for accurate claims processing. *** Description is defined by the state.**	

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Modifier	Special Instructions/Notes (if applicable)
UE	For DME other-purchase-used
FQHC and RHC	
Services provided by a health-care professional require one of the following modifiers:	
AH	Use to indicate that the services were performed by a clinical psychologist.
AJ	Use to indicate that the services were performed by a clinical social worker.
AM	Use to indicate that the services were performed by a physician or team member service (includes clinical psychiatrist).
SA	Use to indicate that the services were performed by an advanced practice registered nurse (APRN) or CNM rendering services in collaboration with a physician.
TD	For home services performed by a RN and provided in areas with a shortage of home health agencies.
TE	For home services performed by an LVN and provided in areas with a shortage of home health agencies.
TS	Use to indicate a case management follow-up service.
U1	Licensed professional counselor
U2	Licensed marriage and family therapist
U7*	Physician assistant services for other than assistant at surgery
The following modifiers may be used in addition to the modifier identifying the health-care professional that rendered the service:	
EP	Use to indicate THSteps services (FQHC only).
FP	Use to indicate that the service was part of an annual family planning examination.
TH	Use to indicate the encounter is for antepartum care or postpartum care.
U5*	State-defined modifier for use with case management services.
Abortion	
G7	Use by performing physicians, facilities, anesthesiologists, and CRNAs (with appropriate procedure code) when requesting reimbursement for abortion procedures that are within the scope of the rules and regulations of Texas Medicaid.
Vision	
RB	Use modifier RB to indicate replacement of prosthetic or nonprosthetic eyeglasses or contact lenses.
VP+	Use when billing prosthetic eyeglasses or contact lenses with a diagnosis of aphakia.
Laboratory/Radiology	
26+	Use for laboratory interpretations and radiological procedures.
59-	Code to indicate the procedure or service was independent from other services performed on the same day. Refer to the CMS NCCI website for additional information.
91+	Use for repeat laboratory clinical test.
76	Use for repeat laboratory nonclinical test.
SU+	Indicates necessary equipment is in physician's office for RAST/MAST testing or Pap smears.
TC+	The modifier TC is used for technical radiological procedures.
Q4+	Use for lab/radiology/ultrasound interps by other than the attending physician.
+ Modifier is required for accurate claims processing. *** Description is defined by the state.**	

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Modifier	Special Instructions/Notes (if applicable)
Therapy	
AT+	Must be used to indicate the necessity of an acute condition for occupational therapy (OT), physical therapy (PT), osteopathic manipulation treatment (OMT), or chiropractic services.
GN	Use to indicate outpatient speech language pathology.
GO	Use to indicate outpatient occupational therapy.
GP	Use to indicate outpatient PT.
U4*	Reassessment
THSteps Medical	
AM	Physician, team member service
EP	FQHCs must use modifier EP for services provided under THSteps.
SA	Nurse practitioner rendering service in collaboration with a physician
U5*	Intermediate oral examination with dental varnish
U7*	Physician assistant services for other than assistant at surgery
TD	Registered nurse
THSteps Exceptions to Periodicity	
SC	Medically necessary service or supply
23	Unusual Anesthesia: Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding the modifier *23* to the procedure code of the basic service or by use of the separate five-digit modifier code 09923
32	Mandated Services: Services related to mandated consultation or related services (e.g., peer review organization [PRO], third party payer, governmental, legislative or regulatory requirement) may be identified by adding the modifier 32 to the basic procedure or the service may be reported by use of the five digit modifier 09932
Physicians	
Q5	Informal reciprocal arrangement (period not to exceed 14 continuous days)
Q6	Locum tenens or temporary arrangement (up to 90 days)
Radiology Services	
U6	CT, CTA, MRI, MRA, Cardiac Nuclear Imaging, and PET Scan studies provided in the emergency department. Obstetric ultrasounds provided in the emergency department or during a hospital observation stay.
Durable Medical Equipment	
NU	Use to indicate purchased equipment.
RR	Use to indicate leased equipment.
Telemedicine/Telehealth	
95	Use with appropriate evaluation and management codes.

+ Modifier is required for accurate claims processing.
*** Description is defined by the state.**

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Other Common Modifiers									
AE	AF	AG	AK	AR	CB	CD	CE	CF	CG
KC	KD	KF	LT	M2	RD	RT	SW	SY	TL
U1	U2	U3	UN	UP	UQ	UR	US		

The following modifiers may appear on R&S Reports (they are not entered by the provider):

- *PT.* The DRG payment was calculated on a per diem basis for an inpatient stay because of patient transfer.
- *PS.* The DRG payment was calculated on a per diem basis because the patient exhausted the 30-day inpatient benefit limitation during the stay.
- *PE.* The DRG payment was calculated on a per diem basis because the patient was ineligible for Medicaid during part of the stay. Also used to adjudicate claims with adjustments to outlier payments.

6.3.6 Benefit Code

A benefit code is an additional data element used to identify state programs.

Providers that participate in the following programs must use the associated benefit code when submitting claims and authorizations:

Program	Benefit Code
Comprehensive Care Program (CCP)	CCP
THSteps Medical	EP1
THSteps Dental	DE1
Family Planning Agencies*	FP3
Hearing Aid Dispensers	HA1
Maternity	MA1
County Indigent Health Care Program	CA1
Early Childhood Intervention (ECI) Providers	EC1
Tuberculosis (TB) Clinics	TB1
IDD case management providers	MH2
***Agencies only—Benefit codes should not be used for individual family planning providers.**	

6.4 Claims Filing Instructions

This section contains instructions for completion of Medicaid-required claim forms. When filing a claim, providers should review the instructions *carefully* and complete *all* requested information. A correctly completed claim form is processed faster.

This section provides a sample claim form and its corresponding instruction table for each acceptable Texas Medicaid claim form.

All providers, except those on prepayment review, should submit paper claims to TMHP to the following address:

Texas Medicaid & Healthcare Partnership
Claims
PO Box 200555
Austin, TX 78720-0555

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Providers on prepayment review must submit all paper claims and supporting medical record documentation to the following address:

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

6.4.1 National Correct Coding Initiative (NCCI) Guidelines

The Patient Protection and Affordable Care Act (PPACA) mandates that all claims that are submitted to TMHP be filed in accordance with the NCCI guidelines, including claims for services that have been prior authorized or authorized with medical necessity documentation.

The following NCCI MUE limitations have been deactivated as approved by CMS:

Procedure Codes	Description	Deactivated Limitation (per date of service)	Approved Limitations
A4281, A4282, A4284, A4286	Breast pump replacement parts	1	2 of each part per rolling year
H0005	Group therapy for substance use disorder treatment	1	135 units per calendar year

The CMS NCCI and MUE guidelines can be found on the CMS website at www.cms.gov.

The NCCI guidelines consist of HCPCS or CPT procedure code pairs that must not be reported together and MUEs that determine whether procedure codes are submitted in quantities that are unlikely to be correct.

The NCCI and MUE spreadsheets are published and updated by CMS and are available on the CMS Medicaid NCCI Coding web page under "NCCI and MUE Edits" as follows:

- NCCI edit spreadsheets. The website contains the Medicaid NCCI edit spreadsheet for hospital services and the Medicaid NCCI edit spreadsheet for practitioner services. The spreadsheets list the procedure code pairs that will not be reimbursed separately if they are billed by the same provider with the same date of service. Column 1 procedure codes may be reimbursed and Column 2 procedure codes will be denied. The spreadsheets also contain a column that indicates whether or not a modifier is allowed for services that may be reimbursed separately.
- MUE edit spreadsheets. The website contains the Medicaid MUE edit spreadsheets for hospital services, practitioner services, and supplier services. The spreadsheets list procedure codes and the number of units that may be reimbursed for each procedure code. Units that are submitted beyond these limitations will be denied.

Note: *Providers are required to comply with NCCI and MUE guidelines as well as the guidelines that are published in the Texas Medicaid Provider Procedures Manual, all currently published website articles, fee schedules, and all other application information published on the TMHP website at www.tmhp.com. In instances when Texas Medicaid medical policy is more restrictive than NCCI or MUE guidance, Texas Medicaid medical policy prevails.*

HHSC continue to implement and enforce correct coding initiatives. Providers may see additional claim denials related to NCCI and MUE edits including those services that were prior authorized or authorized with medical necessity documentation.

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If a rendered service does not comply with a guideline as defined by NCCI, medical necessity documentation may be submitted with the claim for the service to be considered for reimbursement; however, medical necessity documentation does not guarantee payment for the service.

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

Claims that were submitted with dates of service from October 1, 2010, through June 30, 2013, will not be reprocessed in accordance with the NCCI guidelines; however, any claims with dates of service on or after October 1, 2010, that are appealed or reprocessed for reasons other than NCCI auditing will be subject to NCCI auditing guidelines.

6.4.1.1 NCCI Processing Categories

The following coding rule categories are applied to claims that are submitted with dates of service on or after October 1, 2010:

Coding Rule Category	Description
Maximum units	CMS has assigned to all procedure codes a maximum number of units that may be submitted for a client per day, regardless of the provider. The maximum number of units for each procedure code is based on the following criteria: • Procedure code description • Anatomical site • CMS sources • Clinical guidelines ***Important:*** *If the maximum number of units has been exceeded on a particular line item, the line item will be denied. The line item will not be cut back to the allowable quantity. The line item may be appealed with the appropriate quantity for consideration.*
NCCI	NCCI is a collection of bundling edits created and sponsored by CMS that are separated into two major categories: Column I and Column II procedure code edits (previously referred to as "Comprehensive" and "Component") and Mutually Exclusive procedure code edits. NCCI edits are applied to services that are performed by the same provider on the same date of service only and do not apply to services that are performed within the global surgical period. Each NCCI code pair edit is associated with a policy as defined in the *National Correct Coding Initiative Policy Manual*. Effective dates apply to code pairs in NCCI and represent the date when CMS added the code pair combination to the NCCI edits. Code combinations are processed based on this effective date. Termination dates also apply to code pairs in NCCI. This date represents the date when CMS removed the code pair combination from the NCCI edits. Code combinations are refreshed quarterly.

6.4.1.2 CPT and HCPCS Claims Auditing Guidelines

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

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

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

The following coding rule categories apply to claims submissions:

Coding Rule Category	Description
Add-on codes	Certain services are commonly carried out in addition to the rendering of the primary procedure and are associated with the primary procedures. These additional or supplemental procedures are referred to as "add-on" procedures. Add-on codes are identified in the CPT Manual with a plus mark ("+") symbol and are also listed in Appendix D of the CPT Manual. Add-on codes are always performed in addition to a primary procedure, and should never be reported as a stand-alone service. When an add-on code is submitted and the primary procedure has not been identified on either the same or different claim, then the add-on code will be denied as an inappropriately-coded procedure. If the primary procedure is denied for any reason, then the add-on code will be denied also.
Deleted HCPCS codes	Procedure codes undergo revision by the AMA and CMS on a regular basis. Revisions typically include adding new procedure codes, deleting procedure codes, and redefining the description of existing procedure codes. These revisions are normally made on an annual basis by the governing entities with occasional quarterly updates. Claims that are received with deleted procedure codes will be validated against the date of service. If the procedure code is valid for the date of service, the claim will continue processing. If the procedure code is invalid for the date of service, the invalid procedure code will be denied.
Diagnosis validity	ICD-10-CM diagnosis codes undergo revision by the Centers for Disease Control and Prevention (CDC) and CMS on a regular basis. Revisions typically include adding new diagnosis codes, deleting diagnosis codes, and redefining the description of existing diagnosis codes. These revisions are normally made on an annual basis. Claims that are received with invalid diagnosis codes will be validated against the date of service. If the diagnosis code is valid for the date of service, the claim will continue processing. If the diagnosis code is invalid for the date of service, the procedure that is referenced to the invalid diagnosis code will be denied.
Diagnosis-age	Certain diagnosis codes are age-specific. If a diagnosis code that is billed does not match the age of the client on that date of service, all services associated with that diagnosis code will be denied.
Diagnosis-gender	Certain diagnosis codes are gender-specific. If the diagnosis code that is billed does not match the gender of the client, all services associated with that diagnosis code will be denied.
Duplicate claim	A duplicate claim is defined as a claim or procedure code detail that exactly matches a claim or procedure code detail that has been reimbursed to the same provider for the same client. Duplicate claims or details include the same date of service, procedure code, modifier, and number of units. Duplicate claims or procedure code details will be denied. ***Note:*** *Modifiers may be used to identify separate services.*

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Coding Rule Category	Description
Evaluation and Management (E/M) services	The AMA defines new and established patients as follows: • A new patient is "one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years." • An established patient is "one who has received a professional service from the physician or another physician of the same specialty who belongs to the same group practice within the past three years." Only one E/M procedure code may be reimbursed for a single date of service by the same provider group and specialty, regardless of place of service. Providers may refer to subsection 9.2.60, "Physician Evaluation and Management (E/M) Services" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for additional information about physician E/M services.
Procedure code definition	The CPT manual assigns each procedure code a specific description or definition to describe the service that is rendered. In order to support correct coding, the procedure code definition rules will deny procedure codes based on the appropriateness of the code selection as directed by the definition and nature of the procedure code.
Procedure code guideline	The CPT manual includes specific reporting guidelines that are located throughout the manual and at the beginning of each section. In order to ensure correct coding, these guidelines provide reporting guidance and must be followed when submitting specific procedure codes.
Procedure-age	Certain procedure codes, by definition or nature of the procedure, are limited to the treatment of a specific age or age group. For example, procedure code 99382 is limited to clients who are 1 through 4 years of age.
Procedure-gender	Certain procedure codes, by definition or nature of the procedure, are limited to the treatment of one gender. For example, hysterectomy procedure code 58150 is limited to female clients.
Total, professional interpretation, and technical services	Diagnostic tests and radiology services are procedure codes that include two components: professional interpretation and technical. The professional interpretation component describes the physician's interpretation and report services and is billed with modifier 26. The technical component describes the technical portion of a procedure, such as the use of equipment and staff needed to perform the service, and is billed with modifier TC. If the professional interpretation and technical components are rendered by the same provider, the total component may be billed using the appropriate procedure code without modifiers 26 and TC. Reimbursement of diagnostic tests and radiology services is limited to no more than the amount for the total component. Providers must refer to the appropriate Texas Medicaid fee schedules to determine payable components for diagnostic and radiology services. Procedure codes that are submitted with an inappropriate modifier will be denied.

