Dear Manual User:

Welcome to the 2008 *Texas Medicaid Provider Procedures Manual*. To enhance usability, this manual is available on a searchable CD-ROM and on the TMHP website at www.tmhp.com.

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

A *Claims Filing Resources* table is located at the end of each service section with page references to all claim instructions, appendices, Medicaid forms, and claim form examples associated with the service.

This manual contains both the Primary Care Case Management (PCCM) and Texas Health Steps (THSteps) manuals. PCCM information can be found primarily in Section 7, though relevant information can be found in other sections. THSteps information is contained in Section 43 and throughout the manual.

The Texas Medicaid Program policy published in this manual represents policy implemented as of October 31, 2007. Policy updates effective after October 31, 2007, are published bimonthly in the *Texas Medicaid Bulletin*.

The November/December 2007 *Texas Medicaid Bulletin* and all *Texas Medicaid Bulletins* through and including the September/October 2008 *Texas Medicaid Bulletin* supplement the 2008 *Texas Medicaid Provider Procedures Manual* and update the policy contained herein.

The *Texas Medicaid Provider Procedures Manual* serves as a comprehensive guide for Texas Medicaid providers, and contains information about Texas Medicaid benefits, policies, and procedures. The manual also includes an overview of the State of Texas Medicaid Managed Care programs to include the State of Texas Access Reform (STAR), STAR+PLUS, PCCM, and NorthSTAR. The information regarding the State of Texas Medicaid Managed Care programs, including Section 7, is not an exhaustive policies and procedures guide. For specific managed care information, contact the individual health plans participating in STAR, STAR+PLUS, and NorthSTAR. For PCCM, refer to the TMHP Telephone and Address Guide included in this manual.

Provider Manual Overview

The 2008 *Texas Medicaid Provider Procedures Manual* is divided into three parts, including:

Part I: Provider Information

The information in Part I is for all health-care providers who are enrolled in the Texas Medicaid Program and provide services to Texas Medicaid clients. In Part I, providers find instructions for providing allowable services and receiving appropriate reimbursement for services. The following sections are included in Part I:

- Introduction.
- TMHP Telephone and Address Guide.
- *Section 1*. Provider Enrollment and Responsibilities.
- *Section 2*. Texas Medicaid Reimbursement.
- *Section 3*. TMHP Electronic Data Interchange (EDI).
- *Section 4*. Client Eligibility.
- *Section 5*. Claims Filing.
- *Section 6*. Appeals.
- *Section 7*. Managed Care.

Part II: Texas Medicaid Services

Part II contains a section for each Texas Medicaid service with information on health-care policy, procedures, and claims filing pertaining to each provider type.

Part III: Appendices

Part III contains the following appendices for quick reference to commonly used information:

- *Appendix A*. State and Federal Offices Communication Guide.
- *Appendix B*. Forms.
- *Appendix C*. THSteps Forms.
- *Appendix D*. Claim Form Examples.
- *Appendix E*. Vendor Drug Program.
- *Appendix F*. Acronym Dictionary.
- *Appendix G*. HIV/AIDS.
- *Appendix H*. Immunizations.
- *Appendix I*. Medical Transportation.
- *Appendix J*. Lead Screening.
- *Appendix K*. Texas Health Steps Statutory State Requirements.
- *Appendix L*. Hearing Screening Information.
- *Appendix M*. THSteps Quick Reference Guide.
- *Appendix N*. THSteps Dental Guidelines.
- *Appendix O*. Women's Health Program.

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Contents

Provider Information

Introduction

Medicaid Program Administration

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

The State of Texas and the federal government share the cost of funding the Texas Medicaid Program. The Health and Human Services Commission (HHSC), the single state Medicaid agency, is responsible for the Title XIX Program. The administration of the program is accomplished through contracts and agreements with medical providers; Texas Medicaid & Healthcare Partnership (TMHP), the claims administrator; MAXIMUS, the enrollment broker; various managed care organizations (MCOs); the Institute for Child Health Policy (ICHP), the quality monitor; and state agencies. Texas Medicaid providers are reimbursed for services through contracts with health-insuring contractors, fiscal agents, or direct vendor payments.

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

Additional information is also provided on the TMHP website at www.tmhp.com. To find information about the various TMHP resources, visit the TMHP website, where the following information can be accessed:

- Workshop information.
- Regional provider relations representatives.
- Publications (manuals, bulletins, etc.).
- Panel reports.
- Eligibility inquiries.
- Claim status inquiries.
- Remittance and Status (R&S) reports.
- Primary Care Case Management (PCCM) regional provider listings.
- PCCM client handbook and other client information.

Refer to: "State and Federal Offices Communication Guide" on page A-1 for addresses and telephone numbers of HHSC and Department of State Health Services (DSHS) regional offices.

TMHP Telephone and Address Guide

TMHP Telephone and Fax Communication

Contact	Telephone/Fax Number
TMHP Contact Center (general information) Automated Inquiry System (AIS)	1-800-925-9126
Provider Enrollment Fax	1-512-514-4214
Comprehensive Care Program (CCP) (CCP prior authorization status and general CCP and Home Health Services information)	1-800-846-7470
Children with Special Health Care Needs (CSHCN) Services Program AIS	1-800-568-2413
CSHCN Fax	1-512-514-4222
Comprehensive Care Inpatient Psychiatric (CCIP) Unit (prior authorization and general information)	1-800-213-8877
Home Health Services (includes Durable Medical Equipment [DME]): 1 – TMHP In-Home Care Customer Service 2 – DME Supplier with completed Title XIX form 3 – Registered Nurse (RN) with completed Plan of Care (POC)	1-800-925-8957
Health Insurance Premium Payment (HIPP)	1-800-440-0493
Long Term Care (LTC) Operations	1-800-626-4117
LTC—Nursing Facilities	1-800-727-5436
Telephone Appeals	1-800-745-4452
TMHP Electronic Data Interchange (EDI) Help Desk	1-888-863-3638
TMHP EDI Help Desk Fax	1-512-514-4228 1-512-514-4230
Texas Health Steps (THSteps) Dental Inquiries	1-800-568-2460
THSteps Medical Inquiries	1-800-757-5691
Third Party Resources (TPR) (Option 2)	1-800-846-7307
TPR Fax	1-512-514-4225
Medicaid Audit/Cost Reports	1-512-506-6117
Medicaid Audit Fax	1-512-506-7811
Family Planning (Tubal Ligation/Vasectomy Consent Forms) Fax	1-512-514-4229
Hysterectomy Acknowledgment Statements Fax	1-512-514-4218

Primary Care Case Management (PCCM) Telephone Communication

Contact	Telephone Number
PCCM Case Management	1-888-276-0702
Clinical Helpline (clients only)	1-800-304-5468
PCCM Client Helpline	1-888-302-6688
PCCM Prenatal Care	1-877-518-0899
PCCM Provider Helpline	1-888-834-7226
PCCM Utilization Management Helpline	1-888-302-6167

Prior Authorization Request Telephone and Fax Communication

Contact	Telephone/Fax Number
Ambulance Authorization (includes out-of-state transfers)	1-800-540-0694
Ambulance Authorization Fax	1-512-514-4205
Home Health Services Fax	1-512-514-4209

Contact	Telephone/Fax Number
Comprehensive Care Program (CCP) Fax	1-512-514-4212
Comprehensive Care Inpatient Psychiatric (CCIP)	1-800-213-8877
CCIP Fax	1-512-514-4211
Outpatient Psychiatric Fax	1-512-514-4213
TMHP Special Medical Prior Authorization Fax (including transplants)	1-512-514-4213
PCCM Utilization Management: Option 1: Inpatient authorization request or notification of admission Option 2: Outpatient authorization request	1-888-302-6167
PCCM Utilization Management Fax	1-512-302-0319
Radiology Services Prior Authorization	1-800-572-2116
Radiology Services Prior Authorization Fax	1-888-693-3210

Prior Authorization Status Telephone Communication

Contact	Telephone Number
Home Health Services (includes Durable Medical Equipment [DME]): 1 – TMHP In-Home Care Customer Service 2 – DME Supplier with completed Title XIX form 3 – Registered Nurse (RN) with completed Plan of Care (POC)	1-800-925-8957
CCP	1-800-846-7470
PCCM: Option 1 – 1: Inpatient authorization status Option 2 – 1: Outpatient authorization status	1-888-302-6167

Written Communication with TMHP

All CMS-1500 forms (excluding Ambulance, Radiology/Laboratory, Immunization Services, Rural Health, and Mental Health Rehabilitation) sent to TMHP for the first time, as well as claims being resubmitted because they were initially denied as *incomplete claims*, must be sent to the following address:

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

The post office box addresses must be used for the specific items listed in the following table:

Correspondence	Address
Appeals/adjustments of claims (except zero paid/zero allowed on Remittance & Status [R&S] reports) Electronically rejected claims past the 95-day filing deadline and within 120 days of electronic rejection report	Texas Medicaid & Healthcare Partnership Appeals/Adjustments PO Box 200645 Austin, TX 78720-0645
All first-time claims	Texas Medicaid & Healthcare Partnership Claims PO Box 200555 Austin, TX 78720-0555
Ambulance/Comprehensive Care Program (CCP) requests (for prior authorization and appeals)	Texas Medicaid & Healthcare Partnership Comprehensive Care Program (CCP) PO Box 200735 Austin, TX 78720-0735

Correspondence	Address
Children with Special Health Care Needs (CSHCN) Services Program claims	Texas Medicaid & Healthcare Partnership Attn: CSHCN Services Program Claims PO Box 200855 Austin, TX 78720-0735
Dental prior authorization requests	Texas Medicaid & Healthcare Partnership Dental Prior Authorization PO Box 202917 Austin, TX 78720-2917
Home Health Services prior authorizations	Texas Medicaid & Healthcare Partnership Home Health Services PO Box 202977 Austin, TX 78720-2977
Medicaid Audit correspondence	Texas Medicaid & Healthcare Partnership Medicaid Audit PO Box 200345 Austin, TX 78720-0345
Medical Necessity forms 3652, 3618, and 3619, and purpose code E information	Texas Medicaid & Healthcare Partnership Long Term Care—Nursing Facilities PO Box 200765 Austin, TX 78720-0765
Medically Needy Clearinghouse (MNC) or Spend Down Unit correspondence	Texas Medicaid & Healthcare Partnership Medically Needy Clearinghouse PO Box 202947 Austin, TX 78720-2947
Provider enrollment correspondence	Texas Medicaid & Healthcare Partnership Provider Enrollment PO Box 200795 Austin, TX 78720-0795
Other provider correspondence	Texas Medicaid & Healthcare Partnership Provider Relations PO Box 202978 Austin, TX 78720-0978
Send all other written communication to TMHP	Texas Medicaid & Healthcare Partnership (Department) 12357-B Riata Trace Parkway, Suite 150 Austin, TX 78727
Third Party Resource (TPR)/Tort correspondence	Texas Medicaid & Healthcare Partnership Third Party Resources/Tort PO Box 202948 Austin, TX 78720-9981
Provider Enrollment Contract/Credentialing	Texas Medicaid & Healthcare Partnership PCCM Contracting/Credentialing PO Box 200795 Austin, TX 78720-4270

Other TMHP Information

TMHP Contact Center

The TMHP Contact Center is available during the hours of 7 a.m. to 7 p.m., Central Time, Monday through Friday.

The TMHP Contact Center assists with questions such as:

- Provider enrollment procedures.
- Claims filing procedures.
- Policy information.

The TMHP Contact Center is available to assist providers and clients. Please review the telephone and fax communication guides in this section for a list of contact phone and fax numbers.

For questions or information about Medicaid eligibility, clients are referred to their caseworker or the local Health and Human Services Commission (HHSC) office.

Automated Inquiry System (AIS)

AIS provides the following information and services through the use of a touch-tone telephone: claim status, patient eligibility, benefit limitations, Medically Needy case status, Family Planning, current weekly payment amount, and claim appeals.

Eligibility and claim status information is available on AIS 23 hours a day, 7 days a week with scheduled down time between 3 a.m. and 4 a.m., Central Time. All other AIS information is available from 6 a.m. until 6 p.m., Central Time, Monday through Friday. AIS offers 15 transactions per call.

For full instructions on the use and benefits of AIS, refer to the Automated Inquiry System (AIS) User's Guide available on www.tmhp.com or call the TMHP Contact Center at 1-800-925-9126 for faxed instructions.

TMHP Provider Relations

The TMHP Provider Relations Department comprises a staff of Austin- and field-based provider relations representatives whose goal is to serve the healthcare community by furnishing a variety of services and activities designed to inform and educate healthcare providers about Texas Medicaid Program activities and claim submission procedures.

Provider Relations activities include the following:

- *Provider education through planned events*. Provider representatives conduct a planned program of educational workshops, in-services, and training sessions designed to keep all actively-enrolled providers informed of the latest policies, claim processing procedures, and federal and state regulations affecting the Texas Medicaid Program.
- *Problem identification and resolution*. A staff of research coordinators is available to assist providers with clarification of Medicaid policies and assist with in-depth problem claim submission issues after initial inquiries are made with the TMHP Contact Center. Coordinators work closely with field-based regional representatives to coordinate the educational needs of the community.
- *Relationship with professional healthcare organizations*. To ensure that Texas associations that represent healthcare professions have up-to-date information about the requirements for participation in the Texas Medicaid Program, the Provider Relations Department maintains a work relationship with these organizations. Also, the Provider Relations Department participates in several events sponsored by Texas healthcare associations, such as conventions and conferences.

Visit www.tmhp.com for Provider Relations contact information, or call the TMHP Contact Center at 1-800-925-9126 for assistance.

TMHP EDI Help Desk

The TMHP Electronic Data Interchange (EDI) Help Desk assists Medicaid providers with EDI transactions. The TMHP EDI Help Desk is available at 1-888-863-3638 from 7 a.m. to 7 p.m., Central Time, Monday through Friday.

TMHP EDI Help Desk activities and responsibilities include, but are not limited to, the following:

- Enrolling providers for electronic billing.
- Qualifying vendors for TMHP EDI production through testing.
- Diagnosing claim transmission problems through research.
- Consulting with provider billing personnel, billing services, and software vendors regarding TMHP EDI.

TMHP EDI Help Desk staff assists with questions about TMHP EDI, TDHconnect software, TexMedConnect, and electronic transmissions at 1-888-863-3638.

Providers who employ hardware or software vendors should contact those vendors for the resolution of technical problems.

State of Texas Access Reform (STAR) Program

Contact	Telephone
STAR, STAR+PLUS, and NorthSTAR Help Line (MAXIMUS)	1-800-964-2777

Refer to: "Telephone Communication with HHSC and the Department of State Health Services (DSHS)" on page A-4 for agency telephone numbers.

Section

1

Provider Enrollment and Responsibilities

1.1 Provider Enrollment

1.1.1 TMHP Provider Enrollment

The National Provider Identifier (NPI) final rule, Federal Register 45, *Code of Federal Regulations* (CFR) Part 162, established the NPI as the standard unique identifier for health-care providers and requires covered health-care providers, clearinghouses, and health plans to use this identifier in *Health Insurance Portability and Accountability Act* (HIPAA)-covered transactions. An NPI is a 10-digit number assigned randomly by the National Plan and Provider Enumeration System (NPPES).

A provider of medical services (including an out-of-state provider) who wants to be eligible for Texas Medicaid reimbursement must obtain an NPI from NPPES, complete the required Texas Medicaid provider enrollment application forms, and enter into a written provider agreement with HHSC. TMHP Provider Enrollment supplies these forms. Request forms from and submit completed forms to the following address:

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

Providers may download the Texas Medicaid Provider Enrollment Application at www.tmhp.com.

Note: *During the Texas Medicaid Program enrollment process, the Claims Administrator may waive the mandatory prerequisite for Medicare enrollment for certain providers whose type of practice is pediatric-based and who will never bill Medicare.*

A provider identifier is issued when TMHP determines that a provider qualifies for participation.

Refer to: "Medicaid Service Provided Outside Texas" on page 2-6 for additional criteria that must be met for out-of-state providers to enroll in the Texas Medicaid Program.

A new enrollment application must be completed and a new provider identifier must be issued when one of the following changes:

- Medicare Number—If Medicare has issued a new Medicare number, the provider must complete and submit a Texas Medicaid Provider Enrollment Application in order to enroll the new location or with a new group.
- Change of Ownership—The new owner must do the following:
  - Obtain recertification as a Title XVIII (Medicare) facility under the new ownership.
  - Complete the Texas Medicaid Provider Enrollment Application.
  - Provide TMHP with a copy of the Contract of Sale (specifically, a signed agreement that includes the identification of previous and current owners in language that specifies who is liable for overpayments that were identified subsequent to the change of ownership, that includes dates of service before the change of ownership).
  - Provide a listing of all of the provider identifiers affected by the change of ownership.
  - Submit any change in ownership, corporate officers, or directors to TMHP Provider Enrollment *within 10 calendar days of the change.*
- Provider Status (individual, group, performing provider, or facility)—Providers leaving group practices must send a signed letter on company letterhead to TMHP that states the date of termination. The letter should include the provider identifier, effective date of termination, and the group's provider identifier. The letter should be signed by an authorized representative of the group or the individual provider leaving the group. If the provider is joining a new group practice or enrolling as an individual, the provider must complete and submit a Texas Medicaid Provider Enrollment Application to request enrollment in the new group or as an individual provider.
- Physical Address—If a provider is changing an address, and the address is within the Medicare locality, the provider must complete and submit a Provider Information Change (PIC) Form. A W9 is required if the provider is changing the mailing address. If the address is not within the Medicare locality and Medicare has issued a new Medicare number, the provider must complete and submit a Texas Medicaid Provider Enrollment Application in order to enroll the new location. Dental providers must complete a TMHP Dental Provider Enrollment Application for each practice location.
- Provider Type—Providers must submit a separate Texas Medicaid Provider Enrollment Application for each provider type enrollment requested.

TMHP must receive all claims for Texas Medicaid Program services within 95 days of each date of service or within 95 days of the date the provider identifier is issued, whichever occurs later. Claims will be rejected until TMHP has issued an actual provider identifier.

Note that 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 receipt of notice of Medicaid enrollment, the provider must contact the appropriate TMHP Authorization Department before providing services to a Medicaid client that require a prior authorization number. 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. Providers should refer to the

specific manual section for details on authorization requirements and any timeframe guidelines for authorization request submissions.

Providers who have not been assigned a provider identifier and have general claim submission questions may refer to Section 5, "Claims Filing" for assistance with claim submission. If additional general information is needed, providers may call 1-800-925-9126 to obtain information. Due to HIPAA privacy guidelines, specific client and claim information cannot be provided. Providers who have already been assigned a provider identifier and have questions about submitting claims, may call the same number and select the option to speak with a TMHP call center representative.

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

Refer to: "Copy of License/Temporary License/Certification" on page 1-4.

1.1.2 Enrollment in Medicaid Managed Care Programs

Texas Medicaid providers who wish to become a primary care provider for Primary Care Case Management (PCCM) clients must enroll with PCCM.

To be reimbursed for services provided to other Medicaid Managed Care clients, providers must enroll with the health plan in which their patients are enrolled. In addition, providers may be eligible to enroll in Medicaid Managed Care health plans as primary care providers.

Refer to: "Medicaid Managed Care" on page 7-4 for more information about PCCM and Managed Care enrollment.

1.1.3 Required Enrollment Forms

The following sections provide information on the forms required to enroll in the Texas Medicaid Program.

Refer to: "Enrollment" in each Medicaid service section for more information.

1.1.3.1 Texas Medicaid Provider Enrollment Application

The Texas Medicaid Provider Enrollment Application must be submitted by all providers who want to enroll in the Texas Medicaid Program, and it must be signed by the person who is applying for enrollment. If the applicant is an entity, a Principal of the entity must sign the application. "Principal" is defined in "Provider and Principal Information Forms" on page 1-3. If the provider is enrolled in Medicare, the provider must submit a copy of the Medicare Confirmation Letter. Applications must be complete in order to process and issue a provider identifier.

Refer to: "Provider and Principal Information Forms" on page 1-3 for a definition of Principal.

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

Providers will be notified of incomplete applications and will have 30 business days to provide the requested missing information. If the information is not provided within 30 business days, TMHP will terminate the enrollment process and a new enrollment application must be submitted. Providers are required to review their enrollment application for correctness and completeness before submitting it to TMHP.

1.1.3.2 HHSC Medicaid Provider Agreement

The HHSC Medicaid Provider Agreement must be submitted by all providers who enroll in the Texas Medicaid Program and must be signed by the person applying for enrollment. If the applicant is an entity, a Principal of the entity must sign the application. "Principal" is defined in "Provider and Principal Information Forms" on page 1-3. This form is an agreement between HHSC and the provider performing services under the State Plan wherein the provider agrees to certain contract provisions as a condition of participation. All pages of the agreement must be present with the enrollment application even if the forms are blank because they are not pertinent to the provider's situation.

1.1.3.3 Provider and Principal Information Forms

The Provider Information Form (PIF-1) must be personally completed by all providers enrolling in the Texas Medicaid Program. A separate Principal Information Form (PIF-2) must be personally completed by each Principal of the Provider before enrollment in the Texas Medicaid Program. Principals of the Provider include an owner with a direct or indirect ownership or control interest of five percent or more. Principals also include corporate officers and/or directors, limited or non-limited partners, or shareholders of a professional corporation, professional association, limited liability company, or other legally designated entity. Principals further include any employee of the Provider who exercises operational or managerial control over the entity, or who directly or indirectly conducts the day-to-day operations of the entity. The PIF-1 and the PIF-2 must be signed by the individual to whom it applies or, in the case of an entity, signed by a Principal of the entity and notarized before they are returned to TMHP. These forms were designed across multiple state agencies to help meet the requirements set forth by the 75th Legislature's Senate Bill (S.B.) 30 to enhance the enrollment requirements for potential providers, meet federal requirements for enrollment, and improve the integrity of the Texas Medicaid Program.

1.1.3.4 Disclosure of Ownership and Control Interest Statement

The Disclosure of Ownership and Control Interest Statement must be submitted by all providers, excluding the performing providers of a group. This form provides TMHP Provider Enrollment with the appropriate information to enroll the provider as a sole proprietor, corporation, partnership, or nonprofit organization. This information determines if other enrollment forms are required. Providers are required to submit any change in ownership, corporate officers, or directors to TMHP Provider Enrollment within 10 calendar days of the change.

1.1.3.5 Internal Revenue Service (IRS) W-9 Form

The IRS W-9 Form is completed and submitted by all providers excluding performing providers of a group.

1.1.3.6 Medicaid Audit Information Form

The Medicaid Audit Information Form is required by facilities such as hospitals, home health agencies, federally qualified health centers, rural health clinics (RHCs), and dialysis facilities.

1.1.3.7 Corporate Board of Directors Resolution

All providers who indicate that they are a corporation on the Disclosure of Ownership and Control Interest Statement are required to submit the Corporate Board of Directors Resolution. This form indicates the individual (by name) who is authorized by the corporation to sign the agreement forms. The secretary of the corporation must sign the Corporate Board of Directors Resolution and notarize it. If a business is city or government-owned, this form is not required. All other necessary forms are signed by the person who is authorized by the city or government charter. If the potential provider is unsure who is authorized, the following criteria apply: city–mayor; county–judge; government–governor, chancellor, chairman of the board, or president. After becoming a provider or as an owner of a provider, corporations must keep TMHP informed of changes in officers, directors, and ownership of the corporation if the ownership is five percent or more ownership interest.

1.1.3.8 Certificate of Good Standing (Board Corporation Act, Article 2.45)

The Certificate of Good Standing must be submitted by all corporations that are not exempt from Franchise Tax. The Certificate of Good Standing prevents a corporation that is delinquent in Franchise Tax from being awarded a contract or granted a license or permit by the state or agency of the state. Providers must obtain the Certificate of Good Standing from the Comptroller's Office. Corporations that are nonprofit or exempt from Franchise Tax are not required to submit this form. These corporations have what the Comptroller's Office refers to as a "501C IRS Exemption." Indicate this exemption by signing the appropriate line on the Disclosure of Ownership & Control Interest Statement and marking *exempt* on the W-9 form. Out-of-state providers who do not conduct business in Texas are also exempt from submitting this form.

1.1.3.9 Certificate of Formation or Certificate of Filing

The provider must submit the Certificate of Formation or Certificate of Filing form. Obtain the form from the Office of the Secretary of State with which the corporation is registered. The name on this form must match the legal name shown on the W-9 form. Out-of-state providers are exempt from submitting this form.

Note: *Corporations formed prior to January 1, 2006, should submit their Certificate of Incorporation.*

1.1.3.10 Certificate of Authority

The Certificate of Authority and any required certifications to provide certain services must be submitted when a corporation is registered in a state other than Texas. Obtain this form from the Office of the Secretary of State of Texas. It takes the place of the Certificate of Incorporation. The form identifies the legal name of the corporation and is proof that the corporation is registered to do business in Texas.

1.1.3.11 Copy of License/Temporary License/Certification

TMHP receives licensure information from the following licensing boards:

- Texas Medical Board.
- Texas State Board of Dental Examiners.
- Texas State Board of Examiners of Psychologists.
- Texas Board of Chiropractic Examiners.
- Texas Board of Nursing.

Once enrolled in the Texas Medicaid Program, a reminder letter will be automatically generated and sent to providers 60 days before the provider's license expires. When the license is renewed, providers licensed by the boards listed above will not need to contact TMHP with renewal information.

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

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

1.1.3.12 Group Practices

A provider group participating in the Medicare Program that applies to be a Texas Medicaid group provider must complete a Texas Medicaid Provider Enrollment Application. Groups participating in Medicare must have a current Medicare number before enrolling with the Texas Medicaid Program. A valid and current Medicare number must be maintained. Performing providers of a Medicare group must also have a current Medicare number before enrolling in the Texas Medicaid Program. A current and valid Medicare number must be maintained. Providers must complete Section B of the application to enter the Medicare group provider number and Medicare performing provider numbers for each provider within the group.

Note: *During the Texas Medicaid Program enrollment process, the Claims Administrator may waive the mandatory prerequisite for Medicare enrollment for certain providers whose type of practice is pediatric-based and who will never bill Medicare.*

If additions or changes occur in the group's enrollment information (for example, a performing provider leaves or enters the group, changes an address, or a provider is no longer licensed) after the enrollment process is completed, the Medicare/Medicaid provider group must notify Medicare and the Texas Medicaid Program in writing within 10 calendar days of occurrence of the changes. Failure to provide this information may lead to administrative action by HHSC.

1.2 Provider Responsibilities

1.2.1 Compliance with Texas Family Code

1.2.1.1 Child Support

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

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

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

1.2.1.2 Reporting Child Abuse or Neglect

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

According to *Rider 19 of the General Appropriations Act*, 78th Legislative Regular Session, 1999, House Bill (H.B.) 1, all Medicaid providers shall comply with the provisions of state law as set forth in Chapter 261 of the *Texas Family Code* relating to investigations of reports of child abuse and neglect and the provisions of HHSC policy. Reimbursement shall only be made to providers who have demonstrated a good faith effort to comply with child abuse reporting guidelines and requirements in Chapter 261 and HHSC policy. Provider staff shall respond to disclosures or suspicions of abuse or neglect of minors, by reporting to the appropriate agencies as required by law.

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

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

1.2.1.3 Procedures for Reporting Abuse or Neglect

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

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

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

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

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

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

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

Reports can be made anonymously.

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

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

1.2.1.4 Procedures for Reporting Suspected Sexual Abuse

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

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

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

Refer to: "Child Abuse Reporting Guidelines, Checklist for HHSC Monitoring" on page B-13.

1.2.1.5 Training

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

1.2.2 Maintenance of Provider Information

Providers must, within 10 calendar days of occurrence, report in writing to TMHP Provider Enrollment changes in address (physical location or accounting), telephone number, name, ownership status, tax ID, and any other information pertaining to the structure of the provider's organization (for example, performing providers). Failure to notify TMHP of changes affects accurate processing and timely claims payment. Providers can update their address information using either the PIC Form on page B-82, or the Demographic Update (DU) Form on the TMHP website.

Providers should use the PIC Form to update physical or mailing addresses, telephone numbers, names, tax identification numbers (TIN), provider status, and other provider information on file with the Texas Medicaid Program and CSHCN Services Program.

The DU Form is only used to make changes to provider addresses on file with TMHP. Providers can use the DU Form on the TMHP website at any time via the *My Account* link. Providers must create a provider administrator account to access the DU Form on the secure pages of the TMHP website. Non administrator users must be assigned by the provider administrator. Only providers or their authorized representatives can access the provider administrator accounts to obtain and complete the DU Form. Providers will be prompted to verify their address(es) and make necessary changes at least once a year.

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

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

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

1.2.2.1 Online Provider Lookup

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

Providers can use the online update function to update their demographic information on the website. This allows users to view the most current information about the provider. To update demographic information online, authorized users log in to the TMHP website by clicking **Log In** on the homepage. Periodically, administrators may be required to verify their address when logging in to their account. This verification must be completed before the administrator can proceed to the secured portion of the website. The *My Account* page has a link to the Provider Demographic Update webpage. Current information will be displayed with a button to allow editable fields to be changed. Demographic information may be updated only by authorized administrators. This authorization is controlled through the Permissions Management link, also located on the *My Account* page. Fields that can be updated online include the following:

- Address.
- Telephone numbers.
- Office hours.
- Accepting new patients.
- Additional sites where services are provided.
- Languages spoken.
- Additional services offered.
- Medicaid waiver programs.
- Client age or gender limitations.
- Counties served.

The provider's name, gender, specialty, subspecialty, and group or plan affiliation cannot be changed online. Contact TMHP Provider Enrollment at 1-800- 925-9126, option 2, regarding changes to this information.

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

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

Note: *For family planning services, clients may obtain services from any Medicaid-enrolled provider without a referral from their primary care provider.*

1.2.3 Retention of Records and Access to Records and Premises

The provider must maintain and retain all necessary documentation, records, Remittance and Status (R&S) reports, and claims to fully document the services and supplies provided and delivered to a client with Texas Medicaid Program coverage, the medical necessity of those services and supplies, costs included in cost reports or other documents used to determine a payment rate or fee, and records or documents necessary to determine whether payment for those items or services was due and was properly made for full disclosure to HHSC and its designee. A copy of the claim and/or R&S reports only will not meet this requirement.

The documentation includes, without limitation, clinical medical patient records; other records pertaining to the patient; any other records of services, items, equipment, or supplies provided to the patient and payments made for those services; diagnostic tests; documents related to diagnosis; charting; billing records; invoices; treatments; services; laboratory results; X-rays; and documentation of delivery of items, equipment, and supplies. Accessible information must include information that is necessary for the agencies specified in this section to perform statutory functions.

The required information may also include, without limitation, business and accounting records with backup support documentation, statistical documentation, computer records and data, and patient sign-in sheets and schedules. Additionally, it includes all requirements and elements described in Title 1, *Texas Administrative Code* (TAC), §§371.1643(f), 371.1617(a)(2), and 371.1601 (definition of "failure to grant immediate access").

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

The provider must provide immediate access to the provider's premises and records for purposes of reviewing, examining, and securing custody of records, documents, electronic data, equipment, or other requested items, as determined necessary by the requestor to perform statutory functions. Nothing in this section will in any way limit access otherwise authorized under state or federal law. If, in the opinion of the Inspector General or other requestor, the documents may be provided at the time of the request or in less than 24 hours or the Inspector General or other requestor suspects the requested

documents or other requested items may be altered or destroyed, the request must be completed by the provider at the time of the request or in less than 24 hours as provided by the requestor. If, in the opinion of the Inspector General or other requestor, the requested documents and other items requested cannot be completely provided on the day of the request, the Inspector General or requestor may set the deadline for production at 24 hours from the time of the original request.

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

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

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

These documents and claims must be retained for a minimum period of five years from the date of service or until all audit questions, appeal hearings, investigations, or court cases are resolved. Freestanding RHCs must retain their records for a minimum of six years, and hospital-based RHCs must retain their records for a minimum of ten years. These records must be made available immediately at the time of the request to employees, agents, or contractors of HHSC Office of Inspector General (OIG), the Texas Attorney General's Medicaid Fraud Control Unit (MFCU) or Antitrust and Civil Medicaid Fraud Section, TMHP, DFPS, the Department of Aging and Disability Services (DADS), Department of State Health Services (DSHS), Department of Assistive and Rehabilitative Services (DARS), U.S. Department of Health and Human Services (HHS) representative, any state or federal agency authorized to conduct compliance, regulatory, or program integrity functions on the provider, person, or the services rendered by the provider or person, or any agent, contractor, or consultant of any agency or division delineated above. In addition, the provider must meet all requirements of 1 TAC, Part 15, §371.1643(f).

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

1.2.4 Release of Confidential Information

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

Only the client may give written permission for release of any pertinent information before client information can be released, and confidentiality must be maintained in all other respects. If a client's medical records are requested by a licensed Texas health-care provider or a physician licensed by any state, territory, or insular possession of the United States or any State or province of Canada, for purposes of emergency or acute medical care, a provider must furnish such records at no cost to the requesting provider. This includes records received from another physician or health-care provider involved in the care or treatment of the patient. If the records are requested for purposes other than for emergency or acute medical care, the provider may charge the requesting provider a reasonable fee and retain the requested information until payment is received.

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

1.2.5 Compliance with Federal Legislation

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

- Title VI of the *Civil Rights Act of 1964* (Public Law 88-352), Section 504 of the *Rehabilitation Act of 1973* (Public Law 93-112), *The Americans with Disabilities Act of 1990* (Public Law 101-336), Title 40, Chapter 73, of the TAC, all amendments to each, and all requirements imposed by the regulations issued pursuant to these acts. The laws provide in part that no persons in the U.S. shall, on the grounds of race, color, national origin, age, sex, disability, political beliefs, or religion, be excluded from participation in or denied any aid, care, service, or other benefits provided by federal and/or state funding, or otherwise be subjected to any discrimination.

- *Health and Safety Code 85.113* as described in "Model Workplace Guidelines for Businesses, State Agencies, and State Contractors" on page G-2 (relating to workplace and confidentiality guidelines on AIDS and HIV).

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

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

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

1.2.6 Utilization Control — General Provisions

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

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

At the direction of the HHSC OIG, a provider's claims may be manually reviewed before payment. Parameters are developed for prepayment review based on the specific areas of concern identified in each case. As part of the prepayment review process, providers are required to submit paper claims, rather than electronic claims, along with supporting medical record documentation (e.g., clinical notes, progress notes, diagnostic testing results, other reports, superbills, X-rays, and any related medical record documentation) attached to each claim for all services billed. This documentation is used to ascertain that the services billed were medically necessary, billed appropriately, and according to Texas Medicaid Program requirements and policies. Services inconsistent with Texas Medicaid Program requirements and policies are adjudicated accordingly. Claims submitted initially without the supporting medical record documentation will be denied. Additional medical record documentation submitted by the provider for claims denied as a result of the prepayment review process is not considered at a later time. A provider is removed from prepayment review only when determined appropriate by the HHSC OIG. Once removed from prepayment review, a follow-up assessment of the provider's subsequent practice patterns is performed to monitor and ensure continued appropriate use of resources. Noncompliant providers are subject to administrative sanctions up to and including exclusion and contract cancellation, as deemed appropriate by the HHSC OIG as defined in the rules in 1 TAC §371.1643. Providers placed on prepayment review must submit all paper claims and supporting medical record documentation to the following address:

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

1.2.7 Provider Certification/Assignment

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

- Services were personally rendered by the *billing provider* or under the personal supervision of the billing provider, if allowed for that provider type, or under the substitute physician arrangement.
- The information on the claim form is true, accurate, and complete.
- All services, supplies, or items billed were medically necessary for the client's diagnosis or treatment. Exception is allowed for special preventive and screening programs (for example, family planning and Texas Health Steps [THSteps]).
- Medical records document all services billed and the medical necessity of those services.

- All billed charges are usual and customary for the services provided. The charges must not be higher than the fees charged to private-pay patients.
- *The provider will not bill the Texas Medicaid Program for services that are provided or offered to non-Medicaid patients, without charge, discounted or reduced in any fashion including, but not limited to, sliding scales or advertised specials. Any reduced, discounted, free, or special fee advertised to the public must also be offered to Texas Medicaid Program clients.*
- Services were provided without regard to race, color, sex, national origin, age, or handicap.
- The provider of medical care and services files a claim with the Texas Medicaid Program agreeing to accept the Medicaid reimbursement as payment in full for those services covered under the Texas Medicaid Program. The client with Medicaid coverage, or others on their behalf, must not be billed for the amount above that which is paid on allowed services or for services denied or reduced as a result of errors made in claims filing, claims preparation, missed filing deadlines, or failure to follow the appropriate appeal process. However, the client may be billed for noncovered services for which the Texas Medicaid Program does not make any payment. Before providing services, providers should *always* inform clients of their liability for services that are not a benefit of the Texas Medicaid Program, including use of the Client Acknowledgment Statement.
- *The provider understands that endorsing or depositing a Texas Medicaid Program check is accepting money from federal and state funds and that any falsification or concealment of material fact related to payment may be grounds for prosecution under federal and state laws.*

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

- Services offered by or through the Title V agency when the service is a benefit of the Texas Medicaid Program and rendered to an eligible client.
- Services included in the Texas Medicaid client's individualized education plan (IEP) or individualized family service plan (IFSP) if the services are covered under the Title XIX state plan, even though they are free to the users of the services.

Refer to: "Supervision" on page 36-8.

1.2.7.1 Delegation of Signature Authority

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

If the claim is prepared by a billing service or printed by data processing equipment, it is permissible to print "Signature on File" in place of the provider's signature.

When claims are prepared by a billing service, the billing service must obtain and keep a letter on file that is signed by the provider authorizing claim submission.

1.2.8 Billing Clients

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

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

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

Medicaid payment to physicians for covered services includes the incidental services such as completion of required forms submitted by a nursing facility to the physician for signature. It is not acceptable for the physician to charge Texas Medicaid Program clients, their family, or the nursing facility for telephone calls, telephone consultations, or signing forms. Medicaid payment is considered payment in full. The *visit reimbursement* includes the *incident to* required paperwork.

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

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

Refer to: "Outpatient" on page 25-17 for more information about spell of illness.

"Medically Needy Program (MNP)" on page 4-10.

"Private Pay Agreement" on page B-73.

1.2.8.1 Client Acknowledgment Statement

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

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

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

- Any service that is not a benefit of the Texas Medicaid Program (for example, personal care items).
- All services incurred on noncovered days because of eligibility or spell of illness limitation. Total client liability is determined by reviewing the itemized statement and identifying specific charges incurred on the noncovered days. Spell of illness limitations do not apply to medically necessary stays for THSteps clients birth through 20 years of age.
- The reduction in payment that is because of the medically needy spend down (the Medically Needy Program [MNP] is limited to children younger than 19 years of age and pregnant women). The client's potential liability would be equal to the amount of total charges applied to the spend down. Charges to clients for services provided on ineligible days must not exceed the charges applied to spend down.
- All services provided as a private pay patient. If the provider accepts the client as a private pay patient, the provider must advise clients that they are accepted as private pay patients at the time the service is provided and responsible for paying for all services received. In this situation, HHSC strongly encourages the provider to ensure that the client signs written notification so there is no question how the client was accepted. Without written, signed documentation that the Texas Medicaid Program client has been properly notified of the private pay status, the provider cannot seek payment from an eligible Texas Medicaid Program client.
- The client is accepted as a private pay patient pending Texas Medicaid Program eligibility determination and does *not* become eligible for Medicaid retroactively. The provider is allowed to bill the client as a private pay patient if retroactive eligibility is not granted. If the client becomes eligible retroactively, the client notifies the provider of the change in status. Ultimately, the provider is responsible for filing timely Texas Medicaid Program claims. If the client becomes eligible, the provider *must* refund any money paid by the client and file Medicaid claims for all services rendered.

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

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

1.2.9 General Medical Record Documentation Requirements

The *Administrative Simplification Act* of the *Health Insurance Portability and Accountability Act* (HIPAA) of 1996 mandates the use of national coding and trans-

action standards. HIPAA requires that the American Medical Association's (AMA) Current Procedural Terminology (CPT) system be used to report professional services, including physician services. Correct use of CPT coding requires using the most specific code that matches the services provided based on the code's description. Providers must pay special attention to the standard CPT descriptions for the evaluation and management (E/M) services. The medical record must document the specific elements necessary to satisfy the criteria for the level of service as described in CPT. Reimbursement may be recouped when the medical record does not document that the level of service provided accurately matches the level of service claimed. Furthermore, the level of service provided and documented must be medically necessary based on the clinical situation and needs of the patient.

HHSC and TMHP routinely perform retrospective reviews of all providers. HHSC ultimately is responsible for Texas Medicaid utilization review activities. This review includes comparing services billed to the client's clinical record. The following requirements are general requirements for all providers. Any mandatory requirement not present in the client's medical record subjects the associated services to recoupment.

Note: *This list is not all-inclusive. Additional and more specific requirements may apply to special services areas.*

- Mandatory–All entries are legible to individuals other than the author, dated (month, day, and year), and signed by the performing provider.
- Mandatory–Each page of the medical record documents the patient's name and Texas Medicaid number.
- Mandatory–Allergies and adverse reactions (including immunization reactions) are prominently noted in the record.
- Mandatory–The selection of E/M codes (levels of service) is supported by the client's clinical record documentation. The AMA CPT descriptors of key/contributory components with level of service descriptions are used to evaluate the selection of levels of service.
- Mandatory–The history and physical documents the presenting complaint with appropriate subjective and objective information.
- Mandatory–The services provided are clearly documented in the medical record with all pertinent information regarding the patient's condition to substantiate the need and medical necessity for the services.
- Mandatory–Medically necessary diagnostic lab and X-ray results are included in the medical record and abnormal findings have an explicit notation of follow-up plans.
- Mandatory–Necessary follow-up visits specify time of return by at least the week or month.
- Mandatory–Unresolved problems are noted in the record.
- Desirable–Immunizations are noted in the record as *complete* or *up-to-date*.
- Desirable–Personal data includes address, employer, home/work telephone numbers, sex, marital status, and emergency contacts.

1.2.10 Stale-Date Check Process

TMHP has implemented voiding procedures for checks greater than 180 days old. When a check becomes 120 days old, TMHP sends a reminder letter to the payee. This letter notifies the payee of the check's stale date and states that TMHP will void the check if not cashed by this date. TMHP does not guarantee receipt of the 120-day letter, and all checks are voided after 180 days.

Once a check has been voided, the associated claims may not be payable, and the transaction is considered final.

1.2.11 Informing Pregnant Clients About CHIP Benefits

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

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

To qualify for CHIP, a child must be:

- A Texas resident.
- Younger than 19 years of age.
- A citizen or legal permanent resident of the United States.
- Must meet all income and resource guidelines.

CHIP benefits include:

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

- Chiropractic services.

Individuals may apply for CHIP by downloading and completing the application found on the CHIP page of the HHSC website at www.hhsc.state.tx.us/chip or by calling the toll-free CHIP number at 1-800-647-6558.

1.3 Medicare/Medicaid Waste, Abuse, and Fraud Policy

Federal and state regulations and statutes require the Texas Medicaid Program, through the OIG, to have the ability to identify, investigate, sanction, and refer cases of suspected waste, abuse, and/or fraud in the Medicare, Medicaid, or other health and human services programs to prosecutors or licensure and certification boards and agencies. Additionally, HHSC OIG is:

- Provided the authority to exclude from program reimbursement any provider that defrauds or abuses the Texas Medicaid Program.
- Required to exclude from Medicaid participation any individual who is receiving reimbursement under the Texas Medicaid Program and has been suspended from Medicare for conviction of a program-related crime or is not eligible to participate in Medicare when the Federal Office of the Inspector General for the HHS directs such action.

Providers may also refer cases of waste, abuse, and fraud to the OIG for civil damages and penalties (previously referred to as civil monetary penalties), authorized by state statute. Providers (individual or corporate) may be assessed in the amount that was paid, plus interest, plus up to double the amount paid, plus an amount not less than $5,000.00 or more than $15,000.00 for each violation that results in injury to an elderly or disabled person or a person younger than 18 years of age or not more than $10,000.00 for each violation that does not result in injury to a person as described above.

The assessment for each violation is calculated using each line item detail and/or occurrence identified on a claim, cost report, or other document resulting in or supporting fraudulent or abusive billing. Additional civil damages and penalties may be assessed under the Federal Civil Monetary Penalties Law contained in the *Social Security Act* for submitting fraudulent or abusive billings. A provider with assessed civil damages and penalties may be excluded or barred from participating in Medicare, Medicaid, or both.

A provider and the provider's staff are responsible for maintaining a current understanding of the requirements for participation in the Texas Medicaid Program and current policies, claims filing and processing procedures, and federal regulations affecting the Texas Medicaid Program through the following means:

- *Provider education*. Attendance at TMHP educational workshops, group meetings, and training sessions.
- *Texas Medicaid publications*. Use of the *Texas Medicaid Bulletin,* R&S reports, and the *Texas Medicaid Provider Procedures Manual* to inform staff of policy changes, Medicaid directives, and claims processing procedures.
- *Identification and resolution of provider problems*. Correction of deficiencies in operations identified by TMHP, the providers, or HHSC and action to resolve them.
- *Adopted agency rules*. Knowledge of the adopted agency rules published in the 1 TAC, Part 15, including, but not limited to, those related to fraud and abuse contained in Chapter 371.
- *List of Excluded Individuals/Entities by Texas OIG.* List of excluded providers used by participating providers to ensure that newly hired staff or independent contractors and current employees are not excluded by the Texas OIG from participation in the Texas Medicaid Program. Claims paid for services rendered by an excluded provider are subject to recoupment.
- *State and federal statutes*. Statutes pertinent to the Texas Medicaid Program and fraud and abuse within the Texas Medicaid Program.

A provider who delegates or otherwise allows signature authority for claims preparation or other activities to an office staff member or to a billing service is responsible for the provider's own actions and omissions; the actions and omissions of the provider's employees, contractors, and agents; and the accuracy of all information on a claim submitted for payment. This, however, does not absolve these other individuals for their participation in any documents provided to the state or designee with false, inaccurate, or misleading information; or pertinent omissions.

HHSC/OIG may impose one or any combination of administrative actions or administrative sanctions on Texas Medicaid Program providers or other persons when fraud, waste, or abuse is determined. Without limitation, other persons that may be sanctioned if determined to be in violation including those furnishing services or items directly or indirectly; those billing for services; those violating any of the provisions delineated in this section; and any affiliates of a provider or person violating any of the provisions delineated in this section. When administrative sanctions are imposed, the provider or person will be afforded the opportunity to appeal. There is no right of appeal associated with the imposition of administrative actions. The following is a list of administrative actions and sanctions.

Administrative sanctions include, without limitation:

- Exclusion from participation in the Titles V, XIX (Medicaid), and XX programs for a specified period of time, permanently, or indefinitely. Providers who are excluded from the Texas Medicaid Program are automatically excluded from Titles V and XX.
- Suspension of Medicaid payments (payment hold) to a provider.
- Recoupment of Medicaid overpayments.

- Recoupment of Medicaid overpayments projected from a sampling process.
- Restricted Medicaid reimbursement for a specified period of time or indefinitely. Specific services will not be reimbursed to an individual provider during the time the provider is on restricted reimbursement; however, other services, as determined by the HHSC/OIG will be reimbursed.
- Cancellation of the Medicaid provider contract or provider agreement.
- Debarment or suspension under the authority of the CFR.

Administrative actions include:

- Transfer to a closed-end contract or provider agreement for a specified period of time or a provisional or probationary contract or provider agreement with variable case-by-case options applied to the terms and conditions.
- Attendance at provider education sessions.
- Prior authorization of selected services.
- Prepayment review.
- Post-payment review.
- Attendance in informal or formal provider corrective action meetings.
- Submission of additional documentation or justification that is not normally required to accompany submitted claims. Failure to submit legible documentation or justification requested will result in denial of the claim.
- Oral, written, or personal educational contact with the provider.
- Posting of a surety bond or providing a letter of credit.
- Having a subpoena served to compel an appearance for testimony or the production of relevant evidence, as determined by the HHSC/OIG.

People who induce, solicit, receive, offer, or pay any remuneration (including, but not limited to, bribes, kickbacks, or rebates) directly or indirectly in relation to referrals, purchases, leases, or arrangements of services covered by Medicare or the Texas Medicaid Program may be in violation of state statutes and guilty of a federal felony offense. Current legislation allows for suspension of providers convicted of a criminal offense related to Medicare or the Texas Medicaid Program. Statutes provide that committing a felony in the Medicaid or Medicare programs may involve punishment ranging from 5 to 99 years, or life in prison and an optional monetary fine. Inducements may include a service, cash in any amount, entertainment or any item of value.

Following is a non-exclusive list of grounds/criteria for the Inspector General's administrative enforcement and/or referral for criminal, civil, or licensure or certification investigation and judicial action regarding program violations by any provider or person. Violations result from a provider or person who knew or should have known the following were violations. The headings of each group listed below are provided solely for organization and convenience and are not elements of any program violation.

1) Claims and Billing.
   a) submitting or causing to be submitted a false statement or misrepresentation, or omitting pertinent facts when claiming payment under the Texas Medicaid or other HHS program or when supplying information used to determine the right to payment under the Texas Medicaid or other HHS program;
   b) submitting or causing to be submitted a false statement, information or misrepresentation, or omitting pertinent facts to obtain greater compensation than the provider is legally entitled to;
   c) submitting or causing to be submitted a false statement, information or misrepresentation, or omitting pertinent facts to meet prior authorization requirements;
   d) submitting or causing to be submitted under Title XVIII (Medicare) or a state health-care program claims or requests for payment containing unjustified charges or costs for items or services that substantially exceed the person's usual and customary charges or costs for those items or services to the public or the private pay patients unless otherwise authorized by law;
   e) submitting or causing to be submitted claims with a pattern of inappropriate coding or billing that results in excessive costs to the Texas Medicaid or other HHS program;
   f) billing or causing claims to be filed for services or merchandise that were not provided to the recipient;
   g) submitting or causing to be submitted a false statement or misrepresentation that, if used, has the potential of increasing any individual or state provider payment rate or fee;
   h) submitting or causing to be submitted to the Texas Medicaid or other HHS program a cost report containing costs not associated with the Texas Medicaid or other HHS program or not permitted by the Texas Medicaid or other HHS program policies;
   i) presenting or causing to be presented to an operating agency or its agent a claim that contains a statement or representation that the person knows or should have known to be false;
   j) billing or causing claims to be submitted to the Texas Medicaid or other HHS program for services or items furnished personally by, at the medical direction of, or on the prescription or order of a person who is excluded from the Texas Medicaid Program, other HHS program, or Medicare or has been excluded from and not

reinstated within the Texas Medicaid Program, other HHS program, or Medicare;

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

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

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

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

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

2) Records and Documentation.

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

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

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

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

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

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

c) failing to provide immediate access, upon request by a requesting agency, to the premises or to any records, documents, and other items or equipment the provider is required by federal or state law or regulation or by contract to maintain in order to participate in the Texas Medicaid or other HHS program (see subparagraphs (a) and (b) of this paragraph), or failing to provide records, documents, and other items or equipment upon written request that are determined necessary by the Inspector General to complete their statutory functions related to a fraud and abuse investigation, including without limitation all requirements specified in 1 TAC §371.1643(f) of this subchapter. “Immediate access” is deemed to be within 24 hours of receiving a written request, unless the requesting agency has reason to suspect fraud or abuse or to believe that requested records, documents, or other items or equipment are about to be altered or destroyed, thereby necessitating access at the actual time the request is presented or, in the opinion of the Inspector General, the request may be completed at the time of the request and/or in less than 24 hours;

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

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

3) Program-Related Convictions.

a) pleading guilty or nolo contendere, agreeing to an order of probation without adjudication of guilt under deferred adjudication, or being a defendant in a court judgment or finding of guilt for a violation relating to performance of a provider agreement or program violation of Medicare, the Texas Medicaid Program, other

HHS program, or any other state's Medicaid program;

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

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

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

e) being convicted in connection with the interference with or obstruction of any investigation into any criminal offense that would support mandatory exclusion under 1 TAC §371.1655 of this subchapter or any offense listed within paragraph (3) of this subsection regarding program-related convictions; *and*

f) being convicted of any offense that would support mandatory exclusion under 1 TAC §371.1655 of this subchapter.

4) Provider Eligibility.

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

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

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

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

e) loss or forfeiture of corporate charter.

5) Program Compliance.

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

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

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

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

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

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

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

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

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

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

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

l) committing an act described in the *Social Security Act*, §1128A (mandatory exclusion) or §1128B (permissive exclusion);

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

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

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

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

6) Delivery of Health-Care Services.

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

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

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

7) Improper Collection and Misuse of Funds.

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

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

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

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

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

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

8) Licensure Actions.

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

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

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

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

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

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

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

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

e) engaging, as an MCO, a PCCM or an association, group or individual health-care provider furnishing services through managed care, in a fraudulent activity in connection with the enrollment in the organization's managed care

plan of an individual eligible for medical assistance or in connection with marketing the organization's services to an individual eligible for medical assistance;

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

g) failing, as an MCO, to comply with any term within a contract with a Texas Medicaid or other HHS program operating agency to provide health-care services to Texas Medicaid or HHS program recipients; *and*

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

10) Cost Report Violations.

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

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

c) including unallowable cost items on a cost report;

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

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

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

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

11) Kickbacks and Referrals.

a) violating any of the provisions specified in 1 TAC §371.1721(b) of this subchapter relating to kickbacks, bribes, rebates, referrals, inducements, or solicitation;

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

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

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

Involvement in any of the aforementioned items may result in provider or individual exclusion or suspension from the Texas Medicaid Program. Providers or individuals are notified in writing of action taken, including appeal and reinstatement procedures.

Providers and individuals who have been excluded from the Texas Medicaid Program may be reinstated only by the HHSC OIG. If the OIG approves an individual's request for reinstatement, a written notice will be sent to that individual. The written notification will specify the date on which participation in the Texas Medicaid Program will be effective.

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

1.3.1 Reporting Waste, Abuse, and Fraud

Individuals with knowledge about suspected Medicaid waste, abuse, or fraud of provider services must report the information to the HHSC OIG. To report waste, abuse, or fraud, go to www.hhs.state.tx.us and select **Reporting Waste, Abuse, and Fraud**. Individuals may also call the OIG hotline at 1-800-436-6184 to report waste, abuse, or fraud if they do not have access to the Internet. All information provided is protected by the HHSC/OIG privacy statement. This means that the information provided will remain confidential.

Providers may voluntarily investigate and report matters involving possible fraud, waste, abuse, or inappropriate payments of Medicaid funds in their own office. Providers are required to report these activities to HHSC/OIG when identified. It is the intention of HHSC/OIG to endeavor to

work collaboratively, and not adversarially, with providers who choose to self-report. To get additional information on self-reporting and to determine how to self-report, see the website oig.hhsc.state.tx.us/ProviderSelfReporting/Self_Reporting.aspx.

1.3.2 Suspected Cases of Provider Waste, Abuse, and Fraud

The HHSC OIG is responsible for minimizing the opportunity for provider waste, abuse, and fraud. HHSC takes appropriate action to protect clients and the Texas Medicaid Program when providers of services are suspected of committing waste, abuse, or fraud. HHSC OIG is responsible for establishing criteria for identifying cases of possible waste, abuse, or fraud and recouping all overpayments from a provider. Some circumstances may result in referral of a provider to the Texas Attorney General's MFCU or Antitrust and Civil Medicaid Fraud Section for further investigation, whereas other circumstances might result in administrative sanctions or actions deemed appropriate by the HHSC OIG.

1.3.3 Employee Education on False Claims Recovery

In accordance with the *United States Code* (USC), Title 42, §1396a(a)(68), and as a condition for receiving payments, any entity that receives or makes annual Medicaid payments of at least $5,000,000 shall establish written policies for all employees of the entity as well as all employees of any contractor or agent of the entity (including management) that provide detailed information about the following laws and their role in preventing and detecting waste, fraud, and abuse in federal health-care programs:

- The federal *False Claims Act* (31 USC §§3729-3733).
- Administrative remedies for false claims and statements as provided in Chapter 38 of Title 31, USC.
- Texas law relating to civil and criminal penalties for false claims (including Chapter 36 of the *Human Resources Code*; Section 35A.02 of the *Penal Code*; Title 1, Chapter 371, Subchapter G of the TAC; and other applicable law).
- Whistleblower protections under the above laws (including section 36.115 of the *Human Resources Code*).

The entity must also include, as part of the above written policies, detailed provisions regarding the policies and procedures of the entity for detecting and preventing fraud, waste, and abuse. In addition, the entity must also include in any employee handbook a specific discussion of the following:

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

1.4 Texas Medicaid Program Limitations and Exclusions

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

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

- Autopsies.
- Biofeedback therapy.
- Bladder stimulators (Pacemaker).
- Breast implants.
- Cardiac rehabilitation programs.
- Care and treatment related to any condition for which benefits are provided or available under Workers' Compensation laws.
- Cellular therapy.
- Chemolase injection (chymodiactin, chymopapain).
- Chemonucleolysis intervertebral disc.
- Custodial care.
- Dentures or endosteal implants for adults.
- Dermabrasion.
- Direct graduate medical education for teaching hospitals.
- DME such as wheelchairs, crutches, and walkers, except when these items are prior authorized as a home health benefit.
- DME (except THSteps-Comprehensive Care Program [CCP] and home health).
- Dressings/supplies billed in physician's office.
- Ergonovine provocation test.
- Excise tax.
- Fabric wrapping of abdominal aneurysms.
- Fetal fibronectin.
- Gastric stapling/bypass.
- Hair analysis.
- Heart–lung monitoring during surgery.
- Histamine therapy–intravenous.
- Hyperthermia.
- Hysteroscopy for infertility.
- Immunizations or vaccines unless they are otherwise covered by the Texas Medicaid Program. (These limitations do not apply to services provided through the THSteps Program).
- Immunotherapy for malignant diseases.
- Inborn errors of metabolism.
- Infertility.

- Inpatient hospital services to a client in an institution for tuberculosis, mental disease, or a nursing section of public institutions for the mentally retarded.
- Inpatient hospital tests that are not specifically ordered by a physician/doctor who is responsible for the diagnosis or treatment of the client's condition.
- Intestinal bypass surgery and gastric stapling for the treatment of morbid obesity.
- Intragastric balloon for obesity.
- Intravenous embolization–cerebral, maxillary, and renal.
- Joint sclerotherapy.
- Keratoprosthesis/refractive keratoplasty.
- Laetrile.
- Mammoplasty for gynecomastia.
- More than $200,000 per client per benefit year (November 1 through October 31) for any medical and remedial care services provided to a hospital inpatient by the hospital. If the $200,000 amount is exceeded because of an admission for an approved organ transplant, the allowed amount for that claim is excluded from the computation. This limitation does not apply to clients eligible for the THSteps-CCP.
- More than 30 days of inpatient hospital stay per spell of illness–each spell of illness must be separated by 60 consecutive days during which the client has not been an inpatient in a hospital.

  Important:*THSteps-CCP provides medically necessary, federally allowable treatment for Medicaid/THSteps clients birth through 20 years of age. Some medical services that usually would not be covered under Medicaid may be available to CCP-eligible clients. An additional 30-day spell of illness begins with the date of specified covered organ transplant. No spell of illness limitation exists for Medicaid THSteps clients younger than 21 years of age.*

  Note: *Members of the STAR and STAR+PLUS programs are not limited by the spell of illness.*
- Obsolete diagnostic tests.
- Oral medications, except when billed by a hospital and given in the emergency room or the inpatient setting (hospital take-home drugs or medications given to the client are not a benefit).
- Orthoptics (except THSteps-CCP).
- Orthotics (except THSteps-CCP).
- Outpatient and nonemergency inpatient services provided by military hospitals.
- Outpatient behavioral health services performed by a licensed chemical dependency counselor (LCDC), psychiatric nurse, mental health worker, social worker, or psychological associate regardless of physician or licensed psychologist supervision.
- Oxygen (except THSteps-CCP and home health).
- Payment for eyeglass materials or supplies regardless of cost if they do not meet Texas Medicaid Program specifications.
- Payment to physicians for supplies is not an allowable charge. All supplies, including anesthetizing agents such as *Xylocaine*, inhalants, surgical trays, or dressings, are included in the surgical payment.
- Penile prosthesis.
- Podiatry, optometric, and hearing aid services in long term care facilities, unless ordered by the attending physician.
- Private room facilities except when a critical or contagious illness exists that results in disturbance to other patients and is documented as such when it is documented that no other rooms are available for an emergency admission, or when the hospital only has private rooms.
- Procedures and services considered experimental or investigational.
- Prosthetic and orthotic devices.
- Prosthetic eye or facial quarter.
- Psychiatric services:
  - Outpatient behavioral health services exceeding 30 visits per calendar year for which no prior authorization has been given.
  - Reimbursement is not available for inpatient psychiatric hospital services, including physician fees, delivered to clients between 22 (21 in Texas) and 64 years of age.
  - Outpatient behavioral health services in freestanding psychiatric hospitals for Medicaid (except THSteps-CCP and NorthSTAR Program clients in the Dallas Managed Care Service Area).
  - Each individual behavioral health practitioner is limited to a combined total of 12 hours of Medicaid reimbursement per day for behavioral health services.

Refer to: "Licensed Marriage and Family Therapist (LMFT)" on page 29-1, "Licensed Clinical Social Worker (LCSW)" on page 28-1, "Licensed Professional Counselor (LPC)" on page 30-1, "Physician" on page 36-1, and "Psychologist" on page 38-1 for further information.

- Quest test (infertility).
- Recreational therapy.
- Review of old X-ray films.
- Routine circumcision for clients age one year and older.
- Separate fees for completing or filing a Medicaid claim form. The cost of claims filing is to be incorporated in the provider's usual and customary charges to all clients.
- Services and supplies to any resident or inmate in a public institution.

- Services or supplies for which benefits are available under any other contract, policy, or insurance, or which would have been available in the absence of the Texas Medicaid Program.
- Services or supplies for which claims were not received within the filing deadline.
- Services or supplies not reasonable and necessary for diagnosis or treatment.
- Services or supplies not specifically provided by the Texas Medicaid Program.
- Services or supplies provided in connection with a routine physical examination, except in connection with family planning services, THSteps, or the Medicaid Managed Care programs.
- Services or supplies provided in connection with cosmetic surgery except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member, or when prior authorized for specific purposes by TMHP (including removal of keloid scars).
- Services or supplies provided outside of the U.S., except for deductible and coinsurance portions of Medicare benefits as provided for in this manual.
- Services or supplies provided to a client after a finding has been made under utilization review procedures that these services or supplies are not medically necessary.
- Services or supplies provided to a Texas Medicaid client before the effective date of his or her designation as a client, or after the effective date of his or her denial of eligibility.
- Services payable by any health, accident, other insurance coverage, or any private or other governmental benefit system, or any legally liable third party.
- Services provided by an interpreter (except sign language interpreting services requested by a physician).
- Services provided by ineligible, suspended, or excluded providers.
- Services provided by the client's immediate relative or household member.
- Services provided by Veterans Administration facilities or U.S. Public Health Service Hospitals.
- Sex change operations.
- Silicone injections.
- Social and educational counseling except for family planning and genetics education and counseling services.
- Sterilization reversal.
- Sterilizations (including vasectomies) unless the client has given informed consent 30 days before surgery, is mentally competent, and is 21 years of age or older at the time of consent (This policy complies with 42 CFR §441.250, Subpart F).
- Take-home and self-administered drugs except as provided under the vendor drug or family planning pharmacy services.
- Tattooing.
- Telephone calls with clients or pharmacies (except as allowed for case management).
- Thermogram.
- Treatment for obesity.
- Treatment of flatfoot conditions and the prescription of supportive devices (including special shoes), the treatment of subluxations of the foot and routine foot care more than once every six months, including the cutting or removal of corns, warts, or calluses, the trimming of nails, and other routine hygienic care.
- Whole blood or packed red cells when available at no cost to the client.

Refer to: "Organ/Tissue Transplants" on page 36-98.

"Genetic Services" on page 22-1.

"Family Planning Services" on page 20-1 for specific coverage.

"Elective Sterilization Services" on page 36-45 for sterilization requirements.

"THSteps Medical and Dental Administrative Information" on page 43-5.

"Vendor Drug Program" on page E-1 for information about oral medications.

Section

2

Texas Medicaid Reimbursement

2.1 Reimbursement

Texas Medicaid Program reimbursements are available to all enrolled providers by check or electronic funds transfer (EFT). With EFT, TMHP directly deposits reimbursement into a provider's bank account. Stale-dated checks (i.e., checks that are older than 180 days) that have not been cashed are voided and/or applied to any outstanding accounts receivable. If the balance on a stale-dated check after it has been applied to accounts receivable is over $5,000, written notification is sent to the provider 30 days before the void occurs.

2.1.1 Electronic Funds Transfer

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

2.1.1.1 Using EFT

As a result of the 76th legislature, House Bill (H.B.) 2085 recommends that all Texas Medicaid providers receive payment by EFT. All providers are strongly encouraged to participate in EFT. EFT does not require special software and providers can enroll immediately. Complete the EFT form, include a deposit slip or canceled check, and mail the items to:

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

Refer to: "Electronic Funds Transfer (EFT) Authorization Agreement" on page B-38

2.1.1.2 Advantages of EFT

- Stop payments are no longer necessary because no paper is involved in the transaction process.
- Payment theft is less likely to occur because the process is handled electronically rather than by paper.
- Deposited funds are available for withdrawal the Thursday morning following the completed financial cycle.
- Upon deposit, the bank considers the transaction immediately collected. No float is attached to EFT deposits for Texas Medicaid funds.
- TMHP includes provider and Remittance and Status (R&S) report numbers with each transaction submitted. If the bank's processing software captures and displays the information, both numbers would appear on the banking statement.

2.1.1.3 Enrollment Procedures

The Electronic Funds Transfer (EFT) Authorization Agreement can be requested by contacting the Provider Enrollment department at 1-800-925-9126. Completed EFT forms can be faxed to 1-512-514-4214. Please include:

- EFT Enrollment Form.
- Organization name.
- Contact name.
- Address.
- Contact telephone number.
- Contact fax number.

To enroll for EFT, providers must submit a completed Electronic Funds Transfer (EFT) Authorization Agreement to TMHP. A voided check or copy of a deposit slip must be attached to the enrollment form. One form should be filled out for each billing provider identifier, including an original signature of the provider.

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

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

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

Refer to: "Electronic Funds Transfer (EFT) Authorization Agreement" on page B-38.

2.2 Reimbursement Methodology

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

Note: *Medicaid reimbursement through the State of Texas Access Reform (STAR), STAR+PLUS, and NorthSTAR Program health plans may differ according to the provider's contract with the health plan.*

2.2.1 Fee Schedules

The Texas Medicaid Program reimburses certain providers based on rates published in fee schedules. These rates are uniform statewide and by provider type. According to this type of reimbursement methodology, the provider is paid the lower of its billed charges or the Medicaid rate published in the applicable fee schedule available at www.tmhp.com.

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

- *Ambulance.* The Medicaid rates for ambulance services are calculated in accordance with 1 TAC §355.8600 and are listed in Section 8 of this manual.
- *Ambulatory Surgical Center (ASC)*. The Medicaid rates for ASCs are calculated in accordance with 1 TAC §355.8121. The current ASC/hospital-based ambulatory surgical center (HASC) fee schedule is available on the TMHP website. There is also an insert to the fee schedule available on the TMHP website. (See also Section 9 of this manual.)
- *Birthing Center*. The Medicaid rates for birthing centers are calculated in accordance with 1 TAC §355.8181 and are listed in Section 10 of this manual.
- *Blind Children's Vocational Discovery and Development Program*. The Medicaid rate for this service is calculated in accordance with 1 TAC §355.8381 and is listed in Section 11 of this manual.
- *Case Management for Children and Pregnant Women (CPW)*. The Medicaid rates for this service are calculated in accordance with 1 TAC §355.8401 and are listed in Section 12 of this manual.
- *Targeted Case Management for Early Childhood Intervention (ECI)*. The Medicaid rate for this service is calculated in accordance with 1 TAC §§355.8421 and 355.8423 and is listed in Section 13 of this manual.
- *Certified Nurse-Midwife (CNM)*. The Medicaid rates for CNMs are calculated in accordance with 1 TAC §355.8161. The current CNM fee schedule is available on the TMHP website. (See also Section 14 of this manual.)
- *Certified Registered Nurse Anesthetist (CRNA)*. According to 1 TAC §355.8221, the Medicaid rate for CRNAs is 92 percent of the rate reimbursed to a physician anesthesiologist for the same service. The current CRNA fee schedule is available on the TMHP website. (See also Section 15 of this manual.)
- *Certified Respiratory Care Practitioner (CRCP) Services.* The Medicaid rate per daily visit for 1-99503 is calculated in accordance with 1 TAC §355.8089. (See also Section 16 of this manual.)
- *Chemical Dependency Treatment Facility (CDTF)*. The Medicaid rates for CDTF services are calculated in accordance with 1 TAC §355.8241 and are listed in Section 17 of this manual.
- *Chiropractic Services*. The Medicaid rates for chiropractic services are calculated in accordance with 1 TAC §355.8081 and 1 TAC §355.8085 and are listed in Section 18 of this manual.
- *Dental*. The Medicaid rates for dentists are calculated as access-based fees in accordance with 1 TAC §355.8085, 1 TAC §355.8441(11), and 1 TAC §355.455(b). The current fee schedule is available on the TMHP website. (See also Section 19 of this manual.)
- *Durable Medical Equipment (DME)*. The current DME fee schedule is available on the TMHP website at www.tmhp.com. Home health agencies (HHAs) are reimbursed for DME and expendable supplies in accordance with 1 TAC §355-8021 (b)-(c). Texas Health Steps (THSteps) is reimbursed for DME and expendable supplies in accordance with 1 TAC §355-8441 (4)-(5). (See also Sections 24 and 43 of this manual.)
- *Family Planning Services*. The Medicaid rates for family planning services are calculated in accordance with 1 TAC §355.8584 and are listed in Section 20 of this manual.
- *Genetic Services*. The procedure codes and Medicaid rates for genetic services are listed in Section 22 of this manual.
- *Hearing Aid and Audiometric Evaluations*. Newborn hearing screenings are provided at the birthing facility before hospital discharge and, as such, are reimbursed in accordance with the reimbursement methodology for the specific type of birthing facility. Outpatient hearing screening and diagnostic testing services for children are provided by physicians and are reimbursed in accordance with the reimbursement methodology for physician services at 1 TAC §355.8085 and 1 TAC §355.8141. (See also Section 23 of this manual.)
- *Texas Medicaid (Title XIX) Home Health Services*. The reimbursement methodology for professional services delivered by HHAs are statewide visit rates calculated in accordance with 1 TAC §355.8021(a). (See also Section 24 of this manual.)
- *Independent Laboratory*. The Medicaid rates for independent laboratories are calculated in accordance with 1 TAC §355.8081 and §355.8610, and the *Deficit Reduction Act of 1984* (DEFRA). By federal law, Medicaid payments for a clinical laboratory service cannot exceed the Medicare payment for that service. Early Periodic Screening, Diagnosis, and Treatment (EPSDT)/THSteps medical and newborn screening laboratory services provided by the Department of State Health Services (DSHS) Laboratory are reimbursed based on actual costs in accordance with 1 TAC §355.8610. (See also Sections 26 and 43 of this manual.)

- *Indian Health Service*s. The reimbursement methodology for outpatient services provided in Indian Health Services Facilities operating under the authority of Public Law 93-638 is located at 1 TAC §355.8620. The procedure code for reimbursing these services is 1-T1015, and the current encounter rate is $256.
- *In-Home Total Parenteral Nutrition (TPN)/Hyperalimentation Supplier*. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8087. The procedure codes reimbursable to these providers are listed in Section 27 of this manual.
- *Licensed Marriage and Family Therapist (LMFT)*. According to 1 TAC §355.8091, the Medicaid rate for LMFTs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085. (See also Section 29 of this manual.)
- *Licensed Clinical Social Worker (LCSW)*. According to 1 TAC §355.8091, the Medicaid rate for LCSWs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085. (See also Section 28 of this manual.)
- *Licensed Professional Counselor (LPC)*. According to 1 TAC §355.8091, the Medicaid rate for LPCs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085. (See also Section 30 of this manual.)
- *Maternity Service Clinic (MSC)*. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8201. The procedure codes reimbursable to these providers are listed in Section 31 of this manual, and the Medicaid rates are listed in the current fee schedule, which is available on the TMHP website.
- *Mental Health (MH) Mental Retardation (MR)*. The Medicaid rates for MH case management are calculated in accordance with 1 TAC §355.743 and those for MR service coordination are calculated in accordance with 1 TAC §355.746. The Medicaid rates for MH rehabilitative services are calculated in accordance with 1 TAC §355.781. The procedure codes covered by these services are listed in Section 32 of this manual.
- *Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS).* According to Title 1 TAC §355.8281, the Medicaid rate for NPs and CNSs is 92 percent of the rate paid to a physician (doctor of medicine [MD] or doctor of osteopathy [DO]) for the same service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections. The current NP and CNS fee schedule is available on the TMHP website. (See also Section 34 of this manual.)
- *Physical Therapists/Independent Practitioner*s. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8081 and §355.8085. The procedure codes reimbursable to these providers are listed in Section 35 of this manual, and the Medicaid rates are listed in the current fee schedule, which is available on the TMHP website.
- *Physician*. The Medicaid rates for physicians and certain other practitioners are calculated in accordance with 1 TAC §355.8085. The current fee schedule is available on the TMHP website. For more information about physician services, see Section 2.2.1.1, "Physician Services in Outpatient Hospital Setting" on page 2-5 and Section 36, "Physician" on page 36-1.
- *Physician Assistant (PA)*. According to 1 TAC §355.8093, the Medicaid rate for PAs is 92 percent of the rate paid to a physician (MD or DO) for the same service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections. The current fee schedule for PAs is available on the TMHP website. (See also Section 37 of this manual.)
- *Psychologist*. The Medicaid rates for psychologists are calculated in accordance with 1 TAC §355.8081 and §355.8085. The procedure codes reimbursable to psychologists are listed in Section 38 of this manual, and the Medicaid rates are listed in the current fee schedule, which is available on the TMHP website.
- *Radiological and Physiological Laboratory and Portable X-Ray Supplier*. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8081 and §355.8085. The procedure codes reimbursable to these providers are listed in Section 39 of this manual, and the Medicaid rates are listed in the current fee schedule, which is available on the TMHP website.
- *Renal Dialysis Facility*. The Medicaid rates for these providers are composite rates based on calculations specified by the Centers for Medicare & Medicaid Services (CMS). The procedure codes reimbursable to these providers are listed in Section 40 of this manual, and the Medicaid rates are listed in the current fee schedule, which is available on the TMHP website.
- *School Health and Related Services (SHARS)*. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8443. The procedure codes reimbursable to these providers are listed in Section 42 of this manual and the district-specific interim rates are posted on the HHSC Rate Analysis website for Acute Care Services.
- *Texas Health Steps (THSteps)*. THSteps reimburses by provider type in accordance with 1 TAC §355.8441. Approved providers enrolled in the Texas Medicaid Program are reimbursed for THSteps services in the same manner as they are reimbursed for other Medicaid services. Some of the procedure codes reimbursable under THSteps are listed in Section 43 of this manual. THSteps-Comprehensive Care Program (CCP) reimburses for DME and expendable supplies in accordance with 1 TAC §355.8441(4)-(5).
- *Tuberculosis (TB) Clinic*s. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8341. Procedure codes and applicable rates for these providers are listed in Section 44 of this manual.

- *Vision Care (Optometrists, Opticians)*. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8081 and §355.8085. The current fee schedule for optometrists is available on the TMHP website. (See also Section 45 of this manual.)

Call the TMHP Contact Center at 1-800-925-9126 to request one of the referenced fee schedules or visit the TMHP website at www.tmhp.com.

2.2.1.1 Physician Services in Outpatient Hospital Setting

Section 104 of the *Tax Equity and Fiscal Responsibility Act of 1982* (TEFRA) requires that Medicare/Medicaid limit reimbursement for those physician services furnished in outpatient hospital settings (e.g., clinics and emergency situations) that are ordinarily furnished in physician offices. The limit is 60 percent of the Medicaid rate for the service furnished in physician offices. The following table identifies the services applicable to the 60 percent limitation when furnished in outpatient hospital settings:

Procedure Codes		
1-99201	1-99202	1-99203
1-99204	1-99205	1-99211
1-99212	1-99213	1-99214
1-99215	1-99281	1-99282
1-99283	1-99284	1-99285

These procedures are designated with note code “1” in the current fee schedule, which is available on the TMHP website. The following list shows the services excluded from the 60 percent limitation:

- Services furnished in rural health clinics (RHCs).
- Surgical services that are covered ASC/HASC services.
- Anesthesiology and radiology services.
- Emergency services provided in a hospital emergency room after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in one of the following:
  - Serious jeopardy to the client’s health.
  - Serious impairment to bodily functions.
  - Serious dysfunction of any bodily organ or part.

Exception: *Because of TEFRA, Medicaid reimbursement for a payable nonemergency office service performed in the outpatient department of a hospital is limited to 60 percent of the Medicaid rate for that service. If the condition qualifies as an emergency, the 60 percent professional service reimbursement limit does not apply.*

2.2.1.2 Drugs/Biologicals

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

The following guidelines are effective for dates of service on and after October 1, 2006, with respect to fee decisions for physician-administered drugs/biologicals:

- Vaccines and infusion drugs furnished through an item of implanted DME are based on the lesser of documented provider acquisition/invoice cost (if available) or 89.5 percent of the average wholesale price (AWP).
- Certain, specific drugs studied by the Office of Inspector General (OIG)/General Accounting Office (GAO) are based on the lesser of documented provider acquisition/invoice cost (if available) or the recommended percentages of AWP resulting from those studies (Table 1 in §20 of Chapter 17 of the *Medicare Claims Processing Manual*, Pub. 100-04).
- The remaining drugs/biologicals not listed in two previous bullets above that are covered by Medicare are based on the lesser of documented provider acquisition/invoice cost (if available) or 106 percent of average sales price (ASP).
- Those remaining drugs/biologicals not listed in the first two bullets above that are not covered by Medicare are based on the lesser of documented provider acquisition/invoice cost or one of the following:
  - 89.5 percent of AWP if the drug/biological is considered a new drug/biological (i.e., approved for marketing by the Food and Drug Administration within 12 months of implementation as a benefit of the Texas Medicaid Program); or
  - 85.0 percent of AWP if the drug/biological does not meet the definition of a new drug (above).

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

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

2.2.2 Reasonable Cost/Interim Rates

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

2.2.3 Hospitals

Inpatient hospital services are reimbursed in accordance with 1 TAC §355.8063. Reimbursement for in-state children's hospitals is made in accordance with 1 TAC §355.8063(o). Guidelines for additional reimbursement to disproportionate share hospitals are located at 1 TAC §355.8065, while the reimbursement methodology for disproportionate share hospitals is located at 1 TAC §355.8067. Supplemental payment guidelines to certain rural public hospitals are located at 1 TAC §355.8069.

2.2.4 Provider-Specific Visit Rates

Medicaid provider-specific prospective payment system (PPS) visit rates for RHCs are calculated in accordance with 1 TAC §355.8101, and those for federally qualified health centers (FQHCs) are calculated in accordance with 1 TAC §355.8261. (See also Section 21 for more information regarding FQHCs and Section 41 for RHCs.)

2.2.5 Manual Pricing

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

2.3 Professional Providers and Outpatient Facilities Reimbursement Reduction

The 2008–2009 *General Appropriations Act* (Article II, Special Provisions, Section 57(a)(3)(i), H.B. 1, 80th Legislature, Regular Session, 2007) eliminated the 2.5 percent Medicaid payment reduction that had been applied to Medicaid payments for professional providers and outpatient facilities since September 1, 2003. The elimination of the 2.5 percent Medicaid payment reduction is effective with dates of service beginning September 1, 2007.

No change in payments for Medicaid and Medicaid Managed Care inpatient claims were made effective September 1, 2007. Therefore, the reduced standard dollar amount (SDA) and reduced TEFRA cost reimbursement for inpatient hospitals remains.

2.4 Additional Payments to High-Volume Providers

High-volume provider payments to primary care providers, specialists, and dentists end effective with dates of service beginning September 1, 2007. High-volume provider payments to outpatient hospitals and ASCs/HASCs continue.

Outpatient hospital services are those services provided by outpatient hospitals and ASCs/HASCs. The definition of a high-volume outpatient hospital provider is one that was paid a minimum of $200,000 during the qualifying period. This criterion captured about 95 percent of total outpatient hospital spending. Similar criteria were developed for ASCs/HASCs, such that providers accounting for 95 percent of total payments were designated as high-volume providers. Payments to high-volume outpatient hospitals were increased by 5.2 percent. The new payment amount was implemented by increasing the discount factor for designated high-volume providers of outpatient hospital services from 80.3 percent to 84.48 percent. ASCs/HASCs that qualify as high-volume providers also receive a 5.2 percent increase in payment rates.

2.5 Medicaid Service Provided Outside Texas

Any eligible provider in a state other than Texas who provides services to Texans eligible for Medicaid is entitled to bill the Texas Medicaid Program. The provider must contact TMHP Provider Enrollment to obtain the appropriate forms, requirements, and guidelines for claims filing; complete the forms; and return them to TMHP.

The Texas Medicaid Program covers medical assistance services provided to eligible Texas recipients while absent from Texas, as long as they do not leave Texas to receive out-of-state medical care that can be received in Texas. Services provided outside the state are covered to the same extent medical assistance is furnished and covered in Texas when the provider meets one or more of the following requirements of 1 TAC 355.8083:

- The medical services are needed because of a medical emergency documented by the attending physician or other provider.

  Note: *Providers enrolled for this criteria will be enrolled for a period of 90 days from the enrollment date.*

- The services are medically necessary and, in the opinion of the attending physician or other provider, the recipient's health is endangered if he is required to travel to Texas.

  Note: *Providers enrolled for this criteria will be enrolled for a period of 90 days from the enrollment date.*

- The department or its designee determines that the medically necessary services are more readily available in the state where the recipient is located.
- The customary or general practice for recipients in a particular locality is to use medical resources in the other state.
- The department makes Title IV-E adoption assistance or Title IV-E foster care maintenance payments for a child who is also eligible for Texas medical assistance benefits.

- Other out-of-state medical care may be considered when prior authorized by the department or its designee.

  Note: *Providers enrolled for this criteria will be enrolled for a period of 90 days from the enrollment date.*

Providers located in a state other than Texas but within 200 miles of the Texas border are not considered out-of-state providers and therefore do not need to meet one of the six TAC criteria. Enrollment applications for these providers will be processed as an in-state Medicaid provider.

Payments to out-of-state providers enrolled in the Texas Medicaid Program are made according to the usual, customary, and reasonable charges or the stipulated fee for services as appropriate for the provided care. Payment of practitioners, providers, or suppliers who are reimbursed on a reasonable charge basis may not exceed the lesser of:

- The Medicaid reasonable charge or fee determined for the same services in the state of Texas; *or*
- When mutually agreed on by the contractor and state agency, 100 percent of the Medicare reasonable charge determination for the same service in the state where the service was provided.

Inpatient hospital stays are reimbursed according to the Texas prospective payment methodology (diagnosis related group [DRG]). Payments made on a reasonable cost basis are mutually determined by the state agency and the contractor.

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

Refer to: "Procedure Codes Requiring Prior Authorization" on page 36-140.

2.6 Medicare Crossover Reimbursement

2.6.1 Part A

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

- If the Medicare payment amount equals or exceeds the Medicaid payment rate, Medicaid does not pay the Medicare Part A coinsurance/deductible on a crossover claim.
- If the Medicare payment amount is less than the Medicaid payment rate, Medicaid pays the Medicare Part A coinsurance/deductible, but the amount of the payment is limited to the lesser of the coinsurance/deductible or the amount remaining after the Medicare payment amount is subtracted from the Medicaid payment rate.

2.6.2 Part B

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

- If the Medicaid client is eligible for Medicaid only as a qualified Medicare beneficiary (QMB), Medicaid pays the Medicare Part B coinsurance/deductible on valid Medicare claims.
- If the Medicaid client is not a QMB, Medicaid pays the client's Part B:
  - Deductible liability on valid, assigned Medicare claims.
  - Coinsurance liability on valid, assigned Medicare claims that are within the amount, duration, and scope of the Medicaid program, and would be covered by Medicaid when the services are provided, if Medicare did not exist.

Medicaid payment of a client's coinsurance/deductible liabilities satisfies the Medicaid obligation to provide coverage for services that Medicaid would have paid in the absence of Medicare coverage.

2.7 Federal Financial Participation (FFP) Rate

The FFP rates for providers who receive the federal matching share portion of Medicaid reimbursement or the enhanced federal matching share portion of Medicaid reimbursement for services provided to Children's Health Insurance Program (CHIP) clients are effective for dates of service on or after October 1, 2007, at an FFP rate of 60.56 percent and an enhanced FFP rate of 72.39 percent. The FFP is subject to change on October 1 of each year or as otherwise directed by CMS.

Section

3

TMHP Electronic Data Interchange (EDI)

3.1 Paper or Electronic Submissions

Providers may submit claims and other requests using paper forms or faster electronic methods. HHSC and TMHP encourage providers to submit claims and other requests electronically. Providers can participate in the most efficient and effective method of submitting requests to TMHP by submitting through the TMHP EDI Gateway. TMHP uses the *Health Insurance Portability and Accountability Act* (HIPAA)-compliant American National Standards Institute (ANSI) ASC X12 4010A file format through secure socket layer (SSL) and virtual private networking (VPN) connections for maximum security. Providers can access TMHP's electronic services through www.tmhp.com, TexMedConnect, TDHconnect, vendor software, and billing agents. TDHconnect users should contact the TMHP EDI Help Desk at 1-888-863-3638 or visit the TMHP website at www.tmhp.com for TDHconnect software questions.

3.1.1 Advantages of Electronic Services

- *It's fast.* No more waiting by the mailbox or phone inquiries; know what's happening to claims in less than 24 hours and receive reimbursement for approved claims within a week. TexMedConnect users can submit individual requests interactively and receive a response immediately.
- *It's free.* All electronic services offered by TMHP are free, including TexMedConnect and its technical support and training.
- *It's easy.* TMHP offers free workshops for TexMedConnect, Medicaid billing, and many other topics, as well as a large library of reference materials and manuals on www.tmhp.com.
- *It's safe.* TMHP EDI services use VPN and SSL connections, just like the United States government, banks, and other financial institutions, for maximum security.
- *It's accurate.* TexMedConnect and most vendor software programs have features that let providers know when they've made a mistake, which means fewer rejected and denied claims. Rejected claims are returned with messages that explain what's wrong, so the claim can be corrected and resubmitted right away.
- *It's there when it's needed.* Electronic services are available day and night; from home, the office, or anywhere in the world.
- *It makes record keeping and research easy.* Not only can TexMedConnect be used to send and receive claims, it can retrieve Electronic Remittance and Status (ER&S) reports, perform claim status inquiries, and archive claims. TexMedConnect can generate and print reports on everything it sends, receives, and archives.

3.1.2 Electronic Services Available

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

3.2 TMHP Website

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

- Information and registration for upcoming provider education/training sessions.
- Publications such as bulletins, banner messages, and provider manuals.
- A TMHP News section with announcements of program changes and other important information.
- Forums, polls, and questionnaires.

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

- Texas Medicaid Program enrollment information.
- CSI.
- Eligibility Verification.
- ER&S report download option.
- Claims submission.
- Claims appeals.
- Complete instructions for setting up a Provider Administrator account and the use of online CSI, EV, and ER&S reports.

New services are always being added to the website. Please visit www.tmhp.com for the latest information on TMHP online services.

3.3 Electronic Billing

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

3.3.1 TexMedConnect

TexMedConnect is a free, web-based, claims submission application provided by TMHP. Technical support and training for TexMedConnect are also available free from TMHP. Providers can submit claims, eligibility requests, claim status inquiries, adjustments, appeals, and download ER&S reports (in either PDF or ANSI 835 formats) using TexMedConnect. TexMedConnect can interactively submit individual claims that are processed in seconds. To use TexMedConnect, providers must have:

- An internet service provider (ISP).
- One of the following internet browsers:

- Microsoft Internet Explorer.
- Netscape Navigator.

A broadband connection is recommended but not required. Providers that use TexMedConnect can find the online instruction manual on the homepage and on the EDI page of the TMHP website at www.tmhp.com.

3.3.2 Vendor Software

Providers that do not use TexMedConnect must use vendor software to create, submit, and retrieve data files. Providers can use software from any vendor listed on the EDI Submitter List, which is located on the EDI page of the TMHP website at www.tmhp.com. There are hundreds of software vendors that have a wide assortment of services and that have been approved to submit electronic files to TMHP. Providers that plan to access TMHP's electronic services with vendor software should contact the vendor for details on software requirements. TMHP does not make vendor recommendations or provide any assistance for vendor software. Not all vendor software offers the same features or levels of support. Providers are encouraged to research their software thoroughly to make certain that it meets their needs and that it has completed testing with TMHP.

3.3.3 Billing Agents

Billing agents are companies or individuals who submit electronic files to TMHP on behalf of the provider. Generally, this means that the provider uses a product that sends billing or other information to the billing agent who processes it and transmits it to TMHP and other institutions. A complete list of billing agents who have completed the testing process and been certified by TMHP can be found on the EDI Submitter List, which is located on the EDI page of the TMHP website at www.tmhp.com. TMHP does not make billing agent recommendations or provide any assistance for billing agents' software or services. TMHP has no information on the software or other requirements of billing agents. Providers should contact the billing agent to obtain information about their products and processes.

3.4 Setting up Access

Providers must setup their software or billing agent services to access the TMHP EDI Gateway. Providers who use billing agents or software vendors should contact those organizations for information on installation, settings, maintenance, and their processes and procedures for exchanging electronic data.

Providers that download the ANSI 835 file through TexMedConnect and providers that use vendor software must request a submitter ID. A submitter ID is necessary for vendor software to access TMHP's electronic services. It serves as an electronic mailbox for the provider and TMHP to exchange data files. To order a submitter ID, providers must call the EDI Help Desk at 1-888-863-3638. Providers that use a billing agent do not need a submitter ID.

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

Refer to: "Electronic Remittance and Status (ER&S) Agreement (2 Pages)" on page B-100.

3.5 Training

The TMHP EDI Help Desk does not provide training. Providers should contact their TMHP Provider Relations representative or attend one of the training workshops provided by TMHP to receive training for TexMedConnect and other billing issues. Additional information about training opportunities is available at www.tmhp.com/C18/Workshops. Providers may also use the many reference materials and workbooks available on the website.

3.6 Electronic Transmission Reports

Providers are required to retain all claim and electronic file transmission records. Providers must verify that all claims submitted to TMHP are received and accepted. Providers must also track claims submissions against their claims payments to detect and correct all claim errors. For further information about provider responsibility and electronic submissions, refer to "Provider Responsibilities" on page 1-5.

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

3.7 Vendor Implementation

TMHP requires all software vendors and billing agents to complete EDI testing before access to the production server is allowed. Vendors that wish to begin testing may either call the EDI Help Desk at 1-888-863-3638 or visit the EDIFECS testing site at editesting.tmhp.com and use the *TMHP Support* link. An EDIFECS account will be created for the vendor to begin testing EDI formats once they have enrolled for testing. After the successful completion of EDIFECS testing and the submission of a Trading Partner Agreement, vendors must then complete end-to-end testing on the TMHP test server. Software vendors and billing agents must be partnered with at least

one Texas provider before a test submitter ID can be issued. When end-to-end testing has been completed, the software vendor or billing agent will be added to the EDI Submitter List. Providers and billing agents may then order production submitter IDs for use with the vendor's software. Companion guides and vendor specifications are available on the EDI page of the TMHP website at www.tmhp.com.

3.7.1 Supported File Types

TMHP EDI supports the following electronic HIPAA-compliant ANSI ASC X12 4010A transaction types:

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

3.8 Forms

The following forms are available in Appendix B, "Forms:"

- “Electronic Remittance and Status (ER&S) Agreement (2 Pages)” on page B-100.
- “Claim Status Inquiry (CSI) Authorization Form” on page B-14.

Note: *Photocopy these forms and retain the originals for reuse.*

Section

4

Client Eligibility

4.1 General Medicaid Eligibility

Providers are responsible for requesting and verifying current Medicaid eligibility information about the client by asking the client to produce the Medicaid Identification form issued for the month that services are being rendered. Clients should share eligibility information with providers. If clients have lost their identification or forgotten to bring it to appointments, providers may verify their eligibility through the Automated Inquiry System (AIS), TMHP Electronic Data Interchange (EDI) Gateway, or by accessing the TMHP website and treat the clients the same as though they had presented a Medicaid Identification (Form H3087) or Medicaid Verification Letter (H1027). Medicaid clients in Cameron, Hidalgo, and Travis counties are now issued a Medicaid Access Card—a plastic smart card that automates client check-in and eligibility verification. In these counties, clients use their Medicaid Access Card in place of the Medicaid Identification Form (Form H3087) to identify themselves as eligible for Medicaid. If a Medicaid client with one of these cards sees a provider for service in an area that is not using the new process, providers can still verify the client's Medicaid eligibility either by using existing processes or by calling the TMHP Contact Center at 1-800-925-9126.

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

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

Most children in the state of Texas foster care program are automatically eligible for Medicaid. To ensure that these children have access to the necessary health-care services for which they are eligible, providers can accept the Medicaid Eligibility Verification Form H1027 as evidence of Medicaid eligibility. Although this form may not have a Medicaid number, it is an official state document that establishes Medicaid eligibility.

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

Refer to: "Medicaid Identification, Verification" on page 4-4.

Retroactive Eligibility

Medicaid coverage may be assigned retroactively for a client. For claims for an individual who has been approved for Medicaid coverage but has not been assigned a Medicaid client number, the 95-day filing deadline does not begin until the date the notification of eligibility is received from HHSC and added to the TMHP eligibility file. The date the client's eligibility is added to the TMHP eligibility file is the add date. To ensure the 95-day filing deadline is met, providers must verify eligibility and add date information by calling AIS or using TMHP EDI's electronic eligibility verification.

Reminder: *The add date is the date the client's eligibility was added to the TMHP eligibility file.*

When authorization is required for a Medicaid service, authorization requests for clients with retroactive eligibility must be submitted after the client's eligibility has been added to TMHP's eligibility file. For accurate claims processing, an authorization request must be submitted to TMHP before a claim submission. Providers have 95 days from the add date to obtain authorization for services that have already been performed.

PCCM providers must obtain prior authorization requests within 95 days of the add date and before claims submission.

If a person is not eligible for medical services under the Texas Medicaid Program on the date of service, reimbursement for all care and services provided must be resolved between the provider and the client receiving the services. Providers are not required to accept Medicaid for services provided during the retroactive eligibility period and may continue to bill the client for those services. This guideline does not apply to nursing facilities certified by the Department of Aging and Disability Services (DADS). If it is the provider's practice not to accept Medicaid for services during the retroactive eligibility period, the provider must use the policy consistently for all clients who request retroactive eligibility. Providers must inform the client about the policy before rendering services. If providers accept Medicaid assignment for the services and want to submit a claim for Medicaid-covered services

for clients who receive retroactive eligibility, providers must refund payments received from the client before billing Medicaid for the services.

Note: *The Medicaid Managed Care programs do not generally have retroactive eligibility.*

Clients who are not eligible for Medicaid but meet certain income guidelines may receive family planning services through other family planning funding sources. Clients not eligible for Medicaid are referred to a family planning provider.

Refer to: Department of State Health Services (DSHS) website, www.dshs.state.tx.us/famplan/, for information about family planning and the locations of family planning clinics receiving Title V, X, or XX funding from DSHS.

The provider should also check the date on the Form H3087 under Medicaid Date to see if the client has retroactive coverage for previous bills. Clients with retroactive coverage are only issued one Medicaid Identification showing the retroactive period. The Texas Medicaid Program considers all services between the Medicaid Date and the Valid Through Date for reimbursement. Providers can determine whether a client has retroactive coverage for previous bills by verifying eligibility on www.tmhp.com, transmitting an electronic eligibility request, or calling AIS or the TMHP Contact Center.

Refer to: "Medicaid Identification Form H3087" on page 4-19.

"Medicaid Managed Care" on page 7-4.

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

HHSC processes Medicaid applications for pregnant women within 15 business days of receipt. Once certified, a Medicaid Identification (Form H3087) will be issued to verify eligibility and to facilitate provider reimbursement.

Medicaid Buy-In Program for Employed Individuals with Disabilities

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

Participants will have a Medicaid identification card that indicates the Medicaid services for which they are eligible. MBI participants in urban service areas will be served through traditional Medicaid (fee-for-service) and MBI participants in Primary Care Case Management (PCCM) counties will be served through PCCM.

4.1.1 Eligibility Verification

To verify client Medicaid eligibility, use the following options:

- Verify the client's Medicaid eligibility using form H1027 or H3087.

Refer to: "Medicaid Identification, Verification" on page 4-4.

- Verify electronically through TMHP EDI. Providers may inquire about a client's eligibility by electronically submitting the following information for each client:
  - Medicaid or Children with Special Health Care Needs (CSHCN) Services Program identification number, *or*
  - One of the following combinations: Social Security number and last name; Social Security number and date of birth; or last name, first name, and date of birth. Narrow the search by entering the client's county code or sex.
- Submit verifications in batches limited to 5,000 inquiries per transmission.
- Contact AIS at 1-800-925-9126, 1-512-335-5986, 1-512-335-6033, 1-512-335-6217, or 1-512-345-6476.
- Contact the TMHP Contact Center at 1-800-925-9126.
- Submit a hard-copy list of clients to TMHP. This service is only used for clients with eligibility that is *difficult* to verify. A charge of $15 per hour plus $0.20 per page payable to TMHP applies to this eligibility verification. The list includes names, gender, and dates of birth if the Social Security and Medicaid identification numbers are unavailable. TMHP can check the client's eligibility manually, verify eligibility, and provide the Medicaid identification numbers. Mail the lists to the following address:

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

PCCM primary care providers can also check the current month's panel report of clients assigned to their practice to determine whether the client's name and Medicaid number appear on the list. If the client's name and Medicaid number are shown, eligibility is guaranteed for that month only.

Refer to: "Monthly Client Panel Report" on page 7-30.

4.2 Medicaid Identification, Verification

Providers are responsible for requesting and verifying current eligibility information from the client by asking the client to produce Medicaid Identification (Form H3087 or H1027) issued for the month that services are provided. Providers must accept either of these documents as valid proof of eligibility. Providers should retain a copy for their records to ensure the person is eligible for Medicaid when

the services are provided. The provider should request additional identification when unsure the person presenting the form is the person identified on the form. The provider should check the Eligibility Date to see if the client has possible retroactive coverage for previous bills.

Important: *Providers must review limitations identified on the client's Form H3087 or Form H1027. Clients may be limited to one primary provider or pharmacy. QMB clients will be limited to Medicaid coverage of the Medicare Part A premiums, if any, Medicare Part B premiums, and Medicare deductibles and coinsurance for Medicare services.*

Only those clients listed on the Medicaid Identification form are eligible for Medicaid. If a person insists he or she is eligible for Medicaid but cannot produce a current Medicaid Identification form, providers can verify eligibility through AIS or TMHP EDI. Providers must document this verification in their records and treat the client as usual.

HHSC issues one of the following only when Form H3087 is lost or stolen or in the event of temporary emergency Medicaid:

- *Form H1027-A*. Medical Eligibility Verification is used to indicate eligibility for clients who receive regular Medicaid coverage.
- *Form H1027-B.* Medicaid Qualified Medicare Beneficiary (MQMB) is issued to clients eligible for MQMB coverage.
- *Form H1027-C*. Qualified Medicare Beneficiary (QMB) is issued to clients who are eligible for QMB coverage only.

Refer to: "QMB, MQMB" on page 4-8.

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

Note: *When treating a STAR Program member, providers must refer to Form H3087 and, if applicable, the member's health plan ID card.*

If the client is reported as eligible and no other limitations of eligibility affect the intended service, proceed with the service. Eligibility during a previous month does not guarantee eligibility for the current month. Forms H1027, H3087, and the PCCM Monthly Panel Report are the *only* documents that are honored as verification of Medicaid eligibility. The right side of Form H3087 consists of information about limited services provided to clients. A check mark on the line to the right of the client's name indicates eligibility for a particular service.

Important: *Emergency THSteps dental services, or THSteps dental or medical check ups services may be provided when medically necessary.*

- Reminders of medical and dental check ups appear under the client's name during the month the client is eligible for routine check ups.
- All Medicaid clients birth through 20 years of age are eligible to receive medically necessary dental services.

Providers should update the appropriate columns of the Medicaid Identification to indicate services received by the client. Providers put a slash (/) with an initial and date in the column to indicate the service was provided. Providers can check the third party resource (TPR) column on the Form H3087 to determine if the client has other health insurance.

Refer to: "Third Party Resources (TPR)" on page 4-14 for more information and "Medicaid Identification Form H3087" on page 4-19.

4.3 Restricted Medicaid Coverage

The following limitations may appear on the Medicaid Identification form, indicating client eligibility is restricted to specific services. Unless otherwise indicated by "LIMITED" appearing on the form, the client is not limited to a single provider.

4.3.1 Emergency Only

The word "EMERGENCY" on the form indicates the client is restricted to coverage for an emergency medical condition. Emergency medical condition is defined under "Emergency Care" on page 4-7.

Note: *Certification for emergency Medicaid occurs after the fact. This coverage is retroactive and limited to the specific dates of service of the emergency.*

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

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

Any service provided after the emergency condition is stabilized is not payable.

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

4.3.2 Client Limited Program

In Texas, Medicaid-eligible clients are identified for the Health and Human Services' Limited Program based on federal and state requirements. Traditional Medicaid (non-managed care) clients can be limited to a primary care provider and/or a primary care pharmacy. Medicaid Managed Care members can be limited to a primary care pharmacy.

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

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

After analysis through the neural network component of the Medicaid Fraud and Abuse Detection System (MFADS), qualified medical personnel validate the initial identification and determine candidates for limited status. The validation process includes consideration of medical necessity. For the limited status designation, medical necessity is defined as the need for medical services as to the amount and frequency established by accepted standards of medical practice for the preservation of health, life, and the prevention of more impairments. Except for specialist consultations, services rendered to a client by more than one provider for the same or similar condition during the same time frame may not be considered medically necessary.

4.3.2.1 Limited Medicaid Identification

Clients with limited status receive a Form H3087 with the printed word "LIMITED." A *limited client is* defined as "a client who is limited to a designated primary care provider and/or primary care pharmacy." The designated provider names are printed on the form under the word "LIMITED." The limited Medicaid Identification identifies a client who has overutilized the services. Only one client is identified on a LIMITED Form H3087. For questions about pharmacy services for clients limited to a primary care pharmacy, contact the Limited Program Hotline at 1-800-436-6184, option 4.

The Limited Program may also alert providers by means of a *special message* on the Form H3087, when the form was reportedly used by an unauthorized person or persons, or for an unauthorized purpose. In these cases, the provider is asked to verify the client's identity by requesting personal identification that carries a photograph, such as a driver's license.

Payment for services to a limited Medicaid client, who is not in a managed care plan, is made to the designated provider only, unless services result from a designated provider referral or emergency. An automated review process determines if the claim includes the limited primary care provider's provider identifier as the billing, performing, or referring provider. When the limited primary care provider's provider identifier is not indicated on the claim, the claim is not paid. Exceptions to this rule include emergency care and services that are included in "Exceptions to Limited Status" on page 4-6. Appeals for denied claims are submitted to TMHP and must include the designated Medicaid provider identifier for reimbursement consideration.

When limited traditional Medicaid clients attempt to obtain nonemergency services from someone other than their limited provider, the provider does one of the following:

- Verify the limited status with HHSC at 1-800-436-6184, option 4, TMHP at 1-800-925-9126, or online at www.tmhp.com.
- Attempt to contact the limited primary care provider for a referral. If no referral is obtained, the provider must inform clients that they are financially responsible for the services.

4.3.2.2 Exceptions to Limited Status

The provider is not required to provide some services. Limited clients may go to any provider for the following services or items:

- Ambulance services.
- Anesthesia.
- Assistant surgery.
- Case management services.
- Chiropractic services.
- Counseling services provided by a chemical dependency treatment facility.
- Eye exams for refractive errors.
- Eyeglasses.
- Family planning services (regardless of place of service [POS]).
- Genetic services.
- Hearing aids.
- Home health services.
- Laboratory services (including interpretations).
- Licensed clinical social worker (LCSW) services.
- Licensed professional counselor (LPC) services.
- Mental health rehabilitation services.
- Mental retardation diagnostic assessment (MRDA) performed by an MRDA provider.
- Nursing facility services.
- Obstetrical/gynecological (OB/GYN) services.

  Note: *The once a year well-woman check up is covered without a referral. All other OB/GYN services require appropriate referrals.*
- Primary home care.
- Psychiatric services.
- Radiology services (including interpretations).
- School Health and Related Services (SHARS).
- THSteps-CCP.
- THSteps medical and dental services.

For referrals or questions, contact:

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

4.3.2.3 Selection of Designated Provider, Pharmacy

Traditional Medicaid clients identified for limited status can participate in the selection of one primary care provider, primary care pharmacy, or both from a list of participating Medicaid providers. Eligible providers cannot be under administrative action, sanction, or investigation. In general, the designated primary care provider's specialty is general practice, family practice, or internal medicine. Other specialty providers may be selected on a case-by-case basis. Primary care providers can include, but are not limited to: a physician, physician assistant, physician group, advanced practice nurse, outpatient clinic, rural health clinic (RHC), or federally qualified health center (FQHC).

Medicaid Managed Care clients identified for limited status can participate in the selection of pharmacy providers *only* from participating Medicaid providers who are not under administrative action, sanction, or investigation.

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

When a candidate for the designated provider is determined, HHSC contacts the provider by letter. When the provider agrees to be the designated provider, HHSC sends letters of confirmation to the designated provider and the client confirming the name of the client, primary care provider or primary care pharmacy, and the effective date of the limited arrangement.

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

4.3.2.4 Duration of Limited Status

The Limited Program duration of limited status is the following:

- Initial limited status period–minimum of 36 months.
- Second limited status period–additional 60 months.
- Third limited status period–will be for the duration of eligibility and all subsequent periods of eligibility.
- Clients arrested, indicted, or convicted of a nonfelony crime related to Medicaid fraud will be assigned limited status for 60 months or the duration of eligibility and subsequent periods of eligibility up to or equal to 60 months.

HHSC uses the same time frames for clients whose LIMITED Form H3087 includes a special message.

Clients are removed from limited status at the end of the specified limitation period if their use of medical services no longer meets the criteria for limited status. A medical review also may be initiated at the client's or provider's request. Clients or providers call the Limited Program at 1-800-436-6184 to request this review.

Providers may request to no longer serve as a client's designated provider at any time during the limited period by calling the Limited Program. Providers are asked to serve or refer the client until another arrangement is made. New arrangements are made as quickly as possible.

4.3.2.5 Referral to Other Providers

Traditional Medicaid clients in limited status may be referred by their designated provider to other providers. For the referral or second provider to be paid, the provider identifier of the referring designated provider must be in Block 17 or 17a of the CMS-1500 claim form. Claims submitted electronically (see "TMHP Electronic Claims Submission" on page 5-13) must have the six-digit Medicare core number of the referring designated provider in the Referring Provider Field. Consult with your vendor for the location of this field in your electronic claims format.

4.3.2.6 Emergency Care

If an emergency medical condition occurs, the limited restriction does not apply. The term *emergency medical condition is defined* as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Important: *A provider who sends in an appeal because a claim was denied with 00066 must include the performing provider identifier, not just a name or group provider identifier. Appeals without a performing provider identifier are denied. The license number of the designated provider must be entered in Block 83 on the UB-04 CMS-1450 or in the appropriate electronic field for nonemergency inpatient and outpatient claims to be considered for reimbursement.*

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

4.3.2.7 Hospital Services

An inpatient hospital claim for a limited traditional Medicaid client is considered for reimbursement if the client meets Medicaid eligibility and admission criteria.

Hospital admitting personnel are asked to check the name of the designated provider printed under the word "LIMITED" on the client's LIMITED Medicaid Identification and inform the admitting physician of the designated provider's name if the two are different.

Provider claims for nonemergency inpatient services for limited traditional Medicaid clients are considered for payment *only* when the designated provider identifier appears on the claim form as the billing, performing, or referring physician.

Information about claims reimbursement for limited clients may be received by calling the TMHP Contact Center at 1-800-925-9126 or Assessment Utilization Services at 1-800-436-6184.

4.3.3 QMB, MQMB

The term "QMB" or "MQMB" on the form indicates the client is a Qualified Medicare Beneficiary (QMB) or a Medicaid Qualified Medicare Beneficiary (MQMB). The *Medicare Catastrophic Coverage Act of 1988* requires Medicare premiums, deductibles, and coinsurance payments to be paid for individuals who meet the following criteria:

- Client is enrolled in Medicare Part A.
- Income does not exceed 100 percent of the FPL (consistent with federal law).
- Resources do not exceed twice the resource limit of Supplemental Security Income (SSI) Program.

Important: *Clients limited to QMB are not eligible for THSteps or THSteps-CCP Medicaid benefits.*

Note: *Clients eligible for STAR+PLUS who have Medicare and Medicaid are MQMBs. Medicaid reimburses for the coinsurance and deductibles as well as Medicaid-only services for the MQMB client.*

QMBs do not receive Medicaid benefits other than Medicare deductible and coinsurance liabilities. MQMBs *do* qualify for Medicaid benefits not covered by Medicare in addition to Medicaid payment of Medicare deductible and/or coinsurance.

Refer to: "Medicare/Medicaid Clients" on page 4-13 and "QMB/MQMB Clients" on page 4-13.

4.3.4 Hospice Program

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

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

When clients elect hospice services, they waive their rights to all other Medicaid services related to their terminal illness. They do not waive their rights to Medicaid services unrelated to their terminal illness. Medicare and Medicaid clients must elect both the Medicare and Medicaid Hospice programs. Individuals who elect hospice care are issued a Medicaid Identification (Form H3087) with "HOSPICE" printed on it. Clients may cancel their election at any time.

Direct policy questions about the hospice program to DADS at 1-512-438-3519.

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

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

When the services are unrelated to the terminal illness, Medicaid (TMHP) pays its providers directly. For questions about hospice billing, call TMHP at 1-800-626-4117. Providers are required to follow Medicaid guidelines for prior authorization when filing claims to TMHP for hospice clients. Fax authorization requests to 1-512-514-4209.

Nonhospice providers may be reimbursed directly by TMHP for services rendered to a Medicaid hospice client.

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

4.3.4.1 Medical Services Not Related to the Terminal Illness

Providers must submit a claim for Medicaid services to TMHP with 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, providers must send an appeal with the following information:

- A copy of the Remittance and Status (R&S) report, with the client/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.

4.3.4.2 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 nonhospice 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 nonhospice provider may appeal the decision with the following information:

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

4.3.4.3 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.