6.4.2 Claim Form Requirements

6.4.2.1 Provider Signature on Claims

Every paper CMS-1500, American Dental Association (ADA) Dental Claim Form, and 2017 Claim Form must be submitted with the provider's or an authorized representative's handwritten signature (or signature stamp) in the appropriate block of the claim form. Signatory supervision of the authorized

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representative is required. Providers delegating signature authority to a member of the office staff or to a billing service remain responsible for the accuracy of all information on a claim submitted for payment. Initials are only acceptable for first and middle names. The last name must be spelled out. An acceptable example is J.A. Smith for John Adam Smith. An unacceptable example is J.A.S. for John Adam Smith. Typewritten names must be accompanied by a handwritten signature; in other words, a typewritten name with signed initials is not acceptable. The signature must be contained within the appropriate block of the claim form. Claims prepared by computer billing services or office-based computers may have "Signature on File" printed in the signature block, but it must be in the same font that is used in the rest of the form. For claims prepared by a billing service, the billing service must retain a letter on file from the provider authorizing the service.

Printing the provider's name instead of "Signature on File" is unacceptable. Because space is limited in the signature block, providers should not type their names in the block. Claims not meeting these specifications appear in the "Paid or Denied Claims" sections of the R&S Reports.

6.4.2.2 Group Providers

Providers billing as a group must give the performing provider NPI on their claims as well as the group provider NPI. This requirement excludes THSteps medical providers.

6.4.2.3 Supervising Physician Provider Number Required on Some Claims

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

If a referral or order for services to a Texas Medicaid client is based on a client evaluation that was performed by the supervised provider, the billing provider's claim must include the names and NPIs of both the ordering provider and the supervising provider. The billing provider must obtain all of the required information from the ordering or referring provider before submitting the claim to TMHP.

Providers who submit TexMedConnect electronic claims for professional, ambulance, or vision services can provide the claim information in the designated field for the supervising provider of the referring or ordering provider.

Providers can refer to TexMedConnect instructions on the TMHP website at www.tmhp.com for details about the "Referring/Other Supervising Provider" field for professional, ambulance, and vision electronic claims.

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

6.4.2.4 Ordering or Referring Provider NPI

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

- If the ordering or referring provider is enrolled in Texas Medicaid as a billing or performing provider, the billing or performing provider NPI must be used on the claim as the ordering or referring provider.
- If the ordering or referring provider is not currently enrolled in Texas Medicaid as a billing or performing provider, the provider must enroll to receive an ordering or referring-only taxonomy and benefit code. After the ordering or referring provider is enrolled, the ordering or referring provider's NPI must be used on the claim as the ordering or referring provider.

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

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Claims that are submitted without the ordering or referring provider's NPI and claims submitted with an NPI for a provider who is not enrolled in Texas Medicaid may be subject to retrospective review and denial for a missing or invalid NPI.

Note: *Providers who enroll in Texas Medicaid as ordering- and referring-only providers can use their NPI for orders and referrals for Texas Medicaid clients and CSHCN Services Program clients.*

6.4.2.5 Attending Provider NPI Requirements

The attending provider is the individual who would normally be expected to certify and re-certify the medical necessity of the number of services rendered or who has primary responsibility for the patient's medical care and treatment.

Note: *Outpatient claim providers may be instructed to submit the ordering provider name and NPI number in the attending provider field.*

6.4.2.6 Prior Authorization Numbers on Claims

Claims filed to TMHP must contain only one prior authorization number per claim. Prior authorization numbers must be indicated on the appropriate electronic field or on the paper claim forms in the indicated block:

- CMS-1500—Block 23
- UB-04 CMS-1450—Block 63
- ADA—Block 2
- Family Planning—Block 30

6.4.2.7 Newborn Clients Without Medicaid Numbers

If a Medicaid eligible newborn has not been assigned a Medicaid number on the DOS, the provider may temporarily submit claims using the mother's Medicaid identification number until the newborn's individual Medicaid number has been assigned. Once the newborn's Medicaid number is assigned, the provider must use the newborn's number for all subsequent claims.

All claims must be filed within 95 days of the DOS. Providers verify eligibility through TexMedConnect or by calling the AIS or the TMHP Contact Center at 800-925-9126.

6.4.2.8 Multipage Claim Forms

6.4.2.8.1 Professional Claims

The approved electronic claims format is designed to list 50 line items. The total number of details allowed for a professional claim by the TMHP claims processing system (C21) is 28. If the services provided exceed 28 line items on an approved electronic claims format or 28 line items on paper claims, the provider must submit another claim for the additional line items.

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

Note: *Providers who submit professional claims for inpatient services are required to include only the facility's NPI on the CMS-1500 paper claim form or electronic equivalent.*

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6.4.2.8.2 Institutional Claims

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

An EDI approved electronic format of the UB-04 CMS-1450 is designed to list 71 lines. C21 merges like revenue codes together to reduce the lines to 28 or less.

Providers submitting electronic claims using TexMedConnect may not submit more than 28 lines. If the services exceed the 28 lines, the provider may submit another claim for the additional lines or merge codes.

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

When splitting a claim, all pages must contain the required information. Usually, there are logical breaks to a claim. For example, the provider may submit the surgery charges in one claim and the subsequent recovery days in the next claim.

TEFRA hospitals are required to submit all charges.

6.4.2.8.3 Inpatient Hospital Claims

Medicaid present-on-admission (POA) reporting is required for all inpatient hospital claims that are paid under prospective payment basis methodology. No hospitals are exempt from this POA requirement.

Medicare crossover hospital claims must also comply with the Medicaid requirement to include the POA values. Claims submitted without the POA indicators are denied. POA values are:

POA Value	Description	Payment
Y	Diagnosis was present at the time of admission.	Payment will be made by Texas Medicaid when a hospital acquired condition (HAC) is present.
N	Diagnosis was not present at the time of admission.	No payment will be made by Texas Medicaid when an HAC is present.
U	Documentation was insufficient.	No payment will be made by Texas Medicaid when an HAC is present.
W	Clinically undetermined.	Payment will be made by Texas Medicaid when an HAC is present.
Blank	Exempt from POA Reporting	Exempt from POA Reporting

Note: *Texas Medicaid follows Medicare guidelines for payments referenced in the above table.*

Depending on the POA indicator value, the DRG may be recalculated, which could result in a lower payment to the hospital facility provider. If the number of days on an authorization is higher than the number of days allowed as a result of a POA DRG recalculation, the lesser of the number of days is reimbursed.

Refer to: *Federal Register*, Vol. 76, No. 108 (for CMS).

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6.4.2.9 Attachments to Claims

To expedite claims processing, providers must supply all information on the claim form itself and limit attachments to those required by TMHP or necessary to supply information to properly adjudicate the claim. The following claim form attachments are required when appropriate:

- All claims for services associated with an elective sterilization must have a valid Sterilization Consent Form attached or on file at TMHP.
- Nonemergency ambulance transfers must have documentation of medical necessity including out-of-locality transfers.
- For fee-for-service clients, providers filing to TMHP for Medicaid payment of Medicare coinsurance and deductible according to current payment guidelines must attach the paper MRAN received from Medicare or a Medicare intermediary or the computer generated MRANs from the CMS-approved software applications MREP for professional services or PC-Print for institutional services. Providers that submit paper crossover claims must submit only one of the approved MRAN formats.
- For MAP clients, providers filing to TMHP for Medicaid payment of Medicare coinsurance and deductible according to current payment guidelines must submit with the paper claim the TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template with the MAP EOB. If the template and MAP EOB contain conflicting information, the claim will not be processed and will be returned to the provider.
- Medically necessary abortions performed (on the basis of a physician's professional judgement, the life of the mother is endangered if the fetus were carried to term), or abortions provided for pregnancy related to rape or incest must have a signed and dated physician certification statement. Elective abortions are *not* benefits of Texas Medicaid.
- Hysterectomies must have a Hysterectomy Acknowledgment Statement attached or on file at TMHP.

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

- 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.*

6.4.2.10 Clients with a Designated or Primary Care Provider

Claims for clients with a primary care provider or designated provider (i.e., Texas Medicaid fee-for-service clients enrolled as Limited Program clients) must indicate the primary care provider or designated provider NPIs in the billing or performing provider fields.

When clients receive services from a different provider, such as a specialist, the primary care provider or designated provider's information must be included in the referring provider fields on the claim.

6.5 CMS-1500 Paper Claim Filing Instructions

The following providers bill for services using the ANSI ASC X12 837P 5010 electronic specifications or the CMS-1500 paper claim form:

Providers
Ambulance
ASC (freestanding)

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Providers
Case Management for Blind and Visually Impaired Children (BVIC), Case Management for Early Childhood Intervention (ECI), and Case Management for Children and Pregnant Women
Certified nurse-midwife (CNM)
Certified registered nurse anesthetist (CRNA)
Certified respiratory care practitioner (CRCP)
Chemical dependency treatment facilities
Chiropractor
Clinical nurse specialist (CNS)
Dentist (doctor of dentistry practicing as a limited physician)
DME
Family planning agency that does not also receive funds from the HHSC Family Planning Program
FQHC
Genetic service agency
Hearing aid
IDD case management
In-home total parenteral nutrition (TPN) supplier
Laboratory
Licensed dietitian (CCP only)
Licensed clinical social worker (LCSW)
Licensed professional counselor (LPC)
Maternity service clinic (MSC)
Mental health (MH) targeted case management
Mental health (MH) rehabilitative services
Nurse practitioner (NP)
Occupational therapist (CCP only)
Optician/optometrist/ophthalmologist
Orthotic and prosthetic supplier (CCP only)
Pharmacy
Physical therapist
Physician (group and individual)
Physician assistant (PA)
Podiatrist
Private duty nurse (PDN) (CCP only)
Psychologist
Radiology
Rural Health Clinics rendering services to THSteps clients
School Health and Related Services (SHARS)
Speech language pathologist (CCP only)
THSteps medical
Tuberculosis clinic

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Providers obtain copies of the CMS-1500 paper claim form from a vendor of their choice; TMHP does not supply them.

6.5.1 CMS-1500 Electronic Billing

Electronic billers must submit CMS-1500 paper claim forms with TexMedConnect or approved vendor software that uses the ANSI ASC X12 837P 5010 format. Specifications are available to providers developing in-house systems, software developers, and vendors on the TMHP website at www.tmhp.com/topics/edi. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 888-863-3638.

Refer to: Subsection 3.2, "Electronic Billing" in "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information about electronic billing.

6.5.2 CMS-1500 Claim Form (Paper) Billing

Claims must contain the billing provider's complete name, physical address with ZIP +4 code, taxonomy, and benefit code (if applicable). Claims without this information cannot be processed. Each claim form must have the appropriate signatory evidence in the signature certification block.

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

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

6.5.3 CMS- 1500 Provider Definitions

The following definitions apply to the provider terms used on the CMS-1500 paper claim form:

Referring Provider

The referring provider is the individual who directed the patient for care to the provider that rendered the services being submitted on the claim form.

Examples include, but are not limited to the following:

- A primary care provider referring to a specialist
- An orthodontist referring to an oral and maxillofacial surgeon
- A physician referring to a physical therapist
- A provider referring to a home health agency

Ordering Provider

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

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

Rendering Provider

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

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

Supervising Provider

The supervising provider is the individual who provided oversight of the rendering provider and the services listed on the CMS-1500 paper claim form.

An example would be the supervision of a resident physician.

Purchased Service Provider

A purchased service provider is an individual or entity that performs a service on a contractual or reassignment basis.

Examples of services include the following:

- Processing a laboratory specimen
- Grinding eyeglass lenses to the specifications of the referring provider
- Performing diagnostic testing services (excluding clinical laboratory testing) subject to Medicare's antimarkup rule

In the case where a substitute provider is used, that individual is not considered a purchased service provider.

6.5.4 CMS-1500 Instruction Table

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

Block No.	Description	Guidelines
1a	Insured's ID No. (for program checked above, include all letters)	Enter the client's nine-digit patient number from the Medicaid identification form. For other property & casualty claims: Enter the Federal Tax ID or SSN of the insured person or entity.
2	Patient's name	Enter the client's last name, first name, and middle initial as printed on the Medicaid identification form. If the insured uses a last name suffix (e.g., Jr, Sr) enter it after the last name and before the first name.
3	Patient's date of birth Patient's sex	Enter numerically the month, day, and year (MM/DD/YYYY) the client was born. Indicate the client's gender by checking the appropriate box. Only one box can be marked.
5	Patient's address	Enter the client's complete address as described (street, city, state, and ZIP code).
8	Benefit code	Enter the benefit code (if applicable) for the billing provider.
9	Other insured's name	For special situations, use this space to provide additional information such as: If the client is deceased, enter "DOD" in block 9 and the time of death in 9a if the services were rendered on the date of death. Enter the date of death in block 9b.

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Block No.	Description	Guidelines
10a 10b 10c	Is patient's condition related to: a. Employment (current or previous)? b. Auto accident? c. Other accident?	Check the appropriate box. If other insurance is available, enter appropriate information in blocks 11, 11a, and 11b.
11 11a 11b	Other health insurance coverage	• If another insurance resource has made payment or denied a claim, enter the name of the insurance company. The other insurance EOB or denial letter must be attached to the claim form. • If the client is enrolled in Medicare attach a copy of the MRAN to the claim form. • For Workers Compensation and other property and casualty claims: (Required if known) Enter Workers' Compensation or property and casualty claim number assigned by the payer.
11c	Insurance plan or program name	Enter the benefit code, if applicable, for the billing or performing provider.
12	Patient's or authorized person's signature	Enter "Signature on File" or the patient's or authorized person's legal signature. When the legal signature is entered, enter the date signed in eight-digit format (MMDDYYYY). TMHP will process the claim without the signature of the patient.
14	Date of current	Enter the first date (MM/DD/YYYY) of the present illness or injury. For pregnancy enter the date of the last menstrual period. If the client has chronic renal disease, enter the date of onset of dialysis treatments. Indicate the date of treatments for PT and OT.
17	Name of referring physician or other source	Enter the name (First Name, Middle Initial, Last Name) and credentials of the professional who referred, ordered, or supervised the service(s) or supplies on the claim. If multiple providers are involved, enter one provider using the following priority order: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider Do not use periods or commas within the name. A hyphen can be used for hyphenated names. Enter the applicable qualifier to identify which provider is being reported. DN = Referring Provider DK = Ordering Provider DQ = Supervising Provider Supervising Physician for Referring Physicians: If there is a Supervising Physician for the referring or ordering provider that is listed in Block 17, the name and NPI of the supervising provider must go in Block 19.

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

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Block No.	Description	Guidelines
24a	Date(s) of service	Enter the date of service for each procedure provided in a MM/DD/YYYY format. If more than one date of service is for a single procedure, each date must be given on a separate line. **NDC** In the shaded area, enter the: • NDC qualifier of N4 (e.g., N4). • The 11-digit NDC number on the package or vial from which the medication was administered. Do not enter hyphens or spaces within this number (e.g., 00409231231). ***Example:*** *N400409231231* ***Refer to:*** Subsection 6.3.4, "National Drug Code (NDC)" in this section.
24b	Place of service	Select the appropriate POS code for each service from the table under subsection 6.3.1.1, "Place of Service (POS) Coding" in this section.
24c	EMG (THSteps medical checkup condition indicator)	Enter the appropriate condition indicator for THSteps medical checkups. ***Refer to:*** Subsection 4.3.6, "THSteps Medical Checkups" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).
24d	Fully describe procedures, medical services, or supplies furnished for each date given	Enter the appropriate procedure codes and modifier for all services billed. If a procedure code is not available, enter a concise description. **NDC** In the shaded area, enter a 1- through 12-digit NDC quantity of unit. A decimal point must be used for fractions of a unit (e.g., 0.025). ***Refer to:*** Subsection 6.3.4, "National Drug Code (NDC)" in this section.
24e	Diagnosis pointer	In 24 E, enter the diagnosis code reference letter (pointer) as shown in Form Field 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference number for each service should be listed first, other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. Diagnosis codes must be entered in Form Field 21 only. Do not enter diagnosis codes in Form Field 24E.
24f	Charges	Indicate the usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay clients.

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Block No.	Description	Guidelines
24g	Days or units	If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed). ***Note:*** *The maximum number of units per detail is 9,999.* **NDC** In the shaded area, enter the NDC unit of measurement code. There are 5 allowed values: F2, GR, ML, UN or ME. ***Refer to:*** Subsection 6.3.4, "National Drug Code (NDC)" in this section.
24j	Rendering provider taxonomy code (performing)	Enter the taxonomy code of the individual rendering services unless otherwise indicated in the provider specific section of this manual. Enter the taxonomy code in the shaded area of the field. Entered the NPI in the unshaded area of the field.
26	Patient's account number	**Optional:** Enter the client identification number if it is different than the subscriber/insured's identification number. Used by provider's office to identify internal client account number.
27	Accept assignment	**Required** All providers of Texas Medicaid must accept assignment to receive payment by checking **Yes**.
28	Total charge	Enter the total charges. For multi-page claims enter "continue" on initial and subsequent claim forms. Indicate the total of all charges on the last claim. ***Note:*** *Indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form.*
29	Amount paid	Enter any amount paid by an insurance company or other sources known at the time of submission of the claim. Identify the source of each payment and date in block 11. If the client makes a payment, the reason for the payment must be indicated in block 11.
30	Balance due	If appropriate, subtract block 29 from block 28 and enter the balance.
31	Signature of physician or supplier	The physician, supplier, or an authorized representative must sign and date the claim. Billing services may print "Signature on File" in place of the provider's signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice. ***Refer to:*** Subsection 6.4.2.1, "Provider Signature on Claims" in this section.

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Block No.	Description	Guidelines
32	Service facility location information	If services were provided in a place other than the client's home or the provider's facility, enter name, address, and ZIP+4 code of the facility where the service was provided. This is a required field for services provided in a facility. The facility provider number, name, and address are not optional.
32A	NPI	Enter the NPI of the service facility location.
33	Billing provider info & PH #	Enter the billing provider's name, physical address, city, state, ZIP+4 code, and telephone number.
33A	NPI	Enter the NPI of the billing provider.
33B	Other ID #	Enter the taxonomy code of the billing provider.

6.6 UB-04 CMS-1450 Paper Claim Filing Instructions

The following provider types may bill electronically or use the UB-04 CMS-1450 paper claim form when requesting payment:

Provider Types
ASCs (hospital-based)
Comprehensive outpatient rehabilitation facilities (CORFs) (CCP only)
FQHCs ***Note:*** *Must use CMS-1500 when billing THSteps.*
Home health agencies
Hospitals • Inpatient (acute care, rehabilitation, military, and psychiatric hospitals) • Outpatient
Indian Health
Renal dialysis center
Personal Care Services (PCS)
RHCs (freestanding and hospital-based) ***Note:*** *Must use CMS-1500 when billing THSteps.*

If a service is rendered in the facility setting but the facility's medical record does not clearly support the information submitted on the facility claim, the facility may request additional information from the physician before submitting the claim to ensure the facility medical record supports the filed claim.

> ***Note:*** *In the case of an audit, facility providers will not be allowed to submit an addendum to the original medical records for finalized claims.*

6.6.1 UB-04 CMS-1450 Electronic Billing

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

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Refer to: Subsection 3.2, "Electronic Billing" in "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for more information about electronic billing.

Note: *The maximum number of electronic claim details that will be accepted electronically is 71. Only 28 details will be processed.*

6.6.2 UB-04 CMS-1450 Claim Form (Paper) Billing

Providers obtain the UB-04 CMS-1450 paper claim forms from a vendor of their choice.

Note: *To avoid claim denial, only the provider's NPI should be placed in form locators 76-79 of the UB-04 CMS-1450 paper claim form or in the referring provider field on the electronic claim unless the client is a limited client.*

Completed UB-04 CMS-1450 claims must contain the billing provider's full name, physical address, including the ZIP+4 Code, NPI, taxonomy and benefit code (if applicable). Claims *without* this information in the appropriate fields *cannot* be processed.

Refer to: The Institutional paper claim form (CMS-1450) CMS website at www.cms.gov for more information about the CMS-1450 paper claim form. Providers can purchase CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms. Providers can find examples of completed claim forms on the Claim Form Examples page of the TMHP website at www.tmhp.com.

Subsection 6.6.3, "UB-04 CMS-1450 Instruction Table" in this section.

6.6.3 UB-04 CMS-1450 Instruction Table

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

Block No.	Description	Guidelines
1	Unlabeled	Enter the hospital name, street, city, state, ZIP+4 Code, and benefit code (if applicable).
3a	Patient control number	**Optional:** Any alphanumeric character (limit 16) entered in this block is referenced on the R&S Report.
3b	Medical record number	Enter the patient's medical record number (limited to ten digits) assigned by the hospital.
4	Type of bill (TOB)	Enter a TOB code. First Digit—Type of Facility: 1 Hospital 2 Skilled nursing 3 Home health agency 7 Clinic (rural health clinic [RHC], federally qualified health center [FQHC], and renal dialysis center [RDC]) 8 Special facility Second Digit—Bill Classification (except clinics and special facilities): 1 Inpatient (including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital-referenced diagnostic services, for example, laboratories and X-rays) 7 Intermediate care

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Block No.	Description	Guidelines
		Second Digit—Bill Classification (clinics only): 1 Rural health 2 Hospital-based or independent renal dialysis center 3 Free standing 5 CORFs Third Digit—Frequency: 0 Nonpayment/zero claim 1 Admit through discharge 2 Interim-first claim 3 Interim-continuing claim 4 Interim-last claim 5 Late charges-only claim 6 Adjustment of prior claim 7 Replacement of prior claim
6	Statement covers period	Enter the beginning and ending dates of service billed.
8a	Patient identifier	**Optional:** Enter the patient identification number if it is different than the subscriber/insured's identification number. Used by providers office to identify internal patient account number.
8b	Patient name	Enter the patient's last name, first name, and middle initial as printed on the Medicaid identification form.
9a–9b	Patient address	Starting in 9a, enter the patient's complete address as described (street, city, state, and ZIP+4 Code).
10	Birthdate	Enter the patient's date of birth (MM/DD/YYYY).
11	Sex	Indicate the patient's gender by entering an "M" or "F."
12	Admission date	Enter the numerical date (MM/DD/YYYY) of admission for inpatient claims; date of service (DOS) for outpatient claims; or start of care (SOC) for home health claims. Providers that receive a transfer patient from another hospital must enter the actual dates the patient was admitted into each facility.
13	Admission hour	Use military time (00 to 23) for the time of admission for inpatient claims or time of treatment for outpatient claims.
14	Priority (Type) of Admission or Visit	Providers can refer to the National Uniform Billing Code website at www.nubc.org for the current list of Priority (Type) of Admission or Visit codes.
15	Point of Origin for Admission or Visit	Providers can refer to the National Uniform Billing Code website at www.nubc.org for the current list of Point of Origin for Admission or Visit codes.
16	Discharge hour	For inpatient claims, enter the hour of discharge or death. Use military time (00 to 23) to express the hour of discharge. If this is an interim bill (patient status of "30"), leave the block blank.
17	Patient Discharge Status	Providers can refer to the National Uniform Billing Code website at www.nubc.org for the current list of Patient Discharge Status Codes.
18–28	Condition codes	Enter the two-digit condition code "05" to indicate that a legal claim was filed for recovery of funds potentially due to a patient.
29	ACDT state	**Optional:** Accident state.
31-34	Occurrence codes and dates	Providers can refer to the National Uniform Billing Code website at www.nubc.org for the current list of Occurrence Codes.

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Block No.	Description	Guidelines
35-36	Occurrence span codes and dates	For inpatient claims, enter code "71" if this hospital admission is a readmission within seven days of a previous stay. Enter the dates of the previous stay. For inpatient claims, enter occurrence span code 82 for the "from" and "through" dates of the hospital-at-home care. For charges of the at-home care room and board, enter revenue code 0161.
39-41	Value codes	Accident hour–For inpatient claims, if the patient was admitted as the result of an accident, enter value code 45 with the time of the accident using military time (00 to 23). Use code 99 if the time is unknown. For inpatient claims, enter value code 80 and the total days represented on this claim that are to be covered. Usually, this is the difference between the admission and discharge dates. In all circumstances, the number in this block is equal to the number of covered accommodation days listed in Block 46. For inpatient claims, enter value code 81 and the total days represented on this claim that are not covered. The sum of Blocks 39–41 must equal the total days billed as reflected in Block 6.
42-43	Revenue codes and description	For inpatient hospital services, enter the description and revenue code for the total charges and each accommodation and ancillary provided. List accommodations in the order of occurrence. List ancillaries in ascending order. The space to the right of the dotted line is used for the accommodation rate. **NDC** This block should include the following elements in the following order: • NDC qualifier of N4 (e.g., N4) • The 11-digit NDC number on the package or vial from which the medication was administered. Do not enter hyphens or spaces within this number (e.g., 00409231231). • The unit of measurement code. There are 5 allowed values: F2, GR, ML, UN, or ME (e.g., GR). • The unit quantity with a floating decimal for fractional units (limited to 3 digits, e.g., 0.025). ***Example:*** *N400409231231GR0.025* ***Refer to:*** Subsection 6.3.4, "National Drug Code (NDC)" in this section.

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Block No.	Description	Guidelines
44	HCPCS/rates	**Inpatient:** Enter the accommodation rate per day. Match the appropriate diagnoses listed in Blocks 67A through 67Q corresponding to each procedure. If a procedure corresponds to more than one diagnosis, enter the primary diagnosis. Each service and supply must be itemized on the claim form. **Home Health Services** Outpatient claims must have the appropriate revenue code and, if appropriate, the corresponding HCPCS code or narrative description. ***Refer to:*** Subsection 4.5.5, "Outpatient Hospital Revenue Codes" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information on which revenue codes require HCPCs codes. **Outpatient:** Outpatient claims must have the appropriate Healthcare Common Procedure Coding System (HCPCS) code. ***Refer to:*** Subsection 4.5.5, "Outpatient Hospital Revenue Codes" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information on which revenue codes require HCPCs codes. Each service, except for medical/surgical and intravenous (IV) supplies and medication, must be itemized on the claim form or an attached statement. ***Note:*** *The UB-04 CMS-1450 paper claim form is limited to 28 items per inpatient and outpatient claim.* *If necessary, combine IV supplies and central supplies on the charge detail and consider them to be single items with the appropriate quantities and total charges by dates of service. Multiple dates of service may not be combined on outpatient claims.*
45	Service date	Enter the numerical date of service that corresponds to each procedure for outpatient claims. Multiple dates of service may not be combined on outpatient claims.
45 (line 23)	Creation date	Enter the date the bill was submitted.
46	Serv. units	Provide units of service, if applicable. For inpatient services, enter the number of days for each accommodation listed. If applicable, enter the number of pints of blood. When billing for observation room services, the units indicated in this block should always represent hours spent in observation.
47	Total charges	Enter the total charges for each service provided.
47 (line 23)	Totals	Enter the total charges for the entire claim. ***Note:*** *For multi-page claims enter "continue" on initial and subsequent claim forms. Indicate the total of all charges on the last claim and the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form.*

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Block No.	Description	Guidelines
48	Noncovered charges	If any of the total charges are noncovered, enter this amount.
50	Payer Name	Enter the health plan name.
51	Health Plan ID	Enter the health plan identification number.
54	Prior payments	Enter amounts paid by any TPR, and complete Blocks 32, 61, 62, and 80 as required: • Block 32 - Occurrence code and date. • Block 61 - Insured group name • Block 62 - Insurance group number • Block 80 - Remarks. This section is used for requesting the 110-day rule for a third party insurance.
56	NPI	Enter the NPI of the billing provider.
57	Code code (CC)	**Optional:** Area to capture additional information necessary to adjudicate the claims. Required when, in the judgment of the provider, the information is needed to substantiate the medical treatment and is not supported elsewhere on the claim data set.
58	Insured's name	If other health insurance is involved, enter the insured's name.
60	Medicaid identification number	Enter the patient's nine-digit Medicaid identification number.
61	Insured group name	Enter the name and address of the other health insurance.
62	Insurance group number	Enter the policy number or group number of the other health insurance.
63	Treatment authorization code	Enter the prior authorization number if one was issued.
65	Employer name	Enter the name of the patient's employer if health care might be provided.
66	Diagnosis/ Procedure Code Qualifier	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. 9 = ICD-9-CM 0 = ICD-10-CM
67	Principal diagnosis (DX) code and present on admission (POA) indicator	Enter the ICD-10-CM diagnosis code in the unshaded area for the principal diagnosis to the highest level of specificity available. **Required:** POA Indicator—Enter the applicable POA indicator in the shaded area for inpatient claims. ***Refer to:*** Subsection 6.4.2.8.3, "Inpatient Hospital Claims" in this section for POA values.