4.3.4.4 Physician Oversight Services

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

4.3.5 Presumptive Eligibility (PE)

PE provides temporary Medicaid coverage to pregnant women whose family income does not exceed the state's Medicaid limit. The intent of PE is to provide the earliest possible access to prenatal care to improve maternal and child health. Clients with PE receive immediate, short-term Medicaid eligibility while their formal Medicaid application is processed.

4.3.5.1 Services

Medicaid-covered services during the PE period are limited to medically necessary medical services provided during pregnancy and certain preventive services such as family planning. Labor, delivery, inpatient services, and THSteps medical or dental services are not covered during the PE period. If the woman is determined eligible for regular Medicaid for the same period of time, regular Medicaid coverage overlays the PE period providing the full range of services. Although the eligibility process for PE coverage is restricted to qualified providers, services may be obtained from any enrolled Medicaid provider.

4.3.5.2 Qualified Provider Enrollment

To be eligible as a qualified provider for PE determinations the following federal requirements must be met. The provider must:

- Be an eligible Medicaid provider.
- Provide outpatient hospital services, RHC services, *or* clinic services furnished by or under the direction of a physician without regard to whether the clinic is administered by a physician (includes family planning clinics).
- Receive funds from or participate in one of the following:
  - The migrant health centers.
  - Community health centers.
  - *The Stewart McKinney Act* (homeless).
  - Maternal and Child Health Services Block Grant Program.
  - *The Indian Self-Determination and Education Assistance Act*.
  - Special Supplemental Food Program for Women, Infants, and Children (WIC).
  - The Commodity Supplemental Food Program of the *Agriculture and Consumer Protection Act* of 1973.
  - A state perinatal program (including family planning programs).
  - The Indian Health Service must be a health program or facility operated by a tribe or tribal organization under the *Indian Self-Determination and Education Assistance Act*. Indian Health Service providers can refer to "Provider Enrollment" on page 1-2 for more information about the enrollment procedures for the Texas Medicaid Program.
- Be determined by HHSC to be capable of making PE determinations.

Family planning agency providers may be eligible to enroll as PE providers. To enroll as a qualified provider for PE, the provider must request a Presumptive Eligibility Qualified Provider Enrollment Packet from the following address:

HHSC
Attn: Texas Works
Presumptive Eligibility Program
PO Box 149030
Mail Code W-323
Austin, TX 78714-9030

Before final approval as a qualified PE provider, an operating plan must be developed with the regional HHSC client self-support regional director's office. The rules for PE identify minimal agreements that must be included in this plan.

4.3.5.3 Process

A qualified provider designated by HHSC requests that the pregnant woman complete a Medicaid application form. The qualified provider determines eligibility for PE

coverage based on verification of pregnancy and a determination that the family's income is less than the current Medicaid limit for pregnant women.

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

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

4.3.5.4 Medicaid Identification (Form H3087)

A Form H3087 with PE printed on top is issued for PE coverage. Medicaid coverage for PE continues through the last day of the month indicated on the form. Form H3087 with PE indicates that Medicaid-covered services during the PE period do not include labor, delivery, inpatient services, and THSteps medical and dental services. The PE ID indicates eligibility for limited Medicaid services during the PE period (e.g., eye exams, eyeglasses, hearing aids, and family planning services). If the woman is certified for regular Medicaid, she receives the regular Form H3087.

If other members in the family are determined to be eligible for Medicaid, they receive a separate Form H3087 from the one issued to the pregnant woman.

Claims filing procedures for clients with PE are the same as those for all clients with Medicaid.

4.4 CHIP Perinatal Program

The Children's Health Insurance Program (CHIP) Perinatal Program, a program extending CHIP perinatal benefits for 12 months to the unborn children of non-Medicaid eligible women began on January 1, 2007. This program allows pregnant women who are ineligible for Medicaid due to income (186 to 200 percent of the FPL) or immigration status (with an income at or below 200 percent of FPL) to receive prenatal care, and provides CHIP benefits to the child upon delivery for the duration of the coverage period.

4.4.1 Program Benefits

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

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

Program benefits after the child is born Include:

- Two postpartum visits for the mother.
- Traditional CHIP benefits for the newborn.

4.4.2 Claims

Inpatient services under CHIP Perinatal for unborn children and women between 0 and 185 percent of the FPL will be reimbursed as follows:

For women with income at or below 185 percent FPL:

- Hospital facility charges paid through Emergency Medicaid and processed by TMHP.
- Professional service charges paid and processed through CHIP.

For newborns with a family income at or below 185 percent FPL:

- Hospital facility charges paid through the CHIP Perinatal Program and processed by TMHP.
- Professional service charges are paid and processed through CHIP.

Inpatient services (limited to labor with delivery) for unborn children and women with income between 186 and 200 percent of FPL will be covered under CHIP Perinatal, and these claims will be paid by the CHIP Perinatal health plan.

4.4.3 Client Eligibility Verification

Texas Vital Statistics will not send providers a PCN once it is issued. Providers can obtain eligibility information and the newborn's PCN by performing an eligibility inquiry on the TMHP website at www.tmhp.com or through AIS at 1-800-925-9126.

4.5 Medically Needy Program (MNP)

The MNP with spend down is limited to children younger than age 19 years and pregnant women.

The MNP provides Medicaid benefits to children (younger than 19 years of age) and pregnant women whose income exceeds the eligibility limits under Temporary Assistance for Needy Families (TANF) or one of the Medical Assistance Only (MAO) programs for children but is not enough to meet their medical expenses. Coverage is available for services within the amount, duration, and scope of the Texas Medicaid Program.

Note: *Individuals are considered adults the month after they turn 19 years of age.*

Medicaid benefits, including family planning and THSteps preventive services through the MNP, are available to:

- Pregnant teens (younger than 19 years of age) and women.
- Children younger than 19 years of age.

The MNP is not an assistance program; MNP provides access to Medicaid benefits. MNP application is made through HHSC. HHSC determines:

- If the applicant meets basic Medicaid eligibility requirements.
- If the applicant is eligible without spend down (the difference between the applicant's net income and the MNP income limits). If over the Medicaid limit, the spend down amount is determined based on the MNP income limit.

If the applicant is eligible without spend down (income is below the medically needy income limits), the caseworker certifies the applicant to be eligible for Medicaid.

If spend down is applicable, HHSC issues a Medical Bills Transmittal (Form H1120) to the MNP applicant that indicates the spend down amount, months of potential coverage (limited to the month of application and any of the three months before the application month that the applicant has unpaid medical bills), and the HHSC contact information.

The applicant is responsible for paying the spend down portion of the medical bills. The TMHP Medically Needy Clearinghouse (MNC) determines which bills may be applied to the applicant's spend down according to state and federal guidelines. No Medicaid coverage may be granted until the spend down is met.

Newborns of mothers who must meet a spend down before becoming eligible for Medicaid are *not* automatically eligible for the full year of newborn coverage because the child's mother would not be continuously eligible for Medicaid. If the mother meets spend down in the month pregnancy terminates and the Medicaid effective date is before or on the day pregnancy terminates, then the newborn and mother are eligible for the birth month and the two following months. Hospitals and other providers that complete newborn reporting forms should continue to follow the procedures in "Eligibility Process" on page 25-9 of this manual for these newborns.

4.5.1 Spend Down Processing

Applicants are instructed to submit all their medical bills or completed claim forms for application toward their spend down to TMHP MNC along with Form H1120. Charges from the bills or completed claim forms are applied in date of service order to the spend down amount, which is met when the accumulated charges equal the spend down amount.

Providers can assist medically needy clients with their application by giving them current, itemized statements or completed claim forms to submit to MNC. MNC holds manually completed claim forms used to meet spend down for ten calendar days preceding the completion of the spend down case, then forwards them to claims processing. The prohibition against billing clients does not apply until Medicaid coverage is provided.

Current itemized statements or completed claim forms must include the following:

- Statement date.
- Provider name.
- Client name.
- Date of service.
- All services provided and charges.
- Current amount due.
- Any insurance or client payments with date of payment (the date and amount of any insurance or payments).

Important: *Amounts used for spend down are deducted from the total billed amount by the provider. Using older bills may provide earlier eligibility for the client.*

Unpaid bills incurred before the month of potential eligibility (the month with spend down) may be used to meet spend down. Itemized statements must be dated within 60 days of the date received at TMHP MNC.

Clients have 30 days to submit their bills or completed claim forms. Thirty-day extensions are available to the client as necessary to gather all needed information.

The unpaid balance on currently due accounts may be applied toward the spend down regardless of the date of service. All bills or completed claim forms must be itemized showing the provider's name, client's name, dates of service, statement date, services provided, charge for each service, total charges, amounts and dates of payments, and total due.

Bills for past accounts must be current, itemized statements (dated within the last 60 days) from the provider verifying the outstanding status of the account and the current balance due. Accounts that have had payments made by an insurance carrier including Medicare must be accompanied by the carrier's explanation of benefits (EOB) or Remittance Advice showing the specific services covered and amounts paid.

If the MNC requests additional information, the applicant has 30 days from the date of the clearinghouse letter to respond. This response may be the return of the information requested, a request for an extension of the response period, or a request to withdraw the bill from consideration. The provider can assist by furnishing the additional information to the applicant.

All communication about submission of billing information is carried out between MNC and the applicant; however, providers can assist clients by:

- Providing clients with current itemized statements or completed claim forms.
- Encouraging clients to submit *all* their medical bills or completed claim forms incurred from *all* providers at the same time.

- Submitting manual claim forms directly to MNC or to applicants for the MNP, to be used to meet spend down.

Bills or claim forms submitted to MNC are for application toward the spend down only. Submitting a bill or claim forms for spend down is *not* a claim for reimbursement. *No* claims reimbursement is made from such submittals unless the claim form is complete. The provider must file a Medicaid claim after eligibility has been established to have reimbursement considered by the Texas Medicaid Program. If the provider assisted the client with submission of a claim form, the MNC retains all claim forms for ten calendar days preceding the completion of the spend down case. The MNC then forwards all claim forms directly to claims processing to have reimbursement considered by the Texas Medicaid Program.

MNC informs the applicant and HHSC when the spend down is met. HHSC certifies the applicant for Medicaid and sends the Medicaid Identification form to the applicant when Medicaid eligibility is established. Clients are encouraged to inform medical providers of their Medicaid eligibility and make arrangements to pay the charges used to meet the spend down amount. When notified of Medicaid eligibility, the provider asks if the client has retroactive eligibility for previous periods. All bills submitted to MNC are returned to the client, except for claim forms. An automated letter specific to the client's spend down case is attached, indicating which:

- Bills/charges were used to meet the spend down.
- Bills/charges the client is responsible for paying in part or totally.
- Bills the provider may submit to Medicaid for reimbursement consideration.
- Claims are received and forwarded to TMHP claims processing.

Providers may inquire about status, months of potential eligibility, Medicaid or case number, and general case information by calling the TMHP Contact Center at 1-800-925-9126.

Medically needy applicants who have a case pending or have not met their spend down are considered private-pay clients and may receive bills and billing information from providers. No claims are filed to Medicaid. A claim that is inadvertently filed is denied because of client ineligibility.

4.5.2 Closing an MNP Case

Medically needy cases are closed by MNC for the following reasons:

- Bills were not received within the designated time frame (usually 30 days from the date the case is established by the HHSC worker).
- The client failed to provide requested additional case/billing information within 30 days of MNC request date.
- Insufficient charges were submitted to meet spend down, and the client did not respond to a request for additional charges to be submitted within 30 days of the notification letter.

Charges submitted after the spend down has been met will not reopen the case automatically. The client must call the Client Hotline at 1-800-335-8957.

4.5.3 Medically Needy Program for CSHCN Services Program Clients

The CSHCN Services Program requires client participation in MNP. Clients are given 60 days of provisional CSHCN eligibility, and referred to the Medicaid/MNP. Clients must provide CSHCN with a Medicaid and MNP determination of eligibility before the end of the 60-day provisional eligibility period. When clients send CSHCN a copy of the written Medicaid/MNP determination before the end of the 60 days, CSHCN pays for all covered medical services provided during the 60 days if the client is not eligible for Medicaid.

If a client sends the Medicaid/MNP determination after the 60-day period, CSHCN eligibility begins on the date CSHCN receives the determination. CSHCN only pays for prescription drugs (not over-the-counter), meals, lodging, transportation, expendable medical supplies, nutritional supplements, glucose monitors, transportation of remains, and total parenteral nutrition (TPN) during the provisional eligibility period. An additional 30 days of provisional eligibility may be granted under unusual circumstances.

Additionally, CSHCN may ask clients to apply to the Medicaid/MNP when $2,000 or more in medical bills has been paid or is expected to be paid by CSHCN. Clients are given 60 days to apply to the Medicaid/MNP and send the determination to CSHCN. A client's CSHCN eligibility is terminated if he or she does not comply with the request to apply to Medicaid/MNP. CSHCN clients receive no limitations on benefits during this period for their program-covered diagnosis or services. For more information, call the CSHCN MNP at 1-800-252-8023.

Refer to: "Medically Needy Claims Filing" on page 5-83.

4.6 Women's Health Program (WHP)

In January 2007, HHSC launched a new family planning program, the WHP. The goal of the program is to expand access to family planning services that reduce unintended pregnancies in the eligible population. WHP participants receive a limited, family planning benefit that supports the goal of the program. WHP participants do not have access to full Medicaid coverage.

The WHP provides an annual family planning exam, family planning services, and contraception to women who are 18 to 44 years of age, United States citizens or eligible immigrants, and Texas residents with a net family income at or below 185 percent of the FPL.

Refer to: "Women's Health Program" on page 0-1 for additional information.

4.7 Breast and Cervical Cancer Program

Through the Breast and Cervical Cancer Program (BCCP), the state of Texas provides Medicaid benefits to eligible women who were screened through the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program and found to need treatment for breast or cervical cancer, including precancerous conditions.

The Texas Department of State Health Services (DSHS) receives the CDC funds and awards these funds to providers across the state to perform breast and cervical cancer screenings and diagnostic services. Previously, women were only considered screened through the CDC program if all or part of their screening and diagnostic services were paid for with CDC funds.

The provider base that can screen and diagnose a woman so that she may be eligible for Medicaid through the program was expanded and women are now considered "screened" through the CDC program even if CDC funds were not used to pay for their screening and diagnostic services. The expansion opens the program up to more providers so that more women can receive treatment for breast or cervical cancer through the Texas Medicaid Program.

To be eligible to receive Texas Medicaid benefits under BCCP, a woman must be screened through the CDC program and found to need treatment for breast or cervical cancer, including precancerous conditions. Only women at or below 200 percent of the federal poverty level are eligible to receive screening services under the CDC program. A woman must also be under 65 years of age, a U.S. citizen or qualified alien, and uninsured or otherwise not eligible for Medicaid. Women eligible to receive Texas Medicaid under BCCP receive Medicaid benefits for the duration of their cancer treatment.

4.8 Medicare/Medicaid Clients

When a service is a benefit of Medicare and Medicaid, and both programs cover the client, the claim must be filed with Medicare first. Additional Medicare/Medicaid coverage information is in the specific service sections. Providers do not file a claim to Medicaid until Medicare has dispositioned the claim. The payment received from Medicare and the coinsurance and/or deductible payment from Medicaid must be considered reimbursement in full.

Providers must accept Medicare assignment to receive coinsurance and deductible amounts from Medicaid on services provided to clients. If a provider has not accepted a Medicare assignment, the provider may receive payment of the Medicare deductible and coinsurance from TMHP on behalf of the QMB or MQMB client.

Providers accepting Medicare/Medicaid assignment cannot legally require the client to pay the Medicare coinsurance and/or deductible amounts.

If the Medicare intermediary is TrailBlazer, LLC, Palmetto, or Mutual of Omaha, the Medicaid portion is transferred to TMHP through a Coordination of Benefits Coordinator (COBC), if the claim was processed as assigned. This benefit allows providers to receive disposition from both carriers while only filing the claim once. Providers allow 60 days from the date of Medicare's disposition for a claim to be shown on the Medicaid R&S report. Claims totally denied by Medicare are not automatically transferred to TMHP. If the Medicare intermediary is a company other than those listed, the provider must send a paper copy of the intermediary's Remittance Advice or Remittance Notice to TMHP for payment of the coinsurance and/or deductibles.

Refer to: "Reimbursement Methodology" on page 2-2 and "Claims Filing Instructions" on page 5-20.

4.8.1 QMB/MQMB Clients

Medicaid pays the beneficiary's Parts A and B deductibles and coinsurance liabilities on valid Medicare claims. These claims must be filed with Medicare first.

These guidelines exclude clients living in a nursing facility who receive a vendor rate for client care through DADS.

Refer to: "Reimbursement Methodology" on page 2-2 for limitations on reimbursement.

4.8.2 Medicare Part B Crossovers

Based on Medicare determination of the beneficiary's eligibility and the status of the annual deductible, the Medicare intermediary pays the provider a percentage of the allowed amount for covered Part B services. Medicaid pays the deductible if any is applied to the Medicare claim. Medicaid also pays the coinsurance liabilities according to Medicaid benefits and limitations.

Federal regulations require that the Texas Medicaid Program pay all Medicare deductible and coinsurance payments to nursing facilities, regardless if the provider has filed the claims as assigned to Medicare. The following programs qualify as Medicare Part B crossover claims: QMB, MQMB, and client TPs 13 or 14, with base plan 10, and category R.

Therefore, even if the provider has not accepted Medicare assignment, the provider may receive payment of the Medicare deductible and coinsurance on behalf of the QMB, MQMB, client TPs 13 or 14, base plan 10, and category R client. If the provider has collected money from the client and also received reimbursement from TMHP, the provider is required to refund the client's money.

The *Social Security Act* requires that Medicaid payment for physician services under Medicare Part B be made on an assignment-related basis.

If Medicaid does not reimburse or does not reimburse the full deductible or coinsurance, the provider is not allowed to bill the client.

4.8.3 Clients Without QMB/MQMB Status

Medicare is primary to Medicaid, and providers must bill Medicare first for their claims. Medicaid's responsibility for coinsurance and/or deductible is determined in accordance with the Medicaid benefits and limitations including the 30-day spell of illness. TMHP denies claims if the client's coverage reflects Medicare Part A coverage and Medicare has not been billed first.

Providers must check the client's Medicare card for Part A coverage before billing the Texas Medicaid Program.

Refer to: "Medicare Crossover Reimbursement" on page 2-7.

4.9 Contract with Outside Parties

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

4.10 Third Party Resources (TPR)

Federal and state laws require the use of Medicaid funds for the payment of most medical services only after all reasonable measures have been made to use a client's TPR or other insurance.

A TPR is a source of payment for medical services other than Medicaid or Medicaid managed care organization (MCO), the client, and non-TPR sources. TPR includes payments from any of the following sources:

- Private health insurance including assignable indemnity contracts.
- Health maintenance organization (HMO).
- Public health programs available to clients with Medicaid such as Medicare and Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).
- Profit and nonprofit health plans.
- Self-insured plans.
- No-fault automobile insurance such as personal injury protection (PIP) and automobile medical insurance.
- Liability insurance.
- Life insurance policies, trust funds, cancer policies, or other supplemental policies.
- Workers' Compensation.
- Other liable third parties.

Reminder: *Adoption agencies/foster parents are no longer considered a TPR. Medicaid is primary in these circumstances.*

Non-TPR sources are secondary to Texas Medicaid and may only pay benefits after the Texas Medicaid Program. The following are the most common non-TPR sources. If providers have questions about others not listed, they may contact a provider relations representative.

- Department of Assistive and Rehabilitative Services (DARS), Blind Services.
- Texas Kidney Health Care Program.
- Crime Victims' Compensation Program.
- Muscular Dystrophy Association.
- CSHCN Services Program.
- Texas Band of Kickapoo Equity Health Program.
- Maternal and Child Health (Title V).
- State Legalization Impact Assistance Grant (SLIAG).
- Adoption Agencies.
- Home and Community-based Waivers Programs through the Department of Aging and Disability Services (DADS).

Denied claims or services that are not a benefit of Medicaid may be submitted to non-TPR sources.

If a claim is submitted inadvertently to a non-TPR source listed above before submission to TMHP, the claim may be submitted to TMHP using the filing deadlines identified under "Filing Deadlines" on page 5-77.

If a non-TPR source erroneously makes a payment for a dual-eligible for services also covered by Medicaid, the payment is refunded to the non-TPR source.

Any indemnity insurance policy that pays cash to the insured for wages lost or for days of hospitalization rather than for specific medical services is considered a TPR *if the policy is assignable to someone else*. HHSC has assignment to any Medicaid applicant's or client's right of recovery from TPRs, to the extent of the cost of medical care services paid by Medicaid. The Texas Medicaid Program requires a provider take all reasonable measures to use a client's TPRs before billing Medicaid.

A provider who furnishes services and participates in the Texas Medicaid Program may not refuse to furnish services to an eligible client because of a third party's potential liability for payment of the services.

Eligible clients may not be held responsible for billed charges that are in excess of the TPR payment for services covered under the Texas Medicaid Program. If the TPR pays less than the Medicaid-allowable amount for covered services, the provider should submit a claim to TMHP for any additional allowable amount. Additionally, eligible clients enrolled in private HMOs must not be charged the copayment amount because the provider has accepted Medicaid assignment.

4.10.1 Workers' Compensation

Payment of covered services under Workers' Compensation constitutes reimbursement in full. The client should not be billed. Those services not covered by Workers' Compensation should be billed to TMHP.

4.10.2 Adoption Cases

- TMHP/Medicaid, not the adoption agency, should be billed for all medical services that are a benefit of the Texas Medicaid Program.
- If a claim is inadvertently sent to the adoption agency before it is sent to TMHP, TMHP must receive the claim within 95 days of the date of disposition from the adoption agency denial, payment, request for refund or recoupment, to be considered for payment.
- If the adoption agency inadvertently makes a payment for services covered by Medicaid, the provider should refund the payment to the agency.

Refer to: "Claims Filing Deadlines" on page 5-7.

A copy of the non-TPR disposition must be submitted with the claim and received at TMHP within 95 days from the date of the disposition (denial, payment, request for refund, or recoupment of payment by the non-TPR source).

4.10.3 Medicaid Identification (Form H3087)

When Medicaid billing information is obtained from the client, the provider examines the TPR column of the Form H3087 to determine if the client has other health insurance. The following indicators may be found in the TPR column:

- "M" indicates that the client is eligible for Medicare. The provider must file with Medicare before filing with Medicaid. The "M" is followed by a Medicare claim identification number.
- "P" and "M" indicate that the client has other insurance and Medicare coverage. Both must be billed before billing Medicaid.

To ensure receipt of TPR disposition of payment or denial, the provider must obtain an assignment of insurance benefits from the client at the time of service. Providers are asked not to provide claim copies or statements to the client.

Family planning services providers are not required to bill a client's TPRs before filing the claim with TMHP. Federal regulations protect the client's confidential choice of birth control and family planning services. Confidentiality is *jeopardized* when seeking information from TPRs.

SHARS and Early Childhood Intervention (ECI) providers are required to bill private insurance before billing Medicaid. School districts, special education cooperatives, and ECI providers must have parental permission to bill a client's private insurance.

If the provider is aware that a client has other health insurance, and "P" is not recorded in the TPR column of the Medicaid Identification, the provider must notify TMHP of the details concerning the type of policy and scope of benefits.

Contact TPR at 1-800-846-7307 or write to the following address:

Texas Medicaid & Healthcare Partnership
Third Party Resources Unit
PO Box 202948
Austin, TX 78720-9981

4.10.4 THSteps Requirements

THSteps dentists are not required to bill other insurance before billing Medicaid; however, if the provider is aware of other insurance, the provider documents the other insurance in the client's medical record. TMHP processes the claim for payment, determines if a TPR exists, and seeks reimbursement from the TPR.

THSteps medical check up providers rendering services to clients who are not in a managed care program must file directly to TMHP. TMHP processes the claim for payment, determines if a TPR exists, and seeks payment from the TPR.

Note: *THSteps medical check up providers are not required to pursue TPR.*

Refer to: "Other Insurance" on page 42-12 for more information.

4.10.5 Other Insurance Reimbursement

To the extent allowed by federal law, a health-care service provider must seek reimbursement from available third-party health coverage or insurance that the provider knows about or should know about before billing the Texas Medicaid Program. All claims for clients with other insurance coverage must reference the information (see "Other Insurance Claims Filing" on page 5-75), regardless of whether a copy of the EOB from the insurance company is submitted with the claim.

4.10.6 Refunds to TMHP Resulting from Other Insurance Payments and Conditions Surrounding Provider Billing of Third Party Insurers

Providers are prohibited expressly from receiving payment from Medicaid, billing a TPR, and then refunding to Medicaid the lesser of the two payments. This section outlines some portions of those rules that providers must follow when billing third party insurers. This summary does not include all the TPR provisions to which providers must adhere; thus, providers review the complete text of Title 1 *Texas Administrative Code* (TAC) §§354.2321 and 354.2322 for a full description of provider requirements surrounding recovery from third parties.

Any refunds due to TMHP are not to be held until the end of an accounting year. Because providers must accept assignment, they must accept Medicaid payment as payment in full for covered services and they may not use payment by another TPR to make up the difference

between the amount billed and the Medicaid payment. Any payment received from another TPR must be refunded to TMHP if the following conditions are not met.

Providers who identify a TPR within 12 months from the date of service, and wish to submit a claim for payment to a third party health insurer after a claim for payment has been submitted to and paid by TMHP, *must* refund any amounts paid by TMHP before submitting a claim for payment to the third party.

Providers are limited to the Medicaid payable amount and are required to accept the amount paid by TMHP as payment in full if:

- A claim for payment is submitted to and paid by TMHP.
- The provider failed to refund TMHP before submitting a claim for payment to a third party as outlined in the third paragraph above.

Third party payments received after receipt of the TMHP payment must be refunded to TMHP in full, even if the amount paid by the third party insurer exceeds the Medicaid payment.

If the amount paid by a third party health insurer is less than the amount payable for the service by Medicaid, providers may bill TMHP for the difference between the amount paid by the third party health insurer and the Medicaid payable amount, if a claim was filed timely and in accordance with all the applicable rules.

In accordance with the TPR rules (1 TAC §§354.2321 [g] and 354.2322 [i]), "any provider who accepts Medicaid payment as payment in full for services and retains any amount in excess of the Medicaid payable amount from a third party and conceals or fails to account to the department for the third party amount, resulting in excessive or duplicate payment for the same service, may be referred for investigation and prosecution for violations of state and/or federal Medicaid or false claims laws."

When making TPR refunds, providers should make the check payable to TMHP and send it with a completed Refund Information Form addressed to the attention of TMHP Cash Reimbursement.

Include the following information with the TPR refund:

- Client name and Medicaid number.
- Copy of the R&S report listing the paid claim (if available).
- Date of service.
- Provider name, number, or both.
- Name and address of the attorney or casualty insurance company (including the policy and claim number).
- Subscriber information.
- Amount of insurance payment.

Refer to: "Texas Medicaid Refund Information Form" on page B-104.

4.10.7 Accident-Related Claims

TMHP monitors all accident claims to determine whether another resource may be liable for the medical expenses of clients with Medicaid coverage. Providers are requested to ask clients whether medical services are necessary because of accident-related injuries. If the claim is the result of an accident, providers enter the appropriate code and date in Block 10 of the CMS-1500 claim form, and Blocks 32ab to 35ab on the UB-04 CMS-1450 claim form.

If payment is immediately available from a known third party such as Workers' Compensation or PIP automobile insurance, that responsible party must be billed before Medicaid and the insurance disposition information must be filed with the Medicaid claim. If the third party payment is substantially delayed because of contested liability or unresolved legal action, a claim may be submitted to TMHP for consideration of payment.

TMHP processes the liability-related claim and pursues reimbursement directly from the potentially liable party on a postpayment basis. Include the following information on these claims:

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

4.10.8 Accident Resources, Refunds

Acting on behalf of HHSC, TMHP has specific rights of recovery from any settlement, court judgment, or other resources awarded to a client with Medicaid coverage (*Texas Human Resources Code*, Chapter 32.033). In most cases, TMHP works directly with the attorneys, courts, and insurance companies to seek reimbursement for Medicaid payments. If a provider receives a portion of a settlement for services also paid by Medicaid, the provider must make a refund to TMHP. Any provider filing a lien for the entire billed amount must contact the Third Party Resources Unit at TMHP for Medicaid postpayment activities to be coordinated. A provider may not file a lien for the difference between the billed charges and the Medicaid payment. A lien may be filed for services not covered by Medicaid. A lien is the liability of the client with Medicaid coverage.

Providers should contact the Third Party Resources Unit at TMHP after furnishing an itemized statement and/or claim copies for any accident-related services billed to Medicaid if they received a request from an attorney, a casualty insurance company, or a client.

The provider furnishes TMHP with the following information:

- Client's name.
- Medicaid ID number.
- Dates of service involved.
- Name and address of the attorney or casualty insurance company (including the policy and claim number).

This information enables TMHP to pursue reimbursement from any settlement. Use the "Tort Response Form" on page B-113 to report accident information to TMHP. When the form is completed, remit it to the TMHP Third Party Resources Unit (the address and fax number are on the form).

Providers may contact the TMHP Third Party Resources Unit by calling 1-800-846-7307 or mailing to the following address:

Texas Medicaid & Healthcare Partnership
Third Party Resources Unit
PO Box 202948
Austin, TX 78720-9981

4.10.8.1 Providers Filing Liens for Third Party Reimbursement

Any provider filing a lien for the entire billed amount must contact the TMHP Third Party Resources Unit for Medicaid post payment activities to be coordinated.

A provider may file a lien for the entire billed amount only after meeting the criteria in 1 TAC §354.2322, summarized below. Providers who identify a third party, within 12 months from the date of service, and wish to submit a bill or other written demand for payment or collection of debt to a third party after a claim for payment has been submitted and paid by Medicaid must refund any amounts paid before submitting a bill or other written demand for payment or collection of debt to the third party for payment, and they must comply with the provisions set forth in 1 TAC §354.2322, which states: Providers may retain a payment from a third party in excess of the amount Medicaid would otherwise have paid only if the following requirements are met:

- The provider gives notice to the client or the attorney or representative of the client that the provider may not or will not submit a claim for payment to Medicaid and the provider may or will pursue a third party, if one is identified, for payment of the claim. The notice must contain a prominent disclosure that the provider is prohibited from billing the client or a representative of the client for any Medicaid-covered services, regardless of whether there is an eventual recovery or lack of recovery from the third party or Medicaid.
- The provider establishes the right to payment separate of any amounts claimed and established by the client.
- The provider obtains a settlement or award in its own name separate from a settlement obtained by or on behalf of the client or award obtained by or on behalf of the client, or there is an agreement between the client or attorney or representative of the client and the provider, that specifies the amount that will be paid to the provider after a settlement or award is obtained by the client.

4.10.8.2 Submission of Informational Claims

A provider must submit an informational claim to HHSC within the 95 days from the date of service. Informational claims will not be accepted after the 95-day filing deadline.

All informational claims must be submitted to HHSC by certified mail. PCCM, STAR+PLUS, and traditional Medicaid informational claims should be sent to HHSC for processing. Providers that identify a Medicaid recipient who is receiving benefits provided by a Medicaid Managed Care Organization (MCO) cannot submit an informational claim to HHSC.

An informational claim is a paper claim form UB-04 CMS-1450 or CMS-1500 submitted to the HHSC/TPR address with an indication that the provider is seeking payment from a third party for a tort-related liability. Providers cannot submit informational claims electronically. *Do not send informational claims to TMHP.* When sending an informational claim, the provider must complete an Informational Inquiry Form. Only one Inquiry Form per client is required.

Refer to: "Informational Inquiry Form" on page B-51.

Providers may inquire on the status of an informational claim by calling HHSC toll-free at 1-800-436-6184 (option 5). This toll-free line *only* answers questions about informational claims.

To ensure that HHSC Third Party Resources Unit receives the original informational claims, providers should send original informational claims by certified mail to the following address:

HHSC/OIG/TPR
INFOC
Mail Code 1354 PO Box 85200
Austin, TX 78708-5200

Note: *Faxed informational claims will not be accepted.*

4.10.8.3 Informational Claim Conversion to Claim for Payment

Providers who have filed informational claims with HHSC, but have not received payment from the third party within 18 months from the date of service, must choose before the end of the 18th month from the date of service to do one of the following:

- Continue to pursue a claim against the third party for payment and forego the right to submit a written request for the conversion of the informational claim for payment by Medicaid.
- Submit a letter on hospital or provider letterhead by fax or mail requesting the conversion of the informational claim to a claim for payment by Medicaid. The letter must include the following information: client's name, Medicaid ID, Date of Service, and Total Billed amount

as originally stated on the UB-04 CMS-1450 or CMS-1500. HHSC does not accept or pay any claim for payment after 18 months from the date of service has elapsed, regardless of whether an informational claim has been timely filed. All other filing deadlines apply.

Mailing Address:
HHSC/OIG/TPR
INFOC
Mail Code 1354 PO Box 85200
Austin, TX 78708-5200
Fax: 1-512-833-6484

All payment deadlines are enforced regardless of the provider's decision to pursue a third party claim. Once timely notification has been received by HHSC to convert the informational claim to a claim for payment, HHSC forwards the informational claim to TMHP. Informational claims converted to actual claims are not a guarantee of payment by TMHP.

4.10.9 Long Term Care Providers

A nursing facility, home health services provider, or any other similar long term care services provider that is Medicare-certified must:

- Seek reimbursement from Medicare before billing the Texas Medicaid Program for services provided to an individual who is eligible to receive similar services under the Medicare program.
- Appeal Medicare claim denials for payment, as directed by the department.

A nursing facility, home health services provider, or any other similar long term care services provider that is Medicare-certified is not required to seek reimbursement from Medicare before billing the Texas Medicaid Program for a person who is Medicare-eligible and has been determined as not being homebound.

4.11 NorthSTAR (Behavioral Health Program in Dallas Service Area Only)

The state implemented a behavioral health organization (BHO) program known as NorthSTAR. NorthSTAR provides mental health and chemical dependency (behavioral health) services.

NorthSTAR replaces traditional Medicaid behavioral health specialty services for those Medicaid clients who are required to join the NorthSTAR Program. Behavioral health specialty providers must not bill TMHP for behavioral health services that are provided to enrollees with behavioral health diagnoses in the NorthSTAR Program. Medicaid providers who are considered behavioral health specialists include psychiatrists, psychologists, LPCs, licensed marriage and family therapists (LMFTs), LMSWs, and TCADA-licensed chemical dependency programs for children and adolescents. In general, acute care hospitals behavioral health specialty services are defined as inpatient stays in which the primary diagnosis is a behavioral health diagnosis.

Behavioral health specialists and hospitals no longer bill TMHP for behavioral health services provided to clients who are enrolled in or eligible for membership in the NorthSTAR Program. If a claim is submitted to TMHP for a NorthSTAR-enrolled client, it will be denied with instructions for the provider to submit the claim to the client's BHO.

Behavioral health providers follow a new set of rules to receive payment for services provided to Medicaid clients who are enrolled in NorthSTAR.

The new rules are as follows. A behavioral health provider must:

- Be a provider of the plan's NorthSTAR network to receive payment for most services provided to the members.
- Obtain prior approval for some nonemergency services. This rule applies when providing treatment to a NorthSTAR member, whether or not in the Dallas service area.
- Provide services to Medicaid clients not eligible to enroll in a NorthSTAR BHO. TMHP will continue to pay these clients Medicaid claims. These clients live in a nursing facility, Intermediate Care Facility for the Mentally Retarded (ICF-MR), the state hospitals' IMD over age 65 program, or children who are in the custody of the Texas Department of Protective and Regulatory Services (in foster care).
- Bill Medicare for Medicare-covered services. TMHP continues to pay deductible and coinsurance charges for Medicare services for these clients.

Exception: *Exceptions include emergency care and medically necessary treatment episodes that began before the client joined a NorthSTAR Plan.*

Clients enroll in the NorthSTAR plan Value Options. When a Medicaid client requests services, call Value Options at 1-888-800-6799 to verify if the client is a member of NorthSTAR. Also call this number to get information on joining the plan's networks.

If clients would like to join NorthSTAR, they may call MAXIMUS, the state's enrollment broker, at 1-800-964-2777. The MAXIMUS staff is trained to help potential members understand both the STAR and NorthSTAR programs. NorthSTAR also provides behavioral health services to some people who are not Medicaid-eligible. These people are provided a greater variety of services than what is available under the Texas Medicaid Program.

Behavioral health providers do *not* bill TMHP for services provided to NorthSTAR members.

4.12 Medicaid Identification Form H3087

Following are examples of Forms H3087-G1, H3087-G2, H3087-GL, H3087-GM, and H3087-S4. The actual Medicaid forms can be identified by a watermark Medicaid Eligibility Verification (Form H1027-A).

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/24/2008	610098	40	30	02	123456789	AUGUST 31, 2008

4

952-X 123456789 40 30 02 030711
JOHN DOE
743 GOLF IRONS
DEL VALLE TX 78617

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

Under 21 years old? Please call your doctor, nurse or dentist to schedule a checkup if you see a reminder under your name. If there is no reminder, you can still use Medicaid to get health care that you need.

A ✓ on the line to the right of your name means that you can get that service too.

READ THE BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

¿Tiene menos de 21 años? Por favor, llame a su doctor, enfermera o dentista para hacer una cita si hay una nota debajo de su nombre. Aunque no haya ninguna nota, puede usar Medicaid para recibir la atención médica que necesite.

Las marcas ✓ a la derecha en el mismo renglón donde está su nombre significan que usted puede recibir esos servicios también.

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	DENTAL SERVICES	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JOHN DOE	08-27-1997	M	07-09-2008			✓	✓	✓		✓	✓

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-G1/April 2007

FOR THE CLIENT: About your Medicaid ID Form

This is your Medicaid Identification form. A new Medicaid Identification form will be mailed to you each month. Take your most recent Medicaid Identification form with you when you visit your doctor or receive services from any of your health care providers. This form helps health care providers know which services you can receive and to bill Medicaid.

If you receive a letter from HHSC stating that the Medicaid program will not pay for certain health services your provider thinks you need, the letter will inform you of your right to ask for a fair hearing to appeal the denial of services. The letter will tell you whom to call or where you can write to request a hearing.

NOTE: According to state law a recipient of Medicaid automatically gives HHSC his or her right to financial recovery from personal health insurance, other recovery sources and money received as a result of personal injuries, to the extent HHSC has paid for medical services. This allows HHSC to recover the costs of medical services paid by the Medicaid program. Any applicant or recipient who knowingly withholds information regarding any sources of payment for medical services violates state law.

Get Answers to Your Questions		
Question	**Contact**	**Phone**
Whom can I call to find out which services are paid by Medicaid?	**Medicaid Hotline**	**1-800-252-8263**
Whom can I call if I get a bill from a Medicaid provider?	**Texas Medicaid Healthcare Partnership Client Hotline**	**1-800-335-8957**
Whom should I call if I need help finding or contacting a doctor, dentist, case manager, or other Medicaid provider for someone 21 years old or younger?	**Texas Health Steps**	**1-877-847-8377**
Who can drive me to my Medicaid provider?	**Medical Transportation**	**1-877-633-8747**
Who can help me if I have questions or problems with my health plan, or my Primary Care Case Management (PCCM) doctor?	**STARLINK**	**1-866-566-8989**
If I am receiving help paying my high medical bills and I need information about my case, whom do I call?	**Texas Medicaid Healthcare Partnership Client Hotline**	**1-800-335-8957**
Whom can I call to find out about nursing home care, adult day care or other long-term care services?	**Department of Aging and Disability Services Consumer Rights Hotline**	**1-800-458-9858**
Who can tell me about how my other insurance might affect my Medicaid benefits?	**Texas Medicaid Healthcare Partnership Third Party Resources Hotline**	**1-800-846-7307**
To whom do I report Medicaid fraud, waste or abuse?	**Office of Inspector General**	**1-800-436-6184**
Whom do I talk to about helping me pay my private insurance premiums?	**Health Insurance Premium Program Hotline**	**1-800-440-0493**
Whom do I talk to if I receive supplemental security income and I need to change my address?	**Social Security Administration**	**1-800-772-1213**
Whom do I call if I have questions about my Medicare Rx Prescription Program?	**Medicare**	**1-800-MEDICARE (1-800-633-4227)**

PARA EL CLIENTE: información sobre la forma de identificación de Medicaid

Esta es su forma de Identificación de Medicaid. Se le enviará por correo una nueva forma de Identificación de Medicaid cada mes. Lleve con usted la forma más reciente cuando vaya al doctor o reciba servicios de uno de sus proveedores de atención médica. Esta forma ayuda a los proveedores de atención médica a saber cuáles servicios puede recibir usted y a facturar a Medicaid.

Si recibe una carta de la Comisión de Salud y Servicios Humanos (HHSC) indicando que el programa Medicaid no pagará ciertos servicios de salud que su proveedor cree que usted necesita, la carta le informará de su derecho de pedir una audiencia imparcial para apelar la negación de servicios. La carta le indicará a quién debe llamar o a dónde puede escribir para solicitar una audiencia.

NOTA: según las leyes estatales una persona que recibe Medicaid le otorga automáticamente a la HHSC su derecho a recuperación económica de un seguro de salud personal, otras fuentes de recuperación y dinero que reciba por lesiones personales, hasta en la medida en la que la HHSC haya pagado por servicios médicos. Esto le permite a la HHSC recuperar los costos de servicios médicos pagados por el programa Medicaid. Cualquier solicitante o cliente que a sabiendas retenga información sobre las fuentes de pago por servicios médicos viola la ley estatal.

Reciba respuestas a sus preguntas		
Pregunta	Contacto	Teléfono
¿A quién puedo llamar para información sobre que servicios paga el Medicaid?	Línea directa de Medicaid	1-800-252-8263
¿A quién puedo llamar si recibo una cuenta de un proveedor de Medicaid?	Línea Directa del Cliente de Texas Medicaid Healthcare Partnership	1-800-335-8957
¿A quién debo llamar si necesito ayuda para encontrar o comunicarme con un doctor, dentista, administrador de casos u otro proveedor de Medicaid para alguien que tiene 21 años o menos?	Pasos Sanos de Texas	1-877-847-8377
¿Quién me puede llevar a mi proveedor de Medicaid?	Transporte médico	1-877-633-8747
¿Quién me puede ayudar si tengo preguntas o problemas con mi plan de salud o con mi doctor de Primary Care Case Management (PCCM)?	STARLINK	1-866-566-8989
Si estoy recibiendo ayuda para pagar mis cuentas médicas elevadas y necesito información sobre mi caso, ¿a quién llamo?	Línea Directa del Cliente de Texas Medicaid Healthcare Partnership	1-800-335-8957
¿A quién puedo llamar para información sobre la atención en una casa para convalecientes, cuidado de adultos durante el día, u otros servicios de atención a largo plazo?	Línea Directa del Derecho al Consumidor del Departamento de Servicios a Adultos Mayores y Personas Discapacitadas	1-800-458-9858
¿Quién me puede decir como puede afectar mi otro seguro médico mis beneficios de Medicaid?	Línea Directa de Recursos de Terceros de Texas Medicaid Healthcare Partnership	1-800-846-7307
¿A quién le denuncio el fraude, malgasto o abuso de Medicaid?	Oficina de la Fiscalía General	1-800-436-6184
¿Con quién hablo sobre ayuda para pagar mis primas de seguro privado?	Línea Directa del Programa de Primas de Seguro de Salud	1-800-440-0493
¿Con quién hablo si recibo Seguridad de Ingreso Suplementario y necesito cambiar mi dirección?	Administración de Seguro Social	1-800-772-1213
¿A quién llamo si tengo preguntas sobre mi Programa de Medicare Rx para Medicamentos con Receta?	Medicare	1-800-MEDICARE (1-800-633-4227)

Form H3087/Page 2/03-2007

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

1 ATFF 01-00001

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/05/2008	610098		40	02	123456789	JULY 31, 2008

952-X 123456789 40 02 030731
JANE DOE
743 GOLF IRONS
HUNTINGTON TX 75949

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

Under 21 years old? Please call your doctor, nurse or dentist to schedule a checkup if you see a reminder under your name. If there is no reminder, you can still use Medicaid to get health care that you need.

A ✓ on the line to the right of your name means that you can get that service too.

READ THE BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

¿Tiene menos de 21 años? Por favor, llame a su doctor, enfermera o dentista para hacer una cita si hay una nota debajo de su nombre. Aunque no haya ninguna nota, puede usar Medicaid para recibir la atención médica que necesite.

Las marcas ✓ a la derecha en el mismo renglón donde está su nombre significan que usted puede recibir esos servicios también.

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	DENTAL SERVICES	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	12-09-1999	F	06-01-2008			✔	✔	✔		✔	✔

THSTEPS MEDICAL AND DENTAL CHECK-UP DUE / NECESITA SU EXAMEN MEDICO Y DENTAL DE THSTEPS

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-G2/April 2007

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030
RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

41 ATFF 01-00041
Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/15/2008	610098		37	02	123456789	JULY 31, 2008

LIMITED

952-X 123456789 37 02 030731
JANE DOE
743 GOLF IRONS
CROCKETT TX 75835

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

Under 21 years old? Please call your doctor, nurse or dentist to schedule a checkup if you see a reminder under your name. If there is no reminder, you can still use Medicaid to get health care that you need.

A ✓ on the line to the right of your name means that you can get that service too.

READ THE BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

¿Tiene menos de 21 años? Por favor, llame a su doctor, enfermera o dentista para hacer una cita si hay una nota debajo de su nombre. Aunque no haya ninguna nota, puede usar Medicaid para recibir la atención médica que necesite.

Las marcas ✓ a la derecha en el mismo renglón donde está su nombre significan que usted puede recibir esos servicios también.

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	DENTAL SERVICES	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	01-05-1997	F	06-01-2008				✓	✓		✓	✓

LIMITED

TO DOCTOR: **
JAMES B SMITH MD **
WEST MEDICAL BLDG. **
111 EAST 18TH AVE. **
AUSTIN TX 78759 **

TO PHARMACY:
HAPPY PHARMACY
11223 WEST 27th

AUSTIN TX 78759

FOR ADDITIONAL INFORMATION REGARDING LIMITATION TO ONE PRIMARY CARE PROVIDER AND/OR PHARMACY
Call the Limited Program at 1-800-436-6184

PARA MÁS INFORMACIÓN SOBRE EL USO DE UN SOLO PROFESIONAL MÉDICO O UNA SOLA FARMACIA
Llame al Programa Limitado a 1-800-436-6184

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-GL/April 2007

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

198 ATFF 01-00198

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: VÁLIDA HASTA:
07/15/2008	610098		01	02	123456789	JULY 31, 2008

Primary Care Case Management (PCCM)

952-X 123456789 01 02 030731
JANE DOE
743 GOLF IRONS
HOUSTON TX 77143

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

You now receive your Medicaid medical care through Primary Care Case Management (PCCM). Your primary care provider (PCP) is listed below. If you want to pick a different PCP, call toll-free 1-888-302-6688.

Your PCP is your first stop for getting medical care. When you are sick or injured, your PCP will help you. Your PCP can also assist with THSteps checkups for children and teenagers, prenatal and well woman care. For more information, read your handbook, Primary Care Provider and Hospital List, or call PCCM toll-free at 1-888-302-6688.

READ BACK OF THIS FORM!

TODA PERSONA NOMBRADA A CONTINUACIÓN PUEDE RECIBIR SERVICIOS DE MEDICAID

Usted ahora recibe la atención médica de Medicaid por medio de Primary Care Case Management (PCCM). El nombre de su Proveedor de Cuidado Primario (PCP) aparece a continuación. Si quiere escoger a otro PCP, llame gratis al 1-888-302-6688.

Su PCP es el primer lugar al que debe ir para recibir atención médica. Cuando esté enfermo o lesionado, su PCP le ayudará. También le puede ayudar con los chequeos de Pasos Sanos de Texas para niños y jóvenes, con la atención prenatal y los chequeos preventivos para la mujer. Para más información, lea el manual titulado Lista de Proveedores de Cuidado Primario y Hospitales, o llame gratis a PCCM al 1-888-302-6688.

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	DENTAL SERVICES	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	02-04-1985	F	07-01-2008			✔	✔	✔		✔	✔
PCCM /1-800-123-4567 / DR. JEREMY IRONS												

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-S4/April 2007

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

15 ATFF 01-00015

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/24/2008	610098	13	13	04	123456789	JULY 31, 2008

MQMB

952-X 123456789 13 13 04 030731
JANE DOE
743 GOLF IRONS
GRANGER TX 76530

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

Under 21 years old? Please call your doctor, nurse or dentist to schedule a checkup if you see a reminder under your name. If there is no reminder, you can still use Medicaid to get health care that you need.

A ✓ on the line to the right of your name means that you can get that service too.

READ THE BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

¿Tiene menos de 21 años? Por favor, llame a su doctor, enfermera o dentista para hacer una cita si hay una nota debajo de su nombre. Aunque no haya ninguna nota, puede usar Medicaid para recibir la atención médica que necesite.

Las marcas ✓ a la derecha en el mismo renglón donde está su nombre significan que usted puede recibir esos servicios también.

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	DENTAL SERVICES	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	01-14-1946	F	09-01-2008		123456789HIC	✔				✔	✔

NOTICE TO PROVIDER

This recipient is eligible for regular Medicaid benefits.

This recipient is also eligible for coverage of Medicare deductible and coinsurance liabilities on valid Medicare claims. Coverage is subject to Medicaid reimbursement limitations.

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-GM/April 2007

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030
RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

2 ADEQ 01-00002
Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
04/09/2008	012338	41	02		111111111	AUGUST 31, 2008

Women's Health Program

952-X 111111111 41 02 070430
SUSIE Q CITIZEN
11111 MAIN STREET
AUSTIN TX 77777

4

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	
222222222	SUSIE Q CITIZEN	01-21-1980	F	02-01-2008		

You must take this Medicaid Identification form with you when you visit your doctor or receive Medicaid services from any of your health care providers. This form helps health care providers know which services you can receive and how to bill Medicaid. You will receive a new Medicaid Identification form each month while you are eligible for Medicaid services.

You are enrolled in Women's Health Program. If you would like to apply for other Medicaid services, call us toll free at **2-1-1**, Monday through Friday, 8 a.m. to 8 p.m. Central Time.

Notice to Providers

Women's Health Program services covered by Medicaid during the period of eligibility are limited to:

An annual visit and exam.

Contraception, except emergency contraception.

Debe llevar con usted esta forma de identificación de Medicaid cuando vaya al doctor o reciba servicios de Medicaid de uno de sus proveedores de atención médica. Esta forma ayuda a los proveedores de atención médica a saber que servicios puede recibir y cómo cobrarle a Medicaid. Recibirá una nueva forma de identificación de Medicaid cada mes que llene los requisitos para recibir servicios de Medicaid.

Usted está inscrita en el programa Programa de Salud de la Mujer. Si quiere solicitar otros servicios de Medicaid, llámenos gratis al **2-1-1**, de lunes a viernes, de 8 a.m. a 8 p.m. hora central.

Aviso a los proveedores

Los servicios del programa Programa de Salud de la Mujer que cubre Medicaid durante el periodo de elegibilidad están limitados a :

Una visita y un examen anuales.

Anticonceptivos, salvo los anticonceptivos de emergencia.

Form H3087-WH/January 2007

Texas Health and Human Services Commission/**Form H1027-A**/01-2007

Medicaid Eligibility Verification
Confirmación de elegibilidad para Medicaid

	Name of Doctor/Nombre del doctor	**Name of Pharmacy**/Nombre de la farmacia

THIS FORM COVERS ONLY THE DATES SHOWN BELOW. IT IS NOT VALID FOR ANY DAYS BEFORE OR AFTER THESE DATES.
ESTA FORMA ES VÁLIDA SOLAMENTE EN LAS FECHAS INDICADAS ABAJO. NO ES VÁLIDA NI ANTES NI DESPUÉS DE ESTAS FECHAS.

☐ **Each person listed below has applied and is eligible for MEDICAID BENEFITS for the dates indicated below, but has not yet received a client number. Do not submit a claim until you are given a client number. Pharmacists have 90 days from the date the number is issued to file clean claims. However, check your provider manual because other providers may have different filing deadlines. Call the eligibility worker named below if you have not been given the client number(s) within 15 days.**

☐ **Each person listed below is eligible for MEDICAID BENEFITS for dates indicated below. The Medicaid Identification form is lost or late. The client number must appear on all claims for health services.**

Date Eligibility Verified	Verification Method ☐ **Local DCU** ☐ **SAVERR Direct Inquiry** ☐ **Regional Procedure** ☐ **S.O DCU (A & D Staff Only)**	BIN **610098**

CLIENT NAME NOMBRE DEL CLIENTE	**DATE OF BIRTH** FECHA DE NACIMIENTO	**CLIENT NO.** CLIENTE NÚM.	**ELIGIBILITY DATES** PERIODO DE ELEGIBILIDAD		**MEDICARE CLAIM NO.** NÚM. DE SOLICITUD DE PAGO DE MEDICARE	**STAR/STAR+PLUS/PCCM HEALTH PLAN INFORMATION** INFORMACIÓN DEL PLAN DE SALUD STAR/STAR+PLUS/PCCM **Plan Name and Member Services Toll-Free Telephone No.** Nombre del plan y teléfono gratuito de Servicios para Miembros
			From/Desde	**Through**/Hasta		

I hereby certify, under penalty of perjury and/or fraud, that the above client(s) have lost, have not received, or have no access to the Medicaid Identification (Form H3087) for the current month. I have requested and received Form H1027-A, Medical Eligibility Verification, to use as proof of eligibility for the dates shown above. I understand that using this form to obtain Medicaid benefits (services or supplies) for people not listed above is fraud and is punishable by fine and/or imprisonment.

CAUTION: If you accept Medicaid benefits (services or supplies), you give and assign to the state of Texas your right to receive payments for those services or supplies from other insurance companies and other liable sources, up to the amount needed to cover what Medicaid spent.

Por este medio certifico, bajo pena de perjurio y/o fraude, que los clientes nombrados arriba hemos perdido, no hemos recibido o por otra razón no tenemos en nuestro poder la Identificación para Medicaid (Forma H3087) del corriente mes. Solicité y recibí esta Confirmación de Elegibilidad Médica (Forma H1027-A) para comprobar nuestra elegibilidad para Medicaid durante el periodo cubierto especificado arriba. Comprendo que usar esta confirmación para obtener beneficios (servicios o artículos) de Medicaid para alguna persona no nombrada arriba como beneficiario constituye fraude y es castigable por una multa y/o la cárcel.

ADVERTENCIA: Si usted acepta beneficios de Medicaid (servicios o artículos), otorga y concede al estado de Texas el derecho a recibir pagos por los servicios o artículos de otras compañías de seguros y otras fuentes responsables, hasta completar la cantidad que se requiere para cubrir lo que haya gastado Medicaid.

Signature–Client or Representative/Firma–Cliente o Representante _____ **Date**/Fecha _____

Office Address and Telephone No./Oficina y Teléfono

Name of Worker (type)/Nombre del trabajador	Worker BJN	Worker Signature **X**	Date
Name of Supervisor* (type)/Nombre del supervisor*	Supervisor* BJN	Supervisor Signature **X**	Date

***or Authorized Lead Worker**/*o Trabajador encargado

Medicaid clients do not have to pay bills which Medicaid should pay. It is very important that you tell your doctor, hospital, drugstore, and other health care providers right away that you have Medicaid. If you do not tell them that you have Medicaid, you may have to pay these bills. If you get a bill from a doctor, hospital, or other health care provider, ask the provider why they are billing you. If you still get a bill, call the Medicaid hotline at 1-800-252-8263 for help. If Medicaid will not pay the bill or if Medicaid benefits (services and supplies) are denied, you may request a fair hearing by writing to the address or calling the telephone number listed on the letter you get.

Note: Family planning clinics and other providers give free physical exams, lab tests, birth control methods (including sterilization) and contraceptive counseling.

El cliente de Medicaid no tiene que pagar cuentas médicas que Medicaid debe pagar. Es muy importante que usted diga inmediatamente a su médico, al hospital, a la farmacia y a otros proveedores de servicios médicos que usted tiene Medicaid. Si no les dice que tiene Medicaid, puede que usted tenga que pagar estas cuentas. Si usted recibe una cuenta de un doctor, un hospital, u otro proveedor de servicios médicos, pregunte por qué le mandó la cuenta. Si todavía le mandan una cuenta, llame al número directo de Medicaid al 1-800-252-8263 para pedir ayuda. Si Medicaid no va a pagar la cuenta o si se niegan los beneficios de Medicaid (los servicios o los artículos), usted puede pedir por escrito una audiencia imparcial. La dirección y el número de teléfono aparecen en la carta que recibió.

NOTA: Las clínicas de planificación familiar y los otros proveedores ofrecen gratis exámenes físicos, análisis de laboratorio, métodos anticonceptivos (inclusive la esterilización) y consejería sobre los anticonceptivos.

Provider Information/Información para el proveedor

Only those people listed under "CLIENT NAME" have Medicaid coverage. Payment is allowed ONLY for services received during the eligibility dates reflected on the front of this form.

Note: Payment for Family Planning Services is available without the consent of the client's parent or spouse. Confidentiality is required. Family planning drugs, supplies, and services are exempt from the prescription drug and "LIMITED" restrictions.

Key to terms that may appear on this form:

Limited– Except for family planning services, and for Texas Health Steps (EPSDT), medical screening, dental, and hearing aid services, the client is limited to seeing the doctor **and/or** limited to using the pharmacy named on the form for drugs obtained through the Vendor Drug Program. In the event of an emergency medical condition as defined below, the "LIMITED" restriction does not apply.

Emergency– The client is limited to coverage for an emergency medical condition. This means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (who possesses an average knowledge of health and medicine) would think that the absence of immediate medical attention could reasonably be expected to result in (1) placing the patient's health in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.

Hospice– The client is in hospice and waives the right to receive services related to the terminal condition through other Medicaid programs. If a client claims to have canceled hospice, call the local hospice agency or DHS to verify.

QMB– The Medicaid agency is providing coverage of Medicare premiums, deductible, and coinsurance liabilities, but the client is not eligible for regular Medicaid benefits.

MQMB– The Medicaid agency is providing regular Medicaid coverage as well as coverage of Medicare premiums, deductibles, and coinsurance liabilities.

PE– Medicaid covers only family planning and medically necessary outpatient services.

STAR/STAR+PLUS/PCCM Health Plan– The client is enrolled in the Medicaid Managed Care program and is assigned to the health plan named on the form.

Women's Health Program– Medicaid coverage is limited to an annual exam, health screenings and contraceptives. The client is not eligible for regular Medicaid benefits.

Note to Pharmacy: Medicaid will pay for more than three prescriptions each month for any Medicaid client who is under age 21, or lives in a nursing facility, or has the STAR/STAR+PLUS Health Plan, or gets services through the Community Living Assistance and Support Services (CLASS), Community Based Alternatives (CBA) and other non-SSI community-based waiver programs. Clients with Medicare who are enrolled in STAR+PLUS may be limited to three prescriptions per month.

Section

5

Claims Filing

5.1 Claims Information

Because Texas Medicaid Program cannot make payments to clients, the provider who performs the service must file an assigned claim. Federal regulations prohibit providers from charging clients a fee for completing or filing Medicaid claim forms. Providers are not allowed to charge TMHP for filing claims. The cost of claims filing is part of the usual and customary rate for doing business.

5.1.1 TMHP Processing Procedures

TMHP processes claims for the traditional (fee-for-service) Medicaid and Medicaid Managed Care programs.

Medicaid claims are subject to the following procedures:

- TMHP verifies all required information is present.
- Claims filed under the same provider identifier and program 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.

  Weekly claim/financial activity, with or without payments, initiate an R&S report being sent to a provider. The report identifies pending, paid, denied, and adjusted claims. If no claim activity or outstanding account receivables exist during the time period, the provider does not receive an R&S report for the week.

Refer to: "Medicaid Managed Care" on page 7-4 for TMHP claims processing information related to Medicaid Managed Care.

5.1.1.1 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 Family Planning (Titles V, X, XX) providers, since these providers are not reimbursed through the Compass21 (C21) system.*

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 can do 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. Providers who are already enrolled do not need to take any action regarding their designation at this time.

The fiscal agent:

- Rejects all claims not payable under Texas Medicaid Program 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.

5.1.2 Prior Authorization Requests Through the TMHP Website

Providers can submit prior authorization requests for the following services on the TMHP website.

Home Health:

- Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies.
- Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy.
- Medicaid Certificate of Necessity for Chest Physiotherapy Device.
- Statement for Initial Wound Therapy System In-Home Use.
- Statement for Recertification of Wound Therapy System In-Home Use.
- Wheelchair/Scooter/Stroller Seating Assessment (THSteps-CCP/Home Health Services).
- Home Health Services Plan of Care (POC).

Primary Care Case Management (PCCM):

- Primary Care Case Management (PCCM) Inpatient/Outpatient Authorization.

Comprehensive Care Inpatient Psychiatric (CCIP):

- Psychiatric Hospital Initial Admission Request.
- Psychiatric Inpatient Extended Stay Request.

Comprehensive Care Program (CCP):

- THSteps-CCP ECI Request for Initial/Renewal Outpatient Therapy
- Request for Initial Outpatient Therapy.
- Request for Extension of Outpatient Therapy.
- Donor Human Milk Request.
- Pulse Oximeter.
- Wheelchair/Scooter/Stroller Seating Assessment (THSteps-CCP/Home Health Services).
- Texas Medicaid Palivizumab (*Synagis*) Prior Authorization Request.
- THSteps-CCP Prior Authorizations Request:
  - Apnea Monitor.
  - Bed/Crib.
  - Formula.
  - Total Parenteral Nutrition (TPN)/Hyperalimentation.
  - Private Duty Nursing.
  - Miscellaneous.

Ambulance:

- Short-Term (1 to 60 days).
- Long-Term (180 days).

Special Medical Prior Authorizations (SMPA):

- Extended Outpatient Psychotherapy/Request.

Links to these new online functions are available from the *"I would like to..."* links located on the right-hand side of homepage at www.tmhp.com. Select **Submit a prior authorization request** to submit a new request or **Search for/extend an existing prior authorization** to check the status of or extend an authorization request that was previously submitted through the TMHP website.

The benefits of submitting authorizations on the TMHP website include:

- Online editing to ensure that the required information is submitted correctly.
- The authorization number is issued within seconds of submission and confirms that the authorization request was accepted. Providers must still check the status of authorization requests before they provide services to determine whether the authorization was approved or denied.
- Notification of approvals and denials is available more quickly.
- Online authorization requests, extensions, and status checks can be performed at the provider's convenience.

Instructions for submitting authorization requests on the TMHP website are located in the Help section at the bottom of the Prior Authorization page.

Prior authorizations that are submitted online will be processed using the same guidelines as authorizations submitted through existing channels, such as on paper, via fax, or by telephone.

Document Requirements and Retention

If the information provided in the online request is insufficient to support medical necessity, TMHP Prior Authorization staff may request providers to submit additional paper documentation to support the medical necessity of the service or services being requested for authorization.

Submission of prior authorization requests on the secure pages of the TMHP website does not replace adherence to and completion of the paper forms/documentation requirements outlined in the TMPPM and other publications.

Documentation requirements include, but are not limited to:

- Completion and retention in the client's medical record of all required prior authorization forms (TMPPM, Appendix B) and documentation supporting medical necessity of the service requested.
- Adherence to signature and date requirements for prior authorization forms and other required forms maintained in the client record. This includes:
  - Completion and signatures prior to requesting the authorization online.
  - Original handwritten signatures; computerized or stamped signatures are not accepted by the Texas Medicaid Program.

In addition, the printed copy of the Online Request Form must be maintained in the client's medical record.

Any mandatory requirement not present in the client's medical record subjects the associated services to recoupment.

Refer to: "General Medical Record Documentation Requirements" on page 1-11 for further information.

Providers are required to register on the website and assign an administrator for each Texas Provider Identifier (TPI) and National Provider Identifier (NPI), if not already assigned. Users configured with administrator rights automatically have permission to submit prior authorization requests. The TPI administrator must assign submission privileges for non-administrator accounts. Billing services and clearinghouses are required to obtain access to protected health care information through the appropriate administrator of each TPI/NPI provider number for which they are contracted to provide services.

Acknowledgement Statement

Before submitting each prior authorization request, the provider and authorization request submitter must read, understand, and agree to the certification and terms and conditions of the prior authorization request.

The provider and authorization request submitter are both held accountable for their declarations when they acknowledge their agreement and consent. They

acknowledge consent by checking the "We Agree" checkbox after reviewing the certification and terms and conditions.

Certification Statement:

> "The Provider and Authorization Request Submitter certify that the information supplied on the prior authorization form and any attachments or accompanying information constitute true, correct, and complete information. The Provider and Authorization Request Submitter understand that payment of claims related to this prior authorization will be from Federal and State funds, and that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and/or state law. Fraud is a felony, which can result in fines or imprisonment."
>
> "By checking 'We Agree' you agree and consent to the Certification above and to the TMHP 'Terms and Conditions.'"

Terms and Conditions:

> "I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the States Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or U.S. Dept. of Health and Human Services may request. I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge. I certify that the services listed above are/were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction."
>
> "Notice: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim, based on information provided on the Prior Authorization form, will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State law."

Failure to provide true and accurate information, omit information, or provide notice of changes to the information previously provided may result in termination of the provider's Medicaid enrollment and/or personal exclusion from the Texas Medicaid Program.

5.1.3 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 filed 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, TDHconnect, or a third party vendor. The proceeding claim filing instructions in this manual apply to paper and electronic submitters. Although the examples of claims filing instructions refer to their inclusion on the paper claim form, claim data requirements apply to all claim submissions, regardless of the media. Claims must contain the provider's complete name, address, and provider identifier to avoid unnecessary delays in processing and payment.

Note: *Providers rendering services to State of Texas Access Reform (STAR) and STAR+PLUS Program members must file claims and encounters with the appropriate health plan using the health plan's guidelines.*

Exception: *File Primary Care Case Management (PCCM) claims with TMHP.*

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for instructions on accessing the TMHP website and filing electronically and "Medicaid Managed Care" on page 7-4.

5.1.3.1 Quick Tips on Expediting Paper Claims

Using the guidelines in the *Do* table *enhances* the accuracy and timeliness of paper claims processing:

Do
Use original claim forms.
Use black ink (not a black marker).
Print claim data within the defined boxes on the claim form.
Use all capital letters.
Use a laser printer for best results.
Use paper clips on claims or appeals if they include attachments.
Detach claims at perforated lines before mailing.
Use 10x13 inch envelopes to mail claims.
Use the TMHP Standardized Medicare Remittance Advice Notice (MRAN) form, or an MRAN printed from Medicare Remit Easy Print (MREP) (professional services) or PC-Print (institutional services) when sending the Remittance Advice from Medicare.
Submit a claim form with all MRANs and R&Ss.
Place the claim form on top when sending new claims, followed by any medical records or attachments.
Number the pages appropriately when sending attachments, (e.g., 1 of 2, 2 of 2).
Indicate continuation when multiple claims for the same client.
Circle one claim per R&S report page when appealing a claim. Place the R&S report page on top of the appeal.
Use only approved standard forms.

Conversely, the items in the *Do Not* table *delay* paper claims processing:

Do Not
Use copies of claim forms.
Use red ink or highlighters.
Use dashes or slashed in date fields.
Use fonts smaller than 8 points.
Use a dot matrix printer, if possible.
Use labels, stickers or stamps.
Use glue, tape, or staples.
Fold claim forms, appeals or correspondence.
Send duplicate copies of information.
Use paper smaller or larger than 8 ½ x 11. Scan equipment will accept 8 ½ x 11 paper.
Mail claims with correspondence for other departments, this may delay claims processing.
Total each claim form when the claim is a continuation of multiple claims for the same client.
Print claim data outside of claim form field boxes.

5.1.4 Claims Filing Deadlines

For questions or assistance about the Texas Medicaid Program, call the TMHP Contact Center at 1-800-925-9126.

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 the Texas Medicaid Program does not provide coverage for late claims.

Exception: *The Texas Administrative Code (TAC) allows HHSC to consider exceptions to the 95-day filing deadline under special circumstances. Unless otherwise stated below, claims must be received by TMHP within 95 days from each date of service (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 2008:

Date	Holiday
January 1, 2008	New Year's Day
January 21, 2008	Martin Luther King, Jr. Day
February 18, 2008	President's Day
May 26, 2008	Memorial Day
July 4, 2008	Independence Day
September 1, 2008	Labor Day
October 13, 2008*	Columbus Day
November 11, 2008	Veteran's Day
November 27, 2008	Thanksgiving Day
November 28, 2008	Day After Thanksgiving
December 24, 2008	Christmas Eve
December 25, 2008	Christmas Day
December 26, 2008	Day After Christmas

* Columbus Day is a 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 filed by the hospital must be received by TMHP within 95 days from the discharge date or last DOS on the claim.
- Hospitals 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 younger than 21 years of age.
- Children's hospitals 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. Claims submitted by newly enrolled providers must be received within 95 days of the date the new provider identifier is issued, and within 365 days of the DOS.
- 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. 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*.

Important: *Providers should request and keep copies of any Forms 1027 and H3087 submitted by clients. A copy is required during the appeal process if the client's eligibility becomes an issue.*

- If a client becomes retroactively eligible or loses Medicaid eligibility and is later determined to be eligible, the 95-day filing deadline begins on the date that the eligibility start date was added to TMHP files (the add date).
- 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 submit the TMHP Standardized MRAN Form or the computer-generated MRANs from the Centers for Medicare & Medicaid Services (CMS)-approved software application Medicare Remit Easy Print (MREP) for professional services or PC-Print for institutional services with a completed claim form to TMHP.

- 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 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 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 and/or 120-filing deadline. For this, the provider must provide the following: certification receipt, log to include information in the packet, Medicaid number, billed amount, and a signed claim copy. The provider needs to keep such proof about multiple claims submissions if the provider identifier is pending.*

- If the provider is trying 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. 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 the Texas Medicaid Program.

Refer to: "Third Party Resources (TPR)" on page 4-14 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 federal 365-day filing requirement must still be met.
- A C21 process allows a Title V, X, or XX 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 Title V, X, or XX. In this instance, the Medicaid 95-day filing deadline is in effect and must be met or the claim will be denied.

Note: *In accordance with federal regulations, all claims must be initially filed with TMHP within 365 days of the DOS.*

Refer to: "Claims Filing Instructions" on page 5-6 for more information.

"Provider Enrollment" on page 1-2 for information on the provider enrollment process.

"Appeal Methods" on page 6-2 for information on the process for submitting appeals.

"Exceptions to the 95-Day Filing Deadline" on page 5-8.

"Automated Inquiry System (AIS)" on page xiii to learn how to retrieve client eligibility information by telephone.

"Third Party Resources (TPR)" on page 4-14.

"Eligibility Verification" on page 4-4.

"Provider Inquiries—Status of Claims" on page 5-75.

5.1.4.1 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 Contract Management.

HHSC Claims Administrator Contract Management makes the final decision about whether claims fall within one of the exceptions to the 95-day filing deadline. Only providers can submit exception requests. Requests from billing companies, vendors, or clearinghouses are not accepted unless accompanied by a signed authorization from the provider (with each appeal). Without provider authorization, these requests are returned without further action.

HHSC considers exceptions only when one of the following situations exists. The provider must submit an affidavit or statement and any additional information identifying details of cause for the delay, the exception being requested, and verification that the delay was not caused by neglect, indifference, or lack of diligence of the provider or the provider's employee or agent. The person who knows the facts must make the affidavit or statement.

HHSC Claims Administrator Contract Management determines if the claim falls within one of the following exceptions:

1) Catastrophic event that substantially interferes with normal business operations of the provider, or damage or destruction of the provider's business office or records by a natural disaster, including but not limited to fire, flood, or earthquake; or damage or destruction of the provider's business office or records by circumstances that are clearly beyond the provider's control including, but not limited to, criminal activity. The damage or destruction of business records or criminal activity exception does not apply to any negligent or intentional act of an employee or agent of the provider because these people are presumed to be within the provider's control. The presumption can be rebutted only when the intentional acts of the employee or agent leads to termination of employment and filing of criminal charges against the employee or agent.

Providers requesting an exception based on exception (1) must submit independent evidence of insurable loss claims; medical, accident, or death records; or police or fire report substantiating the exception of damage, destruction, or criminal activity.

2) Delay or error in the eligibility determination of a client or delay because of erroneous written information from the department, another state agency, or health insuring agent.

   Providers requesting an exception based on exception (2) must submit the written document from HHSC or its designee that contains the erroneous information or explanation of the delayed information.

3) Delay because of electronic claim or system implementation problems.

   Providers requesting an exception based on exception (3) must submit the written repair statement, invoice, computer or modem-generated error report (indicating attempts to transmit the data failed for reasons outside the control of the provider), or the explanation for the system implementation problems. The documentation must include a detailed explanation made by the person making the repairs or installing the system specifically indicating the relationship and impact of the computer problem or system implementation to claims submission, and a detailed statement explaining why alternative billing procedures were not initiated after the delay in repairs or system implementation was known.

4) Submission of claims within the 365-day federal filing deadline when services are authorized retroactively.

   Providers requesting an exception based on exception (4) must submit a written, detailed explanation of the facts and documentation to demonstrate the 365-day federal filing deadline was met.

5) Client eligibility is determined retroactively and the provider is not notified of retroactive coverage.

   Providers requesting an exception based on exception (5) must include a written, detailed explanation of the facts and activities illustrating the provider's efforts in requesting eligibility information for the client. The explanation must contain dates, contact information, and any responses from the client.

Exception requests must be submitted in writing to the following address:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code-91X
PO Box 204077
Austin, TX 78720-4077

Note: *HHSC will only consider exceptions to the 95-day filing deadline for claims that were submitted within the 365-day federal filing deadline from the date of service as outlined in 1 TAC §354.1003.*

5.1.4.2 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: "Claims Filing Instructions" on page 5-20.

Hospitals appealing final technical denials, admission denials, DRG changes, continued-stay denials, or cost/day outlier denials refer to "Appeals" on page 6-1 for complete appeal information.

5.1.4.3 Claims with Incomplete Information and Zero Paid Claims

Claims listed on the Remittance and Status (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 process faster than appeals. Claims can be resubmitted past the 95-day deadline as new day claims if the following fields have not changed:

- Provider identifiers.
- Client Medicaid number.
- Dates of service.
- Total billed amount.

All other appeal guidelines remain unchanged.

5.1.4.4 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 from the DOS.

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

Electronic billers notify TMHP about missing claims when:

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

5.1.5 HHSC Payment Deadline

Payment deadline rules, as defined by HHSC, affect all providers with the exception of LTC and Family Planning Titles V, X, and XX.

The new HHSC payment deadline rules for the fiscal agent arrangement ensure that state and federal financial requirements are met. TMHP is required to finalize and/or pay claims, within a determined time frame (see table below), based on provider, claim, or eligibility type.

The following table describes the new payment deadline rules:

Type	Description
All Providers	Medicaid/CSHCN payments, excluding crossovers, cannot be made after 24 months from each DOS on the claim (discharge date for inpatient claims.)
Refugee Clients	The payable period for all refugee Medicaid payments is the federal fiscal year (October-September) in which each DOS (discharge date for inpatient claims) occurs plus 1 additional federal fiscal year.
Medicaid Crossover Claims	The crossover file create date is the date in which the file is received by Medicaid. The state has 24 months from the create date to pay the crossover claim. For paper submissions, the state has 24 months from the Medicare disposition date to pay a crossover claim.
Retroactive SSI Eligibility (clients)	The payment deadline is derived from the client's eligibility "add date"; to allow 24 months from the add date for the retroactive Supplemental Security Income (SSI)-eligible client.
County Indigent SSI Eligibility (clients)	The payment deadline is derived from the client's eligibility add date; to allow 24 months from the add date to pay the claim.

Claims and appeals 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 "Paper Appeals" on page 6-3 for instructions. All appeals of OIG recoupments must be submitted by paper, no electronic or telephone appeals will be accepted.*

5.1.5.1 Filing Deadline Calendar for 2007

Note: *If the 95th or 120th day falls on a weekend or holiday, the filing or appeal deadline is extended to the next business day.*

Date of Service or Disposition	95 Days	120 Days
01/01 (001)	**04/06** (096)	**05/01** (121)
01/02 (002)	**04/09** (099)	**05/02** (122)
01/03 (003)	**04/09** (099)	**05/03** (123)
01/04 (004)	**04/09** (099)	**05/04** (124)
01/05 (005)	**04/10** (100)	**05/07** (127)
01/06 (006)	**04/11** (101)	**05/07** (127)
01/07 (007)	**04/12** (102)	**05/07** (127)
01/08 (008)	**04/13** (103)	**05/08** (128)
01/09 (009)	**04/16** (106)	**05/09** (129)
01/10 (010)	**04/16** (106)	**05/10** (130)
01/11 (011)	**04/16** (106)	**05/11** (131)
01/12 (012)	**04/17** (107)	**05/14** (134)
01/13 (013)	**04/18** (108)	**05/14** (134)
01/14 (014)	**04/19** (109)	**05/14** (134)
01/15 (015)	**04/20** (110)	**05/15** (135)
01/16 (016)	**04/23** (113)	**05/16** (136)
01/17 (017)	**04/23** (113)	**05/17** (137)
01/18 (018)	**04/23** (113)	**05/18** (138)
01/19 (019)	**04/24** (114)	**05/21** (141)
01/20 (020)	**04/25** (115)	**05/21** (141)
01/21 (021)	**04/26** (116)	**05/21** (141)
01/22 (022)	**04/27** (117)	**05/22** (142)
01/23 (023)	**04/30** (120)	**05/23** (143)
01/24 (024)	**04/30** (120)	**05/24** (144)
01/25 (025)	**04/30** (120)	**05/25** (145)
01/26 (026)	**05/01** (121)	**05/29** (149)
01/27 (027)	**05/02** (122)	**05/29** (149)
01/28 (028)	**05/03** (123)	**05/29** (149)
01/29 (029)	**05/04** (124)	**05/29** (149)
01/30 (030)	**05/07** (127)	**05/30** (150)
01/31 (031)	**05/07** (127)	**05/31** (151)
02/01 (032)	**05/07** (127)	**06/01** (152)
02/02 (033)	**05/08** (128)	**06/04** (155)
02/03 (034)	**05/09** (129)	**06/04** (155)
02/04 (035)	**05/10** (130)	**06/04** (155)
02/05 (036)	**05/11** (131)	**06/05** (156)
02/06 (037)	**05/14** (134)	**06/06** (157)
02/07 (038)	**05/14** (134)	**06/07** (158)
02/08 (039)	**05/14** (134)	**06/08** (159)
02/09 (040)	**05/15** (135)	**06/11** (162)
02/10 (041)	**05/16** (136)	**06/11** (162)
02/11 (042)	**05/17** (137)	**06/11** (162)
02/12 (043)	**05/18** (138)	**06/12** (163)
02/13 (044)	**05/21** (141)	**06/13** (164)
02/14 (045)	**05/21** (141)	**06/14** (165)
02/15 (046)	**05/21** (141)	**06/15** (166)
02/16 (047)	**05/22** (142)	**06/18** (169)
02/17 (048)	**05/23** (143)	**06/18** (169)
02/18 (049)	**05/24** (144)	**06/18** (169)
02/19 (050)	**05/25** (145)	**06/19** (170)
02/20 (051)	**05/29** (149)	**06/20** (171)
02/21 (052)	**05/29** (149)	**06/21** (172)
02/22 (053)	**05/29** (149)	**06/22** (173)
02/23 (054)	**05/29** (149)	**06/25** (176)
02/24 (055)	**05/30** (150)	**06/25** (176)
02/25 (056)	**05/31** (151)	**06/25** (176)
02/26 (057)	**06/01** (152)	**06/26** (177)
02/27 (058)	**06/04** (155)	**06/27** (178)
02/28 (059)	**06/04** (155)	**06/28** (179)
03/01 (060)	**06/04** (155)	**06/29** (180)
03/02 (061)	**06/05** (156)	**07/02** (183)
03/03 (062)	**06/06** (157)	**07/02** (183)
03/04 (063)	**06/07** (158)	**07/02** (183)
03/05 (064)	**06/08** (159)	**07/03** (184)
03/06 (065)	**06/11** (162)	**07/05** (186)
03/07 (066)	**06/11** (162)	**07/05** (186)
03/08 (067)	**06/11** (162)	**07/06** (187)
03/09 (068)	**06/12** (163)	**07/09** (190)
03/10 (069)	**06/13** (164)	**07/09** (190)
03/11 (070)	**06/14** (165)	**07/09** (190)
03/12 (071)	**06/15** (166)	**07/10** (191)
03/13 (072)	**06/18** (169)	**07/11** (192)
03/14 (073)	**06/18** (169)	**07/12** (193)
03/15 (074)	**06/18** (169)	**07/13** (194)
03/16 (075)	**06/19** (170)	**07/16** (197)
03/17 (076)	**06/20** (171)	**07/16** (197)
03/18 (077)	**06/21** (172)	**07/16** (197)
03/19 (078)	**06/22** (173)	**07/17** (198)
03/20 (079)	**06/25** (176)	**07/18** (199)
03/21 (080)	**06/25** (176)	**07/19** (200)
03/22 (081)	**06/25** (176)	**07/20** (201)
03/23 (082)	**06/26** (177)	**07/23** (204)
03/24 (083)	**06/27** (178)	**07/23** (204)
03/25 (084)	**06/28** (179)	**07/23** (204)
03/26 (085)	**06/29** (180)	**07/24** (205)
03/27 (086)	**07/02** (183)	**07/25** (206)
03/28 (087)	**07/02** (183)	**07/26** (207)
03/29 (088)	**07/02** (183)	**07/27** (208)
03/30 (089)	**07/03** (184)	**07/30** (211)
03/31 (090)	**07/05** (186)	**07/30** (211)
04/01 (091)	**07/05** (186)	**07/30** (211)
04/02 (092)	**07/06** (187)	**07/31** (212)
04/03 (093)	**07/09** (190)	**08/01** (213)
04/04 (094)	**07/09** (190)	**08/02** (214)
04/05 (095)	**07/09** (190)	**08/03** (215)
04/06 (096)	**07/10** (191)	**08/06** (218)
04/07 (097)	**07/11** (192)	**08/06** (218)
04/08 (098)	**07/12** (193)	**08/06** (218)
04/09 (099)	**07/13** (194)	**08/07** (219)
04/10 (100)	**07/16** (197)	**08/08** (220)
04/11 (101)	**07/16** (197)	**08/09** (221)
04/12 (102)	**07/16** (197)	**08/10** (222)
04/13 (103)	**07/17** (198)	**08/13** (225)
04/14 (104)	**07/18** (199)	**08/13** (225)
04/15 (105)	**07/19** (200)	**08/13** (225)
04/16 (106)	**07/20** (201)	**08/14** (226)
04/17 (107)	**07/23** (204)	**08/15** (227)
04/18 (108)	**07/23** (204)	**08/16** (228)
04/19 (109)	**07/23** (204)	**08/17** (229)
04/20 (110)	**07/24** (205)	**08/20** (232)
04/21 (111)	**07/25** (206)	**08/20** (232)
04/22 (112)	**07/26** (207)	**08/20** (232)
04/23 (113)	**07/27** (208)	**08/21** (233)
04/24 (114)	**07/30** (211)	**08/22** (234)
04/25 (115)	**07/30** (211)	**08/23** (235)
04/26 (116)	**07/30** (211)	**08/24** (236)
04/27 (117)	**07/31** (212)	**08/27** (239)
04/28 (118)	**08/01** (213)	**08/27** (239)
04/29 (119)	**08/02** (214)	**08/27** (239)
04/30 (120)	**08/03** (215)	**08/28** (240)
05/01 (121)	**08/06** (218)	**08/29** (241)
05/02 (122)	**08/06** (218)	**08/30** (242)
05/03 (123)	**08/06** (218)	**08/31** (243)
05/04 (124)	**08/07** (219)	**09/04** (247)
05/05 (125)	**08/08** (220)	**09/04** (247)
05/06 (126)	**08/09** (221)	**09/04** (247)
05/07 (127)	**08/10** (222)	**09/04** (247)
05/08 (128)	**08/13** (225)	**09/05** (248)
05/09 (129)	**08/13** (225)	**09/06** (249)
05/10 (130)	**08/13** (225)	**09/07** (250)
05/11 (131)	**08/14** (226)	**09/10** (253)
05/12 (132)	**08/15** (227)	**09/10** (253)
05/13 (133)	**08/16** (228)	**09/10** (253)
05/14 (134)	**08/17** (229)	**09/11** (254)
05/15 (135)	**08/20** (232)	**09/12** (255)
05/16 (136)	**08/20** (232)	**09/13** (256)
05/17 (137)	**08/20** (232)	**09/14** (257)
05/18 (138)	**08/21** (233)	**09/17** (260)
05/19 (139)	**08/22** (234)	**09/17** (260)
05/20 (140)	**08/23** (235)	**09/17** (260)
05/21 (141)	**08/24** (236)	**09/18** (261)
05/22 (142)	**08/27** (239)	**09/19** (262)
05/23 (143)	**08/27** (239)	**09/20** (263)
05/24 (144)	**08/27** (239)	**09/21** (264)
05/25 (145)	**08/28** (240)	**09/24** (267)
05/26 (146)	**08/29** (241)	**09/24** (267)
05/27 (147)	**08/30** (242)	**09/24** (267)
05/28 (148)	**08/31** (243)	**09/25** (268)
05/29 (149)	**09/04** (247)	**09/26** (269)
05/30 (150)	**09/04** (247)	**09/27** (270)
05/31 (151)	**09/04** (247)	**09/28** (271)
06/01 (152)	**09/04** (247)	**10/01** (274)
06/02 (153)	**09/05** (248)	**10/01** (274)
06/03 (154)	**09/06** (249)	**10/01** (274)
06/04 (155)	**09/07** (250)	**10/02** (275)
06/05 (156)	**09/10** (253)	**10/03** (276)
06/06 (157)	**09/10** (253)	**10/04** (277)
06/07 (158)	**09/10** (253)	**10/05** (278)
06/08 (159)	**09/11** (254)	**10/09** (282)
06/09 (160)	**09/12** (255)	**10/09** (282)
06/10 (161)	**09/13** (256)	**10/09** (282)
06/11 (162)	**09/14** (257)	**10/09** (282)
06/12 (163)	**09/17** (260)	**10/10** (283)
06/13 (164)	**09/17** (260)	**10/11** (284)
06/14 (165)	**09/17** (260)	**10/12** (285)
06/15 (166)	**09/18** (261)	**10/15** (288)
06/16 (167)	**09/19** (262)	**10/15** (288)
06/17 (168)	**09/20** (263)	**10/15** (288)
06/18 (169)	**09/21** (264)	**10/16** (289)
06/19 (170)	**09/24** (267)	**10/17** (290)
06/20 (171)	**09/24** (267)	**10/18** (291)
06/21 (172)	**09/24** (267)	**10/19** (292)
06/22 (173)	**09/25** (268)	**10/22** (295)
06/23 (174)	**09/26** (269)	**10/22** (295)
06/24 (175)	**09/27** (270)	**10/22** (295)
06/25 (176)	**09/28** (271)	**10/23** (296)
06/26 (177)	**10/01** (274)	**10/24** (297)
06/27 (178)	**10/01** (274)	**10/25** (298)
06/28 (179)	**10/01** (274)	**10/26** (299)
06/29 (180)	**10/02** (275)	**10/29** (302)
06/30 (181)	**10/03** (276)	**10/29** (302)
07/01 (182)	**10/04** (277)	**10/29** (302)
07/02 (183)	**10/05** (278)	**10/30** (303)
07/03 (184)	**10/09** (282)	**10/31** (304)
07/04 (185)	**10/09** (282)	**11/01** (305)
07/05 (186)	**10/09** (282)	**11/02** (306)
07/06 (187)	**10/09** (282)	**11/05** (309)
07/07 (188)	**10/10** (283)	**11/05** (309)
07/08 (189)	**10/11** (284)	**11/05** (309)
07/09 (190)	**10/12** (285)	**11/06** (310)
07/10 (191)	**10/15** (288)	**11/07** (311)
07/11 (192)	**10/15** (288)	**11/08** (312)
07/12 (193)	**10/15** (288)	**11/09** (313)
07/13 (194)	**10/16** (289)	**11/12** (316)
07/14 (195)	**10/17** (290)	**11/12** (316)
07/15 (196)	**10/18** (291)	**11/12** (316)
07/16 (197)	**10/19** (292)	**11/13** (317)
07/17 (198)	**10/22** (295)	**11/14** (318)
07/18 (199)	**10/22** (295)	**11/15** (319)
07/19 (200)	**10/22** (295)	**11/16** (320)
07/20 (201)	**10/22** (295)	**11/16** (320)
07/21 (202)	**10/24** (297)	**11/19** (323)
07/22 (203)	**10/25** (298)	**11/19** (323)
07/23 (204)	**10/26** (299)	**11/20** (324)
07/24 (205)	**10/29** (302)	**11/21** (325)
07/25 (206)	**10/29** (302)	**11/26** (330)
07/26 (207)	**10/29** (302)	**11/26** (330)
07/27 (208)	**10/30** (303)	**11/26** (330)
07/28 (209)	**10/31** (304)	**11/26** (330)
07/29 (210)	**11/01** (305)	**11/26** (330)
07/30 (211)	**11/02** (306)	**11/27** (331)
07/31 (212)	**11/05** (309)	**11/28** (332)
08/01 (213)	**11/05** (309)	**11/29** (333)
08/02 (214)	**11/05** (309)	**11/30** (334)
08/03 (215)	**11/06** (310)	**12/03** (337)
08/04 (216)	**11/07** (311)	**12/03** (337)
08/05 (217)	**11/08** (312)	**12/03** (337)
08/06 (218)	**11/09** (313)	**12/04** (338)
08/07 (219)	**11/12** (316)	**12/05** (339)
08/08 (220)	**11/12** (316)	**12/06** (340)
08/09 (221)	**11/12** (316)	**12/07** (341)
08/10 (222)	**11/13** (317)	**12/10** (344)
08/11 (223)	**11/14** (318)	**12/10** (344)
08/12 (224)	**11/15** (319)	**12/10** (344)
08/13 (225)	**11/16** (320)	**12/11** (345)
08/14 (226)	**11/19** (323)	**12/12** (346)
08/15 (227)	**11/19** (323)	**12/13** (347)
08/16 (228)	**11/19** (323)	**12/14** (348)
08/17 (229)	**11/20** (324)	**12/17** (351)
08/18 (230)	**11/21** (325)	**12/17** (351)
08/19 (231)	**11/26** (330)	**12/17** (351)
08/20 (232)	**11/26** (330)	**12/18** (352)
08/21 (233)	**11/26** (330)	**12/19** (353)
08/22 (234)	**11/26** (330)	**12/20** (354)
08/23 (235)	**11/26** (330)	**12/21** (355)
08/24 (236)	**11/27** (331)	**12/27** (361)
08/25 (237)	**11/28** (332)	**12/27** (361)
08/26 (238)	**11/29** (333)	**12/27** (361)
08/27 (239)	**11/30** (334)	**12/27** (361)
08/28 (240)	**12/03** (337)	**12/27** (361)
08/29 (241)	**12/03** (337)	**12/27** (361)
08/30 (242)	**12/03** (337)	**12/28** (362)
08/31 (243)	**12/04** (338)	**12/31** (365)
09/01 (244)	**12/05** (339)	**12/31** (365)
09/02 (245)	**12/06** (340)	**12/31** (365)
09/03 (246)	**12/07** (341)	**01/02** (002)
09/04 (247)	**12/10** (344)	**01/02** (002)
09/05 (248)	**12/10** (344)	**01/03** (003)
09/06 (249)	**12/10** (344)	**01/04** (004)
09/07 (250)	**12/11** (345)	**01/07** (007)
09/08 (251)	**12/12** (346)	**01/07** (007)
09/09 (252)	**12/13** (347)	**01/07** (007)
09/10 (253)	**12/14** (348)	**01/08** (008)
09/11 (254)	**12/17** (351)	**01/09** (009)
09/12 (255)	**12/17** (351)	**01/10** (010)
09/13 (256)	**12/17** (351)	**01/11** (011)
09/14 (257)	**12/18** (352)	**01/14** (014)
09/15 (258)	**12/19** (353)	**01/14** (014)
09/16 (259)	**12/20** (354)	**01/14** (014)
09/17 (260)	**12/21** (355)	**01/15** (015)
09/18 (261)	**12/27** (361)	**01/16** (016)
09/19 (262)	**12/27** (361)	**01/17** (017)
09/20 (263)	**12/27** (361)	**01/18** (018)
09/21 (264)	**12/27** (361)	**01/22** (022)
09/22 (265)	**12/27** (361)	**01/22** (022)
09/23 (266)	**12/27** (361)	**01/22** (022)
09/24 (267)	**12/28** (362)	**01/22** (022)
09/25 (268)	**12/31** (365)	**01/23** (023)
09/26 (269)	**12/31** (365)	**01/24** (024)
09/27 (270)	**12/31** (365)	**01/25** (025)
09/28 (271)	**01/02** (002)	**01/28** (028)
09/29 (272)	**01/02** (002)	**01/28** (028)
09/30 (273)	**01/03** (003)	**01/28** (028)
10/01 (274)	**01/04** (004)	**01/29** (029)
10/02 (275)	**01/07** (007)	**01/30** (030)
10/03 (276)	**01/07** (007)	**01/31** (031)
10/04 (277)	**01/07** (007)	**02/01** (032)
10/05 (278)	**01/08** (008)	**02/04** (035)
10/06 (279)	**01/09** (009)	**02/04** (035)
10/07 (280)	**01/10** (010)	**02/04** (035)
10/08 (281)	**01/11** (011)	**02/05** (036)
10/09 (282)	**01/14** (014)	**02/06** (037)
10/10 (283)	**01/14** (014)	**02/07** (038)
10/11 (284)	**01/14** (014)	**02/08** (039)
10/12 (285)	**01/15** (015)	**02/11** (042)
10/13 (286)	**01/16** (016)	**02/11** (042)
10/14 (287)	**01/17** (017)	**02/11** (042)
10/15 (288)	**01/18** (018)	**02/12** (043)
10/16 (289)	**01/22** (022)	**02/13** (044)
10/17 (290)	**01/22** (022)	**02/14** (045)
10/18 (291)	**01/22** (022)	**02/15** (046)
10/19 (292)	**01/22** (022)	**02/19** (050)
10/20 (293)	**01/23** (023)	**02/19** (050)
10/21 (294)	**01/24** (024)	**02/19** (050)
10/22 (295)	**01/25** (025)	**02/19** (050)
10/23 (296)	**01/28** (028)	**02/20** (051)
10/24 (297)	**01/28** (028)	**02/21** (052)
10/25 (298)	**01/28** (028)	**02/22** (053)
10/26 (299)	**01/29** (029)	**02/25** (056)
10/27 (300)	**01/30** (030)	**02/25** (056)
10/28 (301)	**01/31** (031)	**02/25** (056)
10/29 (302)	**02/01** (032)	**02/26** (057)
10/30 (303)	**02/04** (035)	**02/27** (058)
10/31 (304)	**02/04** (035)	**02/28** (059)
11/01 (305)	**02/04** (035)	**02/29** (060)
11/02 (306)	**02/05** (036)	**03/03** (063)
11/03 (307)	**02/06** (037)	**03/03** (063)
11/04 (308)	**02/07** (038)	**03/03** (063)
11/05 (309)	**02/08** (039)	**03/04** (064)
11/06 (310)	**02/11** (042)	**03/05** (065)
11/07 (311)	**02/11** (042)	**03/06** (066)
11/08 (312)	**02/11** (042)	**03/07** (067)
11/09 (313)	**02/12** (043)	**03/10** (070)
11/10 (314)	**02/13** (044)	**03/10** (070)
11/11 (315)	**02/14** (045)	**03/10** (070)
11/12 (316)	**02/15** (046)	**03/11** (071)
11/13 (317)	**02/19** (050)	**03/12** (072)
11/14 (318)	**02/19** (050)	**03/13** (073)
11/15 (319)	**02/19** (050)	**03/14** (074)
11/16 (320)	**02/19** (050)	**03/17** (077)
11/17 (321)	**02/20** (051)	**03/17** (077)
11/18 (322)	**02/21** (052)	**03/17** (077)
11/19 (323)	**02/22** (053)	**03/18** (078)
11/20 (324)	**02/25** (056)	**03/19** (079)
11/21 (325)	**02/25** (056)	**03/20** (080)
11/22 (326)	**02/25** (056)	**03/21** (081)
11/23 (327)	**02/26** (057)	**03/24** (084)
11/24 (328)	**02/27** (058)	**03/24** (084)
11/25 (329)	**02/28** (059)	**03/24** (084)
11/26 (330)	**02/29** (060)	**03/25** (085)
11/27 (331)	**03/03** (063)	**03/26** (086)
11/28 (332)	**03/03** (063)	**03/27** (087)
11/29 (333)	**03/03** (063)	**03/28** (088)
11/30 (334)	**03/04** (064)	**03/31** (091)
12/01 (335)	**03/05** (065)	**03/31** (091)
12/02 (336)	**03/06** (066)	**03/31** (091)
12/03 (337)	**03/07** (067)	**04/01** (092)
12/04 (338)	**03/10** (070)	**04/02** (093)
12/05 (339)	**03/10** (070)	**04/03** (094)
12/06 (340)	**03/10** (070)	**04/04** (095)
12/07 (341)	**03/11** (071)	**04/07** (098)
12/08 (342)	**03/12** (072)	**04/07** (098)
12/09 (343)	**03/13** (073)	**04/07** (098)
12/10 (344)	**03/14** (074)	**04/08** (099)
12/11 (345)	**03/17** (077)	**04/09** (100)
12/12 (346)	**03/17** (077)	**04/10** (101)
12/13 (347)	**03/17** (077)	**04/11** (102)
12/14 (348)	**03/18** (078)	**04/14** (105)
12/15 (349)	**03/19** (079)	**04/14** (105)
12/16 (350)	**03/20** (080)	**04/14** (105)
12/17 (351)	**03/21** (081)	**04/15** (106)
12/18 (352)	**03/24** (084)	**04/16** (107)
12/19 (353)	**03/24** (084)	**04/17** (108)
12/20 (354)	**03/24** (084)	**04/18** (109)
12/21 (355)	**03/25** (085)	**04/21** (112)
12/22 (356)	**03/26** (086)	**04/21** (112)
12/23 (357)	**03/27** (087)	**04/21** (112)
12/24 (358)	**03/28** (088)	**04/22** (113)
12/25 (359)	**03/31** (091)	**04/23** (114)
12/26 (360)	**03/31** (091)	**04/24** (115)
12/27 (361)	**03/31** (091)	**04/25** (116)
12/28 (362)	**04/01** (092)	**04/28** (119)
12/29 (363)	**04/02** (093)	**04/28** (119)
12/30 (364)	**04/03** (094)	**04/28** (119)
12/31 (365)	**04/04** (095)	**04/29** (120)
01/01 (001)	**04/07** (098)	**04/30** (121)

5.1.5.2 Filing Deadline Calendar for 2008

Note: *If the 95th or 120th day falls on a weekend or holiday, the filing or appeal deadline is extended to the next business day..*

Date of Service or Disposition	95 Days	120 Days
01/01 (001)	**04/07** (098)	**04/30** (121)
01/02 (002)	**04/07** (098)	**05/01** (122)
01/03 (003)	**04/07** (098)	**05/02** (123)
01/04 (004)	**04/08** (099)	**05/05** (126)
01/05 (005)	**04/09** (100)	**05/05** (126)
01/06 (006)	**04/10** (101)	**05/05** (126)
01/07 (007)	**04/11** (102)	**05/06** (127)
01/08 (008)	**04/14** (105)	**05/07** (128)
01/09 (009)	**04/14** (105)	**05/08** (129)
01/10 (010)	**04/14** (105)	**05/09** (130)
01/11 (011)	**04/15** (106)	**05/12** (133)
01/12 (012)	**04/16** (107)	**05/12** (133)
01/13 (013)	**04/17** (108)	**05/12** (133)
01/14 (014)	**04/18** (109)	**05/13** (134)
01/15 (015)	**04/21** (112)	**05/14** (135)
01/16 (016)	**04/21** (112)	**05/15** (136)
01/17 (017)	**04/21** (112)	**05/16** (137)
01/18 (018)	**04/22** (113)	**05/19** (140)
01/19 (019)	**04/23** (114)	**05/19** (140)
01/20 (020)	**04/24** (115)	**05/19** (140)
01/21 (021)	**04/25** (116)	**05/20** (141)
01/22 (022)	**04/28** (119)	**05/21** (142)
01/23 (023)	**04/28** (119)	**05/22** (143)
01/24 (024)	**04/28** (119)	**05/23** (144)
01/25 (025)	**04/29** (120)	**05/27** (148)
01/26 (026)	**04/30** (121)	**05/27** (148)
01/27 (027)	**05/01** (122)	**05/27** (148)
01/28 (028)	**05/02** (123)	**05/27** (148)
01/29 (029)	**05/05** (126)	**05/28** (149)
01/30 (030)	**05/05** (126)	**05/29** (150)
01/31 (031)	**05/05** (126)	**05/30** (151)
02/01 (032)	**05/06** (127)	**06/02** (154)
02/02 (033)	**05/07** (128)	**06/02** (154)
02/03 (034)	**05/08** (129)	**06/02** (154)
02/04 (035)	**05/09** (130)	**06/03** (155)
02/05 (036)	**05/12** (133)	**06/04** (156)
02/06 (037)	**05/12** (133)	**06/05** (157)
02/07 (038)	**05/12** (133)	**06/06** (158)
02/08 (039)	**05/13** (134)	**06/09** (161)
02/09 (040)	**05/14** (135)	**06/09** (161)
02/10 (041)	**05/15** (136)	**06/09** (161)
02/11 (042)	**05/16** (137)	**06/10** (162)
02/12 (043)	**05/19** (140)	**06/11** (163)
02/13 (044)	**05/19** (140)	**06/12** (164)
02/14 (045)	**05/19** (140)	**06/13** (165)
02/15 (046)	**05/20** (141)	**06/16** (168)
02/16 (047)	**05/21** (142)	**06/16** (168)
02/17 (048)	**05/22** (143)	**06/16** (168)
02/18 (049)	**05/23** (144)	**06/17** (169)
02/19 (050)	**05/27** (148)	**06/18** (170)
02/20 (051)	**05/27** (148)	**06/19** (171)
02/21 (052)	**05/27** (148)	**06/20** (172)
02/22 (053)	**05/27** (148)	**06/23** (175)
02/23 (054)	**05/28** (149)	**06/23** (175)
02/24 (055)	**05/29** (150)	**06/23** (175)
02/25 (056)	**05/30** (151)	**06/24** (176)
02/26 (057)	**06/02** (154)	**06/25** (177)
02/27 (058)	**06/02** (154)	**06/26** (178)
02/28 (059)	**06/02** (154)	**06/27** (179)
02/29 (060)	**06/03** (155)	**06/30** (182)
03/01 (061)	**06/04** (156)	**06/30** (182)
03/02 (062)	**06/05** (157)	**06/30** (182)
03/03 (063)	**06/06** (158)	**07/01** (183)
03/04 (064)	**06/09** (161)	**07/02** (184)
03/05 (065)	**06/09** (161)	**07/03** (185)
03/06 (066)	**06/09** (161)	**07/07** (189)
03/07 (067)	**06/10** (162)	**07/07** (189)
03/08 (068)	**06/11** (163)	**07/07** (189)
03/09 (069)	**06/12** (164)	**07/07** (189)
03/10 (070)	**06/13** (165)	**07/08** (190)
03/11 (071)	**06/16** (168)	**07/09** (191)
03/12 (072)	**06/16** (168)	**07/10** (192)
03/13 (073)	**06/16** (168)	**07/11** (193)
03/14 (074)	**06/17** (169)	**07/14** (196)

Date of Service or Disposition	95 Days	120 Days
03/15 (075)	**06/18** (170)	**07/14** (196)
03/16 (076)	**06/19** (171)	**07/14** (196)
03/17 (077)	**06/20** (172)	**07/15** (197)
03/18 (078)	**06/23** (175)	**07/16** (198)
03/19 (079)	**06/23** (175)	**07/17** (199)
03/20 (080)	**06/23** (175)	**07/18** (200)
03/21 (081)	**06/24** (176)	**07/21** (203)
03/22 (082)	**06/25** (177)	**07/21** (203)
03/23 (083)	**06/26** (178)	**07/21** (203)
03/24 (084)	**06/27** (179)	**07/22** (204)
03/25 (085)	**06/30** (182)	**07/23** (205)
03/26 (086)	**06/30** (182)	**07/24** (206)
03/27 (087)	**06/30** (182)	**07/25** (207)
03/28 (088)	**07/01** (183)	**07/28** (210)
03/29 (089)	**07/02** (184)	**07/28** (210)
03/30 (090)	**07/03** (185)	**07/28** (210)
03/31 (091)	**07/07** (189)	**07/29** (211)
04/01 (092)	**07/07** (189)	**07/30** (212)
04/02 (093)	**07/07** (189)	**07/31** (213)
04/03 (094)	**07/07** (189)	**08/01** (214)
04/04 (095)	**07/08** (190)	**08/04** (217)
04/05 (096)	**07/09** (191)	**08/04** (217)
04/06 (097)	**07/10** (192)	**08/04** (217)
04/07 (098)	**07/11** (193)	**08/05** (218)
04/08 (099)	**07/14** (196)	**08/06** (219)
04/09 (100)	**07/14** (196)	**08/07** (220)
04/10 (101)	**07/14** (196)	**08/08** (221)
04/11 (102)	**07/15** (197)	**08/11** (224)
04/12 (103)	**07/16** (198)	**08/11** (224)
04/13 (104)	**07/17** (199)	**08/11** (224)
04/14 (105)	**07/18** (200)	**08/12** (225)
04/15 (106)	**07/21** (203)	**08/13** (226)
04/16 (107)	**07/21** (203)	**08/14** (227)
04/17 (108)	**07/21** (203)	**08/15** (228)
04/18 (109)	**07/22** (204)	**08/18** (231)
04/19 (110)	**07/23** (205)	**08/18** (231)
04/20 (111)	**07/24** (206)	**08/18** (231)
04/21 (112)	**07/25** (207)	**08/19** (232)
04/22 (113)	**07/28** (210)	**08/20** (233)
04/23 (114)	**07/28** (210)	**08/21** (234)
04/24 (115)	**07/28** (210)	**08/22** (235)
04/25 (116)	**07/29** (211)	**08/25** (238)
04/26 (117)	**07/30** (212)	**08/25** (238)
04/27 (118)	**07/31** (213)	**08/25** (238)
04/28 (119)	**08/01** (214)	**08/26** (239)
04/29 (120)	**08/04** (217)	**08/27** (240)
04/30 (121)	**08/04** (217)	**08/28** (241)
05/01 (122)	**08/04** (217)	**08/29** (242)
05/02 (123)	**08/05** (218)	**09/02** (246)
05/03 (124)	**08/06** (219)	**09/02** (246)
05/04 (125)	**08/07** (220)	**09/02** (246)
05/05 (126)	**08/08** (221)	**09/02** (246)
05/06 (127)	**08/11** (224)	**09/03** (247)
05/07 (128)	**08/11** (224)	**09/04** (248)
05/08 (129)	**08/11** (224)	**09/05** (249)
05/09 (130)	**08/12** (225)	**09/08** (252)
05/10 (131)	**08/13** (226)	**09/08** (252)
05/11 (132)	**08/14** (227)	**09/08** (252)
05/12 (133)	**08/15** (228)	**09/09** (253)
05/13 (134)	**08/18** (231)	**09/10** (254)
05/14 (135)	**08/18** (231)	**09/11** (255)
05/15 (136)	**08/18** (231)	**09/12** (256)
05/16 (137)	**08/19** (232)	**09/15** (259)
05/17 (138)	**08/20** (233)	**09/15** (259)
05/18 (139)	**08/21** (234)	**09/15** (259)
05/19 (140)	**08/22** (235)	**09/16** (260)
05/20 (141)	**08/25** (238)	**09/17** (261)
05/21 (142)	**08/25** (238)	**09/18** (262)
05/22 (143)	**08/25** (238)	**09/19** (263)
05/23 (144)	**08/26** (239)	**09/22** (266)
05/24 (145)	**08/27** (240)	**09/22** (266)
05/25 (146)	**08/28** (241)	**09/22** (266)
05/26 (147)	**08/29** (242)	**09/23** (267)
05/27 (148)	**09/02** (246)	**09/24** (268)

Date of Service or Disposition	95 Days	120 Days
05/28 (149)	**09/02** (246)	**09/25** (269)
05/29 (150)	**09/02** (246)	**09/26** (270)
05/30 (151)	**09/02** (246)	**09/29** (273)
05/31 (152)	**09/03** (247)	**09/29** (273)
06/01 (153)	**09/04** (248)	**09/29** (273)
06/02 (154)	**09/05** (249)	**09/30** (274)
06/03 (155)	**09/08** (252)	**10/01** (275)
06/04 (156)	**09/08** (252)	**10/02** (276)
06/05 (157)	**09/08** (252)	**10/03** (277)
06/06 (158)	**09/09** (253)	**10/06** (280)
06/07 (159)	**09/10** (254)	**10/06** (280)
06/08 (160)	**09/11** (255)	**10/06** (280)
06/09 (161)	**09/12** (256)	**10/07** (281)
06/10 (162)	**09/15** (259)	**10/08** (282)
06/11 (163)	**09/15** (259)	**10/09** (283)
06/12 (164)	**09/15** (259)	**10/10** (284)
06/13 (165)	**09/16** (260)	**10/14** (288)
06/14 (166)	**09/17** (261)	**10/14** (288)
06/15 (167)	**09/18** (262)	**10/14** (288)
06/16 (168)	**09/19** (263)	**10/14** (288)
06/17 (169)	**09/22** (266)	**10/15** (289)
06/18 (170)	**09/22** (266)	**10/16** (290)
06/19 (171)	**09/22** (266)	**10/17** (291)
06/20 (172)	**09/23** (267)	**10/20** (294)
06/21 (173)	**09/24** (268)	**10/20** (294)
06/22 (174)	**09/25** (269)	**10/20** (294)
06/23 (175)	**09/26** (270)	**10/21** (295)
06/24 (176)	**09/29** (273)	**10/22** (296)
06/25 (177)	**09/29** (273)	**10/23** (297)
06/26 (178)	**09/29** (273)	**10/24** (298)
06/27 (179)	**09/30** (274)	**10/27** (301)
06/28 (180)	**10/01** (275)	**10/27** (301)
06/29 (181)	**10/02** (276)	**10/27** (301)
06/30 (182)	**10/03** (277)	**10/28** (302)
07/01 (183)	**10/06** (280)	**10/29** (303)
07/02 (184)	**10/06** (280)	**10/30** (304)
07/03 (185)	**10/06** (280)	**10/31** (305)
07/04 (186)	**10/07** (281)	**11/03** (308)
07/05 (187)	**10/08** (282)	**11/03** (308)
07/06 (188)	**10/09** (283)	**11/03** (308)
07/07 (189)	**10/10** (284)	**11/04** (309)
07/08 (190)	**10/14** (288)	**11/05** (310)
07/09 (191)	**10/14** (288)	**11/06** (311)
07/10 (192)	**10/14** (288)	**11/07** (312)
07/11 (193)	**10/14** (288)	**11/10** (315)
07/12 (194)	**10/15** (289)	**11/10** (315)
07/13 (195)	**10/16** (290)	**11/10** (315)
07/14 (196)	**10/17** (291)	**11/12** (317)
07/15 (197)	**10/20** (294)	**11/12** (317)
07/16 (198)	**10/20** (294)	**11/13** (318)
07/17 (199)	**10/20** (294)	**11/14** (319)
07/18 (200)	**10/21** (295)	**11/17** (322)
07/19 (201)	**10/22** (296)	**11/17** (322)
07/20 (202)	**10/23** (297)	**11/17** (322)
07/21 (203)	**10/24** (298)	**11/18** (323)
07/22 (204)	**10/27** (301)	**11/19** (324)
07/23 (205)	**10/27** (301)	**11/20** (325)
07/24 (206)	**10/27** (301)	**11/21** (326)
07/25 (207)	**10/28** (302)	**11/24** (329)
07/26 (208)	**10/29** (303)	**11/24** (329)
07/27 (209)	**10/30** (304)	**11/24** (329)
07/28 (210)	**10/31** (305)	**11/25** (330)
07/29 (211)	**11/03** (308)	**11/26** (331)
07/30 (212)	**11/03** (308)	**12/01** (336)
07/31 (213)	**11/03** (308)	**12/01** (336)
08/01 (214)	**11/04** (309)	**12/01** (336)
08/02 (215)	**11/05** (310)	**12/01** (336)
08/03 (216)	**11/06** (311)	**12/01** (336)
08/04 (217)	**11/07** (312)	**12/02** (337)
08/05 (218)	**11/10** (315)	**12/03** (338)
08/06 (219)	**11/10** (315)	**12/04** (339)
08/07 (220)	**11/10** (315)	**12/05** (340)
08/08 (221)	**11/12** (317)	**12/08** (343)
08/09 (222)	**11/12** (317)	**12/08** (343)

Date of Service or Disposition	95 Days	120 Days
08/10 (223)	**11/13** (318)	**12/08** (343)
08/11 (224)	**11/14** (319)	**12/09** (344)
08/12 (225)	**11/17** (322)	**12/10** (345)
08/13 (226)	**11/17** (322)	**12/11** (346)
08/14 (227)	**11/17** (322)	**12/12** (347)
08/15 (228)	**11/18** (323)	**12/15** (350)
08/16 (229)	**11/19** (324)	**12/15** (350)
08/17 (230)	**11/20** (325)	**12/15** (350)
08/18 (231)	**11/21** (326)	**12/16** (351)
08/19 (232)	**11/24** (329)	**12/17** (352)
08/20 (233)	**11/24** (329)	**12/18** (353)
08/21 (234)	**11/24** (329)	**12/19** (354)
08/22 (235)	**11/25** (330)	**12/22** (357)
08/23 (236)	**11/26** (331)	**12/22** (357)
08/24 (237)	**12/01** (336)	**12/22** (357)
08/25 (238)	**12/01** (336)	**12/23** (358)
08/26 (239)	**12/01** (336)	**12/29** (364)
08/27 (240)	**12/01** (336)	**12/29** (364)
08/28 (241)	**12/01** (336)	**12/29** (364)
08/29 (242)	**12/02** (337)	**12/29** (364)
08/30 (243)	**12/03** (338)	**12/29** (364)
08/31 (244)	**12/04** (339)	**12/29** (364)
09/01 (245)	**12/05** (340)	**12/30** (365)
09/02 (246)	**12/08** (343)	**12/31** (366)
09/03 (247)	**12/08** (343)	**01/02** (002)
09/04 (248)	**12/08** (343)	**01/02** (002)
09/05 (249)	**12/09** (344)	**01/05** (005)
09/06 (250)	**12/10** (345)	**01/05** (005)
09/07 (251)	**12/11** (346)	**01/05** (005)
09/08 (252)	**12/12** (347)	**01/06** (006)
09/09 (253)	**12/15** (350)	**01/07** (007)
09/10 (254)	**12/15** (350)	**01/08** (008)
09/11 (255)	**12/15** (350)	**01/09** (009)
09/12 (256)	**12/16** (351)	**01/12** (012)
09/13 (257)	**12/17** (352)	**01/12** (012)
09/14 (258)	**12/18** (353)	**01/12** (012)
09/15 (259)	**12/19** (354)	**01/13** (013)
09/16 (260)	**12/22** (357)	**01/14** (014)
09/17 (261)	**12/22** (357)	**01/15** (015)
09/18 (262)	**12/22** (357)	**01/16** (016)
09/19 (263)	**12/23** (358)	**01/20** (020)
09/20 (264)	**12/29** (364)	**01/20** (020)
09/21 (265)	**12/29** (364)	**01/20** (020)
09/22 (266)	**12/29** (364)	**01/20** (020)
09/23 (267)	**12/29** (364)	**01/21** (021)
09/24 (268)	**12/29** (364)	**01/22** (022)
09/25 (269)	**12/29** (364)	**01/23** (023)
09/26 (270)	**12/30** (365)	**01/26** (026)
09/27 (271)	**12/31** (366)	**01/26** (026)
09/28 (272)	**01/02** (002)	**01/26** (026)
09/29 (273)	**01/02** (002)	**01/27** (027)
09/30 (274)	**01/05** (005)	**01/28** (028)
10/01 (275)	**01/05** (005)	**01/29** (029)
10/02 (276)	**01/05** (005)	**01/30** (030)
10/03 (277)	**01/06** (006)	**02/02** (033)
10/04 (278)	**01/07** (007)	**02/02** (033)
10/05 (279)	**01/08** (008)	**02/02** (033)
10/06 (280)	**01/09** (009)	**02/03** (034)
10/07 (281)	**01/12** (012)	**02/04** (035)
10/08 (282)	**01/12** (012)	**02/05** (036)
10/09 (283)	**01/12** (012)	**02/06** (037)
10/10 (284)	**01/13** (013)	**02/09** (040)
10/11 (285)	**01/14** (014)	**02/09** (040)
10/12 (286)	**01/15** (015)	**02/09** (040)
10/13 (287)	**01/16** (016)	**02/10** (041)
10/14 (288)	**01/20** (020)	**02/11** (042)
10/15 (289)	**01/20** (020)	**02/12** (043)
10/16 (290)	**01/20** (020)	**02/13** (044)
10/17 (291)	**01/20** (020)	**02/17** (048)
10/18 (292)	**01/21** (021)	**02/17** (048)
10/19 (293)	**01/22** (022)	**02/17** (048)
10/20 (294)	**01/23** (023)	**02/17** (048)
10/21 (295)	**01/26** (026)	**02/18** (049)
10/22 (296)	**01/26** (026)	**02/19** (050)

Date of Service or Disposition	95 Days	120 Days
10/23 (297)	**01/26** (026)	**02/20** (051)
10/24 (298)	**01/27** (027)	**02/23** (054)
10/25 (299)	**01/28** (028)	**02/23** (054)
10/26 (300)	**01/29** (029)	**02/23** (054)
10/27 (301)	**01/30** (030)	**02/24** (055)
10/28 (302)	**02/02** (033)	**02/25** (056)
10/29 (303)	**02/02** (033)	**02/26** (057)
10/30 (304)	**02/02** (033)	**02/27** (058)
10/31 (305)	**02/03** (034)	**03/02** (061)
11/01 (306)	**02/04** (035)	**03/02** (061)
11/02 (307)	**02/05** (036)	**03/02** (061)
11/03 (308)	**02/06** (037)	**03/03** (062)
11/04 (309)	**02/09** (040)	**03/04** (063)
11/05 (310)	**02/09** (040)	**03/05** (064)
11/06 (311)	**02/09** (040)	**03/06** (065)
11/07 (312)	**02/10** (041)	**03/09** (068)
11/08 (313)	**02/11** (042)	**03/09** (068)
11/09 (314)	**02/12** (043)	**03/09** (068)
11/10 (315)	**02/13** (044)	**03/10** (069)
11/11 (316)	**02/17** (048)	**03/11** (070)
11/12 (317)	**02/17** (048)	**03/12** (071)
11/13 (318)	**02/17** (048)	**03/13** (072)
11/14 (319)	**02/17** (048)	**03/16** (075)
11/15 (320)	**02/18** (049)	**03/16** (075)
11/16 (321)	**02/19** (050)	**03/16** (075)
11/17 (322)	**02/20** (051)	**03/17** (076)
11/18 (323)	**02/23** (054)	**03/18** (077)
11/19 (324)	**02/23** (054)	**03/19** (078)
11/20 (325)	**02/23** (054)	**03/20** (079)
11/21 (326)	**02/24** (055)	**03/23** (082)
11/22 (327)	**02/25** (056)	**03/23** (082)
11/23 (328)	**02/26** (057)	**03/23** (082)
11/24 (329)	**02/27** (058)	**03/24** (083)
11/25 (330)	**03/02** (061)	**03/25** (084)
11/26 (331)	**03/02** (061)	**03/26** (085)
11/27 (332)	**03/02** (061)	**03/27** (086)
11/28 (333)	**03/03** (062)	**03/30** (089)
11/29 (334)	**03/04** (063)	**03/30** (089)
11/30 (335)	**03/05** (064)	**03/30** (089)
12/01 (336)	**03/06** (065)	**03/31** (090)
12/02 (337)	**03/09** (068)	**04/01** (091)
12/03 (338)	**03/09** (068)	**04/02** (092)
12/04 (339)	**03/09** (068)	**04/03** (093)
12/05 (340)	**03/10** (069)	**04/06** (096)
12/06 (341)	**03/11** (070)	**04/06** (096)
12/07 (342)	**03/12** (071)	**04/06** (096)
12/08 (343)	**03/13** (072)	**04/07** (097)
12/09 (344)	**03/16** (075)	**04/08** (098)
12/10 (345)	**03/16** (075)	**04/09** (099)
12/11 (346)	**03/16** (075)	**04/10** (100)
12/12 (347)	**03/17** (076)	**04/13** (103)
12/13 (348)	**03/18** (077)	**04/13** (103)
12/14 (349)	**03/19** (078)	**04/13** (103)
12/15 (350)	**03/20** (079)	**04/14** (104)
12/16 (351)	**03/23** (082)	**04/15** (105)
12/17 (352)	**03/23** (082)	**04/16** (106)
12/18 (353)	**03/23** (082)	**04/17** (107)
12/19 (354)	**03/24** (083)	**04/20** (110)
12/20 (355)	**03/25** (084)	**04/20** (110)
12/21 (356)	**03/26** (085)	**04/20** (110)
12/22 (357)	**03/27** (086)	**04/21** (111)
12/23 (358)	**03/30** (089)	**04/22** (112)
12/24 (359)	**03/30** (089)	**04/23** (113)
12/25 (360)	**03/30** (089)	**04/24** (114)
12/26 (361)	**03/31** (090)	**04/27** (117)
12/27 (362)	**04/01** (091)	**04/27** (117)
12/28 (363)	**04/02** (092)	**04/27** (117)
12/29 (364)	**04/03** (093)	**04/28** (118)
12/30 (365)	**04/06** (096)	**04/29** (119)
12/31 (366)	**04/06** (096)	**04/30** (120)
01/01 (001)	**04/06** (096)	**05/01** (121)

5.2 TMHP Electronic Claims Submission

TMHP uses the HIPAA-compliant American National Standards Institute (ANSI) ASC X12 4010A file format through secure socket layer (SSL) and virtual private networking (VPN) connections for maximum security.