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Block No.	Description	Guidelines
67A-67Q	Secondary DX codes and POA indicator	Enter the ICD-10-CM diagnosis code in the unshaded area to the highest level of specificity available for each additional diagnosis. Enter one diagnosis per block, using Blocks A through J only. A diagnosis is not required for clinical laboratory services provided to nonpatients (TOB "141"). ***Exception:*** *A diagnosis is required when billing for estrogen receptor assays, plasmapheresis, and cancer antigen CA 125, immunofluorescent studies, surgical pathology, and alphafetoprotein.* ***Note:*** *ICD-10-CM diagnosis codes entered in 67K–67Q are not required for systematic claims processing.* **Required:** POA indicator—Enter the applicable POA indicator in the shaded area for inpatient claims. ***Refer to:*** Subsection 6.4.2.8.3, "Inpatient Hospital Claims" in this section for POA values.
69	Admit DX code	Enter the ICD-10-CM diagnosis code indicating the cause of admission or include a narrative ***Note:*** *The admitting diagnosis is only for inpatient claims.*
70a-70c	Patient's reason DX	**Optional:** New block indicating the patient's reason for visit on unscheduled outpatient claims.
71	Prospective Payment System (PPS) code	**Optional:** The PPS code is assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.
72a-72c	External cause of injury (ECI) and POA indication	**Optional:** Enter the ICD-10-CM diagnosis code in the unshaded area to the highest level of specificity available for each additional diagnosis. **Required:** POA indicator—Enter the applicable POA indicator in the shaded area for inpatient claims. ***Refer to:*** Subsection 6.4.2.8.3, "Inpatient Hospital Claims" in this section for POA values.
74	Principal procedure code and date	Enter the ICD-10-CM procedure code for each surgical procedure and the date (MM/DD/YYYY) each was performed.
74a-74e	Other procedure codes and dates	Enter the ICD-10-CM procedure code for each surgical procedure and the date (MM/DD/YYYY) each was performed.
76	Attending provider	Enter the attending provider name and NPI. Outpatient claims require an attending provider. Inpatient claims, services that require an attending provider are defined as those listed in the ICD-10-CM coding manual volume 3, which includes surgical, diagnostic, or medical procedures.
77	Operating	Enter operating provider's name (last name and first name) and NPI number of the operating provider.

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Block No.	Description	Guidelines
78-79	Other	Other provider's name (last name and first name) and NPI. NPI number of the referring and prescribing provider. Other operating physician—An individual performing a secondary surgical procedure or assisting the operating physician. Required when another operating physician is involved. Rendering provider—The health-care professional who performed, delivered, or completed a particular medical service or nonsurgical procedure. ***Important:*** *Qualifier 82 is required to identify the rendering provider for acute care inpatient and outpatient institutional services.* ***Note:*** *If the referring physician is a resident, Blocks 76 through 79 must identify the physician who is supervising the resident.*
80	Remarks	This block is used to explain special situations such as the following: • The home health agency must document in writing the number of Medicare visits used in the nursing plan of care and also in this block. • If a patient stays beyond dismissal time, indicate the medical reason if additional charge is made. • If billing for a private room, the medical necessity must be indicated, signed, and dated by the physician. • If services are the result of an accident, the cause and location of the accident must be entered in this block. The time must be entered in Block 39. • If laboratory work is sent out, the name and address or the provider identifier of the facility where the work was forwarded must be entered in this block. • If the services resulted from a family planning provider's referral, write "family planning referral." • If services were provided at another facility, indicate the name and address of the facility where the services were rendered. • Request for 110-day rule for a third party insurance.
81A-81D	Other identification (ID) number	Enter the taxonomy code (non-NPI number) of the billing provider.

6.6.4 Filing Tips for Outpatient Claims

The following are outpatient claim filing tips:

- Use HCPCS codes in Block 44 when available and give a narrative description in Block 43 for all services and supplies provided.

Important: *Services and supplies that exceed the 28 items per claim limitation must be submitted on an additional UB-04 CMS-1450 paper claim form and will be assigned a different claim number by TMHP.*

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- Combine central supplies and bill as one item. IV supplies may be combined and billed as one item. Include appropriate quantities and total charges for each combined procedure code used. Using combination procedure codes conserves space on the claim form.
- The 28-item limitation per claim: a UB-04 CMS-1450 paper claim form submitted with 28 or fewer items is given an internal control number (ICN) by TMHP. Multipage claim forms are processed as one claim for that client *if all* pages contain 28 or fewer items.
- Itemized Statements: Itemized statements are not used for assignment of procedure codes. HCPCS codes or narrative descriptions of procedures *must* be reflected on the face of the UB-04 CMS-1450 paper claim form. Attachments will only be used for clarification purposes.

Refer to: Subsection 6.3.3, "Procedure Coding" in this section.

6.7 American Dental Association (ADA) Dental Claim Filing Instructions

Providers billing for dental services and Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) dental services may bill electronically or use the ADA claim form.

Note: *TMHP is responsible for reimbursing all THSteps dental services provided by dentists.*

6.7.1 ADA Dental Claim Electronic Billing

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

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

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for more information about electronic filing.

6.7.2 ADA Dental Claim Form (Paper) Billing

All participating THSteps dental providers are required to submit a ADA Dental claim form for paper claim submissions to Texas Medicaid. These forms may be obtained by contacting the ADA at 800-947-4746.

Claims must contain the billing provider's complete name, physical address, NPI, and taxonomy code. Claims without a provider name, physical address, NPI, and taxonomy code cannot be processed.

6.7.3 ADA Dental Claim Form

Samples of the ADA Dental Claim form can be found on the ADA website at www.ada.org.

6.7.4 ADA Dental Claim Form Instruction Table

The following table is an itemized description of the questions appearing on the form. Thoroughly complete the ADA Dental claim form according to the instructions in the table to facilitate prompt and accurate reimbursement and reduce follow-up inquiries.

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ADA Block No.	ADA Description	Instructions
1	Type of Transaction	For Texas Medicaid, check the Statement of Actual Services Box. The other two boxes are not applicable. Do not use the ADA Dental Claim Form as a Texas Medicaid Prior Authorization form. ***Refer to:*** THSteps Dental Mandatory Prior Authorization Request Form on the TMHP website at www.tmhp.com.
2	Predetermination/ Preauthorization Number	Enter prior authorization number if assigned by Medicaid.
3	Company/Plan Name, Address, City, State, ZIP Code	Enter TMHP and the address. ***Refer to:*** Subsection A.11, "Written Communication With TMHP" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*).
4	Other Dental or Medical Coverage	Check applicable box. If both "Dental" and "Medical" are marked, complete blocks 5–11 for dental only.
5-11	Other Coverage Information	General notes: • Enter the information for non-Medicaid insurance coverage. • Enter the information for the policyholder or subscriber, not necessarily the patient. May be a parent or legal guardian of the patient receiving treatment.
5	Name of Policyholder/ Subscriber in # 4	Enter the policyholder/subscriber name.
6	Date of Birth (MM/DD/ CCYY)	Enter policyholder/subscriber eight-digit date of birth (MM/ DD/YYYY).
7	Gender	Check the appropriate box for the policyholder/subscriber gender
8	Policyholder/Subscriber ID	Enter policyholder/subscriber identifier.
9	Plan/Group Number	Enter policyholder/subscriber plan/group number.
10	Patient's Relationship to Person Named in # 5	Enter the patient's relationship to policyholder/subscriber.
11	Other Insurance Company/Dental Benefit Plan Name, Address, City, State, ZIP Code	Enter the contact information for the insurance company providing the non-Medicaid coverage.
12	Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code	Enter the Medicaid patient's last name, first name, and middle initial as printed on the Medicaid identification form.
13	Date of Birth (MM/DD/ CCYY)	Enter the Medicaid patient's date of birth (MM/DD/YYYY).

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ADA Block No.	ADA Description	Instructions
14	Gender	Check the appropriate box for the Medicaid patient's gender.
15	Policyholder/Subscriber ID	Enter nine-digit patient number from the Medicaid identification form.
16	Plan/Group/Number	Enter the billing provider's benefit code, if applicable.
17	Employer Name	Not applicable to Texas Medicaid.
18	Relationship to Policyholder/ Subscriber in # 12 Above	Not applicable to Texas Medicaid.
19	Reserved for Local Use	Leave blank and skip to Item 20. (Field was previously used to report "Student Status") Include the appropriate modifier.
20	Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code	Not applicable to Texas Medicaid.
21	Date of Birth (MM/DD/CCYY)	Not applicable to Texas Medicaid.
22	Gender	Not applicable to Texas Medicaid.
23	Patient ID/Account # (Assigned by Dentist)	**Optional**: Enter the patient identification number if it is different than the subscriber/insured's identification number. Used by dental office to identify internal patient account number.
24	Procedure Date (MM/DD/CCYY)	Enter the eight-digit date of service (MM/DD/YYYY).
25	Area of Oral Cavity	Not applicable to Texas Medicaid.
26	Tooth System	Not applicable to Texas Medicaid.
27	Tooth Number(s) or Letter(s)	Enter the Tooth ID as required for procedure code. ***Refer to:*** Subsection 3.2.14, "Tooth Identification (TID) and Surface Identification (SID) Systems" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).
28	Tooth Surface	Enter Surface ID as required for procedure code. ***Refer to:*** Subsection 3.2.14, "Tooth Identification (TID) and Surface Identification (SID) Systems" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).
29	Procedure Code	Use an appropriate Current Dental Terminology (CDT) procedure code.
29a	Diagnosis Code Pointer	Enter the letter(s) from Box 34 that identified the diagnosis code(s)applicable to the dental procedure. List the primary diagnosis pointer first.
29b	Procedure Quantity	Enter the number of times (01-99) the procedure identified in Item 29 is delivered to the patient on the date of service shown in item 24. The default value is "01".
30	Description	Provide a brief description of the service provided (e.g., abbreviation of the procedure code's nomenclature).

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ADA Block No.	ADA Description	Instructions
31	Fee	Enter usual and customary charges for each service listed. Charges must not be higher than the fees charged to private pay clients.
31a	Other Fee(s)	When other changes applicable to dental services provided must be reported, enter the amount here. Charges may include state tax and other charges imposed by regulatory bodies. Identify the source of each payment date in Block 11. If the client makes a payment, the reason for the payment must be identified in Block 11.
32	Total Fee	Enter the sum of all fees in Block 31. For multi-page claims, enter "continue" on initial and subsequent claim forms. Indicate the total of all charges on the last claim. ***Note:*** *Indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form.*
33	Missing Teeth Information	Mark an "X" on each missing tooth. For identifying missing permanent dentition only. Report missing teeth when pertinent to periodontal, prosthodontic (fixed and removable), or implant services procedures on a particular claim.
34	Diagnosis Code List Qualifier	Enter "AB= ICD-10" to identify the diagnosis code source.
34a	Diagnosis Codes(s)	Enter up to four applicable diagnosis codes after each letter (A-D). The primary diagnosis code is entered adjacent to the letter "A".
35	Remarks	Use this space for: • Explanation of exception to periodicity. • The facility name and address and NPI if the place of treatment indicated in Block 38 is not the provider's office. • Explanation of emergency if indicated in Block 45. • To provide more information such as reports for local orthodontia codes, 999 codes, multiple supernumerary teeth, or remarks.
36	Patient/Guardian signature	Not applicable to Texas Medicaid.
37	Subscriber signature	Not applicable to Texas Medicaid.

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ADA Block No.	ADA Description	Instructions
38	Place of Treatment	Enter the 2-digit place of service (POS) code for professional claims, which is a Health Insurance Portability and Accountability Act (HIPAA) standard. Frequently used POS codes include the following: • 11=Office • 12=Home • 21=Inpatient hospital • 22= Outpatient hospital • 31=Skilled nursing facility • 32= Nursing facility
39	Enclosures	Enter a "Y" or "N" to indicate whether or not there are enclosures of any type included with the claim submission (e.g., radiographs, oral images, models).
40	Is Treatment for Orthodontics?	Check Yes or No as appropriate.
41	Date Appliance Placed	Not applicable to Texas Medicaid.
42	Months of Treatment Remaining	Not applicable to Texas Medicaid.
43	Replacement of Prosthesis?	Not applicable to Texas Medicaid.
44	Date Prior Placement	Not applicable to Texas Medicaid.
45	Treatment Resulting from (Check applicable box)	Providers are required to check the Other Accident box for emergency claim reimbursement. If the Other Accident box is checked, information about the emergency must be provided in Block 35.
46	Date of Accident (MM/DD/CCYY)	Not applicable to Texas Medicaid.
47	Auto Accident State	Not applicable to Texas Medicaid.
48	Name, Address, City, State, ZIP Code	Enter the name and physical address of the billing group or individual provider. Do not enter the name and address of a provider employed within a group.
49	NPI	Enter the billing provider's NPI for a group or an individual. Do not enter the NPI for a provider employed within a group.
50	License Number	Not applicable to Texas Medicaid.
51	Social Security Number (SSN) or Tax Identification Number (TIN)	Not applicable to Texas Medicaid.
52	Telephone Number	Enter the area code and number for the billing group or individual Do not enter the telephone number of a provider employed within a group.
52A	Additional Provider ID	Enter the taxonomy code assigned to the billing dentist or dental entity. Do not enter the taxonomy code for a provider employed within a group.

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ADA Block No.	ADA Description	Instructions
53	Signed (Treating Dentist)	Required-Signature of treating dentist or authorized personnel. Billing services may print "Signature on File" in place of the provider's signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice. ***Refer to:*** Subsection 6.4.2.1, "Provider Signature on Claims" in this section.
54	NPI	Enter the NPI for the dentist enrolled as part of a group who treated the patient. Does not apply to individual providers.
55	License Number	Not applicable to Texas Medicaid.
56	Address, City, State, ZIP Code	Not applicable to Texas Medicaid.
56A	Provider Specialty Code	This block is optional.
57	Telephone Number	Not applicable to Texas Medicaid.
58	Additional Provider ID	**Required:** Enter the taxonomy code for the dentist's enrolled as part of a group who treated the patient. Does not apply to individual providers.

6.8 Family Planning Claim Filing Instructions

The following providers bill for services using the ANSI ASC X12 837P 5010 electronic specifications or the CMS-1500 paper claim form:

Providers
Clinical nurse specialist (CNS)
Family Planning title agencies contracted with HHSC
Federally Qualified Health Center (FQHC)
Nurse practitioner (NP)
Physician
Physician assistant (PA)

6.8.1 Family Planning Electronic Billing

Electronic billers must submit family planning claims with TexMedConnect or approved vendor software that uses the ANSI ASC X12 837P 5010 format. Specifications are available to providers developing in-house systems, software developers, and vendors on the TMHP website at www.tmhp.com/topics/edi. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 888-863-3638.

Refer to: Subsection 3.2, "Electronic Billing" in "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information about electronic billing.

6.9 Family Planning Claim Form (Paper Billing)

Claims must contain the billing providers complete name, physical address, NPI, and taxonomy code. Claims without a provider name, physical address, NPI, and taxonomy code cannot be processed.

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6.9.1 2017 Claim Form

A copy of a blank 2017 Claim Form and copies of example completed claim forms are available on the Claim Form Examples page of the TMHP website at www.tmhp.com.

6.9.2 2017 Claim Form Instruction Table

The instructions describe what information must be entered in each of the block numbers of the 2017 Claim Form.

Block No.	Description	Guidelines	Required (Paper)
1	Program	Check the box for the specific program to which these services are billed: • Family Planning Program: XIX (Check this box for Title XIX family planning services and for Healthy Texas Women (HTW) program services) • DSHS Family Planning Program (DFPP)	XIX, DFPP (All)
2a	Billing provider NPI	Enter the billing provider's ten-digit NPI.	All
2b	Billing provider taxonomy code	Enter the billing provider's taxonomy code.	All
3	Provider name	Enter the provider's name as enrolled with TMHP.	All
4	Eligibility date (DFPP)	Enter the date (MM/DD/CCYY) this client was designated eligible for DFPP services. For DFPP, the eligibility date can be found on the following forms: • INDIVIDUAL Eligibility Form (EF05-14215) • HOUSEHOLD Eligibility Form (EF05-14214) • HOUSEHOLD Eligibility Worksheet (EF05-13227) • An approved DSHS substitute	DFPP
5	DSHS Client no. (Medicaid PCN if XIX)	If previous DFPP, claims or encounters have been submitted to TMHP, enter the client's nine-digit DSHS client number, which begins with "F." If the client has Title XIX Medicaid, enter the client's nine-digit client number from the Medicaid Identification form. If this is a new client, without Medicaid, leave this block blank and TMHP will assign a DSHS client number for the client.	XIX
6	Patient's name (last name, first name, middle initial)	Enter the client's last name, first name, and middle initial as printed on the Medicaid Identification Form, if Title XIX, or as printed in the provider's records, if DFPP.	All
7	Address (street, city, state)	Enter the client's complete home address as described by the client (street, city, and state). This reflects the location where the client lives.	All
7a	ZIP Code	Enter the client's ZIP Code.	All
8	County of residence	Enter the county code that corresponds to the client's address. Please use the HHSC county codes.	All

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Block No.	Description	Guidelines	Required (Paper)
9	Date of birth	Enter numerically the month, day, and year (MM/DD/CCYY) the client was born.	All
10	Sex	Indicate the client's sex by checking the appropriate box.	All
11	Patient status	Indicate if this is the client's first visit to this provider (new patient) or if this client has been to this provider previously (established patient). If the provider's records have been purged and the client appears to be new to the provider, check "New Patient."	All
12	Patient's Social Security number	Enter the client's nine-digit Social Security number (SSN). If the client does not have a SSN, or refuses to provide the number, enter 000-00-0001.	All
13	Race (code #)	Indicate the client's race by entering the appropriate race code number in the box. Aggregate categories used here are consistent with reporting requirements of the Office of Management and Budget Statistical Direction. Race is independent of ethnicity and all clients should be self-categorized as White, Black or African American, American Indian or Native Alaskan, Asian, Native Hawaiian or other Pacific Islander, or Unknown or Not Reported. An "Hispanic" client must also have a race category selected.	All
13a	Ethnicity	Indicate whether the client is of Hispanic descent by entering the appropriate code number in the box. Ethnicity is independent of race and all clients should be counted as either Hispanic or non-Hispanic. The Office of Management and Budget defines Hispanic as "a person of Mexican, Puerto Rican, Cuban, Central, or South American culture or origin, regardless of race."	All
14	Marital status	Indicate the client's marital status by entering the appropriate marital code number in the box.	All
15	Family income (all)	DFPP: Use the gross monthly income calculated and reported on the INDIVIDUAL Eligibility Form (EF05-14215), the HOUSEHOLD Eligibility Form (EF05-14214), or the HOUSEHOLD Eligibility Worksheet (EF05-13227). Title XIX: Enter the gross monthly income reported by the client. Be sure to include all sources of income If income is received in a lump sum, or if it is for a period of time greater than a month (e.g., for seasonal employment), divide the total income by the number of months included in the payment period. If income is paid weekly, multiply weekly income by 4.33. If paid every two weeks, multiply amount by 2.165. If paid twice a month, multiply by 2. Enter $1.00 for clients not wishing to reveal income information.	All

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Block No.	Description	Guidelines	Required (Paper)
15a	Family size	DFPP: Use the family size reported on the eligibility assessment tool. Title XIX providers: Enter the number of family members supported by the income listed in Box 15. Must be at least "one."	All
16	Number times pregnant	Enter the number of times this client has been pregnant. If male, enter zero.	XIX
17	Number live births	Enter the number of live births for this client. If male, enter zero.	XIX
18	Number living children	Enter the number of living children this client has. This also must be completed for male clients.	XIX
19	Primary birth control method before initial visit	Enter the appropriate code letter (a through r) in the box.	XIX
20	Primary birth control method at end of this visit	Enter the appropriate code letter (a through r) in the box.	XIX
21	If no method used at end of this visit, give reason (required only if #20=r)	If the primary birth control method at the end of the visit was "no method" (r), you must complete this box with an appropriate code letter from this block (a through g).	XIX (only if #20=r)
22	Is there other insurance available?	Check the appropriate box.	Optional
23	Other insurance name and address	Enter the name and address of the health insurance carrier.	Optional
24a	Insured's policy/ group no.	Enter the insurance policy number or group number.	Optional
24b	Provider benefit code	Benefit code, if applicable for the billing provider.	Optional
25	Other insurance paid amount	Enter the amount paid by the other insurance company. If payment was denied, enter "Denied" in this block.	Optional
25a	Date of notification	Enter the date of the other insurance payment or denial in this block. This must be in the format of MM/DD/CCYY.	Optional
26	Name of referring provider	If a non-family planning service is being billed, and the service requires a referring provider, enter the provider's name.	XIX (if available)
27b	Referring NPI	If a non-family planning service is being billed and the service requires a referring provider identifier, enter the referring provider's NPI.	XIX

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Block No.	Description	Guidelines	Required (Paper)
28	Level of practitioner	Enter the level of practitioner that performed the service. Primary care or generalist physicians and specialists are correctly classified as "Physicians." Certified nurse-midwives, nurse practitioners, clinical nurse specialists, and physician assistants providing encounters are correctly categorized as "Midlevel." Encounters provided by a registered nurse or a licensed vocational nurse would be categorized as "Nurse." Encounters provided by staff not included in the preceding classifications would be correctly categorized as "Other." If a client has encounters with staff members of different categories during one visit, select the highest category of staff with whom the client interacted. Optional for agencies not receiving any DFPP funding.	DFPP
29	Diagnosis code (Relate Items A-L to service line 32E)	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. 9 = ICD-9-CM 0 = ICD-10-CM Enter the patient's diagnosis and/or condition codes. List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field.	All
30	Authorization number	Enter the authorization number for the client, if appropriate.	Optional
31	Date of occurrence	Use this section when billing for complications related to sterilizations, contraceptive implants, or intrauterine devices (IUDs). This block should contain the date (MM/DD/CCYY) of the original sterilization, implant, or IUD procedure associated with the complications currently being billed.	All, if billing complications
32A	Dates of service	Enter the dates of service (DOS) for each procedure provided in a MM/DD/CCYY format. If more than one DOS is for a single procedure, each date must be given (such as 3/16, 17, 18/2010). Electronic Billers Medicaid does not accept multiple (to-from) dates on a single-line detail. Bill only one date per line. **NDC** In the shaded area, enter the: • NDC qualifier of N4 (e.g., N4) • The 11-digit NDC number on the package or vial from which the medication was administered. Do not enter hyphens or spaces within this number (e.g., 00409231231). ***Example:*** *N400409231231*	All

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Block No.	Description	Guidelines	Required (Paper)
32B	Place of service	Enter the appropriate POS code for each service from the POS table in the Texas Medicaid Provider Procedures Manual. If the client is registered at a hospital, the POS must indicate inpatient or outpatient status at the time of service.	All
32C	Reserved for local use	Leave this block blank. ***Note:*** *TOS codes are no longer required for claims submission.*	Optional
32D	Procedures, services, or supplies CPT/ HCPCS modifier	Enter the appropriate CPT or HCPCS procedure codes for all procedures/services billed. **NDC** In the shaded area, enter the NDC quantity of units administered (up to 12 digits, including the decimal point.). A decimal point must be used for fractions of a unit.	All
32E	Dx. ref. (29)	Enter the diagnosis line item reference (A-L) for each service or procedure as it relates to each ICD diagnosis code identified in Block 29. When multiple services are performed, the primary reference number for each service should be listed first, other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. Diagnosis codes must be entered in Form Field 29 only. Do not enter diagnosis codes in Form Field 32E.	All
32F	Units or days (quantity)	If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed). **NDC** In the shaded area, enter the NDC unit of measurement code. There are 5 allowed values: F2, GR, ML, UN or ME.	All
32G	$Charges	Indicate the charges for each service listed (quantity multiplied by reimbursement rate). Charges must not be higher than fees charged to private-pay clients.	All
32H (a)	Performing provider taxonomy code	Members of a group practice (except pathology and renal dialysis groups) must identify the taxonomy code of the provider within the group who performed the service. ***Note:*** *To avoid unnecessary denials, DFPP providers should include the performing provider's taxonomy code on the claim. Although not required for DFPP claims, if a claim or encounter that was submitted through DFPP is later determined eligible to be paid under Title XIX, the claim will be denied if the performing provider information is missing.*	XIX

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Block No.	Description	Guidelines	Required (Paper)
32H (b)	Performing provider number (XIX only)-NPI	**Optional:** Members of a group practice (except pathology and renal dialysis groups) must identify NPI of the provider within the group who performed the service. ***Note:*** *To avoid unnecessary denials, DFPP providers should include the performing provider's taxonomy code on the claim. Although not required for DFPP claims, if a claim or encounter that was submitted through DFPP is later determined eligible to be paid under Title XIX, the claim will be denied if the performing provider information is missing.*	XIX
33	Federal tax ID number/EIN (optional)	Enter the federal TIN (Employer Identification Number [EIN]) that is associated with the provider identifier enrolled with TMHP. ***Note:*** *To avoid unnecessary denials, PHC and EPHC providers should include the federal tax ID on the claim. Although not required for PHC and EPHC claims, if a claim or encounter that was submitted through PHC or EPHC is later determined eligible to be paid under Title XIX, the claim will be denied if the tax ID information is missing.*	XIX, DFPP
34	Patient's account number (optional)	Enter the client's account number that is used in the provider's office for its payment records.	Optional
35	Patient copay assessed (DFPP)	If the client was assessed a copayment (DFPP), enter the dollar amount assessed. If no copay was assessed, enter $0.00. Copay cannot be assessed for Title XIX clients. Copayment must not exceed $30.00 for DFPP patients.	DFPP
36	Total charges	Enter the total of separate charges for each page of the claim. Enter the total of all pages on last claim if filing a multipage claim.	All
37	Signature of physician or supplier	The physician/supplier or an authorized representative must sign and date the claim. Billing services may print "Signature on file" in place of the provider's signature if the billing service obtains and retains on file a letter signed and dated by the provider authorizing this practice. When providers enroll to be an electronic biller, the "Signature on file" requirement is satisfied during the enrollment process.	All

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Block No.	Description	Guidelines	Required (Paper)
38	Name and address of facility where services were rendered (if other than home or office)	If the services were provided in a place other than the client's home or the provider's facility, enter name, address, and ZIP Code, of the facility (such as the hospital or birthing center) where the service was provided. Independently practicing health-care professionals must enter the name and number of the school district/cooperative where the child is enrolled (SHARS). For laboratory specimens sent to an outside laboratory for additional testing, the complete name and address of the outside laboratory should be entered. The laboratory should bill Texas Medicaid for the services performed.	XIX
38a	NPI	Enter the NPI of the provider where services were rendered (if other than home or office).	XIX
39	Physician's, supplier's billing name, physical address, ZIP Code, and telephone number	Enter the billing provider name, physical address, city, state, ZIP Code, and telephone number.	Optional

6.10 Vision Claim Form

All vision services must be billed on a CMS-1500 paper claim form or the appropriate electronic formats. Vision claims submitted on other forms are denied with EOB 01145, "Claim form not allowed for this program."

For eyewear claims beyond program benefits, (e.g., replacing lost or destroyed eye wear), providers must have the patient sign the "Patient Certification Form" and retain in their records. Do not submit form to TMHP.

Refer to: Medicaid Vision Eyewear Client Certification Form on the TMHP website at www.tmhp.com.

The following table shows the blocks required for vision claims on a CMS-1500 paper claim form.