Claims may be submitted electronically to TMHP through TexMedConnect on the TMHP website at www.tmhp.com, TDHconnect, 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: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for more information.

5.2.1 Electronic Claim Acceptance

Providers should verify that their electronic professional claims were accepted by the Texas Medicaid Program 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. For more information on electronic claims submissions refer to "Electronic Billing" on page 3-2, visit www.tmhp.com, or call the EDI Help Desk at 1-888-863-3638.

5.2.2 Electronic Rejections

The most common reasons for electronic professional claim rejections are:

- *Client information does not match.* Client information does not match the patient control number (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 or TDHconnect, send an interactive eligibility request to obtain an exact match with TMHP's record. If not using TexMedConnect or TDHconnect, verify through the TMHP website or call AIS at 1-800-925-9126 to verify client information. A lack of complete client eligibility information causes a rejection and possibly delayed payment. To prevent delays when submitting claims electronically:
  - Always include the first and last name of the client on the claim in the appropriate fields.
  - Always enter the client's complete, valid nine-digit Medicaid number. Valid Medicaid numbers begin with 1, 2, 3, 4, or 5. CSHCN 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 provider identifier, Medicare six-digit core number, or universal provider identification number (UPIN) must be present when billing for consultations, laboratory, or radiology. Consult the software vendor for this field's location on the electronic claims entry form.
- *Performing Physician ID field blank or invalid.* When the billing provider identifier is a *group* practice, the performing provider identifier for the physician who performed the service must be entered. Consult the software vendor for this field's location on the electronic claim form.
- *Facility Provider field blank or invalid.* When place of service (POS) is anywhere other than home or office, the facility's provider identifier must be present. If the provider identifier is not known, enter the name and address of the facility. Consult the software vendor for this field's location on the electronic claims entry form.
- *Invalid Type of Service or Invalid Type of Service/Procedure code combination.* In certain cases some procedure codes will require a modifier to denote the procedure's 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: "Modifier Requirements for TOS Assignment" on page 5-14 for TMHP EDI modifier information.

5.2.2.1 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.*

- *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 medical license number or UPIN number is required in Fields 78–79. Consult the software vendor for the location of this field on the electronic claims entry form.

Refer to: "PCCM" on page 7-23.

5.2.3 Resubmission of TMHP EDI Rejections

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

5.2.4 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, year, and hour that a batch was received. The batch ID format is JJJYHSSS, where each character is defined as follows:

- *JJJ—Julian date.* The three J characters represent the Julian date that the file was received by the TMHP EDI Gateway. The first character (J) is displayed as a letter, where E = 0, F = 1, G = 2, and H = 3. The last two characters (JJ) are displayed as numbers. All three characters (JJJ) together represent the Julian date.
- *Y—Year.* The Y character represents the last digit of the calendar year when the TMHP EDI Gateway receives the file. For example, a "5" in this position indicates the year 2005.
- *H—Hour.* The H character is displayed as a letter, representing the hour of the day that the TMHP EDI gateway received the file. The following letter codes represent the 24 hours of military time:

Letter to Hour Conversion			
A = 0	B = 1	C = 2	D = 3
E = 4	F = 5	G = 6	H = 7
I = 8	J = 9	K = 10	L = 11
M = 12	N = 13	O = 14	P = 15
Q = 16	R = 17	S = 18	T = 19
U = 20	V = 21	W = 22	X = 23

- *SSS—Sequence number.* This part of the batch ID is a unique sequence number that is EDI-assigned and does not impact determining the Julian date, year, or hour.

For example, the batch ID E085LDS1 means that the TMHP EDI gateway received the file on January 8, 2005, during the hour of 11 a.m.

Refer to: "Electronic Appeal Submission" on page 6-2 for instructions for using TMHP EDI batch IDs to prove timely filing.

5.2.5 Modifier Requirements for TOS Assignment

Modifiers for TOS assignment are *not* required for Texas Health Steps (THSteps) Dental claims (claim type 021), Inpatient Hospital claims (claim type 040), or Medicare Crossover claims (claim types 030, 031, 050). Additionally, procedures submitted by specific provider types such as genetics, eyeglass, THSteps medical, and birthing centers are assigned the appropriate TOS based on the provider type and/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 below.

5.2.5.1 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.

5.2.5.2 Anesthesia

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

5.2.5.3 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.

5.2.5.4 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 fee schedule.*

Additionally, the following procedure codes do not require a modifier for TOS assignment and are processed automatically as a technical component with a TOS T:

Procedure Codes		
T-77401	T-77402	T-77403
T-77404	T-77406	T-77407
T-77408	T-77409	T-77411
T-77412	T-77413	T-77414
T-77416	T-77417	T-93005
T-93017	T-93041	T-93225
T-93226	T-93231	T-93232
T-93236	T-93721	T-95824

5.2.5.5 Durable Medical Equipment (DME)

For DME, use one of the following modifiers: NU, RR, or UE.

Using modifier NU results in TOS J being assigned, modifier RR results in TOS L, and modifier UE results in TOS 9.

5.2.5.6 Telemedicine

For telemedicine services, Texas Medicaid-enrolled providers bill using the GT modifier with the appropriate evaluation and management code. Rural health clinic (RHC) and federally qualified health clinic (FQHC) providers bill using encounter codes with the AM and SA modifiers.

Place modifier AM or SA in the *first* modifier field on the claim form together with modifier GT in the *second* modifier field.

5.2.5.7 THSteps Medical Modifiers

The following are modifiers to be used for filing THSteps medical claims: AM, SA, and U7.

An FQHC provider must also use modifier EP.

Refer to: "THSteps-Comprehensive Care Program (CCP)" on page 43-33 for more instructions on billing THSteps medical claims.

5.2.6 Preferred Provider Organization (PPO)

PPO discounts are not considered a part of other insurance payments. Electronic submitters must supply the PPO discount amount when submitting other insurance information; however, this information is not included in the total other insurance payment during claims processing. Paper submitters are not required to add the PPO discount to the other insurance payment.

5.3 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 Current Procedural Terminology (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

5.3.1 Diagnosis Coding

The Texas Medicaid Program requires providers to provide *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* diagnosis codes on their claims. The *only* diagnosis coding structure accepted by the Texas Medicaid Program is the ICD-9-CM. Diagnosis codes must be to the highest level of specificity available. In most cases a written description of the diagnosis is not required. ICD-9-CM evaluation and management codes are not payable as a primary diagnosis.

All V-codes are acceptable as diagnoses except the following nonspecific codes:

Diagnosis Codes				
V030	V031	V032	V033	V034
V035	V036	V037	V0381	V0382
V0389	V039	V040	V041	V042
V043	V044	V045	V046	V047
V048	V0481	V0482	V0489	V050
V051	V052	V053	V054	V058
V059	V060	V061	V062	V063
V064	V065	V066	V068	V069
V070	V071	V078	V079	V109
V1200	V1201	V1202	V1203	V1209
V121	V122	V1260	V1261	V1269
V1270	V1271	V1272	V1279	V1300
V1321	V1329	V133	V134	V135
V1361	V1369	V137	V138	V139
V140	V141	V142	V143	V144

Diagnosis Codes				
V145	V146	V147	V148	V149
V1501	V1502	V1503	V1504	V1505
V1506	V1507	V1508	V1509	V1541
V1542	V156	V157	V1581	V1582
V1584	V1585	V1586	V1587	V1588
V1589	V159	V160	V161	V162
V1640	V1641	V1642	V1643	V1649
V1651	V1659	V166	V167	V168
V169	V171	V172	V173	V174
V175	V176	V177	V1781	V1789
V1859	V200	V201	V202	V210
V211	V212	V2130	V2131	V2132
V2133	V2134	V2135	V218	V219
V260	V261	V2621	V2622	V2629
V2631	V2632	V2633	V2634	V2635
V2639	V264	V2641	V2649	V2651
V2652	V268	V2681	V2689	V269
V289	V426	V4281	V4282	V4283
V4284	V4289	V4574	V4575	V4576
V4577	V4578	V4579	V4586	V460
V4611	V4612	V4613	V4614	V462
V468	V469	V4981	V4982	V4983
V4984	V4985	V4989	V499	V500
V501	V503	V5041	V5042	V5049
V508	V509	V520	V521	V522
V523	V524	V528	V529	V534
V538	V539	V570	V5721	V5722
V574	V5781	V5789	V579	V582
V5830	V5831	V5832	V585	V589
V5901	V5902	V5909	V591	V592
V593	V594	V595	V596	V5970
V5971	V5972	V5973	V5974	V598
V599	V600	V601	V602	V603
V604	V605	V606	V608	V609
V610	V6110	V6111	V6112	V6120
V6129	V613	V6141	V6149	V616
V617	V618	V619	V620	V621
V622	V623	V624	V625	V626
V6281	V6282	V6283	V6284	V6289
V629	V630	V631	V632	V638
V639	V650	V651	V6511	V6519
V652	V653	V6540	V658	V659
V665	V666	V667	V669	V680
V6801	V6809	V681	V682	V6881

Diagnosis Codes				
V6889	V689	V690	V691	V692
V693	V694	V695	V698	V699
V700	V702	V703	V704	V706
V707	V708	V709	V7211	V7212
V7219	V729	V730	V731	V732
V733	V734	V735	V736	V7388
V7389	V7398	V7399	V740	V741
V742	V743	V744	V745	V746
V748	V749	V750	V751	V752
V753	V754	V755	V756	V757
V758	V759	V762	V763	V7641
V7642	V7643	V7644	V7645	V7646
V7647	V7649	V7650	V770	V771
V772	V773	V774	V775	V776
V777	V778	V780	V781	V782
V783	V788	V789	V800	V801
V802	V803	V810	V811	V812
V813	V814	V815	V816	V8271
V8279	V8489	V8551	V8552	V8553
V8554	V860	V861		

These nonspecific codes can be used for a general description but may not be referenced to a specific procedure code. Generally, V-codes are supplementary and are used only when the client's condition cannot be classified to categories 001 through 999. The use of observation diagnosis codes V718 and V717 results in claim denial with EOB 00543, "Documentation insufficient to verify medical necessity. Resubmit the claim with signed claim copy, R&S report copy, and complete documentation of medical necessity."

Independent laboratories, pathologists, and radiologists are not required to provide diagnosis codes except when billing for procedures identified under "Diagnosis Requirements" on page 26-8.

5.3.1.1 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 the Texas Medicaid Program for ambulance claims processing. The two-digit origin and destination codes are still required for claims processing.*

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

POS	2-Digit Numeric Codes (Electronic Billers)	1-Digit Numeric Codes (Paper Billers)
Office	11, 15, 50, 60, 65, 71, 72	1
Home	12	2
Inpatient hospital	21, 51, 52, 55, 56, 61	3
Outpatient hospital	22, 23, 24, 62	5
Birthing center	25	7
Other location	03, 04, 05, 06, 07, 08, 26, 34, 41, 42, 53, 99	9
Skilled nursing facility, intermediate care facility, intermediate care facility for mentally retarded	31, 32, 54	4
Extended care facility (rest home, domiciliary or custodial care, nursing facility boarding home)	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 an RHC are billed using national POS code 72.*

5.3.2 Type of Service (TOS)

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

Refer to: "Modifier Requirements for TOS Assignment" on page 5-14 for information about modifiers for TMHP EDI.

5.3.2.1 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
9	Other (e.g., prosthetic eyewear, contacts, ambulance)
C	Home health services
D	TB clinic
E	Eyeglasses
F	Ambulatory surgical center (ASC)/hospital-based ambulatory surgical center (HASC)
G	Genetics
I	Professional component for radiology, laboratory, or radiation therapy
J	DME purchase new
L	DME rental
P	Birthing center
R	Hearing aid
S	THSteps medical
T	Technical component for radiology, laboratory, or radiation therapy
W	THSteps dental

5.3.3 Procedure Coding

The procedure coding system used by the Texas Medicaid Program is called the Healthcare Common Procedure Coding System (HCPCS). HCPCS provides health-care providers and third party payers a common coding structure.

HCPCS is designed around a five-character numeric or alphanumeric base for all codes. HCPCS consists of two levels of codes. HCPCS is updated annually to ensure an up-to-date coding structure. It is updated using the latest edition of the CPT manual and nationally established HCPCS codes released by CMS. Scheduled updates are announced in Medicaid bi-monthly bulletins.

The two levels of codes are as follows:

5.3.3.1 Level I

CPT (The American Medical Association's [AMA's] *Physicians' Current Procedural Terminology*):

- All numeric—consist of five digits.
- Represent 80 percent of HCPCS.
- Maintenance—responsibility of the AMA, which updates annually.
- Updates by the AMA are coordinated with CMS before their distribution of modifications to third party payers.

- Anesthesia codes from CPT.

5.3.3.2 Level II

HCPCS Codes

- 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).
- *Updating*: Responsibility of the CMS Maintenance Task Force.
- All *alphanumeric* consisting of a single alpha character (A through V) followed by four numeric digits.
- The single alpha character represents the following:

Alpha	Description
A	Supplies, ambulance, administrative, miscellaneous
B	Enteral and parenteral therapy
E	DME and oxygen
G	Procedures/professional (temporary)
H	Rehab and behavioral health services
J	Drugs (administered other than orally)
K	Durable Medical Equipment Regional Carriers (DMERC)
L	Orthotic and prosthetic procedures
M	Medical
P	Laboratory
Q	Temporary procedures
R	Radiology
S	Private payer
T	State Medicaid agency
V	Vision and hearing services

5.3.4 Modifiers

Modifiers describe and qualify the services provided by the Texas Medicaid Program. 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:

Modifier	Special Instructions/Notes (if applicable)
Surgeons	
50	
53	Used for physician reporting of a discontinued procedure. For outpatient/ASC reporting of a discontinued procedure, see modifier 73 and 74.
54+	Surgeons who do not provide the postoperative care for a patient *must* bill the surgery code with modifier 54. The modifier will reimburse the surgeon at 80 percent of the allowed amount.
55+	Physicians who provide only the postoperative care may bill the appropriate visit codes and *must* use modifier 55 to indicate only postoperative care services were provided. Services indicated as postoperative care only by use of this modifier will not be denied as part of the global surgical fee.
62+	Cosurgery. Two surgeons perform the specific procedure(s).
66+	Cosurgery. Two surgeons are necessary to perform the highly complex surgical 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.
SF	
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	
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.
Routine Foot Care	
TT+	Use with routine foot care procedures rendered in a nursing home when multiple patients are seen.
Injections	

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

Modifier	Special Instructions/Notes (if applicable)
ET+	
JA	Administered intravenously
JB	Administered subcutaneously
KX+	Use modifier KX to indicate the injection was due to: • Oral route contraindicated or an acceptable oral equivalent is not available. • Injectable medication is the accepted treatment of choice. Oral medication regimens have proven ineffective or are not available. • Patient has a temperature over 102 degrees (documented on the claim) and a high level of antibiotic is needed quickly. • Injection is medically necessary into joints, bursae, tendon sheaths, or trigger points to treat an acute condition or the acute flare up of a chronic condition.
Visits	
52+	Use with normal newborn care if the service did not comprise a THSteps screen.
76+	
FP+	
TH+	Use with evaluation and management procedures to specify antepartum or postpartum care.
25	Used to describe circumstances in which an office visit was provided at the same time as other separately identifiable services.
Anesthesia	
One of the following modifiers must be used by physicians in conjunction with the CPT code for anesthesia services:	
AA	
AD	
QK	
Modifier FP must be used when billing anesthesia for a sterilization procedure	
FQHC and RHC	
Services provided by a health-care professional require one of the following modifiers:	
AH	
AJ	
AM	
SA	
TD	For home services provided in areas with a shortage of home health agencies.
+ Modifier is required for accurate claims processing. *** Description is defined by the state.**	

Modifier	Special Instructions/Notes (if applicable)
TE	For home services provided in areas with a shortage of home health agencies.
U1	
U2	
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	
FP	
GT	If the encounter is using telemedicine, use GT in the second modifier field.
TH	
TU	For services provided outside of normal business hours to a client enrolled in the PCCM program.
Certified Registered Nurse Anesthetist (CRNA)	
One of the following modifiers must be used by CRNAs in conjunction with the CPT code for anesthesia services:	
QX	
QZ	
The following modifier must be used when billing anesthesia for a sterilization procedure:	
FP	
Abortion	
G7	
Vision	
RP+	Use modifier RP to indicate replacement lenses and/or frames
VP+	
Laboratory/Radiology	
26+	Used with TOS I (interpretation) for laboratory and radiological procedures.
91+	
FP+	Use with 99000 for lab handling services related to family planning.
SU+	Indicates necessary equipment is in physician's office for RAST/MAST testing or Pap smears.
TC+	The modifier TC is used with TOS T (technical) for radiological procedures.
TS	Use with 76811 or 76812 to indicate a follow-up or repeat ultrasound exam.
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.**	

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	
GO	
GP	
U4*	Reassessment
THSteps Medical	
AM	
EP	FQHCs must use modifier EP for services provided under THSteps.
SA	
U7*	Physician assistant services for other than assistant at surgery
Physicians	
Q5	Informal reciprocal arrangement (period not to exceed 14 continuous days)
Q6	Locum tenens or temporary arrangement (up to 90 days)
Radiologists	
U6	CT, CTA, MRI, and MRA studies provided in the emergency department

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

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

*** Must be used by providers rendering Early Childhood Intervention (ECI)-THSteps/CCP therapy and nutritional services.**

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

- *CC.* The code used by the provider was changed by TMHP.
- *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 (does not apply to admissions after September 1, 1989).
- *PE.* The DRG payment was calculated on a per diem basis because the patient was ineligible for Medicaid during part of the stay (does not apply to admissions after September 1, 1989). Also used to adjudicate claims with adjustments to outlier payments.

Note: *Modifiers PT, PS, and PE will appear for DRG claims only.*

5.3.5 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
CSHCN Services Program	CSN
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	ECI
Tuberculosis (TB) Clinics	TB1

***Agencies only—Benefit codes should not be used for individual family planning providers.**

5.4 Claims Filing Instructions

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

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

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

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

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

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

5.4.1 Claim Form Requirements

When filing claims for a STAR or STAR+PLUS Program members, providers should follow the client's STAR or STAR+PLUS health plan's claim filing requirements.

5.4.1.1 Provider Signature on Claims

Each CMS-1500, 2006 ADA, and Family Planning 2017 *paper claim* form submitted must have the handwritten signature (or signature stamp) of the provider or an authorized representative in the appropriate block of the claim form. Signatory supervision of the authorized representative is required. Providers delegating signature authority to a member of the office staff or to a billing service remain responsible for the accuracy of all information on a claim submitted for payment. Initials are only acceptable for first and middle names. The last name must be spelled out. An acceptable example is J.A. Smith for John Adam Smith. An unacceptable example is J.A.S. for John Adam Smith. Typewritten names *must* be accompanied by a handwritten signature; in other words, a typewritten name with signed initials is *not* acceptable. The signature *must* be contained within the appropriate block of the claim form. Claims prepared by computer billing services or office-based computers may have "Signature on File" printed in the signature block, but it must be in the same font that is used in the rest of the form. For claims prepared by a billing service, the billing service must retain a letter on file from the provider authorizing the service.

Printing the provider's name instead of "Signature on File" is unacceptable. Because space is limited in the signature block, providers should not type their names in the block. Claims not meeting these specifications are in the "Paid or Denied Claims (Hospital) R&S Report" on page 5-62 section of the R&S report.

Refer to: "Sample Letter - XUB Computer Billing Service Inc." on page B-84.

5.4.1.2 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 claim forms as indicated below:

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

5.4.1.3 Clients Without Medicaid Numbers

If an individual has not been assigned a Medicaid number on the DOS, the provider must wait until a Medicaid client number is assigned to file the claim. The provider writes the number instead of "Pending." The 95-day filing period begins on the "add date," which is the date the eligibility is received and added to the TMHP eligibility file. Providers verify eligibility and add date through TexMedConnect or TDHconnect or by calling AIS or the TMHP Contact Center at 1-800-925-9126 after the number is received.

Providers must check Medicaid eligibility regularly to file claims within the required 95-day filing deadline.

Refer to: "Client Eligibility" on page 4-1.

5.4.1.4 Multipage Claim Forms

The CMS-1500 claim form is designed to list six line items in Block 24. An approved electronic claims format is designed to list 50 line items. 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. 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 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.

The total number of details allowed for a UB-04 CMS-1450 claim form is 28. The TMHP claims processing system (C21) accepts a total of 61 details and merges like revenue codes together to reduce the lines to 28 or less. If the C21 merge function is unable to reduce the lines to 28 or less, the claim will be denied, and the provider must reduce the number of details and resubmit the claim.

Note: *Each surgical procedure code listed in block 74 of the claim form is counted as one detail and is included in the 28-detail limitation.*

An approved electronic format of the UB-04 CMS-1450 is designed to list 61 lines in Block 43 or its electronic equivalent. C21 merges like revenue codes together to reduce the lines to 28 or less. If the C21 merge cannot reduce the lines to 28 or less, the claim denies, and the provider

needs to reduce the lines and resubmit the claim. Providers submitting electronic claims using TexMedConnect or TDHconnect 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. 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.

5.4.1.5 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.
- Providers filing for coinsurance, deductible, or both on Medicare claims to TMHP must attach the TMHP Standardized MRAN form or the computer generated MRANs from the CMS-approved software applications Medicare Remit Easy Print (MREP) for professional services or PC-Print for institutional services. Providers that submit paper crossover claims must submit only one of the three approved MRAN formats—the new TMHP Standardized MRAN Forms, MREP, or PC-Print. Paper crossover claims submitted with multiple MRAN forms (e.g., TMHP Standardized MRAN Forms and any other MRAN) with conflicting information will not be processed and will be returned to the provider.This requirement does not apply to claims transferred automatically to TMHP from the Medicare intermediary.
- 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 the Texas Medicaid Program.
- Hysterectomies must have a Hysterectomy Acknowledgment Statement attached or on file at TMHP.

Refer to: "Hysterectomy Services" on page 36-50.

5.5 CMS-1500 Claim Filing Instructions

The following providers bill for services using the ANSI ASC X12 837P 4010A electronic specifications or the CMS-1500 claim form:

Providers
Ambulance
ASC (freestanding)
Birthing center
Case Management: blind and visually impaired children (BVIC), ECI, and Children and Pregnant Women (CPW)
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 or durable medical equipment–home health services (DMEH) supplier (CCP and home health services)
Family planning agency that does not also receive funds from Title V, X, or XX
FQHC
Genetic service agency
Hearing aid
In-home total parenteral nutrition (TPN)/hyperalimentation supplier
Laboratory
Licensed dietitian (CCP only)
Licensed clinical social worker (LCSW)
Licensed professional counselor (LPC)
Maternity service clinic (MSC)
Mental health (MH) rehabilitative services
Nurse practitioner (NP)
Occupational therapist (CCP only)
Optician/optometrist/opthamologist
Orthotic and prosthetic supplier (CCP only)
Physical therapist
Physician (group and individual)
Physician assistant (PA)
Tuberculosis clinic
Podiatrist
Private duty nurse (PDN) (CCP only)
Psychologist
Radiology

Providers
School Health and Related Services (SHARS)
Speech language pathologist (CCP only)
THSteps medical

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

5.5.1 CMS-1500 Electronic Billing

Electronic billers must submit CMS-1500 claim forms with TexMedConnect, TDHconnect, or approved vendor software that uses the ANSI ASC X12 837P 4010A format. Specifications are available to providers developing in-house systems, software developers, and vendors on the TMHP website at www.tmhp.com/EDI. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 1-888-863-3638.

Refer to: "Electronic Billing" on page 3-2 for information about electronic billing.

5.5.2 CMS-1500 Claim Form (Paper) Billing

Claims must contain the billing provider's complete name, address, or provider identifier. A claim without a provider name, address, or provider identifier cannot be processed. Each claim form must have the appropriate signatory evidence in the signature certification block.

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

Refer to: "CMS-1500 Claim Form (Paper) Billing" on page 5-23.

"CMS-1500 Claim Filing Instructions" on page 5-22.

5.5.3 CMS-1500 Blank Claim Form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ . _____ 3. _____ . _____

2. _____ . _____ 4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

5.5.4 CMS-1500 Instruction Table

The instructions describe what information must be entered in each of the block numbers of the CMS-1500 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 patient's nine-digit client number from the Medicaid Identification.
2	Patient's name	Enter the patient's last name, first name, and middle initial as printed on the Medicaid Identification Form (Form H3087).
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 patient's sex by checking the appropriate box.
5	Patient's address	Enter the patient's complete address as described (street, city, state, and ZIP Code).
9	Other insured's name	For special situations, use this space to provide additional information. Other uses include, but are not limited to the following: • If the patient is deceased, enter the date of death. If the services were rendered on the date of death, indicate the time of death. • If the service is a sterilization, identify the date and time of surgery. • If the patient has chronic renal disease, enter the date of onset of dialysis treatments. **Ambulance Hospital-to-Hospital Transfers** Indicate the services required from the second facility and unavailable at the first facility.
10	Was condition related to: A) Patient's employment B) Auto accident C) Other accident	Indicate by checking the appropriate box. If applicable, enter all available information for other health insurance coverage in Block 11.
11a–b	Other health insurance coverage	If another insurance resource has made payment, write "(Name) Insurance Company paid $(Amount) on (Date)." If another insurance resource has been billed and denied the claim, write "(Name) Insurance Company denied claim on (Date)." Attach a copy of the denial letter or form to the Medicaid claim. If the patient has health, accident, or other insurance policies or is covered by private or government benefit system which may pay in full or in part for the services billed on this form, enter all pertinent information available (in Box 9 a-d). If the patient is enrolled in Medicare, enter the patient's Health Insurance Claim (HIC) number from the Medicare Identification Card. The notation of "Denied" indicates the TPR denied the claim.
11c	Insurance plan or program name	Enter the benefit code, if applicable, for the billing or performing provider.
12	Patient or authorized person's signature	Providers are encouraged to obtain the patient's signature on claim forms; however, TMHP will process the claim without the signature of the patient. The patient's signature authorizes the release of the claim's medical information.
14	Date of injury or date of last menstrual period	If the services provided are accident or maternity-related, indicate the date of injury of the accident or the date of the last menstrual period.

Block No.	Description	Guidelines
17	Name of referring physician or other source	Enter the complete name of the referring provider in the following situations: • Electronic billers must enter the provider identifier, six-digit Medicare number, or UPIN. • Clinical pathology consultations to hospital inpatients or outpatients must identify the attending physician. • Nonemergency services provided to limited clients on referral from the designated physician must identify the designated physician's nine-digit provider identifier. • Consultation services must identify the referring physician. • Services provided to a client in a nursing facility (skilled nursing facility [SNF], intermediate care facility [ICF], or extended care facility [ECF]) must identify the attending physician. • Laboratory and radiology services must identify the ordering physician. • Speech-language therapy must identify the ordering physician. • Physical therapy must identify the ordering physician. • Occupational therapy must identify the ordering physician. • In-home TPN/hyperalimentation services must identify the ordering physician. • THSteps-CCP services must identify the referring provider. • Do not use Medicare number for limited clients. For limited clients, use a nine-digit provider identifier in 17a. Electronic billers should use the Medicare six-digit code number or provider identifier. • The referring provider must be the primary care provider if the client is in a STAR or STAR+PLUS health plan. If there is not a referral from the primary care provider, a prior authorization number (PAN) must be on the claim. • Claims received without this information will be returned to the provider. **Physician Claims (Referring Physician)** A referring physician is required for consultation, laboratory, radiology, and radiation therapy procedures. The complete name and address or the provider identifier of the referring physician must be in Block 17 of the claim form. **Freestanding ASC Claims** The performing surgeon/referring physician name/number must be identified.
17a	Other ID#	Enter the Other ID number, such as a Texas Medicaid nine-digit provider identifier (TPI), or Universal Provider Identification Number (UPIN), of the referring provider, ordering provider, or other source.
17b	NPI	**Optional** Enter the NPI of the referring provider, ordering provider, or other source.
19	Reserved for local use	**Multiple Transfers** Indicate that the claim is part of a multiple transfer and provide the other client's complete name and Medicaid number. Provide information about the accident including the date of occurrence, how it happened, whether it was self-inflicted or employment-related.
20	Was laboratory work performed outside your office?	Check the appropriate box. The information is not required to process claims, but it may be requested for retrospective review. If "YES," enter the name and address or provider identifier of the facility that performed the service in Block 32. Medicaid regulations require a provider bill only for those laboratory services that he or she actually performed. Any services performed outside of the provider's office must be billed by the performing laboratory or radiology center.

Block No.	Description	Guidelines
21	Diagnosis or nature of illness or injury	Enter the ICD-9-CM diagnosis code to the highest level of specificity available complete to five digits for each diagnosis observed. A pathologist is not required to supply a diagnosis except for: estrogen receptor assays, HLTVIII, plasmapheresis, and anatomical pathology specimens. Radiology groups are required to provide a diagnosis for inflammatory process localization using radioactive tracer (Gallium 67), graphic stress telethermometry, computed tomography (CT) scans, echography, arteriography, venography, and magnetic resonance imaging (MRI). The statement of medical necessity for abortions and the rationale for the decision must be included if it is not attached to the claim. **Ambulance** Ambulance providers must provide a concise description for each diagnosis observed or enter the ICD-9-CM diagnosis code to the highest level of specificity available complete to five-digits for each diagnosis observed. **Chiropractors** Chiropractors must indicate the exact level of subluxation (use of diagnosis codes 7390, 7391, 7392, 7393, 7394, 7395, 7398, 83900, 83901, 83902, 83903, 83904, 83905, 83906, 83907, 83908, 83920, 83921, and 83949 may be indicated in lieu of a written description) and the date of the X-ray that demonstrates the degree of subluxation. **THSteps medical check ups** For paper and electronic billers, the diagnosis code is V202.
23	Prior authorization no. (PAN)	Enter the PAN issued by TMHP, if applicable.
24	Various	24a through 24J—General Notes: • Each line contains two sections—a shaded and an unshaded portion. Unless otherwise specified, all required information in Blocks 24A through 24J should be entered in the unshaded portion. • The CMS-1500 claim form is designed to list only six-line items in Block 24. If more than six-line items are billed for the entire claim, a provider must attach additional forms with no more than 28-line items for the entire claim. • Type of service (TOS) codes are no longer required for claims submissions.
24A	Date of service (DOS)	Enter the DOS for each procedure provided in a MM/DD/YYYY format. If more than one DOS is for a single procedure, each date must be given (such as “03/16, 17, 18/2005”). **Electronic Billers** Medicaid does not accept multiple (to-from) dates on a single line detail. Bill only one date per line. “To” dates of service are not used on electronic claims.
24B	Place of service (POS)	Select the appropriate POS code for each service from the POS table under Place of Service (POS) Coding of this manual, “Place of Service (POS) Coding” on page 5-16. If the patient is registered at a hospital, the POS must indicate inpatient or outpatient status at the time of service. **Ambulance** The POS for all ambulance transfers is the destination. **THSteps medical check ups** For paper billers, the POS will always be “1” or “O.” For electronic billers, the POS will always be “11.”
24C	EMG (THSteps medical check up condition indicator)	Enter the appropriate condition indicator for THSteps medical check ups.

Block No.	Description	Guidelines

24D	Fully describe procedures, medical services, or supplies furnished for each date given	Enter the appropriate procedure codes for all procedures/services billed. If a procedure code is not available, enter a concise description.
		Give complete information for:
		• *Injections.* Provide a breakdown of each injection and separate the charge for an injection from the office visit charge. Indicate the name of the drug, strength, and dosage; and the necessity for the injection by using one of the modifiers.
		• *Sutures.* Indicate number of sutures, length, and location of laceration.
		• *Laboratory.* Indicate the specific type of laboratory procedure.
		• *X-ray.* Indicate the number of views and type.
		• When unusual or extenuating circumstances occur, give a brief medical report.
		• *THSteps medical check ups.* Use a modifier to identify provider.
		• *Ambulance.* The pick-up point and destination must be indicated on the claim form.
		• *Anesthesiologists and CRNAs.* Enter the appropriate CPT anesthesia procedure code for all procedures billed. If the anesthesia is given for more than one procedure, identify all procedures performed and indicate which is considered the major procedure. A breakdown of charges is not necessary. Enter the time in minutes.
		• Enter one of the following modifiers as appropriate:
		  • Anesthesiologists use "AA," "AD," or "QK."
		  • CRNAs use "QX" or "QZ."
		• Use modifiers (e.g., acute, left, right) to describe services (refer to "Modifiers" on page 5-18 of this manual).
		• *Eyewear.* When billing for eyewear, the prescription must be entered; the new prescription must be placed on Line five and the old prescription on Line 6.

24E	Diagnosis pointer	Enter the line item reference (1, 2, 3, or 4) for each service or procedure as it relates to each ICD-9-CM diagnosis code identified in Block 21. If a procedure is related to more than one diagnosis, the primary diagnosis the procedure is related to must be the one identified. Do not enter more than one reference per procedure. This could result in denial of the service.
24F	Charges	Indicate the usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay patients.
24G	Days or units	If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed.)
24J	Rendering provider ID# (performing)	Enter the provider identifier for the individual rendering services. Enter the TPI in the shaded area of the block. **Optional** Enter the NPI in the unshaded area of the block. Members of a group practice (except pathology and renal dialysis groups) must identify the provider identifier of the doctor/clinic within the group who performed the service. The number that identifies the doctor/clinic as a member of that group practice should not appear in Block 33 and must not be used to bill the Texas Medicaid Program. The space is also used to provide additional information, such as pertinent comments that may explain unusual procedure.
26	Patient's account number	**Optional** Any alphanumeric characters (up to 15) in this block are referenced on the R&S report.
27	Accept assignment	**Required** All providers of Texas Medicaid Program services must accept assignment to receive payment. Providers must check "YES." Electronic billers must submit a "Y."
28	Total charge	Enter the total of separate charges for each page of the claim. Enter the total of all pages on last claim if filing a multi-page claim.

Block No.	Description	Guidelines
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 and dated by the provider authorizing this practice. **Refer to:** "Provider Signature on Claims" on page 5-21.
32	Name and address of facility where services rendered, if other than home or office	If services were provided in a place other than the patient's home or the provider's facility, enter name, address, and ZIP Code, and the provider identifier of the facility where the service was provided. **Ambulance** For ambulance transfers, if the destination is a hospital, enter the name and address, and the provider identifier of the facility. **Laboratory** For laboratory specimens sent to an outside laboratory for additional testing, the complete name and address or the provider identifier of the outside laboratory should be entered. The laboratory should bill the Texas Medicaid Program for the services performed.
32a	NPI	**Optional** Enter the NPI of the service facility location.
32b	Other ID#	Enter the other ID number, such as a nine-digit TPI or UPIN, of the service facility location.
33	Physician or supplier's name, address, ZIP Code, and telephone number	Enter the Texas Medicaid Program provider name, street, city, state, ZIP Code, and telephone number of the billing provider.
33a	NPI	**Optional** Enter the NPI of the billing provider.
33b	Other ID#	Enter the TPI number of the billing provider.

5.6 UB-04 CMS-1450 Claim Filing Instructions

The following provider types may bill electronically or use the UB-04 CMS-1450 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
Renal dialysis center
RHCs (freestanding and hospital-based)

5.6.1 UB-04 CMS-1450 Electronic Billing

Electronic billers must submit UB-04 CMS-1450 claims with TexMedConnect, TDHconnect, or approved vendor software that uses the ANSI ASC X12 837I 4010A format. Specifications are available to providers developing in-house systems and software developers and vendors. Because each software package is different, field locations may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 1-888-863-3638.

Refer to: "Electronic Billing" on page 3-2 for more information about electronic billing.

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

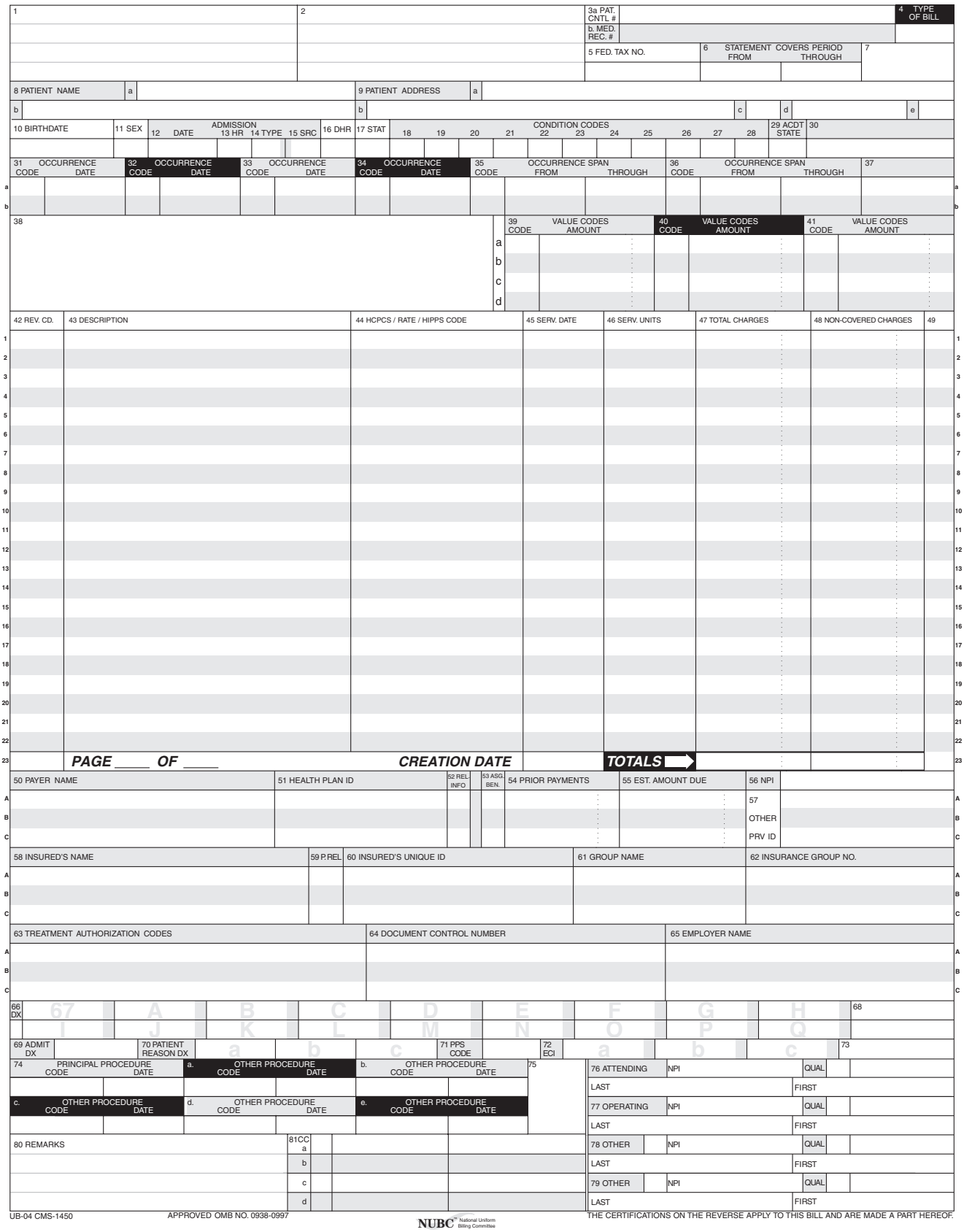
Providers obtain the UB-04 CMS-1450 claim forms from a vendor of their choice.

Note: *To avoid claim denial, only the provider's Texas license number is preceded by "TX" and should be placed in form locators 82 and 83 of the UB-04 CMS-1450 claim form or in the referring provider license number field on the electronic claim unless the client is a limited client.*

Completed UB-04 CMS-1450 claims must contain the billing provider's full name, address, and/or provider identifier. A claim *without* a provider name, address, or provider identifier *cannot* be processed.

Refer to: "UB-04 CMS-1450 Instruction Table" on page 5-32.

5.6.3 UB-04 CMS-1450 Blank Claim Form



5.6.4 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 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	Provider name, address, and telephone number	Enter the hospital name, street, city, state, ZIP Code, and telephone number.
2	Unlabeled	**Optional** No guidelines for this block.
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) Most commonly used: 111 Inpatient hospital 131 Outpatient hospital 141 Nonpatient (laboratory or radiology charges) 331 Home health agency* 711 RHCs 721 RDCs 731 FQHCs * Use TOB 331 only. All other TOBs are invalid and will deny.	This block has been expanded from 3 to 4 characters with a 0 always as the first digit. Claims will be processed based on the last three digits. Enter the three-digit TOB code. First Digit—Type of Facility: 1 Hospital 2 Skilled nursing 3 Home health agency 7 Clinic (rural health clinic [RHC], federally qualified health center [FQHC], and renal dialysis center [RDC]) 8 Special facility Second Digit—Bill Classification (except clinics and special facilities): 1 Inpatient (including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital-referenced diagnostic services, for example, laboratories and X-rays) 7 Intermediate care Second Digit—Bill Classification (clinics only): 1 Rural health 2 Hospital-based or independent renal dialysis center 3 Free standing 5 CORFs Third Digit—Frequency: 0 Nonpayment/zero claim 1 Admit through discharge 2 Interim-first claim 3 Interim-continuing claim 4 Interim-last claim 5 Late charges-only claim 6 Adjustment of prior claim 7 Replacement of prior claim
6	Statement covers period	For inpatient and home health claims, enter the beginning and ending dates of service billed. For inpatient claims, this is usually the date of admission and discharge.

Block No.	Description	Guidelines
7	Unlabeled	**Optional** No guidelines for this block.
8a	Patient identifier	**Optional** Enter the patient identification number if it is different than the subscriber/insured's identification number.
8b	Patient name	Enter the client's last name, first name, and middle initial as printed on the Medicaid identification form.
9a–9b	Patient address	Starting in 9a, enter the client's complete address as described (street, city, state, and ZIP Code).
10	Birth date	Enter the month, day, and year (MM/DD/YYYY) the client was born.
11	Sex	Indicate the client's sex by entering an "M" or "F."
12	Admission date	Enter the numerical date (MM/DD/YYYY) of admission for inpatient claims; date of service (DOS) for outpatient claims; or start of care (SOC) for home health claims. ***Note:*** *Providers that receive a transfer patient from another hospital must enter the original admission date to identify the payor.*
13	Admission hour	Use military time (00 to 23) for the time of admission for inpatient claims or time of treatment for outpatient claims. Code 99 is not acceptable. This block is not required for nonpatients (TOB 141), home health claims (TOB 331), RHCs (TOB 711), or FQHCs (TOB 731).
14	Type of admission	Enter the appropriate type of admission code for inpatient claims: 1 Emergency 2 Urgent 3 Elective 4 Newborn (This code requires the use of special source of admission code in Block 15.) 5 Trauma center
15	Source of admission	Enter the appropriate source of admission code for inpatient claims. For type of admission 1, 2, or 3: 1 Physician referral 2 Clinic referral 3 Health maintenance organization (HMO) referral 4 Transfer from a hospital 5 Transfer from skilled nursing facility (SNF) 6 Transfer from another health-care facility 7 Emergency room 8 Court/law enforcement 9 Information not available For type of admission 4 (newborn): 1 Normal delivery 2 Premature delivery 3 Sick baby 4 Extramural birth 5 Information not available

Block No.	Description	Guidelines
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. Code 99 is not acceptable.
17	Patient status	For inpatient claims, enter the appropriate two-digit code to indicate the patient's status as of the statement "through" date: 01 Routine Discharge 02 Discharged to another short-term general hospital 03 Discharged to SNF 04 Discharged to ICF 05 Discharged to another type of institution 06 Discharged to care of home health service organization 07 Left against medical advice 08 Discharged/transferred to home under care of a Home IV provider 09 Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims) 20 Expired or did not recover 30 Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG) 40 Expired at home (hospice use only) 41 Expired in a medical facility (hospice use only) 42 Expired—place unknown (hospice use only) 43 Discharged/Transferred to a federal hospital (such as a Veteran's Administration [VA] hospital) 50 Hospice—Home 51 Hospice—Medical Facility 61 Discharged/ Transferred within this institution to a hospital-based Medicare-approved swing bed 62 Discharged/ Transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital. 63 Discharged/ Transferred to a Medicare certified long-term care hospital (LTCH) 64 Discharged/ Transferred to a nursing facility certified under Medicaid but not certified under Medicare 65 Discharged/ Transferred to a Psychiatric hospital or psychiatric distinct part unit of a hospital 66 Discharged/transferred to a critical access hospital (CAH)
18–28	Condition codes	Enter the two-digit condition code "05" and date (MM/DD/YYYY) on which the legal claim was filed for recovery of funds potentially due to a client as a result of legal action that was initiated by or on behalf for the client if this condition is applicable to the claim.
29	ACDT state	**Optional** Accident state.
30	Unlabeled	**Optional** No guidelines for this block.
31–34	Occurrence codes and dates	Enter the appropriate code(s) and date(s). Blocks 54, 61, 62, and 84 must also be completed as required. **Refer to:** "Occurrence Codes" on page 5-41.
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.

Block No.	Description	Guidelines
39–41	Value codes	Accident hour–For inpatient claims, if the client was admitted as the result of an accident, enter value code 45 with the time of the accident using military time (00 to 23). Use code 99 if the time is unknown. For inpatient claims, enter value code 80 and the total days represented on this claim that are to be covered. Usually, this is the difference between the admission and discharge dates. In all circumstances, the number in this block is equal to the number of covered accommodation days listed in Block 46. For inpatient claims, enter value code 81 and the total days represented on this claim that are not covered. The sum of Blocks 39–41 must equal the total days billed as rejected 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. ***Note:*** *All claims for services submitted on a UB-04 CMS-1450 form based on procedure codes rather than revenue codes will be denied. Claims for services based on procedure codes, including drugs and other injections, must be billed using a CMS-1500 claim form.* a) Revenue code 001 is for the total charge and must be the last revenue code on the list. ***Exception:*** *Electronic billers must not use revenue code 001. Use of this code causes the claim billed amount to be doubled. Electronic billers should not put a code in this block.* b) Laboratory—If laboratory work is sent out, the name and address or nine-digit Medicaid provider identifier of the laboratory where the work was forwarded must be entered. c) Medical/Surgical Supplies—Itemize these services provided in the inpatient facility (such as infusion pumps, traction setups, and crutches only for inpatient use). If provided to all admitted patients, admission kits should be billed using revenue code 270. d) Fetal Monitoring—Charges must be billed using revenue code 732.

Block No.	Description	Guidelines
44	HCPCS/rates	**Inpatient:** Enter the accommodation rate per day. Enter the numerical date of service (MM/DD/YY) for each service rendered and the block number of the 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. **Outpatient:** Outpatient claims must have the appropriate Healthcare Common Procedure Coding System (HCPCS) code or narrative description. Do not use revenue codes for billing these services. Enter the date of service numerically, and the block number of the diagnosis 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, except for medical/surgical and intravenous (IV) supplies and medication, must be itemized on the claim form or an attached statement. **Example:** a) Emergency Room. Bill as "Emergency room" or "Emergency room charge per use." If the client visits the emergency room more than once in one day, the time must be given for each visit. The time of the first visit must be identified in Block 18, using 00 to 23 hours military time (e.g., 1350 for 1:50 p.m.). Indicate other times on the same line as the procedure code. (Revenue code B-450, B-456, or B-459.) b) Observation Room. Bill as "observation room." (Revenue code B-762.) c) Operating Room. Bill as "Operating Room." (Revenue code B-360, B-361, or B-369.) d) Recovery Room. Bill as "Recovery Room" or "Cast Room" as appropriate. (Revenue code B-710 or B-719.) e) Injections. Must have "Inj.-name of drug; route of administration; the dosage and quantity" or the injection code. f) Drugs and Supplies. Take-home drugs and supplies are not a benefit of the Texas Medicaid Program: • Take-home drugs must be billed with revenue code B-253. • Take-home supplies must be billed with revenue code B-273. • Self-administered drugs must be billed with revenue code B-637. The drug description must include the name, strength, and quantity.

Block No.	Description	Guidelines
44 cont.		g) Radiology. The description should provide the location and the number of views. As an alternative, enter the HCPCS code. The physician must bill professional services by a physician separately. The license number of the ordering physician must be in Block 83. If the client receives the same radiology procedure more than once in one day, the time must be given for each visit. The time of the first visit must be identified in Block 18, using 00 to 23 hours military time (such as 1350 for 1:50 p.m.). Indicate other times on the same line as the procedure code. h) Laboratory. Provide a complete description or use the procedure codes for the laboratory procedures. The physician must bill professional services by a physician separately. Blocks 78–79 must have the license number of the ordering physician. If laboratory work is sent out, enter the name of the test and name and address or Medicaid number of the laboratory where the work was forwarded. If the client receives the same laboratory procedure more than once in one day, give the time for each visit. The time of the first visit must be identified in Block 18, using 00 to 23 hours military time (e.g., 1350 for 1:50 p.m.). Indicate other times on the same line as the procedure code. i) Nuclear Medicine. Provide a complete description. j) Day Surgery. Day surgery should be billed as an inclusive charge using TOS F. Do not bill separately services that were provided in conjunction with the surgery (e.g., lab, radiology, and anesthesia). File claims for unscheduled emergency outpatient surgical procedures with separate charges (e.g., lab, radiology, anesthesia, and emergency room) for all services using TOB 131 and the hospital's provider identifier. ***Note:*** *The UB-04 CMS-1450 claim form is limited to 28 items per 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 Block 46 should always represent hours spent in observation.
47	Total charges	Enter the total charges for each service provided.
48	Noncovered charges	If any of the total charges are noncovered, enter this amount.
51	Provider identifier	Enter the nine-digit provider identifier.
54	Prior payments	Enter amounts paid by any third-party resource (TPR), and complete Blocks 32, 61, 62, and 84 as required.
56	NPI	**Optional** Enter the NPI of the billing provider.

Block No.	Description	Guidelines
57	Other identification (ID) number	Enter the TPI number (non-NPI number) of the billing provider.
58	Insured's name	If other health insurance is involved, enter the insured's name.
60	Medicaid identification number	Enter the patient's nine-digit Medicaid identification number.
61	Insured group name	Enter the name and address of the other health insurance.
62	Insurance group number	Enter the policy number or group number of the other health insurance.
63	Treatment authorization code	Enter the prior authorization number for home health services, freestanding psychiatric facilities, freestanding rehabilitation facilities, and for surgery if one was issued.
65	Employer name	Enter the name of the client's employer if health care might be provided.
67	Principal diagnosis (DX) code and present on admission (POA) indicator	Enter the ICD-9-CM diagnosis code in the unshaded area for the principal diagnosis to the highest level of specificity available. **Optional** POA Indicator—Enter the applicable POA indicator in the shaded area for inpatient claims.
67A–67Q	Other DX codes and POA indicator	Enter the ICD-9-CM diagnosis code in the unshaded area to the highest level of specificity available for each additional diagnosis. Enter one diagnosis per block, using Blocks A through H 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 alpha-fetoprotein.* ***Note:*** *Note: ICD-9-CM diagnosis codes entered in 67I–67Q are not required for systematic claims processing.* **Optional** POA indicator—Enter the applicable POA indicator in the shaded area for inpatient claims.
68	Unlabeled	**Optional** No guidelines for this block.
69	Admit DX code	Enter the ICD-9-CM diagnosis code indicating the cause of admission or include a narrative. ***Note:*** *The admitting diagnosis is only for inpatient claims.*
70a–70c	Patient's reason DX	**Optional** New block indicating the client's reason for visit on unscheduled outpatient claims.
71	Prospective Payment System (PPS) code	**Optional** The PPS code is assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.
72a–72c	External cause of injury (ECI) and POA indication	**Optional** Enter the ICD-9-CM diagnosis code in the unshaded area to the highest level of specificity available for each additional diagnosis. POA indicator—Enter the applicable POA indicator in the shaded area for inpatient claims.
73	Unlabeled	**Optional** No guidelines for this block.

Block No.	Description	Guidelines
74	Principal procedure code and date	Enter the ICD-9-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-9-CM procedure code for each surgical procedure and the date (MM/DD/YYYY) each was performed.
76	Attending provider	Enter the attending provider name and identifiers. **Optional** NPI number of the attending provider. **Required** *TPI must be entered in block to the right of qualifier box, if applicable.* For inpatient claims, enter the physician's license number or UPIN of the provider who performed the service/procedure and/or is responsible for the treatment and plan of care in the following format: 11233333 1 Two-digit state indicator (e.g., TX for Texas). 2 Licensing board indicator examples B = Doctor of Medicine (MD) or Doctor of Osteopathy (DO) D = Dentist P = Podiatrist C = Chiropractor 3 License number. Example: TXBL1234. If the provider has a temporary license number, enter "TEMPO." Example: TXBTEMPO Procedures are defined as those listed in the ICD-9-CM coding manual volume 3, which includes surgical, diagnostic, or medical procedures. For outpatient claims, enter the license number of the physician referring the patient to the hospital.
77	Operating provider	Enter operating provider's name (last name and first name) and identifiers. **Optional** NPI number of the operating provider. **Required** TPI in the block to the right of qualifier box, if applicable. This is required when a surgical procedure code is listed on the claim. Include the name and ID number of the individual with the primary responsibility for performing the surgical procedure(s).

Block No.	Description	Guidelines
78–79	Other (A or B) provider	Other provider's name (last name and first name) and identifiers: **Optional** NPI number of the other provider. See below for additional information. **Required** TPI in the block to the right of qualifier box, if applicable. For outpatient claims, enter the license number for the following: • The ordering physician for all laboratory and radiology services. (If a different physician ordered laboratory or radiology services, enter his or her license number in Block 76, and enter the referring/attending physician's license number or UPIN in this block.) • The designated physician for a limited client when the physician performed or authorized nonemergency care. • Referring provider—The provider who sent the patient to another provider for services. Required on an outpatient claim when the referring provider is different than the attending physician. ***Note:*** *If the referring physician is a resident, Blocks 76 and 78 must identify the physician who is supervising the resident.* 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.
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 patient is deceased, enter the date of death. • If services were rendered on the date of death, enter the time of death. • 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. • Enter the date of onset for patients receiving dialysis services. • Request for 110-day rule for a third party insurance.

Block No.	Description	Guidelines
81A–81D	Code code (CC)	**Optional** Area to capture additional information necessary to adjudicate the claims. required when, in the judgment of the provider, the information is needed to substantiate the medical treatment and is not support elsewhere on the claim data set.

5.6.5 Occurrence Codes

Code	Description	Guidelines
01	Auto accident/auto liability insurance involved	Enter the date of an auto accident. Use this code to report an auto accident that involves auto liability insurance requiring proof of fault.
02	Auto or other accident/ no fault involved	Enter the date of the accident including auto or other where no-fault coverage allows insurance immediate claim settlement without proof of fault. Use this code in conjunction with occurrence codes 24, 50, or 51 to document coordination of benefits with the no-fault insurer.
03	Accident/tort liability	Enter the date of an accident (excluding automobile) resulting from a third party's action. This incident may involve a civil court action in an attempt to require payment by the third party other than no-fault liability. **Refer to:** "Tort Response Form" on page B-113.
04	Accident/employment-related	Enter the date of an accident that allegedly relates to the patient's employment and involves compensation or employer liability. Use this code in conjunction with occurrence codes 24, 50, or 51 to document coordination of benefits with Workers' Compensation insurance or an employer. Only services not covered by Workers' Compensation may be considered for payment by Medicaid.
05	Other accident	Enter the date of an accident not described by the above codes. Use this code to report no other casualty related payers have been determined.
06	Crime victim	Enter the date on which a medical condition resulted from alleged criminal action.
10	Last menstrual period	Enter the date of the last menstrual period when the service is maternity-related.
11	Onset of symptoms	Indicate the date the patient first became aware of the symptoms or illness being treated.
16	Date of last therapy	Indicate the last day of therapy services for OT, PT, or speech therapy (ST).
17	Date outpatient OT plan established or last reviewed	Indicate the date a plan was established or last reviewed for occupation therapy.
24	Date other insurance denied	Enter the date of denial of coverage by a TPR.
25	Date benefits terminated by primary payer	Enter the last date for which benefits are being claimed.
27	Date home health plan of treatment was established	Enter the date the current plan of treatment was established.
29	Date outpatient PT plan established or last reviewed	Indicate the date a plan of treatment was established or last reviewed for physical therapy.

Code	Description	Guidelines
30	Date outpatient speech pathology plan established or last reviewed	Indicate the date a plan of treatment for speech pathology was established or last reviewed.
35	Date treatment started for PT	Indicate the date services were initiated for physical therapy.
44	Date treatment started for OT	Indicate when occupational therapy services were initiated.
45	Date treatment started for speech-language pathology (SLP)	Indicate when speech language pathology services were initiated.

5.6.6 Filing Tips for Outpatient Claims

The following are outpatient claim filing tips:

- Use HCPCS codes in Block 44 when available, or 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 claim form and will be assigned a different claim number by TMHP. Claims may have 61 detail lines for services and supplies plus one detail line for the total amount billed.*

- 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 claim form submitted with 28 or fewer items is given an internal claim 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 claim form. Attachments will only be used for clarification purposes.
- PT/OT procedures are based on time (initial 30 minutes or additional 15 minutes). Use the quantity billed to reflect the number of additional 15-minute increments.

Line Item	Description	Quantity
Example: one hour of PT service should be billed as two line items.		
#1	Therapeutic exercise	1
#2	Additional 15 minutes	2

Refer to: “Procedure Coding” on page 5-17.

5.7 2006 ADA Dental Claim Filing Instructions

Providers billing for dental services and Intermediate Care Facility for the Mentally Retarded (ICF-MR) dental services may bill electronically or use the 2006 American Dental Association (ADA) claim form.

Note: *TMHP is responsible for reimbursing all THSteps dental services provided by dentists, including services rendered to STAR and STAR+PLUS clients.*

5.7.1 2006 ADA Dental Claim Electronic Billing

Electronic billers must submit THSteps dental claims using TexMedConnect, TDHconnect, or in approved vendor software that uses the ANSI ASC X12 837D 4010A format. Specifications are available to providers developing in-house systems and software developers and vendors. Because each software package is different, block locations may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 1-888-863-3638.

Refer to: “TMHP Electronic Data Interchange (EDI)” on page 3-1 for more information about electronic filing.

5.7.2 ADA Dental Claim Form (Paper) Billing

All participating THSteps dental providers are required to submit a 2006 ADA Dental claim form for paper claim submissions to the Texas Medicaid Program. These forms may be obtained by contacting the ADA at 1-800-947-4746.

Important: *Claims must contain the billing provider’s full name, address, and/or provider identifier.*

5.7.3 2006 ADA Dental Claim Form

A sample of the ADA Dental Claim form can be found on the ADA website at www.ada.org/prof/resources/topics/claimform.asp.

5.7.4 2006 ADA Dental Claim Form Instruction Table

The following table is an itemized description of the questions appearing on the form. Thoroughly complete the 2006 ADA Dental claim form according to the instructions in the table to facilitate prompt and accurate reimbursement and reduce follow-up inquiries.

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 2006 ADA Dental Claim Form as a Texas Medicaid Program Prior Authorization form. **Refer to:** "THSteps Dental Mandatory Prior Authorization Request Form" on page B-108.
2	Predetermination/Preauthorization Number	Enter prior authorization number if assigned by Medicaid.
3	Company/Plan Name, Address, City, State, ZIP Code	Enter name and address of Texas Medicaid Program Contractor payer where the claim is to be sent.
4	Other Dental or Medical Coverage?	Leave blank if no other dental or medical coverage (skip Blocks 5-11). Check Yes if dental or medical coverage is available other than Texas Medicaid Program coverage, and complete Blocks 5-11.
5	Name of Policyholder/Subscriber in # 4	Subscriber name if non-Medicaid insurance. This line refers to the insured and is not necessarily the client. May be a parent or legal guardian of the client receiving treatment.
6	Date of Birth (MM/DD/CCYY)	Enter insured's eight-digit date of birth (MM/DD/CCYY) if non-Medicaid insurance. This line refers to the insured and is not necessarily the client. May be a parent or legal guardian of the client receiving treatment.
7	Gender	Check insured's correct gender if non-Medicaid insurance. This line refers to the insured and is not necessarily the client. May be a parent or legal guardian of the client receiving treatment.
8	Policyholder/Subscriber ID	Enter insured's subscriber identifier if non-Medicaid insurance. This line refers to the insured and is not necessarily the client. May be a parent or legal guardian of the client receiving treatment.
9	Plan/Group Number	Enter insured's plan/group number if non-Medicaid insurance. This line refers to the insured and is not necessarily the client. May be a parent or legal guardian of the client receiving treatment.
10	Patient's Relationship to Person Named in # 5	Enter insured's relationship to primary subscriber if non-Medicaid insurance. This line refers to the insured and is not necessarily the client. May be a parent or legal guardian of the client receiving treatment.
11	Other Insurance Company/Dental Benefit Plan Name, Address, City, State, ZIP Code	Information on other carrier, if applicable.
12	Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code	Enter client's last name, first name, and middle initial exactly as written on the Texas Medicaid Identification Form (Form H3087).
13	Date of Birth (MM/DD/CCYY)	Enter client's eight-digit date of birth (MM/DD/CCYY).
14	Gender	Check client's correct gender.

ADA Block No.	ADA Description	Instructions
15	Policyholder/Subscriber ID	Enter client's Medicaid number.
16	Plan/Group/Number	Enter the benefit code, if applicable, of the billing or performing provider.
17	Employer Name	Not applicable to the Texas Medicaid Program.
18	Relationship to Policy-holder/Subscriber in # 12 Above	Not applicable to the Texas Medicaid Program.
19	Student Status	For exception to periodicity, check the full-time student (FTS) box and provide a narrative explanation in Block 35. ***Note:*** *Block 19 may be left blank on claims submitted for emergency/trauma.*
20	Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code	Not applicable to the Texas Medicaid Program.
21	Date of Birth (MM/DD/CCYY)	Not applicable to the Texas Medicaid Program.
22	Gender	Not applicable to the Texas Medicaid Program.
23	Patient ID/Account # (Assigned by Dentist)	**Optional** Used by dental office to identify internal client account number. This block is not required to process the claim.
24	Procedure Date (MM/DD/CCYY)	Enter eight-digit date of service (MM/DD/CCYY).
25	Area of Oral Cavity	Not applicable to the Texas Medicaid Program.
26	Tooth System	Not applicable to the Texas Medicaid Program.
27	Tooth Number(s) or Letter(s)	Enter the Tooth ID as required for procedure code. **Refer to:** "Tooth Identification (TID) and Surface Identification (SID) Systems" on page 19-9.
28	Tooth Surface	Enter Surface ID as required for procedure code. **Refer to:** "Tooth Identification (TID) and Surface Identification (SID) Systems" on page 19-9.
29	Procedure Code	Use appropriate Current Dental Terminology (CDT) procedure code.
30	Description	Enter brief description from the CDT procedure code.
31	Fee	Enter usual and customary charges for each line of service used. Charges must not be higher than the fees charged to private pay clients.
32	Other Fee(s)	Enter other fees (e.g., other insurance payment).
33	Total Fee	Total all fees in column under Block 31.
34	Place an X on each missing tooth	Place an X on each missing tooth as required for procedure code.
35	Remarks	Use the Remarks space for local orthodontia codes, a narrative explanation for exception to periodicity (Block 19), a facility name and address if the place of treatment (Block 38) is not a provider's office, an emergency narrative (Block 45), or additional information, such as reports for 999 codes or multiple supernumerary teeth, or remarks codes.
36	Patient/Guardian signature	Not applicable to the Texas Medicaid Program.
37	Subscriber signature	Not applicable to the Texas Medicaid Program.

ADA Block No.	ADA Description	Instructions
38	Place of Treatment	Check only Provider's office box or Hospital box. Use Hospital if a day surgery facility was used.
39	Number of Enclosures	The Texas Medicaid Program does not require enclosures to accompany a claim. Do not submit radiographs with claims.
40	Is Treatment for Orthodontics?	Check Yes or No as appropriate.
41	Date Appliance Placed	Not applicable to the Texas Medicaid Program.
42	Months of Treatment Remaining	Not applicable to the Texas Medicaid Program.
43	Replacement of Prosthesis?	Not applicable to the Texas Medicaid Program.
44	Date Prior Placement	Not applicable to the Texas Medicaid Program.
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 the Texas Medicaid Program.
47	Auto Accident State	Not applicable to the Texas Medicaid Program.
48	Name, Address, City, State, ZIP Code	Name and address of the billing group or individual provider (not the name and address of a provider employed within a group).
49	NPI	**Optional** Enter required billing dentist's NPI for a group or an individual (not the NPI for a provider employed within a group).
50	License Number	Not applicable to the Texas Medicaid Program.
51	Social Security Number (SSN) or Tax Identification Number (TIN)	Not applicable to the Texas Medicaid Program.
52	Telephone Number	Enter area code and telephone number of billing group or individual (not the telephone number of a provider employed within a group).
52A	Additional Provider ID	Enter the nine-digit TPI assigned to the billing dentist or dental entity (not the CSHCN Services Program provider employed within a group).
53	Signed (Treating Dentist)	Required-Signature of treating dentist or authorized personnel.
54	NPI	**Optional** Enter the performing dentist's (provider who treated the client) NPI number.
55	License Number	Not applicable to the Texas Medicaid Program.
56	Address, City, State, ZIP Code	Not applicable to the Texas Medicaid Program.
56A	Provider Specialty Code	This block is optional.
57	Telephone Number	Not applicable to the Texas Medicaid Program.
58	Additional Provider ID	**Required** Enter performing dentist's (provider who treated the client) nine-digit TPI.

5.8 Family Planning 2017 Claim Form

Family Planning 2017 Claim Form

1. Family Planning Program: V ☐ XIX ☐ XX ☐

1a. Title X Only — Full Pay ☐ Partial Pay ☐ No Pay ☐

2a. Billing Provider TPI

2b. Billing Provider NPI

3. Provider Name

4. Eligibility Date (V or XX) (MM/DD/CCYY)

5. Family Planning No. (Medicaid PCN if XIX)

6. Patient's Name (Last Name, First Name, Middle Initial)

7. Address (Street, City, State)

7a. ZIP code

8. County of Residence

9. Date of Birth (MM/DD/CCYY)

10. Sex F ☐ M ☐

11. Patient Status — New Patient ☐ Established Patient ☐

12. Patient's Social Security Number - -

13. Race (Code #) ☐
White (1) Black (2) AmIndian/AlaskaNat (4) Asian (5)
Unk/NotRep (6) NatHawaii/PacIsland (7) More than one race (8)

13a. Ethnicity ☐
Hispanic (5) Non-Hispanic (0)

14. Marital Status ☐
(1) Married (2) Never Married (3) Formerly Married

15. Family Income (All) $

15a. Family Size

16. Number Times Pregnant

17. Number Live Births

18. Number Living Children

19. Primary Birth Control Method Before Initial Visit ☐

20. Primary Birth Control Method at End of This Visit ☐

a=Oral Contraceptive; b=1-Month hormonal injection; c=3-Month hormonal injection; d=Cervical cap/diaphragm; e=Abstinence; f= Hormonal Implant; g=Male condom; h=Female condom; i=Hormonal/Contraceptive patch; j=Spermicide (used alone); k=Intrauterine device (IUD); l=Vaginal ring; m=Fertility awareness method (FAM); n=Sterilization; o=Contraceptive sponge; p=Other method; q=Method unknown; r=No method (if used for #20, must complete #21)

21. If No Method Used at End of This Visit, Give Reason (Required only if #20 = r) ☐

a=Refused; b=Pregnant; c=Inconclusive Preg Test; d=Seeking Preg; e=Infertile; f=Rely on Partner; g=Medical

22. Is There Other Insurance Available? Y ☐ N ☐ If Y, Complete Items 23 – 25a

23. Other Insurance Name and Address

24a. Insured's Policy/Group No.

24b. Benefit Code

25. Other Insurance Pd. Amt. $

25a. Date of Notification

26. Name of Referring Provider

27a. Referring Other ID

27b. Referring NPI

28. Level of Practitioner
Physician ☐ Nurse ☐ Mid Level ☐ Other ☐

29. Diagnosis Code (Relate Items 1,2,3,or 4 to Item 32D by Line # in 32E)
1. _____ 3. _____
2. _____ 4. _____

30. Authorization Number

31. Date of Occurrence (MM / DD / CCYY)

32. A Dates of Service From MM	DD	CCYY	To MM	DD	CCYY	B Place of Service	C Reserved for Local Use	D Procedures, Services, or Supplies CPT/HCPCS Modifier	E Dx. Ref. (29)	F Units or Days (Quantity) No. of Participants (Teen Counseling)	G $ Charges	H Performing Provider #
												32H(a) TPI 32H(b) NPI
												32H(a) TPI 32H(b) NPI
												32H(a) TPI 32H(b) NPI
												32H(a) TPI 32H(b) NPI
												32H(a) TPI 32H(b) NPI

33. Federal Tax ID Number/EIN

34. Patient's Account No. (optional)

35. Patient Co-Pay Assessed (V, X or XX) $

36. **Total Charges**

37. Signature of Physician or Supplier
Date:
Signed:

38. Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)

38a. NPI

38b. Other ID

39. Physician's, Supplier's Billing Name, Address, Zip Code & Phone No.

Form Revised: January 2007

5.8.1 Family Planning 2017 Claim Form Instructions

Block No.	Description	Guidelines	Required
1	Family planning program	Check the box for the specific entitlement funds to which these family planning services are billed. If the facility also receives Title X funds, the Level of Practitioner (28) must be indicated. ***Note:*** *Claims/Encounters will be cross-checked with Title XIX Medicaid eligibility before Title V, X, or XX processing.*	V, XIX, XX
1a	Title X only	If it is a "Title X Only" encounter, the level of payment must be indicated. If the facility also receives Title X funds, the level of practitioner (28) must be indicated.	X
2a	Billing provider TPI	Enter the billing provider's nine-digit Texas Provider Identifier (TPI).	V, X, XIX, XX
2b	Billing provider NPI	**Optional** Enter the billing provider's NPI.	V, X, XIX, XX
3	Provider name	Enter the provider's name as enrolled with TMHP.	V, X, XIX, XX
4	Eligibility date (V or XX)	Enter the date (MM/DD/CCYY) this client was originally designated eligible for Title V or XX services. If client has V or XX eligibility from a previous visit, enter that eligibility date. For a Title XX client, this information comes from the 2025 claim form. For a Title V client, this information comes from the Texas Eligibility Screening System (TESS).	V, XX
5	Family planning no. (Medicaid PCN if XIX)	If previous V, X, and/or XX claims or encounters have been submitted to TMHP, enter the client's nine-digit family planning 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 family planning client, without Medicaid, leave this block blank and TMHP will assign a family planning 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 Title V, X, or XX.	V, X, XIX, XX
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.	V, X, XIX, XX
7a	ZIP Code	Enter the client's ZIP Code.	V, X, XIX, XX
8	County of residence	Enter the county code that corresponds to the client's address. Please use the HHSC county codes.	V, X, XIX, XX
9	Date of birth	Enter numerically the month, day, and year (MM/DD/CCYY) the client was born.	V, X, XIX, XX
10	Sex	Indicate the client's sex by checking the appropriate box.	V, X, XIX, XX

Block No.	Description	Guidelines	Required
11	Patient status	Indicate if this is the client's first visit to this family planning provider (new patient) or if this client has been to this family planning 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."	V, X, XIX, XX
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.	V, X, XIX, XX
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.	V, X, XIX, XX
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."	V, X, XIX, XX
14	Marital status	Indicate the client's marital status by entering the appropriate marital code number in the box.	V, X, XIX, XX

Block No.	Description	Guidelines	Required
15	Family income (all)	Titles V, XX, XX: Use the gross monthly income calculated and reported on the eligibility assessment tool. Title XIX providers: Enter the gross monthly income reported by the client. Be sure to include all sources of income. No documentation of income is required. For clients who are married (including common-law marriages) or who are 20 years of age or older, enter the gross monthly income of all family members. For unmarried clients age 19 years or younger, enter the gross monthly income of the client only, not the income of all family members. *To calculate gross monthly income for Title XIX:* 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.	V, X, XIX, XX
15a	Family size	Titles V, X, XX: 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."	V, X, XIX, XX
16	Number times pregnant	Enter the number of times this client has been pregnant. If male, enter zero.	V, X, XIX, XX
17	Number live births	Enter the number of live births for this client. If male, enter zero.	V, X, XIX, XX
18	Number living children	Enter the number of living children this client has. This also must be completed for male clients.	V, X, XIX, XX
19	Primary birth control method before initial visit	Enter the appropriate code letter (a through r) in the box.	V, X, XIX, XX
20	Primary birth control method at end of this visit	Enter the appropriate code letter (a through r) in the box.	V, X, XIX, XX
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 Block 21 (a through g).	V, X, XIX, XX (only if #20=r)
22	Is there other insurance available?	Check the appropriate box.	
23	Other insurance name and address	Enter the name and address of the health insurance carrier.	
24a	Insured's policy/group no.	Enter the insurance policy number or group number.	
24b	Benefit code	Benefit code, if applicable for the billing or performing provider.	

Block No.	Description	Guidelines	Required
25	Other insurance paid amount	Enter the amount paid by the other insurance company. If payment was denied, enter "Denied" in this block.	
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.	
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
27a	Referring other ID	If a non-family planning service is being billed and the service requires a referring provider identifier, enter the referring provider's TPI.	XIX
27b	Referring NPI	**Optional** If a non-family planning service is being billed and the service requires a referring provider identifier, enter the referring provider's NPI.	XIX
28	Level of practitioner	Enter the level of practitioner that performed the service. Primary care or generalist physicians and specialists are correctly classified as "Physicians." Certified nurse-midwives, nurse practitioners, clinical nurse specialists, and physician assistants providing family planning encounters are correctly categorized as "Midlevel." Family planning 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 Title X funding.	X
29	Diagnosis code (relate items 1, 2, 3, or 4 to item 32D by line # in 32E)	Enter the ICD-9-CM diagnosis code to the highest level of specificity available; complete to five digits for each diagnosis observed.	V, X, XIX, XX
30	Authorization number	Enter the authorization number for the client, if appropriate.	
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.	V, X, XIX, XX, if billing complications
32A	Dates of service	Enter the dates of service 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, 18/2007). **Electronic Billers** Medicaid does not accept multiple (to–from) dates on a single-line detail. Bill only one date per line.	V, X, XIX, XX

Block No.	Description	Guidelines	Required
32B	Place of service	Enter the appropriate POS code for each service from the POS table under "Place of Service (POS) Coding" on page 5-16. If the client is registered at a hospital, the POS must indicate inpatient or outpatient status at the time of service.	V, X, XIX, XX
32C	Reserved for local use	Leave this block blank. ***Note:*** *Type of service (TOS) codes are no longer required for claims submission.*	
32D	Procedures, services, or supplies CPT/HCPCS modifier	Enter the appropriate CPT or HCPCS procedure codes for all procedures/services billed using the family planning services listed in "Family Planning Services" on page 20-1.	V, X, XIX, XX
32E	Dx. ref. (29)	Enter the diagnosis line item reference (1, 2, 3, or 4) for each service or procedure as it relates to each ICD-9-CM diagnosis code identified in Block 29. If a procedure is related to more than one diagnosis, the primary diagnosis the procedure is related to must be the one identified. Do not enter more than one reference per procedure.	V, X, XIX, XX
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).	V, X, XIX, XX
	No. of participants (teen counseling)	For Teen Group Counseling, enter the total number of participants included in the teen group counseling session. Required for Title XX, Teen Group Counseling claims.	No. of partici-pants is required for Title XX teen group counseling
32G	$ Charges	Indicate the charges for each service listed (quantity times reimbursement rate). Charges must not be higher than fees charged to private-pay clients. Approved rate tables can be found in "Family Planning Services" on page 20-1	V, X, XIX, XX
32H (a)	Performing provider number (XIX only)—TPI	Members of a group practice (except pathology and renal dialysis groups) must identify the nine-digit TPI of the doctor/clinic within the group who performed the service. ***Note:*** *It is recommended that providers complete this block for Titles V, X, and XX when the procedure code that is entered would normally require a performing provider identifier, if it were billed under Title XIX. If a claim or encounter that was submitted for V, X, or XX is later determined as eligible to be paid from Title XIX and the performing provider identifier is missing, the claim will be denied with a request for this information. To avoid unnecessary claim or encounter denial, complete this information for all claims and encounters.*	XIX

Block No.	Description	Guidelines	Required
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 doctor/clinic within the group who performed the service. ***Note:*** *It is recommended that providers complete this block for Titles V, X, and XX when the procedure code that is entered would normally require a performing provider identifier, if it were billed under Title XIX. If a claim or encounter that was submitted for V, X, or XX is later determined as eligible to be paid from Title XIX and the performing provider identifier is missing, the claim will be denied with a request for this information. To avoid unnecessary claim or encounter denial, complete this information for all claims and encounters.*	XIX
33	Federal tax ID number/EIN (optional)	Enter the federal Tax ID Number (TIN) (Employer Identification Number [EIN]) that is associated with the provider identifier enrolled with TMHP.	
34	Patient's account number (optional)	Enter the client's account number that is used in the provider's office for its payment records.	
35	Patient copay assessed	If the client was assessed a copayment (V, X, or XX), 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 25 percent of total charges for Title V or XX patients.	V, X, XX
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.	V, X, XIX, XX
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.	V, X, XIX, XX
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/ECI). 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 the Texas Medicaid Program for the services performed.	XIX

Block No.	Description	Guidelines	Required
38a	NPI	**Optional** Enter the NPI of the provider where services were rendered (if other than home or office).	XIX
38b	Other ID	Enter the nine-digit TPI of the provider where services were rendered (if other than home or office).	XIX
39	Physician's, supplier's billing name, address, ZIP Code, and telephone number	Enter the billing provider name, street, city, state, ZIP Code, and telephone number.	
	Teen group counseling	Providers billing Teen Group Counseling must complete the following blocks: 1. Family planning program—should be Title XX 2. (a-b) Provider numbers/provider identifiers 3. Provider name 5. Family planning No.—Enter 999999999 (electronic billers, enter 999999999 in the Medicaid No. block) 6. Patient's name—Enter "teen group counseling" 12. Patient's Social Security number—should be 999-99-9999 29. Diagnosis code—use V2509 32A. Dates of service 32B. Place of service 32D. Procedures, services, or supplies; CPT/HCPCS modifier 32E. Dx. ref. (29) 32F. No. of participants 32G. $ Charges 33. Federal Tax ID Number/EIN 36. Total charges 37. Signature of physician or supplier	XX—teen group counseling only

5.9 Vision Claim Form

All vision services must be billed on a CMS-1500 claim form or the appropriate electronic formats. The eyeglass prescription must be in Block 24D (line 5 for the new prescription and line 6 for the old prescription). The Patient Certification Form must be retained in the patient's file – *do not submit to TMHP.* Vision care services are benefits of the Texas Medicaid Program only for clients age 21 years of age and older. Vision claims submitted on other forms are denied with EOB 01145, "Claim form not allowed for this program." Providers have 120 days from the date of the R&S report to resubmit claims to TMHP on the CMS-1500, with the R&S report where the claim appears as denied attached.

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

Block No.	Description
1a	Enter the patient's nine-digit client number from the Medicaid Identification Form (H3087).
2	Enter the patient's last name, first name, and middle initial as printed on the Medicaid Identification Form (H3087).
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).

Block No.	Description
9 and 9a–9d	Other insurance or government benefits
10	Was condition related to: a) Patient's employment b) Auto accident c) Other accident
11	Medicare HIC number
12	Patient's or authorized person's signature
13*	Insured or authorized person's signature
17 Name of referring physician or other source 17a Other ID# (TPI) 17b NPI (Optional)	Name, provider identifiers, and address of prescribing medical doctor or doctor of optometry
21	Diagnosis or nature of illness or injury
24A	DOS
24B	POS
24D	Describe procedures, medical services, or supplies furnished for each date given
24D, Line "5" for new prescription 24D, Line "6" for old prescription	Prescription/description of lenses and frames
24E	Diagnosis pointer
24F	Charges
26*	The account number for the patient that is used in the provider's office for its billing records.
27 Check "YES" or "NO"	Accept assignment
28	Total charges
29	Amount paid by other insurance
31	Signature of physician or supplier
32	Name and address of facility where services were rendered if other than home or office
33	Telephone number
33	Physician's or supplier's name, address, city, state, and ZIP code
No longer used	Referral from screening program (THSteps)
Providers must have patients sign the Patient Certification Form and retain in their records. **Refer to:** "Vision Care Eyeglass Patient (Medicaid Client) Certification Form" on page B-115. Do *not* submit to TMHP.	Selection of eyewear beyond program benefits/replacing lost or destroyed eyewear

5.10 Remittance and Status (R&S) Report

The R&S report provides information on pending, paid, denied, and adjusted claims. TMHP provides weekly R&S reports to give providers detailed information about the status of claims submitted to TMHP. The R&S report also identifies accounts receivables established as a result of inappropriate payment. These receivables are recouped from claim submissions. All claims for the same provider identifier and program processed for payment are paid at the end of the week, either by a single check or with Electronic Funds Transfer (EFT). If no claim activity or outstanding account receivables exist during the cycle week, the provider does not receive an R&S report. Providers are responsible for reconciling their records to the R&S to determine payments and denials received.

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

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: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for more information.

5.10.1 R&S Report Delivery Options

TMHP offers three options for the delivery of the R&S report. Although providers can choose any of the following methods, a newly-enrolled provider is initially set up to receive an PDF version of the R&S report.

- *PDF version.* The PDF version of the R&S report is an exact replica of the paper R&S report. The PDF version of the R&S report can be downloaded by registered users of the www.tmhp.com website. The report is available each Monday morning, immediately following the weekly claims cycle. Payments associated with the R&S report are not released until all provider payments are released on the Friday following the weekly claims cycle. *Providers who use the PDF version will not receive paper copies of the R&S report.*
- *Paper version*. Paper R&S reports can be mailed to providers the Friday following the weekly claims cycle. Reimbursement checks are mailed with the paper R&S report, if the provider has not elected EFT.

  Note: *Additional copies of paper R&S reports will be charged to the provider if requested more than 30 days after the original R&S report was issued. There is an initial charge of $9.75 for the request (additional hours = $9.75) with a charge of $0.32 per page and applicable taxes of 8.25 percent.*

In addition to the PDF and paper versions of the R&S report, a third, optional R&S report delivery method is also available. Using HIPAA-compliant EDI standards, the Electronic Remittance & Status (ER&S) report can be downloaded through the TMHP EDI Gateway using TexMedConnect, TDHconnect, or third-party software. The ER&S report is also available each Monday after the completion of the claims processing cycle. For more information about EDI formats and enrollment for the ER&S report, please refer to "TMHP Electronic Data Interchange (EDI)" on page 3-1.

5.10.2 Banner Pages

Banner pages serve two purposes. First, they print the provider's name and address in a location that appears in the window of the envelope. Second, 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 (TPI, NPI, and Atypical Provider Identifier [API]).
- Report sequence number (indicates the week number of the year).
- Date of the week being reported on the R&S report.
- TIN.
- Page number (R&S report begins with page 1).
- AIS telephone number.
- Taxonomy code.

5.10.3 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
300	Family Planning (Titles V, X, and XX)
400	CSHCN
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
055	Family Planning Title V
056	Family Planning Title X
057	Family Planning Title XX
058	Family Planning Title XIX (Form 2017)

Media Source (MMM)

Region	Description
010	Paper
011	Paper adjustment
020	TDHconnect
021	TDHconnect adjustment
030	Electronic (including TexMedConnect)
031	Electronic adjustment (including TexMedConnect)
041	AIS adjustment
051	Mass adjustment
061	Crossover adjustment
071	Retroactive eligibility adjustment
080	State Action Request (SAR)
081	SAR adjustment
090	Phone
091	Referral Identification Monitoring System (RIMS)
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 "Place of Service (POS) Coding" on page 5-16 for the appropriate cross-reference among the two-digit numeric POS codes (Medicare), alpha POS codes, and one-digit numeric code on the R&S report. Providers using electronic claims submission should continue using the same POS codes.
- *Paid Amt.* The final amount allowed for payment per claim detail. The total paid amount for the claim appears on the claim total line.
- *EOB Codes and Explanation of Pending Status (EOPS) Codes.* These codes explain the payment or denial of the provider's claim. The EOB codes are printed next to or directly below the claim. The EOPS codes appear only in "The Following Claims Are Being Processed" section of the R&S report. The codes explain the status of pending claims and are not an actual denial or final disposition. An explanation of all EOB and EOPS codes appearing on the R&S report are printed in the Appendix at the end of the R&S report. Up to five EOB codes are displayed.

- *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.

Refer to: "Modifier Requirements for TOS Assignment" on page 5-14 for a list of the most commonly used modifiers.

5.10.4 R&S Report Section Explanation

5.10.4.1 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 claim form, Block 17).
- *Proc.* ICD-9-CM code indicates the primary surgical procedure used in determining the DRG.

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

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

Refer to: "Claims Information" on page 5-4 for a description of different claim types.

5.10.4.2 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 XXXXXXXXXXXXXXXXXXXXXXX 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."

Refer to: "Modifier Requirements for TOS Assignment" on page 5-14 for a list of the most commonly used modifiers.

5.10.4.3 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:

Accounts Receivable

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

- *Control Number.* A number to reference when corresponding with TMHP.
- *Recoupment Rate.* The percentage of the provider's payment that is withheld each week unless the provider elects to have a specific amount withheld each week.
- *Maximum Periodic Recoupment Amount.* The amount to be withheld each week. This area is blank if the provider elects to have a percentage withheld each week.
- *Original Date.* The date the financial transaction was processed originally.
- *Original Amount.* The total amount owed TMHP.
- *Prior Date.* The date the last transaction on the accounts receivable occurred.
- *Prior Balance.* The amount owed from a previous R&S report.
- *Applied Amount.* The amount subtracted from the current R&S report.
- *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.* If the accounts receivable are claim-specific, the name of the patient on the claim.
- *Claim Number.* If the accounts receivable are claim-specific, the ICN of the original claim.

- *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.

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.)

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 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.

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).

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.

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.

5.10.4.4 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.
- *Amount Paid to IRS for Levies.* The amount remitted to IRS and withheld from the provider's payment due to an IRS levy.
- *Amount Paid to IRS for Backup Withholding.* The amount paid to the IRS for backup withholding.
- *Accounts Receivable Recoupments.* The total amount withheld from the provider's payment due to accounts receivable.
- *Amounts Stopped/Voided.* The total amount of the payment that was voided or stopped with no reissuance of payment.
- *System Reissues.* The amount of the reissed 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.

5.10.4.5 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.

5.10.4.6 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.

5.10.4.7 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.

5.10.5 R&S Report Examples

See the following pages for examples of R&S reports.

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2008

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0855

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

(800) 925-9126

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

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

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BANNER PAGE

(8/24/07 THROUGH 9/14/07) *****ATTENTION ALL MEDICAID PROVIDERS*****

Effective for dates of service on or after September 1, 2007, the Texas Medicaid Program is implementing benefit changes for respiratory syncytial virus (RSV) prophylaxis palivizumab (Synagis). Details of these changes are available on the TMHP website at www.tmhp.com and will also be available in the January/February 2008 *Texas Medicaid Bulletin*, No. 212. For more information, call the TMHP Contact Center at 1-800-925-9126

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

YOUR AIS NUMBER IS 0000000-01
FOR AIS INQUIRY CALL TOLL FREE 1-(800) 925-9126
THE PROVIDER MANUAL PROVIDES DETAILS.
PHYSICAL ADDRESS ON RECORD:
TEXAS PROVIDER
PO BOX 848484
DALLAS, TX 75888-1234

(214) 555-4141

5.10.6.1 Paid or Denied Claims (Hospital) R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2008

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

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PATIENT NAME	CLAIM NUMBER	MEDICAID #	PATIENT ACCT #	MEDICAL RECORD # PATIENT ACCT #	MEDICARE #	EOB	EOB	EOB	EOB	DIAGNOSIS
		---SERVICE DATES---		-----BILLED-----	-----ALLOWED-----					
FROM TO	TOS PROC	QTY CHARGE	QTY CHARGE	POS	PAID AMT	EOB	EOB	EOB	EOB EOB	MOD MOD
********** CLAIMS - PAID OR DENIED **********										
DOE, JANE	10004001020071234567891 2	519090123			01147					V700
05/22/2007 05/22/2007	1 T1015	1.0 71.00	.0 .00	1300 5	.00	00013				U7
			$71.00	$.00	$.00	CLAIM TOTAL				
	00139	PAYMENT WAS REDUCED BY 37.95 DUE TO OTHER INSURANCE PAYMENTS								
DOE, JANE	10004003020071236547896 3	501161789	N12505-010017		01147					V6519
08/20/2007 08/20/2007	1 T1015	1.0 71.00	.0 .00	5	.00	00013				AM
			$71.00	$.00	$.00	CLAIM TOTAL				

IF YOU NEED TO APPEAL ANY CLAIM ON THIS PAGE, YOU MAY APPEAL ELECTRONICALLY FOR THE MOST EXPEDITIOUS PROCESSING. OTHERWISE, MAKE ONE COPY OF THIS PAGE FOR EACH CLAIM TO BE APPEALED, CIRCLE THE CLAIM YOU ARE APPEALING AND DESCRIBE YOUR APPEAL. YOUR APPEAL MUST BE RECEIVED WITHIN 120 DAYS FROM THE DATE OF THE R&S. FOR INFORMATION REGARDING THE ELECTRONIC PROCESS CALL 1-888-863-3638. CLAIMS WITH AN ALLOWED CHARGE OF $0.00 AND A PAID AMOUNT OF $0.00 MUST BE RESUBMITTED WITH A COMPLETED CLAIM AND A COPY OF THIS R&S PAGE TO THE FIRST ADDRESS LISTED ABOVE WITHIN 120 DAYS FROM THE DATE OF THE R&S.

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2008

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TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 35
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PATIENT NAME / PATIENT ACCT #	CLAIM NUMBER	MEDICAID #	PATIENT ACCT #	MEDICAL RECORD #	MEDICARE #	EOB	EOB	EOB	EOB	DIAGNOSIS
---SERVICE DATES--- FROM TO	TOS PROC	-----BILLED----- QTY CHARGE	-----ALLOWED----- QTY CHARGE	POS	PAID AMT	EOB	EOB	EOB	EOB EOB	MOD MOD

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

DOE, JANE 0000	10003001020070440000000		999999900				01147			53081
01/04/2008 01/04/2008	3 99252	1.0	226.00	1.0	56.46	3	55.05	00000 00475 01004		
			$226.00		$56.46		$55.05	CLAIM TOTAL		
PAID CLAIM TOTALS			$226.00		$56.46		$55.05			

****

IF YOU NEED TO APPEAL ANY CLAIM ON THIS PAGE, YOU MAY APPEAL ELECTRONICALLY FOR THE MOST EXPEDITIOUS PROCESSING. OTHERWISE, MAKE ONE COPY OF THIS PAGE FOR EACH CLAIM TO BE APPEALED, CIRCLE THE CLAIM YOU ARE APPEALING AND DESCRIBE YOUR APPEAL. YOUR APPEAL MUST BE RECEIVED WITHIN 120 DAYS FROM THE DATE OF THE R&S. FOR INFORMATION REGARDING THE ELECTRONIC PROCESS CALL 1-888-863-3638. CLAIMS WITH AN ALLOWED CHARGE OF $0.00 AND A PAID AMOUNT OF $0.00 MUST BE RESUBMITTED WITH A COMPLETED CLAIM AND A COPY OF THIS R&S PAGE TO THE FIRST ADDRESS LISTED ABOVE WITHIN 120 DAYS FROM THE DATE OF THE R&S.

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Date: 02/01/2008

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Benefit Code:
Report Seq. Number: 35
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PATIENT NAME / PATIENT ACCT #	CLAIM NUMBER	MEDICAID #	PATIENT ACCT #	MEDICAL RECORD #	MEDICARE #	EOB	EOB	EOB	EOB	DIAGNOSIS
---SERVICE DATES---		-----BILLED-----	-----ALLOWED-----							
FROM TO	TOS PROC	QTY CHARGE	QTY CHARGE	POS	PAID AMT	EOB	EOB	EOB	EOB EOB	MOD MOD

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

ADJUSTMENT CLAIM:

DOE, JANE 11111	10002101120073466666666		9333333400						00207				
02/17/2007	02/17/2007	W	D7280	1.0	600.00	.0	.00	1	.00	01147			J
					$600.00		$.00		$.00	ADJUSTMENT CLAIM TOTAL			

00123 THE CLAIM REPORTED ABOVE IS AN ADJUSTMENT TO PREVIOUS CLAIM 10002102020073555555555 WHICH APPEARS ON R&S DATED 01/14/2007

ORIGINAL CLAIM:

DOE, JANE 11111	10002102020073555555555		9333333400						01147				
02/17/2007	02/17/2007	W	D7280	1.0	600.00	1.0	62.50	1	60.94	00149	01004		J
					$600.00		$62.50		$60.94	ORIGINAL CLAIM TOTAL			

00601 A RECEIVABLE HAS BEEN ESTABLISHED IN THE AMOUNT OF THE ORIGINAL PAYMENT: $60.94. FUTURE PAYMENTS WILL BE REDUCED OR WITHHELD UNTIL SUCH AMOUNT IS PAID IN FULL.

****

IF YOU NEED TO APPEAL ANY CLAIM ON THIS PAGE, YOU MAY APPEAL ELECTRONICALLY FOR THE MOST EXPEDITIOUS PROCESSING. OTHERWISE, MAKE ONE COPY OF THIS PAGE FOR EACH CLAIM TO BE APPEALED, CIRCLE THE CLAIM YOU ARE APPEALING AND DESCRIBE YOUR APPEAL. YOUR APPEAL MUST BE RECEIVED WITHIN 120 DAYS FROM THE DATE OF THE R&S. FOR INFORMATION REGARDING THE ELECTRONIC PROCESS CALL 1-888-863-3638. CLAIMS WITH AN ALLOWED CHARGE OF $0.00 AND A PAID AMOUNT OF $0.00 MUST BE RESUBMITTED WITH A COMPLETED CLAIM AND A COPY OF THIS R&S PAGE TO THE FIRST ADDRESS LISTED ABOVE WITHIN 120 DAYS FROM THE DATE OF THE R&S.

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TPI: 1234567-01
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Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 35
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PAYOUT CONTROL NUMBER	PAYOUT AMOUNT	FYE	EOB	REFUND CHECK NUMBER	REFUND CHECK AMOUNT	PATIENT NAME	PCN	DOS

********** FINANCIAL TRANSACTIONS **********

SYSTEM PAYOUTS

YOUR PAYMENT AND 1099 LIABILITY HAS BEEN INCREASED FOR THE REASON INDICATED BELOW.

2007040555555	3,621.00	2007	06005

TOTAL SYSTEM PAYOUT: $ 3,621.00

****

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2008

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

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PAYOUT CONTROL NUMBER	PAYOUT AMOUNT	FYE	EOB	REFUND CHECK NUMBER	REFUND CHECK AMOUNT	PATIENT NAME	PCN	DOS
********** FINANCIAL TRANSACTIONS **********								
MANUAL PAYOUTS								
A CHECK FOR MEDICAID HAS BEEN SENT SEPARATELY AS PAYMENT FOR THE ITEM(S) LISTED BELOW.								
2007040896523	3.75		06008	999999999	52.82			
TOTAL FOR MEDICAID:	$ 3.75							

5.10.6.6 Accounts Receivables, Void, and Stop Pay R&S Report

For purposes of example, accounts receivables, void, and stop pay appear together on the following R&S report example.

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2008

Mail original claim to:
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P.O. Box 200555
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Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 35
R&S Number: 2460000

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CONTROL NUMBER	RECOUPMENT RATE MAXIMUM PERIODIC RECOUPMENT AMOUNT	ORIGINAL DATE ORIGINAL AMOUNT	PRIOR DATE PRIOR BALANCE	APPLIED AMOUNT	FYE	EOB	PATIENT NAME CLAIM NUMBER
********** FINANCIAL TRANSACTIONS **********							
ACCOUNTS RECEIVABLE							
YOUR PAYMENT WAS REDUCED BY THE APPLIED AMOUNT SHOWN BELOW FOR THE REASONS INDICATED.							
2007123456987	100% 348.70	08/21/2007 348.70	08/21/2007 348.70	348.70	2007	06065	DOE, JANE 10002001020073555555555
TOTAL ACCOUNTS RECEIVABLE				$348.70			
********** FINANCIAL TRANSACTIONS **********							
VOIDS AND STOPS							
CHECK NUMBER: 027159874	CHECK AMOUNT:	2.93	R&S NUMBER:	0	R&S DATE:	02/09/2007	
TOTAL VOID/STOP CHECK AMOUNTS:	$ 2.93						

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2008

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TPI: 1234567-01
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Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 35
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********** FINANCIAL TRANSACTIONS **********
REFUNDS

YOUR REFUND CHECK #000789652 DATED 07/17/2007 WAS RECEIVED BY TMHP AND APPLIED AS FOLLOWS:

CLAIM-SPECIFIC:

ICN	PATIENT NAME	CLIENT NUMBER	DATE OF SERVICE	TOTAL BILLED	AMOUNT APPLIED THIS CYCLE	EOB
10002002020077896523 6985	DOE, JANE	789652369	06/23/2007	100.00	52.51	00124
Subtotal Claim Specific					$ 52.51	

TOTAL REFUND: $ 52.51

Texas Medicaid & Healthcare Partnership
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(800) 925-9126

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TPI: 1234567-01
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Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 35
R&S Number: 2460000

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CONTROL NUMBER	-- MAXIMUM RECOUPMENT -- RATE	AMOUNT	ORIGINAL DATE	ORIGINAL AMOUNT	PRIOR BALANCE	PRIOR DATE	CURRENT AMOUNT	REMAINING BALANCE
********** FINANCIAL TRANSACTIONS **********								
IRS LEVY INFORMATION FOR MEDICAID:								
2005301111111	100%	10,139.91	10/28/2005	10,139.91	9,307.14	08/24/2007	507.08	8,800.06

PAYMENT(S) TOTALING $507.08 WAS REMITTED ON YOUR BEHALF TO THE INTERNAL REVENUE SERVICE DUE TO THE LEVY THAT IS DESCRIBED ABOVE.

****

5.10.6.9 Backup Withholding Penalty Information R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2008

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0855

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TPI: 1234567-01
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Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 35
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PROGRAM	CONTROL NUMBER	ORIGINAL DATE	WITHHELD AMOUNT

********** FINANCIAL TRANSACTIONS **********

BACKUP WITHHOLDING PENALTY INFORMATION:

OUR RECORDS INDICATE THAT YOU HAVE BEEN ASSESSED A PENALTY BY THE INTERNAL REVENUE SERVICE FOR NON-COMPLIANCE WITH BACKUP WITHHOLDING REQUIREMENTS. THEREFORE, YOUR PAYMENT HAS BEEN LOWERED AND THE PENALTY AMOUNT HAS BEEN REMITTED TO THE INTERNAL REVENUE SERVICE. 28% OF YOUR PAYMENT AMOUNT WILL BE WITHHELD WEEKLY UNTIL TMHP RECEIVES A W9 OR LETTER 147C AS REQUESTED IN A B-NOTICE PREVIOUSLY SENT TO YOUR FACILITY OR OFFICE.