Block No.	Description
1a	Enter the patient's nine-digit client number from the Your Texas Benefits Medicaid card.
2	Enter the patient's last name, first name, and middle initial as printed on the Your Texas Benefits Medicaid card.
3	Enter numerically the month, day, and year (MM/DD/YYYY) the client was born. Indicate the patient's sex by checking the appropriate box.
5	Enter the patient's complete address as described (street, city, state, and ZIP Code).
9 and 9a–9d	Other insurance or government benefits

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Block No.	Description
10	Was condition related to: a. Patient's employment b. Auto accident c. Other accident
11	Medicare number
12	Patient's or authorized person's signature
13*	Insured or authorized person's signature
17 Name of referring physician or other source 17b NPI	Name, provider identifiers, and address of prescribing medical doctor or doctor of optometry
21	Diagnosis or nature of illness or injury
24A	DOS
24B	POS
24D	Describe procedures, medical services, or supplies furnished for each date given
24D, Line "5" for new prescription 24D, Line "6" for old prescription	Prescription/description of lenses and frames
24E	Diagnosis pointer
24F	Charges
26*	The account number for the patient that is used in the provider's office for its billing records.
27 Check "YES" or "NO"	Accept assignment
28	Total charges
29	Amount paid by other insurance
31	Signature of physician or supplier
32	Name and address of facility where services were rendered if other than home or office
33	Telephone number
33	Physician's or supplier's name, physical address, city, state, and ZIP code
No longer used	Referral from screening program (THSteps)

6.11 Remittance and Status (R&S) Report

The R&S Report provides information on pending, paid, denied, and adjusted claims. TMHP provides weekly R&S Reports to give providers detailed information about the status of claims submitted to TMHP. The R&S Report also identifies accounts receivables established as a result of inappropriate payment. These receivables are recouped from claim submissions. All claims for the same NPI and program processed for payment are paid at the end of the week, either by a single check or with

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Electronic Funds Transfer (EFT). If no claim activity or outstanding account receivables exist during the cycle week, the provider does not receive an R&S Report. Providers are responsible for reconciling their records to the R&S to determine payments and denials received.

Note: *Providers receive a single R&S Report that details Texas Medicaid activities and provides individual program summaries. Combined provider payments are made based on the provider's settings for Texas Medicaid fee-for-service.*

Providers must retain copies of all R&S Reports for a minimum of five years. Providers must not use R&S Report originals for appeal purposes, but must submit copies of the R&S Reports with appeal documentation.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

6.11.1 R&S Report Delivery Options

TMHP offers two options for the delivery of the R&S Report:

- A PDF version that is available on the TMHP website through the secure provider portal.
- An Electronic Remittance and Status (ER&S) Report that is available through EDI.

The PDF version of the R&S Report is available through TexMedConnect, and can be downloaded by registered users of the TMHP website at www.tmhp.com. The report is available each Monday morning, immediately following the weekly claims cycle. Payments associated with the R&S Report are released the next Friday following the weekly claims cycle. Newly-enrolled providers are initially set up to receive the PDF version of the R&S Report.

The EDI delivery method is also available. Using HIPAA-compliant EDI standards, the (ER&S 835 file) can be downloaded through the TMHP EDI Gateway using third party software. The ER&S Report is available on Thursday the week the provider payments are released.

Note: *In rare instances, payments and R&S delivery may be delayed due to a system outage or holiday.*

In addition to the PDF R&S Report, an optional R&S Report delivery method is also available. Using HIPAA-compliant EDI standards, the ER&S Report can be downloaded through the TMHP EDI Gateway using TexMedConnect or third party software. The ER&S Report is also available each Monday after the completion of the claims processing cycle.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for more information about EDI formats and enrollment for the ER&S Report.

6.11.2 Banner Pages

Banner pages serve two purposes:

- They identify the provider's name and address.
- They are used to inform providers of new policies and procedures.

The title pages include the following information:

- TMHP address for submitting paper appeals
- Provider's name, address, and telephone number
- Unique R&S Report number specific to each report
- Provider identifier (NPI, and atypical provider identifier [API])
- Report sequence number (indicates the week number of the year)
- Date of the week being reported on the R&S Report

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- Tax Identification Number
- Page number (R&S Report begins with page 1)
- AIS telephone number
- Taxonomy code

6.11.3 R&S Report Field Explanation

- *Patient name.* Lists the client's last name and first name, as indicated on the eligibility file.
- *Claim number.* The 24-digit Medicaid ICN for a specific claim. The format for the TMHP claim number is expanded to PPP/CCC/MMM/CCYY/JJJ/BBBBB/SSS.

Acronym	Description
PPP	Program
CCC	Claim type
MMM	Media source (region)
CCYY	Year in which the claim was received
JJJ	Julian date on which the claim was received
BBBBB	TMHP internal batch number
SSS	TMHP internal claim sequence within the batch

Program Type

PPP	Program
001	Long Term Care
100	Medicaid
200	Managed Care (for carve-out services administered by TMHP and PCCM claims with dates of service before March 1, 2012)
300	Family Planning (DSHS Family Planning Program)
400	CSHCN Services Program
999	Default/summary for all media regions

Claim Type

Claim Type	Description
020	Physician/supplier (Medicaid only) (genetics agencies, THSteps [medical only], FQHC, optometrist, optician)
021	THSteps (dental)
023	Outpatient hospital, home health, RHC, FQHC
030	Physician crossovers
031	Hospital outpatient crossovers, home health crossovers, RHC crossovers
040	Inpatient hospital
050	Inpatient crossover
056	DSHS Family Planning Program
058	Family Planning Title XIX

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Media Source (MMM)

Region	Description
010	Paper
011	Paper adjustment
030	Electronic (including TexMedConnect)
031	Electronic adjustment (including TexMedConnect)
041	AIS adjustment
051	Mass adjustment
061	Crossover adjustment
071	Retroactive eligibility adjustment
080	State Action Request
081	State Action Request adjustment
090	Telephone
100	Fax
110	Mail
120	Encounter
121	Encounter Adjustment

- *Medicaid #.* The client's Medicaid number.
- *Patient Account #.* If a patient account number is used on the provider's claim, it appears here.
- *Medical Record #.* If a medical record number is used on the provider's claim, it appears here.
- *Medicare #.* If the claim is a result of an automatic crossover from Medicare, the last ten digits of the Medicare claim number appears directly under the TMHP claim number.
- *Diagnosis.* Primary diagnosis listed on the provider's claim.
- *Service Dates.* Format MMDDYYYY (month, day, year) in "From" and "To" dates of service.
- *TOS/Proc.* Indicates by code the specific service provided to the client. The one-digit TOS appears first followed by a HCPCS procedure code. A three-digit code represents a hospital accommodation or ancillary revenue code. For claims paid under prospective payment methodology, it is the code of the DRG.
- *Billed Quantity.* Indicates the quantity billed per claim detail.
- *Billed Charge.* Indicates the charge billed per claim detail.
- *Allowed Quantity.* Indicates the quantity TMHP has allowed per claim detail.
- *Allowed Charge.* Indicates the charges TMHP has allowed per claim detail. For inpatient hospital claims, the allowed amount for the DRG appears.
- *POS Column*. The R&S Report includes the POS to the left of the Paid Amount. A one-digit numeric code identifying the POS is indicated in this column. Refer to subsection 6.3.1.1, "Place of Service (POS) Coding" in this section for the appropriate cross-reference among the two-digit numeric POS codes (Medicare), and one-digit numeric code on the R&S Report. Providers using electronic claims submission should continue using the same POS codes.
- *Paid Amt.* The final amount allowed for payment per claim detail. The total paid amount for the claim appears on the claim total line.

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- *EOB Codes and Explanation of Pending Status (EOPS) Codes.* These codes explain the payment or denial of the provider's claim. The EOB codes are printed next to or directly below the claim. The EOPS codes appear only in "The Following Claims Are Being Processed" section of the R&S Report. The codes explain the status of pending claims and are not an actual denial or final disposition. An explanation of all EOB and EOPS codes appearing on the R&S Report are printed in the Appendix at the end of the R&S Report. Up to five EOB codes are displayed.
- *Total TEFRA Billed and Allowed Charges.* Indicates claim details that have been denied or reduced.
- *Benefit.* Indicates the three digit benefit code associated with the claim.
- *Modifier.* Modifiers have been developed to describe and qualify services provided. For THSteps dental services two modifiers are printed. The first modifier is the TID and the second is the SID.

6.11.4 R&S Report Section Explanation

6.11.4.1 Claims – Paid or Denied

The heading "Claims – Paid or Denied Claims" is centered on the top of each page in this section. Claims in this section finalized the week before the preparation of the R&S Report. The claims are sorted by claim status, claim type, and by order of client names. The reported status of each claim will not change unless further action is initiated by the provider, HHSC, or TMHP.

The following information is provided on a separate line for all inpatient hospital claims processed according to prospective payment methodology:

- *Age.* Client's age according to TMHP records
- *Sex.* Client's sex according to TMHP records: M = Male, F = Female, U = Unknown
- *Pat-Stat.* Indicates the client's status at the time of discharge or the last DOS on the claim (refer to instructions for UB-04 CMS-1450 paper claim form, Block 17)
- *Proc.* ICD-10-PCS code indicates the primary surgical procedure used in determining the DRG

Important: *Only paper claims appear in this section of the R&S Report. Claims filed electronically without required information are rejected. Users are required to retrieve the response file to determine reasons for rejections.*

TMHP cannot process incomplete claims. Incomplete claims may be submitted as original claims only if the resubmission is received by TMHP within the original filing deadline.

Refer to: Subsection 6.1, "Claims Information" in this section for a description of different claim types.

6.11.4.2 Adjustments to Claims

Adjustments – Paid or Denied is centered at the top of each page in this section. Adjustments are sorted by claim type and then patient name and Medicaid number. Media types 011, 021, 031, 041, 051, 061, 071, and 081 appear in this section. An adjustment prints in the same format as a paid or denied claim.

The adjusted claim is listed first on the R&S Report. EOB 00123, "This is an adjustment to previous claim XXXXXXXXXXXXXXXXXXXXXXXX which appears on R&S Report dated XX/XX/XX" follows this claim. Immediately below is the claim as originally processed. An accounts receivable is created for the original claim total as noted by EOB 00601, "A receivable has been established in the amount of the original payment: $XXX,XXX,XXX.XX. Future payments will be reduced or withheld until such amount is paid in full." prints below the claim indicating the amount to be recouped. This amount appears under the heading, "Financial Transactions Accounts Receivable." EOB 06065, "Account Receivable is due to the adjusted claim listed. For details, refer to your R&S Report for the date listed within the original date field."

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Claims adjusted as a result of a rate change will be listed on the R&S Report with EOB 01154 "This adjustment is a result of a rate change."

Refer to: Subsection 6.2.5, "Modifier Requirements for TOS Assignment" in this section for a list of the most commonly used modifiers.

6.11.4.3 Financial Transactions

All claim refunds, reissues, voids/stops, recoupments, backup withholdings, levies, and payouts appear in this section of the R&S Report. The Financial Transactions section does not use the R&S Report form headings. Additional subheadings are printed to identify the financial transactions. The following descriptions are types of financial items.

6.11.4.3.1 Accounts Receivable

This label identifies money subtracted from the provider's current payment owed to TMHP. Specific claim data are not given on the R&S Report unless the accounts receivable control number is provided which should be referenced when corresponding with TMHP. Accounts receivable appear on the R&S Report in the following format:

- *Control Number.* A number to reference when corresponding with TMHP.
- *Recoupment Rate.* The percentage of the provider's payment that is withheld each week unless the provider elects to have a specific amount withheld each week.
- *Maximum Periodic Recoupment Amount.* The amount to be withheld each week. This area is blank if the provider elects to have a percentage withheld each week.
- *Original Date.* The date the financial transaction was processed originally.
- *Original Amount.* The total amount owed TMHP.
- *Prior Date.* The date the last transaction on the accounts receivable occurred.
- *Medical Record Number.* A number assigned by the provider, if available. This area is blank for purged claims.
- *Prior Balance.* The amount owed from a previous R&S Report.
- *Applied Amount.* The amount subtracted from the current R&S Report.
- *Balance.* Indicates the total outstanding accounts receivable (AR) balance that remains due to TMHP.
- *FYE.* The fiscal year end (FYE) for cost reports.
- *EOB.* The EOB code that corresponds to the reason code for the accounts receivable.
- *Patient Name.* The name of the patient on the claim, if the accounts receivable are claim-specific.
- *Claim Number.* The ICN of the original claim, if the accounts receivable are claim-specific.
- *Backup Withholding Penalty Information.* A penalty assessed by the Internal Revenue Service (IRS) for noncompliance due to a B-Notice. Although the current payment amount is lowered by the amount of the backup withholding, the provider's 1099 earnings are not lowered.
- *Control Number.* TMHP control number to reference when corresponding with TMHP.
- *Original Date.* The date the backup withholding was set up originally.
- *Withheld Amount.* Amount withheld (31 percent) of the provider's checkwrite.

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6.11.4.3.2 IRS Levies

The payments withheld from a provider's checkwrite as a result of a notice from the IRS of a levy against the provider appear in the "IRS Levy Information" section of the R&S Report. Payments are withheld until the levy is satisfied or released. Although the current payment amount is lowered by the amount of the levy payment, the provider's 1099 earnings are not lowered. IRS levies are reported in the following format:

- *Control Number.* TMHP control number to reference when corresponding with TMHP.
- *Maximum Recoupment Rate.* The percentage of the provider's payment that is withheld each week, unless the provider elects to have a specific amount withheld each week.
- *Maximum Recoupment Amount.* The amount to be withheld periodically.
- *Original Date.* The date the levy was set up originally.
- *Original Amount.* The total amount owed to the IRS.
- *Prior Balance.* The amount owed from a previous R&S Report.
- *Prior Date.* The date the last transaction on the levy occurred.
- *Current Amount.* The amount subtracted from the current R&S Report and paid to the IRS.
- *Remaining Balance.* The amount still owed on the levy. (This amount becomes the "previous balance" on the next R&S Report.)

6.11.4.3.3 Refunds

Refunds are identified by EOB 00124, "Thank you for your refund; your 1099 liability has been credited." This statement is verification that dollars refunded to TMHP for incorrect payments have been received and posted. The provider's check number and the date of the check are printed on the R&S Report. Claim refunds appear on the R&S Report in the following format:

- Claim Specific:
  - *ICN.* The claim number of the claim to which the refund was applied this cycle.
  - *Patient Name.* The first name, middle initial, and last name of the patient on the applicable claim.
  - *Medicaid Number.* The patient's Medicaid or CSHCN Services Program number.
  - *Date of Service.* The format MMDDCCYY (month, day, and year) in "From" DOS.
  - *Total Billed.* The total amount billed for the claim being refunded.
  - *Amount Applied This Cycle.* The refund amount applied to the claim.
  - *EOB.* Corresponds to the reason code assigned.
- Nonclaim Specific:
  - *Control Number.* A control number to reference when corresponding with TMHP.
  - *FYE.* The fiscal year for which this refund is applicable.
  - *EOB.* Corresponds to the reason code assigned.

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6.11.4.3.4 Payouts

Payouts are dollars TMHP owes to the provider. TMHP processes two types of payouts: system payouts that increase the weekly check amount and manual payouts that result in a separate check being sent to the provider. Specific claim data are not given on the R&S Report for payouts. A control number is given, which should be referenced when corresponding with TMHP. System and manual payouts appear on the R&S Report in the following format:

- *Payout Control Number.* A control number to reference when corresponding with TMHP.
- *Payout Amount.* The amount of the payout.
- *FYE.* The fiscal year for which the payout is applicable.
- *EOB.* Corresponds to the reason code assigned.
- *Patient Name.* Name of the patient (if available).
- *PCN.* Medicaid number of the patient (if available).
- *DOS.* Date of service (if available).

6.11.4.3.5 Reissues

The provider's 1099 earnings are not affected by reissues. A messages states, "Your payment has been increased by the amount indicated below":

- *Check Number.* The number of the original check.
- *Check Amount.* The amount of the original check.
- *R&S Number.* The number of the original R&S Report.
- *R&S Date.* The date of the original R&S Report.

6.11.4.3.6 Voids and Stops

The provider's 1099 earnings are credited by the amount of the voided/stopped payment.

- *Check Number.* The number of the voided/stopped payment.
- *Check Amount.* The amount of the voided/stopped payment.
- *R&S Number.* The number of the voided/stopped payment.
- *R&S Date.* The date of the voided/stopped payment.

6.11.4.4 Claims Payment Summary

This section summarizes all payments, adjustments, and financial transactions listed on the R&S Report. The section has two categories: one for amounts "Affecting Payment This Cycle" and one for "Amount Affecting 1099 Earnings."

If the provider is receiving a check on this particular R&S Report, the following information is given: "Payment summary for check XXXXXXXXX in the amount of XXX,XXX,XXX.XX." If the payment is EFT: "Payment summary for direct deposit by EFT XXXXXXXXX in the amount of XXX,XXX,XXX.XX." The check number also is printed on the check that accompanies the R&S Report.

Headings for the Payment Summary for "Affecting Payment This Cycle" and "Amount Affecting 1099 Earnings"

- *Claims Paid.* Indicates the number of claims processed for the week and the year-to-date total.
- *System Payouts.* The total amount of system payouts made to the provider by TMHP.
- *Manual Payouts (Remitted by separate check or EFT).* The total amount of manual payouts made to the provider by TMHP.

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- *Amount Paid to IRS for Levies.* The amount remitted to IRS and withheld from the provider's payment due to an IRS levy.
- *Amount Paid to IRS for Backup Withholding.* The amount paid to the IRS for backup withholding.
- *Accounts Receivable Recoupments.* The total amount withheld from the provider's payment due to accounts receivable.
- *Miscellaneous Levies.* The amount withheld from the provider's payment and remitted to HHSC for a SHARS Admin Fee levy.
- *Amounts Stopped/Voided.* The total amount of the payment that was voided or stopped with no reissuance of payment.
- *System Reissues.* The amount of the reissued payment.
- *Claim Related Refunds.* The total amount of claim-related refunds applied during the weekly cycle.
- *Nonclaim Related Refunds.* The total amount of nonclaim-related refunds applied during the weekly cycle.
- *Approved to Pay/Deny Amount.* The total amount of claim payments that were approved to pay/deny within the week. (This column will not be used at this time.)
- *Pending Claims.* The total amount billed for claims in process as of the cutoff date for the report.

6.11.4.5 The Following Claims are Being Processed

In the "Following Claims are Being Processed" section, the R&S Report may list up to five EOPS codes per claim. The claims listed in this section are in process and *cannot be appealed for any reason* until they appear in either the "Claims Paid or Denied," or "Adjustments Paid and Denied" sections of the R&S Report. TMHP is listing the pending status of these claims for informational purposes only. *The pending messages should not be interpreted as a final claim disposition.* Weekly, all claims and appeals on claims TMHP has "in process" from the provider are listed on the R&S Report. The Following Claims are Being Processed claim prints in the same format as a paid or denied claim.

6.11.4.6 Explanation of Benefit Codes Messages

This section lists the descriptions of all EOBs that appeared on the R&S Report. EOBs appear in numerical order.

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

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

6.11.4.7 Explanation of Pending Status Codes Appendix

This section lists the description of all EOPS codes that appeared on the R&S Report. EOPS appear in numerical order.

EOB and EOPS codes may appear on the same pending claim because some details may have already finalized while others may have questions and are pending.

6.11.5 R&S Report Examples

Examples of R&S Reports are available on the TMHP website at www.tmhp.com.

R&S Report Examples
Accounts Receivables R&S Report (For purposes of example, accounts receivables, void, and stop pay appear together.)

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R&S Report Examples
Adjustments R&S Report
Appendix R&S Report
Backup Withholding Penalty Information R&S Report
Banner Page R&S Report
Claims in Process R&S Report
IRS Levy R&S Report
Manual Payouts R&S Report
Paid or Denied Claims (Hospital) R&S Report
Paid or Denied Claims (Physician) R&S Report
Refunds for Managed Care R&S Report
Refunds for Medicaid R&S Report
Reissues R&S Report
Sub-Owner Recoupments R&S Report
Summary R&S Report
System Payouts R&S Report
Void and Stop Pay R&S Report

6.11.6 Provider Inquiries—Status of Claims

TMHP provides several effective mechanisms for researching the status of a claim. Weekly, TMHP provides the R&S Report reflecting all claims with a paid, denied, or pending status. Providers verify claim status using the provider's log of pending claims.

Electronic billers allow ten business days for a claim to appear on their R&S Reports. If the claim does not appear on an R&S Report as paid, pending, or denied, a transmission failure, file rejection, or claims rejection may exist. Providers check records for transmission reports correspondence from the TMHP EDI Help Desk.

The provider allows at least 30 days for a Medicaid paper claim to appear on an R&S Report after the claim has been submitted to TMHP. If a claim has not been received by TMHP and must be submitted a second time, the second claim must also meet the 95-day filing deadline.

The provider allows TMHP 45 days to receive a Medicare-paid claim automatically transmitted for payment of coinsurance or deductible according to current payment guidelines. Claims that fail to cross over from Medicare may be filed to TMHP by submitting a paper MRAN received from Medicare or a Medicare intermediary, the computer generated MRANs from the CMS-approved software applications MREP for professional services or PC-Print for institutional services or, for MAP clients, TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template with the completed claim form.

If the claim does not appear on an R&S Report as paid, pending, or denied, providers can use any of the following procedures to inquire about the status of the claim:

- The provider can use the claim status inquiry function of TexMedConnect on the TMHP website at www.tmhp.com.
- The provider can call AIS at 800-925-9126 to determine if the claim is pending, paid, denied, or if TMHP has no record of the claim.
- If any of the three options above indicates that TMHP has no record of the claim, the provider can call the TMHP Contact Center at 800-925-9126 and speak to a TMHP contact center representative.

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- If the TMHP Contact Center has no record of a claim that was submitted within the original filing deadline, the provider can submit a copy of the original claim to TMHP for processing. Electronic billers may refile the claim electronically. For claims submitted by a hospital for inpatient services, the filing deadline is 95 days from the discharge date or the last DOS on the claim. For all other types of providers, the filing deadline is 95 days from each DOS on the claim.
- If the 95-day filing deadline has passed and the claim is still within 120 days of the date of the rejection report or the R&S Report, the provider can submit a signed copy of the claim and all of the documentation that supports the original claim submission, including any electronic rejection reports, to:

Texas Medicaid & Healthcare Partnership
Inquiry Control Unit
12365-A Riata Trace Parkway, Suite 100
Austin, TX 78727

Providers must retain copies of all R&S Reports for a minimum of five years. Providers must not send original R&S Reports back with appeals. Providers must submit one copy of the R&S Report to TMHP per appeal.

Refer to: Subsection A.12.3, "Automated Inquiry System (AIS)" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*).

6.12 Filing Medicare Primary Claims

When a service is a benefit of both Medicare and Medicaid, the claim must be filed to Medicare first.

Providers should not file a claim with Medicaid until Medicare has dispositioned the claim unless the service is a Medicaid-only service.

All Medicare providers and suppliers who offer services and supplies to Qualified Medicaid Beneficiaries (QMB) or Medicaid Qualified Medicare Beneficiaries (MQMB) must not bill dual eligible clients for Medicare cost-sharing. This includes deductible, coinsurance, and copayments for any Medicaid covered items and services.

Medicaid claims for Qualified Medicare Beneficiary (QMB) and Medicaid Qualified Medicare Beneficiary (MQMB) clients can be filed to Medicaid for consideration of coinsurance and deductible payment as follows:

- Medicare primary claims filed to Medicare Administrative Contractors (MACs) may be transferred electronically to TMHP through a Benefit Coordination and Recovery Center (BCRC).
- Providers can submit crossover claims directly to TMHP using a paper claim form only for the specific circumstances indicated in the following section.
- MAP providers can submit crossover claims directly to TMHP using EDI.

Note: *These guidelines do not apply to services that are rendered to clients who are living in a nursing facility.*

Refer to: Subsection 2.7, "Medicare Crossover Claim Reimbursement" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for information about reimbursement for QMBs and MQMBs.

Subsection 4.9, "Medicare and Medicaid Dual Eligibility" in "Section 4: Client Eligibility" (*Vol. 1, General Information*) for information about MQMBs and QMBs eligibility.

6.12.1 Electronic Crossover Claims

Medicare primary claims filed to MACs may be transferred electronically to TMHP through a BCRC for claims that are processed as assigned. Providers should contact their MAC for more information.

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This electronic crossover process allows providers to receive disposition from both carriers while only filing the claim once. Providers must allow 60 days from the date of Medicare's disposition for a claim to appear on the Medicaid R&S Report.

If all services on the claim are denied by Medicare, the claim is not automatically transferred to TMHP by the MAC through the BCRC. Providers must submit the denied crossover claims to TMHP on paper.

Claims that are submitted to Medicare must include the facility's NPI. Medicare crossover claims must comply with the Medicaid requirement to include a facility NPI. If a Medicare crossover claim includes a service for which Medicaid requires a facility NPI but the claim does not include the facility's NPI number, the claim will be denied by Texas Medicaid. TMHP accepts electronic Medicare Advantage Plan (MAP) crossover claims electronically using EDI.

Important: *TMHP accepts only electronic crossover claims that are automatically transferred to TMHP by the MAC through the BCRC, or through the provider as New Day electronic Medicare Advantage Plans (MAPs) Part C claims. All other New Day crossover claims and all appeals, including Medicare Advantage Plan Part Cs, must be submitted as paper claims. TMHP accepts only paper appeals.*

6.12.1.1 Type of Bills Values for Medicare Crossover Claims

Type of bills (TOB) values in the 12x series may be billed to Medicare for Medicare Inpatient Part B services as appropriate, but TOB values in the 12x series are not valid for Medicaid claims.

Reminder: *Texas Medicaid only allows interim billing and late changes to be submitted on inpatient claims*

6.12.1.2 Medicare Copayments

Claims for Medicare copayments can also be submitted to TMHP. TMHP processes and pays Medicare HMO and Medicare PPO copayments for dual-eligible clients according to Medicaid guidelines.

TMHP may reimburse the copayment in addition to a service the HMO or PPO has denied if the client is eligible for Texas Medicaid and the procedure is reimbursed under Medicaid guidelines. Providers are not allowed to hold the client liable for the copayment.

An office or emergency room (ER) visit (the ER physician is paid only when the ER is not staffed by the hospital) is reimbursed a maximum copayment of $10 per visit. The hospital ER visit is reimbursed at a maximum of $50 to the facility. TMHP pays up to four copayments per day, per client. ER visits are limited to one per day, per client, and are considered one of the four copayments allowed per day.

Refer to: Subsection 2.7.5.2, "Nephrology (Hemodialysis, Renal Dialysis) and Renal Dialysis Facility Providers" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for information about claims for nephrology (hemodialysis, renal dialysis) and renal dialysis facility providers for Medicare crossover Claims.

Subsection 2.7.5, "Exceptions" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for information about exceptions for Medicare Part A, Part B, and Part C (noncontracted MAPs) reimbursement.

6.12.1.3 Requirement for Group Billing Providers – Professional Claims

The performing provider NPI must be included on the professional electronic claim if the billing provider is a group. Claims are processed using the performing provider NPI that is submitted on the Medicare claim.

Important: *The performing provider who is identified on the claim must be a member of the billing provider's group. If the performing provider is not a member of the billing provider group, the detail line item will be denied.*

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A claim is denied if the performing provider NPI is missing, invalid, or is not a member of the billing provider's group. Denied claims may be appealed on paper with the appropriate performing provider information.

6.12.2 Paper Crossovers Claims

TMHP accepts only paper crossover claims or appeals from providers and other entities.

Note: *Electronic crossover claims will only be accepted for Medicare Part C New Day claims.*

The following paper crossover claims may be submitted to TMHP:

- For QMB and MQMB clients, if a crossover claim is not transferred to TMHP electronically through the BCRC, the provider can submit a paper claim to TMHP for coinsurance and deductible reimbursement consideration.
- For MQMB clients, if a claim is denied by Medicare because the services are not a benefit of Medicare or because Medicare benefits have been exhausted, the provider can submit a paper claim to TMHP for coinsurance and deductible reimbursement consideration, and reimbursement consideration for the Medicaid-only services that were denied by Medicare. The Medicare EOB that contains the relevant claim denial must be submitted to TMHP with the completed claim from within 95 days from the Medicare disposition date and 365 days from the date of service. The denied services are processed as Medicaid-only services.

Claims that are submitted to Medicare must include the facility's NPI. Medicare crossover claims must comply with the Medicaid requirement to include a facility NPI. If a Medicare crossover claim includes a service for which Medicaid requires a facility NPI but the claim does not include the facility's NPI number, the claim will be denied by Texas Medicaid.

Important: *Claims that are denied by Medicare for administrative reasons must be appealed to Medicare before they are submitted to Texas Medicaid.*

The paper submission must include all of the following:

- The Medicare Remittance Advice (RA) or Remittance Notice (RN), using the CMS-approved software MREP, for professional services, or PC-Print or a paper MRAN from Medicare.
- The appropriate, completed paper CMS-1500 or UB-04 CMS-1450 paper claim form.

  Note: *Although it is not required, it is strongly recommended that providers send claim forms with their Medicare appeals in case one is needed for further processing.*
- The appropriate TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template for Medicare Advantage Plan only. The template must be submitted with the claims form and the MAP EOB.