MEDICAID:	20010999785236	04/08/2007	125.78

Texas Medicaid & Healthcare Partnership
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Date: 02/01/2008

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Benefit Code:
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R&S Number: 2460000

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********** FINANCIAL TRANSACTIONS **********

REISSUES

YOUR PAYMENT FOR MEDICAID HAS BEEN INCREASED BY THE AMOUNT INDICATED BELOW:

CHECK NUMBER: 028785632 AMOUNT: 745.74 R&S NUMBER: 32854723 R&S DATE: 07/20/2007

TOTAL FOR MEDICAID: $ 745.74

****

Texas Medicaid & Healthcare Partnership
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TPI: 1234567-01
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Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 35
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PATIENT NAME / PATIENT ACCT #	CLAIM NUMBER	MEDICAID #	PATIENT ACCT #	MEDICAL RECORD #	MEDICARE #	EOPS	EOPS	EOPS	EOPS	DIAGNOSIS
---SERVICE DATES---		-----BILLED-----	-----ALLOWED-----							
FROM TO	TOS PROC	QTY CHARGE	QTY CHARGE	POS	PAID AMT	EOPS	EOPS	EOPS	EOPS	EOPS MOD MOD

********** THE FOLLOWING CLAIMS ARE BEING PROCESSED **********

THE EXPLANATION OF PENDING STATUS (EOPS) CODES LISTED ARE NOT FINAL CLAIM DENIALS OR PAYMENT DISPOSITIONS. THE EOPS CODES IDENTIFY THE REASONS WHY A CLAIM IS IN PROCESS. BECAUSE THESE CLAIMS ARE CURRENTLY IN PROCESS, NEW INFORMATION CANNOT BE ACCEPTED TO MODIFY THE CLAIM UNTIL THE CLAIM FINALIZES AND APPEARS AS FINALIZED ON YOUR R&S REPORT. PLEASE REFER TO THE LAST SECTION OF THIS REPORT FOR THE MESSAGES THAT CORRESPOND TO THE EOPS CODES USED ON THIS REPORT.

DOE, JANE 10002003020071234567891O			966666600				00A01			78605
01/15/2007 01/15/2007	1	99213	1.0	201.03						
				$201.03						
PENDING CLAIM TOTALS				$201.03						

****

IF YOUR CLAIM HAS NOT APPEARED ON AN R&S REPORT AS PAID, DENIED OR PENDING WITHIN 30 DAYS OF SUBMISSION TO TMHP, PLEASE CONTACT TELEPHONE INQUIRY AT 1-800-925-9126 AND/OR SEE CLAIMS FILING INSTRUCTIONS IN YOUR PROVIDER MANUAL.

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Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 35
R&S Number: 2460000

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PAYMENT SUMMARY FOR DIRECT DEPOSIT BY EFT 000000098563125 IN THE AMOUNT OF 192.77

	*** AFFECTING PAYMENT THIS CYCLE *** AMOUNT	COUNT	*** AMOUNT AFFECTING 1099 EARNINGS *** THIS CYCLE	YEAR TO DATE
CLAIMS PAID	192.77	2	192.77	1,674.21
SYSTEM PAYOUTS				
MANUAL PAYOUTS (REMITTED BY SEPARATE CHECK OR EFT)				
AMOUNT PAID TO IRS FOR LEVIES				
AMOUNT PAID TO IRS FOR BACKUP WITHHOLDING				
ACCOUNTS RECEIVABLE RECOUPMENTS				-180.74
AMOUNTS STOPPED/VOIDED				
SYSTEM REISSUES				
CLAIM RELATED REFUNDS				-32.24
NON-CLAIM RELATED REFUNDS				
HELD AMOUNT				
PAYMENT AMOUNT	192.77		192.77	1,461.23

APPROVED TO PAY/DENY CLAIMS
PENDING CLAIMS 301.05

**********PAYMENT TOTAL FOR CHECK 000000012345678 IN THE AMOUNT OF 192.77**********

Texas Medicaid & Healthcare Partnership
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Benefit Code:
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R&S Number: 2460000

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EXPLANATION OF BENEFITS CODES MESSAGES

THE FOLLOWING ARE THE DESCRIPTIONS OF THE EOB CODES THAT APPEAR ON THIS REMITTANCE AND STATUS REPORT

00100	A CHARGE WAS NOT NOTED FOR THIS SERVICE.
00149	PROCEDURE PAYMENT BASED ON PROGRAM/BENEFIT PLAN, DATE OF SERVICE AND A MAXIMUM PAYMENT AMOUNT SET BY CMS OR HHSC.
00429	THIS SURGERY/SERVICE/SITUATION DESCRIBED IS NOT ON THE AUTHORIZATION LETTER AND IS NOT PAYABLE.
00475	PAID ACCORDING TO THE TEXAS MEDICAID REIMBURSEMENT METHODOLOGY-TMRM (RELATIVE VALUE UNIT TIMES STATEWIDE CONVERSION FACTOR)
00572	IT IS MANDATORY THAT AUTHORIZATION BE OBTAINED. DUE TO THE LACK OF APPROVAL, THE SERVICE IS NON-PAYABLE.
00757	PROCEDURE PAYMENT BASED ON PROGRAM/BENEFIT PLAN, DATE OF SERVICE AND IS CALCULATED AT THE DETAIL BILLED AMOUNT.
01004	THIS PAYMENT WAS REDUCED 2.5% IN ACCORDANCE WITH THE 78TH TEXAS LEGISLATURE, ARTICLE II OF HOUSE BILL 1, AND SECTION 2.03 OF HOUSE BILL 2292.
01147	PLEASE REFER TO OTHER EOB MESSAGES ASSIGNED TO THIS CLAIM FOR PAYMENT/DENIAL INFORMATION.

THE FOLLOWING ARE THE DESCRIPTIONS OF THE EOP CODES THAT APPEAR ON THIS REMITTANCE AND STATUS REPORT

00I03	OUR FILES INDICATE AN AUTHORIZATION INFORMATION MISMATCH.

5.10.7 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 deductible, coinsurance, or both. Claims that fail to cross over from Medicare may be filed to TMHP by submitting a TMHP Standardized MRAN form or the computer generated MRANs from the CMS-approved software applications Medicare Remit Easy Print (MREP) for professional services or PC-Print for institutional services 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 (www.tmhp.com).
- The provider can use the claim status inquiry function of TDHconnect.
- The provider can call AIS at 1-800-925-9126 to determine if the claim is pending, paid, denied, or if TMHP has no record of the claim.
- If any of three options above indicates that TMHP has no record of the claim, the provider can call the TMHP Contact Center at 1-800-925-9126 and speak to a TMHP contact center representative.
- If the TMHP Contact Center has no record of a claim that was submitted within the original filing deadline, the provider can submit a copy of the original claim to TMHP for processing. Electronic billers may refile the claim electronically. For claims submitted by a hospital for inpatient services, the filing deadline is 95 days from the discharge date or the last DOS on the claim. For all other types of providers, the filing deadline is 95 days from each DOS on the claim.
- If the 95-day filing deadline has passed and the claim is still within 120 days of the date of the rejection report or the R&S report, the provider can submit a signed copy of the claim and all of the documentation that supports the original claim submission, including any electronic rejection reports, to:

  Texas Medicaid & Healthcare Partnership
  Inquiry Control Unit
  12357-A Riata Trace Parkway, Suite 100
  Austin, TX 78727

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

Refer to: "Automated Inquiry System (AIS)" on page xiii for more information.

5.11 Other Insurance Claims Filing

The following information must be provided in the "Other Insurance" field on the paper claim and in the appropriate field of electronic claims. On the CMS-1500, Fields 9 or 11, and 29 must contain the appropriate information:

- Name of the other insurance resource.
- Address of the other insurance resource.
- Policy number and group number.
- Policyholder.
- Effective date if available.
- Date of disposition by other insurance resource (used to calculate filing deadline).
- Payment or specific denial information.

5.11.1 Other Insurance Credits

Providing other insurance payment information, even when no additional payment is expected from TMHP, provides benefit to all parties involved in the Texas Medicaid Program. When a TPR issues a payment or partial payment to a provider, the other insurance credit *must* be indicated on the claim form submitted to TMHP.

This procedure benefits both providers and TMHP even if the TPR payment exceeds the Medicaid allowed amount. Although additional payment may not be issued by TMHP, informing TMHP of the other insurance credit allows TMHP to track the appropriate use of TPRs. Informing TMHP of a TPR credit provides hospitals with a more accurate standard dollar amount (SDA) rate setting and assists the program in tracking recoveries and reducing Medicaid medical expenditures by informing TMHP of liable third parties.

Providers must report TPR correctly in the appropriate block according to claim form instructions.

Refer to: The corresponding block number:

Claim Form	Reference
CMS-1500	Block 29 on page 5-29
UB-04 CMS-1450	Block 54 on page 5-37
THSteps Dental	Block 31 on page 5-45

5.11.1.1 Deductibles

TMHP will consider deductibles for reimbursement when the original third party payor applied the payment amount directly to the clients deductible. The explanation of benefit reflecting the application of the payment by the other insurance (third party payor) and a completed signed claim copy must be submitted to TMHP for consideration.

5.11.1.2 HMO Copayments

The following text contains important information about HMO copayments:

- TMHP processes and pays HMO copayments for private and Medicare HMOs as well as private and Medicare PPO copayments for clients who are eligible for reimbursement under Medicaid guidelines.
- TMHP pays the copayment in addition to the service the HMO or PPO has denied, if the client is eligible for the Texas Medicaid Program and the procedure is reimbursed under Medicaid guidelines. Providers are not allowed to hold the client liable for the copayment.
- An office or emergency room (ER) visit (the ER physician is paid only when the ER is not staffed by the hospital) is reimbursed a maximum copayment of $10 per visit. The hospital ER visit is reimbursed at a maximum of $50 to the facility. TMHP pays up to four copayments per day, per client. ER visits are limited to one per day, per client, and are considered one of the four copayments allowed per day.

Important: *By accepting assignment on a claim for which the client has Medicaid coverage, providers agree to accept payment made by insurance carriers and the Texas Medicaid Program when appropriate as payment in full. The client cannot be held liable for any balance related to Medicaid-covered services.*

The following Medicaid codes have been created for copayments, which are considered an atypical service:

POS 1 - Office	Description
1-CP001	Private HMO copayment—professional
1-CP002	Private PPO copayment—professional
1-CP003	Medicare HMO copayment—professional
1-CP004	Medicare PPO copayment—professional

POS 5 - Outpatient	Description
1-CP005	Private HMO copayment—outpatient
1-CP006	Private PPO copayment—outpatient
1-CP007	Medicare HMO copayment—outpatient
1-CP008	Medicare PPO copayment—outpatient

Note: *Claims submissions for HMO copayments must be received by TMHP within 95 days of the DOS.*

5.11.1.3 Verbal Denial

Providers may call the other insurance resource and receive a verbal denial. The other insurance record can either be updated when the provider files the claim or calls the TPR Customer Service at 1-800-846-7307. When calling TPR Customer Service line and when filing claims to TMHP, the provider must have the information below before any updates are made.

Verbal denial requirements:

- Date of the telephone call to the other insurance resource.
- Insurance company's name and telephone number.
- Name of the individual contacted at the insurance company.
- Policyholder and group information for the client.
- Specific reason for the denial, including the client's type of coverage to enhance the accuracy of future claims processing (for example, a policy that covers inpatient services or physician services only).

Providers that update a client's insurance records through the TMHP TPR Customer Service line must follow the current appeal process once the other insurance information has been updated on the client's file.

5.11.1.4 110-Day Rule

If a TPR has not responded or delays payment or denial of a provider's claim for more than 110 days after the date the claim was billed, Medicaid considers the claim for reimbursement. The following information is required:

- Name and address of the TPR
- Date the TPR was billed (used to calculate filing deadline)
- Statement signed and dated by the provider that no disposition has been received from the TPR within 110 days of the date the claim was billed

When TMHP denies a claim because of the client's other coverage, information that identifies the other insurance appears on the provider's R&S report. The claim is not to be refiled with TMHP until disposition from the TPR has been received or until 110 days have lapsed since the billing of the claim with no disposition from the TPR. A statement from the client or family member which indicates that they no longer have this resource is *not* sufficient documentation to reprocess the claim.

When a provider is advised by a TPR that benefits have been paid to the client, the information must be included on the claim with the date and amount of payment made to the client if available. If a denial was sent to the client, refer to the verbal denial guidelines above for required information. This enables TMHP to consider the claim for reimbursement.

5.11.1.5 Filing Deadlines

Claims that involve filing to a TPR have the following deadlines:

- Claims with a valid disposition (payment or denial) must be received by TMHP within 95 days of the date of disposition by the TPR and within 365 days of the DOS. Appealed claims that were originally denied with EOB 00260, which indicates that the provider files with a TPR, must be received within 95 days of the date of disposition by the TPR or within 120 days of the date on which TMHP denied the claim.
- If more than 110 days have passed from the date a claim was filed to the TPR without a response, the claim is submitted to TMHP for consideration of payment.
- In accordance with federal regulations, all claims must initially be filed with TMHP within 365 days of the DOS.

Refer to: "Third Party Resources (TPR)" on page 4-14 for more information.

5.12 Filing Medicare Primary Paper Claims

Providers are allowed to file Medicare primary paper claims to TMHP for payment of coinsurance and/or deductible for claims that fail to cross over from Medicare electronically.

Providers may submit paper Medicare primary claims using the TMHP Standardized MRAN form or by submitting the adjusted computer generated MRANs from the CMS-approved software applications Medicare Remit Easy Print (MREP) for professional services or PC-Print for institutional services.

5.12.1 Crossover Claim Type 30 TMHP Standardized MRAN Form

TMHP
TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Revised Crossover Claim Type 30
TMHP Standardized Medicare Remittance Advice Notice Form

1	NPI/API											
2	Medicare ID											
3	TPI											
4	Provider Name											
5	Medicaid Client Number											
6	Client Last Name											
7	Client First Name											
8	Medicare Paid Date											
9	Medicare ICN											
10	Patient HIC Number											
11	Detail(s) Information	From DOS	To DOS	POS	Units	CPT	Mods	Charges	Allow	Ded	Coins	Paid	Reason Code
12	Totals Information							Charges	Allow	Ded	Coins	Paid	Reason Code
13	Medicare Prev Paid												

Effective 03192007 - Revised 05312007

5.12.2 Crossover Claim Type 30 Instructions

Providers who bill professional services on the CMS-1500 paper claim form may submit the Crossover Claim Type 30 template with a copy of a completed claim form. All fields (excluding Medicaid information fields) on the form must be completed using the Remittance Advice or Remittance Notice received from Medicare. In addition, all details from the Medicare Remittance Advice/Remittance Notice must be included in the template, regardless if a deductible or coinsurance is due.

The following are the requirements for the Crossover Claim Type 30 template:

Block No.	Field Description	Guidelines
1	NPI/API	Enter the NPI for the billing provider.
2	Medicare ID	Enter the Medicare Provider ID number of the billing provider listed on the Medicare Remittance Advice/Remittance Notice.
3	TPI	Enter the Medicaid Texas Provider Identifier number of the billing provider.
4	Provider Name	Enter the billing provider's name.
5	Medicaid Client Number	Enter the patient's nine-digit Medicaid number from their Medicaid Identification form.
6	Client Last Name	Enter the patient's last name listed on the Medicare Remittance Advice/Remittance Notice.
7	Client First Name	Enter the patient's first name listed on the Medicare Remittance Advice/Remittance Notice.
8	Medicare Paid Date	Enter the Medicare Paid Date listed on the Medicare Remittance Advice/Remittance Notice.
9	Medicare ICN	Enter the Medicare ICN number listed on the Medicare Remittance Advice/Remittance Notice.
10	Patient HIC Number	Enter the patient's Medicare HIC number (Medicare Identification number) listed on the Medicare Remittance Advice/Remittance Notice.
11	From DOS	Enter the first date of service for each procedure in a MM/DD/YYYY format.
11	To DOS	Enter the last date of service for each procedure in a MM/DD/YYYY format.
11	POS	Enter the place of service (POS) listed on the Medicare Remittance Advice/Remittance Notice.
11	Units	Enter the number of units (quantity billed) from the Medicare Remittance Advice/Remittance Notice.
11	CPT	Enter the appropriate procedure code for each procedure/service listed on the Medicare Remittance Advice/Remittance Notice. ***Note:*** *Procedure code listed on the Standardized MRAN form may not match the procedure code listed on the claim form attached.*
11	Mods	Enter the modifier (when applicable) listed on the Medicare Remittance Advice/Remittance Notice for each detail.
11	Charges	Enter the Medicare charges (billed amount) listed on the Medicare Remittance Advice/Remittance Notice for each detail.
11	Allow	Enter the Medicare allowed amount listed on the Medicare Remittance Advice/Remittance Notice for each detail.

Block No.	Field Description	Guidelines
11	Ded	Enter the Medicare deductible amount listed on the Medicare Remittance Advice/Remittance Notice for each detail.
11	Coins	Enter the Medicare Coinsurance amount listed on the Medicare Remittance Advice/Remittance Notice for each detail.
11	Paid	Enter the Medicare paid amount listed on the Medicare Remittance Advice/Remittance Notice for each detail.
11	Reason Code	Enter Medicare's reason code listed on the Medicare Remittance Advice/Remittance Notice for each detail.
12	Total Charges	Enter the Medicare total charges (billed amount) listed on the Medicare Remittance Advice/Remittance Notice. ***Note:*** *A provider may attach additional template forms (pages) as necessary. The combined total charges for all pages should be listed on the last page. All other forms must indicate "Continue" in this block.*
12	Total Allow	Enter the Medicare total allowed amount listed on the Medicare Remittance Advice/Remittance Notice.
12	Total Ded	Enter the Medicare total deductible amount listed on the Medicare Remittance Advice/Remittance Notice.
12	Total Coins	Enter the Medicare total coinsurance amount listed on the Medicare Remittance Advice/Remittance Notice.
12	Total Paid	Enter the Medicare total paid amount listed on the Medicare Remittance Advice/Remittance Notice.
12	Total Reason Code	This field must be left blank.
13	Medicare Prev Paid	Enter the Medicare previous paid amount listed on the Medicare Remittance Advice/Remittance Notice.

5.12.3 Crossover Claim Types 31 and 50

TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Crossover Claim Types 31 and 50
TMHP Standardized Medicare Remittance Advice Notice Form

Medicare Paid Date:		
Provider Name:	**NPI/API/TPI:**	**Medicare ID:**
Street Address:		
City:	**State:**	**ZIP:**

Bill Type	
From DOS	
Through DOS	
Patient Last Name	
Patient First Name	
Medicare HIC	
Medicare ICN	
Total Charges	
Covered Charges	
Non Covered Charges/Reason Code	
DRG Amount	
Deductible	
Blood Deductible	
Coinsurance	
Medicare Paid Amount	
DRG Code	

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5.12.4 Crossover Claim Types 31 and 50 Instructions

Providers who bill inpatient and outpatient crossover claims on a UB-04 CMS-1450 paper claim form may submit the Crossover Claim Types 31 and 50 template with a copy of a completed claim form. All fields (excluding Medicaid information fields) on the form must be completed using the Remittance Advice or Remittance Notice received from Medicare, regardless if a deductible or coinsurance is due.

The following are the requirements for the Crossover Claim Types 31 and 50 template:

Field Description	Guidelines
Medicare Paid Date	Enter the Medicare Paid Date listed on the Medicare Remittance Advice/Remittance Notice.
Provider Name	Enter the billing provider's name.
NPI/API/TPI	Enter the NPI/API/TPI for the billing provider. ***Note:*** *NPI/TPI or API/TPI.*
Medicare ID	Enter the Medicare Provider ID of the billing provider number listed on the Medicare Remittance Advice/Remittance Notice.
Street Address	Enter the billing provider's street address.
City	Enter the billing provider's city.
State	Enter the billing provider's state.
ZIP	Enter the billing provider's ZIP Code.
Bill Type	Enter the Medicare Bill Type listed on the Medicare Remittance Advice/Remittance Notice. ***Note:*** *The Medicare Bill Type may not match the TOB listed on the claim form.*
From DOS	Enter the first date of service for all procedures in a MM/DD/YYYY format.
Through DOS	Enter the last date of service for all procedures in a MM/DD/YYYY format.
Patient Last Name	Enter the patient's last name listed on the Medicare Remittance Advice/Remittance Notice.
Patient First Name	Enter the patient's first name listed on the Medicare Remittance Advice/Remittance Notice.
Medicare HIC	Enter the patient's Medicare HIC number (Medicare Identification number) listed on the Medicare Remittance Advice/Remittance Notice.
Medicare ICN	Enter the Medicare ICN number listed on the Medicare Remittance Advice/Remittance Notice.
Total Charges	Enter the Medicare total charges (billed amount) listed on the Medicare Remittance Advice/Remittance Notice.
Covered Charges	Enter the covered charges listed on the Medicare Remittance Advice/Remittance Notice.
Non Covered Charges/Reason Code	Enter the non covered charges listed on the Medicare Remittance Advice/Remittance Notice followed by the reason code listed on the Medicare Remittance Advice/Remittance Notice.
DRG Amount	Enter the DRG amount listed on the Medicare Remittance Advice/Remittance Notice for inpatient claims, if applicable. ***Note:*** *Outpatient claims do not require a DRG amount.*
Deductible	Enter the Medicare deductible amount listed on the Medicare Remittance Advice/Remittance Notice.
Blood Deductible	Enter the blood deductible listed on the Medicare Remittance Advice/Remittance Notice for inpatient claims, if applicable. ***Note:*** *Outpatient claims do not require a blood deductible amount.*
Coinsurance	Enter the Medicare coinsurance amount listed on the Medicare Remittance Advice/Remittance Notice.

Field Description	Guidelines
Medicare Paid Amount	Enter the Medicare paid amount listed on the Medicare Remittance Advice/Remittance Notice.
DRG Code	Enter the DRG code listed on the Medicare Remittance Advice/Remittance Notice for inpatient claims, if applicable. ***Note:*** *Outpatient claims do not require a DRG code.*

5.12.5 Filing a Medicare-Adjusted Claim

Providers should use an adjusted Medicare Remittance Advice or Remittance Notice and complete a TMHP Standardized MRAN to submit a Medicare-adjusted claim. Providers must ensure that the information on the Medicare Remittance Advice or Remittance Notice matches the information submitted on the TMHP Standardized MRAN form and attach a completed claim form.

Providers can also submit Medicare-adjusted claims using the adjusted computer generated MRANs from the CMS-approved software applications Medicare Remit Easy Print (MREP) for professional services or PC–Print for institutional services.

5.12.6 Medicare/Medicaid Filing Deadlines

TMHP Standardized MRAN forms or computer generated MRANs from the CMS-approved software applications Medicare Remit Easy Print (MREP) for professional services or PC-Print for institutional services must be received by TMHP within 95 days of the Medicare date of disposition in order to be considered for processing. Providers may also submit Medicare adjusted claims by submitting the adjusted computer generated MRANs from the CMS-approved software applications Medicare Remit Easy Print (MREP) for professional services or PC-Print for institutional services.

5.13 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 the Texas Medicaid Program.
- If a bill or a completed CMS claim form was not used to meet spend down and the dates of service are within the client's eligible period, submit the total bill to TMHP.

When eligibility has been established, a TP 55 with spend down client can receive the same care and services available to all other Medicaid clients. If eligibility is established through TP 30 with spend down, the client's Medicaid eligibility is restricted to coverage for an emergency medical condition only. Emergency medical condition is defined under "Emergency Care" on page 4-7.

Refer to: "Medicare Crossover Reimbursement" on page 2-7.

Section

6

Appeals

6.1 Appeal Methods

An appeal is a request for reconsideration of a previously dispositioned claim.

Providers may use three methods to appeal Medicaid claims to TMHP: electronic, Automated Inquiry System (AIS), or paper.

TMHP must receive all appeals of denied claims and requests for adjustments on paid claims within 120 days from the date of disposition of the Remittance and Status (R&S) report on which that claim appears. If the 120-day appeal deadline falls on a weekend or holiday, the deadline is extended to the next business day.

Standard administrative requests and medical appeals must be sent first to TMHP or the claims processing entity as a first-level appeal. After the provider has exhausted all aspects of the appeals process for the entire claim, the provider may submit a second-level appeal to HHSC.

1) A first-level appeal is a provider's initial standard administrative or medical appeal of a claim that has been denied or adjusted by TMHP. This appeal is submitted by the provider directly to TMHP for adjudication and must contain all required information to be considered.
2) A second-level appeal is a provider's final medical or standard administrative appeal to HHSC of a claim that meets *all* of the following requirements:

   a.) It has been denied or adjusted by TMHP.

   b.) It has been appealed as a first-level appeal to TMHP.

   c.) It has been denied again for the same reason(s) by TMHP.

This appeal is submitted by the provider to HHSC, which may subsequently require TMHP to gather information related to the original claim and the first-level appeal. HHSC is the sole adjudicator of this final appeal.

All providers must submit second-level administrative appeals and exceptions to the 95-day filing deadline appeals to the following address:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code 91X
PO BOX 204077
Austin, Texas 78720-4077

Note: *TMHP is not responsible for managing appeals as a result of utilization review (UR) decisions by the HHSC Office of Inspector General (OIG) UR department. These must be submitted to HHSC Medical and UR Appeals.*

Refer to: "Utilization Review Appeals" on page 6-8.

6.1.1 Electronic Appeal Submission

Electronic appeal submission is a method of submitting appeals using a personal computer. The electronic appeals feature can be accessed by a business organization (e.g., billing agents) interfacing directly with the TMHP Electronic Data Interchange (EDI) Gateway, through TexMedConnect, the free web-based application available from TMHP, or through TDHconnect.

The *Health Insurance Portability and Accountability Act* (HIPAA) standard American National Standards Institute (ANSI) ASC X12 837 format is accepted by TMHP EDI.

For other information, contact the TMHP EDI Help Desk at 1-888-863-3638.

6.1.1.1 Advantages of Electronic Appeal Submission

Using electronic appeal submission provides the following advantages to the users:

- Increased accuracy of appeals filed to potentially improve cash flow.
- Maintained audit trails through print and download capabilities.
- Appeal submission windows can be automatically filled in with electronic R&S report information, thereby reducing data entry time.

6.1.1.2 Allowed Electronic Appeals

Electronic appeal submission is available to business organizations (e.g., billing agents) interfacing directly with TMHP EDI, through TexMedConnect, or through TDHconnect.

The HIPAA standard ANSI ASC X12 837 format is accepted by TMHP EDI.

For other information, contact the TMHP EDI Help Desk at 1-888-863-3638.

6.1.1.3 Disallowed Electronic Appeals

The following claims may *not* be appealed electronically:

- Claims that require supporting documentation (e.g., operative report, medical records, home health, hearing aid, and dental X-rays).
- Diagnosis-related group (DRG) assignment.
- Medicare crossovers.
- Claims listed as *pending* or *in process* with explanation of pending status (EOPS) messages.
- Claims denied as *past filing deadline* except when *retroactive* eligibility deadlines apply.
- Claims denied as *past the payment deadline*.

Exception: *Inpatient hospital claims denied for lack of a Hysterectomy Acknowledgment Statement or a Sterilization Consent Form may be appealed electronically if the requested form has been faxed according to the instructions under "Hysterectomy Services" on page 36-50.*

6.1.2 Automated Inquiry System Appeals

The following appeals may be submitted using AIS:

- *Client Eligibility.* The client's correct Medicaid number, name, and date of birth are required.
- *Provider Information (Excluding Medicare Crossovers).* The correct provider identifier is required for the billing provider, performing provider, referring provider, and limited provider. The name and address of the provider are required for the facility and outside laboratory.
- *Claim Corrections.* Providers may correct the following:
  - Patient control number (PCN).
  - Date of birth.
  - Date of onset.
  - X-ray date.
  - Place of service (POS).
  - Quantity billed.
  - Prior authorization number (PAN).
  - Beginning date of service.
  - Ending date of service.
- The following appeals may *not* be appealed through AIS:
  - Claims listed on the R&S report as Incomplete Claims.
  - Claims listed on the R&S report with $0 allowed and $0 paid.
  - Claims requiring supporting documentation (for example, operative report, medical records, home health, hearing aid, and dental X-rays).
  - DRG assignment.
  - Procedure code, modifier, or diagnosis code.
  - Medicare crossovers.
  - Claims listed as *pending* or *in process* with EOPS messages.
  - Claims denied as *past filing deadline* except when retroactive eligibility deadlines apply.
  - Claims denied as *past the payment deadline*.
  - Inpatient Hospital claims requiring supporting documentation.
  - Third party resource (TPR)/Other insurance.

Providers may appeal these denials either electronically or on paper.

Refer to: "Disallowed Electronic Appeals" on page 6-2 to determine if these appeals can be billed electronically. If these appeals cannot be billed electronically, a paper claim must be submitted.

Exception: *Inpatient hospital claims denied for lack of a Hysterectomy Acknowledgment Statement or a Sterilization Consent Form may be appealed if the requested form has been faxed according to the instructions under "Hysterectomy Services" on page 36-50.*

6.1.3 Automated Inquiry System Automated Appeals Guide

To access the AIS automated appeals guide, providers can call 1-800-925-9126 (1-800-568-2413 for Children with Special Health Care Needs [CSHCN] Services Program). Providers may submit up to three fields per claim and 15 appeals per call. If during any step invalid information is entered three times, the call transfers to the TMHP Contact Center for assistance.

6.1.4 Paper Appeals

After determining a claim cannot be appealed electronically or through AIS, appeal the claim on paper by completing the following steps:

1) Copy the R&S page where the claim is paid or denied. A copy of other official notification from TMHP may also be submitted.
2) Circle one claim per R&S page.
3) Identify the reason for the appeal.
4) If applicable, indicate the incorrect information on the claim, and provide the corrected information that should be used to appeal it.
5) Attach a copy of any supporting medical documentation that is required or has been requested by TMHP.
6) Attach a completed claim form.

Reminder: *Do not copy supporting documentation on the opposite side of the R&S report.*

Note: *It is strongly recommended that providers submitting paper appeals retain a copy of the documentation being sent. It also is recommended that paper documentation be sent by certified mail with a return receipt requested. This documentation, along with a detailed listing of the claims enclosed, provides proof that the claims were received by TMHP, which is particularly important if it is necessary to prove that the 120-day appeals deadline has been met. If a certified receipt is provided as proof, the certified receipt number must be indicated on the detailed listing along with the Medicaid number, billed amount, DOS, and a signed claim copy. The provider may need to keep such proof regarding multiple claims submissions if the provider identifier is pending.*

Medicare crossovers and inpatient hospital appeals related to medical necessity denials or DRG assignment/adjustment *must* be submitted on paper with the appropriate documentation.

Submit correspondence, adjustments, and appeals (including routine inpatient hospital claims) to the following address:

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

Exception: *Hospitals appealing HHSC OIG UR Department final technical denials, admission denials, DRG revisions, continued-stay denials, or cost/day outliers must appeal*

to HHSC at the following address:

Texas Health and Human Services Commission
Medical and UR Appeals, H-230
PO Box 85200
Austin, TX 78708-5200

6.1.4.1 Fee-for-Service DRG Adjustment Appeal

Fee-for-service hospital providers that are appealing for a DRG adjustment (higher weight DRG) must provide the original and revised UB-04 CMS-1450, the complete medical record, and a statement defining the reason for the requested change. Hospitals have 120 days from the date of the R&S report to request an addition of a diagnosis or procedure resulting in a DRG adjustment.

Refer to: "Utilization Review Appeals" on page 6-8.

6.1.4.2 Medical Necessity Denial Appeals

Appeals of denials relating to medical necessity decisions made for all medical services with the exception of HHSC Inpatient UR cases may be submitted for further review if providers find denials are inappropriate. All necessary documentation must accompany the request for review. Incomplete appeals and adjustment requests are denied by TMHP with an explanation of benefits (EOB) code requesting additional information.

TMHP reviews each appeal (DRG adjustment and medical necessity) and forwards written notice of final action in the form of a letter or an adjustment transaction on the R&S report.

6.1.4.3 Other Insurance Appeals

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

6.1.5 Appeals Submitted Incorrectly

If an incomplete appeal is received, it is returned to the sender with further appeal instructions and a request for more information. Documentation (either by letter or facsimile) that does not clearly indicate the reason for submission is returned to the sender for clarification.

If an appeal is received that may be more appropriately addressed in another department, the appeal is forwarded to the appropriate department for research and response.

If the TMHP Medical Director or designee identifies a pattern of ineffective use of the appeals process, the provider may be referred to a provider relations representative for assistance.

6.2 Refunds

The TMHP Cash Reimbursement Unit is responsible for processing financial adjustments when overpayment, duplicate payment, payment to incorrect providers, and overpayments because of overlapping payments by Medicaid and another source occur. An overpayment must be refunded to Medicaid, but the amount refunded to TMHP does not exceed the Medicaid payment except in specific situations regarding other insurance payments as stated in "Refunds to TMHP Resulting from Other Insurance Payments and Conditions Surrounding Provider Billing of Third Party Insurers" on page 4-15.

Providers have the option of refunding by issuing a check to TMHP or requesting a recoupment through the paper appeal process. The paper appeal process does not require a provider to issue a check because the refund amount is reduced from the R&S report. To accurately process claim refunds, the TMHP Cash Reimbursement Unit requests that the refund check be accompanied by a Refund Information Form, found on page B-104, with the following information:

- Refunding provider's name and provider identifier.
- Client's name and Medicaid ID number.
- The date the medical service was rendered.
- A copy of the R&S report showing the claim to which the refund is being applied.
- The specific reason for the refund.

If private insurance paid on the claim, the provider gives the exact amount paid and the insurance company's name, address, policy number, and group number.

To request the forms, contact the TMHP Contact Center at 1-800-925-9126, or write to the following address:

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

6.3 Appeals to HHSC Fee-for-Service and PCCM

6.3.1 Administrative Claim Appeals

An administrative appeal is a request for review of (not a hearing on) claims denied by TMHP or claims processing entity for technical and non-medical reasons. There are *two types* of administrative appeals:

1) *Exception requests to the 95-day claim filing deadline.* A provider's formal written request for review of (not a hearing on) a claim that is denied or adjusted by TMHP for failure to meet the 95-day claim filing deadline. This exception should meet the qualifications for one of the five exceptions listed on page 6-5 and should be submitted directly to HHSC.
2) *Standard Administrative Appeal.* A provider's formal written request for review of (not a hearing on) a

claim or prior-authorization that is denied by TMHP for technical and/or non-medical reasons.

An administrative claims appeal is a request for a review as defined in Title 1 *Texas Administrative Code* (TAC) §354.2201(2).

An administrative appeal must be:

- Submitted in writing to HHSC Claims Administrator Contract Management by the provider delivering the service or claiming reimbursement for the service.
- Received by HHSC Claims Administrator Contract Management after the appeals process with TMHP or the claims processing entity has been exhausted, and must contain evidence of appeal dispositions from TMHP or the claims processing entity:
  - All correspondence and documentation from the provider to TMHP or the claims processing entity including copies of supporting documentation submitted during the appeal process.
  - All correspondence from TMHP or the claims processing entity to the provider including TMHP's final decision letter or such from the claims processing entity.
- Complete and contain all of the information necessary for consideration and determination by HHSC Claims Administrator Contract Management to include the following:
  - A written explanation specifying the reason/request for appealing the claim.
  - Supporting documentation for the request.
  - All R&S reports identifying the claims/services in question.
  - Identification of the incorrect information and the corrected information that is to be used to appeal the claim.
  - A copy of the original claim, if available. Claim copies are helpful when the appeal involves medical policy or procedure coding issues. Also provide a corrected signed claim.
  - A copy of supporting medical documentation that is necessary or requested by TMHP.
  - Provider's internal notes and logs when pertinent (cannot be used as proof of timely filing).
  - Memos from the state, TMHP, or claims processing entity indicating any problems, policy changes, or claims processing discrepancies that may be relevant to the appeal.
  - Other documents, such as receipts (i.e., certified mail along with a detailed listing of the claims enclosed), in-service notes, minutes from meetings, etc., if relevant to the appeals. Receipts can be helpful when the issue is late filing.
- Received by HHSC Claims Administrator Contract Management within 120 days from the date of disposition by TMHP or the claims processing entity as evidenced by the R&S sent to providers.

Providers that have submitted their claims electronically must identify the batch submission ID with the date on the electronic claims report. This report must indicate the TMHP assigned batch ID. In addition, this report must include the individual claim that is being appealed. This required information constitutes proof of timely filing.

Note: *Only reports accepted/rejected from TMHP or the claims processing entity to the vendor will be honored unless the provider is a direct submitter (TexMedConnect or TDHconnect). Office notes indicating claims were submitted on time or personal screen prints of claim submissions are not considered proof of timely filing.*

HHSC Claims Administrator Contract Management only reviews appeals that are received within 18 months from the date-of-service. All claims must be paid within 24 months from the date of service as outlined in 1 TAC §354.1003.

Providers must adhere to all filing and appeal deadlines for an appeal to be reviewed by HHSC Claims Administrator Contract Management. The filing and appeal deadlines are described in 1 TAC §354.1003.

Additional information requested by HHSC Claims Administrator Contract Management must be returned to HHSC Claims Administrator Contract Management within 21 calendar days from the date of the letter from HHSC Claims Administrator Contract Management. If the information is not received within 21 calendar days, the case is closed.

A determination made by HHSC Claims Administrator Contract Management is the final decision for claim appeals. No additional consideration is available. Therefore, ensure that all documents pertinent to the appeal are submitted. *New evidence* is required for an additional appeal to HHSC Claims Administrator Contract Management.

Providers mail appeal requests to the following address:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code-91X
PO Box 204077
Austin, Texas 78720-4077

6.3.1.1 Exceptions to the 95-Day Filing Deadline

HHSC Claims Administrator Contract Management is responsible for reviewing requests for exceptions to the 95-day filing deadline (fee-for-service and Primary Care Case Management [PCCM]). HHSC Claims Administrator Contract Management makes the final decision on whether claims fall within one of the exceptions to the 95-day filing deadline. Exception requests must be in writing and mailed directly to HHSC. Only providers can submit exception requests. Requests from billing companies, vendors, or clearinghouses are *not* accepted unless accompanied by a signed authorization from the provider (with each appeal). Without provider authorization, these requests are returned without further action.

HHSC will only consider exceptions to the 95-day filing deadline for claims that are submitted within the 365-day federal filing deadline from the date of service as outlined in 1 TAC §354.1003.

Exceptions to the filing deadline are considered when one of the following situations exists:

- Catastrophic event that substantially interferes with normal business operations of the provider, or damage or destruction of the provider's business office or records by a natural disaster, including but not limited to fire, flood, or earthquake; or damage or destruction of the provider's business office or records by circumstances that are clearly beyond the control of the provider, including but not limited to criminal activity. The damage or destruction of business records or criminal activity exception does not apply to any negligent or intentional act of an employee or agent of the provider because these persons are presumed to be within the control of the provider. The presumption can only be rebutted when the intentional acts of the employee or agent lead to termination of employment and filing of criminal charges against the employee or agent.
- Delay or error in the eligibility determination of a recipient, or delay due to erroneous written information from HHSC, its designee, or another state agency.
- Delay due to electronic claim or system implementation problems experienced by HHSC, its designee, or Texas Medicaid Program providers.
- Submission of claims occurred within the 365-day federal filing deadline, but the claim was not filed within 95 days from the date of service because the service was determined to be a benefit of the Medicaid program, and an effective date for the new benefit was applied retroactively.
- Recipient eligibility is determined retroactively and the provider is not notified of retroactive coverage.

Under the conditions and circumstances listed above, providers must submit the following documentation, if appropriate, and any additional requested information to substantiate approval of an exception. All claims that are to be considered for an exception must accompany the request. HHSC will consider only the claims that are attached to the request.

Additional claims cannot be added to an exception request after the exception request has been completed by HHSC. Additional claims require completed exception request information and will be considered an exception request separate from the original request. Information from a previous request is not linked together by HHSC to complete or understand additional claims.

All exception requests must include an affidavit or statement from the provider stating the details of the cause for the delay, the exception being requested, and verification that the delay was not caused by neglect, indifference, or lack of diligence of the provider or the provider's employee or agent. This affidavit or statement must be made by the person with personal knowledge of the facts.

- Exception requests for catastrophic events must include independent evidence of insurable loss; medical, accident, or death records; or police or fire report substantiating the exception of damage, destruction, or criminal activity.
- Exception requests for the delay or error in the eligibility determination of a recipient or delay due to erroneous written information from HHSC, its designee, or another state agency must include the written document from HHSC or its designee that contains the erroneous information or explanation of the delayed information.
- Exception requests for the delay due to electronic claim or system implementation problems experienced by HHSC, its designee, or Texas Medicaid Program providers must include the written repair statement, invoice, computer or modem generated error report (indicating attempts to transmit the data failed for reasons outside the control of the provider), or the explanation for the system implementation problems. The documentation must include a detailed explanation made by the person making the repairs or installing the system, specifically indicating the relationship and impact of the computer problem or system implementation to claims submission, and a detailed statement explaining why alternative billing procedures were not initiated after the delay in repairs or system implementation was known. If the provider is requesting an exception based upon an electronic claim or system implementation problem experienced by HHSC or its designee, the provider must submit a written statement outlining the details of the electronic claim or system implementation problems experienced by HHSC or its designee that caused the delay in the submission of claims by the provider, any steps taken to notify the state or its designee of the problem, and a verification that the delay was not caused by the neglect, indifference, or lack of diligence on the part of the provider or its employees or agents.
- Exception requests for claims that were submitted within the 365-day federal filling deadline, but were not filed within the 95-days of the date of service because the service was determined to be a benefit of the Texas Medicaid Program and an effective date for the new benefit was applied retroactively, must include a written, detailed explanation of the facts and documentation to demonstrate the 365-day federal filing deadline for the benefit was met.
- Exception requests for recipient eligibility determined retroactively and the provider is not notified of retroactive coverage must include a written, detailed explanation of the facts and activities illustrating the provider's efforts in requesting eligibility information for the client. The explanation must contain dates, contact information, and any responses from the client.

Refer to: "Exceptions to the 95-Day Filing Deadline" on page 5-8 for more detailed information.

6.3.1.2 Exceptions to the 120-day Appeal Deadline

HHSC shall consider exceptions to the 120-day appeal deadline for the situations listed below. The final decision about whether a claim falls within one of the exceptions will be made by HHSC. This is a one-time exception request; therefore, all claims that are to be considered within the request for an exception must accompany the request. Claims submitted after HHSC's determination has been made for the exception will be denied consideration because they were not included in the original request.

- An exception request must be received by HHSC within 18 months from the date of service to be considered. This requirement will be waived for the exceptions listed in bullets b and c below, as well as the situation listed under "Exceptions to the 24-month deadline."
- The following exceptions to the 120-day appeal deadline are considered if the criteria in the previous bullet is met and there is evidence to support one of the bullets below:

  a) Errors made by a third party payor that were outside the control of the provider. The provider must submit a statement outlining the details of the cause for the error, the exception being requested, and verification that the error was not caused by neglect, indifference, or lack of diligence of the provider, the provider's employee, or agent. This affidavit or statement should be made by the person with personal knowledge of the facts. In lieu of the above affidavit or statement from the provider, the provider may obtain an affidavit or statement from the third-party payor including the same information, and provide this to HHSC as part of the request for appeal.

  b) Errors made by the reimbursement entity that were outside the control of the provider. The provider must submit a statement from the original payor outlining the details of the cause of the error, the exception being requested, and verification that the error was not caused by neglect, indifference, or lack of diligence on the part of the provider, the provider's employee, or agent. In lieu of the above reimbursement entity's statement, the provider may submit a statement including the same information and provide this to HHSC as part of the request for appeal.

  c) Claims were adjudicated, but an error in the claim's processing was identified after the 120-day appeal deadline. The error is not the fault of the provider. An error occurred in the claims processing system that is identified after the 120-day appeal deadline has passed.

Adequate back-up documentation *must* also accompany the exception request. Failure to provide adequate documentation results in the case being closed. Providers are notified of the reason for denial. HHSC may request additional information which must be received within 21 calendar days from the date of the letter from HHSC. If the information is not received within 21 calendar days, the case will remain closed.

HHSC must receive a written exception request within 120 days of TMHP's final action. *Multiple requests submitted simultaneously must be sorted by provider identifier first, and then alphabetically by client name.* The orderly submission of exception requests facilitates the review process. Exception requests are returned to the provider if not submitted in the required format.

Additional claims cannot be added to an exception request after the exception request has been completed by HHSC. Additional claims require completed exception request information and will be considered as an exception request separate from the original request. Information from a previous request is not linked together by HHSC to complete or understand additional claims.

6.3.1.3 Exceptions to the 24-Month Payment Deadline

HHSC shall consider exceptions to the 24-month claims payment deadline for the situations listed below. The final decision about whether a claim falls within one of the exceptions will be made by HHSC.

- *Refugee Eligible Status*: The payable period for all Refugee Medicaid eligible recipient claims is the federal fiscal year in which each date of service occurs plus one additional Federal Fiscal year. The date of service for inpatient claims is the discharge date.
- *Medicare/Medicaid Eligible Status*: The payable period for Medicaid/Medicare eligible recipient claims filed electronically is 24 months from the date the file is received from Medicare by TMHP or the claims processing entity. The payable period for Medicaid/Medicare eligible recipient claims filed on paper is 24 months from the date listed on the Medicare Remittance Advice.
- *Retroactive Supplemental Security Income (SSI) Eligible*: The payable period for SSI Medicaid eligible recipients when the Medicaid eligibility is determined retroactively is 24 months from the date the Medicaid eligibility is added to the eligibility file. The date is referred to as the "add date."

Mail exception requests to HHSC at the following address:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code 91X
PO Box 204077
Austin, Texas 78720-4077

Note: *Medicaid health maintenance organization (HMO) providers must communicate with their respective HMOs regarding appeals related to the filing deadline or any exception request policy. HHSC Claims Administrator Contract Management does not have the authority to manage these appeals.*

6.3.2 Medical Necessity Appeals

Medical necessity appeals are defined as disputes regarding medical necessity of services. Providers must appeal to TMHP and exhaust the appeal/grievance process before submitting an appeal to HHSC.

Medical necessity appeals related to UR decisions made by the HHSC OIG UR Department *must* be appealed to HHSC *not* TMHP.

When filing appeals to HHSC, providers must submit copies of all supporting documentation, including information sent to TMHP.

Refer to: "Fee-for-Service DRG Adjustment Appeal" on page 6-4 for additional information.

6.3.3 PCCM DRG Adjustment Appeals

PCCM contracted hospitals may appeal to the HHSC Medical & UR Appeals Unit only if they have followed the prior authorization process with TMHP. The Medical and UR Appeals Unit must receive the written appeal request within 120 days of the date of the last R&S report. If the request is not received within 120 days, the appeal is not conducted, and the TMHP decision is considered final. The request must include a copy of the complete medical record, an original, signed, properly completed, and notarized Affidavit (see "Affidavit" on page B-4), and a letter explaining the reason for the appeal. Extensions of time are not granted for filing the written appeal request, submitting the complete medical record, or submitting the original, properly completed, and notarized affidavit in the format approved by HHSC.

Important: *Only claims denied for medical necessity may be submitted to and considered by the HHSC Medical & UR Appeals Unit. Claims that receive a technical denial are not accepted.*

Refer to: "Appeals of Denied Requests for Authorization" on page 7-40 for additional information about the PCCM inpatient authorization process.

6.3.4 Utilization Review Appeals

Hospitals may appeal adverse UR decisions made by the HHSC OIG UR department to the HHSC Medical and UR Appeals Unit. The written appeal request must be received by the Medical and UR Appeals Unit within 120 days of the date of the original HHSC OIG UR decision letter. If the request is not received within 120 days, the appeal is not conducted, and the HHSC OIG UR decision is considered final. Any claim the facility may have to the Medicaid funds at issue are barred. Extensions of time are not granted for filing the written appeal request, submission of the complete medical record, or the original properly completed notarized affidavit in the format approved by HHSC. Procedures and specific requirements for appealing these decisions can be found in the sections below.

Hospitals may appeal adverse HHSC OIG UR determinations to the following address:

Texas Health and Human Services Commission
Medical and UR Appeals, H-230
PO Box 85200
Austin, TX 78708-5200

Note: *UR Admission Denials, Continued Stay Denials, DRG Revisions, Cost/Day Outlier Denials or Technical Denials issued by Medicaid managed care organizations (MCOs) must be appealed to the appropriate health plan. The HHSC Medical and UR Appeals Unit does not have the authority to manage these appeals.*

6.3.4.1 Admission Denials, Continued Stay Denials, DRG Revisions, and Cost/Day Outlier Denials

If a hospital is dissatisfied with the original retrospective review conducted by the HHSC OIG UR Unit, it may submit a written request for an appeal to the HHSC Medical and Utilization Review Appeals Unit. The HHSC Medical and UR Appeals Unit is responsible for conducting an independent review in response to a provider's appeal. The professional staff uses all of the documentation in the medical record to determine whether an inpatient admission was appropriate and whether the diagnoses and procedures were correct. The HHSC OIG UR Unit screening criteria that are described in 1 TAC §371.204 are not used by this unit to determine the appropriateness of an inpatient admission. The Associate Medical Director for Medicaid/Children's Health Insurance Program (CHIP) performs a complete review for the medical necessity of admission, DRG validation, quality of care, continued stay medical necessity, and ancillary charges (*Tax Equity and Fiscal Responsibility Act* of 1982 [TEFRA] cases) using the medical record documentation submitted on appeal. After completion of the review, the physician renders a final decision on the case. The final decision may include determinations regarding multiple aspects of the admission. The hospital is notified in writing of the final decision. Inpatient admission denials cannot be rebilled as outpatient claims except as noted in "Hospital Outpatient Observation Room Services" on page 25-25.

The request for an appeal must include a copy of the complete medical record, a letter explaining the reasons why the HHSC OIG UR decision is incorrect, a copy of the HHSC OIG UR decision letter, and an original, properly completed, and notarized affidavit in the format approved by HHSC. The affidavit allows the hospital to certify the record as a business and legal document. Complete medical records must be provided to HHSC at no charge. A complete medical record must include, but is not limited to, a discharge summary, history and physical, emergency room record, operative report, pathology report, anesthesia record, consultation reports, physician progress notes, physician orders, laboratory reports, X-ray reports, special diagnostic reports, nurses' notes, and medication records.

Refer to: "Affidavit" on page B-5.

The HHSC Medical UR Unit will notify hospitals if a complete medical record or a properly completed, notarized affidavit is not submitted with the initial appeal request. The hospital has 21 calendar days from the date of notification to submit the requested information. If the required documentation is not received within this time frame, the case is closed without an opportunity for further review, and the original HHSC OIG UR decision is considered the final decision.

If the hospital is still displeased with the appeals decision, the attending physician or medical director of the hospital may request an educational conference with the HHSC Associate Medical Director for Medicaid/CHIP. The educational conference is held by telephone between the Associate Medical Director for Medicaid/CHIP and the hospital medical director or attending physician. It is an opportunity for the physicians to discuss the deciding factors in the case and any hospital billing processes that may have affected the adjudication of the case. The educational conference will not alter the previous appeal decision.

The HHSC Medical and Utilization Review Unit recognizes that hospital staff may use guidelines, such as the American Hospital Association's Coding Clinic, to assist them in identifying diagnoses and/or procedures for statistical and billing purposes. However, the HHSC Medical and Utilization Review Appeals Unit determines the appropriate diagnoses and/or procedures for reimbursement purposes using the documentation in the medical record (submitted on appeal) and the following guidelines:

- *Principal diagnosis assignment.* The diagnosis (condition) established after study to be chiefly responsible for causing the admission of the client to the hospital for care. The principal diagnosis must be treated or evaluated during the admission to the hospital.
- *Secondary diagnosis assignment.* Conditions that affect patient care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, or increased nursing care or monitoring, or, in the case of a newborn (up to 28 days of life), which the physician deems to have clinically significant implications for future health care needs. Normal newborn conditions or routine procedures should not be considered as complications or comorbidities for DRG assignment.

If the principal diagnosis, secondary diagnoses, or procedures are not substantiated in the medical record, not sequenced correctly, or have been omitted, the codes may be changed, added, or deleted by the HHSC Associate Medical Director for Medicaid/CHIP. When it is determined the diagnoses or procedures are substantiated and sequenced correctly, a final DRG assignment is made.

6.3.4.2 Final Technical Denials

Hospitals may submit a request for a written appeal to HHSC Medical and UR Appeals only if the hospital has evidence that the HHSC OIG UR department issued a final technical denial in error, or did not provide proper notification of the final technical denial. The request must include a letter explaining the reasons why the HHSC OIG UR decision is incorrect and a copy of the HHSC OIG UR decision letter.

The written appeal request must be received by HHSC Medical and UR Appeals within 120 days of the date of the original HHSC OIG UR decision letter. If the request is not received within the 120 days, the appeal is not conducted and the HHSC OIG UR decision is considered final. Any claim the facility may have to the Medicaid funds at issue are barred. Extensions of time are not granted for filing the written appeal request.

If the appeal time frame is met, the HHSC Medical and UR Appeals Unit reviews all the documentation and renders a final decision on the case. If it is determined the technical denial was issued correctly by the HHSC OIG UR department, HHSC's decision is upheld. The hospital is notified in writing of the decision. This decision is the final decision of HHSC.

If it is determined that the final technical denial decision should be overturned, the HHSC Medical and UR Appeals Unit will request a copy of the complete medical record and an original, properly completed, notarized affidavit in the format approved by HHSC. The affidavit allows the hospital to certify the record as a business and legal document. The Associate Medical Director for Medicaid/CHIP performs a complete review for the medical necessity of the admission, DRG validation, quality of care or continued stay, and ancillary charges (for TEFRA cases) using the medical record documentation. After completion of the review, the Associate Medical Director renders a final decision on the case. The hospital is notified in writing of the final decision.

If the requested documentation is not received within the required 21-day time frame, the case is closed without further opportunity for review and the original HHSC OIG UR decision is considered final.

6.3.5 Complaints to HHSC—Fee-for-Service and PCCM

Fee-for-service and PCCM providers may file complaints to the HHSC Claims Administrator Contract Management if they find they did not receive full due process from TMHP in the management of their appeal. Fee-for-service and PCCM providers must exhaust the appeals/grievance process with TMHP before filing a complaint with the HHSC Claims Administrator Contract Management.

Refer to: "Appeals to HHSC Fee-for-Service and PCCM" on page 6-4 for information about submission of an appeal to HHSC.

A *complaint* is defined as any dissatisfaction expressed in writing by the provider, or on behalf of that provider, concerning the Texas Medicaid Program. The term

complaint does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the provider's satisfaction and does not include a provider's oral or written dissatisfaction with an adverse determination.

Under the complaint process, the HHSC Claims Administrator Contract Management works with TMHP and providers to verify the validity of the complaint, determine if the established due process was followed in resolving appeals and grievances, and addresses other program and contract issues, as applicable.

Complaints must be in writing and received by the HHSC Claims Administrator Contract Management within 60 calendar days from TMHP's written notification of the final appeal decision.

When filing a complaint, providers must submit a letter explaining the specific reasons they believe the final appeal decision by TMHP is incorrect and copies of the following documentation:

- All correspondence and documentation from the provider to TMHP, including copies of supporting documentation submitted during the appeal process.
- All correspondence from TMHP to the provider, including TMHP's final decision letter.
- All R&S reports of the claims/services in question, if applicable.
- Provider's original claim/billing record, electronic or manual, if applicable.
- Provider's internal notes and logs when pertinent.
- Memos from the state or TMHP indicating any problems, policy changes, or claims' processing discrepancies that may be relevant to the complaint.
- Other documents, such as receipts (i.e. certified mail), original date-stamped envelopes, in-service notes, minutes from meetings, etc., if relevant to the complaint. Receipts can be helpful when the issue is late filing.

Complaint requests may be mailed to the following address:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code 91X
PO Box 204077
Austin, TX 78720-4077

6.3.6 Complaints to HHSC—HMO Services

Medicaid Managed Care providers (HMOs) may file complaints to HHSC Health Plan Operations if they find they did not receive full due process from the HMOs. HHSC is only responsible for the management of complaints from managed care providers. Appeals/grievances, hearings, or dispute resolutions are the responsibility of the health plans. Providers must exhaust their appeals/grievance process with their health plan before filing a complaint with HHSC.

A *complaint* is defined as any dissatisfaction expressed in writing by the provider, or on behalf of that provider, concerning any aspect of the Texas Medicaid Program. The term complaint does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the provider's satisfaction.

Under the complaint process, HHSC works with the health plans and providers to verify the validity of the complaint, determine if the established due process was followed in resolving appeals and grievances, and addresses other program/contract issues, as applicable.

Complaints *must* be in writing and received by HHSC within 60 calendar days from the health plan's written notification of the final action.

When filing a complaint, providers must submit a letter explaining the specific reasons they believe the final appeal decision by the health plan is incorrect and copies of the following documentation:

- All correspondence and documentation from the provider to the health plan, including copies of supporting documentation submitted during the appeals process.
- All correspondence from the health plan to the provider. Correspondence includes the initial determination letter; all appeal determination letters, and the final decision letter.
- All R&S reports of the claims/services in question, if applicable.
- Provider's original claim/billing record, electronic or manual, if applicable.
- Provider's internal notes and logs when pertinent.
- Memos from the state or the health plan indicating any problems, policy changes, or claims processing discrepancies that may be relevant to the complaint.
- Other documents such as receipts (i.e., certified mail), original date-stamped envelopes, in-service notes, minutes from meetings, etc., if relevant to the complaint. Receipts can be helpful when the issue is late filing.

Complaint requests for HMO's may be mailed to the following address:

Texas Health and Human Services Commission
Re: Provider Complaint
Health Plan Operations, H-320
PO Box 85200
Austin, TX 78708

6.4 Cost Report Settlement Appeal Process

A provider who is dissatisfied with the determination contained in the Notice of Amount of Program Reimbursement (NPR) from TMHP Medicaid Audit may request an appeal as follows:

- The request for appeal must be in writing.

- The request for appeal must be filed within 120 calendar days from the date of receipt of the NPR.
- If the amount in controversy is at least $1,000, the request for the appeal must be filed with TMHP Medicaid Audit.
- If the NPR shows that the provider is indebted to the Texas Medicaid Program, TMHP must take the necessary action to recover the overpayment, including a suspension of interim payments. This process will take place even if an appeal has been requested.

6.4.1 Appeals to TMHP Medicaid Audit

A provider's request to appeal his or her NPR must do the following:

- Identify specific individual items in TMHP Medicaid Audit's determination with which the provider disagrees.
- Give the reasons the provider believes these are incorrect.
- Identify the amount in controversy for each item and provide a calculation of that amount.

The appeal may include any materials the provider believes will support its position.

TMHP Medicaid Audit completes a desk review of the appeal within six months of the date of receipt of complete documentation supporting the appeal. TMHP does the following:

- Review the materials submitted by the provider.
- Inform the provider if it appears that the request for an appeal was not timely or the amount of controversy is not at least $1,000.
- Review the record that formed the basis for the determination of the total payment due to the provider.
- Attempt to resolve as many points in controversy as possible with the provider and inform him or her in writing the issues that have been resolved and those that the provider may appeal to HHSC.
- Ensure all available documentation in support of the provider or TMHP Medicaid Audit is part of the record.

To appeal to TMHP Medicaid Audit, send the written notice to the following address within 120 days of receipt of the NPR letter to the following address:

Texas Medicaid & Healthcare Partnership
Medicaid Audit Operations Director
PO Box 200345
Austin, TX 78720-0345

Managed Care

7.1 Medicaid Managed Care

The Texas Medicaid Program, administered by HHSC, operates the Medicaid Managed Care program under the authority of federal waivers and state plan amendments approved by the Centers for Medicare & Medicaid Services (CMS).

7.1.1 Overview

Originally, the Texas Medicaid Managed Care Program was called the State of Texas Access Reform (STAR) Program. The STAR Program was established to explore different methods of building a framework of managed care around segments of the Texas Medicaid Program. In 1995, the Texas Legislature adopted Senate Bill (S.B.) 10 and related legislation that authorized HHSC to undertake a comprehensive restructuring of the Texas Medicaid Program to incorporate managed care delivery systems statewide.

Currently, the Medicaid Managed Care Program consists of two types of health-care delivery systems: health maintenance organizations (HMOs) and Primary Care Case Management (PCCM). HMOs provide services in the metropolitan areas, including Nueces. PCCM provides services in the remaining 202 rural counties. (See page 7-23 for a listing of PCCM counties and page 7-20 for a listing of HMO service areas [SAs].)

The principal objectives of Medicaid Managed Care are to emphasize early intervention and to promote improved access to quality care, thereby significantly improving health outcomes for the target population, with a special focus on prenatal and well-child care.

Clients enrolled in any of the Medicaid Managed Care programs may reside in metropolitan or rural areas. These programs include:

- *The STAR Program* operates under a 1915(b) waiver and provides acute care medical assistance in a Medicaid Managed Care environment for clients who reside in the Bexar, Dallas, El Paso, Harris, Harris Expansion, Lubbock, Nueces, Tarrant, and Travis metropolitan SAs (see “STAR Program” on page 7-12).
- *The STAR+PLUS Program* operates under a 1915(b) waiver and 1915(c) waiver and provides integrated acute and long term services and supports in a Medicaid Managed Care environment for clients who reside in the Bexar, Travis, Nueces, Harris, and Harris Expansion SAs (see “STAR+PLUS Program” on page 7-17).
- *The NorthSTAR Program*, administered by the Department of State Health Services (DSHS), operates under a 1915 (b) waiver and provides integrated behavioral health services under contract with a behavioral health organization (BHO) for clients who reside in the Dallas SA (see “NorthSTAR Program” on page 7-20).
- *The PCCM Program*, administered by TMHP, operates under a state plan amendment for clients who reside in the 202 rural Texas counties (see “PCCM” on page 7-23).

The goals of Medicaid Managed Care are to:

- Improve the access to care for clients enrolled in the programs.
- Increase quality and continuity of care for clients.
- Decrease inappropriate usage of the health-care delivery system, such as emergency rooms (ERs) for nonemergencies.
- Achieve cost-effectiveness and efficiency for the state.
- Promote provider and client satisfaction.

Additional goals for the STAR+PLUS Program include:

- Integrating acute and long term services and supports.
- Coordinating Medicare services for clients who are dual eligible.

Higher use of medical services by traditional Medicaid clients occurs when clients obtain care through ERs or access duplicative services for the same medical condition. In Medicaid Managed Care, clients assume a responsible role in achieving their personal health care by choosing a primary care provider, then actively participating with their primary care provider to access preventive, primary care services. This collaborative approach to health-care delivery usually achieves cost savings for the Texas Medicaid Program by reducing duplicative services and unnecessary emergency and inpatient care.

Although many of the Medicaid Managed Care requirements are similar, each program has established specific objectives, eligibility and enrollment requirements, and claims filing processes, which are detailed in this section.

7.1.2 Third Party Resources

The Third Party Liability program helps reduce Medicaid costs by shifting claims expenses to third-party payers. Third-party payers are entities or individuals that are legally responsible for paying the medical claims of Medicaid recipients. As a condition of eligibility, Medicaid recipients assign their rights (and the rights of any other eligible individuals on whose behalf he or she has legal authority under state law to assign such rights) to medical support and payment for medical care from any third party to Medicaid. Federal law and regulations require states to ensure Medicaid recipients use all other resources available to them to pay for all or part of their medical care before turning to Medicaid. Medicaid pays only after the third party has met its legal obligation to pay (i.e., Medicaid is the payer of last resort). A third party is any individual, entity, or program that is, or may be, liable to pay for any medical assistance provided to a recipient under the approved state Medicaid plan. Third parties may include any of the following:

- Private health insurance.
- Employment-related health insurance.
- Medical support from absent parents.

- Casualty coverage resulting from an accidental injury such as automobile or property insurance (including no-fault insurance).
- Court judgments or settlements from a liability insurer.
- State workers' compensation.
- First party probate-estate recoveries.
- Other federal programs (e.g., Indian Health, Community Health, and Migrant Health programs), unless excluded by statute.

To report if a client has new/changes Private Health Insurance refer to the "Other Insurance Form" on page B-64.

To report if a client has been in an accident or injury refer to the "Tort Response Form" on page B-113.

7.1.3 Client Enrollment

HHSC has targeted specific client groups within the Texas Medicaid population for managed care enrollment. Refer to each program in this section for enrollment information.

In most cases, Medicaid Managed Care enrollment is not retroactive. For exceptions, see "Enrollment of Pregnant Women (Type Program 40)" on page 7-15, "Enrollment of Newborns" on page 7-15, and "Client Enrollment" on page 7-20.

7.1.3.1 Managed Care Eligibility and Effective Date

Benefits under the STAR and STAR+PLUS programs usually begin on the first day of the next month following selection of a primary care provider and plan. NorthSTAR has retroactive enrollment and does not require a primary care provider (see "Client Enrollment" on page 7-20). Benefits under the PCCM Program usually begin on the first day of the next month following Medicaid eligibility. For example, a client who has become eligible for Medicaid benefits for the first time, may be certified and begin to receive benefits under the Texas Medicaid Program on the same day. If the client is also determined to be eligible for managed care, a second and separate enrollment process takes place.

The client does not begin to receive services under Medicaid Managed Care until the first day of the following month (providing enrollment takes place before the *cut-off* date for the following month). Enrollments and disenrollments become effective on the first day of the month (refer to example 1).

Exception: *Newborn enrollments are retroactive to the date of birth.*

STAR and STAR+PLUS Example 1	
Client certified for Texas Medicaid	January 1
Medicaid benefits begin	January 1
Client selects health plan and primary care provider	January 1
Managed care benefits begin	February 1

If a client selects a plan and primary care provider after the *cut-off* date (approximately the 15th of the month) they will not be enrolled in managed care nor appear on a primary care provider's patient list until the second month after their enrollment effective date (refer to example 2).

STAR and STAR+PLUS Example 2	
Client certified for Texas Medicaid	January 1
Medicaid benefits begin	January 1
Client selects health plan and primary care provider	January 20
Managed care benefits begin	March 1

Clients may receive services under the traditional Medicaid program from the first date of eligibility. Claims for these services are billed to TMHP. Once managed care enrollment is in effect, the provider must bill the client's managed care organization for all capitated services or PCCM. Providers continue to bill non-capitated services to TMHP.

Note: *All claims for Supplemental Security Income (SSI) clients in STAR are billed to TMHP.*

7.1.3.2 PCCM

When a client in the PCCM area is determined Medicaid-eligible and is a mandatory enrollee, the client is automatically enrolled in PCCM. Enrollment into PCCM is prospective.

Example	
Client certified for Texas Medicaid	January 2
Medicaid benefits begin	January 1
PCCM benefits begin (automatic enrollment)	February 1

Exception: *Newborn enrollments are retroactive to the date of birth.*

Refer to: "Newborn Claims Submission" on page 7-17

7.1.3.3 Automatic Re-enrollment

If a client loses Medicaid eligibility and then regains eligibility within six months, the client is automatically reassigned to their previous health plan and primary care provider.

7.1.4 Primary Care Provider Changes

7.1.4.1 Client-Initiated Primary Care Provider Changes

A client may change primary care providers for the following reasons:

- The client is dissatisfied with the care or treatment they have received.
- The client's condition or illness would be better treated by another provider type.

- The client's new address is no longer convenient to the primary care provider's location.
- The provider leaves the program (i.e., moves, no longer accepts Medicaid, is removed from Medicaid enrollment, is no longer affiliated with the Medicaid Managed Care Program, or is deceased).
- The client/primary care provider relationship is not mutually agreeable.

HMO and PCCM Primary Care Provider Changes

Primary care provider changes for PCCM, STAR, and STAR+PLUS can be received up to the last business day of the month and made effective by SAVERR/TIERS the first day of the next calendar month, as shown in the following example:

HMO and PCCM Primary Care Provider Changes	
Request received	May 28
Change effective	June 1

7.1.4.2 Provider-Initiated Primary Care Provider Changes

A provider may request a client be reassigned to another primary care provider for any of the following reasons:

- The client is not included in the primary care provider's scope of practice.
- The client is non-compliant with medical advice.
- The client consistently displays unacceptable office decorum.
- The client/primary care provider relationship is not mutually agreeable.

Any request by a provider to reassign a client to another primary care provider must be processed through the applicable managed care program. Before a request for reassignment can be initiated, reasonable measures must be taken to correct the client's behavior. Reasonable measures may include education or counseling by health plan or PCCM staff. The health plan or PCCM will notify the client of the reassignment if all attempts to remedy the situation have failed. Providers should also notify the client about the reassignment in writing and send a copy of the notification to the health plan or PCCM.

7.1.4.3 Medicaid Managed Care-Initiated Primary Care Provider Changes

In addition, a client may be reassigned to another primary care provider for any of the following reasons:

- The primary care provider is sanctioned by HHSC.
- The primary care provider exhibits a documented pattern of unacceptable quality of care.
- The primary care provider inappropriately reduces client's right to access specialty services covered under Medicaid Managed Care.

7.1.5 Health Plan Changes

7.1.5.1 Client-Initiated HMO Plan Changes

Clients have the right to change plans.

For clients in PCCM counties, the only Medicaid Managed Care model available is PCCM. Clients not eligible for Medicaid Managed Care have traditional fee-for-service. HMO health plans are not available in PCCM counties.

Clients must call the enrollment broker to initiate a plan change. If a plan change request is received before the middle of the month, the plan change is effective on the first day of the following month. If the request is received after the middle of the month, the plan change will be effective on the first day of the second month following the request, as shown below.

Example	
Request received on or before	Mid-May
Change effective	June 1
Request received after	Mid-May
Change effective	July 1

Note: *All plan change requests must be processed by the enrollment broker.*

7.1.5.2 Health Plan Managed Care Administrator-Initiated Changes

Each health plan has a limited right to request that a client be disenrolled without the client's consent. HHSC must approve any request for such disenrollment.

A health plan may request that a client be disenrolled for the following reasons:

- The client loans his or her Medicaid Identification Form (Form H3087) to another person to obtain services.
- The client continually disregards the advice of his primary care provider.
- The client repeatedly uses the ER inappropriately.

Before a request for disenrollment can be initiated, reasonable measures must be taken to correct the client's behavior. Reasonable measures may include education or counseling conducted by health plan staff. HHSC will notify the client of the disenrollment if all attempts to remedy the situation have failed. HHSC will also notify the client of the availability of appeal procedures and the HHSC fair hearing process.

Neither the health plan nor a provider may request a disenrollment based on an adverse change in the client's health or the utilization of services which are medically necessary for the treatment of a client's condition.

7.1.6 Client Rights and Responsibilities

7.1.6.1 Client Rights

In Texas, Medicaid Managed Care clients have defined rights and responsibilities. Each health plan and primary care provider share the responsibility to ensure and protect client rights and to assist clients in understanding and fulfilling their responsibilities as plan clients.

Note: *Please refer to "Client Rights and Responsibilities" on page 7-25 for information about client rights and responsibilities related to PCCM.*

Medicaid Managed Care clients have the right to:

- Be treated fairly and with dignity and respect.
- Know that their medical records and discussions with their providers will be kept private and confidential.
- A reasonable opportunity to choose a health-care plan and primary care provider (the doctor or health-care provider they will see most of the time and who will coordinate their care) and to change to another plan or provider in a reasonably easy manner. These opportunities include the right to:
  - Be informed of available health plans and primary care providers in their areas.
  - Be informed of how to choose and change health plans and primary care providers.
  - Choose any health plan that is available in their area and choose a primary care provider.
  - Change their primary care provider.
  - Change health plans without penalty.
  - Be educated about how to change health plans or primary care providers.
- Ask questions and get answers about anything they don't understand, and that includes the right to:
  - Have their provider explain their health-care needs to them and talk to them about the different ways their health-care problems can be treated.
  - Be told why care or services were denied and not given.
- Consent to or refuse treatment and actively participate in treatment decisions, and that includes the right to:
  - Work as part of a team with their provider in deciding what health care is best for them.
  - Say yes or no to the care recommended by their provider.
- Utilize each available complaint and appeal process through the managed care organization and through Medicaid, receive a timely response to complaints, appeals, and fair hearings. These processes include the right to:
  - Make a complaint to their health plan or to the state Medicaid program about their health-care, provider, or health plan.
  - Get a timely answer to their complaint.
  - Access the health plan appeal process and the procedures for doing so.
  - Request a fair hearing from the state Medicaid program and request information about the process for doing so.
- Timely access to care that does not have any communication or physical access barriers. That the right to:
  - Have telephone access to a medical professional 24 hours a day, 7 days a week in order to obtain any needed emergency or urgent care.
  - Get medical care in a timely manner.
  - Be able to get in and out of a health-care provider's office, including barrier free access for persons with disabilities or other conditions limiting mobility, in accordance with the *Americans with Disabilities Act*.
  - Have interpreters, if needed, during appointments with their providers and when talking to their health plan. Interpreters include people who can speak in their native language, assist with a disability, or help them understand the information.
  - Be given an explanation they can understand about their health plan rules, including the health-care services they can get and how to get them.
- Not be restrained or secluded when doing so is for someone else's convenience, or is meant to force them to do something they do not want to do, or to punish them.

7.1.6.2 Client Responsibilities

Medicaid Managed Care health plans and primary care providers should help clients understand their responsibilities. These include the responsibility to:

- Learn and understand each right they have under the Medicaid program. That includes the responsibility to:
  - Learn and understand their rights under the Medicaid program.
  - Ask questions if they do not understand their rights.
  - Learn what choice of health plan is available in their area.
- Abide by the health plan and Medicaid Managed Care policies and procedures. That includes the responsibility to:
  - Learn and follow their health plan rules and Medicaid rules.
  - Choose their health plan and a primary care provider.
  - Make any changes in their health plan and primary care provider in the ways established by Medicaid Managed Care and by the health plan.
  - Keep their scheduled appointments.
  - Cancel appointments in advance when they cannot keep them.
  - Always contact their primary care provider first for nonemergency medical needs.
  - Be sure they have approval from their primary care

provider before going to a specialist (except for self-referred services).
  - Understand when they should and should not go to the ER.
- Share information relating to their health status with their primary care provider and become fully informed about service and treatment options. That includes the responsibility to:
  - Tell their primary care provider about their health.
  - Talk to their providers about their health-care needs and ask questions about the different ways their health-care problems can be treated.
  - Help their providers get their medical records.
- Actively participate in decisions relating to service and treatment options, make personal choices, and take action to maintain their health. That includes the responsibility to:
  - Work as a team with their provider in deciding what health care is best for them.
  - Understand how the things they do can affect their health.
  - Do the best they can to stay healthy.
  - Treat providers and staff with respect.

7.1.6.3 Advance Directives

Federal and state law require providers to maintain written policies and procedures for informing and providing written information to all adult clients 18 years of age and older about their rights under state and federal law, in advance of their receiving care (*Social Security Act* §§1902[a][57] and 1903[m][1][A]). The written policies and procedures must contain procedures for providing written information regarding the client's right to refuse, withhold, or withdraw medical treatment advance directives. These policies and procedures must comply with provisions contained in 42 *Code of Federal Regulations* (CFR) §§434.28 and 489, SubPart I, relating to the following state laws and rules:

- A client's right to self-determination in making health-care decisions.
- The *Advance Directives Act*, Chapter 166, Texas Health and Safety Code, which includes:
  - A client's right to execute an advance written directive to physicians and family or surrogates, or to make a non-written directive to administer, withhold or withdraw life-sustaining treatment in the event of a terminal or irreversible condition.
  - A client's right to make written and non-written Out-of-Hospital Do-Not-Resuscitate Orders.
  - A client's right to execute a Medical Power of Attorney to appoint an agent to make health-care decisions on the client's behalf if the client becomes incompetent.

These policies can include a clear and precise statement of limitation if a participating provider cannot or will not implement a client's advance directive. A statement of limitation on implementing a client's advance directive should include at least the following information:

- A clarification of the provider's conscience objections.
- Identification of the state legal authority permitting a provider's conscience objections to carrying out an advance directive.
- A description of the range of medical conditions or procedures affected by the conscience objection.

A provider cannot require a client to execute or issue an advance directive as a condition for receiving health-care services. A provider cannot discriminate against a client based on whether or not the client has executed or issued an advance directive.

A provider's policies and procedures must require the provider to comply with the requirements of state and federal law relating to advance directives.

7.1.7 Primary Care Provider Requirements and Information

Under Medicaid Managed Care HMOs, eligible Medicaid clients must select a health plan and a primary care provider. Under Medicaid Managed Care PCCM, eligible Medicaid clients do not select a health plan. PCCM eligible Medicaid clients select a PCCM primary care provider. The primary care provider furnishes primary care-related services, arranges for and coordinates referrals for all medically necessary specialty services, and is available for urgent or emergency care, directly or through on-call arrangements, 24 hours a day, 7 days a week (see "Continuous Access" on page 7-10). Primary care includes ongoing responsibility for preventive health care, health maintenance, treatment of illness and injuries, and the coordination of access to needed specialist providers or other services.

Primary care providers can choose to contract with PCCM and HMO health plans simultaneously.

Providers should remember that choosing an HMO does not require that providers terminate their contracts with PCCM.

PCCM providers in the STAR metropolitan areas are encouraged to continue to provide ongoing health-care services to PCCM clients who live in contiguous areas. There may be instances where PCCM clients may choose a PCCM primary care provider in a metropolitan (STAR) SA.

Provider types who are eligible to serve as a primary care provider include:

- Pediatricians.
- Family/general practitioners.
- Internists.
- Obstetrician/gynecologists.
- Nurse practitioners or clinical nurse specialists (family practice, women's health, or pediatrics).

- Certified nurse-midwives.
- Physician assistants (PAs).
- Rural health clinics (RHCs).
- Federally qualified health centers (FQHCs).
- Specialists willing to provide medical homes to clients who have special needs.

PAs may be eligible to enroll with Medicaid Managed Care as primary care providers. Contact the individual Medicaid Managed Care health plan for enrollment information.

The primary care provider either furnishes or arranges for all the client's health-care needs, including well check-ups, office visits, referrals, outpatient surgeries, hospitalizations, and health-related services.

Although primary care providers are encouraged to assist clients in accessing these services, Medicaid Managed Care enrollees may self-refer for the following services:

- Emergency services.
- Family planning.
- THSteps services and immunizations.
- Case Management for Early Childhood Intervention (ECI).
- Case Management for Children and Pregnant Women (CPW).
- Obstetric or gynecological services.
- School Health and Related Services (SHARS).
- Department of Assistive and Rehabilitative Services (DARS) case management.
- DSHS case management.
- Department of Aging and Disability Services (DADS) case management.
- Behavioral health services (contact client's health plan for specific requirements).
- Vision care (including ophthalmologic or therapeutic optometry).

Texas Health Steps (THSteps) providers must be enrolled with Medicaid to be reimbursed for services provided to clients. THSteps services are self-referred. Medicaid HMOs determine how their clients will access THSteps services. The HMO may require the client to go to an in-network THSteps provider or may allow the client to go to any Medicaid THSteps provider, whether or not they are in the HMO's network. Clients in PCCM are encouraged to access their primary care provider for THSteps services, but may self-refer to any Medicaid THSteps provider. Providers who perform THSteps must work in collaboration with the client's primary care provider to ensure continuity of care.

Female clients may access obstetrical and gynecological providers directly.

Behavioral health providers must enroll with each HMO to be reimbursed for services provided to managed care clients. Although managed care clients may self-refer for behavioral health services, HMO health plan providers should contact the client's health plan for specific in-network requirements. If a behavioral health provider practices in the Dallas SA, he must be enrolled as a network provider in the NorthSTAR BHO.

Refer to: "NorthSTAR Program" on page 7-20.

PCCM operates an open-specialty network. Therefore, behavioral health providers do not have to enroll with PCCM. PCCM clients may access behavioral health services from any Medicaid-enrolled behavioral health provider.

Providers cannot enroll Medicaid clients; however, educating clients is encouraged. Medicaid clients must enroll through the official state enrollment form or by calling the STAR Help Line at 1-800-964-2777.

Providers should follow these rules when educating patients:

- Providers may not influence patients to choose one HMO health plan over another or one PCCM provider over another.
- HMO providers must inform patients of all Medicaid Managed Care health plans in which the providers participate.
- HMO providers participating in a Medicaid Managed Care HMO may display state-approved, health-related marketing materials in their offices, provided it is done equally for all HMOs in which they participate. HMO providers cannot give out or display plan-specific marketing items or giveaways to patients.
- Providers and subcontractors may only directly contact potential clients with whom they have an established relationship.
- HMO providers may inform patients of special services offered by all Medicaid Managed Care health plans in which the providers participate.
- HMO providers may inform patients of particular hospital services, specialists, or specialty care available in all plans in which the providers participate.
- HMO providers may assist a patient by contacting a plan (or plans) to determine if a particular specialist or service is available, if the patient requests this information.
- HMO providers may not influence patients based on reimbursement rates or methodology used by a particular plan.
- HMO providers can provide the necessary information for the patient to contact a particular plan but cannot promote any plan over another.
- In no instances can HMO providers stock, reproduce, assist in filling out, or otherwise handle the enrollment form. Information can be provided as outlined above, and patients can be reminded that they can easily enroll over the telephone with the enrollment broker. However, the call must be made by the patient, not by the HMO provider or the provider's agent.
- HMO providers may assist clients with completing the Medicaid application.

- PCCM providers may stock primary care provider selection forms and/or provide a blank primary care provider selection form to the client. They may assist the client in filling out the selection forms. However, they may not in any way influence or coerce the client in making a primary care provider selection. Each client must personally complete, sign, and mail their individual form. Providers are prohibited from supplying provider- identified stationary and/or envelopes to the client for this purpose.
- HMO providers may display stickers indicating they participate in a particular Medicaid Managed Care health plan as long as they do not indicate anything more than "(health plan) is accepted or welcomed here."

7.1.7.1 Continuous Access

Continuous access is an important feature of Medicaid Managed Care. Twenty-four-hour primary care provider availability enables clients to access and use services appropriately, instead of relying on ERs for after-hours care.

Continuous access can be provided through direct access to a primary care provider's office and/or through on-call arrangements with another office or service. Clients should be informed of the primary care provider's normal office hours and should be instructed how to access urgent medical care after normal office hours.

After-Hours Guidelines

Primary care providers are required to have *at least one* of the following arrangements in place to provide 24-hour, 7-day a week access for managed care clients:

- An office phone answered after hours by a medical exchange or a professional answering service. If an answering service is used, the following must be met:
  - The answering exchange or service must be able to contact the primary care provider or a designated back-up provider for immediate assistance.
  - The primary care provider, or designated back-up provider, must be notified of all calls.
  - All calls must be returned in a timely manner by the primary care provider or designated back-up.
  - The answering service must meet the language requirements of the major Medicaid population groups in the primary care provider's area.
- An office phone answered after office hours by an answering machine that instructs the client (in the language of the major Medicaid population groups) to do one of the following:
  - Call the name and phone number of a medical facility where the client can request to speak with a medical professional to determine whether emergency treatment is appropriate.
  - Call another number where the primary care provider can be reached.
  - Call the name and phone number of a medical professional serving as designated back-up. In this situation, the client must be able to speak with the back-up provider or a clinician who can offer immediate assistance.
- An office phone transferred after hours to another location where someone will answer and be able to contact the primary care provider or designated back-up provider

Unacceptable Phone Arrangements

The telephone answering procedures listed below are *not* acceptable:

- An office phone that is answered only during office hours.
- An office phone that is answered by a recording or an answering service that directs clients to go to the ER.
- An office phone answered after hours by an answering machine recording that tells clients to leave a message.
- An office phone answering machine recording that informs clients of regular office hours and requests that they call back during those hours.
- PCCM providers may not direct clients to call the PCCM nurse helpline in order to meet the primary care provider 24-hour continuous coverage requirements.

7.1.7.2 Cultural Competency and Sensitivity

HHSC values the diversity of the Texas Medicaid population and requires Medicaid Managed Care to provide programs to support clients from diverse cultural backgrounds:

- Helplines are staffed by both Spanish- and English-speaking customer service representatives who, at any time, may access a multi-language translation service for assistance.
- Articles in the *Texas Medicaid Bulletin* and educational workshops include topics that focus on cultural sensitivity and the need for culturally competent staff in primary care provider offices.

Providers are expected to comply with the laws concerning discrimination on the basis of race, color, national origin, or sex.

Limited English Proficiency

Medicaid providers are required to provide services in the languages of the major Medicaid population groups they serve and to ensure quality appropriate translations. Title VI, section 601, of the *Civil Rights Act* of 1964 states that "no person in the United States shall on the basis of race, color, or national origin, be excluded from participating in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

HHSC requires Medicaid providers to ensure persons with limited English proficiency have equal access to the medical services to which they are legally entitled.

Meeting the requirements of Title VI may require the primary care provider to take all or some of the following steps at no cost or additional burden to the beneficiary with limited English proficiency:

- Have a procedure for identifying the language needs of patients/clients.
- Have access to proficient interpreters during hours of operation.
- Develop written policies and procedures regarding interpreter services.
- Disseminate interpreter policies and procedures to staff and ensure staff awareness of these policies and procedures and of their Title VI obligations to persons with limited English proficiency.

In order to meet interpretation requirements, providers may choose to incorporate into their business practice any of the following (or equally effective) procedures:

- Hire bilingual staff.
- Hire staff interpreters.
- Use qualified volunteer staff interpreters.
- Arrange for the services of volunteer community interpreters (excluding the client's family or friends).
- Contract with an outside interpreter service.
- Use a telephone interpreter service such as Language Line Services.
- Develop a notification and outreach plan for beneficiaries with limited English proficiency.

Complaints and reports of non-compliance with Title VI regulations are handled by the Office for Civil Rights (OCR).

Additional information, including the complete guidance memorandum on prohibition of discrimination against persons with limited English proficiency issued by the OCR, can be found on the Internet at www.hhs.gov/ocr/lep/guide.html.

7.1.7.3 Primary Care Provider-to-Client Ratio and Capacity

HHSC oversees all Medicaid Managed Care providers for accessibility and quality of care. If HHSC determines that providers do not have, or fail to maintain, the capacity or capability of providing quality, accessible care, their clients will be reduced through a freeze on new enrollments to the provider's panel. HHSC may reassign current clients from the provider's panel/roster if required accessibility and quality of care to clients is jeopardized.

7.1.8 Medicaid Managed Care Complaints and Fair Hearings

Medicaid Managed Care providers may file complaints with HHSC if they find they did not receive full due process from the respective managed care health plan.

Appeals/grievances or dispute resolution is the responsibility of each managed care health plan or PCCM. Providers must exhaust the complaints/grievance process with their managed care health plan or PCCM before filing a complaint with HHSC.

Please refer to the respective health plan or PCCM for information about specific complaint policies and procedures. For PCCM, please see "Provider Complaints and Appeals" on page 7-42. For NorthSTAR, see "Complaints and Appeals" on page 7-21. For HMOs, refer to the respective health plan's policies and procedures.

7.1.9 Claims Filing Information

TMHP processes claims for the following clients/programs:

- All PCCM claims (whether TANF or SSI).
- All SSI clients who are in the STAR Program
- The following services for PCCM, STAR+PLUS, or STAR clients:
  - ECI Case Management.
  - DSHS case management (except for the Dallas SA where clients are enrolled in NorthSTAR).
  - DADS services (except for the Dallas SA where clients are enrolled in NorthSTAR).
  - CPW Case Management.
  - SHARS.
  - DARS.
  - THSteps Dental (dentist services only).
  - Tuberculosis services provided by DSHS-approved providers.
  - Vendor Drug Program (out-of-office drugs).
  - Audiology services and hearing aids for children under the age of 21 (hearing screening services are provided through the THSteps Program and are capitated) through the Program for Amplification for Children of Texas (PACT).

A claim must be submitted to TMHP for processing for a patient who was classified as SSI on the date of admission to a hospital. However, if the patient was an HMO client as of the date of admission to the hospital and was admitted as TANF- (i.e., not SSI) certified, but changed to SSI during the same hospital stay, the claim must be submitted to the client's HMO for payment of the entire hospital stay.

If the provider of services is not the client's assigned primary care provider, the primary care provider's name and provider identifier must be entered in the Referring Provider field of the approved electronic format, in boxes 17 and 17a of the CMS-1500 claim form, or boxes 78 and 79 of the UB-04 CMS-1450 claim form, indicating a referral from the primary care provider. If this information is missing and the treating provider is not the assigned primary care provider on the dates of service, the claim will be denied.

Providers submitting claims for SSI voluntary clients must follow the client's individual plan requirements for referrals, authorization, admission notification, and concurrent review. The plan is responsible for notifying TMHP of the services that they have approved so those claims can be processed accordingly. Claims for SSI clients who are voluntarily enrolled in PCCM or an HMO will be paid at traditional Medicaid rates.

All traditional Medicaid processing guidelines are followed in processing these claims including the 95-day filing deadline. Send claims through regular mail to the following address:

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

Claims delivered by UPS or other courier methods are to be addressed to the following:

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

TMHP Electronic Claims Submission

Electronic claims submission is available to providers filing claims for PCCM clients and all SSI voluntary clients in STAR HMOs. Providers must use their provider identifier when billing. For assistance with enrolling to file electronic claims, contact the TMHP Electronic Data Interchange (EDI) Help Desk at 1-888-863-3638, or a provider representative. Contact individual plans for information on electronic claims submissions to STAR HMOs (refer to chart, STAR Program SAs).

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for more information about electronic claims submission.

7.1.9.1 Claims for Pregnant Women (TP40)

Claims for pregnant women who are on type program 40 should be directed to the health plan listed on the Medicaid Identification Form (Form H3087). In some instances, a primary care provider will not be assigned for the first month of eligibility. These claims should be filed with the following temporary primary care provider number as the referring provider: PCCTP4001. For clients who do not yet have a primary care provider assigned, call the client's health plan for more information. If a health plan name does not appear on a STAR client's Medicaid Identification Form (Form H3087), call the STAR Help Line at 1-800-964-2777.

For PCCM clients who do not yet have a primary care provider assigned, call the PCCM Client Helpline at 1-888-302-6688 to select a primary care provider.

7.2 STAR Program

7.2.1 Overview

The principal objectives of the STAR Program are to emphasize early intervention and to promote improved access to quality care, thereby significantly improving health outcomes for the target population, with a special focus on prenatal and well-child care.

Currently, the STAR Program consists of only one type of health-care delivery system (HMO) in select Texas counties. The selected grouping of counties is known as a service area (SA).

7.2.1.1 STAR HMO Model

In the HMO model, each STAR health plan is responsible for contracting with providers and/or delegated network to create a health-care provider delivery network. Mandatory clients who reside in one of the SA counties where this model is available are required to select a health plan and a primary care provider. The client selects the primary care provider from the HMO provider directory.

7.2.2 Client Eligibility

HHSC has targeted these client groups within the Texas Medicaid population for STAR Program enrollment:

Base Plan	Category	Type Program	Description	Bexar, Harris, Harris Expansion, Nueces, and Travis SAs	Dallas, El Paso, Lubbock, and Tarrant SAs
	02	1	Money grant and Medicaid	M	M
	02	3	MAO RSDI increase	M	M
	02	7	12 months transitional Medicaid resulting from increase in earnings	M	M
	02	20	4 months transitional Medicaid resulting from receipt of child support	M	M
	02	29	12 through 18 months transitional Medicaid following end of state time-limited TANF	M	M
	02	37	12 months transitional Medicaid resulting from loss of 90 percent earned income disregard	M	M
	02	40	Pregnant women with income <185 percent Federal Poverty Limit (FPL)	M	M
	02	43	Children < 1 year of age at 185 percent FPL	M	M
	02	44	Children 6 through 19 years of age at 100 percent FPL	M	M
	02	45	Newborn of Medicaid eligible mother to 1 year of age	M	M
	02	47	Children ineligible for TANF due to applied income of stepparent or grandparent	M	M
	02	48	Children 1 though 5 years of age at 133 percent FPL	M	M
	02	61	TANF state plan, money grant and Medicaid	M	M
13	03 or 04	3	MAO RSDI increase, no Medicare	X	V
13	03 or 04	12	SSI manually certified adults, no Medicare	X	V
V=Voluntary, M= Mandatory, X= Not Eligible					

Base Plan	Category	Type Program	Description	Bexar, Harris, Harris Expansion, Nueces, and Travis SAs	Dallas, El Paso, Lubbock, and Tarrant SAs
13	03 or 04	12	SSI manually certified children <21 years of age, no Medicare	X	V
13	03 or 04	13	SSI recipient, adults, no Medicare	X	V
13	03 or 04	13	SSI recipient, children <21, no Medicare	X	V
13	03 or 04	18	Disabled Adult Children denied SSI due to increase in RSDI benefits, no Medicare	X	V
13	03 or 04	19	Transitional SSI Medicaid, no Medicare	X	V
13	03 or 04	22	Early Age Widows/Widowers, no Medicare	X	V
V=Voluntary, M= Mandatory, X= Not Eligible					

To ensure reimbursement, it is essential that all health-care providers verify eligibility before medical care is provided to STAR Program clients, except in cases of emergency. In situations where emergency care must be provided, the client's STAR health plan and primary care provider should be determined as soon as possible.

STAR Program clients' Medicaid Identification Forms (Form H3087) will indicate their participation in the STAR Program. Additionally, STAR health plans provide their clients an HMO identification card. Both forms of identification should be requested when determining whether or not the client is a STAR Program client.

7.2.3 Client Enrollment

A STAR Program client may choose a STAR health plan and primary care provider. To maximize enrollment, the STAR Program offers four alternative ways that clients can enroll:

- *Telephone Enrollment*. A client can enroll in the STAR Program by calling 1-800-964-2777. A customer care representative will provide essential education about the program and details needed for enrollment.
- *Mail-in Enrollment*. If calling is not convenient, a client may enroll by completing the STAR Program enrollment form and dropping it in the mail using the postage-paid, self-addressed envelope. Enrollment forms are mailed to all eligible mandatory clients along with a brochure explaining the program and provider directories for each plan.
- *Onsite Enrollment*. In addition to telephone and mail-in enrollment, clients can enroll by talking with a STAR Program customer care representative at a local HHSC office, at Women, Infants, and Children (WIC) classes, community facilities, or during enrollment events.
- *Default Enrollment*. The final method of enrollment is through an assignment process. If a client does not exercise the right to choose a STAR health plan and primary care provider, the client will be assigned to a plan and/or primary care provider. The following factors are considered when processing a default enrollment:
  - Client's past claims history, taking into account an established relationship with a STAR participating primary care provider.
  - Client's age.
  - Client's sex.
  - Client's geographic proximity to the primary care provider.

7.2.3.1 STAR Help Line (STAR Enrollment Broker)

Hours	8 a.m. to 8 p.m., Central Time, Monday through Friday
Telephone	1-800-964-2777
Telecommunications device for the deaf (TDD)	1-800-267-5008

7.2.3.2 Enrollment of Pregnant Women (Type Program 40)

Women who are on Medicaid type program 40 may be retroactively enrolled in STAR. Women who are certified for Medicaid type program 40 on or before the 10th of the month will be enrolled in STAR beginning the first of the month of certification. Those who are certified after the 10th of the month will be on fee-for-service the month of certification and will be enrolled in STAR beginning the first of the month following the month of certification.

There are two exceptions to this rule:

- Women who are certified at any time in their estimated month of delivery will be enrolled in STAR the first of the following month (prospective enrollment).
- Women who are certified at any time in their actual month of delivery (if known by HHSC before certification) will be enrolled in STAR the first of the following month (prospective enrollment).

It is important that providers call the number listed on the Medicaid Identification Form (Form H3087) for plan and provider information.

***Example 1**: Woman Certified in Her 6th Month*

Client certified for Texas Medicaid	August 1
Medicaid benefits begin	August 1
STAR Program benefits begin	August 1

***Example 2**: Woman Certified in Her 6th Month*

Client certified for Texas Medicaid	August 12
Medicaid benefits begin	August 1
STAR Program benefits begin	September 1

***Example 3**: Woman Certified in Her 9th Month*

Client certified for Texas Medicaid	August 5
Medicaid benefits begin	August 1
STAR Program benefits begin	September 1

A pregnant woman who is on type program 40 has 16 days from the date of application to choose a STAR health plan. If she does not choose a STAR health plan, one will be chosen for her.

Expedited Medicaid Managed Care Enrollment for Pregnant Women

The enrollment broker contacts the client to begin the enrollment process and assists the client in selecting an HMO. The client may also contact the enrollment broker directly at 1-800-964-2777 (STAR Help Line). To protect continuity of care and client choice, the enrollment broker will work with each pregnant woman to select a health plan that includes her current prenatal care provider or to choose an obstetrical care provider that meets her needs.

Until coverage begins in a Medicaid Managed Care Program, clients will be covered under traditional Medicaid fee-for-service. Clients may initially receive a Medicaid Identification Form (Form H3087) that shows them to be a client of a STAR health plan but does not list the plan name. To ensure proper billing, providers should call the enrollment broker at 1-800-964-2777 (STAR Help Line) to obtain the name of the client's health plan. The health plan name should appear on the Medicaid Identification Form (Form H3087) the following month. However, client eligibility should always be verified.

Within 14 days of enrolling in a new health plan, a plan representative will contact the new client to help arrange the first prenatal appointment. Physicians should also expect contact from the health plans to facilitate prenatal appointments for new clients. Physicians and other prenatal care providers are encouraged to make prenatal appointments within two weeks.

Enrollment of Newborns

STAR health plans are responsible for all covered services provided to newborn clients. In the STAR Program, newborns are automatically assigned to the STAR health plan the mother is enrolled with at the time of the newborn's birth. The effective date of the newborn's enrollment is the same as the newborn's date of birth.

In the STAR+PLUS Program, newborns are enrolled in the STAR plan offered by the mother's STAR+PLUS plan, if available. If the STAR+PLUS plan does not also provide STAR services in the SA, the newborn is automatically enrolled in traditional Medicaid until the mother selects a STAR plan for the newborn.

As with the traditional Medicaid program, there may be a delay of up to several months from the date of birth (DOB) for a newborn to receive a Medicaid client number. Providers should check with each STAR health plan for claim filing requirements.

If the newborn has not yet been assigned a primary care provider, the Medicaid Identification Form (Form H3087) will indicate that the client is "Newborn" and instruct the provider to "Call Plan" to inquire about filing a claim.

Refer to: "Newborn Claims Submission" on page 7-17 and "STAR+PLUS Program" on page 7-17.

Timely Notification and Assignment of Medicaid ID for Newborns

Hospitals that submit their birth certificate information utilizing the DSHS, Bureau of Vital Statistics (BVS) electronic Certificate Manager software and the HHSC Form 7484, receive a rapid and efficient assignment of a newborn Medicaid identification number. This process expedites reimbursement to hospitals and other providers involved in newborn care.

Call 1-512-458-7367 for further questions or comments about this process.

7.2.4 Service Area and STAR HMO Choices

Service Area	Counties	STAR Health Plans Available	STAR Health Plan Provider Services
Bexar	Atascosa, Bexar, Comal, Kendall, Guadalupe, Wilson, and Medina	Aetna Community First Health Plans Superior Health Plan	1-800-248-7767 1-800-434-2347 1-877-391-5921
Dallas	Dallas, Collin, Ellis, Hunt, Kaufman, Navarro, and Rockwall	Amerigroup Texas, Inc. Parkland Community Health Plan Unicare Health Plans of Texas	1-800-454-3730 1-888-672-2277 1-866-480-4830
El Paso	El Paso	El Paso First Superior Health Plan	1-877-532-3778 1-877-391-5921
Harris/Harris Expansion	Brazoria, Fort Bend, Galveston, Harris, Montgomery, Waller	Amerigroup Texas, Inc. Community Health Choice Molina Healthcare of Texas Texas Children's Health Plan United Healthcare of Texas	1-800-454-3730 1-888-760-2600 1-866-449-6849 1-800-990-8247 1-866-331-2243
Lubbock	Crosby, Floyd, Garza, Hale, Hockley, Lamb, Lubbock, Lynn, Terry	FIRSTCARE Superior Health Plan	1-800-264-4111 1-877-391-5921
Nueces	Aransas, Bee, Calhoun, Jim Wells, Kleberg, Nueces, Refugio, San Patricio, Victoria	Amerigroup Community Care Driscoll Children's Health Plan Superior Health Plan	1-800-454-3730 1-877-324-3627 1-877-391-5921
Tarrant	Denton, Hood, Johnson, Parker, Tarrant, Wise	Aetna Amerigroup Community Care Cook Children's Health Plan	1-800-306-8612 1-800-454-3730 1-800-964-2247
Travis	Bastrop, Burnet, Caldwell, Hays, Lee Travis, Williamson	Amerigroup Community Care Superior Health Plan	1-800-454-3730 1-877-391-5921

Refer to: “PCCM” on page 7-23 for details relating to PCCM areas.

7.2.5 STAR Program Benefits

STAR Program clients receive all the benefits of the traditional Texas Medicaid Program and the following additional benefits:

- Annual adult well-checks.
- Removal of the inpatient spell of illness limitation.
- Unlimited medically necessary prescription drugs for adults.

7.2.5.1 Annual Adult Well-Check

An annual adult physical exam performed by the client’s primary care provider is an additional benefit of the STAR Program for clients 21 years of age and older. The annual physical exam is performed in addition to family planning services. This service is provided to healthy individuals for the purpose of promoting health and preventing injury or illness.

The annual examination should be age and health risk appropriate and should include all the clinically indicated elements of history, physical examination, laboratory/diagnostic examination, and patient counseling that are consistent with good medical practice. Providers are encouraged to adopt a nationally recognized, evidence-based standard for the elements of the annual exam, such as the guidelines published by the American Academy of Family Physicians at www.aafp.org.

This service is only reimbursable when performed by the current designated primary care provider on the date of service and is allowed once per state fiscal year (September 1 through August 31), per client.

The following appropriate codes may be billed:

- 99385 and 99386 for a new patient.
- 99395 and 99396 for an established patient.

7.2.5.2 Spell of Illness

STAR clients are not limited to the 30-day spell of illness (see "Texas Medicaid Program Limitations and Exclusions" on page 1-19 for more information on the spell of illness limitation). Members younger than 21 years of age already have this benefit under the Comprehensive Care Program (CCP).

7.2.5.3 Prescriptions

STAR Program members who are age 21 years or older are permitted to receive unlimited medically necessary prescription drugs. The elimination of the three prescription limit per month for adult clients enrolled in STAR allows the provider greater flexibility in treating and managing a client's health-care needs. Prescription reimbursement continues to be processed through the HHSC Vendor Drug Program. All Medicaid clients who are younger than 21 years of age receive unlimited medically necessary prescription drugs.

7.2.6 Claims Filing Information

All claims for Medicaid Managed Care clients enrolled in a STAR HMO must be submitted to the STAR health plan in which the client is enrolled at the time of service (or date of admission for inpatient hospital claims). The STAR HMO, as a secondary payor, does not determine payment based on the primary payor's authorization of services and/or approval of hospital stays.

Exception: *TMHP processes some claims for HMO clients. See "Claims Filing Information" on page 7-11 for details.*

7.2.6.1 Newborn Claims Submission

Newborns are automatically assigned to the STAR health plan the mother is enrolled with at the time of the newborn's birth. The effective date of the newborn's enrollment is the same as the newborn's date of birth. Claims for services provided to newborns should be filed with the mother's STAR health plan. Providers filing claims for services provided to newborns are still responsible for meeting the Medicaid filing deadlines, which in most cases is within 95 days of each date of service.

HMO Newborn Claims Filing

Claims for newborns who are clients of an HMO should be filed directly with the client's HMO.

Health-care providers should file newborn claims using the newborn's Medicaid identification number as soon as it is made available to them.

HMOs must pay providers for inpatient and professional services related to neonatal care for up to 48 hours after vaginal delivery and 96 hours after cesarean delivery. (Prior authorizations and primary care provider assignment cannot be a reason for denial of claims.)

HMOs may require prior authorizations for hospital and professional services beyond the 48/96 hour time limits.

Authorization requests, utilization review questions, and claim status inquiries and appeals should be directed to the STAR health plan in which the client is enrolled.

Note: *Telephone numbers and addresses for claims submission and appeals for STAR HMOs can be found in the appropriate HMO provider policies and procedures manual for the appropriate SA.*

Refer to: "Claims Filing Information" on page 7-19 for information about claims filing for STAR+PLUS.

"Claims Filing Information" on page 7-21 for information about claims filing for NorthSTAR.

7.3 STAR+PLUS Program

7.3.1 Overview

In 1995, the Texas Legislature adopted S.B. 10 and related legislation that authorized HHSC to undertake a comprehensive restructuring of the Texas Medicaid Program to incorporate Medicaid Managed Care delivery systems statewide. STAR+PLUS is the result of Texas Senate Concurrent Resolution 55 of the 74th Legislature (1997), which directed HHSC to develop and implement a long term care integrated model demonstration program.

The STAR+PLUS Program is an HMO delivery system.

Clients eligible for Medicaid under the SSI Programs residing in Bexar, Harris/Harris Expansion, Nueces, and Travis SAs began enrolling in STAR+PLUS. STAR+PLUS integrates acute care and long term care into a Medicaid Managed Care delivery system for eligible Medicaid clients under the SSI Program. HHSC is the operating agency for STAR+PLUS. It is designed to improve access to care, provide care in the least restrictive setting, and provide more accountability and control on costs.

7.3.1.1 HMO Model

In the HMO model, the STAR+PLUS health plan is responsible for contracting with providers and/or delegated network to create a health-care provider delivery network. SSI clients who reside in one of the SA counties where this model is an option, and who have selected an HMO, are required to select a primary care provider from the HMO provider directory if they are not covered by Medicare. SSI clients who are also covered by Medicare (Dual Eligible clients) must select a STAR+PLUS HMO to receive Medicaid community based long term care.

Children born to STAR+PLUS clients will be enrolled with the STAR plan operated by the same HMO if available. If the STAR+PLUS plan does not also operate a STAR plan,

the newborn is automatically enrolled into traditional Medicaid, and the mother is given the opportunity to choose a STAR health plan for the newborn.

7.3.1.2 Service Areas

The STAR+PLUS Program is mandatory for clients 21 years of age or older and voluntary for clients under 21 years of age under SSI programs who reside in the following SAs: Bexar, Harris/Harris Expansion, Nueces, and Travis.

The following STAR+PLUS health plans are available:

Service Area	Counties	Health Plans	Telephone Number
Bexar	Atascosa, Bexar, Comal, Guadalupe, Kendall, Medina, Wilson	Molina Healthcare of Texas Superior HealthPlan, Amerigroup Community Care	1-866-449-6849, Option 1 1-877-391-5921, Option 3 1-800–454-3730
Harris/Harris Expansion	Brazoria, Fort Bend, Galveston, Harris, Montgomery, Waller	Amerigroup Community Care Evercare of Texas, Inc. Molina Healthcare of Texas	1-800–454-3730 1-888-887-9003 1-866-449-6849, Option 1
Nueces	Aransas, Bee, Calhoun, Jim Wells, Kleberg, Nueces, Refugio, San Patricio, Victoria	Evercare of Texas, Inc. Superior HealthPlan	1-888-887-9003 1-877-391-5921, Option 3
Travis	Bastrop, Burnet, Caldwell, Hays, Lee, Travis, Williamson	Amerigroup Community Care Evercare of Texas, Inc.	1-800–454-3730 1-888-887-9003

7.3.1.3 Client Eligibility

HHSC has targeted these client groups within the Texas Medicaid population for STAR+PLUS Program enrollment:

- Enrollment for category 01, 03, 04 (SSI aged, blind and disabled clients) and the following program types are *mandatory* for STAR+PLUS:

Type Program	Description
03	Denied SSI clients who are Medicaid-eligible under Pickle provisions.
12	SSI client.
13	SSI client.
14	***Note:*** *Only those client that have been determined eligible for the 1915 (c) STAR+PLUS Waiver (SPW) will be enrolled in STAR+PLUS. All other clients in TP 14 are excluded from participation.*
18	Disabled adult children denied SSI dues to increase in Social Security benefits.
22	Denied SSI clients who receive widow/widower Social Security benefits.
51	Medicaid and community-based nursing care services.

- Enrollment for category 03 and 04, SSI blind and disabled children, and type program 19, Medicaid and community-based waiver program for children younger than age 21 years, may enroll in a STAR+PLUS HMO.

Refer to: “Client Enrollment” on page 7-5 for more information on eligibility effective dates.

7.3.1.4 Dual Eligible Clients

Many STAR+PLUS clients are eligible for Medicaid and Medicare. STAR+PLUS HMOs are not at risk for the delivery of acute care services needed by these clients.

Most STAR+PLUS clients with Medicare and Medicaid are Medicaid Qualified Medicare Beneficiaries (MQMBs). MQMBs receive Medicare benefits through a Medicare risk product (HMO) or Medicare fee-for-service insurance program. To reduce confusion, HHSC has mandated that STAR+PLUS MQMBs continue to receive all their acute care services as they do today, with Medicare being the primary payor

and traditional Medicaid, through TMHP, the secondary payor. Providers are to continue billing for Medicare acute care services through the client's Medicare HMO or fee-for-service insurer following the rules of the Medicare insurer. If the client is in both a Medicare and Medicaid HMO, the client uses the Medicare primary care provider, and providers follow the Medicare HMO's medical management rules for authorization, concurrent review, etc. MQMBs choose a Medicaid HMO but do not choose a Medicaid primary care provider.

Refer to: Sections on MQMBs in this manual for further instructions.

"Claims Filing Information" on page 7-19 for MQMB reimbursement requirements.

Dual eligible adults continue to be limited to three prescriptions unless they have joined the Medicare HMO also offered by their STAR+PLUS plan. With the implementation of the Medicare prescription benefit in January 2006, dual eligible clients no longer receive any prescription benefit through Medicaid.

7.3.1.5 Ineligible Clients

Clients not eligible for STAR+PLUS who will remain in the traditional Medicaid program include clients who are:

- Participating in a Home and Community-Based Waiver other than the Nursing Facility Waiver:
  - Community Living Assistance and Support Services (CLASS) Waiver Program.
  - Medically Dependent Children's Program (MDCP) Waiver Program.
  - Home and Community Services (HCS) Waiver Program.
  - Mental Retardation Local Authority (MRLA) Waiver Program.
  - Deaf/Blind Multiple Disabled Waiver Program.
  - Texas Home Living (TXHML)
- Residents in a nursing facility
- Residents in intermediate care facilities for the mentally retarded (ICF-MR)
- Residents of state hospitals or institutions for mental diseases.
- Frail Elderly (or 1929B) Program recipients.
- Recipients of In-Home and Family Support Program Services.
- Qualified Medicare Beneficiaries (QMBs).
- Undocumented aliens.
- Clients who receive limited Medicaid benefits and do not qualify for participation in the Vendor Drug Program.

7.3.2 STAR+PLUS Program Benefits

STAR+PLUS Program clients receive all the benefits of the traditional Texas Medicaid Program and the following additional benefits:

- Annual adult well-checks.
- Spell of Illness policy defined in "Spell of Illness" on page 7-17.
- Prescriptions policy defined in "Prescriptions" on page 7-17 (for STAR+PLUS members that are not dual eligibles).

7.3.3 Claims Filing Information

The claims filing guidelines found in "Claims Filing Information" on page 7-11, also apply to STAR+PLUS.

In addition to the claim types found on page 7-11, TMHP processes claims for the following STAR+PLUS clients/programs:

- All crossovers for deductibles and coinsurance on STAR+PLUS MQMBs.
- All claims for Medicaid-only services (refractions, hearing exams, etc.) provided to STAR+PLUS MQMBs.

TMHP will process and consider for payment inpatient hospital accommodations and related inpatient services (anything billed on an inpatient UB-04 CMS-1450 claim form). These services *must* be prior authorized by the client's HMO. After the provider requests prior authorization from the HMO, the HMO will forward the authorization to TMHP, and claims will be processed and considered for payment against the services authorized by the HMO. Claims received by TMHP without a prior authorization from the HMO will be denied.

For STAR+PLUS clients, the HMO will be responsible for processing and paying professional services. All authorizations, if required, for these claims must be submitted to the HMO and all claims for professional services must be submitted to the HMO.

STAR+PLUS MQMBs receive services and have their acute care claims processed as though they are not in a Medicaid Managed Care program. TMHP is responsible for reimbursing all Medicare coinsurance and deductibles that meet Medicaid payment criteria, as well as for all services that are a benefit of the Medicaid program (refractions, hearing exams, etc.) that are not covered under the Medicare program.

7.3.3.1 STAR+PLUS Mental Health Claims

Freestanding psychiatric facility claims and inpatient claims with a behavioral health primary diagnosis submitted for clients who are enrolled in a STAR+PLUS plan will be processed by the STAR+PLUS HMOs. TMHP will deny these claims. Providers must file these types of claims with the appropriate HMO.

Note: *This does not include claims for mental health case management and rehabilitative services delivered by Mental Health and Mental Rehabilitative (MHMR) facilities. Those services remain carved out of this managed care model.*

7.4 NorthSTAR Program

7.4.1 Overview

NorthSTAR, in the Dallas SA, provides behavioral health services (mental health, chemical dependency, and substance abuse treatment) for Medicaid enrollees through a BHO. NorthSTAR also serves a clinically and financially eligible non-Medicaid population.

NorthSTAR is known as a *behavioral health carve-out* of the STAR Program in the Dallas SA. Medicaid provides access to physical health care while NorthSTAR provides mental health and chemical dependency (behavioral health) services.

NorthSTAR provides easier access to a comprehensive array of behavioral health services and providers. The program's goal is to provide clinically necessary behavioral health services to enrollees, through a network of qualified and credentialed providers.

In the NorthSTAR Program, ValueOptions is the sole BHO and is responsible for contracting with providers and maintaining a behavioral health-care provider delivery network. The BHO also:

- Offers education and support to the provider network.
- Performs utilization management through authorization of services, concurrent review, and special studies.
- Performs quality assurance monitoring and activities.
- Provides client services including education and outreach.
- Processes claims.

7.4.2 Provider Requirements and Information

In the STAR Program, clients select a primary care provider from among the providers who have contracted with a STAR HMO or PCCM. In the NorthSTAR Program, a client may have several different providers for different specialty behavioral health services. The BHO will arrange behavioral health services and make referrals to specific providers within the BHO network.

Providers are encouraged to coordinate care with physical health providers in the Medicaid Managed Care and traditional Medicaid programs. Behavioral health providers may do this by notifying the Medicaid Managed Care or traditional Medicaid provider. Behavioral health providers may also notify the BHO that the client is receiving services.

Providers interested in becoming a ValueOptions network provider can obtain additional information by contacting ValueOptions at 1-888-800-6799.

Note: *If a behavioral health provider practices in the Dallas SA, he must be enrolled as a network provider in the NorthSTAR BHO (ValueOptions) to provide services to NorthSTAR enrollees. Providers who serve NorthSTAR enrollees without being in the provider network or without prior authorization in nonemergency situations risk nonpayment of claims.*

7.4.3 Service Area

The NorthSTAR Program is available in the Dallas SA. The following counties are included: Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall.

The ValueOptions Provider Services contact telephone number is 1-888-800-6799.

7.4.3.1 Client Eligibility

Most Medicaid clients residing in the Dallas SA must enroll in NorthSTAR. All STAR Program enrollees are subject to mandatory enrollment in NorthSTAR. Once enrolled in NorthSTAR, ValueOptions will coordinate enrollee behavioral health services.

Refer to: "Medicaid Identification Form H3087" on page 4-19 for a sample of the Medicaid Identification Form (Form H3087).

Note: *NorthSTAR Program enrollment information is not reflected on the Medicaid Identification Form (Form H3087), but enrollment can be confirmed by the BHO or the enrollment broker.*

Medicaid clients residing in the Dallas SA that are not eligible to enroll in a NorthSTAR BHO are:

- Medicaid clients living in a nursing facility.
- Medicaid clients living in an ICF-MR.
- Medicaid clients living in state hospitals' Institutions for Mental Disease Over Age 65 Program.
- Children who are in the custody of the Department of Family and Protective Services (DFPS) (in foster care).
- Certain Medicaid clients that are ineligible for NorthSTAR such as type program 55.

Refer to: "Client Enrollment" on page 7-14 for further information on STAR Program eligible client program types and for further information on STAR Program eligibility effective dates.

7.4.4 Client Enrollment

When a Medicaid enrollee requests services, the provider should contact ValueOptions or the enrollment broker to verify enrollment in NorthSTAR. If the client is not currently enrolled in NorthSTAR, the provider may give the client the telephone number of the enrollment broker so the client may become enrolled in NorthSTAR.

The enrollment broker staff is trained to assist potential clients in their understanding of both the STAR and NorthSTAR programs.

Medicaid clients must enroll via the enrollment broker if during regular working hours. If it is an emergency and after regular business hours, the NorthSTAR BHO can enroll a Medicaid client into NorthSTAR.

Medicaid clients may also mail in the enrollment using the NorthSTAR enrollment form. Non-Medicaid clients may be enrolled by NorthSTAR at designated enrollment sites.

Client enrollment is retroactive to the NorthSTAR eligibility certification date. Example:

NorthSTAR Example	
Client certified for Texas Medicaid in the NorthSTAR SA	January 1
Medicaid benefits begin	January 1
Client enrolls in NorthSTAR	January 20
NorthSTAR benefits begin	January 1

7.4.4.1 NorthSTAR Enrollment Broker

Hours	8 a.m. to 8 p.m., Central Time, Monday through Friday
Telephone	1-800-964-2777
Telephone TDD	1-800-267-5008

7.4.4.2 Guidelines for Working with NorthSTAR Clients

Clients enrolled in NorthSTAR, like any other clients, have these rights:

- To be treated with respect, dignity, privacy and confidentiality, and without discrimination.
- To consent to or refuse treatment and actively participate in treatment decisions.
- To use each available complaint process and to receive a timely response to complaints.
- To receive timely access to care that does not have any communication or physical access barriers.

7.4.5 Claims Filing Information

All behavioral health claims for NorthSTAR enrollees in the Dallas SA must be filed to the NorthSTAR BHO, ValueOptions. Behavioral health specialists and hospitals are not to bill TMHP for behavioral health services provided to clients who are enrolled in or eligible for enrollment in the NorthSTAR Program.

Exception: *Claims with a primary diagnosis of developmental disability (mental retardation, autism, pervasive developmental disorder) are submitted to TMHP.*

If a behavioral health claim is submitted to TMHP for any diagnosis other than a developmental disabilty, it is denied. If it is paid erroneously, TMHP recoups it later.

7.4.5.1 Hospital Billing

In the Dallas SA, SSI clients are subject to mandatory enrollment in Medicaid Managed Care through the NorthSTAR Program. In some instances, general acute care hospitals treat a NorthSTAR client with a primary behavioral health diagnosis. In that instance, the general acute care hospital needs to seek authorization and reimbursement from ValueOptions using the CMS-1500 form for outpatient services and UB-04 CMS-1450 for inpatient services.

7.4.5.2 Behavioral Health Billing

Services provided under the STAR Program are billed to the STAR HMO in which the patient is enrolled. The STAR Program in the Dallas SA covers medically necessary physical health-care services and behavioral health services that are delivered by medical providers, such as primary care physicians, FQHCs, and RHCs. STAR also covers ambulatory laboratory and ancillary services required to diagnose or treat behavioral health conditions and psychological testing for certain non-behavioral health diagnoses.

The program-related forms are the CMS-1500 and UB-04 CMS-1450.

7.4.5.3 Prior Authorization Requirements

To receive payment for services to ValueOptions clients, providers must be enrolled with ValueOptions. (Exceptions include emergency care and medically necessary treatment episodes that began before the client joined a NorthSTAR plan.) ValueOptions requires that the provider obtain prior authorization for most nonemergency services. If the provider does not obtain prior authorization, they may not get payment for services. These rules apply whether the provider's practice or facility is located in or out of the Dallas SA.

7.4.6 Complaints and Appeals

A *complaint* is defined as any dissatisfaction expressed in writing by the provider, or on behalf of that provider, concerning any aspect of the health plan. The term *complaint* does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the provider's satisfaction.

Appeals/grievances, hearings, or dispute resolution is the responsibility of ValueOptions. Providers must exhaust the appeals/grievance process with ValueOptions before filing a complaint with NorthSTAR Provider Relations. Under the complaint process, NorthSTAR Provider Relations works with ValueOptions and providers to verify the validity of the complaint, determine if the established due process was followed in resolving appeals and grievances, and addresses other program/contract issues, as applicable. When filing a complaint, providers must submit a letter explaining the specific reasons they believe the final appeal decision by the NorthSTAR health plan is incorrect and copies of the following documentation as appropriate:

- All R&S reports of the claims/services in question, if applicable.
- Provider's claims/billing records (electronic or manual) related to the complaint.

- Provider's internal notes and logs when pertinent.
- Memos from the state or the health plan indicating any problems, policy changes, or claims processing.
- Discrepancies that may be relevant to the complaint.
- Other documents such as receipts (i.e., certified mail).
- Original date-stamped envelopes, in-service notes.
- Minutes from meetings, etc., if relevant to the complaint.

All NorthSTAR providers must exhaust the ValueOptions complaint and appeals process first. After this process is exhausted and if the outcome is unsatisfactory, NorthSTAR providers may file complaints/appeals with NorthSTAR Provider Relations at the following address:

NorthSTAR Provider Relations
DSHS
909 W. 45th Street
PO Box 12668
Austin, TX 78711-2668

Quality Improvement Monitoring

Direct quality of care concerns to ValueOptions or NorthSTAR Provider Relations at the following address:

NorthSTAR Provider Relations
DSHS
909 W. 45th Street
PO Box 12668
Austin, TX 78711-2668

7.5 PCCM

7.5.1 Overview

PCCM is a service delivery model under the Texas Medicaid Managed Care Program and is administered by TMHP. It is not an HMO. PCCM is a network of primary care providers and hospitals under contract with HHSC. PCCM primary care providers and hospitals contract directly with HHSC. PCCM clients select or are assigned a primary care provider from among those who have contracted with HHSC. PCCM was originally implemented as one of the health-care delivery options available under the STAR Program, but is no longer part of the STAR Program.

PCCM is available in the following counties:

PCCM Counties					
Anderson	Andrews	Angelina	Archer	Armstrong	Austin
Bailey	Bandera	Baylor	Bell	Blanco	Borden
Bosque	Bowie	Brazos	Brewster	Briscoe	Brooks
Brown	Burleson	Callahan	Cameron	Camp	Carson
Cass	Castro	Chambers	Cherokee	Childress	Clay
Cochran	Coke	Coleman	Collingsworth	Colorado	Comanche
Concho	Cooke	Coryell	Cottle	Crane	Crockett
Culberson	Dallam	Dawson	Deaf Smith	Delta	DeWitt
Dickens	Dimmit	Donley	Duval	Eastland	Ector
Edwards	Erath	Falls	Fannin	Fayette	Fisher
Foard	Franklin	Freestone	Frio	Gaines	Gillespie
Glasscock	Goliad	Gonzales	Gray	Grayson	Gregg
Grimes	Hall	Hamilton	Hansford	Hardeman	Hardin
Harrison	Hartley	Haskell	Hemphill	Henderson	Hidalgo
Hill	Hopkins	Houston	Howard	Hudspeth	Hutchinson
Irion	Jack	Jackson	Jasper	Jeff Davis	Jefferson
Jim Hogg	Jones	Karnes	Kenedy	Kent	Kerr
Kimble	King	Kinney	Knox	Lamar	Lampasas
LaSalle	Lavaca	Leon	Liberty	Limestone	Lipscomb
Live Oak	Llano	Loving	Madison	Marion	Martin
Mason	Matagorda	Maverick	McCulloch	McLennan	McMullen
Menard	Midland	Milam	Mills	Mitchell	Montague
Moore	Morris	Motley	Nacogdoches	Newton	Nolan
Ochiltree	Oldham	Orange	Palo Pinto	Panola	Parmer
Pecos	Polk	Potter	Presidio	Rains	Randall
Reagan	Real	Red River	Reeves	Roberts	Robertson
Runnels	Rusk	Sabine	San Augustine	San Jacinto	San Saba
Schleicher	Scurry	Shackelford	Shelby	Sherman	Smith
Somervell	Starr	Stephens	Sterling	Stonewall	Sutton
Swisher	Taylor	Terrell	Throckmorton	Titus	Tom Green
Trinity	Tyler	Upshur	Upton	Uvalde	Val Verde
Van Zandt	Walker	Ward	Washington	Webb	Wharton
Wheeler	Wichita	Wilbarger	Willacy	Winkler	Wood
Yoakum	Young	Zapata	Zavala		

The Southeast Region (Chambers, Hardin, Jefferson, Liberty, and Orange Counties) previously was part of the STAR Program. Culberson, Hudspeth, and Blanco Counties, previously STAR HMO counties, changed to PCCM-only counties on September 1, 2005.

7.5.2 Contact Numbers

Provider Helpline

Monday through Friday, 7 a.m. to 7 p.m., Central Time
1-888-834-7226, option 5, then option 1, then option 5
Fax: 1-512-506-7002

Client Helpline

Monday through Friday, 7 a.m. to 7 p.m., Central Time
1-888-302-6688

PCCM Inpatient/Outpatient Prior Authorization Line

Outpatient and Prior Authorization, Notifications, Prior Authorizations and Updates to Existing Authorizations
Monday through Friday, 7 a.m. to 7 p.m., Central Time
1-888-302-6167
Fax: 1-512-302-5039

Community Health Services (CHS) Helpline

Case Management and Health and Program Benefit Education
Monday through Friday, 8 a.m. to 5 p.m., Central Time
1-888-276-0702 (Voice mail is available outside of normal business hours.)

The Nurse Helpline

24 hours a day, 7 days a week
1-800-304-5468

7.5.3 Client Eligibility

HHSC has targeted the following client groups for PCCM enrollment:

Type	Program	Enrollment Code
1	Regular TANF	M
3	MAO RSDI Increases - No Medicare	M*
7	12 months Medicaid denied due to earnings	M
12	SSI Manually Certified - No Medicare	M*
13	SSI Recipient - No Medicare	M*
18	Disabled Adult Children denied SSI due to increase in SS benefits - No Medicare	M*
19	Transitional SSI - No Medicare	V
20	04 months Medicaid - TANF	M
29	12 months transitional Medicaid - limited TANF	M
22	Early Age Widows/Widowers - No Medicare	M*
37	12 months transitional Medicaid denied due to earned income; disregards ending	M
40	Pregnant women	M
43	Children under 1 year of age with income below 185% FPIL	M
44	Children 6-19 yrs. with income below 100% FPIL	M
45	Children up to 1 year of age born to Medicaid eligible mother	M
47	Medicaid for deprived children with step-grandparent income	M
48	Children 1-5 years of age with income below 133% FPIL	M
61	TANF State Program	M

M = Mandatory, V = Voluntary, M* = Mandatory adults ages 21 yrs. of age and older

To verify a client's eligibility and primary care provider, use one or more of the following eligibility resources:

- Medicaid Identification Form (Form H3087).
- Primary care provider change notification letter (see "Primary Care Provider Changes" on page 7-26).
- Monthly panel report.
- Daily primary care provider change list.
- TMHP website at www.tmhp.com.
- TMHP EDI.
- Automated Inquiry System (AIS) at 1-800-925-9126, option 1.
- PCCM Provider Helpline at 1-888-834-7226.
- TMHP Contact Center at 1-800-925-9126, option 5.

In some situations, an eligibility response may indicate that the provider should contact PCCM to verify the primary care provider information. For more information, please call the TMHP Contact Center at 1-800-925-9126, or the PCCM Provider Helpline at 1-888-834-7226.

7.5.4 Client Enrollment

Enrollment into PCCM is mandatory for Medicaid clients residing in one of the PCCM counties and who meet the following criteria:

- Low-income families (primarily women and children).
- Blind and disabled individuals who receive SSI and are age 21 years and older.

Children under the age of 21 who receive SSI may enroll on a voluntary basis. Elderly and disabled Medicaid clients who live in a nursing home or who are enrolled in community based long-term care will remain in traditional

Medicaid. Clients on Medicare and individuals enrolled in the Medically Needy Program are not eligible for PCCM enrollment.

7.5.5 Online Provider Lookup

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

Providers can use the online update function to update their demographic information on the website. This allows users to view the most current information about the provider. To update demographic information online, authorized users log in to the TMHP website by clicking "Log In" on the homepage. Periodically, administrators may be required to verify their address when logging in to their account. This verification must be completed before the administrator can proceed to the secured portion of the website. The "My Account" page has a link to the Provider Demographic Update webpage. Current information will be displayed with a button to allow editable fields to be changed. Demographic information may be updated only by authorized administrators. This authorization is controlled through the Permissions Management link, also located on the "My Account" page. Fields that can be updated online include the following:

- Address.
- Telephone numbers.
- Office hours.
- Accepting new patients.
- Additional sites where services are provided.
- Languages spoken.
- Additional services offered.
- Medicaid waiver programs.
- Client age or gender limitations.
- Counties served.

The provider's name, gender, specialty, subspecialty, and group or plan affiliation cannot be changed online. Contact TMHP Provider Enrollment at 1-800-925-9126, option 2, regarding changes to this information.

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

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

Note: *For family planning services, clients (regardless of Medicaid eligibility) have the freedom of choice to obtain services from any Medicaid-enrolled provider.*

7.5.6 Client Rights and Responsibilities

7.5.6.1 Client Rights

PCCM clients have defined rights and responsibilities. PCCM and primary care providers share the responsibility to ensure and protect client rights and to assist clients in understanding and fulfilling their responsibilities as plan clients.

PCCM clients have the right to:

- Be treated fairly and with dignity and respect.
- Know that their medical records and discussions with their providers will be kept private and confidential.
- A reasonable opportunity to choose a primary care provider (the doctor or health-care provider they will see most of the time and who will coordinate their care) and to change to another provider in a reasonably easy manner. These opportunities include the right to:
  - Be informed of available primary care providers in their areas.
  - Be informed of how to choose and change primary care providers.
  - Change their primary care provider.
- Ask questions and get answers about anything they don't understand, and that includes the right to:
  - Have their provider explain their health-care needs to them and talk to them about the different ways their health-care problems can be treated.
  - Be told why care or services were denied and not given.
- Consent to or refuse treatment and actively participate in treatment decisions, and that includes the right to:
  - Work as part of a team with their provider in deciding what health care is best for them.
  - Say yes or no to the care recommended by their provider.
- Utilize each available complaint and appeal process through PCCM and through Medicaid, receive a timely response to complaints, appeals, and fair hearings. These processes include the right to:
  - Make a complaint to PCCM or to the state Medicaid program about their health-care, provider, or PCCM.
  - Get a timely answer to their complaint.
  - Access the PCCM appeal process and the procedures for doing so.
  - Request a fair hearing from the state Medicaid program and request information about the process for doing so.
- Timely access to care that does not have any communication or physical access barriers. That includes the right to:
  - Have telephone access to a medical professional 24 hours a day, 7 days a week in order to obtain any needed emergency or urgent care.

- Get medical care in a timely manner.
- Be able to get in and out of a health-care provider's office, including barrier free access for persons with disabilities or other conditions limiting mobility, in accordance with the *Americans with Disabilities Act*.
- Have interpreters, if needed, during appointments with their providers and when talking to PCCM. Interpreters include people who can speak in their native language, assist with a disability, or help them understand the information.
- Be given an explanation they can understand about PCCM rules, including the health-care services they can get and how to get them.

- Not be restrained or secluded when doing so is for someone else's convenience, or is meant to force them to do something they do not want to do, or to punish them.

7.5.6.2 Client Responsibilities

PCCM and primary care providers should help clients understand their responsibilities. These include the responsibility to:

- Learn and understand each right they have under the Medicaid program. That includes the responsibility to:
  - Learn and understand their rights under the Medicaid program.
  - Ask questions if they do not understand their rights.
- Abide by PCCM and Medicaid Managed Care policies and procedures. That includes the responsibility to:
  - Learn and follow PCCM rules and Medicaid rules.
  - Choose a primary care provider.
  - Make any changes in their primary care provider in the ways established by Medicaid Managed Care.
  - Keep their scheduled appointments.
  - Cancel appointments in advance when they cannot keep them.
  - Always contact their primary care provider first for nonemergency medical needs.
  - Be sure they have approval from their primary care provider before going to a specialist (except for self-referred services).
  - Understand when they should and should not go to the ER.
- Share information relating to their health status with their primary care provider and become fully informed about service and treatment options. That includes the responsibility to:
  - Tell their primary care provider about their health.
  - Talk to their providers about their health-care needs and ask questions about the different ways their health-care problems can be treated.
  - Help their providers get their medical records.
- Actively participate in decisions relating to service and treatment options, make personal choices, and take action to maintain their health. That includes the responsibility to:
  - Work as a team with their provider in deciding what health care is best for them.
  - Understand how the things they do can affect their health.
  - Do the best they can to stay healthy.
  - Treat providers and staff with respect.

7.5.7 Primary Care Provider Selection and Changes

7.5.7.1 Selecting a Primary Care Provider

The primary care provider selection process allows new PCCM clients to choose their primary care provider before one is assigned. Clients can select a primary care provider by calling the PCCM Client Helpline at 1-888-302-6688 or mail the PCCM Primary Care Provider Selection form to TMHP.

PCCM clients have up to 75 days to select a primary care provider and 105 days to select a primary care provider for their newborn. If clients do not make a selection within the specified time period, a primary care provider will be assigned.

Default Assignment

If a client does not exercise the right to choose a PCCM primary care provider, the client will be auto-assigned a primary care provider. The following factors are considered when processing a default assignment:

- Client's past claims history, taking into account an established relationship with a PCCM primary care provider.
- Client's age.
- Client's sex.
- Client's geographic proximity to the primary care provider.

PCCM clients are required to obtain health care from their selected or assigned primary care provider. If the Medicaid Identification Form (H3087) lists either PCCNEWB01 (newborns) or PCCPCCM01 (all clients except newborns) as the primary care provider, any PCCM enrolled primary care provider can render health-care services to the client.

7.5.7.2 Primary Care Provider Changes

PCCM clients may change their primary care provider by calling the PCCM Client Helpline at 1-888-302-6688 or by submitting the PCCM Primary Care Provider Selection Form located on the PCCM website at www.tmhp.com.

PCCM clients receive a primary care provider change notification letter after requesting a change to their primary care provider.

If a client request for a primary care provider change is successful, the notification letter will list the name of the new primary care provider and the effective date of the change. Clients will be instructed to take both the notification letter and their Medicaid ID Form (Form H3087) to the new primary care provider's office.

Successful requests for primary care provider changes that are received through the last business day of the month usually become effective on the first day of the next month and are reflected on the following:

- The client's Medicaid Identification Form (Form H3087).
- All eligibility verification systems.
- The claims payment system.
- The client's primary care provider change notification letter.

Requests received after the middle of the month and through the last business day of the month, become effective on the first day of the next month and are reflected on:

- All eligibility verification systems.
- Claims payment system.
- The client's primary care provider change notification letter.

Clients will also receive a notification letter if their primary care provider request is unsuccessful. If a change request is unsuccessful, the notification letter provides possible reasons that the request was not processed and a number for the client to call for assistance.

7.5.7.3 Provider Initiated Primary Care Provider Changes

Occasionally, the relationship between a client and their primary care provider may become unsatisfactory to one or both parties. A provider may request a client be reassigned to another primary care provider for any of the following reasons:

- The client is not included in the primary care provider's scope of practice.
- The client is non-compliant with medical advice.
- The client consistently displays unacceptable office decorum.
- The client/primary care provider relationship is not mutually agreeable.

If the relationship with the client is unsatisfactory due to behavioral issues on the client's part, the primary care provider should contact PCCM CHS at 1-888-276-0702 to request assistance in resolving the problem. A community health coordinator can intervene and help providers with non-adherent and disruptive patients in most instances. The referral can also be made by submitting the PCCM Community Health Services Referral Request Form via fax to PCCM CHS at 1-512-302-0318. A copy of the PCCM Community Health Services Referral Request Form can be found on page B-68.

If the relationship with the client cannot be improved, the provider must notify TMHP in writing to request reassignment of a client to another primary care provider before the request can be processed. The primary care provider must also notify the client in writing stating the reason for the reassignment. A copy of the letter to the client may serve as notification to TMHP.

TMHP will notify the client of the reassignment in writing and request that the client choose another primary care provider. Primary care provider requests to reassign a client usually take 60 days before the change is made. During this time, the primary care provider is responsible for providing primary care to the client or referring the client to another provider for medically necessary care.

7.5.8 Provider Enrollment

Primary care providers can choose to contract with PCCM and HMO health plans simultaneously. A PCCM primary care provider's contractual obligations are identified in the contract between HHSC and each primary care provider. *PCCM primary care provider obligations are in addition to those required for Medicaid program participation* and are intended to ensure that PCCM clients have access to quality health care from trained and credentialed providers.

Refer to: "Primary Care Provider Requirements and Information" on page 7-8.

"Provider Enrollment" on page 1-2.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

7.5.8.1 Credentialing Committee

The Credentialing Committee is charged with the responsibility of reviewing each provider applicant's file to ensure that enrolling physicians and other health-care professionals are qualified to perform services as PCCM providers.

The committee reviews each provider applicant's file and decides whether the provider should be recommended to the HHSC Medical Director as a primary care provider in the PCCM provider network. If HHSC approves the recommendation, the provider is accepted as a participating provider for three years.

The Credentialing Committee is also charged with the responsibility of recredentialing PCCM providers, which occurs every three years after initial credentialing.

The Credentialing Committee also reviews and approves credentialing policies and procedures for PCCM.

7.5.8.2 Members of the Credentialing Committee

The Credentialing Committee is comprised of the following members:

- Chair: Medical Director, HHSC Medicaid and Children's Health Insurance Program (CHIP) Programs.
- Co-Chair: Associate Medical Director, HHSC Medicaid and CHIP Programs.
- Co-Chair: Medical Director, TMHP.
- Associate Medical Director, TMHP.
- Contracting and Credentialing Manager, TMHP.
- Quality Services Officer, TMHP.

If a committee member is unable to attend a meeting, the member may appoint a designee.

7.5.8.3 Credentialing Committee Frequency/Logistics

The Credentialing Committee meets monthly, or as required, to review new applications for credentialing/recredentialing. The PCCM Contracting and Credentialing staff will have previously completed the initial screening for each provider in accordance with the standards of the National Committee for Quality Assurance (NCQA).

7.5.8.4 Credentialing Committee Action

The TMHP Medical Director, as the Co-Chair, is charged with implementing the credentialing and recredentialing standards for participating providers in PCCM. The HHSC Medical Director also reviews submitted documentation and recommends acceptance or rejection of each provider.

When a primary care provider's PCCM credentialing file is complete, the TMHP Medical Director and Credentialing Committee verify all credentials and present their findings to the HHSC Medical Director for Medicaid and CHIP Programs (HHSC Medical Director), at the Credentialing Committee meeting. The HHSC Medical Director reviews the credentials and determines whether the applicant meets HHSC credentialing criteria. The decision to accept a provider as a PCCM primary care provider is made by HHSC in accordance with basic credentialing standards.

Based on this action, the HHSC executes the contract of approved providers. PCCM then notifies each approved applicant in writing of the application's status. For approved providers, the notification includes:

- A fully executed provider contract.
- The date upon which the contract is effective.
- Conditions of participation in PCCM.
- Recredentialing requirements.

7.5.8.5 Credentialing Grievance Committee

The Credentialing Grievance Committee reviews provider requests for reconsideration of credentialing decisions. Applicants who are not approved are notified by certified mail of the denial, the reason for the denial, and the process for reconsideration. Applicants may request reconsideration by submitting evidence that the deficiency(ies) for which the original application was denied has/have been corrected.

A provider has 30 days to request a reconsideration of a recredentialing denial to the Credentialing Grievance Committee. Such requests must be in writing and submitted to the following address:

Primary Care Case Management (PCCM)
Credentialing Grievance Committee
Credentialing Mail Code MC-B05
PO Box 204270
Austin, TX 78720-4270

Members of the Credentialing Grievance Committee

The Credentialing Grievance Committee is composed of the following members:

- Medical Director, HHSC Medicaid and CHIP Programs, or designee.
- Medical Director, TMHP.
- Contracting and Credentialing Manager, TMHP.
- Provider Services Director, TMHP.
- Staff person from HHSC Medicaid/CHIP/PCCM.

Credentialing Grievance Committee Frequency/Logistics

The Credentialing Grievance Committee convenes within 60 days after receipt of a grievance or request for reconsideration. The provider is notified of the date, time, and location of the grievance hearing before the Credentialing Grievance Committee. The provider may attend the grievance hearing.

Notification of the Credentialing Grievance Committee's Decision

The provider is notified in writing of the decision of the Credentialing Grievance Committee within 45 days after adjournment of the hearing. The Credentialing Grievance Committee forwards its recommendations to HHSC following the hearing.

A decision of the Credentialing Grievance Committee may be submitted for reconsideration to:

Texas Health and Human Services Commission
Office of General Counsel
4900 N. Lamar, 4th Floor
Austin, TX 78751

7.5.8.6 Primary Care Provider Termination/Disenrollment

Primary care providers may terminate the PCCM agreement by providing 90 days prior written notice. Ninety days prior notice is requested to allow sufficient time to complete the reassignment process of clients in a primary care provider's panel to new primary care providers.

Individual provider agreements will terminate automatically upon a provider's death, the sale of the provider's practice, or termination as a participant in the Texas Medicaid Program.

HHSC may terminate a provider agreement by providing 30 days prior written notice. An HHSC initiated provider termination would be instituted for a provider who does not consistently meet plan requirements.

Refer to: "Monitoring Provider Performance" on page 7-36

Clinics must notify PCCM within 30 days when a provider employee leaves the employ of or terminates his contract with the clinic, or is no longer willing to function as a primary care provider.

Termination or disenrollment notification should be sent to the following address:

Primary Care Case Management (PCCM)
Contracting and Credentialing Department MC-B05
PO Box 204270
Austin, TX 78720-4270

All correspondence must include the primary care provider's contracted provider identifier on signed letterhead or providers should contact the Provider Enrollment/Contracting and Credentialing Department at 1-800-925-9126, option 2, to request a Provider Information Change (PIC) form.

Refer to: "Provider Information Change Form" on page B-75.

7.5.8.7 Additional Criteria for Primary Care Providers

All PCCM primary care providers must meet credentialing/recredentialing criteria. Primary care providers are also required to meet the following criteria:

- *Ability to Perform or Supervise the Ambulatory Primary Care Services of Clients*. Provider performance is monitored on an ongoing basis. The PCCM Administrator follows up on evidence of poor performance and addresses identified problems immediately to ensure that high-quality care is delivered to clients.
- *Admitting Privileges*. The primary care provider must maintain admitting privileges with a hospital which is a participating provider in PCCM, or make arrangements with another Texas licensed physician who is an eligible Medicaid provider and who maintains admitting privileges with a contracted PCCM hospital.

7.5.8.8 Miscellaneous Provisions

Several other provisions apply to primary care provider participation in PCCM:

- A primary care provider agreement may be modified only by written agreement signed by all parties.
- A primary care provider agreement is not assignable by a primary care provider, either in whole or in part, without the prior written consent of the HHSC.
- primary care provider agreements shall be governed and construed in accordance with the laws of the State of Texas.
- A primary care provider shall be required to bring all legal proceedings against HHSC in the Texas state courts.
- An agreement shall become effective only upon the primary care provider's completion of the provider credentialing process and a determination by the HHSC or its designee that the primary care provider meets all of the requirements for participation in PCCM.

7.5.9 Support Services

7.5.9.1 Provider Support Services

PCCM core support services to primary care providers include:

- *Provider Helpline.* The PCCM Provider Helpline at 1-888-834-7226 is available to assist PCCM providers with a broad range of Medicaid and PCCM issues. Toll-free customer service lines are available Monday through Friday, from 7 a.m. to 7 p.m., Central Time, and are answered directly by call center representatives.
- *Provider Relations Representatives.* Provider relations representatives conduct informational and educational workshops, group meetings, and training sessions for office practices and groups when requested, and can assist in enrolling new primary care providers in PCCM. To contact the provider relations representative serving your area, call the TMHP Contact Center at 1-800-925-9126 or visit the TMHP website at www.tmhp.com.
- *Medical Director Services.* The TMHP Medical Director maintains overall responsibility for utilization management procedures, quality improvement activities and reporting, health education for both clients and providers, authorization requirements, and claim appeals related to the appropriateness of specific medical procedures or services. To contact the Medical Director, call 1-512-506-7000, and press "0" for the operator.
- *Primary Care Provider and Hospital List.* PCCM prepares and distributes to clients a listing of all PCCM providers. This listing identifies those providers who are accepting new patients, those who are accepting established patients only, and those who provide THSteps services. This listing is updated on a quarterly basis. To

request a copy of the listing, contact the PCCM Provider Helpline at 1-888-834-7226 or visit the TMHP website at www.tmhp.com.

- *Monthly Panel Report.* PCCM provides to primary care providers a list of clients who have selected or who have been assigned to the primary care provider for management and coordination of their health care. This list is available online at www.tmhp.com, or by calling the PCCM Provider Helpline at 1-888-834-7226. Clients on this list are eligible for PCCM services throughout the entire month.

7.5.9.2 Client Support and Education

PCCM provides educational services to its clients. The most significant of these are three helplines:

- *Client Helpline.* The non-clinical Client Helpline at 1-888-302-6688 is the primary resource for clients seeking information or answers to questions. Clients may call the helpline to discuss concerns and file complaints regarding the operation and management of PCCM. The helpline operates from 7 a.m. to 7 p.m., Central Time, Monday through Friday. After hours, a recorded message instructs clients who need assistance with clinical, urgent, or emergent situations to contact the PCCM nurse helpline at 1-800-304-5468.
- *Community Health Services (CHS).* PCCM clients are eligible to receive services provided by CHS. CHS staff includes registered nurses, social workers, nutritionists, and health educators from all over Texas who can provide counseling for clients who do not keep appointments, or who inappropriately use the ER. CHS staff can also educate PCCM clients about the role of a primary care provider, the referral process, or the Medicaid change from fee-for-service to managed care. CHS staff can also provide information about disease prevention, care coordination, and location of resources. CHS staff is available to meet with clients in a provider's office. Providers can refer clients for CHS services by calling the CHS toll-free number at 1-888-276-0702, Monday through Friday, 8 a.m. to 5 p.m., Central Time. A message can be left after 5 p.m. and before 8 a.m. TMHP staff will return calls on the next business day. Providers can also fax a PCCM Community Health Services Referral Request Form to 1-512-302-0318. Providers can refer up to four clients on a request form. The PCCM Community Health Services Referral form is located on page B-67.
- *Nurse Helpline.* PCCM provides a toll-free clinical nurse helpline at 1-800-304-5468 for all PCCM clients. The nurse helpline is staffed (nationally) by registered nurses who use physician-developed, symptom-based algorithms and 1,200 sets of self-care instructions to provide information, triage, and clinical assessment services for health plan clients 24 hours a day, 7 days a week. The nurse helpline nurses do not diagnose; they assess the client's symptoms and guide the client to the most appropriate care setting. The nurse helpline number is widely publicized to PCCM clients. The nurse helpline can:
  - Provide triage, assistance, and reassurance to clients.
  - Direct clients to the most appropriate care setting.

If a nurse determines that a client needs emergency care, the nurse will direct the client to the nearest emergency facility or contact 9-1-1 on the client's behalf.

In addition, PCCM publishes a semi-annual newsletter in both English and Spanish for client heads of household. The focus of the newsletter is on health-related topics (such as the importance of well-child care, and the significance of early entry into prenatal care), but it also provides useful information about services to improve clients' access to health care, such as nonemergent medical transportation, community child care resources, and clinical services offered during nontraditional hours of operation.

Linguistic Services

It is the provider's responsibility to ensure that interpretive services are available to his practice. Interpretive services include language interpreters, American Sign Language (ASL) interpreters, and RELAY TEXAS (TDD) access. When interpretive services are necessary to ensure effective communications regarding treatment, medical history, or health education, PCCM providers may contact the PCCM nurse helpline at 1-800-304-5468. For assistance to clients who are hearing impaired, call RELAY TEXAS (TDD) at 1-800-735-2988. If the provider's staff is in need of translation services to meet requirements on limited English proficiency, call 1-800-752-0093.

Refer to: "Provider Responsibilities" on page 7-33.

"Cultural Competency and Sensitivity" on page 7-10.

7.5.9.3 Monthly Client Panel Report

The monthly client panel report verifies the primary care provider's PCCM client assignments for the current month and identifies clients who may be eligible for THSteps services. Primary care providers can obtain their monthly panel report containing a list of clients assigned to them by accessing the TMHP website at www.tmhp.com. However, providers may request a paper panel report by calling the PCCM Provider Helpline at 1-888-834-7226. Providers are strongly encouraged to obtain their panel report from the TMHP website as it contains other valuable information that is not included on the paper report.

Clients appearing on the monthly panel report are eligible for services for the entire calendar month.

Based on the number of clients appearing on the monthly panel report, the primary care provider receives a monthly case management fee. This payment is processed by TMHP.

Refer to: "Claims Filing Information" on page 7-44.

Panel Closings

PCCM primary care providers may choose to close their panel to new assignments. To close a panel, primary care providers should contact the PCCM Provider Enrollment, Contracting/Credentialing Department in writing (by mail or fax) to request a suspension of new enrollments or assignments to his practice. All correspondence must include the provider's contracted provider identifier on signed letterhead. Should the provider choose to re-open his panel, contact the PCCM Contracting/Credentialing Department in writing (by mail or fax) to request the panel be re-opened to new assignments. Providers should notify PCCM at least 30 days before re-opening their panel. Providers may contact the Provider Enrollment, Contracting/Credentialing Department for a Provider Information Change Form to close and re-open a panel.

Refer to: "Provider Information Change Form" on page B-75.

7.5.10 Covered Services

PCCM clients are entitled to all medically necessary services that are benefits of the Texas Medicaid Program. Except as specified below, primary care providers shall provide (directly or through referrals) all Medicaid-covered services.

Refer to: "Referrals" on page 7-36.

Spell of Illness

Reimbursement to hospitals for adult inpatient services is limited to the patient "spell of illness." The spell of illness is defined as "30 days of inpatient hospital care, which may accrue intermittently or consecutively." After 30 days of inpatient care have been provided, reimbursement for additional inpatient care is not considered until the patient has been out of an acute care facility for 60 consecutive days.

Prescriptions

As in fee-for-service Medicaid, adult PCCM clients 21 years of age and older are limited to three medicine prescriptions each month. When more than three prescriptions per month are needed, providers may prescribe maintenance medication(s) to cover more than a one month supply.

Annual Adult Physical Exams

Annual well visit exams are excluded for PCCM adult clients age 21 years of age and older except for well-woman annual exams provided as part of family planning or obstetrics/gynecology (OB/GYN) medical visits.

7.5.10.1 Self-Referred Services

PCCM clients may select any Medicaid-enrolled provider to access the following services *without a referral*:

- *Emergency Services.* In case of a medical emergency, clients may seek emergency medical services from the nearest facility. To ensure continuity of care, the emergency facility is asked to contact the client's primary care provider within 24 hours or the next business day after providing services. Primary care providers or a primary care provider's designee must be available to respond to an ER call promptly. If the emergency visit results in an admission, the facility also must notify PCCM to receive authorization prior to claims submission.

  Refer to: "PCCM Inpatient Authorization Process" on page 7-37.

- *OB/GYN Services.* PCCM clients may select a PCCM-contracted OB/GYN as their primary care provider. As a primary care provider, the OB/GYN is responsible for providing or arranging for all medically necessary services. PCCM clients may also seek direct services of any Medicaid-enrolled OB/GYN, family practitioner, or internal medicine provider who is not their primary care provider for the following services:
  - One well-woman examination per year.
  - Care related to pregnancy.
  - Care for all active gynecological conditions.
  - Diagnosis, treatment, and referral to a Medicaid-enrolled specialist for any disease or condition within the scope of the designated professional practice of a licensed obstetrician or gynecologist, including treatment of medical conditions concerning the breasts.

  A referral from the PCCM client's primary care provider is not required as long as the provider rendering services is a Medicaid-enrolled OB/GYN, family practitioner, or internal medicine provider.
- *Family Planning Services.* Family planning services include preventive health, medical counseling, and educational services that assist individuals in planning and/or preventing pregnancy and achieving optimal reproductive and general health. Primary care providers are encouraged to provide these services if requested by a client. Clients are not required to obtain family planning services through their primary care provider. Family planning is a service that does not require a primary care provider referral. Clients may go to a DSHS Family Planning state-contracted Medicaid facility for family planning services. Inpatient services must be delivered in a PCCM-contracted hospital/facility.
- *THSteps.* PCCM clients may select any THSteps-enrolled Texas Medicaid provider to perform THSteps services. If a THSteps screening is performed by a provider who is not the client's primary care provider, this information should be forwarded to the client's primary care provider so that the client's medical record can be updated.

  Refer to: "Texas Health Steps (THSteps)" on page 43-1.

- *Vision Services.* Clients do not need a referral to access necessary covered vision services Covered vision services are:
  - One eye exam each state fiscal year (September 1 through August 31) for clients under age 21 unless there is a diopter change of 0.5 or more.
  - Replacement of lost or damaged eyeglasses for

clients under age 21.

- One eye exam every 24 months for assessing the need for eyeglasses for adults.
- Unlimited medically necessary eye exams for a diagnosis of illness or injury.

  Medicaid clients can select an ophthalmologist or therapeutic optometrist for Medicaid eye care benefit services (not surgery) without a referral from a primary care provider or any other type of prior authorization.

  PCCM clients may also select therapeutic optometrists for the services listed below without a referral from a primary care provider or any other type of prior authorization:

Procedure Codes			
2-65205	2-65210	2-65220	2-65222
2-65286	2-65430	2-67820	2-67938
2-68530	2-68761	2-68801	2-68810
2-68840			

- *Behavioral Health Services.* Behavioral health services do not require a primary care provider referral. These services include mental health and substance abuse services by a Medicaid-enrolled psychiatrist, psychologist, licensed professional counselor (LPC), licensed clinical social worker (LCSW), licensed marriage and family therapist (LMFT), and Texas Commission on Alcohol and Drug Abuse (TCADA) licensed facility.

Refer to: "Behavioral Health Services" on page 7-33.

"Psychiatric Services" on page 36-110.

"Psychologist" on page 38-1.

"Licensed Professional Counselor (LPC)" on page 30-1.

"Licensed Clinical Social Worker (LCSW)" on page 28-1.

"Licensed Marriage and Family Therapist (LMFT)" on page 29-1.

- *Case Management for ECI.* See "Targeted Case Management for Early Childhood Intervention (ECI)" on page 13-1.
- *Case Management for CPW*. See "Case Management for Children and Pregnant Women (CPW)" on page 12-1.
- *SHARS.* Clients may select any qualified provider to access medically necessary and reasonable services to ensure that Medicaid-eligible children with disabilities receive the benefits mandated by federal and state legislation that guarantees a free and appropriate public education. See "School Health and Related Services (SHARS)" on page 42-1.
- *School-Based Clinic Services.* Clients may receive services from school-based clinics without a referral from their primary care provider. See "School Health and Related Services (SHARS)" on page 42-1.
- *FQHC and RHC After-Hours Care.* After-hours care provided by FQHCs and RHCs do not require a referral from the client's primary care provider. After-hours care for FQHCs and RHCs is defined as care provided on weekends, on federal holidays, or before 8 a.m. and after 5 p.m., Monday through Friday. FQHCs and RHCs that provide after-hours services to PCCM clients must submit claims with modifier TU.

7.5.10.2 Community Health Services (CHS)

The goal of the PCCM CHS program is to facilitate the coordination of health related services required by PCCM clients. This means collaborating with providers, clients, and their families in identifying problems and resources, and removing barriers in accessing treatment and services. PCCM community health coordinators are located in all PCCM SAs. Examples of services offered by staff include:

- Provide counseling for clients who miss appointments.
- Provide counseling for clients who inappropriately use the ER.
- Educate clients about obtaining PCCM services.
- Management of high-risk pregnancies in conjunction with the client's physician.
- Pediatric care coordination and education services for acute and chronically ill children.
- Case management for all chronic and/or complex cases identified and eligible for CHS.
- Assistance in accessing state and community resources.
- Assistance in improving healthy behaviors and treatment compliance.
- Provide health education on a variety of health-related topics.

By offering the above services, PCCM assists both providers and clients with early, expedited access and intervention, increasing the likelihood of improved health outcomes.

Clients can be referred for health-care management and/or education on the following subjects:

- A newly diagnosed condition.
- Asthma management.
- Coronary artery disease.
- Chronic obstructive pulmonary disease.
- Dental health.
- Diabetes management.
- Effective use of benefits.
- Hypertension.
- Nutrition.
- Otitis media.
- Prenatal education.
- Parenting and child development.

- Puberty education.
- Safety.
- Smoking cessation.

Community health coordinators assist clients in obtaining food, clothing, and other resources by linking them with public and/or private community organizations.

Providers interested in scheduling a community health education program in their office or referring a PCCM client for CHS can do so by:

- Completing the "Primary Care Case Management (PCCM) Community Health Services Referral Request Form" on page B-67 and faxing to 1-512-302-0318; or
- Calling the CHS Intake staff at 1-888-276-0702, Monday through Friday, 8 a.m. to 5 p.m., Central Time. A message can be left between 5 p.m. and 8 a.m. TMHP staff will return calls on the next business day.

7.5.10.3 Behavioral Health Services

Behavioral health services are provided for the treatment of mental disorders, emotional disorders, and chemical dependency disorders. Behavioral health services do not require a primary care provider referral. PCCM clients may self-refer to any Medicaid-enrolled behavioral health provider for treatment. A referral from the client's primary care provider is not required. A primary care provider may, in the course of treatment, refer a patient to a behavioral health provider for an assessment or for treatment of an emotional, mental, or chemical dependency disorder. A primary care provider may also provide behavioral health services within the scope of his practice.

PCCM clients may receive any behavioral health service that is medically necessary, currently covered by the Texas Medicaid Program, and provided by a Medicaid-enrolled behavioral health provider. Behavioral health providers include psychiatrists, psychologists, LCSWs, LPCs, LMFTs, and TCADA licensed facilities. See each individual aforementioned section for benefits and limitations.

In addition, many services are offered through DADS and DSHS that do not require a referral. These include case management for mental health and mental retardation, mental health rehabilitative services, and mental retardation diagnosis and assessment.

Behavioral health providers are encouraged to contact a client's primary care provider to discuss the patient's general health. Primary care providers are encouraged to maintain contact with the behavioral health provider to document behavioral health assessments and treatments and to inform the behavioral health provider of any condition the client may have that could impact the behavioral health service delivery. However, client approval for any exchange of information between the primary care provider and behavioral health provider is required. Please use the "Primary Care Case Management (PCCM) Behavioral Health Consent Form" on page B-65.

Primary care providers are responsible for documenting referrals to behavioral health providers and any known self-referrals for behavioral health services in each client's medical record.

Outpatient Services

Outpatient Behavioral health services that exceed 30 visits per client, per calendar year must be prior authorized by TMHP. Clinicians should plan therapy with the 30-encounter limitation in mind and should request extension authorizations before the client's twenty-fifth visit. The current policies and guidelines require that authorizations be obtained before rendering service.

Fax the completed form, "Request for Extended Outpatient Psychotherapy/Counseling Form" on page B-83 to TMHP/Special Medical Prior Authorizations at 1-512-514-4213 for prior authorization. Refer to individual provider sections of this manual for additional information on extension requirements ("Psychologist" on page 38-1, "Psychiatric Services" on page 36-110, "Licensed Clinical Social Worker (LCSW)" on page 28-1, "Licensed Marriage and Family Therapist (LMFT)" on page 29-1, "Licensed Professional Counselor (LPC)" on page 30-1) or contact TMHP at 1-800-925-9126.

Inpatient Services

PCCM requires notification for urgent or emergent inpatient psychiatric care in an acute care facility prior to claims submission for in-network facilities. Scheduled admissions for psychiatric care require prior authorization. Out-of-network admissions require notification within the next business day and submission of clinical information to determine appropriateness for transfer to a contracted facility. Fax the completed PCCM Inpatient/Outpatient Authorization Form to the PCCM Inpatient Prior Authorization Department at 1-512-302-5039 or call 1-888-302-6167.

Prior authorization is required for psychiatric admissions of patients under 21 years of age to a freestanding psychiatric facility. Fax the completed "Psychiatric Inpatient Initial Admission Request Form" on page B-76 to 1-512-514-4211 to obtain authorization. Inpatient psychiatric admissions to freestanding facilities for clients 21 years of age and older are not covered under the Texas Medicaid Program.

Refer to "Psychiatric Hospital/Facility (Freestanding) (THSteps-CCP Only)" on page 43-83 for additional information concerning the requirements of freestanding psychiatric admissions, or contact the TMHP Comprehensive Care Inpatient Psychiatric (CCIP) Unit at 1-800-213-8877.

7.5.11 Provider Responsibilities

In addition to the requirements listed in "Provider Requirements and Information" on page 7-20, PCCM primary care providers have clearly defined roles, responsibilities, and contractual requirements.

Verifying Primary Care Provider Assignment

At the time that an appointment is made, the provider should ask the client for the name of the primary care provider on the client's Medicaid Identification Form (Form H3087) or the client's primary care provider change notification letter (if applicable). If a different primary care provider is listed, direct the client to go to the provider listed on their Medicaid Identification Form (Form H3087) or to request a change.

Note: *Providers may not request primary care provider changes for their clients. Federal guidelines prohibit influence by providers on a patient's choice of their primary care provider.*

Primary Care Provider Services

PCCM defines the services to be provided and the responsibilities to be assumed by a PCCM primary care provider as follows:

- The primary care provider agrees to provide primary care services to PCCM clients. Primary care services are all medical services required by a client for the prevention, detection, treatment and cure of illness, trauma, or disease, which are covered and/or required services under the Texas Medicaid Program. The primary care provider must ensure that clients under the age of 21 receive all services required by the THSteps program. All services must be provided in compliance with all generally accepted medical standards for the community in which services are rendered.
- Provide or arrange for medically necessary care within the following guidelines:
  - *Urgent Care.* Within 24 hours after the request
  - *Routine Care*. Within two weeks after the request
  - *Physical/Wellness Exams*. Within four to eight weeks after the request
  - *Prenatal Care.* Initial visit within 14 calendar days of the request or by the 12th week of gestation
- Refer clients to an approved Texas Medicaid provider or PCCM-contracted facility when the needed services are not available through the primary care provider's office or clinic. Specialists to whom primary care providers refer clients also should schedule appointments within the timeframes described above. Primary care providers may contact the PCCM Provider Helpline (1-888-834-7226) for a list of contracted facilities.
- Coordinate, monitor, and document medical treatment and covered services delivered by all providers to each client, including treatment during inpatient stays.
- Comply with all authorization and notification requirements of PCCM.
- Verify the eligibility of each client prior to providing covered services to determine whether the client is eligible for services under PCCM on the date of service.
- Coordinate care for children receiving services from or who have been placed in the conservatorship of DFPS. Primary care providers are responsible for furnishing or arranging for all medically necessary services while the child is under the conservatorship of DFPS and until the child is placed in foster care and is no longer eligible for PCCM enrollment.
- Cooperate with and participate in PCCM utilization management (UM) programs.
- Maintain hospital admitting privileges at a PCCM-contracted facility as applicable or maintain a referral relationship with a provider with admitting privileges.
- Provide preventive services using clinically accepted guidelines and standards.

7.5.11.1 Office and Medical Records Standards

To ensure that each onsite office or facility used to deliver health care to PCCM clients is safe, sanitary, and accessible, PCCM has defined standards for offices and other facilities:

- A site visit is conducted for each location as part of the evaluation process.
- An office compliance audit ensures that the facility meets defined standards.
- Evaluators use the visit as an opportunity to interact with the provider and office staff.
- Evaluators are prepared to explain the program and promote a strong network relationship.

For a provider to be considered for PCCM participation, all office sites must be in compliance with the "conditions of participation" stipulated in the provider contract. PCCM staff conducts an office onsite review at each primary care site prior to the acceptance of the provider into PCCM. Subsequently, Provider Relations staff performs routine audits at primary care office sites every two years.

The "Primary Care Case Management (PCCM) Pre-Contractual/Recredentialing Site and Medical Record Evaluation" on page B-70 is used to evaluate a provider's office:

- Offices that are found to be marginally acceptable receive a follow-up visit within 90 days.
- PCCM may recommend that HHSC cancel a provider's contract if office conditions do not meet defined standards after notice of required corrective action has been provided, and time to make changes has been made available.

7.5.11.2 Medical Records Standards

A PCCM provider is required to maintain comprehensive and accurate medical records to ensure quality and continuity of care. Each provider must maintain and make available medical records in accordance with the applicable provider agreement.

Content of Medical Record

Each patient's medical record must include patient identification information, progress notes, and laboratory, referral, and consultation notes. Data to be maintained includes:

- Patient identification information:

  - Patient's full name, address, and phone number.
  - Patient's history, including: past and present medical condition of patient and family, past illnesses and surgeries, X-ray and lab tests, immunizations, documentation of discussion of Advance Directives (patients 21 years of age and older).
- Present physiological condition:
  - Drug or allergy sensitivities.
  - Current medications.
- Progress notes:
  - Patient's complaint or reason for visit.
  - Results of physical examinations.
  - Tests, procedures, and medications ordered by physician.
  - Diagnoses and problems identified.
  - Health education/preventive services performed.
- Laboratory, referral, and consultation notes:
  - Laboratory and X-ray reports.
  - Consultation and referral consultation reports.
- Copies of reports concerning hospital admissions including:
  - Authorizations.
  - Surgical reports.
  - Discharge summaries.

Refer to: "General Medical Record Documentation Requirements" on page 1-11.

In addition, PCCM providers performing THSteps comprehensive medical check ups must document all components of the check up. These documentation requirements are detailed in "Documentation of Completed Check Ups" on page 43-15.

Upon request, a provider will supply PCCM staff with copies of client medical records, as outlined in the provider agreement, for implementation of utilization management, quality improvement, and grievance programs.

Confidentiality of Medical Records

The relationship and all communication between physician and patient are privileged. Accordingly, the medical record containing information about the relationship is confidential.

A physician's code of ethics, as well as Texas and federal laws, protect against the disclosure of the contents of medical records to persons or agencies that are not properly authorized to receive such information.

For a provider to release the contents of a patient's medical record to a third party, the patient must first authorize the disclosure by signing and dating an authorization form. If the record is for a deceased individual, the executor of the estate must authorize the release.

PCCM's policy is to allow only medical personnel and health professionals who are directly involved in the delivery or evaluation of a patient's records to access the medical record. All requests for medical record information must be handled according to policy and law.

An authorization from the patient for release of medical information is not required when the release is requested by and made to PCCM, TMHP, HHSC, the external quality review organization, or the Texas Attorney General's Medicaid Fraud Control Unit.

Medical Records Audits

PCCM Provider Relations staff performs a general medical record review of the primary care provider's practice as part of the credentialing and recredentialing process and as part of the quality improvement program. The "Primary Care Case Management (PCCM) Pre-Contractual/Recredentialing Site and Medical Record Evaluation" on page B-70 is used to evaluate provider medical records as part of the credentialing and recredentialing process.

Medical record audit results are submitted to the Medical Director and, if necessary, to the Credentialing Committee for review. Depending upon review findings, the Credentialing Committee will assist the Medical Director in concluding the audit in one of three ways:

- Recommending that HHSC accept the provider.
- Recommending that HHSC reject the provider on the basis of poor medical record documentation and procedures.
- Recommending that HHSC accept the provider conditionally with the provision that certain changes must be made and standards must be met within a specified timeframe.

These recommendations apply to audits of an initial review of a provider as well as those of subsequent reviews.

If a provider has been found to be marginally in compliance with requirements, he will be given training and education directed at correcting the deficiency. PCCM will establish a system to audit this provider every 60 days for a maximum of three follow-up audits:

- Each audit must show substantial improvement over the previous audit.
- Following the third follow-up audit, if no improvement has been noted, PCCM will work with HHSC to apply sanctions and monitor performance closely.
- Subsequent to these measures, if the provider is still not in full compliance, PCCM will recommend to HHSC that the provider be terminated from the plan.

Medical records may also be reviewed in conjunction with provider profiling to identify opportunities to improve care and services.

Access and Availability Standards

PCCM staff routinely evaluates and monitors provider compliance with scheduling requirements. These scheduling requirements are designed to enhance access to health services and to provide assurance of service availability based on the urgency of need:

- *Urgent Care*. Within 24 hours after the request.
- *Routine Care*. Within two weeks after the request.
- *Physical/Wellness Exams*. Within four to eight weeks after the request.
- *Prenatal Care*. Initial visit within 14 calendar days of the request or by the 12th week of gestation.

Refer to: "Primary Care Provider Requirements and Information" on page 7-8.

7.5.12 Monitoring Provider Performance

PCCM is responsible for monitoring quality of care and, if necessary, recommending that HHSC disenroll providers who do not meet plan requirements.

Among the indicators used to monitor PCCM providers' performance are:

- *Client Comments and Complaints.* The PCCM Complaints Department closely monitors the activities associated with client complaints as they relate to quality assurance and utilization management reviews for specific provider performances. The reports of these activities are used to trigger separate actions and inquiries about performance.
- *Office Site Reviews.* PCCM staff undertakes a variety of assessments as part of quality improvement activities and provider service activities. The results of these reviews are made part of the file of performance factors and indicators assessed during the recredentialing process.
- *Compliance With 24-Hour Access Standards.* PCCM staff conducts audits to assess the degree of compliance with Medicaid Managed Care access standards. Client comments and complaints may trigger reviews of specific providers. The results of these reviews are considered in the recredentialing process.
- *Ability to Perform or Directly Supervise Ambulatory Primary Care Services for Clients.* Provider performance is monitored on an ongoing basis. PCCM staff follows up evidence of poor performance and addresses identified problems immediately to ensure that high-quality care is delivered to plan clients.
- *Admitting Privileges.* PCCM staff verifies that each provider maintains membership on the medical staff with admitting privileges at a minimum of one accredited contracted hospital or has an acceptable (timely and complete transfer of patients and records) arrangement with a primary care provider who has such admitting privileges.
- *Continuing Medical Education Credits.* Provider Enrollment/Contracting and Credentialing staff monitors each provider's activities in the area of continuing medical education credits.
- *Education Sessions.* PCCM provides a series of educational sessions that include aspects of UM and case management. Provider contracts require that each primary care provider attend at least one educational session each year.
- *Valid Drug Enforcement Administration (DEA) Certification.* Proof of DEA certification must be submitted as part of the application process and will be maintained by PCCM in its credentialing files.
- *Performance Within Scope of Individual Licensure and PCCM Credentialing.* PCCM staff provider applications include a statement providing assurance that a certified registered nurse practitioner, nurse midwife, or PA will perform services only within the scope of his licensure, and that the individual will be disciplined immediately if this agreement is violated.
- *Compliance with Fraud and Abuse Policy.* PCCM will recommend to HHSC that a network provider be suspended immediately upon notification from any source that the provider:
  - Has been terminated or suspended from participation in the Medicaid or Medicare Program.
  - Has lost his or her license.
  - Has been convicted of a criminal act.

PCCM employs the above indicators as part of its oversight function. Findings are cataloged and analyzed for patterns of performance that require special attention. Where warranted, the results are made part of the recredentialing process. Failure to adhere to the above standards of performance will be grounds for suspension or termination.

7.5.13 Referrals

PCCM primary care providers function as the medical home for PCCM clients. Primary care providers are responsible for arranging and coordinating appropriate referrals to other providers, including specialists, and for managing, monitoring, and documenting the services of other providers.

Referrals are an integral component of PCCM's healthcare delivery program. Referrals ensure that clients gain access to all necessary and appropriate covered services and that care is delivered in the most clinically suitable and cost-effective setting.

Referral procedures are designed to capture the information needed to support and manage the utilization of services by the provider network. Proper documentation of referrals is necessary for accurate medical record keeping.

Primary care providers are responsible for the appropriate coordination and referral of PCCM clients for the following services:

- CPW case management services.
- DARS case management services.
- ECI case management services.
- Mental retardation targeted case management.
- SHARS.
- Texas Commission for the Blind case management services.
- THSteps medical case management.

- THSteps dental (including orthodontics).
- Tuberculosis services.
- Vendor drugs.

7.5.13.1 Open Specialty Referral Network

PCCM operates an open specialty referral network. Primary care providers may refer patients to any Texas Medicaid-approved specialist within the State of Texas that accepts PCCM clients for covered health services. Medically necessary referrals to specialists do not require authorization from PCCM.

For all referrals, primary care providers should furnish their provider identifier and complete information on treatment procedures and diagnostic tests performed prior to the referral. The referral should specify the following:

- Initial diagnosis/diagnoses.
- Reason for the referral.
- Services requested from the referral specialist.
- Number of authorized visits (optional).

Primary care providers may make a referral to another primary care provider or a specialist during periods of absence or unavailability. Primary care providers may also make a referral if a client requests a second medical opinion.

After receiving a referral specialist's report, if ongoing treatment for an illness is required, primary care providers have the discretion to specify the period of time or number of visits authorized for ongoing treatments to be given by the specialist.

The referring primary care provider's identifier must be entered on all claims submitted by the treating provider, indicating the primary care provider authorized the services. It is the responsibility of the treating specialist to ensure that the patient continues to be an eligible PCCM client throughout the period of treatment.

7.5.13.2 Referral Form

No form for a referral to a specialist is required. However, primary care providers are encouraged to use the PCCM Referral Form. This form reflects accepted practices in the Texas medical community.

The use of this form will simplify:

- Dissemination of necessary information to the specialist.
- Documentation for the client's medical record of the specialist's diagnosis and treatment.

Refer to: "Primary Care Case Management (PCCM) Referral Form" on page B-69.

One copy of the referral form should be given to the specialist.One copy should be maintained in the client's medical record.

7.5.14 Specialist Responsibilities

Specialists are responsible for furnishing medically necessary services to PCCM clients who have been referred by their primary care provider for specified treatment or diagnosis. While the specialist does not contract with PCCM, all facility services should be delivered in a contracted PCCM facility.

Specialists are responsible for verifying the eligibility of the referred client prior to providing treatment.

To ensure continuity of care for clients, the specialist must maintain communication with the client's primary care provider. This communication should ensure that the primary care provider's medical records adequately document the specialist services provided, all results or findings, and all recommendations. The specialist may use the lower half of the PCCM Referral Form for this purpose.

When a primary care provider refers a client to a specialist, the specialist should review the case with the primary care provider to fully understand the services being requested. Services requiring more than one visit should be coordinated with the primary care provider for approval of additional visits. Referrals from a primary care provider must be documented in both the primary care provider's and the specialist's records.

If a specialist determines that a client's condition warrants attention (i.e., hospitalization or diagnostic procedures), the specialist should seek authorization from the PCCM Inpatient/Outpatient Prior Authorization Department by telephone at 1-888-302-6167 or by fax at 1-512-302-5039.

Emergency treatment does not require authorization.

Refer to: "Facility/Hospital Services" on page 7-38.

7.5.14.1 Specialist-to-Specialist Referrals

Referrals from one specialist to another for a medically necessary service must be authorized by the client's primary care provider or, if the client does not have a primary care provider, the specialist can call the PCCM Client Helpline to obtain a one-time appointment approval.

7.5.15 PCCM Inpatient Authorization Process

7.5.15.1 Definitions

Authorization. The process of obtaining approval for the delivery of services.

Routine/Non-Emergent Condition. A symptom or condition that is neither acute nor severe and can be diagnosed and treated immediately, or that allows adequate time to schedule an office visit for a history, physical and/or diagnostic studies prior to diagnosis and treatment.

Urgent Condition. A symptom or condition that is not an emergency, but requires further diagnostic work-up and/or treatment within 24 hours to avoid a subsequent emergent situation.

Emergent/Emergency. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction to any bodily organ or part.

Emergency services means covered inpatient and outpatient services that are as follows:

- Furnished by a provider that is qualified to furnish these services under this title.
- Needed to evaluate or stabilize an emergency medical condition.

Poststabilization Services. Covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or to improve or resolve the enrollee's condition.

Observation Services. Services received within a hospital setting, which are "reasonable and necessary" to evaluate an outpatient condition or determine the need for possible admission to the hospital as an inpatient.

Notification. The process by which a facility informs PCCM that a client has been admitted as an inpatient to their facility on an urgent or emergent basis.

7.5.15.2 Professional Services

ER Services

Primary care providers should become actively involved in educating PCCM clients regarding the appropriate use of the ER and other emergency services. Providers should also notify PCCM of any client who may need further education regarding the appropriate use of the ER by calling the Client Helpline at 1-888-302-6688, or by using the PCCM Community Health Services Referral Request Form.

Refer to: "Primary Care Case Management (PCCM) Community Health Services Referral Request Form" on page B-67.

7.5.15.3 Facility/Hospital Services

Requests for prior authorization or notification of admissions for PCCM clients may be submitted via phone by calling the PCCM Inpatient Prior Authorization Department at 1-888-302-6167,faxed to 1-512-302-5039 using the PCCM Inpatient/Outpatient Authorization Form, or online through the TMHP website at www.tmhp.com. Online instructions for submitting authorization requests via the TMHP website can be found in the Help section at the bottom of the Prior Authorization screen.The provider must check the authorization request status before services are provided to confirm whether the authorization has been approved or denied. See "Prior Authorization Requests Through the TMHP Website" on page 5-4 for additional information about mandatory documentation requirements and retention.

All requests must include the following information:

- Facility name and provider identifier.
- Client name, Medicaid number (PCN), and date of birth.
- Requesting (admitting) physician's name and provider identifier.
- Name of person completing form.
- Date completed.
- Telephone number.
- Fax number.
- Admit date.
- Diagnosis codes (primary, secondary, etc.).
- Diagnosis Related Groups (DRG) code (for DRG facilities).
- Procedure codes.
- Discharge date.
- Clinical information to support medical necessity if required.

Note: *Submit medical records pertaining only to the service for the prior authorization that is being requested.*

If the provider's request is determined to be incomplete, the Inpatient Prior Authorization Department contacts the provider requesting the specific information needed to make the authorization determination and places the request in pending status. If the requested information is not received by the second business day, the information is requested again. If the information is not received by the fourth business day from the date the request was placed in pending status, the request is denied. A denial letter is sent to the facility and/or the requesting physician. When the requested information is received within four business days from the original pend date, the authorization is processed.

For most admissions, a letter of notification/authorization is faxed to the requesting facility or the requesting physician once the determination is complete. For scheduled inpatient admissions, both the facility and the physician will receive faxed notification.

Authorization is a condition of reimbursement. It is not a guarantee of payment.

If the DRG submitted on a claim does not match the DRG on the authorization, one of the following will occur:

- If the lesser of the two DRGs can be derived, the claim will be paid at the lower amount.
- If the lesser of the two DRGs cannot be derived, the claim will be denied.

Claims are adjudicated based on the authorization that was completed at the time of the claim submission. To avoid a DRG mismatch and the denial of the claim when there is a change to an existing authorization (e.g., a change to the discharge date, diagnosis, DRG, or

procedure), the facility is required to submit an updated PCCM Inpatient/Outpatient Authorization Form before the claim is submitted. The form can be submitted either by fax to 1-512-302-5039 or by contacting the Inpatient Prior Authorization Department at 1-888-302-6167.

Notification of urgent and emergent admissions is only required before a claim is submitted. Providers are encouraged to submit the notification after DRG information is complete to avoid updating the DRG because of a DRG mismatch and a change to the admitting diagnosis.

If the services rendered are different or more complex than the ones that were authorized, providers should contact the PCCM Inpatient Prior Authorization Department to update the authorization before the claim is submitted.

For non-DRG facilities, the claim will pay at the lower number of inpatient days when the length of stay that is billed is different from the length of stay that was authorized. If there is a change to an existing authorization, providers should contact the PCCM Inpatient Prior Authorization Department with the update before the claim is submitted.

7.5.15.4 ER Services

ER providers are authorized by PCCM to furnish the medically necessary appropriate treatment of PCCM clients. The ER provider must perform the medical screening examination; i.e, assess the medical needs of a PCCM client who appears in the ER to determine the medical necessity of services and the appropriate setting for rendering services.

ER providers must determine a patient's status based on the urgent, emergent, and non-emergent definitions noted in "Definitions" on page 7-37. In some cases, medically necessary services are needed to determine the patient's condition. The necessity of these services must be documented in the medical record. ER providers are paid for medically necessary services required to determine and stabilize the patient's condition.

If a determination is made that the client has a *routine/non-emergent* condition, the client's primary care provider should be notified by phone, fax, or electronic mail, so that follow-up care can be arranged by the primary care provider as appropriate.

If a determination is made that the client has an *urgent* condition, the client's primary care provider should be notified by phone, fax, or electronic mail, so that follow-up care can be arranged within 24 hours.

If the client has an *emergent* condition, the ER must treat the client until the condition is stabilized or until the client can be admitted or transferred. Once the client is stabilized, the ER staff must notify the client's primary care provider to arrange for medically necessary hospital admission or follow-up care. If the ER staff is unable to contact the primary care provider (or designated on-call provider) within one hour, the ER staff should treat the client and report the primary care provider's unavailability by contacting the PCCM Provider Helpline at 1-888-834-7226.

Hospitals are eligible to bill for any services required in the medical screening examination and stabilization of a PCCM client. All services must be supported by the clinical record.

When treatment is provided to a PCCM client, *professional* and *facility* services must be billed separately.

Reimbursement of emergency facility and ancillary charges for diagnostic tests, monitoring, and treatment is based on the actual services rendered. The hospital is paid at its current Medicaid reimbursement rate.

7.5.15.5 Observation Services

Observation services are those received within a hospital setting, which are "reasonable and necessary" to evaluate an outpatient condition or determine the need for possible admission to the hospital as an inpatient. Some patients, while not requiring hospital admission, may require a period of observation in the hospital environment as an outpatient. Observation services may be provided in any part of the hospital where a patient placed in observation can be assessed, examined, monitored, and/or treated in the course of the customary handling of patients by the facility. Observation services after the 23rd hour are *not* payable by the Texas Medicaid Program. If the patient is going to be admitted, the patient's status must be changed from observation to inpatient prior to the 24th hour.

If an inpatient admission occurs from an observation status, the Inpatient Prior Authorization Department must be notified. Notification of admission is the responsibility of the admitting facility. If necessary, notification of admission is accepted from the physician's office. The payment for the inpatient admission includes the observation stay. Notification of admission is required prior to claim submission to avoid claim denial.

7.5.15.6 Urgent and Emergent Admissions

Notification of admission is required prior to claim submission to avoid claim denial. Notification of admission is the responsibility of the admitting facility. However, if necessary, notification of admission is accepted from the physician.

Notification is not required for 23-hour observation stays, unless the stay is converted to an inpatient status. The following information should be included on the notification:

- Facility name and provider identifier.
- Client name, Medicaid number (PCN), and date of birth.
- Requesting (admitting) physician's name and provider identifier.
- Name of person completing form.
- Date completed.
- Phone number.
- Fax number.

- Admit date.
- Diagnosis codes (primary, secondary etc.).
- DRG code (for DRG facilities).
- Procedure codes.
- Discharge date.
- Clinical information to support medical necessity if required.

Note: *Submit medical records pertaining only to the service for the prior authorization that is being requested.*

If the provider's request is determined to be incomplete, the Inpatient Prior Authorization Department contacts the provider requesting the specific information needed to make the authorization determination and places the request in pending status. If the requested information is not received by the second business day, the information is requested again. If the information is not received by the fourth business day from the date the request was placed in pending status, the request is denied. A denial letter is sent to the facility and/or the requesting physician. When the requested information is received within four business days from the original pend date, the authorization is processed.

If an emergent admission is necessary, the hospital must notify PCCM prior to claim submission. Failure to notify the PCCM Inpatient Prior Authorization Department prior to claim submission will result in denial of the claim.

Notification of emergency admissions can be provided by calling the PCCM Inpatient Prior Authorization Department at 1-888-302-6167, or faxing to 1-512-302-5039.

7.5.15.7 OB/Newborn Notification

Routine

Authorization is not required for routine obstetrical and newborn care within the routine length of stay (48 hours for vaginal deliveries and 96 hours for C-section deliveries).

Non-Routine

All obstetrical and newborn admissions with non-routine clinical status (complicated condition or DRG) or non-routine length of stay (over 48 hours for vaginal deliveries and 96 hours for C-section deliveries) require notification of admission and clinical documentation prior to claim submission. Notification of admission is the responsibility of the admitting facility. However, if necessary, notification of admission is accepted from the physician. Notification of admission is required prior to claim submission to avoid claim denial.

7.5.15.8 Scheduled Inpatient Admissions

Prior authorization is required for all scheduled inpatient admissions. Prior authorization of admission is a shared responsibility of the admitting facility and physician, but only one provider (admitting facility or physician) is required to submit an authorization request.

7.5.15.9 Appeals of Denied Requests for Authorization

If an authorization request for admission or service is denied, the requesting provider will receive a denial letter from the PCCM Prior Authorization Department. Where appropriate, the hospital or facility involved is also notified of the denial.

Requests for reconsideration for prior authorizations for inpatient services are subject to the following steps:

1) Provider submits a request for prior authorization to the prior authorization unit and obtains the authorization or a denial for the authorization from TMHP.
2) If the provider is not satisfied with the results of step 1, they can appeal step 1 by submitting additional information/documentation to TMHP. This step can be repeated multiple times as long as the provider is submitting additional information/documentation.
3) If the provider is not satisfied with the outcome determined by TMHP in step 2 and no additional information is available to submit to TMHP, the provider may submit a request for reconsideration to HHSC (only if step 1 is complete and step 2 is thoroughly exhausted).

These steps are applicable prior to filing the claim. Filing deadlines should be taken into consideration, and HHSC will not review if steps 1 and 2 were not followed.

Refer to: "Appeals" on page 6-1 and "Authorization Appeals" on page 7-43.

7.5.15.10 Out-of-Network Inpatient Services

Out-of-network hospitals are reimbursed only for inpatient services provided to PCCM clients as the result of an emergency admission. Out-of-network facilities must notify the Inpatient Prior Authorization Department of a client admission within the next business day following the admission. Medical documentation must be submitted with notification to determine appropriateness for transfer to a contracted facility. Scheduled medical and surgical admissions or any non-emergent admission must be precertified indicating the reason why the patient must be admitted or transferred to an out-of-network facility (i.e., the services needed are not provided in a network facility, the patient had an emergent condition requiring admission while away from the SA).

A routine OB/newborn admission to an out of network facility does not require notification or prior authorization.

Non-routine OB/newborn services require prior authorization within the next business day following the determination that the services are non-routine.

Refer to: Refer to "OB/Newborn Notification " on page 7-40 for the definition of routine and non-routine OB/newborn Services.

After a patient in an out-of-network hospital is stabilized, additional services are considered non-covered benefits. The out-of-network hospital may, however, request an

exception to the stabilization policy by contacting the PCCM Inpatient Prior Authorization Department at 1-888-302-6167:

- The hospital must state the circumstances surrounding the emergency admission and provide an estimate of the additional number of days required until the patient is discharged.
- PCCM grants exceptions based on the information provided by the non-contracted hospital and issues a authorization for billing purposes if an exception is granted.
- Although in some cases the PCCM Inpatient Prior Authorization Department may require additional time to review the circumstances of the request for exception, it normally reviews the request and contacts the out-of-network hospital within 36 hours of its request. The Inpatient Prior Authorization Department will either provide the non-contracted hospital with a authorization or deny the exception request.
- Should a stabilization exception be denied, any inpatient services provided to the PCCM client at the out-of-network hospital will cease to be a covered benefit 24 hours after the hospital is notified.

Nonemergency inpatient admissions are not a covered benefit at out-of-network hospitals and are considered for reimbursement only if authorization has been received from the PCCM Inpatient Prior Authorization Department or the client would experience an undue burden traveling to a network hospital. In this case, a *hardship exemption* may be granted. This exemption permits reimbursement of a nonemergency admission at an out-of-network hospital.

To obtain a hardship exemption, the attending physician or designee must contact the PCCM Inpatient Prior Authorization Department at 1-888-302-6167 before any nonemergency admission to an out-of-network hospital and provide details to substantiate why the client would experience an undue burden traveling to a network hospital.

If the details substantiate undue burden, the PCCM Inpatient Prior Authorization Department will grant the exemption and issue a authorization. The physician can then admit the patient to the out-of-network hospital.

Note: *Under no circumstances will authorization for an undue travel burden be granted after a patient has been admitted for a nonemergency condition to an out-of-network hospital.*

Primary care providers referring clients to specialists should make the specialist aware of the PCCM non-contracted hospital admission policy.

7.5.16 Outpatient Prior Authorization Process

The following outpatient procedures require prior authorization:

- Computed tomography (CT) imaging.
- Computed tomography angiography (CTA).
- Magnetic resonance imaging (MRI).
- Magnetic resonance angiography (MRA).
- All laser surgeries.
- Some endoscopic procedures.
- Some podiatry procedures.
- pH probe tests.
- Sleep studies.
- Some surgical procedures.

Prior authorization for clients with retroactive eligibility must be obtained by the PCCM provider within 95 days of the add date and before claims submission.

Refer to: "Computed Tomography (CT) and Magnetic Resonance Imaging (MRI)" on page 39-4 for more information about MRI/MRA and CT/CTA authorizations.

The following outpatient procedures do not require prior authorization:

- Anesthesia services (type of service 7).
- Surgeries performed on an outpatient emergent basis (retrospective authorization must occur for claims payment).
- Application/removal of casts, splints, or strapping (excluding podiatry office procedures and services).
- Burns — local treatment (does not include skin grafts or long-term wound care).
- Catheterization of blood vessels (excluding heart catheterizations) for diagnosis or therapy (includes venous access, puncture of shunt, etc.).
- Cholecystectomy.
- Circumcision, newborn and for phimosis (up to 21 years of age).
- Fractures/dislocations (closed or open treatment).
- Incision and drainage of abscesses.
- Injection procedures for radiology or in conjunction with surgical procedures.
- Intubation/tracheostomy tube changes.
- Polysomnography.
- Removal of foreign bodies.
- Removal of pressure equalization tubes with or without grafts.
- Repair of lacerations/wounds (includes the eye).
- Replacement of gastrostomy tubes.
- Replantation of digits.
- Sterilization procedures (male and female).

- Urodynamics.
- Esophageal manometry.
- Ultrasounds.
- Holter monitors.
- Tympanostomy.
- Tonsillectomy for client's under 12 years of age.
- Adenoidectomy for client's under 12 years of age.
- Bronchoscopy.
- Sigmoidoscopy.
- Proctosigmoidoscopy.
- Permanent removal of nail/nail matrix.
- Colonoscopy (except with endoscopic ultrasound exam or fine needle biopsy).
- Esophageal Endoscopy (except for ablation procedures).
- Appendectomy for ruptured appendix or incidental removal.
- Hernia repair (except initial repair under 5 years of age with strangulation or incarceration).
- Upper GI Endoscopy (except for drainage of psuedocyst or placement of gastrostomy tube).

Requesting Prior Authorization

Requests for prior authorization of outpatient services may be made by faxing a completed PCCM Inpatient/Outpatient Authorization Form to the Outpatient Prior Authorization Department at 1-512-302-5039, by calling 1-888-302-6167, or through the TMHP website at www.tmhp.com. Other forms will not be accepted for outpatient prior authorizations or updates.

Refer to: "Prior Authorization Requests Through the TMHP Website" on page 5-4 for more information.

The request must include the following information:

- Facility name and provider identifier.
- Client name, Medicaid number (PCN), and date of birth.
- Requesting (admitting) physician's name and provider identifier.
- Name of person completing form.
- Date completed.
- Telephone and fax number.
- Admit date.
- Diagnosis codes (primary, secondary, etc.).
- Procedure codes.
- Clinical information to support medical necessity is required.

If the prior authorization request is determined to be incomplete, the Outpatient Prior Authorization Department faxes the provider a letter requesting the specific information needed to make the prior authorization determination and places the request in pending status. At least two additional attempts to call and/or fax the provider to obtain this information will be made during the next four business days. If the requested information is not received by the fourth business day, a letter is sent to the client stating that the prior authorization request cannot be processed until the provider responds with the specific information necessary to complete the prior authorization request. This client letter is sent along with a copy of the initial letter to the provider that lists the specific information necessary to make the prior authorization determination. If the provider does not submit the information necessary to complete the prior authorization request within seven calendar days from the date of the letter sent to the client, a letter is sent to the provider and the client notifying them of the denial of service due to incomplete or missing information.

A letter of authorization determination is faxed to the requesting provider once the request is completed.

Authorization is a condition of reimbursement. It is not a guarantee of payment.

Claims are processed based on the authorization completed at the time of claim submission.

If there is a change in an existing authorization (i.e., change in diagnosis or change in procedure), the facility/provider is required to submit an updated PCCM Inpatient/Outpatient Authorization Form with clinical documentation supporting the change or contact the Outpatient Prior Authorization Department with the update prior to claim submission to avoid claim denial.

Providers performing urgent or emergent outpatient procedures that require authorization must contact the PCCM Outpatient Prior Authorization Department within 7 calendar days to obtain the authorization.

7.5.17 Transportation Services

7.5.17.1 Nonemergency Transportation

Nonemergency transportation services are available to eligible Medicaid clients who have no other means of transportation. This service is known as the Medical Transportation Program (MTP) and is detailed in "Medical Transportation" on page I-1.

For information on emergency transportation, see "Ambulance" on page 8-1.

7.5.18 Provider Complaints and Appeals

7.5.18.1 Conflict Resolution

The relationship between client and primary care provider may become unsatisfactory to one or both parties. The primary care provider should contact the PCCM Provider Helpline or write to request assistance in resolving the situation.

PCCM will initiate one or more of the following steps:

- Contact the client and the provider to assess the situation and provide educational information that may clarify the situation, if applicable.

- Refer the situation to CHS staff for education or to help clarify the situation.
- Refer the situation to the Complaint Resolution Team, if applicable.
- Begin complaint/grievance resolution.
- Reassign the client to another primary care provider.

7.5.18.2 Provider Complaints

PCCM provides for due process in resolving provider complaints. Procedures governing the provider complaints process are designed to identify and resolve provider complaints in a timely and satisfactory manner. The majority of complaints are resolved within 30 calendar days.

Complaints must be submitted in writing to:

Primary Care Case Management (PCCM)
Complaints Unit MC-C04
PO Box 204270
Austin, TX 78720-4270
Or faxed to: 1-888-235-8399

Question regarding the status of a complaint or the complaint process should be directed to the PCCM Provider Helpline at 1-888-834-7226.

Provider Complaint Policy

PCCM takes seriously and acts on each provider complaint. Depending on the level and nature of the complaint, PCCM works with the provider to resolve the issue or directs the complaint to the appropriate PCCM department.

- *Complaints Unit.* Complaints that concern the relationship between a provider or provider's staff and a client.
- *Medical Affairs Division.* Complaints that relate to utilization of services (including ER use), denial of continued stay, and all clinical and access issues. This includes provider's appeal of an adverse authorization decision.
- *PCCM Administration.* Complaints that concern the relationship between a provider and any PCCM staff person or complaints about the overall plan management.

If the complaint relates to a medical issue, the Medical Affairs staff may assist in the resolution of the complaint.

The provider complaints process applies only to the resolution of disputes within the control of PCCM, such as administrative or medical issues. The provider complaint process does not apply to allegations of negligence against third parties, including other participating providers. These complaints are referred to HHSC for review and evaluation and are resolved by HHSC staff with support from PCCM staff.

Provider Complaint Procedures

The PCCM Complaints Unit handles all provider complaints. The processing of provider complaints is described below:

- Providers must submit their complaint in writing or by telephone. All requests to remove clients from their panel must be in writing (see "Provider-Initiated Primary Care Provider Changes" on page 7-6.)
- Providers will receive a written acknowledgement letter from PCCM within five business days of receipt of the complaint.
- Referrals to other departments, such as Provider Services or Medical Affairs, are made as appropriate.
- Complaints dealing with the quality of, access to, or continuity of care are referred to the PCCM Primary Care Provider Contract Compliance Department for follow-up and inclusion in the provider file.
- If the complaint cannot be resolved within 30 calendar days, the provider is notified in writing or by phone of the status of the complaint.

If the provider believes he or she did not receive due process from PCCM, the provider may file a complaint with HHSC. However, providers must exhaust the appeals/grievance process with PCCM before filing a complaint with HHSC.

Refer to: "Medicaid Managed Care Complaints and Fair Hearings" on page 7-11.

"Complaints to HHSC—Fee-for-Service and PCCM" on page 6-9.

7.5.18.3 Authorization Appeals

A denial is issued when an authorization or update to an existing request by a physician or a facility is not approved by the TMHP Medical Director or designee.

A medical necessity denial is issued when the documentation provided fails to support the need for requested service or the client's condition/service requested does not warrant the level or location of care the provider requested.

A denial is also issued when the provider has failed to comply with PCCM policies and procedures. These include failure to:

- Notify of an inpatient stay.
- Obtain authorization for an elective/scheduled service prior to the delivery of service.

A denial may also be issued if:

- The provider or the location of service is not within the network.
- The patient is no longer eligible for coverage.
- The service is not a benefit of the Texas Medicaid Program.

The appeals or authorization reconsideration process affords the provider the opportunity to dispute a denial and explain or justify the original request.

Refer to: "Appeals" on page 6-1.

Appeal Procedures for Denials Other Than Medical Necessity

Level I: Review by TMHP

If the provider has evidence that he complied with policy, he may request a reconsideration of a denial by resubmitting the authorization request with additional information to support the reconsideration and a copy of the denial letter by fax to the PCCM Inpatient or Outpatient Prior Authorization Department that issued the denial prior to submitting the claim.

Level II: Additional Review by TMHP.

If the provider is not satisfied with the results of the Level 1 review, they can appeal by submitting additional information/documentation to TMHP.

Level III: Review by HHSC

If a provider believes he did not receive full consideration under the appeals process, he may file an appeal with HHSC. Providers must exhaust the appeals process with TMHP before filing an appeal with the HHSC.

Refer to: "Appeals to HHSC Fee-for-Service and PCCM" on page 6-4.

If it is determined that the provider did not receive full consideration, HHSC will work with the provider and PCCM to ensure that a proper review of the appeal is conducted.

Hospitals may appeal to the HHSC Medical and UR Appeals Unit only if they have followed the prior authorization process with TMHP. The Medical and UR Appeals Unit must receive the written appeal request within 120 days from the date of the last R&S report. If the request is not received within 120 days, the appeal is not conducted, and the TMHP decision is considered final. This request must include a copy of the complete medical record, an original signed, properly completed, notarized Affidavit (see "Affidavit" on page B-4), and a letter explaining the reason for the appeal. Extensions of time are not granted for filing the written appeal request, submission of the complete medical record, or the original properly completed notarized affidavit in the format approved by HHSC.

Appeal Procedures for Medical Necessity Denials

Level I: Review by TMHP

Providers can appeal medical necessity denials by resubmitting the authorization request with additional clinical information to support the appeal and a copy of the denial letter by fax to the PCCM Inpatient or Outpatient Prior Authorization Department that issued the denial prior to submitting the claim.

Upon receipt of the request:

- The Medical Director or designee reviews the information and makes a determination.
- After the determination is made, the Medical Affairs nurse sends the resolution letter to the appealing provider.

If dissatisfied with the reconsideration decision, a provider can request another reconsideration by resubmitting the authorization request with additional clinical information not previously submitted to support the requested services and a copy of the denial letter by fax to the PCCM Inpatient or Outpatient Prior Authorization Department that issued the decision prior to submitting the claim for the services.

Once a provider has submitted a claim for services, reconsiderations for medical necessity cannot be performed by the PCCM Prior Authorizations Departments. The provider will need to follow the process for administrative claims appeals.

Refer to: "Appeals to HHSC Fee-for-Service and PCCM" on page 6-4.

Level II: Additional Review by TMHP

If the provider is not satisfied with the results of the Level 1 review, they can appeal by submitting additional information/documentation to TMHP.

Level III: Review by HHSC

Providers must exhaust the appeals process with TMHP before filing a complaint with HHSC.

If a provider believes he did not receive full consideration under the appeals process, he may file a complaint with HHSC.

Refer to: "Complaints to HHSC—Fee-for-Service and PCCM" on page 6-9.

"Medicaid Managed Care Complaints and Fair Hearings" on page 7-11.

7.5.19 Claims Filing Information

All PCCM claims are submitted to TMHP, whether TANF or SSI. In addition to fee-for-service payments, providers enrolled as PCCM primary care providers receive a case management fee of $5.00 per client, per month. The fee-for-service reimbursement for PCCM is based on the Texas Medicaid Reimbursement Methodology (TMRM) structure.

7.5.19.1 Case Management Fee

The case management fee is administrative compensation for managing the medical care of PCCM clients who have either selected or who have been assigned to the primary care provider's practice as their *medical home*. The fee:

- Is paid to the primary care provider whether or not the client is seen that month.
- Is paid to the primary care provider in a separate check no later than the 10th state business day of each month.

Two reports are made available to primary care providers on a monthly basis. The client panel report lists the PCCM clients who have selected or who have been assigned to each primary care provider's practice. This report is available electronically at www.tmhp.com, or in hard copy by calling the PCCM Provider Helpline at 1-888-834-7226.

The second report, a case management summary, is produced by TMHP and accompanies the case management fee check.

If there are any discrepancies in either report, providers are to contact their TMHP provider relations representative. Providers are to call the Provider Helpline (1-888-834-7226) prior to returning a check. This allows PCCM to provide necessary research and assistance.

Refer to: "Monthly Client Panel Report" on page 7-30.

7.5.19.2 PCCM Newborn Claims Filing

PCCM newborns are automatically assigned to the PCCM at the time of the newborn's birth. The effective date of the newborn's enrollment is the same as the newborn's date of birth. Claims filing procedures for PCCM newborns will continue to be handled under the traditional Medicaid billing guidelines through TMHP.

Health care providers should file newborn claims using the newborn's Medicaid Identification number as soon as it is made available to them. Claims submitted for newborns that have not yet been assigned a primary care provider should show PCCNEWB01 as the referring provider identifier. While the provider is listed as PCCNEWB01, any Medicaid provider can see the newborn. Claims submitted for newborns will be accepted even if a primary care provider has not been selected or assigned. Parents of a newborn have up to 105 days to select a primary care provider for their baby. If parents do not select a primary care provider, a primary care provider is selected for the newborn on the basis of claims history.

Once the baby is assigned a primary care provider and a Medicaid number, normal billing and referral procedures will be in effect.

7.5.19.3 Network Hospitals

A network hospital is one that is contracted to provide services to PCCM clients. Individual reimbursement arrangements are negotiated for the HHSC by PCCM Hospital Contracting.

For all SAs, all inpatient services to PCCM clients, including services provided to PCCM clients receiving SSI benefits, are reimbursed at the PCCM rate.

7.5.19.4 Out-of-Network Hospitals

An out-of-network hospital is one that is not contracted to provide services to PCCM clients:

- Out-of-network hospitals are reimbursed only for inpatient services provided to PCCM clients as the result of an emergency admission. Inpatient services are reimbursed at the rate paid by the traditional Medicaid program.
- Reimbursement for emergency treatment will be made at the current Medicaid rates.

Hospitals that are not contracted with PCCM are reimbursed according to traditional Medicaid rates.

7.5.19.5 Emergency Outpatient Services

If the client presents at a hospital emergency outpatient facility, the physician should provide the medically necessary medical screening examination and stabilization services immediately, and the client should be referred back to the primary care provider for follow-up care. Reimbursement for emergency outpatient services requires that the medical record document the medically necessary services.

The hospital should contact the client's primary care provider within 24 hours or the next business day to advise that emergency treatment has been provided. In addition, if a procedure requiring authorization was performed while in the emergency department, the hospital must contact the PCCM Outpatient Prior Authorization Department within 7 calendar days to obtain the authorization. If the condition results in an inpatient admission, the hospital must notify the PCCM Inpatient Prior Authorization Department prior to claim submission. Reimbursement in cases of emergency treatment will be based on the actual services rendered. The hospital will be reimbursed at its current Medicaid reimbursement rate.

Refer to: "PCCM Inpatient Authorization Process" on page 7-37.

"Outpatient Prior Authorization Process" on page 7-41.

7.5.19.6 Nonemergency Outpatient Clinic Services

All hospitals are reimbursed for outpatient clinic services at their current Medicaid outpatient reimbursement rate.

7.5.19.7 PCCM Claims Details

To avoid PCCM claim denials, the primary care provider's name and provider identifier must be entered in the referring provider field of the appropriate claim form, indicating a referral from the primary care provider if the treating provider is not the client's primary care provider at the time of service.

If this information is missing and the treating provider is not the assigned primary care provider on the date of service, the claim will be denied.

For services requiring authorization, enter the authorization number in the prior authorization field. The PCCM Authorization Request Form is not required with the claims submission.

Refer to: "PCCM Inpatient Authorization Process" on page 7-37.

7.5.19.8 Claims for Specialist Services

Specialists may bill for health-care services provided to PCCM clients if the patient was referred by the client's primary care provider. To indicate a referral from the client's primary care provider, the primary care provider's name and provider identifier must be included in the Referring Physician field (boxes 17 and 17A) on the

CMS-1500 claim form. A referral is not required if a specialist is providing a service that does not require a referral from a primary care provider.

Reimbursement for specialists is based on the current Medicaid fee-for-service rates.

Refer to: “Referrals” on page 7-36 and “Self-Referred Services” on page 7-31.

Part II

Texas Medicaid Services

Ambulance

8.1 Enrollment

To enroll in the Texas Medicaid Program, ambulance providers must operate according to the laws, regulations, and guidelines governing ambulance services under Medicare Part B; equip and operate under the appropriate rules, licensing, and regulations of the state in which they operate; acquire a license from the Texas Department of State Health Services (DSHS), approving equipment and training levels of the crew; and enroll in Medicare.

A hospital-operated ambulance provider must be enrolled as an ambulance provider and submit claims using the ambulance provider identifier, not the hospital provider identifier (see "Medicare/Medicaid Coverage" on page 8-7).

Note: *Air ambulance providers are not required to enroll with Medicare.*

Reminder: *When ambulance providers enroll in the Texas Medicaid Program, they accept Medicaid payment as payment in full. They cannot bill clients for Texas Medicaid-covered benefits.*

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

8.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with a Medicaid Managed Care health plan to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

Note: *Services for STAR+PLUS Program Medicaid Qualified Medicare Beneficiaries (MQMBs) must be prior authorized and processed by TMHP.*

Refer to: "Managed Care" on page 7-1 for more information.

8.2 Reimbursement

Ground and air ambulance providers are reimbursed in accordance with 1 TAC §355.8600. See also "Ambulance Procedure Codes" on page 8-8 for ambulance procedure codes and fees.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement methodologies.

"Texas Medicaid Program Limitations and Exclusions" on page 1-19 for information on Medicaid exclusions.

8.3 Benefits and Limitations

The Texas Medicaid Program reimburses for nonemergency and emergency transports.

For ground transportation, providers must bill procedure codes 9-A0428 and 9-A0425, for nonemergency transports or 9-A0429 and 9-A0425 with modifier ET for emergency transport. Providers must bill the appropriate mileage with the appropriate base rate procedure code.

For air transportation, providers must bill either with procedure codes 9-A0430 and 9-A0435, or 9-A0431 and 9-A0436. Providers must bill the appropriate mileage with the appropriate base rate procedure code.

When submitting a claim for water transport services, providers are to use procedure code 9-A0999. The claim suspends for manual review and pricing.

Cardiopulmonary resuscitation (CPR) billed as an ambulance service by an ambulance provider will be denied.

The payment rates represent a global payment. It is inappropriate to bill for any supplies or other services related to the transport, unless otherwise specified in this section.

The accuracy of the information about a client's condition which requires the transport and the medical necessity of the transport are the responsibility of the ambulance provider. The ambulance provider may be sanctioned, including exclusion from the Medicaid Title XIX programs, for completing or signing a claim form that includes false or misleading representations of the client's condition or the medical necessity of the transport.

8.3.1 Emergency Ambulance Transport Services

An emergency ambulance transport service is a benefit when the client has an emergency medical condition. An emergency medical condition is defined, according to 1 TAC §354.1111, as a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, or symptoms of substance abuse) such that a prudent layperson with an average

knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following:

a) Placing the client's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

b) Serious impairment to bodily functions.

c) Serious dysfunction of any bodily organ or part.

Facility-to-facility transfers are appropriate as emergencies when the client has an emergency medical condition that the first facility is unable to treat.

The transport must be to an appropriate facility. An appropriate facility is the nearest medical facility that is equipped to provide medical care for the illness or injury of the client involved. An appropriate facility includes the institution, equipment, personnel, and capability to provide the services necessary to support the required medical care.

8.3.1.1 Prior Authorization for Emergency Out-of-State Transport

All emergency out-of-state (air and ground) transports require authorization before the transport is considered for payment.

Prior authorization for emergency transports is required for out of State providers with the exception of those providers located within 200 miles of the Texas border.

Refer to: Section 2.5, "Medicaid Service Provided Outside Texas" on page 2-6 for additional information on providers who are not considered out-of-state providers.

To initiate the prior authorization process, providers must call 1-800-540-0694.

TMHP is responsible for processing prior authorization requests for all Medicaid clients, Primary Care Case Management (PCCM) clients, and all STAR+PLUS MQMBs.

According to 1 TAC §354.1111, nonemergency transport is defined as ambulance transport provided by an ambulance provider for a Medicaid client to or from a scheduled medical appointment, to or from another licensed facility for treatment, or to the client's home after discharge from a hospital. Non-emergency transport is appropriate when the Medicaid client's medical condition is such that the use of an ambulance is the only appropriate means of transport, e.g., alternate means of transport are medically contraindicated.

8.3.1.2 Emergency Transport Billing

When billing emergency transports electronically, a minimum of one diagnosis description or the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code must be entered on the claim form or in the diagnosis code field for electronic billers. A claim that has "see attached" as the only information in the diagnosis block is not processed for payment consideration.

Transports may be appealed as emergency claims only. Emergency transports that are denied cannot be accepted on appeal as nonemergency transports. Emergency transports billed as nonemergency services are denied.

Note: *Emergency and nonemergency claims may be billed electronically to the Texas Medicaid Program. For electronic billers, the hospital's provider identifier must be entered in the Facility ID field. Providers should consult their software vendor for the location of this field on the electronic claim form.*

All emergency claims submitted on paper are required to have the following documentation:

- Distance of transport traffic patterns.
- Time of transport.
- Acuity of client.

Place of Service Codes

National place of service (POS) codes 41 and 42 are accepted by the Texas Medicaid Program.

Condition Codes

Electronic billers should use as many condition codes as needed to fully describe the client's condition.

The following condition codes are accepted by the Texas Medicaid Program:

Condition Codes				
01	02	03	04	05
06	07	08	09	60

Condition code 60 is used to notify TMHP that the client was taken to the nearest facility.

Origin and Destination Codes

All claims submitted on paper or electronically must include the two-digit origin and destination codes. The origin is the first digit, and the destination is the second digit. The following are the origin and destination codes accepted by the Texas Medicaid Program:

Origin and Destination Codes					
D	E	G	H	I	J
N	P	R	S	X	

8.3.2 Nonemergency Ambulance Services

According to *Human Resource Code* (HRC) §32.024 (t), Medicaid enrolled physician, nursing facility, health-care provider, or other responsible party is required to obtain authorization before an ambulance is used to transport a client in circumstances not involving an emergency.

Refer to: "Medical Transportation" on page I-1 for more information about nonemergency transportation.

8.3.2.1 Nonemergency Ambulance Transport Prior Authorization

Facilities and other requesting providers must request and obtain prior authorization before contacting the ambulance provider for the transport of a Medicaid client whose medical condition is such that the use of an

ambulance is the only appropriate means of transport, e.g., alternate means of transport are medically contraindicated. In addition, the HRC states that a provider who is denied payment for non-emergency ambulance transport may be entitled to payment from the nursing facility, health-care provider, or other responsible party that requested the service if payment under the Medical Assistance Program is denied because of lack of prior authorization and the provider submits a copy of the bill for which payment was denied.

TMHP responds to nonemergency transport prior authorization requests within 48 hours of receipt of the request. It is recommended that all requests for a prior authorization number (PAN) be submitted in sufficient time to allow TMHP to issue the PAN before the date of the requested transport. If the client's medical condition is not appropriate for transport by ambulance, non-emergency ambulance services are not a benefit. Prior authorization is a condition for reimbursement but is not a guarantee of payment. The client and provider must meet all of the Medicaid requirements, such as client eligibility and claim filing deadlines.

These prior authorization requirements also apply to Medicaid providers who participate in PCCM. Medicaid providers who participate in one of the Medicaid Managed Care HMO plans must follow the requirements of their plan.

The TMHP Ambulance Unit reviews the prior authorization requests to determine whether the client's medical condition is appropriate for transport by ambulance. Incomplete information may cause the request to be denied.

The following information assists TMHP in determining the appropriateness of the transport:

- An explanation of the client's physical condition that establishes the medical necessity for transport. The explanation must clearly state the client's conditions requiring transport by ambulance.
- The necessary equipment, treatment, or personnel used during the transport.
- The origination and destination points of the client's transport.

8.3.2.2 Nonemergency Prior Authorization Process

Medicaid providers and TMHP use the following prior authorization process:

1) The client's physician, nursing facility, Intermediate Care Facility for the Mentally Retarded (ICF-MR), health-care provider, or other responsible party completes the online prior authorization request on the TMHP website at www.tmhp.com. Alternately, the provider may fax a copy of the "Ambulance Fax Cover Sheet" on page B-5 to the TMHP Ambulance Unit at 1-512-514-4205. A request may be submitted up to 60 days before the date on which the non-emergency transport will occur. Information and documentation listed on the form must be sent with the request before the transport to the medical appointment. Documentation requirements are outlined in this section under "Supporting Documentation" on page 8-5.
2) TMHP reviews all of the documentation it receives. An online prior authorization request submitted on the TMHP website at www.tmhp.com is responded to with an online approval or denial. Alternately, a letter of approval or denial is faxed to the requesting provider. The client is notified by mail if the authorization request is denied or downgraded. Reasons for denial include documentation that does not meet the criteria of a medical condition that is appropriate for transport by ambulance, or that the client is not eligible for the dates of services requested. Clients may appeal prior authorization request denials by contacting TMHP Client Notification at 1-800-414-3406.
3) The requesting provider contacts the transporting ambulance provider and supplies the ambulance provider with the PAN and the dates of service that were approved.
4) Hospitals may call TMHP at 1-800-540-0694, complete the online authorization request, or fax to 1-512-514-4205 to request a PAN when discharging a client or transporting the client to another facility.

Refer to: "Prior Authorization Requests Through the TMHP Website" on page 5-4 for additional information, including mandatory documentation requirements and retention.

Providers are not required to fax medical documentation to TMHP; however, in certain circumstances, TMHP may request the hospital fax the supporting documentation.

Incomplete online or faxed request forms are not considered a valid authorization request and are returned as a denial.

Ambulance provider claims submitted without a PAN are denied. A provider who is denied payment for nonemergency ambulance transport because of failure to obtain prior authorization or because a request for prior authorization was denied can appeal to TMHP. If the review shows that prior authorization was not obtained before transport, the denial of reimbursement will be upheld. If the review shows that prior authorization was obtained before transport or that the request for prior authorization was improperly denied based on the documentation of medical necessity submitted initially, the denial of reimbursement may be overturned.

8.3.2.3 Nonemergency Prior Authorization and Retroactive Eligibility

If a client's Medicaid eligibility is pending, a PAN must be requested before a nonemergency transport. This request will be initially denied for Medicaid eligibility. When Medicaid eligibility is established, the requestor has 95 days from the date that the eligibility was added to TMHP's files to contact the TMHP Ambulance Unit and request that authorization be reconsidered.

To inquire about Medicaid eligibility, providers can contact the Automated Inquiry System (AIS) at 1-800-925-9126.

8.3.2.4 Prior Authorization Types, Definitions

Short-Term

Short-term prior authorization requests are made for a client whose medical condition is such that use of an ambulance is the only appropriate means of transport. The authorization period for a short-term request is from 0 to 60 days. If the client already has a short-term or long term PAN, the PAN may be used for the ambulance transport.

Clients requiring a hospital-to-hospital and hospital-to-outpatient medical facility transports are issued a PAN for that transport only. The originating hospital is responsible for obtaining the prior authorization.

Long-Term

A 180-day prior authorization is issued to a client and is granted within 24 hours of the time received, excluding weekends and holidays, for the authorization of nonemergency ambulance services. The request will be effective for a period of 180 days from the date of issuance if the request includes a written statement from a physician. An online authorization request may be submitted on the TMHP website at www.tmhp.com. Alternatively, a provider may request this authorization by completing the "Physician's Medical Necessity Certification for Nonemergency Ambulance Transports (Texas Medicaid Program)" on page B-72 (certification form) in its entirety and fax the form to the TMHP Ambulance Unit at 1-512-514-4205. Incomplete forms are not considered a valid authorization request and are returned with a denial letter. The certification form is not considered documentation after the service is rendered and should not be sent with a claim or an appeal. Texas Medicaid no longer approves authorizations for a year.

8.3.2.5 Supporting Documentation

Providers must submit supporting documentation with all prior authorization requests. Examples include:

- Admit and discharge records with prognosis, including emergency room records.
- A history and physical completed within six months or a care plan detailing daily activities from a facility or home health agency.
- A letter on the health-care provider's letterhead including the client's primary mode of mobility and diagnosis history.

In hospital-to-hospital transports or hospital-to-outpatient medical facility transports, the TMHP Ambulance Unit considers information by telephone from the hospital. Beginning June 1, 2005, providers are no longer required to fax medical documentation to TMHP; however, in certain circumstances, TMHP may request the hospital fax the supporting documentation. Hospitals are allowed to release a client's protected health information (PHI) to a transporting emergency medical services provider for treatment, payment, and health-care operations.

8.3.3 Claim Denials and Appeals

Ambulance provider claims submitted for nonemergency transports without the PAN are denied and must be appealed on paper by the provider. The appeal must be accompanied by supporting documentation. Clients may appeal PAN request denials by contacting TMHP Client Notification at 1-800-414-3406.

All ambulance denials (air or ground) must be appealed on paper. Telephone and electronic appeals are not accepted.

For claims or appeals related to prior authorization denials for the 180-day authorization request, the certification form is not considered as documentation after the service is rendered.

On appeal, supporting documentation is critical for determining the client's condition. Ambulance providers who file paper claims must include all information that supports the reason for the transport and attach a copy of the run sheet to the claim. The emergency medical technician (EMT) who transported the client must sign the documentation.

Refer to: "Supporting Documentation" on page 8-5.

8.3.4 Ambulance Disposable Supplies

Reimbursement for disposable supplies is separate from the established global fee for ambulance transports. Providers should use one procedure code, 9-A0382, to combine all payable disposable supplies used (e.g., gauze, bandages, tape, suction catheter, gloves, and mask) during emergency and nonemergency ambulance transports. Reimbursement for this procedure code is limited to a maximum of $20.30 per transport (one-way) and $40.60 round trip. A maximum of two supply procedure codes are allowed per round trip. In situations involving multiple transports on the same date of service, the provider may appeal claims denied because they exceed two supply procedure codes per claim. When billing for nonpayable supplies, providers must bill the appropriate national code. Providers must provide medically necessary supplies for the client's safe transport.

8.3.5 Oxygen

Reimbursement for oxygen is the lesser of the provider's customary profile, the prevailing profile, or the provider's actual charge in accordance with 1 TAC §355.8600. A maximum of two oxygen procedure codes are allowed per round trip. In situations involving multiple transports on the same date of service, the provider may appeal claims that have denied for this two-code limit. Providers must bill the appropriate national code.

8.3.6 Waiting Time

Procedure code 9-A0420 may be billed when it is the general billing practice of local ambulance companies to charge for unusual waiting time (longer than 30 minutes). Providers must use the following procedures:

- Separate charges must be billed for all clients, Medicaid and non-Medicaid, for unusual waiting time.
- The circumstances requiring waiting time and the exact time involved must be documented in Block 24 of the CMS-1500 claim form.
- The amount charged for waiting time must not exceed the charge for a one-way transfer.

Important: *Waiting time is reimbursed up to one hour.*

8.3.7 Extra Attendant or Registered Nurse

Charges for an extra attendant or registered nurse (in addition to the two-person crew) for an ambulance transfer are reimbursed when the claim documents the medical necessity of advanced life-support services (e.g., procedure code 9-A0424). Without documentation of the medical need of the third attendant, the third attendant's services are not reimbursable. The Texas Medicaid Program does not reimburse based on each ambulance provider's internal policy.

8.3.8 Night Call

The Texas Medicaid Program does not reimburse an extra charge for a night call.

8.4 Subscriptions Plans

The *Texas Insurance Code* does not apply to ambulance providers who finance, in part or in whole, an ambulance service by subscription plan. DSHS's license requirements do not permit providers of membership or subscription programs to enroll Medicaid clients. Emergency Medical Services (EMS) Subscription Programs are regulated by the DSHS EMS Compliance Group. An EMS Provider must have specific approval to operate a subscription program. For more information, providers should contact the DSHS, Office of EMS/Trauma Systems Coordination at 1-512-834-6700. A list of EMS office and contact information can be found online at www.dshs.state.tx.us/emstraumasystems/about.shtm.

8.5 Types of Transport

8.5.1 Multiple Client Transports

Multiple client transports occur when more than one client with Medicaid coverage is transported in the same vehicle simultaneously. A claim for each client *must* be completed and must reference *multiple transfers* with the names and Medicaid numbers of other clients sharing the transfer in Block 19 of the CMS-1500 claim form. Providers must enter charges on a separate claim for each client. TMHP adjusts the payment to 80 percent of the allowable base rate for each claim and divides mileage equally among the clients who share the ambulance.

Important: *Mileage determinations are based on the Official State Mileage Guide.*

Refer to: "Claims Filing Instructions" on page 5-20.

8.5.2 Out-of-Locality Transports

Transports to out-of-locality providers are covered if a local facility is not adequately equipped to treat the condition. Transports may be cut back to the closest appropriate facility. O*ut-of-locality* refers to one-way transfers of *50 or more* miles from point of pickup to point of destination.

8.5.3 Air or Boat Transports

Air ambulance transport services, by means of either fixed or rotary wing aircraft, and boat transports may be covered only if one of the following conditions exists:

- The client's medical condition requires immediate and rapid ambulance transportation that could not have been provided by ground ambulance.
- The point of client pick-up is inaccessible by ground vehicle.
- Great distances or other obstacles are involved in transporting the client to the nearest appropriate facility.

Air transport claims may be submitted on paper with supporting documentation. Claims may be submitted electronically with a short description of the client's physical condition in the comment field. If the client's condition cannot be documented, providers must file a paper claim.