Providers that receive Remittance Advice Notices from a Medicare intermediary may submit these in place of the MRAN to TMHP which must contain the following required information:

- Client name
- Medicare number
- NPI
- Dates of service
- Procedure code (Professional and Outpatient claims)
- Billed amount
- Medicare allowed amount or non-covered amount
- Deductible amount

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- Co-insurance amount
- Medicare paid amount
- Medicare ICN
- Quantity billed

6.12.2.1 Deductible or Coinsurance Amount Balancing

The Texas Medicaid claims processing system validates that the total Medicare deductible and coinsurance amounts on the claim header match the sum of the detail Medicare deductible and coinsurance amounts.

For paper crossover claims, providers must submit the same information to Texas Medicaid that was received from Medicare.

Texas Medicaid will reimburse Medicare crossover claims up to the Texas Medicaid allowed amount for Medicaid-covered services. System enhancements have been identified to ensure appropriate age restrictions are enforced applicable to the services rendered.

Example: *For a Medicare service provided to an adult client, if that service is only payable to Medicaid for clients who are 20 years of age and younger, the age restriction will be applied and the Medicaid allowed amount will be zero. Since the Medicare payment exceeds the Medicaid allowed amount or encounter payment for the service, Texas Medicaid will not make a payment for coinsurance liabilities.*

Because Medicare reimbursed more than Medicaid allowed, the client has no liability for any balance or Medicare coinsurance related to the rendered services.

6.12.2.2 TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template

The TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template must be submitted for paper MAP claims only. The template must be submitted with the claim form and the MAP EOB.

Note: *Providers must not submit the template for traditional Medicare crossover claims.*

The following guidelines apply for the submission of the TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Templates:

- The Medicare ICN must be included on the form. Claims are denied if the Medicare ICN is omitted.
- For the TMHP Crossover Professional Claim Type 30 form, the performing provider NPI and taxonomy code must be submitted on each detail line item. A detail line item is denied if the performing provider NPI or taxonomy code is omitted, or if the performing provider is not a member of the group billing provider.
- For the TMHP Crossover Outpatient Facility Claim Type 31 form, the detail line items are required. Claims are denied if the details are omitted.
- The TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template must be submitted with a completed claim form and MAP EOB, must be legible, and must identify only one client per page. Providers must not submit handwritten MAP templates.

Claims that do not meet these standards are not processed and are returned to the provider.

By submitting the TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Templates to TMHP, the provider attests that the information included in the template matches the EOB that was received from the MAP. If the information on the template does not exactly match the information on the RA or RN, the claim may be denied.

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Refer to: Subsection 6.20, "Forms" in this section for the TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Templates and instructions.

Subsection 2.7, "Medicare Crossover Claim Reimbursement" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

6.12.2.3 Crossover Paper Claims Filing Deadlines

The paper crossover claim with all required, EOBs, templates, and forms must be received by TMHP within 95 days of the Medicare date of disposition and 365 days from the date of service in order to be considered for processing.

6.12.3 Filing Medicare-Adjusted Claims

TMHP accepts crossover appeals only on paper.

Providers may submit Medicare-adjusted claims by submitting the adjusted Medicare RA/RNs (paper or electronic) and the appropriate TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template. The information on the Medicare RA/RN must exactly match the information submitted on the TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template.

Refer to: Subsection 3.7.1, "Medicaid Relationship to Medicare" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information on hospital Medicare claims filing requirements.

Important: *TMHP does not accept electronic crossover appeals.*

6.13 Medically Needy Claims Filing

TMHP must receive claims for unpaid bills not applied toward spend down within 95 days from the date eligibility was added to the TMHP client eligibility file (add date). These bills must be on the appropriate claim form (for example, CMS-1500 or UB-04 CMS-1450). Providers are allowed to submit completed CMS claim forms directly to the Medically Needy Clearinghouse (MNC) or to applicants for the Medically Needy Program (MNP) to be used to meet spend down. The completed CMS claim forms used to meet spend down are held for ten calendar days by the MNC, then forwarded to TMHP claims processing. Claims for services provided after the spend down is met must be received within 95 days from the date eligibility is added. Inpatient hospital facility claims must be received within 95 days from the date of discharge or last DOS on the claim. This applies when eligibility is not retroactive.

The client's payment responsibilities are as follows:

- If the entire bill was used to meet spend down, the client is responsible for payment of the entire bill.
- If a portion of one of the bills was used to meet the spend down, the client is responsible for paying the portion applied toward the spend down, unless it exceeds the Medicaid allowable amount.
- The claim must show the *total* billed amount for the services provided. Charges for ineligible days or spend down amounts should *not* be deducted or noncovered on the claim.
- A client's payment toward spend down is *not* reflected on the claim submitted to TMHP.
- A client is not required to pay the spend down amount before a claim is filed to Medicaid.
- Payments made by the client for services not used in the spend down but were incurred during an eligible period must be reimbursed to the client before the provider files a claim to TMHP.
- Services that require prior authorization and are provided before the client becomes eligible for Medicaid by meeting spend down are not reimbursable by Texas Medicaid.
- If a bill or a completed CMS claim form was not used to meet spend down and the dates of service are within the client's eligible period, submit the total bill to TMHP.

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When eligibility has been established, a type program (TP) 56 with spend down client can receive the same care and services available to all other Medicaid clients. If eligibility is established through TP 32 with spend down, the client's Medicaid eligibility is restricted to coverage for an emergency medical condition only. Emergency medical condition is defined under subsection 4.3.2.2, "Exceptions to Lock-in Status" in "Section 4: Client Eligibility" (*Vol. 1, General Information*).

6.14 Claims Filing for Consumer-Directed Services (CDS)

Clients who participate in the CDS option for both PCS and a waiver program, through HHSC are required to choose one Financial Management Services Agency (FMSA) to provide services through both programs. FMSAs are permitted to file only the financial management services (FMS) fee, also known as the monthly administrative fee, through one program. The FMSA should file the FMS claim through the program with the highest reimbursement rate. Currently, the waiver programs have a higher reimbursement rate for the FMS fee than the Texas Medicaid PCS benefit, so a FMSA should file claims for the monthly FMS fee through the waiver programs.

The U8 modifier, which is used when submitting claims for the monthly PCS administrative fee, must be prior authorized. The DSHS case managers have two options when sending a prior authorization request for PCS to TMHP:

- If a client is only using the CDS option for Texas Medicaid PCS, a case manager will submit a prior authorization request to TMHP that approves the U8 modifier and either the U7 or UB modifier. In this case, the provider authorization notification letter will include the U8 modifier and the U7 or UB modifier.
- If a client is using the CDS option for both Texas Medicaid PCS and a waiver program, a case manager will submit a prior authorization request to TMHP that approves either the U7 or UB modifier. The U8 modifier will not be prior authorized in this situation.

When a provider authorization notification letter is received by a FMSA, the provider should verify that the correct modifiers have been prior authorized for each PCS client. Providers who think that the approved modifiers are incorrect should contact the DSHS case manager and ask for the correct modifiers to be submitted to TMHP for prior authorization.

6.15 Claims Filing for Home Health Agency Services

Providers must use only type of bill (TOB) 321 in Form Locator (FL) 4 of the UB-04 CMS-1450. Other TOBs are invalid and will result in a claim denial. Home Health Services must be submitted to TMHP in an approved electronic format or on a CMS-1500 or a UB-04 CMS-1450 paper claim form. Submit home health DME and medical supplies to TMHP in an approved electronic format, or on a CMS-1500 or on a UB-04 CMS-1450 paper claim form. Providers may purchase CMS-1500 or UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply them.

When completing a CMS-1500 or a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as TMHP does not key information from attachments.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information about electronic claims submissions.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in this section for instructions on how to complete paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in this section.

Outpatient claims must have the appropriate revenue code and, if appropriate, the corresponding Healthcare Common Procedure Coding System (HCPCS) code or narrative description. The prior authorization number must appear on the CMS-1500 paper claim form in Block 23 and in Block 63 of

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the UB-04 CMS-1450 paper claim form. The certification dates or the revised request date on the POC must coincide with the DOS on the claim. Prior authorization does not waive the 95-day filing deadline requirement.

6.16 Claims for Medicaid Hospice Clients Not Related to the Terminal Illness

When the services are unrelated to the terminal illness, providers must submit a claim for Medicaid services to TMHP. The claim must include a statement and documentation from the hospice that the services billed are not related to the client's terminal illness.

If TMHP denies the claim, the following information must be submitted with the providers appeal.

- A copy of the R&S Report, with the client or claim number in question circled
- Clinical records, which may be obtained from the hospice provider
- Supporting documentation giving reasons the services billed are not related to the terminal illness

Refer to: Subsection 4.3.3, "Hospice Program" in "Section 4: Client Eligibility" (*Vol. 1, General Information*) for more information related to Medicaid hospice client benefits and eligibility.

6.16.1 Medical Services When Client is Discharged From Hospice

Submit claims to TMHP for Medicaid services with a statement that the services billed were provided after the client was discharged from the Hospice Program. The provider must obtain a copy of Form 3071, Medicaid Hospice Cancellation, from the Hospice Program to support the discharge.

If TMHP denies the claim, the provider may appeal the decision with the following information:

- A copy of the R&S Report, with the client or claim number in question circled
- Supporting documentation stating that the client was not in hospice at the time

6.16.2 Claims Address for Medicaid Hospice Clients Not Related to the Terminal Illness

Mail paper claims to the following address:

Texas Medicaid & Healthcare Partnership
PO Box 200105
Austin, TX 78720-0105

Appeal claims by writing to the following address:

Texas Medicaid & Healthcare Partnership
PO Box 200645
Austin, TX 78720-0645

6.16.3 Lab and X-Ray

Submit claims for services unrelated to the terminal illness to TMHP. Submit claims for services related to the terminal illness to the hospice provider.

6.17 Claims for Texas Medicaid and CSHCN Services Program Eligible Clients

The CSHCN Services Program is the payer of last resort when clients have other insurance, including Texas Medicaid and private carriers. The CSHCN Services Program does not supplement a client's Texas Medicaid benefits; however, services that are not a benefit of Texas Medicaid, such as hospice and medical foods, may be covered by the CSHCN Services Program.

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6.17.1 New Claim Submissions

New claims that are submitted for clients who are eligible for both Texas Medicaid and CSHCN Services Program benefits during the same eligibility period will be processed through the appropriate program and may result in a separate claim for each program. The Medicaid claim number and disposition will be listed under the "Claims – Paid or Denied" section of the Medicaid/Managed Care R&S Report. If the claim includes services that are not benefits of Texas Medicaid but are benefits of the CSHCN Services Program, a claim will be created with a unique claim number that will be listed under the "Claims – Paid or Denied" section of the CSHCN Services Program R&S Report.

Note: *If all of the services that are submitted on the claim are Texas Medicaid benefits, a CSHCN Services Program claim will not be created. Only a Texas Medicaid claim will be created, and the claim number will appear on the provider's Medicaid/Managed Care R&S Report.*

6.17.2 CSHCN Services Program Claims Reprocessing for Retroactive Texas Medicaid Eligibility

Claims that have already been paid by the CSHCN Services Program for clients who received retroactive Texas Medicaid eligibility for dates of service covered on the paid claims will be reprocessed to pay under the appropriate program. The reprocessed CSHCN Services Program claim number will appear under the "Adjustments – Paid or Denied" section of the CSHCN Services Program R&S Report. An accounts receivable will be created for services covered by Texas Medicaid that will be reflected on the "Financial Transactions" page under the "Accounts Receivable" section of the CSHCN Services Program R&S Report. The claim will be reprocessed to Texas Medicaid and given a new claim number. The new Texas Medicaid claim number and disposition will appear under the "Claims – Paid or Denied" section of the Medicaid/Managed Care R&S Report.

TMHP will contact providers when it reprocesses claims for services that require a Texas Medicaid prior authorization. Providers will be informed that a Texas Medicaid prior authorization must be submitted within a specified time frame for the claim to be considered for processing through Texas Medicaid.

6.18 Claims for State Supported Living Center Residents (SSLC)

Medicaid providers who render off-campus acute care services to Medicaid-eligible State Supported Living Center (SSLC) residents must submit claims directly to Medicaid. This is applicable only to residents of the SSLCs operated by HHSC.

Claims and prior authorization requests for acute care services rendered to these individuals must be submitted to Medicaid. These requests must be submitted according to guidelines for acute care services as indicated in this manual.

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

6.19 Children's Health Insurance Program (CHIP) Perinatal Claims

Claims for services provided to CHIP Perinatal Program clients are submitted to and considered for reimbursement as follows:

- For women with income at or below 198 percent FPL:
  - Hospital facility charges are paid through Emergency Medicaid and processed by TMHP.
  - Professional service charges are paid through the CHIP Perinatal Program and processed through CHIP.

Note: *Delivery-related professional services claims denied by the CHIP Perinatal health plan will be considered for reimbursement through Emergency Medicaid and will require the CHIP Perinatal health plan denial notice. These claims should be submitted through the existing*

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Medicaid appeals process within 95 days from the date of the CHIP Perinatal Health plan denial notice. The provider must provide a copy of the complete explanation of benefits that includes the complete description of the reason for denial.

- For newborns with a family income at or below 198 percent FPL:
  - Hospital facility charges are paid through Medicaid and processed by TMHP.
  - Professional service charges are paid through Medicaid and processed by TMHP.

Inpatient services (limited to labor with delivery) for unborn children and women with income at or below 202 of FPL will be covered under CHIP Perinatal, and these claims will be paid by the CHIP Perinatal health plan.

6.19.1 CHIP Perinatal Newborn Transfer Hospital Claims

TMHP processes CHIP Perinatal newborn transfer hospital claims even if the claim from the initial hospital stay has not been received.

The hospital transfer must have occurred within 24 hours of the discharge date from the initial delivery hospital stay. This change applies only to CHIP Perinatal newborns with a family income at or below 198 percent of the FPL.

Transfer claims must be filed with TMHP on an electronic institutional claim or the UB-04 CMS-1450 paper claim form using admission type 1, 2, 3, or 5 in block 14, source of admission code 4 or 6 in block 15, and the actual date and time the client was admitted in block 12 of the UB-04 CMS-1450 paper claim form.

6.20 Forms

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

Forms
MRAN Form Crossover Claim Type 30 Form and Instructions
MRAN Form Crossover Claim Type 31 Form and Instructions
MRAN Form Crossover Claim Type 50 Form and Instructions
Sample Letter XUB Computer Billing Service Inc

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