8.5.4 Transports for Pregnancies

Transporting a pregnant woman may be covered as an emergency transfer if the client's condition is documented as an emergency situation at the time of transfer.

Claims documenting a home delivery or delivery en route are considered emergency transfers. Premature labor and early onset of delivery (less than 37 weeks gestation) also may be considered an emergency. Active labor without more documentation of an emergency situation is not payable as an emergency transport.

First day of last menstrual period (LMP) or estimated date of delivery (EDD) must be in Block 14 of the claim form and on the documentation.

If the pregnant client is transported in an ambulance on a nonemergency basis, all criteria for nonemergency prior authorization must be met.

8.5.5 Transports to or From State Institutions

Ambulance transports to or from a state-funded hospital for admission or following discharge are covered when nonemergency transfer criteria are met. Ambulance transfers of clients while they are inpatients of the institution are not covered. The institution is responsible for routine nonemergency transportation.

8.5.6 Transports for Nursing Facility Residents

Transports from a nursing facility to a hospital are covered if the client's condition meets emergency criteria. Nonemergency transfers for the purpose of required diagnostic or treatment procedures not available in the nursing facility (such as dialysis treatments at a freestanding facility) are also allowable *only* for clients whose medical condition is such that the use of an ambulance is the only appropriate means of transport, e.g., alternate means of transport are medically contraindicated.

The nursing facility is responsible for providing routine nonemergency transportation for services not provided in the nursing facility. The cost of such transportation is included in the nursing facility vendor rate. This nonemergency transport requires the nursing facility to request and obtain a PAN from the TMHP Ambulance Unit before contacting the ambulance company for the transport.

Transports of nursing facility residents for rehabilitative treatment (for example, physical therapy) to outpatient departments or physicians' offices for recertification examinations for nursing facility care are *not* reimbursable ambulance services.

Claims for services to nursing facility residents must indicate the medical diagnosis or problem requiring treatment, the medical necessity for use of an ambulance for the transport, and the type of treatment rendered at the destination (for example, admission or X-ray).

If a client is returned by ambulance to a nursing facility following hospitalization, the acute condition requiring hospitalization must be noted on the ambulance claim form. This transport is considered for payment only if the client's medical condition is appropriate for transport by ambulance. This nonemergency transport requires the nursing facility to request and obtain a PAN from the TMHP Ambulance Unit before contacting the ambulance company for the transport.

Nursing facilities are responsible for providing or arranging transportation for their residents. Arranging transportation for Medicaid clients includes obtaining prior authorizations for nonemergency ambulance transports. Ambulance providers may assist nursing facilities in obtaining prior authorizations.

Ambulance providers may bill a nursing facility or client for a nonemergency ambulance transport only under the following circumstances:

- *Providers may bill the nursing facility* when the nursing facility requests the nonemergency ambulance transport without a PAN.
- *Providers may bill the client* only when the client requests transport that is not an emergency and the client does not have a medical condition such that the use of an ambulance is the only appropriate means of transport, e.g., alternate means of transport are medically contraindicated. The provider must advise the client of acceptance as a private pay patient at the time the service is provided, and the client is responsible for payment of all services. Providers are encouraged to have the client sign the *Private Pay Agreement.*

Providers may refer questions about a nursing facility's responsibility for payment of a transport to the TMHP Contact Center at 1-800-925-9126 or TMHP provider relations representatives.

8.5.7 No-Transport

The Texas Medicaid Program does not reimburse providers for services that do not result in a transport to a facility, regardless of any medical care rendered. If a client contacts an ambulance provider, but the call does not result in a transport, the provider should have the client sign an acknowledgment statement and bill the client for services rendered.

8.6 Medicare/Medicaid Coverage

Medicaid is the secondary payor to other health insurance sources including Medicare. Ambulance claims for Medicaid and Medicare Part B claims must be filed with Medicare first.

MQMBs are eligible for Medicaid benefits such as ambulance transports. Qualified Medicare Beneficiaries (QMBs) are not eligible for Medicaid benefits. The Texas Medicaid Program is only required to pay for coinsurance and/or deductibles for QMBs. Therefore, providers should not request prior authorization for ambulance services for these clients.

Important: *Providers must use national procedure codes when billing the Texas Medicaid Program.*

Refer to: "Medicare/Medicaid Clients" on page 4-13.

8.6.1 Medicare Paid

Assigned claims filed with and paid by Medicare should automatically transfer to TMHP for payment of the deductible and coinsurance liability.

Providers must submit Medicare-paid claims that do not cross over to TMHP for the coinsurance and deductible. Providers must send the Medicare Remittance Advice Notice (MRAN) with the client information circled in black ink.

8.6.2 Medicare Denied

All claims denied by Medicare for administrative reasons must be appealed to Medicare before they are sent to the Texas Medicaid Program.

An assigned claim that was denied by Medicare because the client has no Part B benefits or because the transport destination is not allowed can be submitted to TMHP for consideration.

Providers must send claims to TMHP on a CMS-1500 claim form with the ambulance provider identifier, unless they are a hospital-based provider. Hospital-based ambulance providers must send Medicare denied claims to TMHP on a CMS-1500 claim form with the ambulance provider identifier and a copy of the MRAN.

Note: *All claims for STAR+PLUS clients with Medicare and Medicaid should follow the same requirements used for obtaining prior authorization for Medicaid-only services from TMHP. The STAR+PLUS HMO is not responsible for reimbursement of these services.*

8.7 Relation of Service to Time of Death

Medicaid benefits cease at the time of the client's death. However, if the client dies in the ambulance while en route to the destination, the Texas Medicaid Program covers the transport. If a physician pronounces the client dead after the ambulance is called, the Texas Medicaid Program covers the ambulance service (base rate plus mileage) to the point of pickup. Providers must indicate the date and time the client died in Block nine of the CMS-1500 claim form. If a physician or coroner pronounces the client dead *before* the ambulance is called, the service is not covered.

Equipment and non-disposable supplies are included in the base rate. These items are not separately reimburseable, and are considered part of another procedure. Therefore, equipment and supplies cannot be billed to the client.

8.8 Ambulance Procedure Codes

Use the following procedure codes when billing for ambulance services provided to Medicaid-eligible clients:

Emergency Code	Limitations	Maximum Fee
9-A0382	Maximum allowable fee of $20.30 is per transport, not to exceed $40.60 round trip.	$20.30
9-A0420		*
9-A0422		*
9-A0424		*
9-A0425 with modifier ET	Use modifier ET to denote emergency services. A0425-ET is denied if it is billed without A0429.	$4.50
9-A0429		$250.00
9-A0430		$2,250.00
9-A0431		$3,000.00
9-A0435		$16.24
9-A0436		$16.24
9-A0999	Use for water ambulance services.	Manually Priced

***Reimbursed at reasonable charge, which is the lesser of the provider's customary profile, the prevailing profile, or the provider's actual charge in accordance with 1 TAC §355.8600.**

Nonemergency Code	Limitations	Maximum Fee
9-A0382	Maximum allowable fee of $20.30 is per transport, not to exceed $40.60 round trip.	$20.30
9-A0420		*
9-A0422		*
9-A0424		*
9-A0425	A0425 is denied if it is billed without A0428	$4.50
9-A0428		$200.00
9-A0430		$2,250.00
9-A0431		$3,000.00
9-A0435		$16.24
9-A0436		$16.24

***Reimbursed at reasonable charge, which is the lesser of the provider's customary profile, the prevailing profile, or the provider's actual charge in accordance with 1 TAC §355.8600.**

8.9 Claims Information

Nonemergency claims filed electronically must include the PAN in the appropriate field.

Reminder: *Providers must submit multiple transports for the same client on the same date of service through one claim submission. Additional claims information can be found within individual topics in this section.*

Providers must submit ambulance services to TMHP on a CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from a vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"CMS-1500 Claim Filing Instructions" on page 5-22. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

8.9.1 Modifiers on Ambulance Claims

Ambulance providers may see the HH modifier on their Remittance and Status (R&S) reports, which indicates the transfer is from a noncontracted to a contracted hospital. It does not affect claim payment or processing.

Modifier TG may be used to indicate advanced life support (ALS) services were provided when billing basic life support (BLS) procedure codes.

Modifier ET is used to denote emergency services.

8.9.2 Claim Filing Resources

Providers may refer to the following sections or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP EDI General Information	3-1
CMS-1500 Claim Filing Instructions	5-22
Communication Guide	A-1
Ambulance Claim Example 1	D-3
Ambulance Claim Example 2	D-3
Ambulance Claim Example 3	D-4
Acronym Dictionary	F-1

Section

9

Ambulatory Surgical Center (ASC)

9.1 Enrollment

To enroll in the Texas Medicaid Program, ASCs must do the following:

- Meet and comply with applicable state and federal laws, rules, regulations, and provisions of the state plan under Title XIX of the *Social Security Act*.
- Be enrolled in Medicare.
- Meet and comply with state licensure requirements for ASCs.
- If Medicare doesn't issue the hospital a Part B ambulance provider number, the hospital must submit a letter from Medicare denying issuance, and a Medicaid-only number will be issued.

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

Out-of-state ASCs that are Medicare-certified as an ASC in the state where they are located and provide services to a Texas Medicaid client may be entitled to participate in the Texas Medicaid Program.

All providers of laboratory services must comply with the rules and regulations of the *Clinical Laboratory Improvement Amendments* (CLIA). Only providers complying with CLIA may be reimbursed for laboratory services.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

"Hospital Ambulatory Surgical Center" on page 25-17 for more information about HASCs.

"Clinical Laboratory Improvement Amendments (CLIA)" on page 26-2.

9.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with Medicaid Managed Care to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual Medicaid Managed Care health plan for enrollment information.

Refer to: "Managed Care" on page 7-1 for more information.

9.2 Reimbursement

The Medicaid rates for ASCs are calculated in accordance with 1 TAC §355.8121. The current ASC/HASC fee schedule and ASC/HASC fee schedule insert are available on the TMHP website at www.tmhp.com/file library/file library/fee schedules. To request a hard copy of the fee schedule and insert, call the TMHP Contact Center at 1-800-925-9126.

When the procedure is not covered by a HCPCS code listed in the fee schedule, the provider should use revenue codes 960, 961, 962, 963, 964, and 969 or the appropriate HCPCS-defined unlisted procedure code from the fee schedule.

Physician and certified registered nurse anesthetist (CRNA) services performed in an ASC must be billed under the physician or CRNA provider identifier and are reimbursed separately.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

"Hospital Ambulatory Surgical Center" on page 25-17 for more information.

9.3 Benefits and Limitations

Refer to: "Family Planning Services" on page 20-1 for implantable contraceptive capsules reimbursement and code information.

"Benefits and Limitations" on page 25-26.

9.4 Claims Information

Freestanding ASC claims must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 paper claim form. Providers must purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply them. Information on the performing surgeon must be supplied in Block 17 of the CMS-1500 claim form for the claim to be processed. Hospital-based ASCs file a UB-04 CMS-1450.

ASCs that wish to bill for nurse anesthetists' services must enroll as a nurse anesthetist group provider and indicate the CRNA performing provider identifier on claims for those services.

Refer to: "Certified Registered Nurse Anesthetist (CRNA)" on page 15-1 for specific billing instructions for CRNA services.

9.5 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-22
UB-04 CMS-1450 Claim Filing Instructions	5-30
Communication Guide	A-1
Ambulatory Surgical Center Claim Example	D-4
Hospital-Based ASC Claim Example	D-17
Acronym Dictionary	F-1

Section

10

Birthing Center

10.1 Enrollment

A birthing center must be licensed as a birthing center by the Department of State Health Services (DSHS) and meet the minimum standards as required by *Health and Safety Code*, Chapter 244.010. To enroll in the Texas Medicaid Program, a birthing center must be licensed to provide a level of service commensurate with the professional services of a doctor of medicine (MD), doctor of osteopathy (DO), or certified nurse-midwife (CNM) who acts as birth attendant. The Texas Medicaid Program only reimburses birthing centers for services determined by the attending physician or CNM to be reasonable and necessary for the care of the mother or newborn child.

Providers cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

A birthing center is a place, facility, or institution where a woman is scheduled to give birth following a normal, uncomplicated (low-risk) pregnancy. This term does not include a hospital, ambulatory surgical center, or residence of the woman giving birth.

Birthing centers are *encouraged* to refer clients for THSteps services.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Texas Health Steps (THSteps)" on page 43-1.

"Provider Enrollment" on page 1-2.

"Medicaid Program Administration" on page vii.

Set up referral procedures for family planning services described in "Family Planning Services" on page 20-1.

DSHS website, www.dshs.state.tx.us/famplan/ for information about family planning and the locations of family planning clinics receiving Title V, X, or XX funding from DSHS.

10.1.1 Medicaid Managed Care Enrollment

Birthing centers may be eligible to enroll in the Medicaid Managed Care Program as primary care providers. Contact the individual Medicaid Managed Care health plan for enrollment information.

Refer to: "Managed Care" on page 7-1 for more information.

10.2 Reimbursement

The Medicaid rates for birthing centers are calculated in accordance with 1 TAC §355.8181.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

10.2.1 Laboratory Services

All providers of laboratory services must comply with the rules and regulations of the *Clinical Laboratory Improvement Amendments* (CLIA). Providers not complying with CLIA will not be reimbursed for laboratory services.

Refer to: "Clinical Laboratory Improvement Amendments (CLIA)" on page 26-2.

10.3 Benefits and Limitations

Birthing centers, using their nine-digit provider identifier, can only submit claims for their facility services (e.g., labor and delivery services). The maternity clinic, physician, CNM, nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA) performing services must submit separate claims for their services because the services they provide (e.g., prenatal, family planning) are not approved birthing center services.

The Texas Medicaid Program reimburses procedure codes 1-99431 and 1-99432 when performed in the birthing center and billed by a physician or CNM.

Procedure code 1-99433 is not payable when performed in the birthing center.

Childbirth education classes and the use of a documented midwife as the birth attendant are not benefits of the Texas Medicaid Program.

The following table lists the allowable procedure codes for birthing center services with the corresponding maximum fees:

Service	Procedure Code	Maximum Fee
Admission	P-99221	$69.60
Delivery	P-59409	$546.19
Admission and Labor	P-S4005 ***Note:*** *S4005 may not be billed in conjunction with 99221 and/or 59409*	$152.03

Health and Safety Code, Chapter 47, requires birthing centers located in a county with a population of more than 50,000 and that has 100 or more births per year to offer

all newborns a hearing screening as a part of the obstetrical care at delivery. For more information regarding newborn hearing screening contact:

DSHS
Program for Amplification for Children of Texas (PACT)
1100 West 49th Street
Austin, TX 78756
1-512-458-7724

Refer all newborns who have abnormal screening results to a local PACT provider for follow-up care. PACT provides services and hearing aids for children ages birth through 20 years of age who have permanent hearing loss and are Medicaid-eligible.

Traditional Medicaid providers are reimbursed for the diagnosis and treatment of abnormal hearing screen follow-up when a local PACT provider is not available. Providers must use procedure codes 5-92585, 5/I/T-92587, and 5/I/T-92588 when billing for follow-up diagnosis of abnormal hearing screens.

Refer to: "Certified Nurse-Midwife (CNM)" on page 14-1.

10.3.1 Newborn Eligibility Process

To provide a Medicaid number to a child born to a mother eligible for Medicaid, birthing centers must complete the "Birthing Center Report (Newborn Child or Children) Form 7484" on page B-10. Use the following guidelines when completing the Form 7484:

- Enter the newborn's name on the form (if known). The use of "Baby Boy" or "Baby Girl" delays the assignment of a Medicaid number.
- Do not complete the form for stillbirths.
- Submit the form to DSHS within five days of the child's birth. The five-day time frame is not mandatory; however, prompt submission expedites the process of determining the child's eligibility.
- Duplicate Birthing Center Report (Newborn Child or Children) Form 7484 as needed. DSHS and TMHP do not supply this form.

Upon receipt of a completed 7484 form, DSHS verifies the mother's eligibility, and within 10 days sends notification letters to the hospital or birthing center, attending physician (if identified), mother, and caseworker. The notice includes the child's Medicaid number and the effective date of coverage. After the child has been added to the eligibility file, DSHS issues a Medicaid Identification Form (Form H3087) to the client.

Note: *Primary Care Case Management (PCCM) clients have up to 105 days to select a primary care provider for their newborns. If clients do not make a selection within the specified time period, a primary care provider will be assigned.*

The attending physician's notification letter is sent to the address on file (by license number) at the Texas Medical Board. This address must be kept current to ensure timely notification. Physicians must submit address changes to the following address:

Texas Medical Board
Customer Information, MC-240
PO Box 2018
Austin, TX 78767-2018

Note: *When billing for a Medicaid Managed Care client, providers must follow the client's health plan guidelines for newborn billing.*

10.4 Claims Information

Birthing center services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 (EDI)" for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"CMS-1500 Claim Filing Instructions" on page 5-22 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

10.4.1 Claim Filing Resources

Refer to the following sections or forms when filing claims:

Resource	Page Number
Austomated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Instructions	5-20
TMHP Electronic Claims Submission	5-13
Communication Guide	A-1
Birthing Center Claim Example	D-1
Acronym Dictionary	F-1

Section

11

Blind Children's Vocational Discovery and Development Program

11.1 Enrollment

The Department of Assistive and Rehabilitative Services (DARS) Division for Blind Services (DBS), is the Medicaid provider of case management for children younger than 16 years of age who are blind and visually impaired.

Providers must meet educational and work experience requirements that are commensurate with their job responsibilities and must be trained in DBS case management activities.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

11.1.1 Medicaid Managed Care Enrollment

DARS DBS providers do not need to enroll with Medicaid Managed Care. All claims for service provided by DARS DBS are submitted to TMHP for all Medicaid clients, including Medicaid Managed Care clients.

11.2 Reimbursement

Case management services for the Blind Children's Vocational Discovery and Development Program (BCVDDP) are reimbursed according to a fixed rate as established by HHSC. DARS DBS providers should bill procedure code G9012.

Refer to: 1 TAC §355.8381 for more information on reimbursement and "Federal Financial Participation (FFP) Rate" on page 2-7 for federal matching percentage.

11.3 Benefits and Limitations

Procedure code G9012 is limited to one per month, per client, regardless of the number of contacts during the month.

Reminder: *A contact is defined as "an activity performed by a Blind Children's Specialist with the client or with another person or organization on behalf of the client to locate, coordinate, and monitor necessary services."*

Refer to: "Department of Assistive and Rehabilitative Services (DARS), Blind Services" on page A-17 of this manual for local addresses of DARS DBS.

Providers must *not* bill a claim when or after the client turns 16 years of age.

Any child with a suspected or diagnosed visual impairment may be referred to BCVDDP. DARS DBS assesses the impact the visual impairment has on the child's development and provides blindness-specific services to increase the child's skill level in the areas of independent living, communication, mobility, social, recreational, and vocational discovery and development. For more information, visit the DARS website at www.dars.state.tx.us.

11.4 Claims Information

BCVDDP Case management services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"CMS-1500 Claim Filing Instructions" on page 5-22." Blocks that are not referenced are not required for processing by TMHP and may be left blank.

11.4.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange	3-1
CMS-1500 Claim Filing Instructions	5-22
TMHP Electronic Claims Submission with the TMHP Website	5-13
Communication Guide	A-1
Blind Children's Vocational Discovery and Development Program (BCVDDP)Claim Form	D-6
Acronym Dictionary	F-1

Section

12

Case Management for Children and Pregnant Women (CPW)

12.1 Overview

Case management services are provided to assist eligible clients in gaining access to necessary medical, social, educational, and other services; encourage cost-effective health and health-related care; discourage over utilization or duplication of services; and make appropriate referrals to providers. Case managers provide the necessary coordination to providers of services when these services are needed by a client.

12.1.1 Eligibility

To be eligible for services, a person must:

- Be eligible for the Texas Medicaid Program.
- Be a pregnant woman with a high-risk condition, or a child (birth through 20 years of age) with a health condition or health risk.
- Be in need of services to prevent illnesses or medical conditions, to maintain function, or to slow further deterioration.
- Want to receive case management services.

Pregnant women with a high-risk condition are defined as women who are pregnant and have one or more high-risk medical and/or personal/psychosocial conditions during pregnancy. Children with a health condition are defined as children with a health condition/health risk or children who have, or are at risk for, a medical condition, illness, injury, or disability that results in limitation of function, activities, or social roles in comparison with healthy same-age peers in the general areas of physical, cognitive, emotional, or social growth and development.

12.1.2 Referral Process

To refer a Medicaid client for CPW services, call 1-877-847-8377 or consult the CPW provider list at www.dshs.state.tx.us/caseman/providerRegion.shtm. A referral for CPW services can be received from any source. A case management provider will contact the family to offer a choice of providers and to obtain information necessary to request prior authorization for case management services.

12.2 Enrollment

Enrollment for CPW providers is a two-step process.

Step 1: Potential providers must submit a Department of State Health Services (DSHS) Case Management for CPW provider application to the DSHS Health Screening and Case Management Unit.

Eligible case managers include registered nurses with a diploma, associate's, bachelor's, or advanced degree or social workers with a bachelor's or advanced degree who are currently licensed by their respective Texas licensure board and whose license is not temporary in nature. Eligible case managers must also have at least two years of cumulative, paid, full-time work experience or two years of supervised full-time, educational, internship/practicum experience in the past ten years. The experience must be with children who are up to 21 years of age and/or pregnant women. The experience must include assessing psychosocial and health needs and making community referrals for these populations.

For more information about provider qualifications and enrollment, contact DSHS at 1-512-458-7111, Ext. 2168, visit the case management website at www.dshs.state.tx.us/caseman/default.shtm, or write to the following address:

Case Management
Health Screening and Case Management Unit
1100 West 49th Street, MC-1938
Austin, TX 78756-3199

Note: *Before providing services, each case manager must attend DSHS case manager training. Training is conducted by DSHS regional staff.*

Step 2: Upon approval by DSHS, potential providers must enroll as a Medicaid provider for CPW and submit a copy of their DSHS approval letter. Facility providers must enroll as a CPW group, and each eligible case manager must enroll as a performing provider for the group. Federally qualified health center (FQHC) facilities that provide CPW services use their FQHC number and will not apply for an additional provider number for CPW.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information about procedures for enrolling as a Medicaid provider.

12.2.1 Medicaid Managed Care Enrollment

CPW providers are not required to enroll with Medicaid Managed Care. All claims for services provided by CPW providers are submitted to TMHP for all Medicaid clients, including Medicaid Managed Care clients. Medicaid Managed Care health plans are not responsible for reimbursing CPW case management program services.

12.3 Benefits and Limitations

CPW services are limited to one contact per day per client. Additional provider contacts on the same day are denied as part of another service rendered on the same day.

Providers must adhere to CPW case management program rules, policies, and procedures.

All services must be prior authorized. One comprehensive visit is approved for all eligible clients. Follow-up visits are authorized based on contributing factors. Additional visits can be requested and may be authorized based on a continuing need for services. A prior authorization number is required on all claims for CPW services.

Note: *Prior authorization is a condition of reimbursement, not a guarantee of payment.*

Approved case management providers may request prior authorization from DSHS by fax (1-512-458-7574) or on the website at www.dshs.state.tx.us/caseman/subpaweb.shtm.

Note: *CPW providers are not required to file claims with other health insurance before filing with Medicaid.*

Reminder: *Billable services are defined in program rule 25 TAC §27.5.*

CPW services are not billable when a client is an inpatient at a hospital or other treatment facility.

Reimbursement for services rendered by providers not approved by the DSHS Health Screening and Case Management Unit will be denied.

Providers must document all services in accordance with program rule, program policy, and Medicaid policy.

12.4 Reimbursement

CPW providers are reimbursed in accordance with Title 1 TAC §355.8401. The procedure code to be used for all CPW services is G9012. Modifiers are used to identify which service component is provided.

Service	Contact Code	Maximum Fee
Comprehensive visit	1-G9012 *with* modifier U5 *and* modifier U2	$124.15
Follow-up face-to-face	1-G9012 *with* modifier U5 *and* modifier TS	$62.08
Follow-up telephone	1-G9012 *with* modifier TS	$23.28

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

The 2.5 percent payment reduction was discontinued effective September 1, 2007.

12.5 Reporting Child Abuse or Neglect

All CPW providers are required to report suspected child abuse or neglect as outlined in "Reporting Child Abuse or Neglect" on page 1-5 and "Training" on page 1-6.

12.6 Technical Assistance

Providers may contact DSHS program staff as needed for assistance with program concerns. Providers should contact TMHP provider relations staff as needed for assistance with claims problems or concerns.

12.6.1 Assistance with Program Concerns

Providers who have questions, concerns, or problems with program rule, policy, or procedure contact DSHS program staff. Contact names and numbers can be obtained from the case management website at www.dshs.state.tx.us/caseman/default.shtm, or by calling 1-512-458-7111, Ext. 2168.

Regional staff make routine contact with providers to ensure providers are delivering services as required.

12.6.2 Assistance with Claims Concerns

Providers should review all Medicaid bulletins for any changes to claim filing requirements. Providers that have questions, concerns, or problems about claims should contact the TMHP provider relations representative in their region. Call the TMHP Contact Center at 1-800-925-9126 for more information about provider relations representatives.

12.7 Claims Information

CPW services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"CMS-1500 Claim Filing Instructions" on page 5-22.

Blocks that are not referenced are not required for processing by TMHP and may be left blank.

12.7.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-22
TMHP Electronic Claims Submission with the TMHP Website	5-13
Communication Guide	A-1
Case Management for Children and Pregnant Women (CPW) Claim Example	D-7
Acronym Dictionary	F-1

Section

13

Targeted Case Management for Early Childhood Intervention (ECI)

13.1 Enrollment

To be a qualified provider, the provider must contact the Texas ECI Program at 1-512-424-6754. ECI providers are eligible to enroll as Texas Medicaid targeted case management providers rendering service to children younger than 3 years of age with a disability and/or developmental delay as defined by ECI criteria. After meeting the case management criteria of the Texas ECI Program, providers must request a Medicaid application from TMHP Provider Enrollment.

To participate in the Texas Medicaid Program, an ECI provider must comply with all applicable federal, state, local laws, and regulations about the services provided. Additionally, facilities must be certified by the Texas ECI Program and must submit a copy of the current contract award with the Texas ECI Program.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

13.1.1 Medicaid Managed Care Enrollment

Texas Medicaid targeted case management providers do not need to enroll with Medicaid Managed Care. File all claims for ECI targeted case management services to TMHP, including those for Medicaid Managed Care clients. Medicaid Managed Care health plans are not responsible for reimbursing ECI targeted case management services.

13.2 Reimbursement

ECI targeted case management services are reimbursed according to a maximum allowable fee established by HHSC. The maximum allowable fee for procedure code 1-G9012 is $141.83 per month.

Refer to: "Reimbursement" on page 2-2 for more information on reimbursement.

Reimbursement for public providers is limited to the federal matching percentage of the maximum allowable fee and is subject to adjustment on October 1 of each year, or as otherwise directed by the Centers for Medicare & Medicaid Services (CMS). Reimbursement for private providers is up to the maximum allowable fee.

The Texas Medicaid Program reimburses covered ECI services when provided in natural environments. Natural environments are defined as settings that individual families identify as natural or normal for their family, including the home, neighborhood, and community settings in which children without disabilities participate. ECI targeted case management services may be provided in the following places of service (POS): office/facility (POS 1), home (POS 2), and other locations (POS 9). POS for ECI targeted case management is determined by the case manager's location at the time the service is rendered.

13.3 Benefits and Limitations

ECI providers are reimbursed for targeted case management services rendered to children younger than 3 years of age with a disability and/or developmental delay as defined by ECI criteria. Service coordination (targeted case management services) can be billed only one time per month per eligible child, regardless of the number of contacts during the month.

Targeted case management services must be stated in the child's Individualized Family Service Plan (IFSP).

ECI services end on the child's third birthday.

Reminder: *A contact is defined as an activity performed by the assigned case manager with the client or with another person or organization on behalf of the client to locate, coordinate, and facilitate access to necessary services.*

13.4 Overview of ECI Services

The Texas ECI Program is a statewide system of services available to families of children from birth to 3 years of age with disabilities or developmental delays. The state agency responsible for ECI services is the Department of Assistive and Rehabilitative Services (DARS). DARS contracts with local ECI programs to provide services in every Texas county.

ECI programs determine eligibility based on evaluations and assessments. Children are eligible if they meet one or more of the following criteria:

- A delay in one or more areas of development.
- Atypical development (children who perform within their appropriate age range on test instruments, but whose patterns of development are different from their peers).
- A medically diagnosed condition (children who have a medically diagnosed condition with a high probability of resulting in developmental delay).

Families and professionals work together to develop an IFSP for appropriate services based on the unique needs of the child and the child's family.

ECI service coordination is provided to all families. Other ECI services may include physical, occupational, speech, and language therapy; service coordination; vision services; auditory services; developmental services; nutrition services; family counseling and education; and assistive technology services and devices.

13.4.1 ECI Referral Requirement

All health-care professionals are required under federal and state regulations to refer children younger than 3 years of age to the Texas ECI Program within two business days of identification of a disability or suspected delay in development.

Referrals may be based on professional judgment or a family's concern. A medical diagnosis or a confirmed developmental delay is not required for referrals.

To refer families for services, call the local ECI program or the DARS Inquiries Line at 1-800-628-5115. Persons who are deaf or hard of hearing can call the TDD/TTY number at 1-866-581-9328. For brochures or more information, call the DARS Inquiries Line or visit the DARS website at www.dars.state.tx.us/ecis.

Refer to: "Early Childhood Intervention (ECI) (THSteps-CCP Only)" on page 43-58 for additional services.

13.5 Claims Information

Targeted case management services by an ECI provider must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

Instructions for completing paper claims are provided in "CMS-1500 Claim Filing Instructions" on page 5-22. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

13.5.1 Assistance with Claims Concerns

Providers should review all Medicaid bulletins for any changes to claim filing requirements. Providers that have questions, concerns, or problems with claims should contact the TMHP provider relations representative in their region. Call the TMHP Contact Center at 1-800-925-9126 for more information about provider relations representatives.

13.5.2 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-22
TMHP Electronic Claims Submission with the TMHP Website	5-13
Communication Guide	A-1
Targeted Case Management for Early Childhood Intervention (ECI) Claim Example	D-6
Acronym Dictionary	F-1

Section

14

Certified Nurse-Midwife (CNM)

14.1 Enrollment

To enroll in the Texas Medicaid Program, a CNM must be a licensed registered nurse recognized by the Texas Board of Nursing (BON) as an advanced practice nurse (APN) in nurse-midwifery and certified by the American College of Nurse-Midwives. A current copy of the provider's American College of Nurse-Midwives Certificate must be submitted with the Medicaid provider enrollment application. A CNM must also be enrolled as a Medicare provider.

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

Refer to: The Department of State Health Services (DSHS) website at www.dshs.state.tx.us /famplan for information about family planning and the locations of family planning clinics receiving Title V, X, or XX funding from DSHS.

CNMs must use their individual provider identifier to bill for services they provide to Medicaid clients.

All providers of laboratory services must comply with the rules and regulations of the *Clinical Laboratory Improvement Amendments* (CLIA). Providers not complying with CLIA are not reimbursed for laboratory services.

A CNM must identify the licensed physician or group of physicians with whom there is an arrangement for referral and consultation if medical complications arise. The collaborating physician does not have to be a participating provider in the Texas Medicaid Program. If the arrangement is changed or canceled, the CNM must notify TMHP Provider Enrollment in writing within two weeks after the change or cancellation.

CNMs are encouraged to participate in or make referrals to family planning agencies.

CNMs may enroll as providers of Texas Health Steps (THSteps) medical check ups for newborns younger than two months of age and adolescent females. Specific information may be found in the THSteps section of this manual.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

"Provider Enrollment" on page 43-5 for more information about enrollment in the THSteps Program.

"Clinical Laboratory Improvement Amendments (CLIA)" on page 26-2.

"Family Planning Services" on page 20-1.

14.1.1 Medicaid Managed Care Enrollment

CNMs are eligible to enroll in Medicaid Managed Care as primary care providers. Contact the individual Medicaid Managed Care health plan for enrollment information.

Refer to: "Managed Care" on page 7-1 for more information.

14.2 Reimbursement

According to 1 TAC §355.8161, the Medicaid rate for CNMs is 92 percent of the rate paid to a physician (doctor of medicine [MD] or doctor of osteopathy [DO]) for the same service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections. The current CNM fee schedule is available on the TMHP website at www.tmhp.com. To request a hard copy, call the TMHP Contact Center at 1-800-925-9126.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

14.3 Benefits and Limitations

CNMs may be reimbursed for primary care services including family planning, gynecology services, THSteps services, treatment of acute minor illnesses, chronic stable conditions provided to women throughout their lives, and to newborns for the first two months of life in addition to the maternity cycle care (antepartum, intrapartum, and postpartum).

CNM-performed services are covered by the Texas Medicaid Program if the services are within the scope of practice for CNMs as defined by state law, consistent with rules and regulations made by the Texas BON or other appropriate state licensing authority.

Laboratory (including pregnancy tests) and radiology services provided during pregnancy must be billed separately from antepartum care visits and received within 95 days from the date of service. Childbirth education classes are not a benefit of the Texas Medicaid Program.

14.3.1 Deliveries

Deliveries must be performed in a participating Medicaid Title XIX general or acute care hospital or special hospital or facility licensed and approved for the operation of maternity and newborn services or in the home setting. Home deliveries by a CNM are reimbursable when the CNM has received prior authorization from TMHP for a home delivery. The CNM must submit a written request for prior authorization during the client's third trimester of pregnancy. The CNM must include a statement signed by a licensed physician who has examined the client during the third trimester and determined at that time that she is not at high risk and is suitable for a home delivery. Requests for home delivery prior authorizations must be submitted to the TMHP Medical Director at the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

Claims submitted for home deliveries performed by a CNM without prior authorization are denied.

CNMs must bill procedure code 59410 with type of service (TOS) 2.

14.3.2 Newborn Exams

Newborn examinations billed with procedure codes 1-99431 and 1-99432 may be counted as a THSteps periodic medical check up when all necessary components are completed and documented in the medical record. Providers may submit a claim to TMHP using their acute care provider identifier. Providers do not have to be enrolled as THSteps providers to bill these newborn codes.

If a brief newborn examination is performed that does not fulfill periodic check up criteria, the provider may bill 1-99431 with modifier 52 (reduced services) or 1-99432 with modifier 52 using their acute care provider identifier. Providers do not have to be enrolled as THSteps providers to bill these procedure codes.

A THSteps newborn screening exam includes family and neonatal history:

- Physical exam, including length, weight, and head circumference.
- Vision and hearing screening.
- Health education.
- State-required newborn hereditary/metabolic laboratory testing.
- Hepatitis B immunization.

Refer to: Section 43.1.6.2, "Newborn Examination" on page 43-9.

Bill antepartum/postpartum services using the following procedure codes with modifier TH:

Procedure Code/Modifier	
1-99201-TH	1-99202-TH
1-99203-TH	1-99204-TH
1-99205-TH	1-99211-TH
1-99212-TH	1-99213-TH
1-99214-TH	1-99215-TH
1-99341-TH	1-99342-TH
1-99344-TH	1-99345-TH

Refer to: "Maternity Service Clinic (MSC)" on page 31-1 for more information about antepartum care, risk assessment, document requirements, postpartum care, and frequency of services.

"Family Planning Services" on page 20-1 for more information.

14.4 Claims Information

CNMs must bill maternity services in one of two ways: itemizing each service individually on one claim form and filing at the time of delivery (the filing deadline is applied to the date of delivery) or itemizing each service individually and submitting claims as the services are rendered (the filing deadline is applied to each individual date of service).

CNM services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "General Medicaid Eligibility" on page 4-3 for information about crossover payments.

"TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Information" on page 5-4" for general information about claims filing.

"CMS-1500 Claim Filing Instructions" on page 5-22.

Blocks that are not referenced are not required for processing by TMHP and may be left blank.

14.4.1 Claim Filing Resources

Refer to the following sections or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-22
TMHP Electronic Claims Submission with the TMHP Website	5-13
Communication Guide	A-1
Certified Nurse-Midwife (CNM) Claim Example	D-7
Acronym Dictionary	F-1

Section

15

Certified Registered Nurse Anesthetist (CRNA)

15.1 Enrollment

To enroll in the Texas Medicaid Program, a CRNA must be a registered nurse (RN) approved as an advanced practice nurse (APN) by the state where the CRNA practices and is currently certified by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists. Medicare enrollment is a prerequisite for enrollment as a Medicaid provider. A current copy of the provider's Council on Certification of Nurse Anesthetists or Recertification of Nurse Anesthetists Certificate must be submitted with the Medicaid provider enrollment application.

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

15.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with Medicaid Managed Care to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

Refer to: "Managed Care" on page 7-1 for more information.

15.2 Reimbursement

A CRNA is reimbursed the lesser of either the CRNA's billed charges or 92 percent of the reimbursement for the same sevice paid a physician (doctor of medicine [MD] or doctor of osteopathy [DO]) anesthesiologist in accordance with 1 TAC §355.8221.

The current CRNA fee schedule is available on the TMHP website at www.tmhp.com/file library/file library /fee schedules. To request a copy, call the TMHP Contact Center at 1-800-925-9126.

The formula to calculate anesthesia reimbursement can be found in the cover letter section of the CRNA Fee Schedule. The formula includes base units, time units, and a conversion factor.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

15.2.1 Base Units

Base units are the relative value units (RVUs) assigned by the Texas Medicaid Program to each anesthesia service billed. The Texas Medicaid Program uses the uniform relative value guide generated by the Texas Medicare Program.

Refer to: Base units assigned to each Current Procedural Terminology (CPT) anesthesia code can be found in the *Texas Medicaid Fee Schedule* posted on the TMHP website.

For correct processing, providers must bill anesthesia services (type of service [TOS] 7) as the first line item. Any other service billed on the same day must be billed as a subsequent line item.

15.2.2 Time Units

Time Units are based on the time in 15-minute increments indicated on the claim by the provider.

Refer to: "Anesthesia for Labor and Delivery" on page 36-25.

For time-based anesthesiology procedure codes, anesthesia time is the time during which an anesthesia practitioner is present with the client. Anesthesia time begins when the anesthesia practitioner begins to prepare the client for the induction of anesthesia in the operating room or the equivalent area and ends when the anesthesia practitioner is no longer in personal attendance. That is, when the client may be safely placed under postoperative supervision. For time-based anesthesiology procedure codes, anesthesia practitioners must document interruptions in anesthesia time in the client's medical record.

Procedure codes 7-01960 and 7-01967 are reimbursed a flat fee, and not by RVU calculation. The time reported should represent the total minutes between the start and stop times for this procedure, regardless of whether the time was actually spent with the client.

For obstetric procedures and diagnoses, use obstetric anesthesia codes.

15.3 Benefits and Limitations

Medically necessary services performed by a CRNA are benefits if the services are within the scope of the CRNA's practice as defined by state law; are prescribed, supervised by, and provided under the direction of a supervising

physician (MD or DO), dentist, or podiatrist licensed in the state in which they practice; or are provided under one of the following conditions:

- No physician anesthesiologist is on the medical staff of the facility where the services are provided (e.g., rural settings).
- No physician anesthesiologist is available to provide the services, as determined by the policies of the facility in which the services are provided.
- The physician performing the procedure requiring the services specifically requests the services of a CRNA.
- The eligible client requiring the services specifically requests the services of a CRNA.
- The CRNA is scheduled or assigned to provide the services according to policies of the facility in which the services are provided.
- The services are provided by the CRNA in connection with a medical emergency.

The Texas Medicaid Program does not reimburse the CRNA for equipment, drugs, or supplies—they are the responsibility of the facility where the CRNA services are provided. If the equipment, drugs, and supplies are covered and reimbursable by the Texas Medicaid Program, payment is considered for the Medicaid-enrolled facility. The basis and amount of reimbursement depends on the reimbursement methodology used by the Texas Medicaid Program for the services and providers involved.

15.3.1 Claims Management Modifiers

CRNAs bill using CPT anesthesia procedure codes and either the QX or QZ modifier.

CRNA Modifier	Description	Time divided by	RVU reduction
QX	CRNA medically directed by the anesthesiologist [RVU + (Minutes / 15)] x Conversion Factor = Allowed amount	15 min	0 %
QZ	CRNA not medically directed by the anesthesiologist; surgeon directing [RVU + (Minutes / 15)] x Conversion Factor = Allowed Amount	15 min	0 %

Refer to: "Anesthesia" on page 36-24 for more information on the reimbursement of anesthesia services.

15.3.2 Epidural, Blood Patch

Procedure code 2-62273 is payable to provider types 04 (independent CRNA) and 05 (independent CRNA group) when medically necessary.

15.4 Claims Information

All CRNA services *must* be billed with a CRNA individual provider identifier or a CRNA group provider identifier. *No* payment for CRNA services will be made under a hospital or physician provider identifier.

CRNA services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"CMS-1500 Claim Filing Instructions" on page 5-22. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

15.4.1 Interpreting the R&S Report

The Billed Qty field on the Remittance and Status (R&S) report reflects only the number of units TMHP processed for time. The RVUs assigned for the procedure code are not shown in the Billed Qty field.

15.4.2 Claim Filing Resources

Refer to the following sections or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-22
TMHP Electronic Claims Submission with the TMHP Website	5-13
Communication Guide	A-1
Certified Registered Nurse Anesthetist (CRNA) Claim Example	D-8
Acronym Dictionary	F-1

Section

16

Certified Respiratory Care Practitioner (CRCP) Services

16.1 Enrollment

To enroll in the Texas Medicaid program, a CRCP must be certified by the Department of State Health Services (DSHS) to practice under *Texas Occupation Code*, Chapter 604. For CRCPs, Medicare certification is not a prerequisite for Medicaid enrollment.

A provider cannot be enrolled if his license is due to expire within 30 days; a current license must be submitted.

CRCPs must enroll as individual providers and comply with all applicable federal, state, and local laws and regulations.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

16.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with Medicaid Managed Care to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual Medicaid Managed Care health plan for enrollment information.

Refer to: "Managed Care" on page 7-1 for more information.

16.2 Reimbursement

Respiratory therapy services provided by a participating CRCP are reimbursed the lesser of the provider's billed charges or the rate calculated in accordance with 1 TAC §355.8089.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

16.3 Benefits and Limitations

TMHP must prior authorize all in-home respiratory therapy services.

Respiratory therapy services provided by a Medicaid provider enrolled as a CRCP may be reimbursed when services are reasonable, medically necessary, and prescribed by the client's physician. These services are for all age groups and do not require the client to be homebound.

Medicaid coverage of CRCP services is available to clients who meet the following criteria:

- Are ventilator-dependent for life support at least six hours per day.
- Are ventilator-dependent for at least 30 consecutive days as an inpatient in one or more hospitals, skilled nursing facilities (SNF), or intermediate care facilities (ICF).
- Require respiratory care as an inpatient in a hospital, SNF, or ICF and would be eligible to have payment made for such inpatient care.
- Have adequate social support services available for care at home.
- Prefer care at home.

16.3.1 Procedure Codes

Procedure code 1-99503 is allowable for CRCP services.

Procedure Code	Client Age	Reimbursement Rate
1-99503	Birth to 20 years of age	$66.68
1-99503	21 to 999 years of age	$71.68

The recommended frequency for procedure code 1-99503 is as follows: one visit daily for the initial seven days of home ventilation therapy; one visit every fourth day through the initial 30 days of home ventilation therapy; and one visit every four weeks thereafter.

Procedure code 1-99503 includes, but is not limited to, the following:

- Respiratory therapy services and treatments prescribed by the client's physician.
- Education of the client and/or appropriate family members/support people about the in-home respiratory care (must include the use and maintenance of required supplies, equipment, and techniques appropriate to the situation).

Procedure code 1-99503 may be reimbursed once per day, up to 24 visits per year.

16.3.2 Prior Authorization

The CRCP must request and receive prior authorization from TMHP for in-home respiratory therapy services. Prior authorization requests must include the dated physician's order, all pertinent medical records, and other information to justify the medical necessity/dependency of ventilator support and/or requested therapy services. Authorization may be given for up to 12 months and may be extended

based on an interim report from the physician that documents the medical necessity and appropriateness of continued in-home respiratory therapy services.

All supporting documentation must be included with the request for authorization. Providers should send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-A Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

16.4 Claims Information

CRCP services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"CMS-1500 Claim Filing Instructions" on page 5-22. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Electronic billers must submit the prior authorization number (PAN) on the electronic claim form. Providers should consult the software vendor for the location of this field in the software.

16.4.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-22
TMHP Electronic Claims Submission with the TMHP website	5-13
Communication Guide	A-1
Certified Respiratory Care Practitioner (CRCP) Claim Example	D-8
Acronym Dictionary	F-1

Section

17

Chemical Dependency Treatment Facility (CDTF)

17.1 Enrollment

Only CDTFs licensed by the Department of State Health Services (DSHS) are eligible to enroll and participate in the Texas Medicaid Program. Each facility must submit a copy of its DSHS license with the enrollment packet. Facilities maintained or operated by the Federal government or directly operated by the State of Texas are exempt from the licensing requirement.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

17.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll in Medicaid Managed Care to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

NorthSTAR is a managed care program in the Dallas service area that covers behavioral health services. A CDTF that provides behavioral health services to clients in NorthSTAR must be a network provider of the NorthSTAR behavioral health organization.

Refer to: "Managed Care" on page 7-1.

17.2 Reimbursement

CDTFs are reimbursed the lesser of the billed amount or the established maximum allowable fee.

The Texas Medicaid Program covers outpatient counseling services for chemically dependent children and adolescents. The Texas Medicaid Program provides reimbursement for the following outpatient counseling services with modifier HF for the substance abuse program:

Procedure Code	Maximum Fee
9-H0004	$11.75
9-H0005	$16.00

Reimbursable procedure codes that are available to the CDTF/DSHS provider type include 9-H0004 with modifier HF and 9-H0005 with modifier HF. Procedure code 9-H0004 is billed in 15-minute intervals. Procedure code 9-H0005 is billed in 1-hour increments.

Refer to: "Reimbursement" on page 2-2 for more information.

17.3 Benefits and Limitations

17.3.1 Outpatient Counseling

CDTF services must be determined by a qualified credentialed counselor (QCC), (as defined by DSHS licensure Standards) to be reasonable and necessary for a person who is chemically dependent. *Chemical dependency* is defined as "meeting at least three of the diagnostic criteria for psychoactive substance dependence" in the latest edition of the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR), Fourth Edition, Text Revision. Sufficient documentation must be maintained in the client record to support the diagnosis and justify the placement decision into the program.

The Texas Medicaid Program covers outpatient counseling services for chemically dependent children and adolescents who are 13 through 17 years of age.

Children who are 10 through 12 years of age and young adults who are 18 through 20 years of age may receive chemical dependency outpatient counseling services only when the screening process indicates that the individual's needs, experiences, and behavior are similar to those of adolescent clients. Every age exception must be clinically justified, documented, and approved in writing by a QCC. Supporting documentation, including written approval by the QCC, must be maintained by the facility in the client record.

Outpatient group counseling is limited to 135 hours per client, per calendar year (January 1 through December 31). Outpatient individual counseling is limited to 26 hours per client, per calendar year. Outpatient group and individual counseling is only payable in the outpatient setting, and place of service (POS) code 5 should be indicated on the paper claim.

CDTF outpatient counseling services do not include chemical dependency education, life skills training, assessments or prevention services. Clients in a residential CDTF are not eligible for CDTF outpatient services.

Modifier HF is required on all procedures billed by CDTF/DSHS.

17.4 Claims Information

CRNA services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"CMS-1500 Claim Filing Instructions" on page 5-22. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

17.4.1 Claim Filing Resources

Electronic billers must bill POS code 22 in the appropriate field and must submit their own nine-character provider identifier in the facility ID field. Providers should consult with their software vendor for the location of this field in the software.

Refer to the following sections and/or forms when filing claims:

Resource	Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
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Communication Guide	A-1
Chemical Dependency Treatment Facility Claim Example	D-9
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Section

18

Chiropractic Services

18.1 Enrollment

To enroll in the Texas Medicaid Program, a doctor of chiropractic medicine (DC) must be licensed by the Texas Board of Chiropractic Examiners and enrolled as a Medicare provider.

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

18.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with Medicaid Managed Care to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

Refer to: "Managed Care" on page 7-1 for more information.

18.2 Reimbursement

The Medicaid rates for chiropractic services are calculated in accordance with 1 TAC §355.8085.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

18.3 Benefits and Limitations

Medicaid reimburses the treatment of a spinal subluxation by manual manipulation of the spine. The exact level of subluxation must be indicated by the appropriate *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) diagnosis code listed in the following table or narrative. Chiropractors are not required to certify that an X-ray is available to demonstrate the existence of a subluxation. However, chiropractors may use an X-ray for this purpose.

The following guidelines apply when documenting a subluxation by X-ray:

- An acute condition is documented by an X-ray taken no more than three months before the date treatment is initiated.
- A chronic condition is documented by an X-ray taken no more than 12 months before the initiation of treatment.
- An older X-ray may be used if the subluxation has existed for more than 12 months and is considered a chronic and permanent condition.

The following diagnosis codes are accepted in lieu of written documentation to indicate treatment and level of subluxation:

Diagnosis Codes				
7390	7391	7392	7393	7394
7395	7398	83900	83901	83902
83903	83904	83905	83906	83907
83908	83920	83921	83949	

Medicaid does not reimburse chiropractors for X-ray services, office visits, injections, supplies, appliances, spinalator treatments, laboratory services, physical therapy, or other adjunctive services furnished by the chiropractors themselves or by others under their orders or directions.

Coverage includes up to 12 treatments per benefit period. For chiropractic services, the Texas Medicaid Program defines a *benefit period* as "12 consecutive months, beginning with the date the client receives the first Medicaid-covered chiropractic treatment." Benefits cannot exceed one treatment per day.

Coverage is limited to the following procedure codes:

Procedure Code	Place of Service	Maximum Fee
1-98940	1, 2	$21.48
1-98941	1, 2	$27.21
1-98942	1, 2	$35.23

The AT modifier is *required* when billing for acute and chronic conditions to identify acute chiropractic manipulative treatment (CMT) services.

Qualified Medicare Beneficiary (QMB) and Medicaid Qualified Medicare Beneficiary (MQMB) clients are excluded from chiropractic limitations. When chiropractic services are submitted for these clients, the service is denied with instructions to bill Medicare first.

18.4 Claims Information

Chiropractic services must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply them.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information

is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"CMS-1500 Claim Filing Instructions" on page 5-22. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

18.4.1 Claim Filing Resources

Providers may refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-22
TMHP Electronic Claims Submission	5-13
Communication Guide	A-1
Chiropractic Services Claim Example	D-9
Acronym Dictionary	F-1

Section

19

Dental

19.1 General Information

Medicaid dental services rules are described under Title 25 *Texas Administrative Code* (TAC) Part 1, Chapter 33. The online version of TAC is available at the Secretary of State's website at www.sos.state.tx.us/tac/index.shtml.

19.2 Provider Enrollment

To become a provider of THSteps and/or ICF-MR dental services, a dentist must:

- Currently be licensed with an active status by the Texas State Board of Dental Examiners (TSBDE) or currently be licensed in the state where the service was performed.
- Practice within the scope of his professional licensure.
- Complete the Dental Provider Enrollment Application and return it to TMHP.

Providers can call the TMHP Contact Center at 1-800-925-9126 to request application forms, or download and print them from the TMHP website at www.tmhp.com. Out-of-state providers should refer to "Medicaid Service Provided Outside Texas" on page 2-6.

A dental provider cannot be enrolled if his or her dental license is due to expire within 30 days; a current license must be submitted. Dental licensure for owners of a dental practice is a requirement of the *Occupations Code*, *Vernon's Texas Codes Annotated* (VTCA), Subtitle D, Chapters 251-267 (the *Dental Practice Act*).

A dentist must complete the Dental Provider Enrollment Application for each separate practice location and will receive a unique provider identifier for each practice location if the application is approved.

The application form includes a written agreement with HHSC.

Dental licensure for owners of a dental practice is a requirement of the Dental Practice Act. All owners of a dental practice must maintain an active license status with the TSBDE to receive reimbursement from the Texas Medicaid Program. Any change in ownership or licensure status for any enrolled dentist must be immediately reported in writing to TMHP Provider Enrollment and will affect reimbursement by the Texas Medicaid Program.

Dental providers may enroll in the THSteps Dental and Intermediate Care Facility for the Mentally Retarded (ICF-MR) Dental Programs or as a Doctor of Dentistry Practicing as a Limited Physician, or both. The enrollment requirements are different with respect to the category of enrollment.

Dentists must specify a category of practice by choosing one of the specialties listed in "Categories of Practice" on page 19-3 of this manual.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Maintenance of Provider Information" on page 1-6

"Provider Enrollment" on page 1-2.

19.2.1 Categories of Practice

All dental providers must declare one of the following categories:

- General practice.
- Pediatric dentist.
- Periodontist.
- Endodontist.
- Oral and maxillofacial surgeon.
- Orthodontist.
- Other (prosthodontist, public health, and others).

19.2.2 THSteps Dental and ICF-MR

Providers may enroll as an individual dentist or as a group practice.

The individual dentist must designate that primary services will be provided within a specific category of practice.

Regardless of the category of practice type designation under THSteps Dental, providers can only bill for THSteps/ICF-MR services.

Refer to: "Categories of Practice" on page 19-3.

"Texas Health Steps (THSteps) Dental Services" on page 19-4 for more information on the types of dental services that are reimbursable or to "Benefits and Limitations" on page 19-36 for more specific information.

19.2.3 THSteps Dental Check Up/Treatment Facilities

All THSteps dental check up/treatment policies apply to examinations and treatment completed in a dentist's office, a health department, clinic setting, or in a mobile/satellite unit. Enrollment of a mobile/satellite unit must be under a dentist or clinic name. Mobile units can be a van or any temporary site away from the primary office and are considered extensions of that office and are not separate entities. The physical setting must be appropriate so that all elements of the check up/treatment can

be completed. The check up must meet the requirements detailed in “Parental Accompaniment” on page K-2. The provider with a mobile unit must obtain a permit from the TSBDE for the unit.

19.2.4 Reporting Child Abuse or Neglect

All THSteps providers are required to report suspected child abuse or neglect as outlined in “Reporting Child Abuse or Neglect” on page 1-5 through “Training” on page 1-6.

19.2.5 Doctor of Dentistry Practicing as a Limited Physician

Providers may enroll as an individual dentist or as a dental group. To enroll as a Doctor of Dentistry Practicing as a Limited Physician, a dentist must:

- Currently be actively licensed by the TSBDE or currently be licensed in the state where the service was performed at that time.
- Have a Medicare provider identification number before applying for and receiving a Medicaid provider identifer.
- Enroll as a Medicaid provider with a limited physician provider identifier.

19.2.6 Medicaid Managed Care Enrollment

THSteps, ICF-MR, and emergency dental service providers do not need to enroll in Medicaid Managed Care.

All claims for services provided by a dentist for THSteps and ICF-MR clients are submitted to TMHP.

If the client is enrolled in Medicaid Managed Care, the dentist must request precertification or approval from the client’s managed care organization (MCO) for anesthesia, facility use, and charges if the dental services are to be provided in an ambulatory surgical center (ASC)/HASC, or as an inpatient or outpatient at a hospital. The dentist must use the MCO's contracted facility and anesthesia provider. These services are included in the capitation rates paid to MCOs, and the facility/anesthesiologist risks nonpayment from the MCO without such prior approval. Coordination of all specialty care is the responsibility of the client's primary care provider. The primary care provider must be notified by the dentist and/or the MCO of the planned services.

19.3 Texas Health Steps (THSteps) Dental Services

THSteps is the Texas version of the Medicaid program known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

THSteps dental services are mandated by Medicaid to provide for the early detection and treatment of dental health problems for Medicaid-eligible clients birth through 20 years of age. THSteps dental service standards are designed to meet federal regulations and incorporate the recommendations of representatives of dental professional organizations at the state and national level.

The *Omnibus Budget Reconciliation Act* (OBRA) of 1989 mandated the expansion of the federal EPSDT program to include any service that is medically necessary and for which federal financial participation (FFP) is available, regardless of the limitations of the Texas Medicaid Program. This expansion is referred to as the Comprehensive Care Program (CCP). Dental services that are a benefit through CCP are designated in the Limitations column of the Medicaid Dental Fee Schedule beginning on page 19-10 with the notation “CCP.”

Note: *According to federal Medicaid guidelines, dental services that are not a benefit under the THSteps Dental Program that are medically necessary, and for which FFP is available, may be considered for THSteps-eligible clients through CCP.*

Refer to: “THSteps Medical and Dental Administrative Information" on page 43-5 for more information.

THSteps’ designated staff (Texas Department of State Health Services [DSHS], Department of Assistive and Disability Services [DADS], or contractor), through outreach and informing, encourage eligible children to use THSteps dental check ups and services when children first become eligible for Medicaid, and each time children are periodically due for their next dental check up.

Children within Medicaid have free choice of Medicaid-enrolled providers and are given names of enrolled providers. Call 1-877-847-8377 for a list of THSteps dental providers in a specific area.

Upon request, DSHS (or its contractor) will assist eligible children with the scheduling of and free transportation to their dental appointment. For transportation arrangements, clients can call the Medical Transportation Program at 1-877-633-8747.

19.3.1 Parental Accompaniment

Children younger than 15 years of age must be accompanied by the child's parent, legal guardian, or other adult authorized by the parent or guardian to THSteps dental appointments unless the services are provided by an exempt entity as required in the Human Resources Code. For additional information and exceptions, see “Parental Accompaniment” on page K-2

19.3.2 THSteps Dental Eligibility

The client must be Medicaid- and THSteps-eligible (birth through 20 years of age) at the time of the service request and service delivery. However, Medicaid approved orthodontic services already in progress may be continued even after the client loses Medicaid eligibility if the orthodontic treatment is begun before the loss of Medicaid eligibility and before the day of the client’s 21st birthday and is completed within 36 months. The client is not eligible for THSteps dental preventive or therapeutic

benefits if the client's Medicaid Identification Form (Form H3087) or Medicaid Eligibility Verification Form (Forms H1027 and H1027-A-C) states any of the following:

- Emergency care only.
- Presumptive eligibility (PE).
- Qualified Medicare beneficiary (QMB).

A check mark will be present in the "Dental" column of the client's Medicaid Identification Form (Form H3087) to indicate that the client is eligible for dental services. A message (THSteps Dental check up due) may appear below the client's name on the monthly client Medicaid Identification Form (Form H3087) stating the client is due for a dental check up, which serves as a reminder to parents to contact their child's dentist and schedule an appointment for their periodic dental check up. This message is printed on the H3087 when the client has not received any dental services (diagnostic, preventive, therapeutic, or orthodontic) for a period of six months.

Clients are not eligible for CCP services on or after their 21st birthday, but are eligible for non-CCP THSteps dental services (see fee schedule for CCP and non-CCP reimbursed services) through the end of the month of their 21st birthday.

Note: *If a client has a birthday on any day except the first day during the month, the new eligibility period is considered to begin on the first day of the following month.*

19.4 ICF-MR Dental Services

ICF-MR dental services are mandated by Medicaid, and reimbursement is provided for treatment of dental problems for Medicaid-eligible residents of ICF-MR facilities who are 21 years of age or older. Residents of ICF-MR facilities who are younger than 21 years of age receive services through the regular THSteps Program. Eligibility for ICF-MR services is determined by DADS.

Procedure codes without a CCP designation in the Limitations column of the dental fee schedule may be billed in a routine manner for ICF-MR clients.

These procedures must be documented as medically necessary and appropriate. ICF-MR clients are not subject to periodicity for preventive care.

For procedure codes with a CCP designation, a provider may request authorization with documentation or provide documentation on the submitted claim.

Refer to: "Medicaid Dental Fee Schedule" on page 19-10.

19.5 THSteps and ICF-MR Provision of Services

All THSteps and ICF-MR dental services shall be performed by the Medicaid-enrolled dental provider except for permissible work delegated to a licensed dental hygienist, dental assistant, or dental technician in a dental laboratory on the premises where the dentist practices, or in a commercial laboratory registered with the Texas State Board of Dental Examiners (TSBDE). The *Texas Dental Practice Act* and the rules and regulations of the TSBDE (22 TAC, Part 5) define the scope of work that dental auxiliary personnel may perform. Any deviations from these practice limitations shall be reported to the TSBDE and HHSC, and could result in sanctions or other actions imposed against the provider.

19.6 Emergency and/or Trauma Related Services for THSteps Clients Younger Than 12 Months of Age

THSteps clients younger than 12 months of age are not eligible for routine dental examinations; however, they may be referred to a dentist by their primary care provider when a medical check up identifies the medical necessity for dental services. Children younger than 12 months of age also can be seen for emergency dental services by the dentist at any time for trauma, early childhood caries, or other oral health problems.

Prior authorization is not required for emergency or trauma-related dental services. Claims for these dental services must be filed separately from nonemergency dental services. Only one emergency or trauma-related dental claim per client, per day may be submitted. Routine therapeutic procedures are not considered emergency or trauma-related procedures.

When billing for emergency or trauma-related dental services, the provider must:

- Enter the word "Emergency" or "Trauma" in the description field (Block 30) of the claim form (also enter a brief description of the Current Dental Terminology [CDT] procedure code used).
- If checking the Other Accident box, briefly describe in the Remarks field, Block 35 of the claim form, what caused the emergency or trauma.
- Check the appropriate box in Block 45, Treatment Resulting From, of the claim form (the options to check are Occupational Illness/Injury, Auto Accident, or Other Accident).

Documentation to support the diagnosis and treatment of trauma must be retained in the client's record.

Note: *Indicating Trauma in the description field allows the provider to be reimbursed for treatment on an emergency, continuing, and long-term basis without regard to periodicity, subject to the client's eligibility and program limitations. An exception to periodicity for THSteps dental services is granted automatically for immediate treatment and any future follow-up treatment, as long as each claim submitted for payment is marked "Trauma" in the*

Description field, Block 30, and the original date of treatment or incident is referenced in the Remarks field, Block 35.

Refer to: "2006 ADA Dental Claim Filing Instructions" on page 5-43.

"Medicaid Identification (Form H3087)" on page 4-15

"Emergency and/or Trauma Related Services for THSteps Clients Younger Than 12 Months of Age" on page 19-5 and "Doctor of Dentistry Practicing as a Limited Physician" on page 36-136

"Medicaid Dental Fee Schedule" on page 19-10.

19.7 Periodicity for THSteps Dental Services

A client is eligible for routine periodic oral evaluations and preventive dental services beginning at 12 months of age and at six-month (181-day) intervals thereafter based on the date of the last dental check up service. The Texas Medicaid Program has adopted the American Academy of Pediatric Dentistry's (AAPD) "Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Children" to serve as a guide and reference for dentists when scheduling and providing services to THSteps clients. These guidelines can be found in Appendix N, pages N-2 through N-4.

In November 2004, the American Dental Association (ADA) in conjunction with the U.S. Food and Drug Administration established "Guidelines for Prescribing Dental Radiographs." The guidelines include type of encounter relevant to the client's age and dental developmental stage. The Texas Medicaid Program has adopted the ADA "Guidelines" to serve as a guide and reference for dentists who treat THSteps clients. These guidelines can be found in Appendix N, pages N-5 through N-8.

The THSteps dental provider may provide any other medically necessary dental service such as emergency, therapeutic, and orthodontic services that is within the Texas Medicaid Program's guidelines and limitations specified for each area as long as the client's Medicaid eligibility is current for the month that dental services are being provided.

19.7.1 Exceptions to Periodicity

If a periodic dental check up has been conducted within the last six months, the client still may be able to receive another periodic dental check up in the same six-month period. For THSteps clients, exceptions to the six-month periodicity schedule for dental check up services may be approved for one of the following reasons:

- Medically necessary service, based on risk factors and health needs (includes clients younger than 12 months of age).
- Required to meet federal/state exam requirements for Head Start, daycare, foster care, or preadoption.
- Clients' choice to request a second opinion or change service providers (not applicable to referrals).
- Subsequent therapeutic services necessary to complete a case for clients younger than 12 months of age when initiated as emergency services, for trauma, or early childhood caries.

The provider should determine if the client is Medicaid-eligible for the month that dental services are to be provided. If the client's Medicaid Identification Form (Form H3087) indicates that the client is eligible for dental services, the client is requesting a periodic dental check up, and the provider's records indicate that they have provided a periodic check up within the current six-month (181-day) interval, the provider may not provide a second periodic check up unless the provider can document medical necessity for the second periodic check up. However, the provider may still provide other dental services that are a benefit as needed.

When the need for an exception to periodicity is established, a narrative explaining the reason for the exception to periodicity limitations must be included on the claim to TMHP, whether electronic or paper. The exception must be indicated in the appropriate block whether filing electronically (check "yes" when prompted) or paper claims (place comments in Block 35.). Documentation must be in the client's file.

For ICF-MR clients 21 years of age and older, the periodicity schedule for preventive dental procedures (exams, prophylaxis, fluoride, and radiographs) does not apply.

Refer to: "Preventive Services" on page 19-13 for periodicity limitations for prophylaxis.

19.8 Dental Referrals

Routine Dental Referrals

Beginning at the age of 12 months, THSteps primary care providers should include in their anticipatory guidance, information on initiation of routine dental services with the recommendation to the client's parent that an appointment be scheduled with a dental provider in order to establish a dental home. If a THSteps dental check up reveals a dental health condition that requires follow-up diagnosis or treatment, the provider performing the dental check up should assist the client in planning follow-up care within their practice or in making a referral to another qualified dental provider.

If the client is enrolled in a Medicaid Managed Care health maintenance organization (HMO) for their medical care, the dental care will be provided by fee-for-service THSteps dental providers. However, other providers, such as the facility and anesthesiology care, must be HMO network providers, and facility and anesthesiology services must be pre-approved by the HMO.

Note: *Clients up to 21 years of age also may self-refer for dental services.*

19.9 Change of Provider

A provider may refer a client to another dental provider for treatment for any of the following reasons:

- Treatment by a dental specialist such as a pediatric dentist, periodontist, oral surgeon, endodontist, or orthodontist is indicated and is in the best interests of the THSteps client.
- The services needed are outside the skills or scope of practice of the initial provider.

A provider may discontinue treatment if there is documented failure to keep appointments by the client, noncompliance with the treatment plan, or conflicts with the client or other family members.

In any such action to discontinue treatment, providers must comply with 22 TAC §108.5, "Patient Abandonment."

The client also may select another provider, if desired.

HHSC may refer the client to another provider as a result of adverse information obtained during a utilization review or resolution of a complaint from either provider or client.

19.9.1 Interrupted or Incomplete Treatment Plans

Authorizations for orthodontic or extensive restorative treatment plans that have been prior authorized for a provider are not transferable to another provider. If a client's treatment plan is interrupted and the services are not completed, the new provider must request prior authorization to complete the interrupted, incomplete, and prior authorized treatment plan initiated by the original provider.

To complete the treatment plan, the client must be eligible for Medicaid with a current client Medicaid Identification Form (Form H3087) or Medicaid Eligibility Verification Form (Form H1027).

If the client does not return for the completion of services and there is documented failure to keep appointments by the client, the dental provider who initiated the services may submit a claim for reimbursement. The claim must be received by TMHP within the 95-day filing deadline from the last date of service.

Refer to: "Transfer of Orthodontic Services" on page 19-38 for more information.

19.10 Client Rights

Dental providers enrolled in the Texas Medicaid Program enter into a written contract with the HHSC to uphold the following rights of the Medicaid client:

- To receive dental services that meet or exceed the standards of care established by the laws relating to the practice of dentistry and the rules and regulations of the TSBDE.
- To receive information following a dental examination regarding the dental diagnosis; scope of proposed treatment, including alternatives and risks; anticipated results; and the need for administration of sedation or anesthesia, including risks.
- To have full participation in the development of the treatment plan and the process of giving informed consent.
- To have freedom from physical, mental, emotional, sexual, or verbal abuse or harm from the provider or staff.
- To have freedom from overly aggressive treatment in excess of that required to address documented medical necessity.

A provider's failure to ensure any of the client rights may result in termination of the provider agreement or contract and other civil or criminal remedies.

19.11 Written Informed Consent and Standards of Care

Only THSteps clients or their parents or legal guardians can give written informed consent for dental services. THSteps clients or their parents or legal guardians who can give written informed consent must receive information following a dental examination about the dental diagnosis, scope of proposed treatment, including alternatives and risks, anticipated results, and need for administration of sedation or anesthesia, including risks. Additionally, they must receive a full explanation of the treatment plan and give written informed consent before treatment is initiated. The parent or guardian being present at the time of the dental visit facilitates the provider obtaining written informed consent. Dentists must comply with TSBDE Rule 22 TAC §108.2, "Fair Dealing."

All standards of care must be adhered to per TSBDE Rules.

THSteps clients must receive:

- Dental services specified in the treatment plan that meet the standards of care established by the laws relating to the practice of dentistry and the rules and regulations of the TSBDE.
- Dental services free from abuse or harm from the provider or the provider's staff.
- Only the treatment required to address documented medical necessity that meets professionally recognized standards of health care as recognized by the TSBDE.

19.12 Mandatory Prior Authorization

Mandatory prior authorization is required for consideration of reimbursement to dental providers who render:

- Orthodontia.
- Implants.
- Fixed prosthetic services.

- Dental general anesthesia.
- A combination of inlays/onlays or permanent crowns in excess of four per client.
- Procedure code D4276.
- Procedure code D7272.
- Procedure code D7472.
- Limited dental services for clients 21 years of age and older (not residing in an ICF-MR facility) whose dental diagnosis is secondary to and causally related to a life-threatening medical condition

Refer to: "Doctor of Dentistry Practicing as a Limited Physician" on page 36-136.

The prior authorization number is required on claims for processing. If the client is not eligible on the date of service or the claim is incomplete, it will affect reimbursement. Prior authorization is a condition for reimbursement; it is not a guarantee of payment.

Post-treatment authorization will not be approved for codes that require mandatory prior authorization.

19.13 Documentation Requirements

The provider should be certain that all staff members, including dentists, are aware of the following documentation requirements and charting procedures:

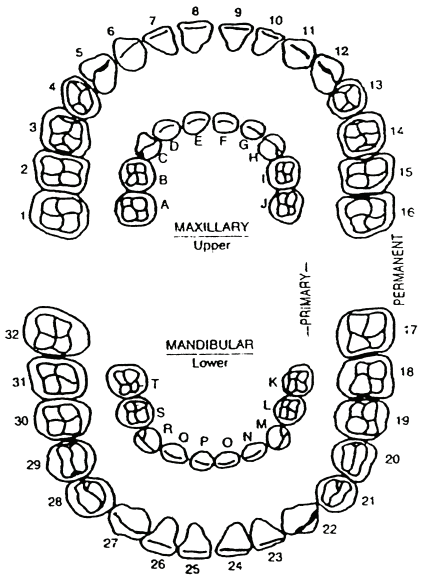
- For THSteps and ICF-MR dental claims, providers are not required to submit preoperative and postoperative radiographs unless these are specifically requested by HHSC, the TMHP Dental Director, or are needed for prior authorization and/or pre-payment review.
- Documentation of all restorative, operative, crown and bridge, and fixed and removable prosthodontics procedures must include medical necessity consistent with professionally recognized standards of health care as recognized by TSBDE. Documentation should include appropriate pretreatment, precementation and postcementation radiographs, study models and working casts, lab prescriptions, and invoices. A panoramic radiograph without additional bitewing radiographs is considered inadequate as a diagnostic tool for caries detection.
- All documentation must be maintained in the client's record for a period of five years to support the medical necessity at the time of any post-payment utilization review. All documentation, including radiographs, must be of diagnostic and appropriate quality.

In any situation where radiographs are required but cannot be obtained, then intraoral photographs must be in the chart.

- Any complications, unusual circumstances encountered, morbidity, and mortality must be entered as a complete narrative in the client's record.
- A provider must maintain a minimum standard of care through appropriate and adequate records, including a current history, limited physical examination, diagnosis, treatment plan, and written informed consent as a reasonable and prudent dentist would maintain. These records as well as the actual treatment must be in compliance with all state statutes, the *Dental Practice Act*, and the TSBDE Rules.
- Documentation for endodontic therapy must include the following: the medical necessity, pretreatment, during treatment and post-treatment periapical radiographs, the final size of the file to which the canal was enlarged, and the type of filling material used. Any reason that the root canal may appear radiographically unacceptable must be entered in the chart. Endodontic therapy must be in compliance with the American Association of Endodontists quality assurance guidelines.
- Documentation for most periodontal services requires a six-point per tooth depth of pocket charting, a complete mouth series of periapical and bitewing radiographs, and any other narratives or supporting documentation consistent with the nationally accepted standards of care of the specialty of periodontics, and which conform to the minimum standard of care for periodontal treatment required of Texas dentists. A panoramic radiograph without additional bitewing or periapical radiographs is considered inadequate for diagnosis of periodontal problems.
- Documentation for surgical procedures requiring a definitive diagnosis for billing a specific ADA code necessitates that a pathology report and a written record of clinical observations be present in the chart, together with any appropriate radiographs, operative reports, and appropriate supporting documentation. All impactions, surgical extractions, and residual tooth root extractions require appropriate preoperative periapical and/or panoramic radiographs (subject to limitations) be present in the chart.
- Any documentation requirements or limitations not mentioned in this manual that are present in the CDT are applicable. The written documentation requirements or limitations in this manual supercede those in the CDT.

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

Claims are denied if the procedure code is not compatible with TID and/or SID. Use the alpha characters to describe tooth surfaces or any combination of surfaces. For SID designation on anterior teeth, use facial (F) and incisal (I). For SID purposes, use buccal (B) and occlusal (O) designations for posterior teeth.



SID	SID	SID	SID
Buccal	DB	DFI	DLIF
Distal	DF	DFL	DOLB
Facial	DI	DFM	MIDF
Incisal	DL	DIL	MIDL
Lingual	DO	DLB	MIDLF
Mesial	IL	DLM	MIFL
Occlusal	MB	DOB	MLBD
	MI	DOL	MLDF
	ML	ILF	MODB
	MO	MBD	MODL
	OB	MID	MODLB
	OL	MIF	MOLB
		MLB	
		MLF	
		MLI	
		MOB	
		MOD	
		MOL	
		OBL	

19.14.1 Supernumerary Tooth Identification

Each identified permanent tooth and each identified primary tooth has its own identifiable supernumerary number. This developed system can be found in the CDT published by the ADA.

The TID for each identified supernumerary tooth will be used for paper and electronic claims and can only be billed with the following procedure codes:

- For primary teeth only: D7111.
- For both primary and permanent teeth the following codes are billable: D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7285, D7286, and D7510.

Permanent Teeth Upper Arch																
Tooth #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Super #	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66

Permanent Teeth Lower Arch																
Tooth #	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
Super #	82	81	80	79	78	77	76	75	74	73	72	71	70	69	68	67

Primary Teeth Upper Arch										
Tooth #	A	B	C	D	E	F	G	H	I	J
Super #	AS	BS	CS	DS	ES	FS	GS	HS	IS	JS

Primary Teeth Lower Arch										
Tooth #	T	S	R	Q	P	O	N	M	L	K
Super #	TS	SS	RS	QS	PS	OS	NS	MS	LS	KS

19.15 Benefits and Limitations

All dental providers must comply with the rules and regulations of the TSBDE, including standards for documentation and record maintenance as stated in the TSBDE Rules 22 TAC §108.7, *Minimum Standard of Care, General*, and §108.8, *Records of the Dentist*.

19.15.1 Medicaid Dental Fee Schedule

For THSteps clients, dental procedure limitations may be waived when *all* the following have been met. The dental procedure is:

- Medically necessary and for which FFP is available.
- Prior authorized by the TMHP Dental Director.
- Properly documented in the client's record (refer to "Documentation Requirements" on page 19-8).

For ICF-MR clients, services designated as CCP-type are available.

In the *Limitations* column of the fee schedule, abbreviations indicate the age range limitations and documentation requirements.

The following abbreviations also appear in a table at the bottom of each page of the fee schedule:

Acronym	Description
A	Age range limitations
CCP	Payable under CCP for clients younger than 21 years of age when THSteps benefits or limits are exceeded
FMX	Intraoral radiographs—complete series
FQHC	Federally qualified health center
MTID	Missing tooth ID(s)
N	Narrative of medical necessity of procedure is required to be retained in the client's record
NC	No charge to Medicaid and may not bill the client
PATH	Pathology report to accompany claims and required to be retained in the client's record
PC	Periodontal charting is required to be retained in the client's record
PHO	Preoperative and postoperative photographs required
PPXR	Preoperative and postoperative radiographs are required and are to be retained in the client's record; do not send with initial claims
PXR	Preoperative radiographs are required and are to be retained in the client's record; do not send with initial claims

19.15.2 Diagnostic Services

Procedure Code	Limitations	Maximum Fee
	Clinical Oral Evaluations	
All evaluations are subject to a six-month (181-day) periodicity, per provider.		
D0120*	A Birth-20	$29.44
D0140*	When used for emergency claims, refer to Section 19.6. Denied when billed on the same date of service as D0160 or D0170 by the same provider. A Birth-20, N	$19.16

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

Procedure Code	Limitations	Maximum Fee
D0145	Not considered medically necessary.	NC
D0150*	May be billed *once* in client's lifetime per provider. A 1-20	$36.04
D0160*	Not payable for routine postoperative follow-up. Denied when billed on the same date of service as procedure code D0140 or D0170 for the same provider. A 1-20, N, CCP	$15.25
D0170*	Denied when billed on the same date of service as procedure code D0140 or D0160 for the same provider. A 1-20	$16.88
D0180*	Limited to once per lifetime per provider; may not be paid on the same day as procedure codes D0120, D0140, D0150, D0160, or D0170. A 13-20	$8.02
	Radiographs/Diagnostic Imaging (Including Interpretation)	
D0210	Number of films required is dependent on age of client. A minimum of eight films is required to be considered a full-mouth series. Adults and children over 12 years of age require 12-20 films, as is appropriate. The Panorex (D0330) with four bitewing radiographs (D0274) may be considered equivalent to the complete or full-mouth series (D0210), and the billed amount for either combination is equivalent to the maximum fee of $72.08. A full-mouth series of radiographs is allowable once every three years by the same dentist. Not allowed as an emergency service. A 2-20	$72.08
D0220	A 1-20	$12.82
D0230	The total cost of periapicals and/or other radiographs cannot exceed the payment for a complete intraoral series. A 1-20	$11.74
D0240	May be billed once per arch and is limited to once per day by the same provider. Periapical films taken at an occlusal angle should be billed as periapical radiograph, code D0230. May be billed as an emergency service. A 7-20	$10.00
D0250	A 1-20, N, CCP	$18.75
D0260	A 1-20, N, CCP	$12.50
D0270	A 1-20	$5.00
D0272	A 1-20	$23.86
D0273	Not considered medically necessary.	NC
D0274	A 2-20	$35.32
D0277	Not to be billed within 36 months of D0210 or D0330. A 2-20	$31.75
D0290	A 1-20, N, CCP	$33.75
D0310	A 1-20, N, CCP	$45.00
D0320	A 1-20, N, CCP	$75.00
D0321	A 1-20, N, CCP	$35.00
D0322	A 1-20, N, CCP	$33.75

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

Procedure Code	Limitations	Maximum Fee
D0330*	Limited to one panoramic film during 3-9 years of age and one film during 10-20 years of age, by the same dentist or a group. Not allowed on emergency claims unless third molars or a traumatic condition is involved. Supplemental bitewings are payable in addition to a panoramic with reimbursement not to exceed the total reimbursement for a full mouth radiograph ($72.08 each). Under 3 years of age, must document the necessity of a panoramic film. The Panorex (D0330) with four bitewing radiographs (D0274) may be considered equivalent to the complete or full-mouth series (D0210), and the billed amount for either combination is equivalent to the maximum fee of $72.08. A 3-20	$65.08
D0340*	Not reimbursable separately when a comprehensive orthodontic or crossbite therapy work-up performed. A 1-20, N, CCP	$33.75
D0350*	For all images taken. Not reimbursable separately when a comprehensive orthodontic or crossbite therapy work-up performed. A 1-20	$18.75
Note: *Radiograph codes do not include the exam. If an exam is also performed, providers must bill the appropriate ADA procedure code.*		
Tests and Examinations		
D0415	A 1-20, N, CCP	$25.00
D0425	Not reimbursable separately. Considered part of another dental procedure.	NC
D0460	Not reimbursable separately when any endodontic procedure code performed. A 1-20, N, CCP	$12.50
D0470*	Not reimbursable separately when crown, fixed prosth-odontics, diagnostic work-up, or crossbite therapy work-up performed. A 1-20, N, CCP	$22.50
Oral Pathology Laboratory		
D0472	By pathology laboratories only. (refer to CPT codes)	NC
D0473	By pathology laboratories only. (refer to CPT codes)	NC
D0474	By pathology laboratories only. (refer to CPT codes)	NC
D0480	By pathology laboratories only. (refer to CPT codes)	NC
D0502	A 1-20, N, CCP	$57.50
D0999	A 1-20, N, CCP	Manually priced

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19.15.3 Preventive Services

Procedure codes D1110, D1120, D1203, D1204, D1206, D1351, D1510, D1515, D1520, and D1525 are denied when billed on the same date of service as any D4000-series periodontal procedure code.

Procedure Code	Limitations	Maximum Fee
	Dental Prophylaxis	
If performing fluoride treatments, procedure codes D1203 and D1204 must be submitted on the same date of service as the cleaning (D1110 and D1120).		
D1110*	Limited to one prophylaxis per client per six-month period (includes oral health instructions). If billed on emergency claim, procedure code will be denied. A 13-20	$56.00
D1120*	Limited to one prophylaxis per client per six-month period (includes oral health instructions). If billed on emergency claim, procedure code will be denied. A 1-12	$37.50
	Topical Fluoride Treatment (Office Procedure)	
D1203*	Includes oral health instructions. A 1-12, N, CCP	$15.00
D1204*	Includes oral health instructions. A 13-20, N, CCP	$15.00
D1206*	Includes oral health instructions. A 1-20, N, CCP	$15.00
	Other Preventive Services	
D1320	A client requiring tobacco counseling may be referred to a THSteps primary care provider.	NC
D1330	Requires documentation of the type of instructions, number of appointments, and content of instructions. This procedure is payable *only* for medically necessary situations that are *non-routine.* This procedure refers to services above and beyond routine brushing and flossing instruction and requires that additional time and expertise have been directed toward the client's care. Oral hygiene instruction is denied when billed on the same day as dental prophylaxis (D1110, D1120) and/or topical fluoride treatments (D1203, D1204, and D1206) by the same provider. Procedure code D1330 is limited to once per client, per year by *any* provider. A 1-20, N, CCP	$12.50
D1351*	Sealants may be applied to the occlusal, buccal, and lingual pits and fissures of any tooth that is at risk for dental decay and is free of proximal caries and free of restorations on the surface to be sealed. Sealants are a benefit when applied to deciduous (baby or primary) teeth or permanent teeth. Replacement sealants will not be reimbursed. Indicate the tooth numbers and surfaces on the claim form. Reimbursement will be considered on a per-tooth basis, regardless of the number of surfaces sealed. A 1-20	$28.82

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Procedure Code	Limitations	Maximum Fee
	Space Maintenance (Passive Appliances)	
	When a client needs a space maintainer and exceeds the listed age limitation, the service can be a benefit under CCP. The provider must justify medical necessity with radiograph(s) and/or a narrative on the prior authorization request and receive prior authorization for consideration of payment of the service. Limitation for space maintainers is to hold the space for the loss of one of the *first or second primary molars* (#A, #B, #I, #J, #K, #L, #S, and #T) or the loss of a *permanent first molar* (#3, #14, #19, and #30). There is no payment for replacement if it was previously paid for by Medicaid/THSteps. Fees for space maintainers include maintenance and repair. One space maintainer is reimbursed per TID, per client, per lifetime. When procedure code D1510 or D1515 have been previously reimbursed, the recementation of space maintainers may be considered for reimbursement to either the same or different THSteps dental provider when billed with procedure code D1550.	
D1510*	A 1-20 (#A, #B, #I, #J, #K, #L, #S, #T), MTID A 3-20 (#3, #14, #19, #30), MTID	$160.00
D1515*	A 1-20 (#A, #B, #I, #J, #K, #L, #S, #T), MTID A 3-20 (#3, #14, #19, #30), MTID	$237.50
D1520*	A 1-20 (#A, #B, #I, #J, #K, #L, #S, #T), MTID A 3-20 (#3, #14, #19, #30), MTID	$75.00
D1525*	A 1-20 (#A, #B, #I, #J, #K, #L, #S, #T), MTID A 3-20 (#3, #14, #19, #30), MTID	$106.25
D1550	A 3-12 (#A, #B, #I, #J, #K, #L, #S, #T), MTID A 3-20 (#3, #14, #19, #30), MTID	$18.75
D1555*	Replacement space maintainers may be considered upon appeal with documentation supporting medical necessity.	

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19.15.4 Therapeutic Services

19.15.4.1 Medicaid Reimbursement Limitations

Medicaid reimbursement is contingent on compliance with the following limitations:

- For documentation requirements, refer to “Documentation Requirements” on page 19-8.
- Total restorative fee per tooth on primary teeth cannot exceed $156.06, the fee for a stainless steel crown. (Exception: D2335)
- All fees for tooth restorations include local anesthesia and indirect pulp protective media, including bases where indicated, without additional charges. These services are considered part of the restoration.
- More than one restoration on a single surface is considered a single restoration.
- To be considered as a multiple surface restoration, the restoration must show definite crossing of the plane of each surface listed for each primary and permanent tooth completed.
- A multiple surface restoration cannot be billed as two or more separate one-surface restorations.
- Restorations and therapeutic care are provided as a Medicaid service based on medical necessity and reimbursed only for therapeutic reasons and not preventive purposes (refer to CDT).

All dental restorations and prosthetic appliances that require lab fabrication may be submitted for reimbursement using the date the final impression was made as the date of service. If the client does not return for final seating of the restoration or appliance, a narrative must be included on the claim form and in the client’s chart in lieu of a postoperative radiograph. The 95-day filing deadline is in effect from the date of the final impression. If the client returns to the office after the claim has been filed,

the dentist is obligated to attempt to seat the restoration or appliance at no cost to the client or the Texas Medicaid Program. For records retention requirements, refer to "Documentation Requirements" on page 19-8.

Direct pulp caps may be reimbursed separately from any final tooth restoration performed on the same tooth (as noted by the TID) on the same date of service by the same provider.

19.15.5 Restorative Services

Procedure Code	Limitations	Maximum Fee
	Amalgam Restorations (Including Polishing)	
D2140*	Reimburse primary TIDs A-T at $61.98; reimburse permanent TIDs 1-5, 12-21, and 28-32 at $65.72. A 1-20, PXR	$65.72
D2150*	Reimburse primary TIDs A-T at $82.90; reimburse permanent TIDs 1-5, 12-21, and 28-32 at $87.46. A 1-20, PXR	$87.46
D2160*	Reimburse primary TIDs A-T at $90.01; reimburse permanent TIDs 1-5, 12-21, and 28-32 at $111.42. A 1-20, PXR	$111.42
D2161*	Reimburse primary TIDs A-T at $52.69; reimburse permanent TIDs 1-5, 12-21, and 28-32 at $60.04. A 1-20, PXR	$60.04
	Resin-Based Composite Restorations—Direct All fees for resin restorations on primary teeth are limited to $170.38, which is the fee for a stainless steel crown (exception: D2335). All fees for resin restorations on permanent teeth are limited to a total of $110.20 for posterior teeth and $170.38 for anterior teeth. Resin restoration includes composites or glass ionomer.	
D2330*	TID C-H, M-R, #6-11, #22-27. A 1-20, PXR	$79.34
D2331*	TID C-H, M-R, #6-11, #22-27. A 1-20, PXR	$105.14
D2332*	TID C-H, M-R, #6-11, #22-27. A 1-20, PXR	$137.28
D2335*	TID C-H, M-R, #6-11, #22-27. A 1-20, PXR	$170.38
D2390*	Reimburse primary anterior TIDs C-H, M-R at $76.98; reimburse permanent anterior TIDs 6-11, 22-27 at $150.00. A 1-20, PXR	$150.00
D2391*	Reimburse primary posterior TIDs A, B, I, J, K, L, S, T at $76.98; reimburse permanent posterior TIDs 1-5, 12-21, 28-32 at $84.08. A 1-20, PXR	$84.08
D2392*	Reimburse primary posterior TIDs A, B, I, J, K, L, S, T at $98.98; reimburse permanent posterior TIDs 1-5, 12-21, 28-32 at $110.20. A 1-20, PXR	$110.20
D2393*	Reimburse primary posterior TIDs A, B, I, J, K, L, S, T at $87.11; reimburse permanent posterior TIDs 1-5, 12-21, 28-32 at $101.18. A 1-20, PXR	$101.18
D2394*	Reimburse primary posterior TIDs A, B, I, J, K, L, S, T at $64.62; reimburse permanent posterior TIDs 1-5, 12-21, 28-32 at $75.06. A 1-20, PXR	$75.06
	Gold Foil Restorations (Permanent Teeth only)	
D2410	A 13-20, N, PPXR, CCP	$75.00
D2420	A 13-20, N, PPXR, CCP	$125.00
D2430	A 13-20, N, PPXR, CCP	$125.00

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

Procedure Code	Limitations	Maximum Fee
	Inlay/Onlay Restorations (Permanent Teeth only)	
	For procedure codes D2510 through D2664 inlay/onlay (permanent teeth only), porcelain is allowed on all teeth. Prior authorization is required for any combination of inlays/onlays or permanent crowns that exceed the limit of four inlays/onlays or permanent crowns.	
D2510	A 13-20, N, PPXR, CCP	$181.25
D2520	A 13-20, N, PPXR, CCP	$264.00
D2530	A 13-20, N, PPXR, CCP	$264.00
D2542	Same as D2520. A 13-20, N, PPXR, CCP	$264.00
D2543	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2544	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2610	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2620	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2630	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2642	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2643	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2644	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2650	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2651	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2652	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2662	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2663	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2664	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
	Crowns—Single Restorations Only	
	For procedure codes D2710 through D2794, single crown restorations (permanent teeth only) the following limitations apply: • Procedure code D2920 is payable to the same THSteps dental provider that performed the original cementation of the crown. • Porcelain is allowed on all teeth. • Prior authorization is required for any combination of inlays/onlays or permanent crowns that exceed the limit of four inlays/onlays or permanent crowns. • Stainless steel crowns and permanent all-metal cast crowns are not reimbursed on anterior permanent teeth (6-11, 22-27).	
D2710	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2720	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2721	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2722	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2740	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2750*	All materials accepted. A 13-20, N, PPXR, CCP	$528.00
D2751*	All materials accepted. A 13-20, N, PPXR	$528.00
D2752	All materials accepted. A 13-20, N, PPXR, CCP	$528.00

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

Procedure Code	Limitations	Maximum Fee
D2780	A 13-20, N, PPXR, CCP	$264.00
D2781	A 13-20, N, PPXR, CCP	$264.00
D2782	A 13-20, N, PPXR, CCP	$264.00
D2783	Anterior teeth only (#6-11 and #22-27). A 13-20, N, PPXR, CCP	$264.00
D2790	Posterior teeth only (#1-5; #12-21; and #28-32). All materials accepted. A 13-20, N, PPXR, CCP	$528.00
D2791*	Posterior teeth only (#1-5; #12-21; and #28-32). All materials accepted. A 13-20, N, PPXR	$264.00
D2792*	Posterior teeth only (#1-5; #12-21; and #28-32). All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2794	A 13-20, N, PPXR, CCP	$264.00
D2799	Denied as global fee to any crown placed.	NC
D2915	A 4-20	$18.75
	Other Restorative Services	
D2910	A 13-20, PXR	$18.75
D2920	A 1-20, PXR	$20.00
D2930*	A 1-20, PXR	$156.06
D2931*	A 1-20, PXR	$162.50
D2932*	A 1-20, PXR ($68.75 per primary tooth)	$68.75
D2933*	Limited to anterior primary teeth only (TID C-H, M-R). A 1-20, N, CCP, PXR	$156.06
D2934*	Limited to anterior primary teeth only (TID C-H, M-R). A 1-20, N, CCP, PXR	$156.06
D2940*	Not allowed on the same date as permanent restoration. A 1-20, PXR	$36.58
D2950*	Not allowed on primary teeth. A 4-20, N, CCP, PXR	$45.00
D2951	Not payable with crowns or D2950. Not allowed on primary teeth. A 4-20, PXR	$12.50
D2952	Not payable with D2950. Not allowed on primary teeth. A 13-20, PXR	$87.50
D2953	Not allowed on primary teeth. A 13-20	$43.75
D2954*	Not payable with codes D2952 or D3950 on the same TID by the same provider. Not allowed on primary teeth. A 13-20, N, CCP, PXR	$75.00
D2955	Not allowed on primary teeth. A 4-20, CCP, PXR	$75.00
D2957	Not allowed on primary teeth. A 13-20, PXR, CCP	$37.50
D2960	A 13-20, N, PPXR, CCP	$112.50
D2961	A 13-20, N, PPXR, CCP	$181.25

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

Procedure Code	Limitations	Maximum Fee
D2962	A 13-20, N, PPXR, CCP	$212.50
D2980	A 13-20, PXR (permanent teeth only)	$50.00
D2999	A 1-20, N, CCP, PXR	Manually priced

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19.15.6 Endodontics Services

Root canal fillings cannot be billed in addition to apexification procedures that have been initiated. Codes D3351, D3352, and D3353 include the final root canal filling.

Medical necessity for all endodontic procedures must be documented in the client's chart and be supported by radiographic documentation.

If the client is pregnant and does not want radiographs, use alternative treatment (temporary) until after delivery.

Procedure Code	Limitations	Maximum Fee
	Pulp Capping Procedure codes D3110 and D3120 will not be reimbursed when billed with the following procedure codes for the same tooth, on the same day by the same provider: D2952, D2953, D2954, D2955, D2957, D2980, D2999, D3220, D3221, D3230, D3240, D3310, D3320, or D3330.	
D3110	A 1-20, N, PXR, CCP	$16.25
D3120	A 1-20, N, PXR, CCP	$30.00
	Pulpotomy	
D3220*	A 1-20, PXR	$87.96
D3221	Denied as global fee to any endodontic procedure.	NC
	Endodontic Therapy on Primary Teeth	
D3230*	Will deny as part of any endodontic procedure. TIDs C-H; M-R. A 1-20, PXR	$38.75
D3240*	TIDs A, B, I, J, K, L, S, T. A 1-20, PXR	$43.98

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

Procedure Code	Limitations	Maximum Fee
Endodontic Therapy (Including Treatment Plan, Clinical Procedures, and Follow-up Care)		
Complete root canal therapy—Pulpectomy is part of root canal therapy and includes all appointments necessary to complete treatment. Diagnostic evaluations and radiographs performed at the initial, periodic, or emergency services visits are reimbursed in addition to the root canal. Reimbursement for a root canal includes the pulpotomy and radiographs performed pre, intra-, and postoperatively. Root canal therapy that has only been initiated—or taken to some degree of completion, but not carried to completion with a final filling—may not be billed as a root canal therapy code. It must be billed using code D3999 with a narrative description of what procedures were completed in the root canal therapy. An initial root canal therapy or retreatment of previous root canal therapy: • Is a benefit under the THSteps dental program when provided to a permanent tooth • Is not a benefit under the THSteps dental program when provided to a primary tooth Documentation supporting medical necessity must be kept in the client's record and include the following: the medical necessity as documented through periapical radiographs of tooth treated showing pre-treatment, during treatment, and post-treatment status; the final size of the file to which the canal was enlarged; and the type of filling material used. Any reason that the root canal may appear radiographically unacceptable must be documented in the client's record.		
D3310*	A 6-20, PPXR	$355.98
D3320*	A 6-20, PPXR	$412.50
D3330*	A 6-20, PPXR	$624.26
D3331	Not payable, use retreatment codes.	NC
D3332	Not payable, use retreatment codes	NC
D3333	Not payable, use retreatment codes	NC
Endodontic Retreatment		
D3346*	A 6-20, PPXR	$156.25
D3347*	A 6-20, PPXR	$206.25
D3348*	A 6-20, PPXR	$275.00
Apexification/Recalcification Procedures		
D3351*	A 6-20, N, PXR, CCP	$75.00
D3352*	A 6-20, N, PXR, CCP	$50.00
D3353*	A 6-20, PPXR, CCP	$100.00
Apicoectomy/Periradicular Services		
D3410	A 6-20, N, PPXR, CCP	$131.25
D3421	A 6-20, N, PPXR, CCP	$162.50
D3425	A 6-20, N, PPXR, CCP	$162.50
D3426	A 6-20, N, PPXR, CCP	$75.00
D3430	A 6-20, N, PPXR, CCP	$50.00
D3450	A 6-20, N, PXR, CCP	$75.00
D3460	Prior authorization required. Submit request with periapical radiographs, for each tooth involved. A 16-20, N, PPXR, CCP	$212.50
D3470	A 6-20, N, PXR, CCP	$125.00

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

Procedure Code	Limitations	Maximum Fee
	Other Endodontic Procedures	
D3910	A 1-20, N, CCP	$18.75
D3920	A 6-20, N, PXR, CCP	$81.25
D3950	A 6-20, N, PXR, CCP	$50.00
D3999	A 1-20, N, PXR, CCP	Manually priced

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

19.15.7 Periodontal Services

Procedure codes D4210 and D4211, when billed for clients younger than 13 years of age, will be initially denied, but may be appealed with documentation of medical necessity. Additionally, preoperative and postoperative photographs will be required for the following procedure codes: D4210, D4211, D4270, D4271, D4273, D4275, D4276, D4355, and D4910.

Preoperative and postoperative photographs will be required when medical necessity is not evident on radiographs for the following procedure codes: D4240, D4241, D4245, D4266, and D4267.

Procedure Code	Limitations	Maximum Fee
	Surgical Services (Including Usual Postoperative Care)	
D4210	A 13-20, N, PPXR, CCP	$162.50
D4211	A 13-20, N, PHO, PXR, CCP	$50.00
D4230	Not considered medically necessary.	NC
D4231	Not considered medically necessary.	NC
D4240	A 13-20, N, FMX, PHO, PXR when medical necessity is not evident on radiographs, PC, CCP	$181.25
D4241	Limited to once per year. A 13-20, N, FMX, PXR, PHO when medical necessity is not evident on radiographs, PC	$55.00
D4245	Per quadrant. A 13-20, N, PXR, PHO when medical necessity is not evident on radiographs, CCP	$181.25
D4249	A six- to eight-week healing period following crown lengthening before final tooth preparation, impression making, and fabrication of a final restoration is required for billing of this code. A 13-20, N, PPXR, CCP	$162.50
D4260	A 13-20, N, FMX, PXR, PC, CCP	$225.00
D4261	Limited to once per year. A 13-20, N, FMX, PXR, PC	$67.00
D4265	Deny as global to other services.	NC

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC= No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

Procedure Code	Limitations	Maximum Fee
D4266	Considered upon submission of an appeal with the following documentation: • Third molar sites: Medical/dental history documenting need due to inadequate healing of bone following third molar extraction, including date of third molar extraction; secondary procedure several months post-extraction; position of the third molar preoperatively; post-extraction probing depths to document continuing bony defect; post-extraction radiographs documenting continuing bony defect; and bone graft and barrier material utilized. • Other than third molar sites: Medical and dental history indicating a co-morbid condition; preoperative radiographs that show evidence of the bony defect; postoperative radiographs that show evidence of the procedure being performed; intra-oral photographs, if the bony defect is not evident on radiographs (this documentation may also be requested by HHSC and/or its agent as deemed necessary); periodontal probing depths documenting bony defect; number of intact walls associated with an angular bony defect; and bone graft and barrier material utilized. A 13-20, N, PPXR, CCP	$275.00
D4267	Considered upon submission of an appeal with the following documentation: • Third molar sites: Medical/dental history documenting need due to inadequate healing of bone following third molar extraction, including date of third molar extraction; secondary procedure several months post-extraction; position of the third molar preoperatively; post-extraction probing depths to document continuing bony defect; post-extraction radiographs documenting continuing bony defect; and bone graft and barrier material utilized. • Other than third molar sites: Medical and dental history indicating a co-morbid condition; preoperative radiographs that show evidence of the bony defect; postoperative radiographs that show evidence of the procedure being performed; intra-oral photographs, if the bony defect is not evident on radiographs (this documentation may also be requested by HHSC and/or its agent as deemed necessary); periodontal probing depths documenting bony defect; and final restoration treatment plan for edentulous site(s). A 13-20, N, PPXR, CCP	$325.00
D4270	A 13-20, N, PPXR, CCP	$193.75
D4271	A 13-20, N, PPXR, CCP	$206.25
D4273	This procedure is performed to create or augment gingiva, to obtain root coverage or to eliminate frenum pull, or to extend the vestibular fornix. A 13-20, N, PPXR, CCP	$225.00
D4274	This procedure is performed in an edentulous area adjacent to a periodontally involved tooth. Gingival incisions are used to allow removal of a tissue wedge to gain access and correct the underlying osseous defect and to permit close flap adaptation. A 13-20, N, PXR, CCP	$125.00

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC= No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

Procedure Code	Limitations	Maximum Fee
D4275	Limited to once per day. A 13-20, PPXR	$225.00
D4276	Prior authorization is required; Not payable in addition to D4273 or D4275 on the same date of service. A 13-20, PPXR	$225.00
	Nonsurgical Periodontal Services	
D4320	A 1-20, PXR	$62.50
D4321	A 1-20, PXR	$100.00
D4341*	D4341 is not payable if provided within 21 days of D4355. A 13-20, FMX, PC, PXR, CCP	$56.25
D4342	May not be paid in addition to procedure codes D4210, D4211, D4240, D4241, D4245, D4249, D4260, D4261, D4266, D4267, D4270, D4271, D4273, D4274, D4275, D4276, D4320, D4321, D4341, D4355, D4381, D4910, D4920, and D4999 on the same day. A 13-20, PC, FMX	$7.00
D4355*	D4355 is not payable if provided within 21 days of D4341. A 13-20, N, PPXR, CCP	$75.00
D4381	A 13-20, N, PXR, CCP	$30.00
	Other Periodontal Services	
D4910	Payable only following active periodontal therapy by any provider as evidenced either by a billed claim for D4240, D4241, D4260, or D4261 or by evidence through client records of periodontal therapy while not Medicaid-eligible. Limited to once per 12 months for the same provider. A 13-20, N, PPXR, CCP (not payable with or after D4355)	$37.50
D4920	A 13-20, N, PXR, CCP	$25.00
D4999	A 13-20, N, PXR, CCP	Manually priced

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC= No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

19.15.8 Prosthodontic (Removable) Services

Procedure Code	Limitations	Maximum Fee
	Complete Dentures (Including Routine Post Delivery Care)	
D5110	A 3-20, PXR	$375.00
D5120	A 3-20, PXR	$375.00
D5130	A 13-20, N, PXR, CCP	$387.50
D5140	A 13-20, N, PXR, CCP	$387.50
	Partial Dentures (Including Routine Post Delivery Care)	
D5211*	A 6-20, PXR, MTID	$275.00
D5212*	A 6-20, PXR, MTID	$275.00
D5213	A 9-20, N, PXR, MTID, CCP	$400.00
D5214	A 9-20, N, PXR, MTID, CCP	$400.00
D5281*	A 9-20, N, PXR, MTID, CCP	$250.00

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC= No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

Procedure Code	Limitations	Maximum Fee
	Adjustments to Dentures	
D5410	A 3-20, PXR	$18.75
D5411	A 3-20, PXR	$18.75
D5421	A 6-20, PXR	$18.75
D5422	A 6-20, PXR	$18.75
	Repairs to Complete Dentures	
D5510	Cost of repairs cannot exceed replacement costs. A 3-20, PXR	$50.00
D5520	Cost of repairs cannot exceed replacement costs. A 3-20, PXR	$43.75
	Repairs to Partial Dentures Cost of repairs cannot exceed replacement costs. A bill for the laboratory portion not to exceed $137.50 must be submitted.	
D5610*	A 3-20, PXR	$115.00
D5620	A 6-20, PXR	$56.25
D5630*	A 6-20, PXR	$50.00
D5640*	A 6-20, PXR	$43.75
D5650*	A 6-20, PXR	$50.00
D5660*	A 6-20, PXR	$62.50
D5670*	Will be denied as part of procedure codes D5211, D5213, D5281, and D5640. A 6-20	$175.00
D5671*	Will be denied as part of procedure codes D5212, D5214, D5281, and D5640. A 6-20	$175.00
	Denture Rebase Procedures	
D5710	A 4-20, PXR	$137.50
D5711	A 4-20, PXR	$137.50
D5720*	A 7-20, PXR	$137.50
D5721*	A 7-20, PXR	$137.50
	Denture Reline Procedures Allowed whether or not the denture was obtained through THSteps or ICF-MR dental services if the reline makes the denture serviceable.	
D5730	A 4-20, N, PXR, CCP	$81.25
D5731	A 4-20, N, PXR, CCP	$81.25
D5740*	A 7-20, N, PXR, CCP	$75.00
D5741*	A 7-20, N, PXR, CCP	$75.00
D5750	A 4-20, PXR	$118.75
D5751	A 4-20, PXR	$118.75
D5760*	A 7-20, PXR	$118.75
D5761*	A 7-20, PXR	$118.75
	Interim Prosthesis	
D5810	A 3-20, N, PXR, CCP	$200.00
D5811	A 3-20, N, PXR, CCP	$200.00

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC= No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

Procedure Code	Limitations	Maximum Fee
D5820	A 3-20, N, PXR, CCP	$162.50
D5821	A 3-20, N, PXR, CCP	$162.50
	Other Removable Prosthetic Services	
D5850	A 3-20, N, PXR, CCP	$37.50
D5851	A 3-20, N, PXR, CCP	$37.50
D5860	A 4-20, N, PXR, CCP	$387.50
D5861	A 4-20, N, PXR, CCP	$387.50
D5862	A 4-20, N, PXR, CCP	$162.50
D5867	Denied as part of any repair or modification of any removable prosthetic.	NC
D5875	Denied as part of any repair or modification of any removable prosthetic.	NC
D5899	A 1-20, N, PXR, CCP	Manually priced
	Maxillofacial Prosthetics	
D5911	A 1-20, N, PXR, CCP	$50.00
D5912	A 1-20, N, PXR, CCP	$90.00
D5913	A 1-20, N, PXR, CCP	$875.00
D5914	A 1-20, N, PXR, CCP	$875.00
D5915	A 1-20, N, PXR, CCP	$875.00
D5916	A 1-20, N, PXR, CCP	$562.50
D5919	A 1-20, N, PXR, CCP	$1,125.00
D5922	A 1-20, N, PXR, CCP	$140.00
D5923	A 1-20, N, PXR, CCP	$337.50
D5924	A 1-20, N, PXR, CCP	$437.50
D5925	A 1-20, N, PXR, CCP	$375.00
D5926	A 1-20, N, PXR, CCP	$450.00
D5927	A 1-20, N, PXR, CCP	$450.00
D5928	A 1-20, N, PXR, CCP	$450.00
D5929	A 1-20, N, PXR, CCP	$900.00
D5931	A 1-20, N, PXR, CCP	$375.00
D5932	A 1-20, N, PXR, CCP	$1,300.00
D5933	A 1-20, N, PXR, CCP	$281.25
D5934	A 1-20, N, PXR, CCP	$562.50
D5935	A 1-20, N, PXR, CCP	$562.50
D5936	A 1-20, N, PXR, CCP	$625.00
D5937	A 1-20, N, PXR, CCP	$262.50
D5951	Ortho only—requires prior authorization. A Birth-20, N, PXR	$140.00
D5952	Ortho only—requires prior authorization. A Birth-20, N, PXR	$843.75
D5953	Ortho only—requires prior authorization. A 13-20, N, PXR	$843.75
D5954	Ortho only—requires prior authorization. A Birth-20, N, PXR	$443.75

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC= No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

Procedure Code	Limitations	Maximum Fee
D5955	Ortho only—requires prior authorization. A Birth-20, N, PXR	$225.00
D5958	Ortho only—requires prior authorization. A Birth-20, N, PXR	$225.00
D5959	Ortho only—requires prior authorization. A Birth-20, N, PXR	$100.00
D5960	Ortho only—requires prior authorization. A Birth-20, N, PXR	$100.00
D5982	A 1-20, N, PXR, CCP	$112.50
D5983	A 1-20, N, PXR, CCP	$162.50
D5984	A 1-20, N, PXR, CCP	$162.50
D5985	A 1-20, N, PXR, CCP	$162.50
D5986	A 1-20, N, PXR, CCP	$50.00
D5987	A 1-20, N, PXR, CCP	$131.25
D5988	A 1-20, N, PXR	$112.50
D5999	A 1-20, N, PXR, CCP	Manually priced

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC= No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

19.15.9 Implant Services

All of the following implant services codes require prior authorization.

Periapical radiographs are required for each tooth involved in the authorization request. The criteria used by the TMHP Dental Director are:

- At least one abutment tooth requires a crown (based on traditional requirements of medical necessity and dental disease).
- Space cannot be filled with removable partial denture.
- The purpose is to prevent the drifting of teeth in all dimensions (anterior, posterior, lateral, and the opposing arch).

Procedure Code	Limitations	Maximum Fee
D6010	A 16-20, N, PPXR, CCP	$1,125.00
D6040	A 16-20, N, PPXR, CCP	$2,000.00
D6050	A 16-20, N, PPXR, CCP	Manually priced
	Implant Supported Prosthetics	
D6053	Deny as global to other services.	NC
D6054	Deny as global to other services.	NC
D6055	A 16-20, N, PXR, CCP	$300.00
D6056	Requires prior authorization. A 16-20, N, PPXR, CCP	$350.00
D6057	Requires prior authorization. A 16-20, N, PPXR, CCP	$350.00
D6058	Not considered medically necessary.	NC
D6059	Not considered medically necessary.	NC
D6060	Not considered medically necessary.	NC
D6061	Not considered medically necessary.	NC

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

Procedure Code	Limitations	Maximum Fee
D6062	Not considered medically necessary.	NC
D6063	Not considered medically necessary.	NC
D6064	Not considered medically necessary.	NC
D6065	Not considered medically necessary.	NC
D6066	Not considered medically necessary.	NC
D6067	Not considered medically necessary.	NC
D6068	Not considered medically necessary.	NC
D6069	Not considered medically necessary.	NC
D6070	Not considered medically necessary.	NC
D6071	Not considered medically necessary.	NC
D6072	Not considered medically necessary.	NC
D6073	Not considered medically necessary.	NC
D6074	Not considered medically necessary.	NC
D6075	Not considered medically necessary.	NC
D6076	Not considered medically necessary.	NC
D6077	Not considered medically necessary.	NC
D6078	Not considered medically necessary.	NC
D6079	Not considered medically necessary.	NC
D6080	A 16-20, N, PXR, CCP	$43.75
D6090	A 16-20, N, PXR, CCP	$137.50
D6095	A 16-20, N, PPXR, CCP	$175.00
D6100	A 16-20, N, PXR, CCP	$225.00
D6199	A 16-20, N, PXR, CCP	Manually priced

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

19.15.10 Prosthodontic (Fixed) Services

All of the following prosthodontic codes require prior authorization.

Periapical radiographs are required for each tooth involved in the authorization request. The criteria used by the TMHP Dental Director are:

- At least one abutment tooth requires a crown (based on traditional requirements of medical necessity and dental disease).
- The space cannot be filled with a removable partial denture.
- The purpose is to prevent the drifting of teeth in all dimensions (anterior, posterior, lateral, and the opposing arch).
- Each abutment or each pontic constitutes a unit in a bridge.

- Porcelain is allowed on all teeth.

Procedure Code	Limitations	Max Fee
	Fixed Partial Dental Pontics	
D6210	A 16-20, PPXR, MTID, CCP	$264.00
D6211	A 16-20, PPXR, MTID, CCP	$264.00
D6212	A 16-20, PPXR, MTID, CCP	$264.00
D6240	A 16-20, PPXR, MTID, CCP	$264.00
D6241	A 16-20, PPXR, MTID, CCP	$264.00
D6242	A 16-20, PPXR, MTID, CCP	$264.00
D6245	A 16-20, PPXR, MTID, CCP	$264.00
D6250	A 16-20, PPXR, MTID, CCP	$264.00
D6251	A 16-20, PPXR, MTID, CCP	$264.00
D6252	A 16-20, PPXR, MTID, CCP	$264.00
D6253	Deny as global to other services.	NC
	Fixed Partial Dental Retainers—Inlays/Onlays	
D6545	A 16-20, PPXR, CCP	$264.00
D6548	A 16-20, PPXR, CCP	$264.00
D6600	Deny as global to other services.	NC
D6601	Deny as global to other services.	NC
D6602	Deny as global to other services.	NC
D6603	Deny as global to other services.	NC
D6604	Deny as global to other services.	NC
D6605	Deny as global to other services.	NC
D6606	Deny as global to other services.	NC
D6607	Deny as global to other services.	NC
D6608	Deny as global to other services.	NC
D6609	Deny as global to other services.	NC
D6610	Deny as global to other services.	NC
D6611	Deny as global to other services.	NC
D6612	Deny as global to other services.	NC
D6613	Deny as global to other services.	NC
D6614	Deny as global to other services.	NC
D6615	Deny as global to other services.	NC
	Fixed Partial Dental Retainers—Crowns	
D6720	A 16-20, PPXR, CCP	$264.00
D6721	A 16-20, PPXR, CCP	$264.00
D6722	A 16-20, PPXR, CCP	$264.00
D6740	A 16-20, PPXR, CCP	$264.00
D6750	A 16-20, PPXR, CCP	$264.00
D6751	A 16-20, PPXR, CCP	$264.00

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Procedure Code	Limitations	Max Fee
D6752	A 16-20, PPXR, CCP	$264.00
D6780	A 16-20, PPXR, CCP	$264.00
D6781	A 16-20, PPXR, CCP	$264.00
D6782	A 16-20, PPXR, CCP	$264.00
D6783	A 16-20, PPXR, CCP	$264.00
D6790	Permanent posterior teeth only. A 16-20, PPXR, CCP	$264.00
D6791	Permanent posterior teeth only. A 16-20, PPXR, CCP	$264.00
D6792	Permanent posterior teeth only. A 16-20, PPXR, CCP	$264.00
	Other Fixed Partial Dental	
D6920	A 16-20, PXR, CCP	$135.00
D6930	A 16-20, PXR, CCP	$37.50
D6940	A 16-20, N, PXR, CCP	$87.50
D6950	A 16-20, N, PXR, CCP	$137.50
D6970	A 16-20, N, PXR, CCP	$100.00
D6972	A 16-20, N, PXR, CCP	$81.25
D6973	A 16-20, N, PXR, CCP	$56.25
D6975	A 16-20, N, PXR, CCP	$125.00
D6976	Prior authorization required. A 16-20, PXR, CCP	$50.00
D6977	Prior authorization required. A 16-20, PXR, CCP	$40.63
D6980	A 16-20, N, PXR, CCP	$68.75
D6999	A 16-20, N, PXR, CCP	Manually priced

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

19.15.11 Oral and Maxillofacial Surgery Services

All oral surgery procedures include local anesthesia, suturing, if needed, and visits for routine postoperative care.

Procedure Code	Limitations	Maximum Fee
D7111	TIDs A-T and AS-TS. A 1-20	$12.00
D7140*	Replaces procedure codes D7110, D7120, and D7130. A 1-20, PXR	$67.04
	Surgical Extractions	
D7210*	Includes removal of the roots of a previously erupted tooth missing its clinical crown. A 1-20, PXR	$102.81
D7220*	A 1-20, PXR	$157.50
D7230*	A 1-20, PXR	$180.00
D7240	A 1-20, PXR	$300.00
D7241	Document unusual circumstance. A 1-20, N, PXR	$156.25

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Procedure Code	Limitations	Maximum Fee
D7250*	Involves tissue incision and removal of bone to remove a permanent or primary tooth root left in the bone from a previous extraction, caries, or trauma. Usually some degree of soft and/or hard tissue healing has occurred. A 1-20, N, PXR	$92.50
	Other Surgical Procedures	
D7260	A 1-20, N, PXR; TIDs 1-16 only.	$137.50
D7261	May not be paid on the same day as D7260; TIDs 1-16 only. A 1-20	$137.50
D7270*	A 1-20, N, PXR, CCP	$110.00
D7272	Requires prior authorization. A 1-20, N, PXR, CCP	$150.00
D7280	A 1-20, N, PXR	$62.50
D7282	Permanent TIDs 1-32 only; may not be paid on the same day as D7280. A 4-20	$62.50
D7283	A 1-20	$25.00
D7285	A 1-20, PXR, PATH, CCP	$75.00
D7286*	A 1-20, PXR, PATH	$62.50
D7287	Not considered medically necessary.	NC
D7290	A 1-20, N, PXR, CCP	$137.50
D7291	A 4-20, N, PXR, CCP	$50.00
	Alveoloplasty—Surgical Preparation of Ridge for Dentures	
D7310	A 1-20, N, PXR, CCP	$56.25
D7320	A 1-20, N, PXR, CCP	$75.00
	Vestibuloplasty	
D7340	A 1-20, N, PXR, CCP	$125.00
D7350	A 1-20, N, PXR, CCP	$250.00
	Surgical Excision of Soft Tissue Lesions	
D7410	A 1-20, PXR, PATH	$100.00
D7411	A 1-20, PXR, PATH	$150.00
D7412	Not considered medically necessary.	NC
D7413	The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A 1-20, N, PXR, PATH, CCP	$100.00
D7414	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1-20, N, PXR, PATH, CCP	$150.00
D7415	Not considered medically necessary.	NC
	Surgical Excision of Intraosseous Lesions	
D7440	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1-20, N, PXR, PATH, CCP	$181.25
D7441	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1-20, N, PXR, PATH, CCP	$237.50

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

Procedure Code	Limitations	Maximum Fee
D7450	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1-20, N, PXR, PATH, CCP	$118.75
D7451	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1-20, N, PXR, PATH, CCP	$162.50
D7460	The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A Birth-20, N, PXR, PATH, CCP	$118.75
D7461	The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A Birth-20, N, PXR, PATH, CCP	$162.50
D7465	The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A 1-20, N, PXR, PATH, CCP	$68.75
Excision of Bone Tissue		
D7471	Denied as global to all extractions	NC
D7472	Prior authorization is required. A 1 -20	$160.00
D7473	Deny as global to other services.	NC
D7485	Deny as global to other services.	NC
D7490	Refer to CPT codes.	NC
Surgical Incision		
D7510*	TID required. A 1-20, PXR	$37.50
D7520	A 1-20, N, PXR, CCP	$125.00
D7530	A 1-20, N, PXR	$50.00
D7540	A 1-20, N, PXR	$100.00
D7550*	A 1-20, N, PXR	$106.25
D7560	A 1-20, N, PXR, CCP	$125.00
D7670	A 1-20, N, PXR, CCP	$81.25
D7671	Not considered medically necessary.	NC
D7771	Not considered medically necessary.	NC
Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions		
D7820	A 1-20, N, PXR	$81.25
D7830	Refer to CPT codes.	NC
D7880	Narrative required on claim form. A 1-20, N, PXR, CCP	$140.00
D7899	Narrative required on claim form. A 1-20, N, PXR, CCP	Manually priced
Repair of Traumatic Wounds		
D7910*	Narrative required on claim form. A 1-20, N, PXR, CCP	$75.00
Complicated Suturing		
D7911	A 1-20, N, PXR, CCP	$81.25
D7912	A 1-20, N, PXR, CCP	$162.50
Other Repair Procedures		
D7960	Narrative required on claim form. A 1-20, N, PXR, CCP	$105.00

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Procedure Code	Limitations	Maximum Fee
D7970*	A 1-20, N, PXR, CCP	$112.50
D7971*	A 1-20, N, PXR, CCP	$43.75
D7972	TIDs 1, 16, 17, and 32 only; may not be paid in addition to D7971 on the same day. A 13-20	$43.75
D7980	A 1-20, N, PXR, CCP	$193.75
D7983	A 1-20, N, PXR, CCP	$162.50
D7997*	Per arch. Prior authorization is required. A 1-20, N, PXR, CCP	$50.00
D7999*	A 1-20, N, PXR, CCP	Manually priced

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19.15.12 Adjunctive General Services

Procedure Code	Limitations	Maximum Fee
	Unclassified Treatment	
D9110*	Emergency service only. The type of treatment rendered and TID must be indicated. It must be a service other than a prescription or topical medication. The reason for emergency and a narrative of the procedure actually performed must be documented. Refer to section 19.6. A 1-20, N	$18.75
D9120	Not considered medically necessary.	NC
	Anesthesia	
Providers must comply with TSBDE Rules, 22 TAC §§108.30–108.35. Any anesthesia type services are paid only to the provider. Criteria for dental therapy under general anesthesia must be used (see page 19-33). A local anesthesia fee is *not* paid in addition to other restorative, operative, or surgical procedure fees. Prior authorization is available for exceptions to periodicity.		
D9210	Claim form narrative should describe the situation if used as a diagnostic tool. A 1-20, N, CCP	$12.50
D9211*	A 1-20, N, CCP	$18.75
D9212*	A 1-20, N, CCP	$31.25
D9215*	Claim form narrative should explain how the doctor initiated a procedure, but could not complete it, and needs to claim the rendered anesthesia. A 1-20, N, CCP	$12.50
D9220	May not be billed with codes D9230 or D9610. Can only be billed with D9221. May be billed twice within a 12-month period. A 1-20	$87.50
D9221	May not be billed with codes D9230 or D9610. Can only be billed with D9220. A 1-20	$31.25
D9230*	May not be billed with code D9220, D9221, D9610, or D9920. May not be billed more than one per client, per day. A 1-20.	$28.38

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

Procedure Code	Limitations	Maximum Fee
D9241	May not be billed with code D9220 or D9221. May not be billed on the same date of service as D9920. May be considered for reimbursement for additional conscious sedation services. A 1-20	$121.88
D9242	May be considered for reimbursement for additional conscious sedation services when billing with procedure code D9242. A 1-20	$29.02
D9248*	May be billed twice within a 12-month period. Must comply with all TSBDE rules, including maintaining a current permit to provide non-IV conscious sedation. A 1-20	$187.50
Professional Consultation		
D9310	An oral evaluation by a specialist of any type who is also providing restorative or surgical services should be billed as D0160. A 1-20, N, CCP	$15.25
Professional Visits		
D9410	Narrative required on claim form. A 1-20	$25.00
D9420	One charge per hospital or ASC case; one case per client in a 12-month period. Documentation supporting the reason that dental services could not be performed in the office setting must be retained in the client's record and may be subject to retrospective review and recoupment. A 1-20, N	$38.00
D9430	Narrative required on claim form. Visits for routine postoperative care are included in all therapeutic and oral surgery fees. A 1-20, N	$15.00
D9440	Narrative required on claim form. Visits for routine postoperative care are included in all therapeutic and oral surgery fees. A 1-20, N	$31.25
D9450	Deny as global to other services.	NC
Drugs		
D9610	Providers must comply with TSBDE *Rules and Regulations*. May not be billed with code D9220, D9221, or D9920. A 1-20, N	$18.75
D9612	Not considered medically necessary.	NC
D9630	May not be billed with codes D9220, D9221, D9230, D9241, D9248, D9610, and D9920. A 1-20, N	$9.00
Miscellaneous Services		
D9910	Per whole mouth application, does not include fluoride. Restricted to once per year. A 18-20, N, CCP	$12.50
D9911	Denied as part of D9910.	NC
D9920	The provider must indicate on the claim the client's medical diagnosis of mental retardation or that the client is ICF-MR eligible. A 1-20	$50.00
D9930*	A 1-20, N	$25.00
D9940	A 13-20, N, CCP	$118.75
D9950	A 13-20, N, CCP	$56.25
D9951	Full mouth procedure. Limited to once per year, per client, any provider. A 13-20, N, CCP	$37.50

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

Procedure Code	Limitations	Maximum Fee
D9952	Full mouth procedure. Payable once per lifetime, any provider. A 13-20, N, CCP	$150.00
D9970	Not considered medically necessary.	NC
D9971	Not considered medically necessary.	NC
D9972	Not considered medically necessary.	NC
D9973	Not considered medically necessary.	NC
D9974*	Must include documentation of medical necessity. A 13-20, CCP	$56.25
D9999*	A 1-20, N, CCP, PPXR	Manually priced

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

19.16 Criteria for Dental Therapy Under General Anesthesia

The dental provider is responsible for determining whether a client meets the minimum criteria necessary for receiving general anesthesia. Additionally, the dental provider must meet the requirements for chart documentation.

If a client does not meet the criteria for general anesthesia, prior authorization is considered with a written request using the THSteps Dental Mandatory Prior Authorization Request Form. Providers must include all appropriate supporting documentation with the submittal. TMHP mails the dental provider a reply to the prior authorization request. The criteria for general anesthesia applies only to treatment of clients who are younger than 21 years of age or ICF-MR.

Refer to: "THSteps Dental Mandatory Prior Authorization Request Form" on page B-108 and "Criteria for Dental Therapy Under General Anesthesia" on page 19-34.

19.16.1 Criteria for Dental Therapy Under General Anesthesia

Total points needed to justify treatment under general anesthesia = 22.

Age of client at time of examination	Points
Less than four years of age	8
Four and five years of age	6
Six and seven years of age	4
Eight years of age and older	2

Treatment Requirements (Carious and/or Abscessed Teeth)	Points
1-2 teeth or one sextant	3
3-4 teeth or 2-3 sextants	6
5-8 teeth or 4 sextants	9
9 or more teeth or 5-6 sextants	12

Behavior of Client**	Points
Definitely negative–unable to complete exam, client unable to cooperate due to lack of physical or emotional maturity, and/or disability	10
Somewhat negative–defiant; reluctant to accept treatment; disobeys instruction; reaches to grab or deflect operator's hand, refusal to take radiographs	4
Other behaviors such as moderate levels of fear, nervousness, and cautious acceptance of treatment should be considered as normal reponses and are not indications for treatment under general anesthesia	0
** Requires that narrative fully describing circumstances be present in the client's chart	

Additional Factors**	Points
Presence of oral/perioral pathology (other than caries), anomaly, or trauma requiring surgical intervention**	15
Failed conscious sedation**	15
Medically compromising of handicapping condition**	15
** Requires that narrative fully describing circumstances be present in the client's chart	

I understand and agree with the dentist's assessment of my child's behavior.

PARENT/GUARDIAN SIGNATURE: _____DATE: _____

Clients in need of general anesthesia who do not meet the 22-point threshold, by report, will require prior authorization.

To proceed with the dental care and general anesthesia, this form, the appropriate narrative, and all supporting documentation, as detailed in Attachment 1, must be included in the client's chart. The client's chart must be available for review by representatives of TMHP and/or HHSC.

PERFORMING DENTIST'S SIGNATURE: _____

DATE: _____License No. _____

Effective Date_01152008/Revised Date_12032007

19.16.2 Criteria for Dental Therapy Under General Anesthesia, Attachment 1

The following is medical dental policy regarding general anesthesia.

Purpose	To justify general anesthesia for dental therapy, the following documentation is required in the client's dental record.
Elements	Note those required (*) and those as appropriate (**)

1) * Client's Demographics including Date of Birth
2) * Relevant Dental and Medical Health History
   ** including Medical Evaluation Justifying Relevant Medical Condition(s)
3) * Dental Radiographs, Intraoral/Perioral Photography, and/or Diagram of Dental Pathology
4) * Proposed Dental Plan of Care
5) * Signed Consent by Parent/Guardian giving permission for the proposed dental treatment and acknowledging that the reason for the use of general anesthesia for dental care has been explained.
6) *The parent/guardian dated signature on the Criteria for Dental Therapy Under General Anesthesia form attesting that they understand and agree with the dentist's assessment of their child's behavior
7) ** Description of Relevant Behavior and Reference Scale
8) ** Other Relevant Narrative Justifying Need for General Anesthesia
9) * Completed Criteria for Dental Therapy Under General Anesthesia form
10) * The dentist's attestation statement and signature may be put on the bottom of the Criteria for Dental Therapy Under General Anesthesia form or included in the chart as a stand-alone form:

I attest that the client's condition and the proposed treatment plan warrant the use of general anesthesia. Appropriate documentation of medical necessity is contained in the client's record and is available in my office.

REQUESTING DENTIST'S SIGNATURE: _____

DATE:_____
Month Day Year

19.17 Hospitalization and ASC/HASC

Dental services performed in an ASC, hospital ambulatory surgical center (HASC), or a hospital (either as an inpatient or an outpatient) may be benefits of THSteps on the medical or behavioral justification provided, or if one of the following conditions exist:

- The procedures cannot be performed in the dental office.
- The client is severely disabled.

Contact the individual HMO for precertification requirements related to the hospital procedure. If services are precertified, the provider receives a precertification number effective for 90 days.

In those areas of the state with Medicaid Managed Care, precertification or approval is required from the client's HMO for anesthesia and facility charges. It is the dental provider's responsibility to obtain precertification from the client's HMO or managed care plan for facility and general anesthesia services.

To be reimbursed by the HMO, the provider must use the HMO's contracted facility and anesthesia provider. These services are included in the capitation rates paid to HMOs, and the facility/anesthesiologist risk nonpayment from the HMO without such approval. Coordination of all specialty care is the responsibility of the client's primary care provider. The primary care provider must be notified by the dentist and/or the HMO of the planned services.

Dentists providing sedation/anesthesia services must have the appropriate current permit from the TSBDE for the level of sedation/anesthesia provided.

The dental provider must be in compliance with the guidelines detailed in "Criteria for Dental Therapy Under General Anesthesia" on page 19-33.

Note: *Post-treatment authorization will not be approved for codes that require mandatory prior authorization.*

19.18 Orthodontic Services (THSteps)

Orthodontic services for cosmetic purposes only are not a benefit of the Texas Medicaid Program. Orthodontic services are limited to the treatment of severe handicapping malocclusion and other special medically necessary circumstances as outlined in Benefits and Limitations below.

19.18.1 Benefits and Limitations

Orthodontic services include the following:

- Correction of severe handicapping malocclusion as measured on the Handicapping Labiolingual Deviation (HLD) Index. Refer to page 19-42 for information on how to score the HLD. A minimum score of 26 points is required for full banding approval (only permanent dentition cases are considered).

Exception: *Retained deciduous teeth and cleft palates with gross malocclusion that will benefit from early treatment. Cleft palate cases do not have to meet the HLD 26-point scoring requirement. However, it is necessary to submit a sufficient narrative and/or outline of the proposed treatment plan when requesting authorization for orthodontic services on cleft palate cases.*

- Crossbite therapy.
- Head injury involving severe traumatic deviation.

The following limitations apply for orthodontic services:

- Orthodontic services for cosmetic purposes only are not a benefit of the Texas Medicaid Program or THSteps.
- Orthognathic surgery, to include extractions, required or provided in conjunction with the application of braces must be completed while the client is Medicaid-eligible in order for reimbursement to be considered.
- Except for D8660, all orthodontic procedures require prior authorization for consideration of reimbursement.
- The THSteps client must be Medicaid/THSteps-eligible when authorization is requested and the orthodontic treatment plan is initiated. It is the provider's responsibility to see that the client has a current Medicaid Identification Form (Form H3087) or Medicaid Eligibility Verification Form (Forms H1027 and H1027-A-C) and that the date of birth on the form indicates the client is younger than 21 years of age and no limitations are indicated.
- Prior authorization is issued to the requesting provider only and is not transferable to another provider. If the client changes providers or if the provider stops practicing dentistry in the Texas Medicaid Program for whatever reason, a new prior authorization must be requested (see "Transfer of Orthodontic Services" on page 19-38).

The following procedure codes, policies, and limitations are applied to the processing and payment of orthodontic services under THSteps dental services:

- Procedure code D8660 is allowed when:
  - The client is referred to an orthodontist for a determination of whether orthodontic services are indicated and to determine the appropriate time to initiate such services.
  - The client is referred to an orthodontist and elects to receive services from another orthodontic provider because of justifiable reasons.
  - Repeat visits at different age levels are required to determine the appropriate time to initiate orthodontic treatment.
- Procedure code D8680 is payable for one retainer per arch, per lifetime, and may be replaced once because of loss or breakage (prior authorization is required).
- Procedure code D8670 should be billed only when an adjustment to the appliances is provided and may not be billed before the date the orthodontic adjustment was performed. The number of visits for monthly adjustments to the appliances is restricted to the number

that was authorized in the treatment plan. However, the number of monthly visits may be amended with appropriate documentation of medical necessity while the client is Medicaid eligible.

- Procedure code D8670 is paid only in conjunction with a history of braces (code D8080), unless special circumstances exist.
- All orthodontic codes and appliances are global fees.
- Separate fees for adjustments to retainers are not payable.
- The appropriate code should be billed for those appliances required as part of the treatment of cleft palate cases.

Special orthodontic appliances may also be used with full banding and crossbite therapy with approval by the TMHP Dental Director.

- Procedure codes D5951, D5952, D5953, D5954, D5955, D5958, D5959, and D5960 are to be used as applicable with documentation of medical necessity. Otherwise, use the appropriate special orthodontic appliance code.
- Full banding is allowed on permanent dentition only, and treatment should be accomplished in one stage and is allowed once per lifetime.

Exception: *Cases of mixed dentition when the treatment plan includes extractions of remaining primary teeth or cleft palate.*

- Crossbite therapy is allowed for primary, mixed, or permanent dentition.
- Providers must not request crossbite correction (limited orthodontics) for a mixed dentition client when there is a need for full banding in the adult teeth. Crossbite therapy is an inclusive charge for treating the crossbite to completion, and additional reimbursement is not provided for adjustments or maintenance.
- If a case is not approved, the dentist may file a claim for payment of the diagnostic work-up necessary to obtain the authorization using procedure codes D0330, D0340, D0350, and D0470. The dentist may receive payment under these procedure codes for no more than two cases out of every ten cases denied. The dentist should determine if the client's condition meets orthodontic benefit criteria before performing a diagnostic work-up.
- Procedure codes D8080, D8050, and D8060, are limited to one per lifetime.

19.18.2 Mandatory Prior Authorization

Prior authorization is required for all THSteps orthodontic services except for procedure code D8660. The prior authorization request must contain the date of service that the orthodontic records were produced. If the request is approved, the date that the records were produced is considered to be the date on which orthodontic treatment begins.

If orthodontic treatment is medically indicated, providers are responsible for obtaining prior authorization for a complete orthodontic treatment plan while the client is eligible for Medicaid and THSteps and younger than 21 years of age.

Prior authorization is a condition for reimbursement; it is not a guarantee of payment.

Upon receipt of prior authorization of complete treatment plans, providers are to advise clients that they will be able to receive the approved treatment services (e.g. orthodontic adjustments, bracket replacements and retainers), even if they lose Medicaid eligibility or reach 21 years of age. Approved orthodontic treatment must be initiated before the loss of Medicaid eligibility and completed within 36 months of the authorization date.

Note: *Providers must submit all orthodontic services for Medicaid Managed Care clients following these guidelines. STAR and STAR+PLUS are not responsible for orthodontic services.*

Requests for orthodontic services must be accompanied by all the following documentation:

- An orthodontic treatment plan. The treatment plan must include all procedures required to complete full treatment (such as, extractions, orthognathic surgery, upper and lower appliance, monthly adjustments, anticipated bracket replacements, appliance removal if indicated, special orthodontic appliances, etc.). The treatment plan should incorporate only the minimal number of appliances required to properly treat the case. Requests for multiple appliances to treat an individual arch are reviewed for duplication of purpose.
- Cephalometric radiograph with tracing models
- Completed and scored HLD sheet with diagnosis of Angle class (26 points required for approval of non-cleft palate cases).
- Facial photographs.
- Full series of radiographs or a panoramic radiograph; diagnostic-quality films are required (copies are accepted and radiographs will not be returned to the provider).
- Any additional pertinent information as determined by the dentist or requested by TMHP's Dental Director Requests for crossbite therapy require properly trimmed models to be retained in the office and must demonstrate the following criteria:
  - Posterior teeth. Not end to end, but buccal cusp of upper teeth should be lingual to buccal cusp of lower teeth.
  - Anterior teeth. The incisal edge of upper should be lingual to the incisal of the opposing arch.

The dentist should be certain that radiographs, photographs, and other information are properly packaged to avoid damage. TMHP is not responsible for lost or damaged materials.

19.18.3 Completion of Treatment Plan

If a client reaches 21 years of age or loses Medicaid eligibility before the authorized orthodontic treatment is completed, reimbursement is provided to complete the orthodontic treatment that was authorized and initiated while the client was younger than 21 years of age, eligible for Medicaid and THSteps, and completed within 36 months. Any orthodontic-related service requested (e.g., extractions or surgeries) must be completed before the loss of client eligibility. Services cannot be added or approved after Medicaid/THSteps eligibility has expired.

19.18.4 Premature Removal of Appliances

The overall fee for orthodontic treatment (D8080) includes the removal of orthodontic brackets and/or treatment appliances. Procedure code D7997 may be used only when the appliances were placed by a different provider with an unaffiliated practice (not a partner or office-sharing arrangement) and one of the following conditions exist:

- There is documentation of a lack of cooperation from the client.
- The client requests premature removal and a release form has been signed by the parent, guardian, or client if he is at least 18 years of age.

Providers must keep a copy of the release form on file and are responsible for this documentation during a review process.

19.18.5 Transfer of Orthodontic Services

Prior authorization issued to a dental provider for orthodontic services is not transferable to another dental provider. The new provider must submit to TMHP a new prior authorization request in order to be approved to complete the orthodontic treatment initiated by the original provider.

The following supporting documentation must accompany the new request for orthodontia services and must include the date of service the orthodontic records were produced:

- All of the documentation as required for the original provider.
- The reason the client left the previous provider, if known.
- An explanation of the treatment status.
- A compete treatment plan addressing all procedures for which authorization is being requested (such as the number of monthly adjustments or retainers required to complete the case).
- A full diagnostic work-up (D8080) with an HLD Index. The score of 26 points will be modified according to any progress achieved.

Exception: *The prior authorization requests for clients who initiate orthodontic services before becoming eligible for Medicaid do not require models or the HLD score sheet, nor does the client have to meet the HLD Index of 26 points. However, a complete plan of treatment is required.*

Note: *Medicaid clients who initiate orthodontic services privately (e.g. pay out of pocket for the orthodontic workup and/or initial banding, etc.) while Medicaid eligible due to not meeting the HLD index 26-points, are not eligible to have their orthodontic services transferred to and reimbursed by Medicaid.*

To request prior authorization to complete the orthodontic treatment initiated by another provider, complete a THSteps Dental Mandatory Prior Authorization Request Form and send it with the complete plan of treatment and appropriate documentation for orthodontic services and/or crossbite therapy to the TMHP Dental Director at the following address:

Texas Medicaid & Healthcare Partnership
THSteps and ICF-MR Dental Authorization and Information
PO Box 202917
Austin, TX 78720-2917

19.18.6 Comprehensive Orthodontic Treatment

Comprehensive orthodontic services (procedure code D8080) are restricted to clients who are 12 years of age and older or clients who have exfoliated all primary dentition.

National procedure codes do not allow for any work-in-progress or partial billing by separating the three orthodontic components: diagnostic work-up, orthodontic appliance (upper), or orthodontic appliance (lower).

When billing for comprehensive orthodontic treatment, D8080, three local codes must be submitted as remarks codes along with code D8080. Local codes (Z2009, Diagnostic work-up approved, Z2011, Orthodontic appliance, upper, or Z2012, Orthodontic appliance, lower) are placed in the Remarks Code field on electronic claims or Block 35 on paper claims.

Note: *If the remarks code and procedure code D8080 are not submitted, the claim will be denied.*

Each remarks code pays the correct reimbursement rate which, when combined, totals the maximum payment of $775. D8080 must be billed on three separate details, with the appropriate remarks code, even if billing for the work-up and full banding. Billing only one detail for a total of $775 will not be accepted.

Example 1: A client is approved for full banding, but after the initial work-up, the client discontinues treatment. This provider would bill the national code D8080 and place the local code Z2009, Diagnostic work-up approved, in the Remarks/comment field. The claim would pay $175.

Example 2: A client is approved for full banding. The provider continues treatment and places the maxillary bands. The provider would bill the national procedure code D8080 and place the local code Z2009, Diagnostic work-up approved, and Z2011, Maxillary bands, in the Remarks/comment field. The claim would pay $475.

All electronic claims for D8080 must have the appropriate remarks code associated with the procedure code.

Providers should adhere to the following guidelines for electronic claim submission so that TMHP can accurately apply the correct remarks code to the appropriate claim detail.

A Diagnostic Procedure Code (DPC) remarks code must be submitted, only once, in the first three bytes of the NTE02 at the 2400 loop.

Example 1: For a claim with one detail, submitted with procedure code D8080 and remarks code Z2009, enter the information as follows: DPCZ2009. The total billed would be $175.

Example 2: For a claim with two details, where details one and two are procedure code D8080 and the remarks codes are Z2009 and Z2011, enter the information as follows: DPCZ2009Z2011. The total billed would be $475.

Example 3: For a claim with three details, where all three details are submitted separately with procedure code D8080, enter the remarks code based on the order of the claim detail as follows: DPCZ2009Z2011Z2012. The total billed would be $775.

This method ensures accurate and appropriate payment for services rendered and addresses the need for partial billing.

19.18.7 Orthodontic Procedure Codes and Fee Schedule

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

Procedure Code	Limitations	Maximum Fee
	Orthodontic Services	
D0330*, D0340*, D0350*, and D0470*	When requested orthodontic cases are submitted for authorization and denied, two out of ten denials will be paid. These four procedure codes, when billed together for denied cases, replace local procedure code Z2010.	$100.00
D7280	A 1 - 20	$62.50
D7997*	Replaces Z2016. Not payable to the dentist who placed the appliance. Includes removal of arch bar and premature removal of braces. A 1 - 20	$50.00
	Interceptive Orthodontic Treatment	
D8050*	Replaces Z2018 and 8110D. Limited to one per lifetime.	$340.00
D8060*	Replaces Z2018 and 8120D. Limited to one per lifetime.	$340.00
D8080*	Replaces Z2009, Z2011, and Z2012. Limited to one per lifetime.	$775.00
	Minor Treatment to Control Harmful Habits	
D8210*	See separate table for associated remarks field code.	See separate table
D8220*	See separate table for associated remarks field code.	See separate table
	Other Orthodontic Services	
D8660*	Replaces Z2008.	$15.00
D8670*	Replaces Z2013.	$68.10
D8680*	Replaces Z2014 and Z2015.	$100.00
D8690*	Bracket replacement.	$20.00
D8691	Not considered medically necessary.	NC
D8692	Limited to one service per arch per lifetime for each retainer.	NC
D8999		Manually priced
*** = Services payable to an FQHC for a client encounter.**		

19.19 Special Orthodontic Appliances

As with all orthodontic services, all removable or fixed special orthodontic applicances must be prior authorized. The prior authorization request must include both the national code and remarks code. However, prior authorization requests may omit the DPC prefix to the eight-digit remarks code.

All removable or fixed special orthodontic appliances must be billed with national procedure code D8210 or D8220. Dental models must be submitted when requesting prior authorization of a thumb-sucking or tongue thrust appliance. To ensure appropriate claims processing, the DPC remarks code (local procedure code) reflecting the specific service is also required. The appropriate remarks codes must be entered on the authorization request form. Failure to follow the following steps will cause the claims to deny. Failure to enter the DPC remarks code and the appropriate procedure code will not result in claim denial; however, manual intervention is required to process the claim, which may result in a delay of payment.

For paper claim submissions, providers must enter the local procedure code in Block 35 (Remarks) of the 2006 ADA claim form.

For electronic submissions, providers enter the DPC remarks code in the Comments field to ensure correct authorization, accurate records, and reimbursement.

For electronic submissions other than TexMedConnect or TDHconnect software submissions, providers must follow the steps below to ensure TMHP accurately applies the correct local procedure code to the appropriate claim detail:

1) The DPC prefix must be submitted, only once, in the first three bytes of the NTE02 at the 2400 loop.
2) In bytes 4-8, providers must submit the remark code (local procedure code) based on the order of the claim detail. Do not enter any spaces or punctuation between remark codes, unless to designate the detail is not billed with D8210 or D8220.

Example: *For a claim with three details, where details one and three are submitted with procedure code D8210 and detail two is not, enter the following information in the NTE02 at the 2400 loop: DPC1014D 1046D. (The space shows that detail two needs no local code.) If all details require a local code, enter DPC, no spaces, and the appropriate local codes.*

To submit using TexMedConnect or TDHconnect software, providers must enter the local code into the Remarks Code field, located under the details header. The Remarks Code field is the field directly after the Procedure Code field. TexMedConnect and TDHconnect software submitters are not required to manually enter the DPC prefix as it is placed in the appropriate field on the TexMedConnect or TDHconnect electronic claim.

The following table identifies the appropriate DPC remarks codes to use when requesting authorization or billing for procedure code D8210 or D8220:

Procedure Code	Remarks Code	Remarks Code Description	Maximum Fee
		Special Orthodontic Appliances	
D8220*	DPC1000D	Appliance with horizontal projections	$250
D8220*	DPC1001D	Appliance with recurved springs	$250
D8220*	DPC1002D	Arch wires for crossbite correction (for total treatment)	$595
D8220*	DPC1003D	Banded maxillary expansion appliance	$375
D8210*	DPC1004D	Bite plate/bite plane	$100
D8210*	DPC1005D	Bionator	$100
D8210*	DPC1006D	Bite block	$250
D8210*	DPC1007D	Bite-plate with push springs	$250
D8220*	DPC1008D	Bonded expansion device	$225
D8210*	DPC1010D	Chateau appliance (face mask, palatal exp and hawley)	$300
D8210*	DPC1011D	Coffin spring appliance	$275
D8220*	DPC1012D	Crib	$100
*** = Services payable to an FQHC for a client encounter.**			

Procedure Code	Remarks Code	Remarks Code Description	Maximum Fee
D8210*	DPC1013D	Dental obturator, definitive (obturator)	$250
D8210*	DPC1014D	Dental obturator, surgical (obturator, surgical stayplate, immediate temporary obturator)	$250
D8220*	DPC1015D	Distalizing appliance with springs	$250
D8220*	DPC1016D	Expansion device	$375
D8210*	DPC1017D	Face mask (protraction mask)	$350
D8220*	DPC1018D	Fixed expansion appliance	$375
D8220*	DPC1019D	Fixed lingual arch	$225
D8220*	DPC1020D	Fixed mandibular holding arch	$100
D8220*	DPC1021D	Fixed rapid palatal expander	$375
D8210*	DPC1022D	Frankel appliance	$100
D8210*	DPC1023D	Functional appliance for reduction of anterior openbite and crossbite	$375
D8210*	DPC1024D	Headgear (face bow)	$150
D8220*	DPC1025D	Herbst appliance (fixed or removable)	$250
D8220*	DPC1026D	Inter-occlusal cast cap surgical splints	$375
D8210*	DPC1027D	Intrusion arch	$100
D8220*	DPC1028D	Jasper jumpers	$100
D8220*	DPC1029D	Lingual appliance with hooks	$100
D8220*	DPC1030D	Mandibular anterior bridge	$175
D8220*	DPC1031D	Mandibular bihelix (similar to a quad helix for mandibular expansion to attempt nonextraction treatment)	$100
D8210*	DPC1032D	Mandibular lip bumper	$100
D8220*	DPC1036D	Mandibular lingual 6x6 arch wire	$100
D8210*	DPC1037D	Mandibular removable expander with bite plane (crozat)	$275
D8210*	DPC1038D	Mandibular ricketts rest position splint	$375
D8210*	DPC1039D	Mandibular splint	$225
D8210*	DPC1040D	Maxillary anterior bridge	$175
D8210*	DPC1041D	Maxillary bite-opening appliance with anterior springs	$100
D8220*	DPC1042D	Maxillary lingual arch with spurs	$100
D8220*	DPC1043D	Maxillary and mandibular distalizing appliance	$100
D8220*	DPC1044D	Maxillary quad helix with finger springs	$325
D8220*	DPC1045D	Maxillary and mandibular retainer with pontics	$175
D8210*	DPC1046D	Maxillary Schwarz	$250
D8210*	DPC1047D	Maxillary splint	$225
D8210*	DPC1048D	Mobile intraoral Arch-Mia (similar to a Bihelix for nonextraction treatment)	$100
D8220*	DPC1049D	Modified quad helix appliance	$275
D8220*	DPC1050D	Modified quad helix appliance (with appliance)	$275
D8220*	DPC1051D	Nance appliance	$100
D8220*	DPC1052D	Nasal stent	$250
D8210*	DPC1053D	Occlusal orthotic device	$175

*** = Services payable to an FQHC for a client encounter.**

Procedure Code	Remarks Code	Remarks Code Description	Maximum Fee
D8210*	DPC1054D	Orthopedic appliance	$250
D8210*	DPC1055D	Other mandibular utilities	$100
D8210*	DPC1056D	Other maxillary utilities	$100
D8220*	DPC1057D	Palatal bar	$225
D8210*	DPC1058D	Post-surgical retainer	$125
D8220*	DPC1059D	Quad helix appliance held with transpalatal arch horizontal projections	$275
D8220*	DPC1060D	Quad helix maintainer	$275
D8220*	DPC1061D	Rapid palatal expander (RPE), such as quad Helix, Haas, or Menne	$350
D8210*	DPC1062D	Removable bite plate	$100
D8210*	DPC1063D	Removable mandibular retainer	$100
D8210*	DPC1064D	Removable maxillary retainer	$100
D8210*	DPC1065D	Removable prosthesis	$175
D8210*	DPC1066D	Sagittal appliance 2 way	$250
D8210*	DPC1067D	Sagittal appliance 3 way	$350
D8220*	DPC1068D	Stapled palatal expansion appliance	$375
D8210*	DPC1069D	Surgical arch wires	$250
D8210*	DPC1070D	Surgical splints (surgical stent/wafer)	$250
D8210*	DPC1071D	Surgical stabilizing appliance	$250
D8220*	DPC1072D	Thumbsucking appliance, requires submission of models	$175
D8210*	DPC1073D	Tongue thrust appliance, requires submission of models	$100
D8210*	DPC1074D	Tooth positioner (full maxillary and mandibular)	$325
D8210*	DPC1075D	Tooth positioner with arch	$100
D8220*	DPC1076D	Transpalatal arch	$100
D8220*	DPC1077D	Two bands with transpalatal arch and horizontal projections forward	$175
D8220*	DPC1078D	W-appliance	$275
*** = Services payable to an FQHC for a client encounter.**			

19.20 How to Score the Handicapping Labiolingual Deviation (HLD) Index

The orthodontic provider must complete and sign the diagnosis (Angle class).

Cleft Palate

Submit a cleft palate case in the mixed dentition only if it can be justified in a narrative why there should be treatment before the client is in the full dentition.

Note: *Intermittent treatment requests may exceed the allowable 26 reimbursable treatment visits.*

Severe Traumatic Deviations

Refers to facial accidents only. Points cannot be awarded for congenital deformity. Severe traumatic deviations do not include traumatic occlusions for crossbites.

Overjet in Millimeters

Score the case exactly as measured, then subtract 2 mm (considered the norm), and enter the difference as the score.

Overbite in Millimeters

Score the case exactly as measured, then subtract 3 mm (considered the norm), and enter the difference as the score. This would be double-counting.

Mandibular Protrusion in Millimeters

Score the case by measurement in mm by the distance from the labial surface of the mandibular incisors to the labial surface of the maxillary incisor. Do not score both overbite and open bite.

Open Bite in Millimeters

Score the case exactly as measured. Measurement should be recorded from the line of occlusion of the permanent teeth, not from ectopically erupted teeth in the anterior segment. Caution is advised in undertaking treatment of open bites in older teenagers, because of the frequency of relapse.

Ectopic Eruption

An unusual pattern of eruption, such as high labial cuspids or teeth that are grossly out of the long axis of the alveolar ridge. Do not include (score) teeth from an arch if that arch is to be counted in the following category of Anterior Crowding. For each arch, either the ectopic eruption or anterior crowding may be scored, but not both.

Anterior Crowding

Anterior teeth that require extractions as a prerequisite to gain adequate room to treat the case. If the arch expansion is to be implemented as an alternative to extraction, provide an estimated number of appointments required to attain adequate stabilization. Arch length insufficiency must exceed 3.5 mm to score for crowding on any arch. Mild rotations that may react favorably to stripping or moderate expansion procedures are not to be scored as crowded.

Labiolingual Spread in millimeters

The score for this category should be the total, in millimeters, of the anterior spaces.

Providers should be conservative in scoring. Liberal scoring will not be helpful in the evaluation and approval of the case. The case must be considered dysfunctional and have a minimum of 26 points on the HLD index to qualify for any orthodontic care other than crossbite correction. Half-mouth cases cannot be approved.

The intent of the program is to provide orthodontic care to clients with handicapping malocclusion to improve function. Although aesthetics is an important part of self-esteem, services that are primarily for aesthetics are not within the scope of benefits of this program.

The proposals for treatment services should incorporate only the minimal number of appliances required to properly treat the case. Requests for multiple appliances to treat an individual arch will be reviewed for duplication of purpose.

If attaining a qualifying score of 26 points is uncertain, providers should include a brief narrative when submitting the case. The narrative may reduce the time necessary to gain final approval and reduce shipping costs incurred to resubmit records.

Providers must properly label and protect all records (especially plaster diagnostic models) when shipping. If plaster diagnostic models are requested by and shipped to TMHP, the provider should assure that the models are adequately protected from breakage during shipping. TMHP will return intact models to the provider.

19.20.1 HLD Score Sheet

This sheet and a Boley Gauge are required to score.

Procedure:

- Occlude client or models in centric position.
- Record all measurements rounded-off to the nearest millimeter.
- Enter score 0 if the condition is absent.
- Overjet is measured from the most protrusive incisor.
- Overbite is measured from the labio-incisal edge of overlapped anterior tooth or teeth to point of maximum coverage.
- Ectopic eruption and anterior crowding: Do not double-score. Record the more serious condition.

PLEASE PRINT CLEARLY:

Client Name:	Date of birth:		Medicaid ID:	
Address: (*Street/City/County/State/Zip Code*)				
CONDITIONS OBSERVED				HLD SCORE
Cleft Palate			Score 15	
Severe Traumatic Deviations Trauma/Accident related only			Score 15	
Overjet in mm. *Minus 2 mm.* *Example: 8 mm. – 2 mm. = 6 points*				=
Overbite in mm. *Minus 3 mm.* Example: 5 mm. – 3 mm. = 2 points				=
Mandibular Protrusion in mm. See definitions/instructions to score (previous page)			x5	=
Open Bite in mm. See definitions/instructions to score (previous page)			x4	=
Ectopic Eruption (Anteriors Only) *Reminder: Points cannot be awarded on the same arch for Ectopic Eruption and Crowding*			Each tooth x3	=
Anterior Crowding *10 point maximum total for both arches combined*	Max.	Mand.	= 5 pts. each arch	=
Labiolingual Spread in mm.				=
TOTAL				=
Diagnosis		For TMHP use only Authorization Number		
Examiner:		Recorder:		
Provider's Signature Please submit this score sheet with records				

19.21 Communication with TMHP

For assistance with claims or client eligibility questions, dental providers may contact a TMHP Contact Center representative on the Dental Inquiry Line or access the Automated Inquiry System (AIS) at 1-800-925-9126.

19.21.1 Dental Inquiry Line

The Dental Inquiry Line (1-800-568-2460) is available Monday through Friday, 7 a.m. to 7 p.m., Central Time, and is the main point of contact for information about dental services and appeals.

Any dental service claim denial may be appealed by telephone if it was not denied as an incomplete claim and does not require one of the following items or conditions:

- Narratives.
- Radiographs.
- Models.
- Other tangible documentation.
- Review by the TMHP Dental Director.

19.21.2 Automated Inquiry System (AIS)

AIS (1-800-925-9126, Option 1) is available 7 days a week, 23 hours a day, with scheduled downtime between 3 a.m. and 4 a.m., and is the main point of contact for client eligibility. AIS requires the use of a touch-tone phone in order to access the system.

Refer to: "Automated Inquiry System (AIS)" on page -xiii for more information.

19.21.3 TMHP Website

Additional information about Medicaid enrollment, general customer service, and provider education/training is available on the TMHP website at www.tmhp.com.

19.21.4 THSteps and ICF-MR Dental Prior Authorization

Submit claims, dental correspondence, and THSteps and ICF-MR prior authorization requests to the appropriate address listed in the table below:

Correspondence	Address
American Dental Association (ADA) dental claim forms	Texas Medicaid & Healthcare Partnership PO Box 200555 Austin, TX 78720-0555
All dental correspondence Prior authorization requests	Texas Medicaid & Healthcare Partnership THSteps and ICF-MR Dental Authorization PO Box 202917 Austin, TX 78720-2917

19.22 Third Party Resources (TPR)

For THSteps and ICF-MR dental claims, TMHP is responsible for determining if a third party resource (TPR) exists and for recouping payment from the TPR.

When the client's Medicaid Identification Form (Form H3087) shows a P in the TPR column indicating the presence of other health insurance, THSteps and ICF-MR dental providers are not required to pursue TPR. The P does not distinguish between medical or dental. Therefore, when clients do not have a readily available private dental insurance identification/verification, dental providers should bill TMHP for reimbursement.

THSteps providers do not have to bill private insurance for dental services. THSteps and ICF-MR dental providers unable to determine whether the client's other insurance provides coverage for dental services should file the claim directly to TMHP even if the provider knows that the client has private insurance. TMHP will reimburse the claim and pursue payment from any other TPR. If a recoupment is made from another payment resource, TMHP will make the appropriate post-payment reconciliation with the dental provider.

Refer to: "Automated Inquiry System (AIS)" on page -xiii.

19.23 Billing TMHP

The examining physician, anesthesiologist, hospital, ASC, or HASC must bill TMHP or the appropriate MCO separately for the medical and facility components of their services. The claim forms used are the CMS-1500 or the UB-04 CMS-1450:

- Type of service (TOS) 7, CPT code 00170 with modifier EP, is for the anesthesiologist or certified registered nurse anesthetist (CRNA) to use on the claim form.
- TOS F, CPT code 41899 with modifier EP, is for the facility to use on the claim form.
- Diagnosis codes, such as 52100 and 5220 are to be used on the claim form by both provider types.
- Modifier EP identifies that the service is associated with THSteps.

To satisfy the preadmission history and physical examination requirements of the hospital, ASC, or HASC, a THSteps medical check up for dental rehabilitation/restoration may be performed by the child's primary care provider. Physicians who are not enrolled as THSteps medical providers should bill for the examination of a client before the procedure with the appropriate evaluation and management code from the following table:

Procedure Code	Place of Service (POS)
1-99202	POS 1 (office)
1-99222	POS 3 (inpatient hospital)
1-99282	POS 5 (outpatient hospital)

Providers enrolled in THSteps Medical should refer to "Exceptions to Periodicity" on page 43-9.

Note: *The dental provider should bill TMHP using the ADA Dental Claim Form to be considered for reimbursement through THSteps Dental Services.*

Refer to: The ADA website at www.ada.org/prof /resources/topics/claimform.asp for a sample of the ADA Dental Claim form.

19.23.1 Billing After Loss of Eligibility

The Texas Medicaid 95-day filing deadline applies to all THSteps and ICF-MR dental services. If a client has lost Medicaid eligibility or turned 21 years of age, continue to file claims for services provided on dates of service the client was eligible. Indicate the actual date of service on the claim form, and enter the authorization number in the appropriate block on each claim filed.

Refer to: "Claims Filing Deadlines" on page 5-7.

19.23.2 Claim Form Completion

All claims, including those from the anesthesiologist and the hospital, ASC, or HASC, must include the appropriate national procedure code(s).

Provider	Diagnosis Code	CPT Code
HASC	52100, 5220	F-41899 with modifier EP
ASC	52100, 5220	F-41899 with modifier EP
ANES	52100, 5220	7-00170 with modifier EP
CRNA	52100, 5220	7-00170 with modifier EP
Use CMS-1500 or UB-04 CMS-1450		

19.24 Claims Information

Note: *THSteps providers do not have to bill private insurance; they can bill TMHP directly.*

All THSteps and ICF-MR claims must be received by TMHP within 95 days from each date of service and submitted to the following address:

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

Dental services must be submitted to TMHP in an approved electronic format or on the ADA Dental Claim Form. Providers may purchase ADA Dental claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing an ADA Dental claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"2006 ADA Dental Claim Filing Instructions" on page 5-43. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

The ADA website at www.ada.org/prof /resources/topics/claimform.asp for a sample of the ADA Dental Claim form.

Claims for emergency, orthodontic, or routine services must each be filed on separate forms. Mixing codes will cause the claim to be denied.

A claim submitted for either emergency or orthodontic services must be marked at the proper box for processing.

A THSteps and ICF-MR dental provider cannot bill the Texas Medicaid Program under his individual performing provider identifier for the services provided by one or more associate dentists practicing in his office as employees or independent contractors with specific employer-employee or contractual relationships. All dentists providing services to Medicaid clients must enroll as THSteps dental providers regardless of employer relationships. The individual provider billing may be reimbursed into a single accounting office to maintain these described relationships.

Note: *A dentist must not use another dentist's provider identifier.*

In any case, a dental group must provide evidence that the practice is 100 percent owned by currently licensed dentists.

The Texas Medicaid Program cannot be billed by a provider for appointments missed by clients. A client with Medicaid cannot be billed for failure to keep an appointment. Only claims for actual services rendered are considered for payment.

Providers should bill the Texas Medicaid Program their usual and customary fees.

The Remittance and Status (R&S) reports received from TMHP should be filed in sequential order in a binder in the provider's office. Electronic R&S reports should be copied for storage.

Refer to: "2006 ADA Dental Claim Filing Instructions" on page 5-43

"Billing Clients" on page 1-10.

19.24.1 Claim Appeals

A claim denied because of age restrictions or other limitations listed in the Medicaid dental fee schedule may be considered for reimbursement on appeal when client medical necessity is provided to the TMHP Dental Director.

All denied claim appeals (see "Appeals" on page 6-1) must be submitted to TMHP with the exception of a request to waive late filing deadlines. TMHP does not have the authority to waive state or federal mandates regarding claim filing deadlines.

If after all appeal processes at TMHP are exhausted, and the provider remains dissatisfied with TMHP's decision concerning the appeal, the provider may file a complaint with the HHSC Claims Administrator Contract Management Unit.

Refer to: "Administrative Claim Appeals" on page 6-4.

Note: *Providers must exhaust the appeals process with TMHP before filing a complaint to the HHSC Claims Administrator Contract Management Unit.*

Refer to: "Paper Appeals" on page 6-3.

19.24.2 Dental Claims Appeal Information

Providers may use three methods to appeal Medicaid claims to TMHP: telephone (AIS), paper, or electronically.

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

The following claims must be appealed on paper; they cannot be appealed either electronically or by using AIS:

- Claims listed on the R&S report as incomplete. These include claims missing required information, such as the signature on the claim. Resubmit the corrected claim with a copy of the R&S report for reprocessing to the TMHP physical address, Attn: Inquiry Control Unit.
- Claims requiring supporting documentation (for example, operative reports, dental records, dental radiographs, or narratives).
- Claims listed as pending or in process with an explanation of pending status (EOPS) message. These claims have not been finalized at the time the R&S report was generated; therefore, they cannot be appealed.
- Claims denied as past filing deadline. The provider must provide a copy of a previous R&S report as proof the claim was received by TMHP within the filing deadline.

To appeal in writing:

If a claim cannot be appealed electronically or by telephone, appeal the claim on paper by completing the following steps:

1) Provide a copy of the R&S report page where the claim is reported.
2) Circle one claim per R&S report page.
3) Identify the information that was incorrectly provided and note the correct information that should be used to appeal the claim. If necessary, specify the reason for appealing the claim.
4) Attach radiographs or other necessary supporting documentation.
5) If available, attach a copy of the original claim. Claim copies are helpful when the appeal involves dental policy or procedure coding issues.
6) Do not copy supporting documentation on the opposite side of the R&S report.
7) It is strongly recommended that providers submitting paper appeals retain a copy of the documentation being sent. It is also recommended that paper documentation be sent via certified mail with a return receipt requested to establish TMHP's receipt of the claim and the date the claim was received. The provider is urged to retain copies of multiple claim submissions if the Medicaid provider identifier is pending.

Note: *Providers have 95 days from the issuance of the provider identifier to submit claims.*

8) Submit the paper appeal with supporting documentation and any radiographs and adjustment requests to the following address:

Texas Medicaid & Healthcare Partnership
Inquiry Control Unit
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727

To appeal by telephone:

1) Contact the Dental Line at 1-800-568-2460.
2) For each claim in question, have the R&S report listing the claim and any supporting documents readily available.
3) Identify the claim submitted for appeal. The internal control number (ICN) will be requested.
4) Supply the information necessary to correct the claim, such as the missing tooth number or letter, the corrected procedure code, surface ID, or Medicaid number.

The appeal will appear as finalized or pending on the following week's R&S report.

Providers may also appeal electronically.

Electronic appeal submission is a method of submitting Texas Medicaid appeals using a personal computer (PC). The electronic appeals feature can be accessed by a business organization bridging directly into the TMHP EDI Gateway or by using TexMedConnect or TDHconnect software. For additional information, contact the TMHP EDI Help Desk at 1-888-863-3638.

Electronic appeals can increase accuracy of claims processing, resulting in a more efficient case flow to the provider:

- Download and printout capabilities help maintain audit trails for the provider.
- Appeal submission windows can be automatically filled in with electronic R&S report information, thereby reducing data entry time.

Electronic appeals submission is available to business organizations (for example, billing organizations, vendors, and clearinghouses) and interfaces directly with TMHP EDI or through TexMedConnect or TDHconnect software.

19.24.3 Frequently Asked Questions About Dental Claims

Q Why is routine dental treatment not a benefit when performed at the same visit as an emergency visit?

A The following are reasons routine dental treatment is not a benefit when performed at the same visit as an emergency visit:

- The purpose of an emergency claim is to allow the provider to treat a true emergency without the concern that routine dental procedures may be denied.
- Medicaid program policy guidelines do not allow payment for both types of services to the same provider at the same visit. True emergency claims process through the audit system correctly when "emergency" is checked on either the paper or electronic claim and the Remarks or Narrative section of the claim form describes the nature of the emergency.

Q Why are some claims for oral exams and emergency exams on the same date for the same client denied?

A Medicaid program policy does not allow an initial oral exam and an emergency exam to be billed on the same date of service for the same client. An emergency exam performed by the same provider in the same six-month time period as an initial exam may be considered for reimbursement only when the claim for the emergency exam indicates it is an emergency and the emergency block is marked. If the claim is not marked as an emergency, the claim wll be denied.

Q How are orthodontic bracket replacements reimbursed? Can the client be charged for bracket replacements?

A The provider uses orthodontic procedure code D8690 to claim reimbursement. Medical necessity must be documented in the client record. Payment is subject to retrospective review.

The client with current Medicaid eligibility should not be charged for bracket replacement. If the provider charges the client erroneously, the provider refunds any amount paid by the client.

Q Why could an appeal of a denied claim take a long time?

A An appeal can take a long time if TMHP is required to research the denied claim and determine the reason the claim did not go through the system. For faster results, providers should submit appeals as soon as possible and not use the entire 120 days allowed to submit the appeal.

The following are guidelines on filing claims efficiently:

- Use R&S report dates to track filed claims.
- File claims electronically through TMHP EDI. Electronic billing does not allow a claim with an incorrect date to be accepted and processed, which saves time for the provider submitting claims and TMHP in processing claims. Call 1-888-863-3638, for more information about TMHP EDI.
- File claims with the correct information included. Most denied claims result from the omission of dates, signature, and narrative, or incorrect ID numbers such as client Medicaid numbers or provider identifiers.

Q Why are only ten appeals allowed per call?

A There is a limit on appeals per call to allow all providers equal access.

Q Why do reimbursement checks sometimes take a long time to arrive?

A Reimbursement may be delayed if a provider fails to submit claims in a timely manner.

Q Does electronic billing result in delayed payment?

A No. Providers who bill electronically report faster results than billing on paper. Providers are encouraged to use TMHP EDI for claims submission.

The following are helpful hints to a more efficiently processed claim:

- Ensure the provider identifier is on all claims.
- Include the performing proper's signature on all paper claims.
- Verify client eligibility for procedures.
- Verify if the procedure code requires a narrative on the claim; the narrative is for medical necessity.
- Include the required client information, including name, birth date, and client number.
- Dental auxiliaries cannot enroll in the Texas Medicaid Program; therefore, they cannot bill the Texas Medicaid Program. Any procedure performed by the auxiliary (i.e., the hygienist or the chairside assistant) must be billed by the supervising dentist, using the dentist's provider identifier.

Reminders:

- Procedure code D9630 is not payable for take home fluorides or drugs. Prescriptions should be given to clients to be filled by the pharmacy for these medications as the pharmacy is reimbursed by the Medicaid Vendor Drug Program. D9630 is payable for medications (antibiotics, analgesics, etc.) administered to a client in the provider's office. Documentation of dosage and route of administration must be provided in the Remarks section of the claim.
- Procedure code D8660 is allowed at different age levels, per provider. If D8660 is billed within six months of D8080, the D8080 will be reduced by the amount that was paid for D8660.
- Prior authorization is required with documentation of medical necessity when replacing lost or broken orthodontic retainers (D8680).
- Prior authorization of orthodontic services is nontransferable. If a client changes an orthodontic provider for any reason, the new provider must submit a separate request for prior authorization. The provider requesting and receiving authorization for the service also must perform the service and submit the claim. Codes listed on the authorization letters are the only codes considered for payment. All other codes billed are denied. Providing the authorization number on the submitted claim results in more efficient claims processing.
- General anesthesia (provided in the dentist office, ambulatory service clinic, and inpatient/outpatient hospital settings) does not require prior authorization, but is required to follow the Criteria for Dental Therapy Under General Anesthesia (see page 19-34) to determine if a client meets the minimum required points for general anesthesia. All THSteps dental charts for dental general anesthesia are subject to retrospective, random review for compliance with the Criteria for Dental Therapy Under General Anesthesia and requirements for chart documentation.
- Providers must not bill a client unless a formal denial for the requested item/service has been issued stating the service is not a benefit of the Texas Medicaid Program and the client has signed the Client Acknowledgment Statement for that specific item/service. A provider must not bill Medicaid clients if the provided service is a benefit of the Texas Medicaid Program.

Refer to: "Client Acknowledgment Statement" on page 1-11

THSteps clients must receive:

- Dental services specified in the treatment plan that meet the standards of care established by the laws relating to the practice of dentistry and the rules and regulations of the TSBDE.
- Dental services free from abuse or harm from the provider or the provider's staff.
- Only the treatment required to address documented medical necessity that meets professionally recognized standards of health care.

19.25 Medicaid Dental Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
THSteps-Dental Program:	
Automated Inquiry System (AIS)	xiii
Client Acknowledgment Statement	1-11
TMHP Electronic Data Interchange (EDI)	3-1
THSteps Dental (ADA) Claim Filing Instructions	5-43
TMHP Electronic Claims Submission	5-13
Criteria for Dental Therapy Under General Anesthesia	19-34
Communication Guide	A-1
THSteps Dental Mandatory Prior Authorization Request Form	B-108
Acronym Dictionary	F-1
Doctor of Dentistry Practicing as a Limited Physician:	
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-22
Example of CMS-1500 Claim Form	5-24, D-10
Communication Guide	A-1
Acronym Dictionary	F-1

19.26 Emergency Services for Medicaid Clients 21 Years of Age and Older

Limited dental services are available for clients 21 years of age and older (not residing in an ICF-MR facility) whose dental diagnosis is secondary to and causally related to a life-threatening medical condition.

Refer to: "Doctor of Dentistry Practicing as a Limited Physician" on page 36-136 for complete description and details.

19.26.1 Long Term Care (LTC) Emergency Dental Services

The Department of Aging and Disability Services (DADS) provides a limited range of dental services for Medicaid-eligible residents of LTC facilities. All claims for dental services provided to LTC residents are submitted to DADS. For information, providers should contact the appropriate LTC facility or DADS at 1-512-438-2633.

19.26.2 Laboratory Requirements

Dental laboratories must be registered with TSBDE laboratories, and technicians must not be under restrictions imposed by TSBDE or a court.

19.26.3 Complaint Management System

The program receives and documents complaints from any source and refers them to the appropriate entity for investigation. Examples of complaints from clients regarding providers include:

- The provider did not consult with the client, explain what services were necessary, or obtain parent/guardian informed consent.
- The treating provider refused to make the child's record available to the new provider.
- The provider did not give the child enough/any local anesthesia or pain medication.
- The provider did not use sterile procedures; the facility and/or equipment were not clean.
- The provider and/or his staff was verbally abusive.
- The client did not receive a service, but the provider billed the Texas Medicaid Program.
- The provider charged a Medicaid client for benefits.

19.27 Utilization Review

HHSC or a designated entity may conduct utilization reviews through automated analysis of a provider's pattern(s) of practice, including peer group analysis. Such analysis may result in a subsequent on-site utilization review. HHSC or its claims processing contractor may conduct utilization reviews at the direction of the Office of Inspector General (OIG), according to HHSC rules.

DSHS may also conduct dental utilization reviews of randomly selected THSteps dental providers. These reviews compare Medicaid dental services that have been reimbursed to a dental provider to the results of an oral examination of the client as conducted by DSHS regional dentists.

Refer to: 25 TAC, Chapter 33, Subchapter H for more information about utilization review.

Section

20

Family Planning Services

20.1 Overview

This section includes information on family planning services funded by Medicaid and non-Medicaid funding sources. Family planning services are preventive health, medical, counseling, and educational services that assist individuals in managing their fertility and achieving optimal reproductive and general health. For information about family planning and the locations of family planning clinics receiving Title V, X, or XX funding from the Department of State Health Services (DSHS), refer to the website at www.dshs.state.tx.us/famplan.

20.2 Family Planning Providers

TMHP processes family planning claims and encounters for four different funding sources administered through DSHS and HHSC. These funding sources include Title V, X, XIX (Medicaid, including the Women's Health Program), and Title XX. Agencies across Texas are awarded contracts for Titles V, X, and XX to provide services to low-income individuals who may not qualify for Medicaid services. These awards are granted through a competitive procurement process. DSHS contracts with a variety of providers, including local health departments, universities and medical schools, private nonprofit agencies, rural health clinics (RHCs), and hospital districts. Some contractors receive more than one type of funding. All contractors serve Medicaid-eligible individuals. Client eligibility requirements, reimbursement methodologies, client copayment guidelines, and covered services differ for each funding source. Family planning funding is not used to provide abortion services.

20.2.1 Women's Health Program

Women's Health Program (WHP) services are covered by the Texas Medicaid Program (Title XIX) and provided on a fee-for-service basis.

Refer to: "Women's Health Program" on page O-1 for a complete list of eligible diagnosis and procedure codes.

20.3 Provider Enrollment

20.3.1 Title XIX Enrollment

Only the following Medicaid provider types may be used to bill family planning services under Title XIX: physician, nurse practitioner (NP), clinical nurse specialist (CNS), physician assistant (PA), certified nurse-midwife (CNM), federally qualified health center (FQHC), or family planning agency. An NP and a CNS must be licensed as a registered nurse (RN) and recognized as an advanced practice nurse (APN) by the Texas Board of Nursing (BON).

Physicians who wish to provide Medicaid obstetric and gynecological (OB-GYN) services are allowed to bypass Medicare enrollment and obtain a Medicaid-only provider identifier for OB-GYN services regardless of provider specialty. Similarly, FQHCs do not need to apply for a separate physician or agency number. Family planning services are payable under the existing FQHC provider identifier using the family planning procedure codes in this section.

Family planning services provided by an RHC will not be paid if billed using the RHC's provider identifier but may be billed using a physician's or NP's provider identifier. An RHC can also apply for enrollment as a family planning agency and bill using the family planning agency's provider identifier. These services provided to an RHC client must be billed using modifiers AJ, AM, SA, or U7. These services must be billed using the appropriate national place of service (72) for an RHC setting.

Family planning agencies must apply for enrollment with TMHP to receive an agency provider identifier. To be enrolled in the Texas Medicaid Program, family planning agencies must meet the following requirements:

- Complete an agency enrollment application.
- Ensure that all services are furnished by, prescribed by, or provided under the direction of a licensed physician in accordance with the Texas Medical Board and/or Texas BON.
- Have a medical director who is a physician currently licensed to practice medicine in Texas, and submit a current copy of the medical director's physician license.
- Have an established record of performance in the provision of both medical and educational/counseling family planning services as verified through client records, established clinic hours, and clinic site locations.
- Provide family planning services in accordance with DSHS standards of client care for family planning agencies.
- Be approved for family planning services by the DSHS Family Planning Program.

The effective date for participation is the date an approved provider agreement with Medicaid is established and the provider is assigned a Medicaid provider identifier.

Providers cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients*

in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

20.3.2 Title V, X, and XX Contractors

Agencies that submit claims or encounters for Title V, X, or XX Family Planning services must have a contract with DSHS. The DSHS Community Health Services Section determines client eligibility and services policy. Refer to the DSHS *Title V, X, and XX Family Planning Manual* for specific eligibility and policy information at www.dshs.state.tx.us/famplan.

20.4 Guidelines for Family Planning Providers

Family planning services are provided by a physician or under physician direction, not necessarily personal supervision. A physician provides direction for family planning services through written standing delegation orders and medical protocols. The physician is not required to be on the premises for the provision of family planning services by an RN, PA, NP, or CNS. Medicaid clients, including limited and managed care clients, are allowed to choose any enrolled family planning service provider.

Family planning clients must be allowed freedom of choice in the selection of contraceptive methods as medically appropriate. They must also be allowed the freedom to accept or reject services without coercion. Services must be provided without regard to age, marital status, sex, race/ethnicity, parenthood, handicap, religion, national origin, or contraceptive preference. Only family planning clients, not their parents, spouses, or any other individuals, may consent to the provision of family planning services funded by Title X, XIX, or combined X and XX funds; however, counseling should be offered to adolescents that encourages them to discuss their family planning needs with a parent, an adult family member, or other trusted adult. For family planning services provided by Title V- or Title XX-only clinics, the consent of a parent or other adult is governed by the *Texas Family Code*, Section 32. For more information, visit www.dshs.state.tx.us/famplan/contractor/rider13.shtm.

20.5 Family Planning Claim Billing

20.5.1 Family Planning and Third Party Insurance

Federal and state regulations mandate that family planning client information be kept confidential. Because seeking information from third-party insurance resources may jeopardize the client's confidentiality, prior insurance billing is not a requirement for billing family planning for any title program.

20.5.2 Claims Information

All family planning services (Titles V, X, XIX, and XX) provided by physicians, PAs, NPs, CNSs, and family planning agencies who also contract with DSHS for Title V, X, or XX must be submitted to TMHP in an approved electronic format or on the Family Planning 2017 claim form (revised January 2007). Providers may copy the Family Planning 2017 claim form provided in this manual on page 5-47 or download it from the TMHP website at www.tmhp.com.

Medicaid family planning providers who do not also contract with DSHS for Title V, X, or XX, may use either the Family Planning 2017 claim form or the CMS-1500 claim form.

Hospitals must use the UB-04 CMS-1450 claims form when billing family planning services. FQHCs may use either the UB-04 CMS-1450 or the Family Planning 2017 claim form to bill family planning Medicaid services; however, if an FQHC also contracts with DSHS to provide Titles V, X, or XX family planning services, the Family Planning 2017 claim form/format must be used to submit all family planning claims, including Title XIX family planning claims. Providers can call the TMHP Contact Center at 1-800-925-9126 to inquire about family planning services, such as reimbursement rates, procedures, or claims filing questions.

Providers may purchase CMS-1500 and UB-04 CMS-1450 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a Family Planning 2017, CMS-1500, or UB-04 CMS-1450 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"Family Planning 2017 Claim Form" on page 5-47

"Family Planning 2017 Claim Form Instructions" on page 5-48 for instructions for completing paper claims.

"CMS-1500 Claim Filing Instructions" on page 5-22, and "UB-04 CMS-1450 Claim Filing Instructions" on page 5-30. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

20.5.2.1 Medicaid Managed Care Claims

Providers must use the CMS-1500 (physician, nonfacility) or UB-04 CMS-1450 (hospital) claim forms and submit claims directly to Medicaid health maintenance organizations (HMOs) for Title XIX family planning services. Title V,

X, or XX claims must always be submitted to TMHP directly using the Family Planning 2017 (Revised January 2007) claims form/format.

Providers submitting claims for family planning services to TMHP for Primary Care Case Management (PCCM) may use the Family Planning 2017 claim form.

Hospitals must use the UB-04 CMS-1450 claim form when billing family planning services.

20.5.2.2 Billing HMOs for Out-of-Network Family Planning Services

Medicaid Managed Care, including STAR+PLUS HMOs, are responsible for reimbursing providers for family planning benefits. A family planning provider does not have to contract with the client's HMO to be reimbursed for family planning services. Title XIX family planning providers should contact the client's health plan for billing instructions.

20.5.2.3 Title X Encounter Filing

In clinics supported by Title X funds, it is important to collect encounter data (such as demographics and services provided) for all family planning clients served, even for full-pay clients, regardless of the funding source to which the claim is billed. These data are used to compile some of the elements of the Family Planning Annual Report. Certain fields on the claim form must be completed for all clients seen at Title X clinics, regardless of the funding source to which the claim is billed. Based on clinic information submitted in the provider's most recent Title X or Title XX request for proposal (RFP), Compass21 rejects all claims from Title X clinics when the claims do not contain all the required information, regardless of the title being billed.

Clients in a Title X clinic who are not billed to another funding source are considered Title X-only clients. In some instances (such as when all Title V or XX funds are expended), services provided to a client normally eligible for another funding source are not billed to that funding source. A client whose income according to family size falls outside the eligibility guidelines for Titles V or XX would also be a Title X-only client. In these cases, a sliding fee scale that has been approved by the DSHS Community Health Services Section must be used to assess client fees for services received.

While it will not result in a payment from DSHS, a Family Planning 2017 Claim Form with Title X encounter information must be submitted to TMHP for all Title X-only clients, so that the required encounter data (demographics, etc.) are collected. Encounter forms for Title X clients are filled out the same way as for the other funding sources. Diagnosis information must be entered, and each of the services and/or tests provided to that client during the visit must be listed on the claim form. Sterilizations provided to Title X clients who are partial pay or no pay must follow the federal guidelines for sterilizations, and a completed Sterilization Consent Form must be faxed to TMHP at 1-512-514-4229. Providers must forward completed encounter forms to TMHP for processing. Payment for Title X services follows the current voucher submittal process outlined by the DSHS Claims Processing Unit.

20.5.2.4 Electronic TDHconnect or TexMedConnect Claims in a Title X-Supported Clinic

All claims and encounters for clients at Title X clinics must have Title X checked in the Title X Payment Level section under the Patient tab of the electronic claim form. This selection ensures that the required fields on the claim form are completed.

Titles V, XIX, and XX

Clients eligible for Title V, XIX, or XX must have the Funding Source box to which the claim is billed (Family Planning Program Block) checked on the Patient tab. The level of practitioner, in the General section of the Claim tab of the electronic claim form, must also be selected by a clinic that uses Title X funds.

Title X Only

The Title X box must be checked and the payment level must be selected in the Title X Payment Level block under the Patient tab. Depending on family size and income, the agency designates Title X clients as full pay, partial pay, or no pay for services. The Level of Practitioner in the General section of the Claim tab of the electronic claim form must also be selected.

20.5.2.5 Paper Form: Family Planning 2017 Claim Forms in a Title X-Supported Clinic

Titles V, XIX, and XX

Clients eligible for Title V, XIX, or XX must have the funding source to which the claim is billed checked in Block 1 of the Family Planning 2017 claim form. Block 28, Level of Practitioner, must be completed for every Family Planning 2017 claim form submitted by a clinic that uses Title X funds.

Title X Only

The payment level must be selected in the Title X Only section of Block 1a. Depending on family size and income, the agency designates Title X clients as full pay, partial pay, or no pay for services. Block 28, Level of Practitioner, must also be completed.

20.5.2.6 Other Electronic Claims in the Title X-Supported Clinic

Electronic claims that are not submitted through TexMedConnect or TDHconnect must follow the specifications for electronic claim submission. Providers should contact their commercial software vendor or TMHP through the TMHP website at www.tmhp.com or call the TMHP EDI Help Desk at 1-888-863-3638 for more information.

20.5.2.7 Title X Payments

Title X encounters submitted do not result in payments to the providers. To receive payment, providers must submit monthly or quarterly Financial Status Reports (FSRs) forms, along with a paper payment voucher, to the DSHS

Contract Development and Support Branch and Claims Processing Unit. Title X providers continue to receive reimbursement from the Comptroller.

20.5.3 Filing Deadlines

Title	Deadline	Appeals
V,X,XX	120 days from the date of service on the claim or date of any third-party insurance explanation of benefits (EOB)	120 days from the date of the Remittance and Status (R&S) report on which the claim reached a finalized status
XIX	95 days from the date of service on the claim or date of any third-party insurance EOB	120 days from the date of the R&S report on which the claim reached a finalized status

Note: *If the filing deadline falls on a weekend or TMHP-recognized holiday, the filing deadline is extended until the next business day.*

20.5.4 Claim Appeals

20.5.4.1 Two Appeal Methods to TMHP for Family Planning Titles V, X, and XX

An appeal is a request for reconsideration of a previously dispositioned claim.

Providers may use two methods to appeal Family Planning (Titles V, X, and XX) claims to TMHP: electronic or paper.

20.5.4.2 Electronic Appeal Submission

Electronic appeal submission is a method of submitting Texas Medicaid appeals using a personal computer (PC). The electronic appeals feature can be accessed by a business organization bridging directly into the TMHP EDI Gateway or by using TexMedConnect or TDHconnect.

Advantages of Electronic Appeal Submission

Using electronic appeal submission provides the following advantages to the users:

- Increased accuracy of appeals filed to potentially improve cash flow.
- Print and download capabilities help maintain audit trails.
- Appeal submission windows can be automatically filled in with electronic R&S report information, thereby reducing data entry time.
- Increases speed of payment processing.

Paper Appeals

Appeal the claim on paper by completing the following steps:

- Make a copy of the R&S page where the claim is reported or other official notification from TMHP.
- Circle one claim per R&S page for each adjustment.
- Identify the incorrect and/or missing information and submit changes that should be used to appeal the claim.
- Attach a copy of supporting medical documentation that is necessary or requested by TMHP.
- Attach a copy of the original claim, if available, or the corrected claim form for the appeal. Claim copies are helpful when the appeal involves medical policy or procedure coding issues.

Submit correspondence, adjustments, and appeals to the following address:

Texas Medicaid & Healthcare Partnership
Inquiry Control Unit
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727

20.5.4.3 Disallowed Appeals

If the provider's claim denies with EOB 00008, "Title X provider must provide level of practitioner information," the provider needs to submit a new claim with the correct level of practitioner. This claim denial cannot be appealed using the above-stated methods.

20.5.5 Billing Procedures for Non-Family Planning Services Provided During a Family Planning Visit

When a non-family planning service is provided during a family planning visit or the client is offered family planning services during a medical visit, the following billing process must be used:

- A family planning agency must bill for non-family planning services using a physician's or NP's provider identifier. The agency provider identifier is used to bill family planning services only.
- A physician, NP, or FQHC must bill both family planning services and non-family planning services, using the correct physician's, NP's, or FQHC's provider identifier.
- An RHC may bill a rural health encounter for a non-family planning medical condition or use the physician's or NP's provider identifier to bill for family planning services. If the RHC also is enrolled as a family planning agency, the family planning services may be billed using the agency's family planning provider identifier and the appropriate national place of service (72) for an RHC setting.

20.5.6 Limited Medicaid Coverage

Title XIX family planning services are exempt from the limited program and rules.

20.5.6.1 Family Planning Services for Undocumented Aliens, Legalized Aliens

Undocumented aliens are identified for limited Medicaid eligibility by the classification of Type Program (TP) 30, 31, 34, and 35. Under the Texas Medicaid Program, these clients are only eligible for emergency services, including emergency labor and delivery. Emergency-only services do not cover family planning under the Texas Medicaid Program to prevent future unintended pregnancies. All providers are strongly encouraged to promote the benefits and availability of family planning services under Titles V, X, and XX for this population. The family planning funding sources cover the provision of contraceptive devices, supplies, counseling, and sterilizations for these clients. Providers are asked to be aware of the importance of referral of these clients to family planning providers who receive Titles V, X, and XX funds with the goal of preventing future unintended pregnancies and births.

20.6 Diagnosis Codes

Providers should use one of the following diagnosis codes in conjunction with all procedures and services. The choice of diagnosis code should be based on the type of family planning service performed.

Diagnoses Codes				
V2501	V2502	V2509	V251	V252
V2540	V2541	V2542	V2543	V2549
V255	V258	V259	V2651	V4551
V4559	V615			

20.7 Procedure Codes and Reimbursement Amounts

The procedure codes and reimbursement amounts listed are authorized for family planning billing by family planning agencies. Use only the codes listed. Failure to do so may result in claim denials.

Refer to: "Limitations" on page 20-7.

20.7.1 Family Planning Annual Exams

A family planning annul exam consists of a comprehensive health history and physical examination, including medical laboratory evaluations as indicated, an assessment of the client's problems and needs, and the implementation of an appropriate contraceptive management plan. The annual exam is allowed once per fiscal year, per client, per provider. Other family planning office or outpatient visits may be billed within the same year.

Note: *Title XIX providers and Title V and XX providers use different codes to file annual exams.*

Title XIX Only

Procedure Code	Fee for Title XIX
1-99204 With modifier FP * or 1-99214 With modifier FP*	$70.64 $41.46
*** = Services payable to an FQHC based on an all-inclusive rate per visit.**	

Title V and XX Only

Procedure Code	Fee for Title V or XX
1-99203 With modifier FP or 1-99214 With modifier FP	$48.27 $41.46

20.7.2 Other Family Planning Office or Outpatient Visits

During any visit for a medical problem or follow-up visit, the following must occur:

- An update of the client's relevant history.
- Physical exam, if indicated.
- Laboratory tests, if indicated.
- Treatment and/or referral, if indicated.
- Education/counseling or referral, if indicated.
- Scheduling of office or clinic visit if indicated.

Title XIX Only

Title XIX providers may use procedure codes 1-99201, 1-99202, 1-99203, 1-99205, 1-99211, 1-99212, 1-99213, and 1-99215 with modifier FP and a family planning diagnosis for other family planning office or outpatient visits. These procedure codes are allowed for routine contraceptive surveillance, family planning counseling/education, contraceptive problems, suspicion of pregnancy, genitourinary infections, and evaluation of other reproductive system symptoms.

Title V and XX Only

For Title V and XX providers, procedure code 1-99213 is allowed for routine contraceptive surveillance, family planning counseling and education, contraceptive problems, suspicion of pregnancy, genitourinary infections, and evaluation of other reproductive system symptoms.

20.7.2.1 Limitations

An annual family planning examination or other family planning office or outpatient visit billed with the FP modifier is not considered for reimbursement when submitted with the same date of service as an additional evaluation and management visit. Providers may appeal denied claims using modifier 25 if the reason for the additional visit was for a separate, distinct service from the family planning visit. Documentation that supports the

provision of a significant, separately identifiable evaluation and management service must be maintained in the client's medical record and made available to the Texas Medicaid Program upon request.

Procedure codes 1-99204, 1-99214, and 1-J7300 are the only allowable codes for RHCs and FQHCs. RHCs providers must bill with modifiers AJ, AM, SA, or U7, and must use the family planning provider identifier.

Up to three encounter rates per calendar year per client may be reimbursed to FQHCs for family planning visits when only family planning services occurred during the visit. Providers must use procedure code 1-J7300, 1-99204, or 1-99214 to receive an encounter rate reimbursement for visits in which only family planning services were provided. For any family planning service other than an intrauterine device (IUD) or an annual exam with a new patient, FQHCs must bill procedure code 1-99214 with the claim to receive an encounter rate reimbursement. This includes family planning services that are not annual exams and visits where only an injection is provided.

20.7.3 Laboratory Procedures

20.7.3.1 Laboratory Procedures—Title V Only

Laboratory tests for Title V clients may be sent to the DSHS laboratory and/or one of its designated affiliates for processing at no cost to the provider. This cost is covered by the Title V Program and the DSHS laboratory.

Providers who choose not to use the DSHS laboratories can send their specimens to another laboratory of their choice, but they are not reimbursed by DSHS for those services. These tests, whether provided by DSHS or another laboratory facility, must be documented on the Family Planning claim form to track the services provided and to collect accurate statewide data.

Refer to: "Laboratory Procedures—Titles V and XX" on page 20-8 to identify which tests are provided by DSHS at no cost to Title V contractors.

20.7.3.2 Laboratory Procedures—Title XIX Only

Medicaid family planning service providers must document all laboratory services ordered in the client's medical record as medically necessary and reference an appropriate diagnosis. Any test specimen sent to a laboratory for interpretation should not be billed on the family planning provider's claim. The laboratory bills the Texas Medicaid Program directly for the tests it performs.

All providers of laboratory services must comply with the rules and regulations of the *Clinical Laboratory Improvement Amendments* (CLIA). Providers not complying with CLIA are not reimbursed for laboratory services. Only the office or lab actually performing the laboratory test procedure and holding the appropriate CLIA certificate may bill for the procedure.

If a provider does not perform the laboratory procedure, the provider may be reimbursed one lab handling fee a day, per client, unless multiple specimens are obtained and sent to different laboratories. Procedure code 1-99000 with modifier FP is paid for handling and/or conveyance of the specimen for transfer from the provider's office to a laboratory.

Handling fees are not paid for Pap smears or cultures. When billing for Pap smear interpretations, the claim must indicate that the screening and interpretation were actually performed in the office (place of service [POS] 1) by using the modifier SU, e.g., 5-88150-SU.

Forward the client's name, address, Medicaid number, and a family planning diagnosis with any specimen, including Pap smears, to the reference laboratory so the laboratory may bill the Texas Medicaid Program for its family planning lab services.

When family planning test specimens, such as Pap smears, are collected, providers must direct the laboratory to indicate that the claim for the test is to be billed as a family planning service, i.e., the procedure must be billed with a family planning diagnosis.

For a complete list of Title XIX laboratory procedures, providers can refer to the Texas Medicaid fee schedules located on the TMHP website at www.tmhp.com /file library/file library/fee schedules.

20.7.3.3 Laboratory Procedures—Titles V and XX

The following list of laboratory procedures and reimbursements are those authorized for billing by Titles V and XX family planning service providers with appropriate documentation in the client's record.

Procedure Code	Title V Fee	Title XX Fee
5-80061	$0*	NA
5-81002	$3.54	$3.54
5-81015	$4.20	$4.20
5-81025	$8.74	$8.74
5-81099	$0*	NA
5-82465	$0*	$6.02
5-82947	$0	$5.42
5-83020	$0*	NA
5-84478	$7.95	$7.95
5-85013	$3.27	$3.27
5-85018	$3.27	$3.27
5-85025	$10.74	$10.74
5-85660	$7.63	$7.63
5-86580	$7.36	$7.36
5-86592	$0*	$5.90

*** Title V providers do not receive reimbursement for services performed free of charge by the DSHS Laboratory. For correct tracking of services performed, providers are required to include these services on their Title V Family Planning claims filed with TMHP.**

Procedure Code	Title V Fee	Title XX Fee
5-86701	$0*	NA
5-86762	$0*	$19.89
5-87070	$11.90	$11.90
5-87205	$5.90	$5.90
5-87797	$0*	$27.71
5-88150	$0*	$14.60
5-88230	$0*	NA

*** Title V providers do not receive reimbursement for services performed free of charge by the DSHS Laboratory. For correct tracking of services performed, providers are required to include these services on their Title V Family Planning claims filed with TMHP.**

Refer to: "Clinical Laboratory Improvement Amendments (CLIA)" on page 26-2

20.7.4 Radiology

Radiology services are to be performed for the purpose of localization of an IUD.

Procedure Code	Fee for Titles V, XIX and XX
4-74000	$22.91
4-74010	$27.00
4-76815	$69.55

Title XIX Only

These procedures can be billed on either the Family Planning 2017 claim form or the CMS-1500 claim form. Physicians, NPs, CNSs, PAs, and FQHCs may bill any radiology code that is medically necessary.

20.7.5 Contraceptive Devices and Related Procedures

The following applies to Titles V, XIX, and XX:

- Procedure codes 1-J7300 or 1-J7302 must be billed with 2-58300 on the same date of service to receive reimbursement for IUD and the insertion of the IUD.
- An IUD insertion/procurement of the IUD may be reimbursed when billed on the same date of service as a dilation and curettage. Procedure code 2-58120 is reimbursed at full allowance. Procedure code 2-58300 may be considered for reimbursement separately from procedure code 1-J7302. Procedure codes 1-J7300 and 1-J7302 are reimbursed at full allowance.
- When a vaginal, cervical, or uterine surgery (e.g., cervical cauterization) is billed for the same date of service as the insertion of the IUD, the surgical procedure is paid at full allowance and the IUD insertion billed using procedure code 2-58300 is paid at half the allowed amount.

For Title XIX only, procedure code 2-58301 may be considered for reimbursement when an IUD is extracted from the uterine cavity. Procedure code 2-58301 is not considered for reimbursement when submitted with the same date of service as an office visit.

Procedure Code	Titles V and XX Fee	Title XIX Fee
9-A4261	$24.22	$24.22
9-A4266	$10.01	$10.01
1-J7300	$387.60	$403.75
1-J7302	$487.76	$420.48
2-11976	$152.25	$152.25
2-57170	$38.00	$38.00
2-58300	$69.00	$69.00
2-58301	$39.01	$39.01

20.7.6 Drugs and Supplies

Procedure Code	Title V and XX Fee	Title XIX Fee
9-A4261	$24.22	$24.22
9-A4266	$10.01	$10.01
9-A4267	$0.22	$0.22
9-A4268	$2.00	$2.00
9-A4269	$4.00	$4.00
1-A9150* with modifier FP	$14.00	NA
1-J1055	$48.10	$48.10
1-J3490	$5.90	$5.01
1-J7303	$35.80	$40.65
1-J7304	$10.62	$15.36
1-S4993	$2.80	$2.80
1-90772**	NA	$2.15

*** Title V and Title XX only. For Title XIX, clients are provided a prescription to be filled through the Vendor Drug Program.**
**** Title XIX only. Not a payable benefit for Titles V and XX.**

20.7.6.1 Dispensing Medication

Family planning providers have a choice of dispensing family planning drugs and supplies directly to the client and billing TMHP or giving clients prescriptions to take to a pharmacy. Family planning drugs and supplies that are dispensed directly to the client are billed to TMHP or a Medicaid managed care organization (MCO), whichever is appropriate for the client. Providers who also contract with DSHS for Title V, X, or XX should refer to the DSHS *Title V, X, and XX Family Planning Policy Manual* for additional guidance on dispensing medication to Title V, X, or XX clients.

Procedure code J3490 may be billed when a prescription medication to treat a genital infection is provided to the client. Procedure code A9150 with modifier FP may be

billed when a nonprescription medication to treat a monilia infection is provided to the client. Family planning drugs and supplies are exempt from the three prescriptions-per-month rule. Additionally, pharmacies under the Vendor Drug Program contract are allowed to fill the prescription for up to six months at a time, rather than a one-month supply.

20.7.6.2 Injection Administration—Title XIX Only

Injection administration billed by a provider is reimbursed separately from the medication. When billing procedure code J1055, the injection administration should be billed using procedure code 1-90772. If billed without procedure code J1055, procedure code 1-90772 must be billed with a family planning diagnosis and a family planning modifier (FP) and a description of the medication in the Remarks field of the claim. Injection administration is not payable to outpatient hospitals.

20.7.7 Medical Counseling and Education

20.7.7.1 Instruction in Natural Family Planning Methods (Per Session)—Title V, XIX , and XX

Procedure code 1-H1010 is intended to instruct a couple or an individual in methods of natural family planning and may consist of two sessions. Each session may be billed separately or the two sessions may be billed together with a total charge for both sessions.

20.7.7.2 Introduction to Family Planning in Hospital Setting/Auspices—Title V and XX Only

Procedure code 1-S9445 with modifier FP consists of an overview of family planning benefits to encourage pregnant or postpartum women to use family planning services following delivery.

20.7.7.3 Nutritionist Visit—Title V Only

Procedure code 1-S9470 is provided by a licensed dietician for clients with a high-risk condition; for example, diabetes, hypertension, lipid disorders, and others. This procedure code may only be billed for clients with a high-risk condition.

Refer to: "Licensed Dietitians (THSteps-CCP Only)" on page 43-59 for more information about Texas Health Steps (THSteps) nutritional counseling for clients birth through 20 years of age.

20.7.7.4 Method-Specific Education/Counseling—Title V and XX Only

Procedure code 1-99401 with modifier FP provides information about the contraceptive method chosen for use by the client, including its proper use, the possible side effects and complications, its reliability, and its reversibility. The service is provided when initiating a contraceptive method, when changing contraceptive methods, or when having difficulty with a current method.

The educational counseling must include at least the following:

- Verbal and written instructions for correct use of the method and self-monitoring.
- Information regarding the method's mode of action, safety, benefits, and effectiveness.
- Information regarding risks, potential side effects, and complications of the method and what to do if they occur.
- Backup method: review when appropriate and instructions on the correct use.
- When prescribing a diaphragm or cervical cap, include a demonstration of the correct insertion and removal procedures.

20.7.7.5 Problem Counseling—Title V and XX Only

Procedure code 1-99402 with modifier FP is billed when clients have problems they wish to discuss that are not related to a contraceptive method. Examples include pregnancy, sexually transmitted diseases (STDs), social and marital problems, health disorders, sexuality concerns, preconception counseling, and options counseling for an unintended pregnancy.

Clients who may become pregnant and in whom the assessment reveals potential pregnancy risks must receive preconception counseling regarding the modification/reduction of that risk.

20.7.7.6 Teen Group Counseling - Title XX Only

Procedure code 1-99411 is used for group presentations and/or discussions conducted with a minimum of five adolescents 19 years of age and younger. Sessions are reimbursed at $1.50 per person for 5 to 49 people or a total of $75 for 50 or more participants. Topics for discussion include, but are not limited to, human anatomy, human sexuality, personal physical care and hygiene, skills to resist sexual coercion, methods of family planning, and STDs. The provider should prepare a written statement for each session that indicates where and when the session was held, the specific topic(s) discussed, and the number of participants. These statements are kept by the provider and may be reviewed by the DSHS Quality Management Branch staff during site visits.

20.7.7.7 Initial Patient Education - Title V and XX Only

Procedure code 1-99429 with modifier FP is provided to facilitate selection of an effective contraceptive method. Every new client requesting contraceptive services or family planning medical services must be provided initial client education either verbally, in writing, or by audio-visual materials. Over-the-counter contraceptive methods may be provided before the client receives the initial client education but must be accompanied by written instructions on correct use. The initial client education may vary according to the educator's evaluation of the client's current knowledge. It may include the following:

- General benefits of family planning services and contraception.
- Information on male and female basic reproductive anatomy and physiology.
- Information regarding the benefits and potential side effects and complications of all available contraceptive methods.
- Information about all of the clinic's available services, the purpose and sequence of clinic procedures, and routine schedule of return visits.
- Breast self-examination rationale and instruction, unless provided during physical exam (for females).
- Information on human immunodeficiency virus (HIV)/STD infection and prevention and safer sex discussion.
- Information about the importance of having a THSteps medical and dental check up.

20.7.8 Sterilization and Sterilization-Related Procedures

Sterilization services are a benefit when billed by an agency, an FQHC, or a physician. FQHCs and physicians must use the most appropriate Current Procedural Terminology (CPT) procedure code for payment. The codes with the global fees listed in the following table are developed for family planning agencies only:

Procedure Code	Fee for Titles V and XX
1-55250*	$253.75
1-58600*	$1800.00
*** Global fee (includes all services, i.e. facility, physician, anesthesia, recovery, and pre- and post-surgical care).**	

Type of service (TOS) 1 must be used by family planning agencies when billing sterilization procedures.

20.7.8.1 Incomplete Sterilizations—Title V and XX only

For incomplete procedures, diagnosis code V641, V642, or V643 must be present on the claim in addition to the diagnosis for sterilization. Providers must use the most appropriate diagnosis code for each situation. Incomplete sterilizations are billed at cost. All charges related to the procedure are tracked cumulatively.

20.7.8.2 Tubal Ligation

Procedure code 1/2-58600 must be used for any sterilization procedure performed on a female client by a family planning agency using Title V, X, XIX, or XX. This procedure code is paid as a global fee to include preoperative, intraoperative, and postoperative services by all parties involved, (i.e., physician, anesthesiologist, facility, laboratory, etc.). Sterilizations are considered to be permanent, once per lifetime procedures. When a client's claim history shows a previous sterilization, providers are asked to appeal and must provide supporting documentation for the need for repeat sterilization. Per federal regulation 42 *Code of Federal Regulations* (CFR) 50, Subpart B, all sterilization procedures require an approved Sterilization Consent Form.

For a complete list of Title XIX sterilization procedures, providers should refer to the Texas Medicaid fee schedules located on the TMHP website at www.tmhp.com/file library/file library/fee schedules.

Refer to: "Sterilization Consent Form (English)" on page B-96 and "Sterilization Consent Form (Spanish)" on page B-97.

"Sterilization Consent Form and Instructions" on page 20-11.

"Women's Health Program" on page O-1 for information on billing the Women's Health Program for sterilizations

20.7.8.3 Vasectomy

Procedure code 1/2-55250 should be used for any sterilization procedure performed on a male by a family planning agency using Title V, X, XIX, or XX. This procedure code is paid as a global fee to include preoperative, intraoperative, and postoperative services by all parties involved (i.e., physician, anesthesiologist, facility, laboratory, etc.). Vasectomies are considered to be permanent, once-per-lifetime procedures. When a client's claim history shows a previous vasectomy, providers will be asked to appeal and must provide supporting documentation for the need for repeat sterilization. Per federal regulation 42 CFR 50, Subpart B, all sterilization procedures require an approved Sterilization Consent Form.

Refer to: "Sterilization Consent Form (English)" on page B-96 and "Sterilization Consent Form (Spanish)" on page B-97.

"Sterilization Consent Form and Instructions" on page 20-11.

20.7.8.4 Anesthesia for Sterilization

Providers must use modifier FP, when reporting anesthesia services for a sterilization procedure.

The following procedure codes require modifier FP, in addition to the regular anesthesia modifier, if the service is a sterilization CPT anesthesia code:

Procedure Codes		
7-00840	7-00920	7-00922
7-00950	7-00851	7-00921
7-00940		

20.7.9 Sterilization Consent Form and Instructions

Per federal regulation 42 CFR 50, Subpart B, all sterilizations require a valid consent form regardless of the funding source. Providers must use the consent form

provided in this manual in Appendix B and ensure all required fields are completed for timely processing. These fields are listed in "Required Fields" on page 20-5.

Providers should fax the Sterilization Consent Form five business days before submitting the associated claim(s) to expedite the processing of the Sterilization Consent Form and associated claim(s). Providers must fax fully completed Sterilization Consent Forms to TMHP at 1-512-514-4229. Claims and appeals are not accepted by fax, so providers can send only Family Planning sterilization correspondence to this fax number. Providers should ensure that both Page 1 and Page 2 of the sterilization consent form are faxed together. Failure to do so may delay claim processing or cause the claim to be denied.

Note: *Hysterectomy Acknowledgment forms discussed in Section 34 are not sterilization consents and should be faxed to 1-512-514-4218.*

Refer to: "Sterilization Consent Form (English)" on page B-96 and "Sterilization Consent Form (Spanish)" on page B-97.

20.7.9.1 Sterilization Consent Form Instructions

Clients must be *21 years of age or older* when the consent form is signed. If the client was 20 years of age or younger when the consent form was signed, the consent is denied. Changing signature dates is considered fraudulent and is reported to the Office of the Inspector General (OIG).

There must be at least 30 days between the date the client signs the consent form and the date of surgery, with the following exceptions:

- Premature delivery—There must be at least 30 days between the date of consent and the client's expected date of delivery.
- Cases of emergency abdominal surgery not associated with pregnancy—There must be at least 72 hours between the date of consent and the date of surgery. Operative reports detailing the need for emergency surgery are required.

Listed below are field descriptions for the Sterilization Consent Form published in this manual. Completion of all sections is required to validate the consent form, with only two exceptions:

- Race and ethnicity designation is requested but not required.
- The Interpreter's Statement is not required as long as the consent form is written in the client's language or the person obtaining the consent speaks the client's language; however, if this section is only partially completed, the consent is not accepted as a valid consent.

This Sterilization Consent Form may be copied for provider use. Providers are encouraged to frequently recopy the original form to ensure legible copies and to expedite consent validation. Providers must fax fully completed Sterilization Consent Forms to TMHP at 1-512-514-4229.

20.7.9.2 Required Fields

All of the fields must be legible in order for the consent form to be valid. Any illegible field results in a denial of the submitted consent form. Resubmission of legible information must be indicated on the consent form itself. Resubmission with information indicated on a cover page or letter is not accepted.

Consent to Sterilization

- Name of doctor or clinic.
- Name of the sterilization operation.
- Client's date of birth (month, day, year).
- Client's name (first and last names are required).
- Client's signature.
- Date of client signature—Client must be 21 years of age or older on this date. This date cannot be altered or added at a later date.

Interpreter's Statement (If Applicable)

- Name of language used by interpreter.
- Interpreter's signature.
- Date of interpreter's signature (month, day, year).

Statement of Person Obtaining Consent

- Client's name (first and last names are required).
- Name of the sterilization operation.
- Signature of person obtaining consent—The statement of person obtaining consent must be completed by the person who explains the surgery and its implications and alternate methods of birth control. The signature of person obtaining consent must be completed at the time the consent is obtained. The signature must be an original signature, not a rubber stamp.
- Date of the person obtaining consent's signature (month, day, year)—Must be the same date as the client's signature date.
- Facility name—Clinic/office where the client received the sterilization information.
- Facility address—Clinic/office where the client received the sterilization information.

Physician's Statement

- Client's name (first and last names are required).
- Date of sterilization procedure (month, day, year)—Must be at least 30 days and no more than 180 days from the date of the client's consent except in cases of premature delivery or emergency abdominal surgery.
- Name of the sterilization operation.
- Expected date of delivery (EDD)—Required when there are less than 30 days between the date of the client consent and date of surgery. Client's signature date must be at least 30 days prior to EDD.
- Circumstances of emergency surgery—Operative report(s) detailing the need for emergency abdominal surgery are required.
- Physician's signature—Stamped or computer-generated signatures are not acceptable.

- Date of physician's signature (month, day, year)—This date must be on or after the date of surgery.

Paperwork Reduction Act Statement

This is a required statement and must be included on every Sterilization Consent Form submitted.

Additional Required Fields

- The following provider identification numbers are required to expedite the processing of the consent form:
  - Texas Provider Identifier (TPI).
  - National Provider Identifier (NPI).
  - Taxonomy.
  - Benefit code.
- Provider/clinic phone number.
- Provider/clinic fax number (If available).
- Family planning title for client—Indicated by circling V, X, XIX, or XX.

20.7.10 Claim Filing Resources

Providers can refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System	xiii
TMHP Electronic Data Interchange (EDI)	3-1
TMHP Electronic Claims Submission	5-13
Family Planning 2017 Claim Form	5-47
Family Planning 2017 Claim Form Instructions	5-48
Communications Guide	A-1
Acronym Dictionary	F-1
Women's Health Program	O-1

Section

21

Federally Qualified Health Center (FQHC)

21.1 Enrollment

To enroll in the Texas Medicaid Program, an FQHC must be receiving a grant under Section 329, 330, or 340 of the *Public Health Service Act* or designated by the U.S. Department of Health and Human Services (HHS) to have met the requirements to receive this grant. FQHCs and their satellites are required to enroll in Medicare to be eligible for Medicaid enrollment. The Centers for Medicare & Medicaid Services (CMS) has granted a waiver for the Medicare prerequisite at the time of initial enrollment of FQHC parents and satellites. FQHC *look-alikes* are *not* required to enroll in Medicare but may elect to do so to receive reimbursement for crossovers.

Refer to: "Medicare-Medicaid Crossover Claims Pricing" on page 21-3.

A copy of the Public Health Service-issued Notice of Grant Award reflecting the project period and the current budget period must be submitted with the enrollment application. A current notice of grant award must be submitted to TMHP Provider Enrollment annually. FQHCs are required to notify TMHP of all satellite centers that are affiliated with the parent FQHC and their actual physical addresses. All FQHC satellite centers billing the Texas Medicaid Program for FQHC services must also be approved by the Public Health Service. For accounting purposes, centers may elect to enroll the Public Health Service-approved satellites using a Federally Qualified Satellite (FQS) provider identifier that ties back to the parent FQHC provider identifier and tax ID number (TIN). This procedure allows for the parent FQHC to have one provider agreement and one cost report that combines all costs from all approved satellites and the parent FQHC. If an approved satellite chooses to bill the Texas Medicaid Program directly, the center must have a separate provider identifier from the parent FQHC and will be required to file a separate cost report.

All providers of laboratory services must comply with the rules and regulations of the *Clinical Laboratory Improvement Amendments* (CLIA). Providers not complying with CLIA will not be reimbursed for laboratory services.

Refer to: "Clinical Laboratory Improvement Amendments (CLIA)" on page 26-2.

"Provider Enrollment" on page 1-2 for more information about enrollment procedures.

New FQHCs must file a projected cost report within 90 days of their designation as an FQHC to establish an initial payment rate. The cost report will contain the FQHC's reasonable costs anticipated to be incurred during the FQHC's initial fiscal year. The FQHC must file a cost report within five months of the end of the FQHC's initial fiscal year. The cost settlement must be completed within 11 months of the receipt of a cost report. The cost per visit rate established by the cost settlement process shall be the base rate. Any subsequent increases shall be calculated as provided herein. A new FQHC location established by an existing FQHC participating in the Texas Medicaid Program will receive the same effective rate as the FQHC establishing the new location. An FQHC establishing a new location may request an adjustment to its effective rate as provided herein if its costs have increased as a result of establishing a new location.

21.1.1 Medicaid Managed Care Enrollment

An FQHC that wants to enroll in Medicaid Managed Care as a primary care provider or specialty provider must contact the individual Medicaid Managed Care health plans for enrollment information.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment and Responsibilities" on page 1-1 for more information about enrollment procedures.

21.1.2 THSteps and Family Planning Enrollment

FQHC providers can enroll as THSteps and Family Planning providers.

21.2 Reimbursement

FQHCs are reimbursed provider-specific prospective payment system encounter rates in accordance with 1 TAC §355.8261.

To be reimbursed for Case Management for Children and Pregnant Women (CPW) an FQHC must be approved by the Department of State Health Services (DSHS), Case Management Branch, as a provider of case management services. The FQHC must bill these services using its FQHC provider identifier and the appropriate procedure code for case management of CPW.

Refer to: "Prospective Payment Methodology" in TAC §355.8261 for more information.

"Case Management for Children and Pregnant Women (CPW)" on page 12-1.

21.2.1 Medicare-Medicaid Crossover Claims Pricing

For FQHC Medicare-Medicaid crossover claims, the Texas Medicaid Program pays the difference between the Medicaid encounter rate and any Medicare payment up to a maximum of the Medicaid encounter rate. If the Medicare payment is larger, no payment is made by Medicaid.

21.2.2 Provider Cost Reporting

FQHC providers are required to submit a copy of their Medicare audited cost report with the fiscal year ending on or after January 1 within 15 days of receipt from Medicare. Submit to the following address:

Texas Medicaid & Healthcare Partnership
Medicaid Audit
PO Box 200345
Austin, TX 78720-0345

21.2.3 Copayments for FQHCs and RHCs

The following copay procedure codes may be considered for reimbursement by the Texas Medicaid Program for FQHCs, rural health clinics (RHCs), and associated providers:

Procedure Codes		
1-CP001	1-CP002	1-CP003
1-CP004	1-CP005	1-CP006
1-CP007	1-CP008	

21.3 Benefits and Limitations

Medicaid coverage is limited to services provided by the center that are covered by the Texas Medicaid Program and are reasonable and medically necessary.

When furnished to a client of the FQHC, medically necessary services include the following:

- Clinical nurse specialist (CNS) services.
- Clinical psychologist services.
- Clinical social worker services; other mental health services.
- Nurse practitioner (NP) services.
- Other ambulatory services included in Medicaid such as family planning, Texas Health Steps (THSteps), birthing center, and maternity service clinic (MSC).
- Physician assistant services.
- Physician services.
- Services and supplies necessary for services that would be covered otherwise, if furnished by a physician or a physician service.
- Vision care services.
- Visiting nurse services to a homebound individual, in the case of those FQHCs located in an area with a shortage of home health agencies.

A visit is a face-to-face encounter between an FQHC client and a physician, PA, NP, certified nurse-midwife (CNM), visiting nurse, qualified clinical psychologist, clinical social worker, other health professional for mental health services, dentist, dental hygienist, or an optometrist. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except where one of the following conditions exists:

- After the first encounter, the client suffers illness or injury requiring additional diagnosis or treatment.
- The FQHC client has a medical visit and an *other* health visit.

A medical visit is a face-to-face encounter between an FQHC client and a physician, physician assistant, NP, CNM, or visiting nurse.

An *other* health visit includes, but is not limited to, a face-to-face encounter between an FQHC client and a qualified clinical psychologist, clinical social worker, other health professional for mental health services, a dentist, a dental hygienist, an optometrist, or a THSteps medical check up.

All services provided that are incident to the encounter should be included in the total charge for the encounter and are not billable as a separate encounter. For example, if an office visit was provided at a charge of $30 and a lab test for $15, the center would bill TMHP procedure code 1-T1015 for $45 and would be reimbursed at the center's encounter rate.

Reminder: *An encounter is defined as a face-to-face meeting between an FQHC client and a physician, PA, NP, CNM, visiting nurse, qualified clinical psychologist, clinical social worker, other health professional for mental health services, dentist, dental hygienist, or an optometrist.*

All services (except for family planning, THSteps medical, THSteps dental, immunizations, and case management for high-risk pregnant women and infants) provided during an encounter *must* be billed using procedure code 1-T1015.

Laboratory and radiology services or the services of a licensed vocational nurse (LVN), registered nurse (RN), nutritionist, or dietitian are *not* considered an encounter, because they are incidental to an encounter with one of the above-mentioned health-care professionals. Providers should continue to include the cost associated with these services on their cost report (they are allowable but do not constitute an encounter).

When an FQHC sees a client younger than 21 years of age for immunizations that are not part of a THSteps check up, the FQHC should bill for the administration of the immunization on the UB-04 CMS-1450 or CMS-1500 claim form using their FQHC provider identifier and the appropriate Medicaid procedure code. If the client is seen only for immunizations, an encounter should not be billed. There

is no change in the billing procedures for those services noted as exceptions. The total billed amount for the service should be the total charge for all services provided during the encounter or incident to the encounter.

Claims should be filed as follows:

Services	Claim Form
CPW case management services	UB-04 CMS-1450 or CMS-1500 claim form
THSteps dental services	American Dental Association (ADA) claim form
THSteps medical services	CMS-1500 claim form.

All claims must be filed using the FQHC provider identifier.

Services provided by a health-care professional require one of the following modifiers with procedure code 1-T1015, to designate the health-care professional providing the services: AH, AM, SA, TD or TE with place of service (POS) 2, or U7.

If more than one health-care professional is seen during the encounter, the modifier should indicate the primary contact. The primary contact is defined as the health-care professional who spends the greatest amount of time with the client during that encounter.

If the encounter is for antepartum care or postpartum care, the modifier TH must be indicated.

The electronic format or the paper claim form allows for multiple modifiers; therefore, if the antepartum or postpartum care or delivery is provided by a CNM, then modifier SA must be indicated on the claim in addition to the appropriate modifier above.

If a physician of the FQHC provides a service in the hospital such as delivery, the FQHC may elect to bill for that service using the physician's provider identifier, if the contract with the physician indicates this occurrence. If the service is billed using the physician number rather than the FQHC's provider identifier, the costs associated with the service must be *excluded* from the cost report and will not be considered during the cost settlement/encounter rate setting process.

After-Hours Care

After-hours care for FQHCs and RHCs is defined as care provided on weekends, on federal holidays, or before 8 a.m. and after 5 p.m. Monday through Friday. After-hours care provided by FQHCs and RHCs do not require a referral from the client's primary care provider. FQHCs and RHCs that provide after-hours services to PCCM clients must submit claims with modifier TU.

Refer to: The following sections for benefit limitation information:

"Benefits and Limitations" on page 10-2 in the Birthing Center section.

"Benefits and Limitations" on page 12-3 in the Case Management for Children and Pregnant Women (CPW) section.

"Benefits and Limitations" on page 19-10 in the Dental section.

"Benefits and Limitations" on page 28-2 in the Licensed Clinical Social Worker (LCSW) section.

"Benefits and Limitations" on page 29-2 in the Licensed Marriage and Family Therapist (LMFT) section.

"Benefits and Limitations" on page 30-2 in the Licensed Professional Counselors (LPCs) section.

"Benefits and Limitations" on page 31-2 in the Maternity Service Clinic section.

"Benefits and Limitations" on page 36-8 in the Physician section.

"Benefits and Limitations" on page 38-2 in the Psychologist section.

"Benefits and Limitations" on page 43-43 in the THSteps section.

"Benefits and Limitations" on page 45-3 in the VIsion Care (Optometrists, Opticians) section.

"Benefits and Limitations" on page O-3 in the Women's Health Program appendix.

21.3.1 Telemedicine

A remote site provider can be an FQHC, RHC, or health-care provider such as a physician, advanced practice nurse (APN), or CNM who is able to independently bill the Texas Medicaid Program for an office visit.

FQHC telemedicine providers must submit their claims using the appropriate encounter code and modifiers. Use modifier AM, U7, or SA in the *first* modifier field on the claim form with the modifier GT in the *second* modifier field.

Refer to: "Telemedicine Services" on page 36-20 for more information.

21.3.2 Newborn Eligibility Process for FQHCs

A child is deemed eligible for services provided by the Texas Medicaid Program for up to one year if the mother is receiving services provided by the Texas Medicaid Program at the time of the child's birth, and if the child continues to live with the mother, and if the mother continues to be eligible for Medicaid or would be eligible for Medicaid if she were pregnant.

Therefore, it is not acceptable to require a deposit for newborn care from a Medicaid client. The child's eligibility ceases if the mother relinquishes her parental rights or if it is determined that the child is no longer part of the mother's household.

Filing a claim for a newborn client under the mother's client number can delay a claim payment.

Note: *When billing for a Medicaid Managed Care client, providers must adhere to the client's health plan's guidelines for newborn billing.*

Claims with charges for newborn care are submitted separately from charges for the mother. Claims submitted for services provided to a newborn child should be filed using the newborn child's Medicaid number. To expedite the claims processing, enter the mother's name in Block 84 of the Remarks field of the UB-04 CMS-1450 claim form. Include this information in Block 4 of the CMS-1500.

To provide information about each child born to a mother eligible for Medicaid, FQHCs with birthing centers should complete Form 7484 *Hospital Report of Newborn Child or Children*. If the newborn's name is known, include it on the form. The use of *Baby Boy* or *Baby Girl* delays the assignment of a number. Filing this form expedites the assignment of a Medicaid number for the newborn child. Do not complete this form for stillbirths.

Refer to: "Hospital Report (Newborn Child or Children) HHSC Form 7484" on page B-49.

The FQHC should complete the form within five days of the child's birth and send it to DSHS. This five-day time frame is not mandatory; however, prompt submission will expedite the process of determining the child's eligibility. FQHCs should duplicate the form as needed because HHSC and TMHP do *not* supply this form.

Upon receipt of a completed form, DSHS verifies the mother's eligibility and sends notices within ten days to the hospital or birthing center, attending physician (if identified), mother, and caseworker. The notice includes the child's Medicaid number and the effective date of coverage. HHSC will issue a client Medicaid Identification form (Form H3087) after the child has been added to the eligibility file.

The attending physician's notification letter is sent to the address on file for the license number at the Texas Medical Board. This address must be kept current to ensure timely notification of attending physicians. Physicians should submit address changes to the following address:

Texas Medical Board
Customer Information, MC-240
PO Box 2018
Austin, TX 78767-2018

21.4 Claims Information

FQHC services must be submitted to TMHP in approved electronic format or on a UB-04 CMS-1450 or CMS-1500 claim form. Providers may purchase UB-04 CMS-1450 or CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a UB-04 CMS-1450 or CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"UB-04 CMS-1450 Claim Filing Instructions" on page 5-30 for instructions on completing paper claims.

"CMS-1500 Claim Filing Instructions" on page 5-22 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

When filing claims for clients who only have Medicaid, providers may use either a UB-04 CMS-1450 or CMS-1500 claim form. Claims for THSteps services provided by FQHC providers must include the EP modifier.

FQHC providers billing for THSteps must use the CMS-1500 claim form and the EP modifier, not the UB-04 CMS-1450 claim form.

For FQHC providers who also have Titles V, X, and XX funding, family planning claims are filed on the "Family Planning 2017 Claim Form" on page 5-47.

When filing for a client who has Medicare and Medicaid coverage, providers must file on the same claim form that was filed to Medicare. The THSteps Dental (ADA) claim form described under FQHC services, Family Planning, Case Management for CPW, and THSteps services may be submitted electronically or on the "ADA Dental Claim Form" on page 5-38.

21.4.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-22
UB-04 CMS-1450 Claim Filing Instructions	5-30
Dental (ADA) Claim Filing Instructions	5-43
TMHP Electronic Claims Submission	5-13
Communication Guide	A-1
Federally Qualified Health Center Report (Newborn Child or Children) Form 7484	B-40
FQHC Encounter (T1015) Claim Example	D-14
FQHC Follow-Up Claim Example	D-14
Acronym Dictionary	F-1

Section

22

Genetic Services

22.1 Enrollment

A provider of genetic services who wishes to enroll in the Texas Medicaid Program must complete the required Medicaid provider enrollment application forms and enter into a written agreement with HHSC. Texas Medicaid provider enrollment forms are available from TMHP, and may be downloaded at www.tmhp.com. Completed applications are submitted to:

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

Prior to enrollment, applicant qualifications for the provision of genetic services are verified and approved by the Department of State Health Services (DSHS). Verification and approval are administered through the Health Screening & Case Management Unit, 1-512-458-7111, ext. 2193. Basic contract requirements are as follows:

- The provider's medical director must be a clinical geneticist (doctor of medicine [MD] or doctor of osteopathy [DO]) who is licensed by the Texas Medical Board and who is board eligible/certified by the American Board of Medical Geneticists (ABMG).
- The provider must use a team of professionals to provide genetic evaluative, diagnostic, and counseling services. The team rendering the services must consist of professional staff including a clinical geneticist (MD or DO) and at least one of the following: nurse, social worker, medical geneticist (PhD), or genetic counselor.

Upon DSHS approval, TMHP issues a provider identifier number and a performing provider identifier for the provision of genetic services.

A provider cannot be enrolled if his or her license is due to expire within 30 days; a current license must be submitted.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

22.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with a Medicaid Managed Care health plan to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

Refer to: "Managed Care" on page 7-1 for more information on Medicaid Managed Care programs.

22.2 Reimbursement

Genetic services providers are reimbursed according to the established allowable maximum fee schedule.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

22.3 Benefits and Limitations

Genetic services providers are reimbursed for the provision of genetic services to evaluate clients for the possibility of a genetic disorder, diagnose such disorders, counsel clients regarding such disorders and their implications for family planning, and provide follow-up of clients with known or suspected disorders.

Genetic services encompass the professional component (examination, diagnosis, consultation, counseling, and follow-up). For all providers, documentation in the medical record must support the level of physician evaluation and management procedure code used.

Providers of genetic services are not limited to geneticists. Physicians (MD, DO) and advanced practice nurses can order genetic laboratory tests and/or provide professional services related to genetic disease management for patients. To provide Medicaid services, each nurse practitioner (NP) or clinical nurse specialist (CNS) must be licensed as a registered nurse and recognized as an advanced practice nurse (APN) by the Texas Board of Nursing (BON).

Genetic services are payable when provided in the office setting (place of service [POS 1]), in the inpatient hospital setting (POS 3), and in the outpatient hospital setting (POS 5).

22.3.1 Genetic Benefit Schedule

For providers enrolled in the Texas Medicaid Program as a geneticist, the additional services described in this section will apply.

22.3.1.1 Genetic Evaluation and Counseling

Only a full-service genetic services provider enrolled in the Texas Medicaid Program as a geneticist may bill the following evaluation and management codes under type of service G.

Procedure Code	Limitations	Maximum Fee
G-96040	None	$26.73
G-99213	None	$50.76
G-99214	None	$81.20
G-99215	One per year, any provider	$147.18
G-99244	One every three years, any provider	$248.68
G-99245	One every three years, any provider	$370.48
G-99254	One every three years, any provider	$248.68
G-99255	One every three years, any provider	$370.48
G-99402	One per pregnancy, per provider*	$50.75
G-99404	One every three years, any provider	$152.25

*** Exception: Additional services are allowed when documentation of medical necessity to repeat a procedure accompanies a claim.**

One office consultation (procedure codes G-99244 or G-99245) may be considered for reimbursement if procedure codes G-99244, G-99245, G-99254, and/or G-99255 have not been submitted and reimbursed in the previous three years.

Inpatient consultations (procedure codes G-99254 and G-99255) may be considered for reimbursement once every three years even if an office consultation has been reimbursed in the previous three years.

In addition to meeting the requirements for the specific physician evaluation and management procedure code, the enrolled geneticist must also provide the following services in the components listed below for consideration of enhanced reimbursement. Documentation in the medical record must support the level of code submitted.

History

The comprehensive history, as part of genetic services, should include an extensive medical and family history covering at least three matriarchal and patriarchal generations. A pedigree is constructed. This history includes any affected individuals in the immediate or extended family, information on pregnancy, plus a developmental, educational, and social history.

The family genetic health history update is performed to update the health history. It consists of noting changes, such as the loss of eyesight or change in muscle control in the health of the client under evaluation. Genetic-related problems identified in newborns or in other family members should also be included in the interval history update.

Examination

The focus of the comprehensive examination related to genetic services may vary according to specific client needs. The comprehensive examination typically includes, but is not limited to, extensive anthropomorphic measurements, such as occipital frontal circumference, height, weight, and measurement of inner canthal and outer canthal distances with calculations of interpupillary distances; ear size and ear placement on the head; philtrum length; internipple distance; and finger and palm lengths as well as a complete physical examination.

Photographs are also taken of the client, both face and total body. Additional photographs are taken of any abnormalities noted upon physical examination for further consultative work and review.

Counseling

Counseling includes prognosis, recurrence risks, family planning implications, and the options available to family members who are at increased risk for giving birth to individuals with the same condition. A counseling procedure code should be submitted if counseling is the only service provided.

22.4 Claims Information

Genetic services must be submitted to TMHP in an approved electronic format or on a CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

TMHP representatives are available for provider questions about genetic services, such as reimbursement rates and procedures. For more information, call the TMHP Contact Center at 1-800-925-9126.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"CMS-1500 Claim Filing Instructions" on page 5-22. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

22.4.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-22
TMHP Electronic Claims Submission with the TMHP	5-13
Communication Guide	A-1
Genetics Services	D-15
Acronym Dictionary	F-1

Section

23

Hearing Aid and Audiometric Evaluations

23.1 Enrollment

To enroll in the Texas Medicaid Program, hearing aid professionals (physicians, audiologists, and fitters and dispensers) who provide hearing evaluations or fitting and dispensing services must be licensed by the licensing board of their profession to practice in the state where the service is performed. Hearing aid providers are only eligible to enroll as individuals and facilities. Additionally, audiologists not wanting to enroll as a hearing aid provider are allowed to enroll separately as audiologists.

Providers cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information on enrollment procedures.

23.1.1 Medicaid Managed Care Enrollment

Hearing aid providers must enroll with Medicaid Managed Care to be reimbursed for services provided to Medicaid Managed Care clients.

23.2 Reimbursement

Hearing aids and audiometric services are reimbursed in accordance with 1 *TAC §*355.8141. Hearing evaluations and the first and second revisits are reimbursed according to the maximum allowable fee. Procedure codes R-99211 and R-99212 should be billed for the first and second revisits, respectively.

Reimbursement for ear molds and the fitting and dispensing fee is limited to the established maximum fee.

Hearing aid procedures indicated with "MR" (Manually Review) must be submitted with the Manufacturer's Suggested Retail Price (MSRP) in the *Comments* field of the claim. If the MSRP is not included in the comments field on the original submission, the claim will be denied. Providers will be required to submit their request as an appeal, and must include an invoice validating the cost of the instrument. The maximum allowable fee for the hearing aid instrument includes:

- Acquisition cost of the hearing aid (the actual cost or net cost of the hearing aid after any discounts have been deducted).
- Manufacturer's postage and handling charges.
- All necessary tubing, cords, and connectors.
- Bone conduction headbands.
- Telephone coils.
- Compression circuits.
- Contralateral Routing of Offside Signal (CROS)/Bilateral Contralateral Routing of Offside Signal (BICROS) features.
- Instructions for care and use.
- One-month supply of batteries.

Charges for hearing aid components must be verified by the manufacturer's invoice and price lists. The fitting and dispensing fee includes the postfitting check of the hearing aid within five weeks after the dispensing date.

Note: *Charges to the client for covered services constitute a breach of the Medicaid contract.*

Refer to: "Reimbursement Methodology" on page 2-2 for more information on reimbursement.

"Billing Clients" on page 1-10 for more information.

Fee schedules for services in this chapter are available on the TMHP website at www.tmhp.com/file library /file library/fee schedules.

23.3 Benefits

Hearing aid services, including hearing aid instruments, are considered for reimbursement when they are medically necessary. Benefits for hearing aid services are determined by statutory and fiscal limitations.

For clients 21 years of age and older, hearing aid services are benefits of the Texas Medicaid Program.

For Medicaid clients 20 years of age and younger, hearing aid services are available through the Department of State Health Services (DSHS) Program for Amplification for Children of Texas (PACT).

An appropriate hearing screening is a mandatory part of each medical check up. When suspicion or indication of a hearing problem occurs, the client should be referred to an enrolled PACT provider. For a list of PACT providers, visit the PACT website at www.dshs.state.tx.us/audio /program.shtm or write to:

DSHS
Program for Amplification for Children of Texas (PACT)
1100 West 49th Street
Austin, TX 78756-3199
1-512-458-7724

23.3.1 Hearing Screenings

Audiometry is the testing of a person's ability to hear various sound frequencies and is performed with the use of electronic equipment. Audiometry is used to identify and diagnose hearing loss. Otoacoustic emissions (OAE) or auditory brainstem response (ABR) audiometry are benefits of the Texas Medicaid Program for infants, children, and adults who cannot be tested by conventional audiometry.

23.3.1.1 Newborn Hearing Screening

Health Safety Code, Chapter 47, *Vernon's Texas Codes Annotated* mandates that a newborn hearing screening occur at the birthing facility before hospital discharge. The hospital is responsible for the purchase of equipment, training of personnel, screening of the newborns, certification of the program according to DSHS standards, and notification to the provider, parents, and DSHS of screening results.

OAE or ABR audiometry are used to screen for newborn hearing and may be performed as early as a few hours after birth when completed by a licensed audiologist. There is no additional Medicaid reimbursement for the newborn hearing screening because the procedure is part of the newborn hospital diagnosis related group (DRG) payment. Hospitals must use procedure code K-09547 to report this newborn hearing screen on the UB-04 CMS-1450 claim form.

This facility-based screening also meets the physician's required component for hearing screening in the inpatient newborn Texas Health Steps (THSteps) check up. The physician must ensure that the hearing screening is completed before discharging the newborn or, when the birthing facility is exempt under the law, that there is an appropriate referral for a hearing screening to a birthing facility participating in the newborn hearing screening program.

The physician must discuss the screening results with the parents, especially if the hearing screening results are abnormal, and order an appropriate referral for further diagnostic testing. If the results are abnormal, the parent's or legal guardian's consent must be obtained to send information to DSHS for tracking and follow-up purposes.

If a physician has any concerns about this process, the physician should contact the hospital administrator or the DSHS Audiology Services Program at 1-512-458-7724.

23.3.1.2 Initial Test at Birth

The provider must do the following:

- Verify that the parents received the results of the hearing screen at the birthing facility.
- Check for obvious physical abnormalities.
- Supply a hearing checklist for parents and instructions on its use (this checklist is discussed at the first in-office THSteps medical check up).
- Provide a referral for further diagnostic audiological testing for an infant with abnormal screening results or who is at high-risk for hearing impairment.

If the Infant is admitted to a birthing facility, the facility where the birth occurs must offer newborn hearing screenings through a program mandated by the Texas State Legislature and certified by the Texas Department of Health.

Procedures for newborn hearing screenings provided during the birth admission are considered part of the newborn delivery payment to the facility and are not considered for reimbursement as separate procedures.

If the infant is not admitted to a birthing facility or is born outside of a birthing facility, procedures for newborn hearing screenings performed during the initial Texas Health Steps (THSteps) visit are considered part of the initial newborn medical check up and are not considered for reimbursement as separate procedures. Providers that are not THSteps-enrolled must refer the infant to an enrolled THSteps provider for an initial THSteps medical check up, which includes a newborn hearing screening.

An initial newborn hearing screening for infants who are not admitted to a birthing facility consists of the following:

- Completing the Hearing Checklist for Parents form.
- Assessing any physical abnormalities.
- Instructing the parent(s) on the use of the hearing checklist.
- Informing the parent(s) of the results.
- Referring the high-risk infant to a physician who renders audiology services.

23.3.1.3 Outpatient Hearing Screening and Diagnostic Testing for Children

As part of the THSteps medical check up, physicians are required to complete the hearing screening component. Separate procedure codes must not be billed when hearing screenings are part of medical check ups or day care/school requirements. Medicaid does not reimburse separately.

For children who are seen in the office setting, THSteps requires a puretone audiometer for visits where objective screening is required. In other childcare settings (e.g., day care; preschool; Head Start; and elementary, middle, and high school), the DSHS Vision and Hearing Screening Program requires that a puretone audiometer be used for hearing screening.

Impedance testing is usually used in the physician's office to monitor children who have a documented history of repeated bouts of otitis media and may be billed separately as a diagnostic hearing test with a THSteps check up. Impedance testing does not meet the requirements for the sensory screening component of the THSteps check up.

23.3.1.4 Three Years of Age and Younger

A hearing screening must be completed during each THSteps medical check up. A THSteps hearing screening consists of the following:

- An observation and history recording obtained from a responsible adult familiar with the child.
- Completion of the Hearing Checklist for Parents form.
- Referral of a high-risk child to a physician who renders audiology services.

23.3.1.5 Three Through 20 Years of Age

For children 3 years through 20 years of age, physicians are required to complete the hearing screening during each THSteps medical check up as part of the check up. Medicaid will not consider the hearing screening for reimbursement separate from the check up. For children who are seen in the office setting, the THSteps program requires a pure tone audiometer at visits where objective screening is required. In other child-care settings, (e.g., day care; preschool; Head Start; elementary, middle, and high school), the TDH Vision and Hearing Screening Program requires that a pure tone audiometer be used for hearing screening. The provider should do the following:

- Assess children with a puretone audiometric hearing screen (1000, 2000, 4000 Hz) at 4 through 10 years of age.
- Perform a subjective hearing evaluation, to include client history and observation of the child for the ability to answer questions and follow directions at all other medical check ups where an audiometric screen is not required.
- Document the results of any school screening audiometric testing program in the 12 months preceding the medical check up.
- Refer any child or adolescent (preschool through twelfth grade) who does not respond to a 25 dB tone at any frequency for a diagnostic hearing evaluation.

23.3.1.6 Abnormal Screening Results

All abnormal hearing screenings for infants and children from 20 years of age and younger should be referred to a local Medicaid provider for follow-up. If the purpose is to determine permanent hearing loss or type of amplification needed, infants and children must be referred to an approved hearing services PACT provider for follow-up.

Traditional Medicaid providers may be reimbursed for the follow-up care when a local PACT provider is not accessible.

All abnormal hearing screenings for clients 21 years of age and older must be referred to a physician who provides audiological services.

23.3.1.7 Adults Hearing Screening 21 Years of Age and Older

ABR and OAE audiometry are benefits of the Texas Medicaid Program for infants, children, and adults and may be used in addition to conventional audiometry for further diagnosis.

23.3.1.8 Hearing Referrals

For clients 20 years of age and younger, providers should refer Medicaid-eligible children identified during the THSteps medical check up as needing a diagnostic hearing evaluation or other hearing services, including hearing aids, to an approved hearing services provider. DSHS provides payment to providers for hearing services provided to children eligible for Texas Medicaid Program services.

Separate procedure codes may be billed for children who require diagnostic hearing testing. The following diagnostic audiometric testing codes may be billed as appropriate: 5/I-92567, 5/I/T-92585, 5-92586, 5/I/T-92587, and 5/I/T-92588.

23.3.2 Hearing Aid Instrument

Medicaid reimbursement for hearing aid instruments is limited to eligible clients, 21 years of age and older, whose air conduction puretone average in the better ear is 45 dB or greater. The client must have medical necessity for a hearing aid instrument and have no medical contraindications for using a hearing aid. Each client must be offered an appropriate new hearing aid instrument within the Medicaid allowable fee schedule. Hearing aid(s) are considered for reimbursement once every six years.

Important: *TMHP may refer people to the Texas Rehabilitation Commission whose jobs are contingent on possession of a hearing aid as well as people appearing to have vocational potential and who need a hearing aid.*

23.3.2.1 Warranty

Each hearing aid instrument dispensed through the Texas Medicaid Program must be a new and current model that meets the performance specifications indicated by the manufacturer and the client's individual hearing needs. A new hearing aid is one that has never been used and carries a full 12-month manufacturer's warranty. The manufacturer's warranty must be effective for 12 months after the dispensing date.

23.3.2.2 30-Day Trial Period

Providers must allow each Medicaid client a 30-day trial period that gives the client time to determine satisfaction with a purchased hearing aid instrument. The trial period consists of 30 consecutive days beginning with the dispensing date. During the trial period, providers may dispense additional hearing aids as medically necessary until the client is satisfied with the results of the aid, or the provider determines that the client cannot benefit

from the dispensing of an additional hearing aid. A new trial period begins with the dispensing date of each hearing aid. Under the Texas Medicaid Program, if the client is not satisfied with the purchased hearing aid instrument, the client may return it to the provider, who must accept it.

If the aid is returned within 30 days, the provider may charge the client a rental fee. Providers must obtain a client-signed acknowledgment statement stating the client is responsible for paying the hearing aid rental fees and retain the signed acknowledgment statement in the client's file. Client must sign the acknowledgment statement prior to receiving the hearing aid. Providers must allow 30 days to elapse from the hearing aid dispensing date before completing a 30-Day Trial Period Certification Statement.

23.3.2.3 Fitting and Dispensing Visit

The fitting and dispensing visit also includes the post-fitting check.

23.3.2.4 First Revisit

Additional counseling is available as needed within a period of six months after the post-fitting check. The first revisit, 99211, includes a hearing aid check.

23.3.2.5 Second Revisit

The second revisit procedure code 99212, includes aided sound field testing performed by a contracted evaluator according to the guidelines specified for the hearing evaluation. If the aided sound field test scores suggest a decrease in hearing acuity, the provider must include puretone and speech audiometry on Form 3503, *Hearing Aid Evaluation Repor*t. The second revisit is available as needed after the post-fitting check and the first revisit.

The following table lists hearing aid instrument, assessment, and revisit procedure codes.

Note: *Hearing aid procedures indicated with "MR" must be submitted with the MSRP in the Comments field of the claim. If the MSRP is not included in the comments field on the original submission, the claim will be denied. Providers will be required to submit their request as an appeal, and must include an invoice validating the cost of the instrument.*

Procedure Code	Medicaid Fee
R-99211	*
R-99212	*
R-V5010	$44.35
R-V5011	$50.00
R-V5030	MR
R-V5040	MR
R-V5050	MR
R-V5060	MR
R-V5070	MR
R-V5080	MR
R-V5090	$100.00
R-V5100	MR
R-V5110	$150.00
R-V5120	MR
R-V5130	MR
R-V5140	MR
R-V5150	MR
R-V5160	$170.00
R-V5170	MR
R-V5180	MR
R-V5190	MR
R-V5200	$170.00
R-V5210	MR
R-V5220	MR
R-V5230	MR
R-V5240	$170.00
R-V5241	$115.00
R-V5242	MR
R-V5243	MR
R-V5244	MR
R-V5245	MR
R-V5246	MR
R-V5247	MR
R-V5248	MR
R-V5249	MR
R-V5250	MR
R-V5251	MR
R-V5252	MR
R-V5253	MR
R-V5254	MR
R-V5255	MR
R-V5256	MR
R-V5257	MR
R-V5258	MR
R-V5259	MR
R-V5260	MR
R-V5261	MR
R-V5262	MR

*** Refer to the Physician Fee Schedule on the TMHP website at www.tmhp.com**

Procedure Code	Medicaid Fee
R-V5263	MR
R-V5264	$18.90
R-V5265	$18.90
R-V5275	$18.90
R-V5298	MR
R-V5299	MR
*** Refer to the Physician Fee Schedule on the TMHP website at www.tmhp.com**	

23.3.3 Audiological Testing

Audiometry is the testing of a person's ability to hear various sound frequencies and is performed with the use of electronic equipment. Audiometry is used to identify and diagnose hearing loss.

Air and bone pure tone audiometry threshold testing assesses air and bone conduction. Speech reception threshold (SRT) and word recognition tests indicate the softest level that a person is able to hear and repeat two-syllable words, and how well a person can repeat words presented at a comfortable listening level. Speech audiometry uses a series of simple recorded words spoken at various volumes into headphones worn by the person being tested. The person repeats each word back as it is heard.

Procedure code 5-92557 is a comprehensive code. If any of the following procedure codes are submitted with the same date of service as procedure code 5-92557, they are denied as part of another service:

Procedure Codes		
5-92551	5-92552	5-92553
5-92555	5-92556	

If three or more of the procedure codes listed above are submitted for reimbursement with the same date of service, they are denied with instructions to submit the appropriate audiometry procedure code (5-92557).

Procedure codes 5-92563, 5-92567, 5-92568, and 5-92569 are diagnostic hearing procedures that may be considered for reimbursement separately.

Tympanometry impedance testing (procedure code 5-92567) should never be used as the sole clinical means to establish the presence or absence of acute or chronic middle ear effusion or infection. Direct otoscopic examination by a suitably qualified provider, with or without pneumatic otoscopy, is the key element of the standard method used to establish a diagnosis of middle ear disease.

Tympanometry must be limited to selected individual cases where its use demonstrably adds to the provider's ability to establish a diagnosis and provide appropriate treatment. Tympanometry is limited to four services per year by the same provider and is based on medical necessity. Medical necessity must be documented in the patient's medical record. Tympanometry does not meet the requirements for a sensory screening component of the THSteps medical check up.

Acoustic reflex testing (procedure codes 5-92568 and 5-92569) provides information about the middle ear, specifically middle ear muscle reflexes in response to sound. The test can help distinguish between sensory (cochlear) hearing loss and neural (retro-cochlear) hearing loss. Acoustic reflex testing (procedure codes 5-92568 and 5-92569) is limited to the following diagnosis codes:

Diagnosis Codes				
2251	3510	3511	3518	3519
38600	38601	38602	38603	38604
38610	38611	38612	38619	3862
38630	38631	38632	38633	38634
38635	38640	38641	38642	38643
38648	38650	38651	38652	38653
38654	38655	38656	38658	3868
3869	3870	3871	3872	3878
3879	3882	38830	38831	38832
38840	38841	38842	38843	38844
38845	3885	38905	38906	38913
38915	38916	38917	38920	38921
38922	7443	7804		

Evoked response testing includes the following procedures:

- ABR, also called brainstem evoked potential (BSER), audiometry is a procedure in which neural discharges from the auditory pathways are measured with surface electrodes situated on the scalp.
- Otoacoustic emissions (OAE) measures response from the cochlea.

Procedure codes 5-92585, 5-92586, 5/I/T-92587, and 5/I/T-92588 may be submitted for evoked response testing.

Each evoked potential test is considered a bilateral procedure. If separate charges are submitted for left- and right-sided tests of the same type, the tests will be combined and considered a quantity of one.

An electroencephalogram (EEG) submitted with the same date of service as an evoked response test is considered for reimbursement at the full reimbursement rate. Evoked response testing is also considered for reimbursement at the full reimbursement rate.

Procedure code 1-95920 is considered for reimbursement in addition to each evoked potential test. Procedure code 1-95920 is limited to a maximum of two hours each day, regardless of provider, without documentation of medical necessity.

23.4 Limitations and Exclusions

The following limitations and exclusions apply:

- Reimbursement for a hearing aid instrument is limited to eligible clients, 21 years of age and older, whose air conduction puretone average in the better ear is 45 dB or greater.
- Hearing aid purchases are limited to one every six years with the exception of clients birth through 20 years of age through PACT.
- Clients birth through 20 years of age must be referred to PACT.
- Services for residents in nursing facilities (skilled nursing facility [SNF], intermediate care facility [ICF], or extended care facility [ECF]) must be ordered by the attending physician. The order must be on the client's chart and state the condition necessitating hearing aid services and must be signed by the attending physician.
- No payment is made for replacement of batteries or cords.
- No payment is made for repairs or replacements of lost, destroyed, or inappropriate hearing aids.
- No binaural fittings are available except in certain documented cases of legally blind, hearing-impaired clients who have no other available resources. This information must be documented in the client's file as well as on the claim submitted for payment for hearing aid services.
- U.S.-manufactured hearing aids must be considered when the purchase price and quality are comparable to those of foreign manufacturers.
- Home visit hearing evaluations and fittings are permitted only with the physician's written recommendation.
- Auditory training, speech, reading, or other rehabilitative services are not included.

Refer to: "CMS-1500 Claim Filing Instructions" on page 5-22.

23.5 Documentation Requirements

TMHP does not require prior authorization for hearing aids and related procedures. Retain reported audiological and medical information in the client's file until requested. The hearing evaluation must be recommended by a physician (with written medical clearance) for the fitting of a hearing aid by completing the Physician's Examination Report. The Hearing Aid Evaluation Report must include an audiometric assessment. This form must provide objective documentation to support improved communication ability with amplification.

Refer to: "Physician's Examination Report" on page B-71.

"Hearing Evaluation, Fitting, and Dispensing Report (Form 3503)" on page B-41.

23.6 Client Eligibility

The provider determines a client's eligibility for hearing aid services by any of the following:

- Asking to see the client's current Medicaid eligibility form (possession of a current Medicaid eligibility form with a check mark in the hearing aid box indicates the client's eligibility for the month).
- Using the Automated Inquiry System (AIS) to determine eligibility for Medicaid and for a hearing aid.
- Verifying client eligibility on the TMHP website at www.tmhp.com.

Important: *AIS provides claim status, client eligibility, benefit limitations, and current check amount.*

Refer to: "Eligibility Verification" on page 4-4.

"Automated Inquiry System (AIS)" on page -xiii for instructions or contact TMHP Customer Service at 1-800-925-9126.

23.7 Claims Information

Hearing aid services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Providers supplying hearing aids for STAR+PLUS Medicaid Qualified Medicare beneficiary (MQMB) clients should submit claims to TMHP, not the STAR+PLUS HMO for the hearing aid.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"CMS-1500 Claim Filing Instructions" on page 5-22. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

23.7.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-Claims Filing Instructions	5-22
Communication Guide	A-1
Hearing Evaluation, Fitting, and Dispensing Report (Form 3503)	B-41
Physician's Examiniation Report	B-71
Hearing Aid Assessments Claim Example	D-15
Acronym Dictionary	F-1

Section

24

Texas Medicaid (Title XIX) Home Health Services

24.1 Enrollment

To enroll in the Home Health Services Program, home health services and Home and Community Support Services (HCSSA) providers must complete the Texas Medicaid Provider Enrollment Application. Medicare certification is required for providers that are licensed as a Licensed and Certified Home Health Agency. Providers that are licensed as a Licensed Home Health Agency are not required to enroll in Medicare as a prerequisite to enrollment with the Texas Medicaid Program.

Licensed and certified home health agencies that are enrolled as Medicaid providers can provide personal care services (PCS) using their existing provider identifier.

PCS for clients younger than 21 years of age will be provided by the Texas Health and Human Services Commission (HHSC) under the PCS benefit.

Refer to: "Personal Care Services (THSteps-CCP Only)" on page 43-65.

To provide Texas Health Steps (THSteps)-Comprehensive Care Program (CCP) services, HCSSA providers must follow the enrollment procedures in Section 43.4, "THSteps-Comprehensive Care Program (CCP)."

Enrolled providers of durable medical equipment (DME) and/or expendable medical supplies will be issued a DME-Home Health Services Provider Identifier that is specific to home health providers. All DME providers must be Medicare-certified before applying for enrollment in the Texas Medicaid Program.

Providers may obtain the application by writing to the following address:

Texas Medicaid & Healthcare Partnership
Provider Enrollment
PO Box 200795
Austin, TX 78720-0795
1-800-925-9126
Fax: 1-512-514-4214

For prior authorization requests on the Home Health Services contact:

Texas Medicaid & Healthcare Partnership
Home Health Services
PO Box 202977
Austin, TX 78720-2977
1-800-925-8957
Fax: 1-512-514-4209

For general questions, such as claims history information, prior authorization history, procedure codes, procedural matters, or to verify if prior authorization has already been issued, call the TMHP Comprehensive Care Program (CCP)-Home Health Provider Line at 1-800-846-7470.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for information about enrollment procedures.

24.1.1 Change of Address/Telephone Number

A current physical and mailing address and telephone number must be on file for the agency/company to receive Remittance & Status (R&S) reports, reimbursement checks, Medicaid provider procedures manuals, the *Texas Medicaid Bulletin* (bimonthly update to the *Texas Medicaid Provider Procedures Manual*), and all other TMHP correspondence. Promptly send all address and telephone number changes to TMHP Provider Enrollment at the address listed above in "Enrollment" on page 24-4.

24.1.2 Pending Agency Certification

Home health agencies and DME-Home Health Services (DMEH) suppliers submitting claims before the enrollment process is complete or without authorization for services issued by TMHP Home Health Services Authorization Department will not be reimbursed. The effective date of enrollment is when all Medicaid provider enrollment forms are received and approved by TMHP.

Upon the receipt of notice of Medicaid enrollment, the agency/supplier must contact TMHP's Home Health Services Authorization Department before serving a Medicaid client for services that require a prior authorization number. Prior authorization cannot be issued before Medicaid enrollment is complete. Regular prior authorization procedures are followed at that time.

Home health agencies that provide laboratory services must comply with the rules and regulations of the *Clinical Laboratory Improvement Amendments* (CLIA). Providers who do not comply with CLIA will not be reimbursed for laboratory services.

Do not submit Home Health Services claims for payment until Medicaid certification is received and a prior authorization number is assigned.

Refer to: "Clinical Laboratory Improvement Amendments (CLIA)" on page 26-2.

24.2 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with a Medicaid Managed Care plan to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

Refer to: "Medicaid Managed Care" on page 7-4.

24.3 Reimbursement

The reimbursement methodology for professional services delivered by home health agencies are statewide visit rates calculated in accordance with 1 TAC §355.8021(a).

Fee schedules for all services in this chapter are available on the TMHP website at www.tmhp.com/file library /file library/fee schedules.

A skilled nurse (SN) and/or home health aide (HHA) visit may be provided up to a maximum of 2.5 hours per visit. A combined total of three SN and/or HHA visits may be reimbursed per day.

When services are provided to more than one client in the same setting, only the units directly provided to each client at distinct, separate time periods will be reimbursed. Provider documentation must support the services were delivered at distinct, separate time periods. Total home health services billed for all clients cannot exceed the individual provider's total number of hours spent at the place of service (POS).

One as needed (PRN) SN visit may be reimbursed every 30 days outside of the prior authorized visits when SN visits have been authorized for the particular client.

For reimbursement purposes, Home Health SN and/or HHA services are always billed as POS 2 (home) regardless of the setting in which the services are actually provided. SN and/or HHA services provided in the day care or school setting will not be reimbursed.

All unique procedure codes must be billed according to the description of the procedure code. The quantity billed must be identified and each procedure code must be listed as separate line items on the claim. SN, HHA, physical therapy (PT), and occupational therapy (OT) visits must be billed in 15 minute increments.

Procedural modifiers are required when billing SN, HHA, PT, and OT visits.

Modifier	Visit Service Category
U2	SN or home health aide second visit per day
U3	SN or home health aide third visit per day
GP	PT
GO	OT

Home health agencies are reimbursed for DME and expendable supplies in accordance with 1 TAC §355.8021. The current DME fee schedule is available on the TMHP website at www.tmhp.com.

Providers may also request a hard copy of the fee schedule by contacting the TMHP Contact Center at 1-800-925-9126.

TMHP manually prices DME and expendable supplies that have no established fee, other than nutritional products, based on the manufacturer's suggested retail price (MSRP) less 18 percent, with documentation of the MSRP submitted by the provider. If there is no MSRP available, reimbursement is at an established percentage of the provider's invoice cost. Nutritional products that require manual pricing are priced at 89.5 percent of the average wholesale price (AWP). The Texas Medicaid Program does not reimburse separately for associated DME charges, including but not limited to, battery disposal fees or state taxes. Reimbursement for any associated charges is included in the reimbursement for a specific piece of equipment.

Refer to: "Texas Medicaid Reimbursement" on page 2-1 for more information about reimbursement.

24.3.1 Eligibility

To verify client Medicaid eligibility and retroactive eligibility, the home health agency or DMEH/medical supplier should contact the Automated Inquiry System (AIS) at 1-800-925-9126 or the TMHP Electronic Data Interchange (EDI) Help Desk at 1-888-863-3638.

Home health clients do not need to be homebound to qualify for services. Providers who have received previous denials based on homebound criteria need to appeal their claims with appropriate documentation to include a copy of the claim, R&S report, and authorization requests.

The Medicaid client must be eligible on the date(s) of services (DOS) and must meet all the following requirements to qualify for Home Health Services:

- Have a medical need for home health professional services, DME, or supplies that are considered a benefit under Home Health Services and as documented in the client's plan of care (POC).
- Receive services that meet the client's existing medical needs and can be safely provided in the client's home.
- Receive prior authorization from TMHP for all home health professional services, DME, or supplies.

Certain DME/supplies may be obtained without prior authorization although providers must retain a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form reviewed and signed by the treating physician for these clients.

Refer to: "Automated Inquiry System (AIS)" on page xiii.

Note: *Medicaid beneficiaries who are under 21 years of age are entitled to all medically necessary private duty nursing (PDN) services and/or home health SN services. Nursing services are medically necessary when the requested services are nursing services as defined in the Texas Nursing Practice Act and its implementing regulations; the requested services correct or ameliorate the beneficiary's disability or physical or mental illness or condition; and there is no third-party resource that is finan-*

cially responsible for the services. Requests for nursing services must be submitted on the required Medicaid forms and must include supporting documentation. The supporting documentation must clearly and consistently describe the beneficiary's current diagnosis, functional status and condition; consistently describe the treatment throughout the documentation; and provide a sufficient explanation of how the requested nursing services correct or ameliorate the beneficiary's disability or physical or mental illness or condition. Medically necessary nursing services will be authorized either as PDN services or as Home Health SN services, depending on whether the beneficiary's nursing needs can be met on a per visit basis.

24.3.1.1 Retroactive Eligibility

When a home health agency is providing services to a client who is pending Medicaid coverage, the agency is responsible for finding out the effective dates for eligibility, which can be done by contacting AIS at 1-800-925-9126 or the TMHP EDI Help Desk at 1-888-863-3638.

TMHP must receive all documentation and claims for clients with retroactive eligibility within 95 days from the date eligibility was added to TMHP's eligibility file.

24.3.1.2 Authorization of Retroactive Eligibility

After the client's eligibility is on TMHP's eligibility file, the agency has *95 days from the add date to obtain authorization for services already rendered.* The agency must contact TMHP Home Health Services Authorization Department to obtain authorization for *current services within three business days of the client's eligibility being added to TMHP's eligibility file.* The nurse who made the initial assessment visit in the client's home should make this call.

24.3.2 Prior Authorization

Prior authorization of initial coverage of home health services (SN, HHA, PT, OT) for an eligible client can be obtained by calling the TMHP Contact Center Home Health Services line at 1-800-925-8957, by fax to 1-512-514-4209 or through the TMHP website at www.tmhp.com.

The following authorization requests can be submitted through the TMHP website at www.tmhp.com:

- Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.
- Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy.
- Medicaid Certificate of Necessity for Chest Physiotherapy Device Form—Initial Request.
- Medicaid Certificate of Necessity for Chest Physiotherapy Device Form—Extended Request.
- Statement for Initial Wound Therapy System In-Home Use.
- Statement for Recertification of Wound Therapy System In-Home Use.
- Wheelchair/Scooter/Stroller Seating Assessment Form (THSteps-CCP/Home Health Services) (Attachments will be sent separately due to size and detailed information).
- Home Health Services Plan of Care (POC).

Refer to: "Prior Authorization Requests Through the TMHP Website" on page 5-4 for more information, including mandatory documentation requirements.

If a client's primary coverage is private insurance, and Medicaid is secondary, prior authorization is required for Medicaid reimbursement.

If the primary coverage is Medicare, and Medicare approves the service, and Medicaid is secondary, prior authorization is not required. TMHP will only pay the coinsurance.

If Medicare denied the service, then Medicaid prior authorization is required. Contact Medicaid within 30 days of receipt of Medicare's final denial letter. The final denial letter from Medicare *must* accompany the authorization request.

If the service is a Medicaid-only service, prior authorization is required.

The provider is responsible for determining if eligibility is effective by using AIS or an electronic eligibility inquiry through TMHP EDI gateway.

The provider must contact TMHP Home Health Services Authorization Department within three business days of the start of care (SOC) for professional services or the DOS for DME/medical supplies to obtain authorization. Following the registered nurse's (RN) assessment/evaluation of the client in the home setting, the nurse who made the initial assessment visit in the client's home should make this call to answer questions about the client's condition as it relates to the medical necessity.

If inadequate or incomplete information is provided or is lacking medical necessity, the provider will be requested to furnish additional documentation as required to make a decision on the request. Providers have two weeks to submit the requested documentation because it often must be obtained from the client's physician. If the additional documentation is received within the two-week period, authorization can be considered for the original date of contact. If the additional documentation is received more than two weeks from the request for the documentation, authorization is not considered before the date the additional documentation is received. It is the DME/supplier/home health agency's responsibility to contact the physician to obtain the requested additional documentation.

TMHP's Home Health Services toll-free number is 1-800-925-8957. The Home Health Services Authorization Checklist is a useful resource for home health agency

providers completing the authorization process. This optional form offers the nurse a detailed account of the client's needs when completed. Contact TMHP In-Home Care Contact Center at 1-800-846-7470 for more information.

Refer to: "Durable Medical Equipment (DME) and Supplies" on page 24-29 for DME/medical supplies prior authorization and "Medicaid Relationship to Medicare" on page 24-70.

Client eligibility for Medicaid is for one month at a time. Providers should verify eligibility every month. Prior authorization does not guarantee payment.

24.4 Home Health Services

The benefit period for home health professional services is up to 60 days with a current POC. In chronic and stable situations, DME and supplies ordered on a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form may be *authorized for up to six months* with medical necessity determination. Because a Medicaid client's eligibility period is for one month, providers should bill for a one month supply at a time, even though prior authorization may be granted for up to six months. This extended authorization period begins on the date that clients receive their first authorized home health service. The Texas Medicaid Program allows additional visits, DME, or supplies that have been determined to be medically necessary and have been authorized by TMHP Home Health Services Authorization Department. Providers must retain all orders, signed and dated Title XIX forms, delivery slips, and invoices for all supplies provided to a client and must disclose them to the HHSC or its designee on request. These records and claims must be retained for a minimum of five years from the date of service (DOS) or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.

24.4.1 Client Evaluation

When a home health agency receives a referral to provide home health services, supplies, or DME for a Medicaid-eligible client, the agency-employed RN should evaluate the client in the home before calling TMHP for prior authorization. Although recommended, a home visit is not required if only DME or supplies are needed and being requested by the physician on a Title XIX form. DME or supplies requested on a Home Health Services POC require an RN home evaluation. It is expected that appropriate referrals will be made between home health agencies and DME suppliers for care. It is recommended that DME suppliers keep open communication with the client's physician for current reporting.

This evaluation should include assessment of the following:

- Medical necessity for home health services, supplies, or DME.
- Safety.
- Appropriateness of care in the home setting.
- Capable caregiver available if clients are unable to perform their own care or monitor their own medical condition.

Following the RN's assessment/evaluation of the client in the home setting for home health services needs, the agency RN who completed the home evaluation must contact TMHP for prior authorization within three business days of the SOC.

24.4.2 Physician Supervision—Plan of Care

For the Home Health Services plan of care (POC) to be valid, the treating physician must sign and date it, and indicate when the services will begin. The home health agency must update and maintain the POC at least every 60 days or as necessitated by a change in condition.

Medicare Form 485 is not accepted as a POC. The Home Health Services POC is the only acceptable form for reimbursement from the Texas Medicaid Program.

24.4.2.1 Written Plan of Care

A Home Health Services POC is required for SN services, HHA, PT, and OT services. The POC is not required as an attachment with the claim, but a signed and dated POC must be retained in the client's medical record with the provider and requesting physician. The client's attending physician must recommend, sign, and date a POC. The POC does not need to be signed by the physician before contacting TMHP for authorization when orders for home care have been received from the physician. The POC shall be initiated by the RN in a clear and legible format. The POC must contain the following information:

- Activities permitted.
- All pertinent diagnoses.
- Available caregiver.
- Client Medicaid number.
- Date the client was last seen by the physician. The client must be seen by a physician within *30 days* of the initial SOC and at least once every six months thereafter unless a diagnosis has been established by the physician and the client is currently undergoing physician care and treatment. The physician visit may be waived when a diagnosis has already been established by the physician and the recipient is under the continuing care and medical supervision of the physician. Any waiver must be based on the physician's written statement that an additional evaluation visit is not medically necessary. The original must be maintained by the requesting physician and a copy must be maintained in the providing provider's files.
- Equipment/supplies required.
- Instructions for timely discharge or referral.

- List all community or state agency services the client receives in the home (e.g., primary home care [PHC], PCS, community-based alternative [CBA], Medically Dependent Children's Program [MDCP]).
- Medications including the dose, route, and frequency.
- Mental status.
- Nutritional requirements.
- Physician license number.
- Prior and current functional limitations.
- Prognosis.
- Provider Medicaid number.
- Rehabilitation potential.
- Safety measures to protect against injury.
- SOC date for home health services.
- Treatments, including amount, duration, and frequency.
- Types of services including amount, duration, and frequency.
- Wound care orders and measurements.

Physician orders for PT and/or OT services must include the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis codes for an acute or exacerbated event, if the following conditions apply:

- PT/OT is being requested.
- Specific procedures and modalities are to be used.
- Amount, frequency, and duration of therapy needed.
- Physical and/or occupational therapy and goals.
- Name of therapist who participated in developing the POC is listed.

The physician and home health agency nursing, PT, and OT personnel must review the POC as often as the severity of the client's condition requires or at least once every 60 days. This signed and dated documentation must be maintained in the client's medical record with the ordering physician and requesting provider. This applies to all written and verbal orders, and plans of care.

Verbal physician orders may only be given to people authorized to receive them under state and federal law. They must be reduced to writing, signed, and dated by the RN or qualified therapist responsible for furnishing or supervising the ordered service, and placed in the client's chart. The physician must sign the written copy of the verbal order within two weeks or per agency policy if less than two weeks. A copy of the written verbal order must be maintained in the client's chart before and after being signed by the physician.

The type and frequency of visits, supplies, or DME must appear on the POC before the physician signs the orders, and may not be added after the physician has signed the orders. If any change in the POC occurs during an authorization period (additional visits, supplies, or DME), the home health agency must call TMHP Home Health Services Authorization Department for authorization and maintain a completed revised request POC signed by the physician.

Coverage periods do not necessarily coincide with calendar weeks or months but instead cover a number of services to be scheduled between a start and end date that is assigned during the prior authorization. The agency *must* contact TMHP within three business days after the SOC date for prior authorization.

Refer to: "Home Health Services Plan of Care (POC)" on page B-47.

"Physical Therapy (PT) Services" on page 24-14.

24.5 Benefits

Home health services include SN services, HHA visits, PT visits, OT visits, DME, and expendable medical supplies that are provided to eligible Medicaid clients at their place of residence.

Medicaid beneficiaries under 21 years of age are entitled to all medically necessary DME. DME is medically necessary when it is required to correct or ameliorate disabilities or physical or mental illnesses or conditions. Any numerical limit on the amount of a particular item of DME can be exceeded for Medicaid beneficiaries under 21 years of age if medically necessary. Likewise, time periods for replacement of DME will not apply to Medicaid beneficiaries under 21 years of age if the replacement is medically necessary. When prior authorization is required, the information submitted with the request must be sufficient to document the reasons why the requested DME item or quantity is medically necessary.

Medicaid beneficiaries under 21 years of age are entitled to all medically necessary PDN services and/or home health SN services. Nursing services are medically necessary when the requested services are nursing services as defined by the Texas *Nursing Practice Act* and its implementing regulations; the requested services correct or ameliorate the beneficiary's disability or physical or mental illness or condition; and there is no third party resource financially responsible for the services. Requests for nursing services must be submitted on the required Medicaid forms and include supporting documentation. The supporting documentation must: clearly and consistently describe the beneficiary's current diagnosis, functional status and condition; consistently describe the treatment throughout the documentation; and provide a sufficient explanation as to how the requested nursing services correct or ameliorate the beneficiary's disability or physical or mental illness or condition. Medically necessary nursing services will be authorized either as PDN services or as Home Health SN services, depending on whether the beneficiary's nursing needs can be met on a per visit basis.

Prior authorization must be obtained for all professional services, some supplies, and most DME from TMHP within *three business days of SOC*. Although providers may supply some DME and medical supplies to a client without prior authorization, they must still retain a copy of the Home

Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form that has been completed and signed by the client's attending physician.

For reimbursement, providers should note the following:

- The client's attending physician must request professional and/or HHA services through a home health agency, and sign and date the POC.
- Claims are approved or denied according to the eligibility, prior authorization status, and medical appropriateness.
- Claims must represent a quantity of 1 month for supplies billed.
- Nursing, nurse aide, PT, and OT services must be provided through a Medicaid-enrolled home health agency. These services must be billed using the home health agency's provider identifier. File these services on a UB-04 CMS-1450 claim form.
- PT, OT, and/or speech therapy (ST) are always billed as POS 2 and may be authorized to be provided in the following locations: home of the client, home of the caregiver/guardian, client's day care facility, or the client's school. Services provided to a client on school premises are only permitted when delivered before or after school hours. The only THSteps-CCP therapy that can be delivered in the client's school during regular school hours are those delivered by school districts as School Health and Related Services (SHARS) in POS 9.
- DME/supplies *must* be provided by either a Medicaid enrolled home health agency's Medicaid/DME supply provider or an independently-enrolled Medicaid/DME supply provider. Both *must* enroll and bill using the provider identifier enrolled as a DME supplier. File these services on a CMS-1500 claim form.

Note: *Medical social services and speech-language pathology services are available to clients 20 years of age and younger and are not a benefit of Home Health Services. These services may be considered a benefit for clients who qualify for THSteps-CCP.*

Use the following type of service (TOS) codes when providing home health services:

TOS	Description
1	Medical services (including some injectable drugs)
9	Medical supplies
C	Home Health Procedure
J	Purchase (new)
L	Rental, monthly

24.5.1 Home Health Skilled Nursing Services

Home health SN services are a benefit of the Home Health Services when a client requires nursing services for an acute condition or an acute exacerbation of a chronic condition that can be met on an intermittent or part-time basis and typically has an end-point. SN visits may be provided on consecutive days. SN visits are intended to provide SN care to promote independence and support the client living at home. Home Health Services must be provided by a licensed and certified home health agency enrolled in the Texas Medicaid Program.

Note: *Nursing visits for the primary purpose of assessing a client's care needs to develop a POC are considered administrative and not billable. These visit costs are reflected on the cost report.*

An *acute condition* is considered a condition or exacerbation that is anticipated to improve and reach resolution within 60 days. An intermittent basis is considered an SN visit provided for less than eight hours per visit and less frequently than daily. Intermittent visits may be delivered in interval visits up to 2.5 hours per visit, not to exceed a combined total of three visits per day. A part-time basis is considered an SN visit provided less than eight hours per day for any number of days per week. Part-time visits may be continuous up to 7.5 hours per day (not to exceed a combined total of three 2.5 hour visits).

SN visits are considered medically necessary for clients who require the following:

- Skillful observations and judgment to improve health status, skilled assessment, or skilled treatments/procedures.
- Individualized, intermittent, acute skilled care.
- Skilled interventions to improve health status, and if skilled intervention is delayed, it is expected to result in the deterioration of a chronic condition or one of the following:
  - Loss of function.
  - Imminent risk to health status due to medical fragility, or risk of death.

When documentation does not support medical necessity for home health SN visits, providers may be directed to possible alternative services based on the client's age and needs.

24.5.1.1 Skilled Nursing Visits

All SN services must be prior authorized.

SN visits are limited to SN procedures performed by an RN or LVN licensed to perform these services under the *Texas Nursing Practice Act* and include direct SN care, and parent or guardian, caregiver training, and education as well as SN observation, assessment, and evaluation by an RN, provided a physician specifically requests that a nurse visit the client for this purpose, and the physician's order reflects the medical necessity for the visit.

For all clients, SN visits may be provided in the following locations:

- Home of the client, parent, guardian, or caregiver.
- Foster homes.
- Independent living arrangements.

Skilled Nursing Care

Skilled nursing care consists of those services that must, under state law, be performed by a RN or LVN, and meet the criteria for SN services specified in the Title 42 *Code of Federal Regulations* (CFR) §§ 409.32, 409.33, and 409.44).

In determining whether a service requires the skill of a licensed nurse, consideration must be given to the inherent complexity of the service, the condition of the client, and the accepted standards of medical and nursing practice.

The fact that the SN service can be, or is, taught to the client or to the client's family or friends does not negate the skilled aspect of the service when the service is performed by a nurse.

If the service could be performed by the average nonmedical person, the absence of a competent person to perform it does not cause it to be an SN service.

If the nature of a service is such that it can safely and effectively be performed by the average nonmedical person without direct supervision of a licensed nurse, the service cannot be regarded as an SN service.

Some services are classified as SN services on the basis of complexity alone (e.g., intravenous and intramuscular injections or insertion of catheters), and if reasonable and necessary to the treatment of the client's illness or injury, would be covered on that basis. However, in some cases, the client's condition may cause a service that would ordinarily be considered unskilled to be considered an SN service. This would occur when the client's condition is such that the service can be safely and effectively provided only by a nurse.

A service which, by its nature, requires the skills of a nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the client, the client's family, or other caregivers. Where the client needs the SN care and there is no one trained, able and willing to provide it, the services of a nurse would be reasonable and necessary to the treatment of the illness or injury.

The SN services must be reasonable and necessary to the diagnosis and treatment of the client's illness or injury within the context of the client's unique medical condition. To be considered reasonable and necessary for the diagnosis or treatment of the client's illness or injury, the services must be consistent with the nature and severity of the illness or injury, the client's particular medical needs, and within accepted standards of medical and nursing practice. A client's overall medical condition is a valid factor in deciding whether skilled services are needed. A client's diagnosis should never be the sole factor in deciding whether the service the client needs is either skilled or not skilled.

The determination of whether the services are reasonable and necessary should be made in consideration of the physician's determination that the services ordered are reasonable and necessary. The services must, therefore, be viewed from the perspective of the condition of the client when the services were ordered, and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.

The SN care must be provided on a part-time or intermittent basis.

Professional Nursing

Professional nursing provided by an RN, as defined in the *Texas Nurse Practice Act*, means the performance of an act that requires substantial specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of professional nursing. The term does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures. Professional nursing involves:

- The observation, assessment, intervention, evaluation, rehabilitation, care and counsel, or health teachings of a person who is ill, injured, infirm, or experiencing a change in normal health processes.
- The maintenance of health or prevention of illness.
- The administration of a medication or treatment as ordered by a physician, podiatrist, or dentist.
- The supervision of delegated nursing tasks or teaching of nursing.
- The administration, supervision, and evaluation of nursing practices, policies, and procedures.
- The performance of an act delegated by a physician.
- Development of the nursing care plan.

Professional nursing also involves assisting in the evaluation of an individual's response to a nursing intervention and the identification of an individual's needs and engaging in other acts that require education and training, as prescribed by board rules and policies, commensurate with the nurse's experience, continuing education, and demonstrated competency.

Vocational Nursing

Vocational nursing, as defined in the *Texas Nurse Practice Act*, means a directed scope of nursing practice, including the performance of an act that requires specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of vocational nursing. The term does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures. Vocational nursing involves:

- Collecting data and performing focused nursing assessments of the health status of an individual.
- Participating in the planning of the nursing care needs of an individual.
- Participating in the development and modification of the nursing care plan.
- Participating in health teaching and counseling to promote, attain, and maintain the optimum health level of an individual.

Vocational Nursing also involves assisting in the evaluation of an individual's response to a nursing intervention and the identification of an individual's needs and engaging in other acts that require education and training, as prescribed by board rules and policies, commensurate with the nurse's experience, continuing education, and demonstrated competency.

Use procedure code C-G0154 for SN services.

24.5.2 Home Health Aide Services

HHA visits are a benefit of Home Health Services when a client requires nursing services for an acute condition or an acute exacerbation of a chronic condition that can be met on an intermittent or part-time basis. HHA visits are intended to provide personal care services under the supervision of a RN, PT, or OT employed by the home health agency to promote independence and support the client living at home.

HHA visits are considered medically necessary for clients who require general supervision of nursing care provided by an HHA over whom the RN is administratively or professionally responsible in addition to the following:

- Skillful observations and judgment to improve health status, skilled assessment, or skilled treatments or procedures.
- Individualized, intermittent, acute skilled care.
- Skilled interventions to improve health status, and if skilled intervention is delayed, it is expected to result in the deterioration of a chronic condition or one of the following:
  - Loss of function.
  - Imminent risk to health status due to medical fragility, or risk of death.

When documentation does not support medical necessity for HHA visits, providers may be directed to possible alternative services based on the client's age and needs.

24.5.2.1 Home Health Aide Visits

HHA visits are intended to provide hands-on personal care, performance of simple procedures as an extension of therapy or nursing services, assistance in ambulation or exercises, and assistance in administering medications that are ordinarily self-administered.

Any HHA services offered by a home health agency must be provided by a qualified HHA under the supervision of a qualified licensed individual (RN, PT, OT) employed by the home health agency.

For all clients, HHA visits may be provided in the following locations:

- Home of the client, parent, guardian, or caregiver.
- Foster homes.
- Independent living arrangements.

The duties of an HHA during a visit include, but are not limited to:

- Ambulation.
- Assistance with medication that is ordinarily self-administered.
- Assisting with nutrition and fluid intake.
- Completing appropriate documentation.
- Exercise.
- Household services essential to the client's health care at home.
- Obtaining and recording the client's vital signs (temperature, pulse, respirations, and blood pressure).
- Observation, reporting and documentation of the client's status, and the care or service furnished.
- Personal care (hygiene and grooming) including but not limited to:
  - Sponge, tub or shower bath.
  - Shampoo, sink, tub or bed bath.
  - Nail and skin care.
  - Oral hygiene.
- Positioning.
- Range of motion.
- Reporting changes in the client's condition and needs.
- Safe transfer.
- Toileting and elimination care.

Use procedure code C-G0156 when billing for HHA services.

24.5.2.2 Supervision of Home Health Aides

Supervision, as defined by the *Texas Nurse Practice act*, is the process of directing, guiding, and influencing the outcome of an individual's performance of an activity.

A RN or therapist (PT/OT) must provide the HHA written instructions for all the tasks delegated to the HHA. A therapist may prepare the written instructions if the client is receiving only HHA visits, which do not include delegated SN tasks, in addition to the therapy services.

The requirements for HHA supervision are as follows:

- When only HHA visits are provided, an RN must make a supervisory visit to the client's residence at least once every 60 days. The supervisory visit must occur when the HHA is providing care to the client.
- When SN, PT, and/or OT visits are provided in addition to a HHA visit, an RN must make a supervisory visit to the client's residence at least every two weeks. The supervisory visit must occur when the HHA is providing care to the client.
- When only PT and/or OT visits are provided in addition to HHA visits, the appropriate therapist may make the supervisory visit in place of an RN. The supervisory visit must occur when the HHA is providing care to the client.
- Documentation of HHA supervision must be maintained in the client's medical record.

24.5.3 Home Health Skilled Nursing and Home Health Aides Services Provider Responsibilities

Providers must be a licensed home health agency enrolled in the Texas Medicaid Program and must comply with all applicable federal, state, and local laws and regulations and Texas Medicaid Program policies and procedures. All providers must maintain written policies and procedures for obtaining consent for medical treatment for clients in the absence of the primary caregiver that meet the standards of the *Texas Family Code*, Chapter 32, and obtaining physician signatures for all telephone orders within 14 calendar days of receipt of the order.

Providers must only accept clients on the basis of a reasonable expectation that the client's needs can be adequately met in the place of service. The essential elements of safe and effective home health SN and/or HHA services include a trained parent, guardian, or caregiver, a primary physician, competent providers, and an environment that supports the client's health and safety needs.

The place of service must be able to support the health and safety needs of the client and must be adequate to accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies required by the client. Necessary primary and back-up utility, communication, and fire safety systems must be available.

Note: *A parent or guardian, primary caregiver, or alternate caregiver may not provide SN and/or HHA services even if he or she is an enrolled provider or employed by an enrolled provider.*

24.5.4 Home Health Skilled Nursing and Home Health Aide Services Prior Authorization Requirements

SN services and HHA visits require prior authorization. Requests must be submitted by fax or in writing by mail. Providers must obtain authorization within three business days of the SOC date for an initial authorization. For recertifications, providers must obtain authorization within seven business days of the new SOC date. During the authorization process, providers are required to deliver the requested services from the SOC date which is the date agreed to by the physician, the RN, the home health agency, and the client, parent, guardian, or caregiver. The SOC must be documented on the POC. A provider requesting prior authorization for SN and/or HHA Services must submit the following documentation:

- A completed client assessment.
- A completed Texas Medicaid Home Health Services POC that must:
  - Be signed and dated by the assessing RN.
  - Signed and dated by the physician or submitted with the signed and dated physician's orders.

Prior authorization of SN or HHA visits requires that a client's primary care physician complete the following steps:

- Provide specific, written, dated orders for SN or home health agency visits or recertification that identifies that the prescribed visits are medically necessary as defined in the Statement of Benefits.
- Maintain documentation in the client's medical record that supports the medical necessity of the prescribed visits.
- Maintain documentation in the client's medical record that demonstrates that the client's medical condition is sufficiently stable to permit safe delivery of the prescribed visits as described in the client's Home Health Services POC.
- Establish a medical plan of care that is maintained in the client's medical record.
- Provide continuing care and medical supervision.
- Review and approve the client's Home Health Services POC once every 60 days or more frequently as the physician determines necessary, including but not limited to a change in the client's condition.

All signatures must be current, unaltered, original, and handwritten; computerized or stamped signatures will not be accepted. All documentation, including all written and verbal orders, and all physician-signed POCs, must be maintained by the ordering physician, and the home health agency must keep the original, signed copy of the POC in the client's medical record.

Requests must be based on the medical needs of the client. Documentation must support the quantity and frequency of intermittent or part-time SN and/or HHA visits that will safely meet the client's needs. The amount and duration of SN and/or HHA visits requested will be evaluated by the claims administrator. The home health agency must ensure the requested services are supported by the client assessment, POC, and the physician's orders.

The length of the authorization is determined on an individual basis and is based on the goals and timelines identified by the physician, home health agency, RN, and client, parent, guardian, or caregiver. SN and HHA visits will be prior authorized for no more than 60 days at a time. As a client's problems are resolved and goals are met, a client's condition is expected to become more stable, and the client's needs for SN and HHA services may decrease.

SN visits to obtain routine laboratory specimens may be considered when the only alternative to obtain the specimen is to transport the client by ambulance. SN visits to address hyperbilirubinemia will not be considered for prior authorization if the client has an open authorization for home phototherapy. Home phototherapy is reimbursed as a daily global fee and includes coverage of SN visits for client or parent, caregiver teaching and monitoring, and customary and routine laboratory work.

SN visits to address total parenteral nutrition (TPN)/hyperalimentation will not be considered for prior authorization if the client has an open authorization for TPN/hyperalimentation. TPN/hyperalimentation is reimbursed as a daily global fee and includes coverage of SN visits for

client, parent, or caregiver teaching and monitoring, customary and routine laboratory work, and enteral supplies and equipment.

Up to a maximum combined total of three SN and HHA visits may be prior authorized per day. One visit may last up to a maximum of 2.5 hours. SN and/or HHA visits may be provided on consecutive days.

When documentation does not support medical necessity for home health SN and/or HHA visits, providers may be directed to possible alternative services based on the client's age and needs.

A prior authorization for SN and/or HHA visits is no longer valid when:

- The client is no longer eligible for Medicaid.
- The client no longer meets the medical necessity criteria for SN and/or HHA services.
- The place of service cannot provide for the health and safety of the client.
- The client, parent, guardian, or caregiver refuses to comply with the attending physician's plan of treatment and compliance is necessary to ensure the health and safety of the client.
- The client changes providers and the change of notification is submitted to the claims administrator in writing with a prior authorization request from the new provider.

A nurse/HHA may be authorized to provide services to more than one client over the span of the day as long as each client's care is based on an individualized POC and each client's needs and POC do not overlap with another client's needs and POC. Settings in which a nurse/HHA provider may provide services in a provider-client ratio greater than 1:1 include, but are not limited to, homes with more than one client receiving home health services, foster homes, and independent living arrangements.

24.5.4.1 Canceling an Authorization

The client has the right to choose their home health agency provider and to change providers. If the client changes providers, TMHP must receive a change of provider letter with a new POC or Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. The client must sign and date the letter, which must include the name of the previous provider, the current provider, and the effective date for the change.

The client is responsible for notifying the original provider of the change and the effective date. Prior authorization for the new provider can only be issued up to three business days before the date TMHP receives the change of provider letter and the new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.

24.5.4.2 Home Health Skilled Nursing Services and Home Health AIDE Services that will not be Prior Authorized

SN visits requested primarily to provide the following will not be prior authorized:

- Respite care.
- Child care.
- Activities of daily living for the client.
- Housekeeping services.
- Routine post-operative disease, treatment, or medication teaching after a physician visit.
- Routine disease, treatment, or medication teaching after a physician visit.
- Individualized, comprehensive case management beyond the service coordination required by the *Texas Nurse Practice Act*.

HHA visits requested primarily to provide the following will not be prior authorized:

- Housekeeping services.
- Services provided to a client residing in a hospital, SN facility or intermediate care facility.

Certain facilities are required by licensure to meet all the medical needs of the client. SNV and/or HHA visits will not be authorized for clients receiving care in any of the following facilities:

- Hospitals.
- SN facilities.
- Intermediate care facilities for the mentally retarded (ICF-MR).
- Special care facilities, including but not limited to, subacute units, and facilities for the treatment of acquired immunodeficiency syndrome (AIDS).

24.5.5 Home Health Skilled Nursing and Home Health Aide Services Assessments and Reassessments

When a provider has received a referral and has physician orders for SN and/or HHA services, the provider must have a RN perform an initial client assessment in the client's home. A client can be referred to a home health agency for SN and/or HHA services by the client, the client's physician, or the client's family.

The client assessment or reassessment should include, but is not limited to, the following:

- Whether the setting can support the health and safety needs of the client and is adequate to accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies required by the client.
- Comprehension level of client, parent, guardian, or caregiver.
- Receptivity to training and ability level of the client, parent, guardian, or caregiver.

- A nursing assessment of medical necessity for the requested visits which includes:
  - Complexity and intensity of the client's care.
  - Stability and predictability of the client's condition.
  - Frequency of the client's need for SN care.
  - Identified medical needs and goals.
  - Description of wounds, if present.
  - Cardiac status.

The initial assessment and any reassessments performed by a RN are required when changes in the client's condition occur during the course of the authorization period. If there is no change in the client's condition, the reassessment must document medical necessity, as defined in the Statement of Benefits, to support continued and ongoing SN and/or HHA visits beyond the initial 60-day authorization period.

24.5.6 Supplies Submitted with a Plan of Care

The cost of incidental supplies used during an SN visit or a HHA visit may be added to the charge of the visit ($10 maximum for supplies and included in C-G0154 visit code). Medical supplies left at the home for the client or a subsequent home health nurse to use must be billed with the provider identifier enrolled as a DME supplier after prior authorization has been granted by the TMHP Home Health Services Prior Authorization Department.

A home health agency provider may request prior authorization for supplies/DME by utilizing the Home Health Services POC or the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.

The home health agency may utilize the Home Health Services POC to submit a prior authorization of supplies/DME that will be used in conjunction with the professional services provided by the agency, such as SN, PT, or OT. The home health agency's DMEH provider identifier must be submitted on the POC and all of the supplies that are requested must be listed in the supplies section of the POC. The POC does not require a physician's signature prior to submission for prior authorization of professional services/DME and supplies.

If the home health agency utilizes the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form, the agency must complete Section A. The physician must complete Section B, and sign prior to submission to TMHP for prior authorization of the requested supplies/DME.

The following information is required to consider these supplies for authorization:

- Item description.
- Procedure code.
- Quantity of each supply requested.
- MSRP for items that do not have a maximum fee assigned.

24.5.7 Medication Administration Limitations

Nursing visits for the purpose of administering medications are not a benefit if one of the following conditions exists:

- The medication is not considered medically necessary to the treatment of the individual's illness or is not Food and Drug Administration (FDA)-approved.
- The administration of medication exceeds the therapeutic frequency or duration by accepted standards of medical practice.
- A medical reason does not prohibit the administration of the medication by mouth.
- The client, a primary caregiver, a family member, and/or neighbor have been taught or can be taught to administer SQ/SC, IM, and IV injections and has demonstrated competency.
- The medication is a chemotherapeutic agent or blood product SQ/SC, IM, and IV injections.

24.5.8 Physical Therapy (PT) Services

As stated in the TAC, in order to be payable as a Home Health Services benefit, PT services must be:

- Requested for a payable ICD-9-CM diagnosis code.
- Provided by a physical therapist or physical therapist assistant. A physical therapist assistant must be supervised by a licensed physical therapist who is currently licensed by the Executive Council of Physical Therapy and Occupational Therapy Examiners.
- For the treatment of an acute musculoskeletal or neuromuscular condition or an acute exacerbation of a chronic musculoskeletal or neuromuscular condition.
- Expected to improve the client's condition in a reasonable and generally predictable period of time, based on the physician's assessment of the client's restorative potential after any needed consultation with the therapist.
- The evaluation and function-oriented treatment of individuals whose ability to function in life roles is impaired by recent or current physical illness, injury, or condition.
- Specific goal-directed activities to achieve a functional level of mobility and communication and prevent further dysfunction within a reasonable length of time based on the therapist's evaluation and physician's assessment and POC.
- PT POC should encourage the client and other caregivers to learn self-therapy skills to the greatest extent possible while still providing all medically necessary services.
- Provided only until the client has reached the maximum level of improvement. Repetitive services designed to maintain function when the maximum level of improvement has been reached are not a benefit. Services related to activities for the general good and

welfare of clients, such as general exercises to promote overall fitness and flexibility, and activities to provide diversion or general motivation are not reimbursed.

- Billed by the home health agency and reimbursed to the home health agency.

Independently-enrolled therapists are not reimbursed under Home Health Services.

PT authorization must be requested by the home health agency's RN and recommended to be done after the RN home assessment. Requests are not accepted, nor authorization granted, directly to the PT or assistant PT.

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit will receive those services through THSteps-CCP.*

Refer to: Section 24.3.1, "Eligibility."

24.5.8.1 Physical Therapy Prior Authorization Procedures

To obtain prior authorization for initial and recertification of PT services provided through a home health agency, providers should contact the TMHP Home Health Services Prior Authorization Department at 1-800-925-8957. Home health agencies must provide an initial or subsequent POC to include PT goals, accurate diagnostic information (including ICD-9-CM diagnosis codes) and PT procedure codes and PT evaluation or re-evaluation results at the time a request is made using the POC.

Use the procedure codes listed in "Physical Therapy/Occupational Therapy Procedure Codes" on page 24-15 of this manual to submit claims for PT services provided through a home health agency. Indicate modifier AT (indicating the service procedure is an acute treatment) on each PT procedure code. PT services should be billed on a UB-04 CMS-1450 claim form.

Refer to: "THSteps-Comprehensive Care Program (CCP)" on page 43-33 for physical therapy services that are not billed as home health services.

"Modifiers" on page 5-18.

24.5.8.2 Limitations

PT services must be billed with the AT modifier and must be provided according to the current (within 60 days) written orders of a physician and must be medically necessary. PT must be billed with CPT procedure codes.

The AT modifier is described as representing treatment provided for an acute condition, or an exacerbation of a chronic condition, which persists less than 180 days from the start of therapy. If the condition persists for more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client's condition has not become chronic and the client has not reached the point of plateauing.

Use procedure code C-97001 for Physical Therapy evaluation codes. PT evaluations are payable once every 180 days for any provider. Use procedure code C-97002 for Physical Therapy re-evaluations. PT re-evaluations are payable one time per month for any provider. Procedure codes C-97001 and C-97002 are not payable on the same day as the following procedure codes:

Procedure Codes		
C-97012	C-97014	C-97016
C-97018	C-97022	C-97024
C-97026	C-97028	C-97032
C-97033	C-97035	C-97039
C-97110	C-97112	C-97116
C-97124	C-97139	C-97140
C-97150	C-97530	

To request wheelchair evaluations, use procedure code 1-97001.

24.5.9 Physical Therapy/Occupational Therapy Procedure Codes

Procedure Codes		
C-97012	C-97014	C-97016
C-97018	C-97022	C-97024
C-97026	C-97028	C-97032
C-97033	C-97035	C-97039
C-97110	C-97112	C-97116
C-97124	C-97139	C-97140
C-97150	C-97530	C-97535
C-97537	C-97542	C-97799

The procedure codes listed above for PT and OT are only payable to Home Health Agencies. Independently enrolled occupational therapists are not paid under Home Health Services.

Therapy services that can be designated either as PT or OT must be requested and billed with the correct procedural modifier.

Modifier	Visit Service Category
GP	PT
GO	OT

PT and OT must be billed with the AT modifier and must be provided according to the current (within 60 days) written orders of a physician and must be medically necessary. PT and OT services are to be billed with CPT procedure codes.

The AT modifier is described as representing treatment provided for an acute condition, or an exacerbation of a chronic condition, which persists less than 180 days from the start of therapy. If the condition persists for more than

180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client's condition has not become chronic and the client has not reached the point of plateauing. Plateauing is the point at which maximal improvement has been documented and further improvement ceases.

24.5.10 Occupational Therapy (OT) Services

As stated in the TAC, to be payable as a Home Health Services benefit, OT services must be:

- Requested for a payable ICD-9-CM diagnosis code.
- Provided by an occupational therapist or an occupational therapy assistant who is currently registered and licensed by the Executive Council of Physical Therapy and Occupational Therapy Examiners. An occupational therapy assistant must be supervised by a licensed occupational therapist.
- For the treatment of an acute musculoskeletal or neuromuscular condition or an acute exacerbation of a chronic musculoskeletal or neuromuscular condition.

OT authorization must be requested by the home health agency's RN and recommended to be done after the RN assessment. Requests are not accepted, nor authorization granted, directly to the occupational therapist or OT assistant.

- For the evaluation and function-oriented treatment of individuals whose ability to function in life roles is impaired by recent or current physical illness, injury, or condition.
- For specific goal-directed activities to achieve a functional level of mobility and communication and prevent further dysfunction within a reasonable length of time based on the therapist's evaluation and physician's assessment and POC.
- Provided only until the client has reached the maximum level of improvement. Repetitive services designed to maintain function when the maximum level of improvement has been reached are not reimbursed. Services related to activities for the general good and welfare of clients, such as general exercises to promote overall fitness and flexibility, and activities to provide diversion or general motivation are not reimbursed.

Refer to: "Occupational Therapists (THSteps-CCP Only)" on page 43-60.

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit will receive those services through THSteps-CCP.*

Refer to: Section 24.3.1, "Eligibility."

24.5.10.1 Occupational Therapy Prior Authorization Procedures

To obtain prior authorization for the initial and recertification of OT services provided through a home health agency, providers should contact the TMHP Home Health Services Prior Authorization Department at 1-800-925-8957. Home health agencies must provide accurate diagnostic information (including ICD-9-CM diagnosis codes), OT procedure codes, and an initial or subsequent plan of care to include OT goals.

Use the codes listed under "Physical Therapy/Occupational Therapy Procedure Codes" to submit claims for OT services that are provided through a home health agency. Bill OT services on a UB-04 CMS-1450 claim form. Use procedure code 1-97003 when requesting prior authorization and billing for wheelchair evaluations.

24.5.10.2 Limitations

OT services must be billed with the AT modifier. Services must be provided according to the current (within 60 days) written orders of a physician and must be medically necessary. OT is billed using CPT procedure codes.

The AT modifier is described as "representing treatment provided for an acute condition, or an exacerbation of a chronic condition, which persists less than 180 days from the start of therapy." If the condition persists for more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client's condition has not become chronic and the client has not reached the point of plateauing.

Plateauing is the point at which maximal improvement has been documented and further improvement ceases. Use procedure codes C-97003 and C-97004 when billing for OT evaluation and re-evaluations.

24.5.11 Medical Supplies

Medical supplies are benefits of the Home Health Services Program if they meet the following criteria:

- A completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form, prescribing the DME and/or supplies must be signed and dated by a physician familiar with the client before requesting prior authorization for all DME and supplies. All signatures and dates must be current, unaltered, original, and handwritten. Computerized or stamped signatures and dates will not be accepted. The completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must include the procedure codes and quantities for the services requested. A copy of the completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must be maintained by the DME provider and the original must be kept by the prescribing physician in the client's medical file.

- The provider *must* contact TMHP within three business days of providing the supplies to the client and obtain authorization, if required.
- The requesting provider and ordering physician must keep all Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Forms and Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Forms on file. The physician must maintain the original signed and dated Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form copy in their records. Providers *must retain* individual delivery slips or invoices for each DOS that document the date of delivery for all supplies provided to a client and must disclose them to HHSC or its designee upon request. Documentation of delivery must include *one* of the following:
  - Delivery slip or invoice signed and dated by client/caregiver
  - The delivery slip or invoice must contain the client's full name and address to which the supplies were delivered, the item description and the numerical quantities that were delivered to the client.
  - A dated carrier tracking document with shipping date and delivery date must be printed from the carrier's website as confirmation that the supplies were shipped and delivered. The dated carrier tracking document must be attached to the delivery slip or invoice.

The dated delivery slip or invoice must include an itemized list of goods that includes the descriptions and numerical quantities of the supplies delivered to the client. This document could also include prices, shipping weights, shipping charges, and any other description.

Note: *These records and claims must be retained for a minimum of five years from the DOS or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.*

- The requesting provider or ordering physician must document medical supplies as medically necessary in the client's POC or on a *completed* Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form. TMHP must prior authorize most medical supplies. They must be used for medical or therapeutic purposes, and supplied through an enrolled DMEH provider in compliance with the client's POC.

HHSC/TMHP reserves the right to request the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and/or Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form at any time.

- Some medical supplies may be obtained without prior authorization; however, the provider must retain a copy of the completed POC or Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form in the client's file. For medical supplies not requiring prior authorization, a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form may be valid for a maximum of six months, unless the physician indicates the duration of need is less. If the physician indicates the duration of need is less than six months, then a new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is required at the end of the determined duration of need.

Refer to: The list of DME/medical supplies that may be provided without prior authorization are located in "Diabetic Supplies/Equipment" on page 24-18; "Nebulizers" on page 24-58; "Vaporizers" on page 24-58; "Incontinence Supplies" on page 24-21; and "Procedure Codes That Do Not Require Prior Authorization" on page 24-67. The items must be used for therapeutic purposes and directly relate to the client's needs and POC.

All purchased equipment must be new upon delivery to client. Used equipment may be utilized for lease, but when purchased, must be replaced with new equipment.

Note: *Client eligibility can change monthly. Providers are responsible for verifying eligibility before providing supplies.*

- Clients with ongoing needs may receive up to six months of prior authorizations for some expendable medical supplies under Home Health Services when requested on a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. Providers may deliver medical supplies as ordered on a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form for up to six months from the date of the physician's signature. In these instances, a review of the supplies requested by the physician familiar with the client's condition, and a new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is required for each new prior authorization request. Requests for authorization can be made up to 60 days before the start of the new authorization period. Professional Home Health Services prior authorization requests require a review by the physician familiar with the client's condition and a physician signature every 60 days when requested on a POC.

Note: *These records and claims must be retained for a minimum of five years from the DOS or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.*

- If a client or caregiver has been instructed and supervised on proper wound care technique and no longer requires SN services, the home health agency (enrolled as a DMEH provider) can continue to provide supplies that enable the client or caregiver to administer care. Supplies may be provided as long as the client meets home health services criteria. The following supplies

are those considered essential to the physician-prescribed treatment of an ill or injured client in their own home. Items not listed may, in selected instances, be required for a particular client. Consideration is given on an individual case basis to items not on this list that are medically documented by the physician's POC. *An RN must evaluate the client in the home setting before the initiation of the POC or have a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form completed and signed by a treating physician serving as a POC for DME and/or supplies.*

The DOS is the date on which supplies are delivered to the client and/or shipped by a carrier to the client as evidenced by the dated tracking document attached to the invoice for that date. The provider must maintain the signed and dated records supporting documentation that an item was not billed before delivery. These records are subject to retrospective review.

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this home health benefit will receive those services through THSteps-CCP.*

Refer to: "Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions (2 Pages)" on page B-42 and "Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form" on page B-44 for copies of forms.

"Durable Medical Equipment Supplier (THSteps-CCP Only)" on page 43-45 for specific information about certain DME and medical supplies.

"Medicare/Medicaid Authorization" on page 24-71 for a list of supplies that do not require prior authorization.

"Eligibility" on page 24-5.

24.5.11.1 Supply Procedure Codes

When submitting supplies on the CMS-1500 claim form, itemize the supplies, including quantities, and also provide the Healthcare Common Procedure Coding System (HCPCS) national procedure codes.

24.5.11.2 Canceling an Authorization

The client has the right to choose their DME/medical supply provider and to change providers. If the client changes providers, TMHP must receive a change of provider letter with a new POC or Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. The client must sign and date the letter, which must include the name of the previous provider, the current provider, and the effective date for the change. The client is responsible for notifying the original provider of the change and the effective date. Prior authorization for the new provider can only be issued up to three business days before the date TMHP receives the change of provider letter and the new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.

24.5.12 Diabetic Supplies/Equipment

Diabetic supplies and equipment are a benefit through Home Health Services. Diabetic supplies and related testing equipment do not require prior authorization unless otherwise specified. The following requirements must be met to qualify for reimbursement:

- The client must be eligible for home health benefits.
- The equipment must be medically necessary.
- The criteria appropriate for the requested equipment must be met.
- Federal financial participation must be available.
- The requested equipment or supplies must be safe for use in the home.

The DME Certification and Receipt Form is required and must be completed before reimbursement can be made for any DME delivered to a client. The certification form must include the name of the item, the date the client received the DME, and the signatures of the provider and the client or primary caregiver. This signed and dated form must be maintained by the DME provider in the client's medical record.

Glucose monitors and external insulin pumps that have been purchased are anticipated to last a minimum of five years and may be considered for replacement when five years have passed and/or the equipment is no longer repairable. The DME may then be considered for prior authorization. Replacement of equipment may also be considered when loss or irreparable damage has occurred. A copy of the police or fire report when appropriate or applicable, and the measures to be taken to prevent reoccurrence must be submitted. Additional services may be reimbursed with prior authorization based on documentation of medical necessity.

In situations where the equipment has been abused or neglected by the client, the client's family or the caregiver, a referral to the Department of State Health Services (DSHS) THSteps Case Management Department will be made by the Home Health Services Prior Authorization Department for clients under 21 years of age. Providers will be notified that the state will be monitoring this client's services to evaluate the safety of the environment for both the client and the equipment.

A Texas Medicaid-eligible client may obtain diabetic supplies and related testing equipment through Home Health Services. The following requirements must be met to qualify for reimbursement under Home Health Services:

A completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form that prescribes the DME and/or medical supplies must be signed and dated by a prescribing physician who is familiar with the client before supplying any medical equipment or supplies. All signatures must be current, unaltered, original, and hand written. Computerized or stamped signatures and dates will not be accepted. The completed, signed, and dated Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must be maintained by the provider and the prescribing physician

in the client's medical record. The physician must maintain the original signed and dated copy of the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. The completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is valid for a period up to six months from the physician's signature date.

The physician must indicate on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form how many times a day the client is required to test blood glucose levels.

24.5.12.1 Blood Testing Supplies

Blood testing supplies for diagnoses other than those listed in the diagnosis table below may be considered for prior authorization with documentation of medical necessity. Quantities will be prior authorized based on the documentation of medical necessity related to the number of tests ordered per day by the physician.

Quantities of blood testing supplies beyond those listed in the procedure code table below for diabetic supplies and limitations, when requested for a diagnosis listed in the diagnosis table below, may be considered for prior authorization with documentation of medical necessity related to the number of tests the physician ordered per day. Blood testing supplies will be reimbursed for the quantities listed in the procedure code table below for diabetic supplies and limitations, or the quantity that was prior authorized.

The quantity of blood testing supplies billed for a one month supply should relate to the number of tests ordered per day by the physician.

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this home health benefit will receive those services through THSteps-CCP. Glucose tabs/gel may be billed with procedure code 9-A9150.*

Blood glucose test/reagent strips (9-A4253) and home glucose disposable monitors with test strips (9-A9275) are limited to a combined total of four per month without prior authorization.

Diabetic Supplies and Limitations

Procedure Code	Maximum Limit
9-A4233	1 per 6 months
9-A4234	1 per 6 months
9-A4235	1 per 6 months
9-A4236	1 per 6 months
9-A4245	As needed
9-A4250	2 boxes/month
9-A4253	4 boxes/month* *Combined total with A9275
9-A4256	2 per year
9-A4258	2 per year
9-A4259	2 boxes/month
9-A4601	1 per 6 months
1-A9150	1 per 6 months* *Use this procedure code for Glucose tabs/gel
9-A9275	4 per month* *Combined total with A4253

Diagnosis Codes

Diagnosis Code				
25000	25001	25002	25003	25010
25011	25012	25013	25020	25021
25022	25023	25030	25031	25032
25033	25040	25041	25042	25043
25050	25051	25052	25053	25060
25061	25062	25063	25070	25071
25072	25073	25080	25081	25082
25083	25090	25091	25092	25093
64800	64801	64802	64803	64804
64880	64881	64882	64883	64884
7751				

Diagnoses not listed above may be considered by HHSC with supporting documentation of medical necessity.

Diabetic supplies and related testing equipment do not require prior authorization unless otherwise specified by HHSC.

24.5.12.2 Blood Glucose Monitors

A blood glucose monitor is a portable battery-operated meter used to determine the level of blood sugar (glucose). Home glucose monitor procedure codes J-E0607, J-E2100, and J-E2101 are benefits of Home Health Services and are allowed reimbursement once every five years.

Prior authorization is not required for the purchase of a standard blood glucose monitor (J-E0607), but is limited to the diagnoses listed in the diagnosis table above. Diagnoses not listed may be considered for prior authorization with supporting documentation of medical necessity.

Invasive continuous glucose monitors (CGMs) are used for diagnostic purposes to assist the clinician in establishing or modifying a client's treatment plan. Invasive CGMs are not benefits of Home Health Services. Noninvasive CGMs are considered investigational and are not benefits of the Texas Medicaid Program.

Prior authorization for blood glucose monitors with special features (procedure codes J-E2100 and J-E2101), such as auditory responses for visually impaired clients may be considered with documentation that supports the medical necessity of the special feature that was requested. This

can be requested either by calling TMHP Home Health Services Prior Authorization Department, or by faxing the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form to TMHP Home Health Services Prior Authorization Department.

To avoid unnecessary denials, physicians must provide correct and complete information, including documentation of the medical necessity of the equipment and/or supplies that are requested. Physicians must maintain documentation of medical necessity in the client's medical record. Requesting providers may be asked for additional information to clarify or complete a request for diabetic equipment or supplies.

Purchase of a blood glucose monitor with integrated voice synthesizer (J-E2100) may be prior authorized with documentation that includes a diagnosis of diabetes and significant visual impairment, including a statement from the physician that the client is unable to use a regular monitor and that the visual impairment is not correctable.

Purchase of a blood glucose monitor with integrated lancing/blood sample (J-E2101) may be prior authorized with documentation that includes a diagnosis of diabetes and significant manual dexterity impairment related to, but not limited to, neuropathy, seizure activity, cerebral palsy, or Parkinson's. The documentation must include a statement from the physician that the client is unable to use a regular monitor and has a significant manual dexterity impairment that is not correctable.

The documentation and a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must be submitted to the Home Health Services Prior Authorization Department.

24.5.12.3 Insulin and Insulin Syringes

Insulin and insulin syringes, all sizes, are reimbursed through the Vendor Drug Program pursuant to a physician's prescription. The Vendor Drug Program enrolls pharmacies only.

24.5.12.4 Insulin Pump

The following procedure codes for the external insulin pumps and associated supplies are a benefit of the Texas Medicaid Program and may be considered through Home Health Services. Note that a replacement leg bag may be requested with procedure code 9-A9900. *The initial leg bag is part of the purchase of the pump.*

Insulin Pump Procedure Codes and Limitations

Procedure Code	Maximum Limitation
9-A4230	10 per month
9-A4231	15 per month
9-A4232	10 per month
9-A4601	1 per 6 months
9-A6257	15 per month
9-A6258	15 per month
9-A6259	15 per month
9-A9900	Leg bag replacement only
J-E0784	1 per 5 years
L-E0784	3 months trial

Prior authorization is required for external insulin pumps (J/L-E0784) with carrying cases and their related supplies. The external insulin pump supplies may be reimbursed separately in addition to the external insulin pump rental.

The following information, which must be documented on the External Insulin Infusion Pump form, is the minimum documentation required for consideration of medical necessity:

- Lab values, current and past blood glucose levels, including glycosylated hemoglobin (Hb/A1C) levels.
- History of severe glycemic excursions, brittle diabetes, hypoglycemic/hyperglycemic reactions, nocturnal hypoglycemia, any extreme insulin sensitivity and/or very low insulin requirements.
- Any wide fluctuations in blood glucose before mealtimes.
- Any Dawn phenomenon where fasting blood glucose level often exceeds 200 mg/dL.
- Day-to-day variations in work schedule, mealtimes and/or activity level, which require multiple insulin injections.
- Completed, signed, and dated Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.

The external insulin pump may be considered for purchase after it has been rented for three months and the physician provides documentation that it is the appropriate equipment for the client and the client is compliant with use. This documentation and a newly completed Home Health Services form and new External Insulin Infusion Pump form must be submitted to TMHP Home Health Services Prior Authorization Department for prior authorization.

An internal insulin pump will not be prior authorized, because reimbursement for the pump is included in the reimbursement for the surgery to place the insulin pump.

A determination will be made by the prior authorization nurse as to whether the equipment will be rented, purchased, repaired, or modified based on the client's needs, duration of use, and the age of the equipment.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the equipment and/or supplies requested. The physician must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for the diabetic equipment or supplies.

24.5.13 Incontinence Supplies and Equipment

Incontinence supplies and DME are defined as disposable supplies such as diapers, briefs, pull-ons, liners, wipes, underpads, skin sealants, protectants, moisturizers, ointments, and DME that are used by a client who has a medical condition that results in a chronic impairment of urination and/or stooling, or that renders them unable to ambulate safely to the bathroom (with or without mobility aids). For the purpose of this policy, a chronic impairment of urination and/or stooling is defined as a condition that is not expected to be medically or surgically corrected and that is of a long and indefinite duration (at least three months).

Incontinence supplies, urinals, and bed pans do not require prior authorization up to their allowed maximum limitations. Prior authorization is required for incontinence supplies if amounts greater than the maximum limits are medically necessary. Incontinence supplies billed for a one-month period should be based on the frequency/quantity ordered by the physician on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.

All claims submitted for DME supplies must include the same quantities or units that are documented on the delivery slip or invoice and on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. They must reflect the number of units by which each product is measured. For example, diapers are measured as individual units. If one package of 300 diapers is delivered, the delivery slip or invoice and the claim must reflect that 300 diapers were delivered and not that one package was delivered. Diaper wipes are measured as boxes/packages. If one box of 200 wipes is delivered, the delivery slip or invoice and the claim must reflect that one box was delivered and not that 200 individual wipes were delivered. There must be one dated delivery slip or invoice for each claim submitted for each client. All claims submitted for DME supplies must reflect the same date as the delivery slip or invoice and the same timeframe covered by the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. The DME Certification and Receipt Form is still required for all equipment delivered.

To request prior authorization for incontinence supplies/equipment, the following documentation must be provided:

- Diagnostic information pertaining to the underlying diagnoses/conditions, to include the client's overall health status.
- Weight and height and/or waist size, when applicable.
- Number of times per day the physician has ordered the supply be used.
- Quantity of disposable supplies requested per month, or quantity of DME requested.

Additional information may be requested to clarify or complete a request for the supplies and equipment.

The Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is valid for up to, but no more than, six months from the date of the physician's signature on the form.

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health benefit will receive those services through THSteps-CCP.*

Refer to: Section 24.3.1, "Eligibility."

24.5.13.1 Incontinence Supplies

Skin sealants, protectants, moisturizers, and ointments for clients 4 years of age and older may be considered for reimbursement with prior authorization for clients who have a medical condition that results in chronic incontinence and increased risk of skin breakdown. Skin sealants, protectants, moisturizers and ointments are limited to a maximum of two per month for clients four years of age and older. Prior authorization for clients younger than 4 years of age must be obtained through THSteps-CCP.

Note: Diapers and briefs *are defined as incontinence items attached with tabs.* Protective underwear and pull-ons *are defined as incontinence items that do not attach with tabs and are slip-on items. Liners are intended to be worn inside diapers, briefs, and pull-ons to increase absorbency.*

For clients four years of age and older with a medical condition that results in chronic incontinence, *diapers, briefs, protective underwear, pull-ons, and liners* may be considered for reimbursement without prior authorization up to a total combination of 300 per month. Amounts beyond 300 per month may be considered for reimbursement when prior authorized. A combination of diapers, briefs, and liners may be considered for reimbursement. A total accumulation of one or more of the following products is limited to a maximum of 300 per month: diapers, briefs, pull-ons, and liners. Amounts beyond 300 per month require prior authorization. Reusable diapers/briefs are not a benefit of Home Health Services.

Note: *Gloves used to change diapers and briefs (including pull-ups) are not considered medically necessary unless the client has skin breakdown or a documented disease that may be transmitted through the urine or stool.*

Diaper wipes (9-A4335), other than urinary skin cleansing products, may be considered for reimbursement without prior authorization for clients who are 4 years of age and older and are also receiving diapers/briefs/pull-ons. Diaper wipes, other than urinary skin cleansing products, are limited to a maximum of two boxes per month. Exceptions will not be considered through Home Health Services. Additional quantities may be considered through THSteps-CCP for clients who are younger than 21 years of age with documentation of medical necessity and prior authorization.

Note: *Providers are to bill procedure code 9-A4335 instead of procedure code 9-A5120 when providing diaper wipes. Inappropriate billing of 9-A5120 will cause the procedure to deny.*

Underpads may be considered for reimbursement without prior authorization for clients who also receive diapers/briefs, urine collection devices, or bowel management supplies. Underpads are limited to a maximum of 150 per month without prior authorization. Amounts greater than 150 per month may be considered for prior authorization with documentation of medical necessity. Reusable underpads are *not* a benefit of Home Health Services.

Note: *The Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form for the supplies listed above must reflect a one month's supply of the incontinence product. More than the maximum allowed amount should not be on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form without prior authorization, unless it has been prior authorized.*

Ostomy supplies may be considered for reimbursement without prior authorization. The physician must specify the type of ostomy device/system to be used and how often it is to be changed on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form without prior authorization. The quantity of ostomy supplies billed for a one-month period should relate to the number of changes per month based on the frequency ordered by the physician.

Urine Collection Devices. The home setting is considered a clean environment, not a sterile one. Sterile incontinence supplies, including gloves, will not be reimbursed in the home setting except when requested by a physician familiar with the client for the following:

- Indwelling urinary catheters.
- Intermittent catheters for clients who:
  - Are immunosuppressed.
  - Have radiologically documented vesico-ureteral reflux.
  - Are pregnant and have a neurogenic bladder due to spinal cord injury.
  - Have a history of distinct, recurrent urinary tract infections, defined as a minimum of two within the prior 12-month period, while on a Program of clean intermittent catheterization.

Note: *Nonsterile gloves may be considered for reimbursement with prior authorization when a family member or friend is performing the catheterization. Nonsterile/sterile gloves for use by a health-care provider in the home setting, such as an RN, LVN, or attendant, are not a benefit of Home Health Services.*

Indwelling catheters and related insertion supplies may be considered for reimbursement without prior authorization for clients who have a documented medical condition that results in a permanent impairment of urination. Indwelling catheters and related supplies are limited to a maximum of two per month. More than two indwelling catheters and related insertion supplies per month requires prior authorization. The physician must indicate on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form how often the client is required to change their indwelling catheter.

Intermittent catheters and related insertion supplies may be considered for reimbursement for those who have a documented medical condition that results in a permanent impairment of urination. Intermittent catheters and related supplies are limited to a maximum of 120 per month. More than 120 intermittent catheters and related insertion supplies requires prior authorization. The physician must indicate on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form how often the client is required to perform intermittent catheterization.

Use procedure codes 9-A4351, and/or 9-A4352 when billing for intermittent catheters. Use procedure code 9-A4353 when billing for Intermittent catheters with insertion supplies. When billing these codes for intermittent hydrophilic catheters use the SC modifier.

External urinary collection devices for clients 4 years of age and older, such as male external catheters and female collection devices, and related supplies may be considered for reimbursement without prior authorization for clients who have a documented and/or diagnosed medical condition that results in a permanent impairment of urination. Male external catheters are limited to 31 per month. Female collection devices may be considered for reimbursement without prior authorization for a maximum of four per month. Prior authorization is required for medically necessary services beyond the limits listed in the Incontinence Procedures and Limitations table. The physician must indicate on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form how often the client is required to change their external urinary collection device.

External urinary collection devices for clients younger than 4 years of age require prior authorization through THSteps-CCP. Documentation of a medical condition that results in an increased urine and/or stool output beyond the typical output for this age group is required for reimbursement consideration.

24.5.13.2 Incontinence Equipment

Incontinence equipment may be considered for reimbursement for clients 4 years of age and older who have a medical condition that results in an inability to ambulate to the bathroom safely (with or without mobility aids).

Urinals and bed pans may be considered for reimbursement without prior authorization for clients who have a documented and/or diagnosed medical condition that results in an inability to ambulate to the bathroom safely (with or without mobility aids). Urinals and bed pans

are considered a purchase as a purchase only. Urinals and bed pans that exceed two per year may be considered with prior authorization.

Commode chairs and foot rests will be considered for prior authorization and reimbursement based on the level of need. The client must meet the criteria for the level commode chair or foot rest requested.

Reimbursement may be considered for a commode chair with or without foot rest if the client also has a stationary bath chair without a commode cutout.

Commode Chairs

Commode chairs are limited to one per five years. Documentation must support the medical necessity of a customized commode chair or the addition of attachments to a standard commode chair.

Level 1: Stationary Commode Chair

A stationary commode chair may be considered for reimbursement with prior authorization for clients who have a medical condition that results in an inability to ambulate to the bathroom safely (with or without mobility aids).

Use procedure codes J-E0163 or J-E0165 for stationary or mobile commode chairs.

Level 2: Mobile Commode Chair

A mobile commode chair with fixed or removable arms may be considered for reimbursement for clients who have a documented medical condition that results in an inability to ambulate to the bathroom safely (with or without mobility aids).

A mobile commode chair with fixed or removable arms may be considered for prior authorization and reimbursement when:

- The client has a medical condition that results in the inability to ambulate to the bathroom safely (with or without mobility aids).
- The client must be on a bowel Program and require a combination commode/bath chair for performing the bowel program and bathing after.
- The client does not also have any type of bath chair. If the client meets the criteria for a stationary bath chair, prior authorization of a stationary chair may be considered.

If the client owns a bath chair and has medical necessity for a mobile commode chair, one may be considered through THSteps-CCP for clients under 21 years of age.

Level 3: Custom Commode Chair

A custom stationary or mobile commode chair with fixed or removable arms and head, neck and or trunk support attachments may be considered for prior authorization and reimbursement when:

- The criteria for a Level 1 or 2 commode chair has been met.
- The client must have a medical condition that results in an inability to support their head, neck, and/or trunk without assistance.
- The client does not also have any type of bath chair.

If the client owns a bath chair and has medical necessity for a mobile commode chair, one may be considered through THSteps-CCP for clients under 21 years of age.

Use procedure codes J-E0163 or J-E0165 and modifier TG (custom) when billing for custom stationary or mobile commode chairs.

Use procedure codes J-E0163 or J-E0165 and modifier TF (non-custom mobile) when billing for non-custom mobile commode chairs.

Extra wide/Heavy Duty Commode Chair

An extra wide/heavy-duty commode chair is defined as one with a width greater than or equal to 23 inches and capable of supporting a client who weighs 300 pounds or more.

An extra wide/heavy-duty commode chair will be considered for prior authorization and reimbursement when the client has met the criteria for a Level 1, 2, or 3 commode chair and weigh 300 pounds or more.

Use procedure code J-E0168 and modifiers TF (mobile) or TG (custom) for an extra-wide/heavy-duty commode chair.

Foot Rest

A *foot rest* is used to support feet during use of commode chair and may be considered for prior authorization and reimbursement when:

- The client has met the criteria for a Level 1, 2, or 3 commode chair.
- The foot rest is necessary to support contractures of the lower extremities; for a client who is paraplegic or quadriplegic.

Use procedure code J-E1399 when billing for a foot rest.

Replacement Commode Pail/Pan

Replacement commode pails or pans may be considered for prior authorization once per year. Additional quantities may be considered for prior authorization with documentation of medical necessity.

Use procedure code J-E0167 when billing for a commode pail or pan.

24.5.13.3 Incontinence Procedure Codes With Limitations

Note: *Any service or combination of services not identified with a # next to the procedure code, except diaper wipes, requires prior authorization if the maximum limitation is exceeded. Items identified with a # always require prior authorization. Requests for prior authorization of diaper wipes that exceed more than two boxes per month will not be considered through Home Health Services.*

Procedure Code	Maximum Limitation
9-A4310	2 per month
9-A4311	2 per month
9-A4312	2 per month
9-A4313	2 per month

Procedure Code	Maximum Limitation
9-A4314	2 per month
9-A4315	2 per month
9-A4316	2 per month
9-A4320	2 per month
9-A4322	4 per month
9-A4326	31 per month
9-A4327	4 per month
9-A4328	4 per month
9-A4330	As needed
9-A4335	2 per month
9-A4338	2 per month
9-A4340	2 per month
9-A4344	2 per month
9-A4346	2 per month
9-A4349	31 per month
9-A4351	120 per month
9-A4351-SC	120 per month
9-A4352	120 per month
9-A4352-SC	120 per month
9-A4353	120 per month
9-A4353-SC	120 per month
9-A4354	2 per month
9-A4355	2 per month
9-A4356	2 per month
9-A4357	2 per month
9-A4358	2 per month
9-A4361	As needed
9-A4362	As needed
9-A4363	As needed
9-A4364	As needed
9-A4365	1 box of 50 per month
9-A4367	As needed
9-A4368	As needed
9-A4369	As needed
9-A4371	As needed
9-A4372	As needed
9-A4373	As needed
9-A4375	As needed
9-A4376	As needed
9-A4377	As needed
9-A4378	As needed
9-A4379	As needed
9-A4380	As needed
9-A4381	As needed

Procedure Code	Maximum Limitation
9-A4382	As needed
9-A4383	As needed
9-A4384	As needed
9-A4385	As needed
9-A4387	As needed
9-A4388	As needed
9-A4389	As needed
9-A4390	As needed
9-A4391	As needed
9-A4392	As needed
9-A4393	As needed
9-A4394	As needed
9-A4395	As needed
9-A4396	As needed
9-A4397	As needed
9-A4398	As needed
9-A4399	As needed
9-A4400	As needed
9-A4402	4 per month
9-A4404	As needed
9-A4405	As needed
9-A4406	As needed
9-A4407	As needed
9-A4408	As needed
9-A4409	As needed
9-A4410	As needed
9-A4411	As needed
9-A4412	As needed
9-A4413	As needed
9-A4414	As needed
9-A4415	As needed
9-A4418	As needed
9-A4420	As needed
9-A4421	As needed
9-A4422	As needed
9-A4428	As needed
9-A4455	4 per month
9-A4554	150 per month
9-A4927#	1 per month
9-A5051	As needed
9-A5052	As needed
9-A5053	As needed
9-A5054	As needed
9-A5055	As needed

Procedure Code	Maximum Limitation
9-A5061	As needed
9-A5062	As needed
9-A5063	As needed
9-A5071	As needed
9-A5072	As needed
9-A5073	As needed
9-A5081	As needed
9-A5082	As needed
9-A5093	As needed
9-A5102	2 per month
9-A5105	4 per year
9-A5112	2 per month
9-A5113	2 per month
9-A5114	2 per month
9-A5120	30 per month
9-A5121	As needed
9-A5122	As needed
9-A5126	As needed
9-A5131	1 per month
9-A5200	2 per month
9-A6250#	2 per month
9-T4521	*300 per Month
9-T4522	*300 per Month
9-T4523	*300 per Month
9-T4524	*300 per Month
9-T4525	*300 per Month
9-T4526	*300 per Month
9-T4527	*300 per Month
9-T4528	*300 per Month
9-T4529	*300 per Month
9-T4530	*300 per Month
9-T4531	*300 per Month
9-T4532	*300 per Month
9-T4533	*300 per Month
9-T4534	*300 per Month
9-T4535	*300 per Month
9-T4543	*300 per month
J-E0163#	1 per 5 years
J-E0163-TF#	1 per 5 years
J-E0163-TG#	1 per 5 years
J-E0165#	1 per 5 years
J-E0165-TF	1 per 5 years
J-E0165-TG#	1 per 5 years
J-E0167#	1 per year
J-E0168#	1 per 5 years
J-E0168-TF#	1 per 5 years
J-E0168-TG#	1 per 5 years
J-E0175#	1 per 5 years
J-E0275	2 per year
J-E0276	2 per year
J-E0325	2 per year
J-E0326	2 per year

Refer to: The Diapers/Briefs/Liners section of "Incontinence Supplies and Equipment" on page 24-21 for an explanation of the item limitations identified with an asterisk (*).

24.5.13.4 Modifiers

Modifier		
TF	TG	SC

24.5.14 Wound Care Supplies and/or Systems

Wound care supplies and systems are designed to assist in healing of wounds in conjunction with an individualized wound care therapy regimen prescribed by a physician. A wound care system includes a medical device and its component supplies designed to assist in healing of wounds unresponsive to conventional wound care therapy. Wound care supplies and wound care systems may be considered for reimbursement through Home Health Services.

Refer to: "Wound Care Supplies and/or Systems" on page 24-25 for more information.

Prior authorization is required for all the medical supplies and wound care systems addressed in this policy and provided through TMHP Home Health Services Prior Authorization Department.

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this home health benefit will receive those services through THSteps-CCP.*

24.5.14.1 Wound Care Supplies

Nonsterile/clean wound care supplies may be considered for prior authorization when documentation supports medical necessity. The home setting is considered a clean environment, not a sterile environment.

Sterile wound care supplies, other than those required with a wound care system, may be considered for prior authorization when documentation supports medical necessity and justifies that nonsterile/clean wound care supplies will not meet the client's needs.

Note: *Established tracheostomies and/or gastrostomies/buttons are not considered wounds, therefore dressing supplies will not be considered for prior authori-*

zation. Dressing supplies for tracheostomies and/or gastrostomies may be considered for prior authorization with documentation of medical necessity.

To request prior authorization for wound care supplies, the following documentation must be provided:

- Accurate diagnostic information pertaining to the underlying diagnosis/condition as well as any other medical diagnoses/conditions, to include the client's overall health status.
- Appropriate medical history related to the current wound:
  - Wound measurements to include length, width and depth, any tunneling and/or undermining.
  - Wound color, drainage (type and amount) and odor, if present.
  - The prescribed wound care regimen, to include frequency, duration and supplies needed.
  - Treatment for infection, if present.
- The client's use of a pressure reducing mattress and/or cushion, when appropriate.
- Identification of the client or caregiver who will be instructed how to perform and will be responsible for the wound care.

Note: *Nonsterile gloves may be considered for prior authorization when necessary to perform medical wound care provided by the client, a family member, or a friend. The home health nursing agency must provide their staff with the appropriate safety supplies as stated in the Occupational Safety and Health Administration (OSHA) requirements. Non-sterile/sterile gloves for use by a health-care provider in the home setting, such as an RN, LVN, or attendant are not a benefit.*

24.5.14.2 Wound Care System

A wound care system includes a medical device and its component supplies designed to assist in healing of wounds unresponsive to conventional wound care therapy. Wound care systems may be considered for reimbursement when prior authorized.

A wound care system may be considered for reimbursement for clients with a Stage III or IV chronic, nonhealing wound, such as a pressure, venous stasis, diabetic ulcer, postsurgical wound dehiscence, nonadhering skin grafts, or surgical flaps required for covering such wounds.

Types of wound care systems include the following:

- *Thermal wound care system.* A heating element provides and maintains a warm, moist wound environment and protects the wound during the healing process by sealing it with an adhesive drape and applying intermittent heat to the surrounding tissue.
- *Sealed suction wound care system.* A sealed suction wound care system provides and maintains a moist wound environment and protects the wound during the healing process by sealing it with an adhesive drape and applying continuous or intermittent suction.

Note: *Portable hyperbaric oxygen chambers that are placed directly over the wound and provide higher concentrations of oxygen to the damaged tissue are not a benefit of Home Health Services.*

24.5.14.3 Thermal Wound Care System

A thermal wound care system consists of an occlusive pocketed wound cover with foam buffer to cover the wound, a warming card that is placed in the wound cover pocket and an electric temperature control unit (TCU). A thermal wound care system delivers safe, controlled warmth to the wound site and peri-wound tissue—without touching the wound. This warmth temporarily increases blood flow and SQ/SC oxygen to the wound and surrounding area to facilitate healing.

Dressing changes associated with a thermal wound care system are performed every one to three days, depending on the amount of exudate produced by the wound. The warming card is used on a single client, but is not required to be changed during treatment except to accommodate a decreasing wound size. The TCU is rented on a monthly basis. The client, family, or caregiver can be taught to perform a thermal wound care system dressing change.

Use procedure codes 9-A6000, L-E0231, and L-E0232 for a thermal wound care system and associated supplies.

24.5.14.4 Sealed Suction Wound Care System

A sealed suction wound care system consists of a cell foam dressing that is placed in the wound bed, a suction catheter tip, an adhesive drape to cover the wound, suction tubing, and a computerized vacuum pump. A sealed suction wound care system uses continuous or intermittent subatmospheric pressure to evacuate the excess interstitial fluid and remove growth factor inhibitors. The removal of inhibitors allows the growth factor to stimulate cell proliferation and migration. Removal of excess fluid also helps decrease peri-wound induration.

Dressing changes associated with a sealed suction wound care system are performed every one to three days depending on the amount of exudate produced by the wound. The computerized vacuum pump is rented on a monthly basis. An RN is required to perform a sealed suction wound care system dressing change.

Use the procedure codes L-E2402 and 9-A6550 for a sealed suction wound care system and associated supplies.

24.5.14.5 Pulsatile Jet Irrigation Wound Care System

A pulsatile jet irrigation wound care system consists of a pistol-style hand piece with a trigger to control the pulsatile jet. A suction pump is used to remove the fluid. The wound is then dressed using standard wound care supplies.

Dressing changes associated with a pulsatile jet irrigation wound care system are performed every one to three days depending on the amount of exudate produced by the wound. An RN is required to perform a pulsatile jet irrigation wound care system dressing change.

Use procedure code L-E1399 for a pulsatile jet irrigation wound care system.

24.5.14.6 Wound Care System Criteria

Initial Criteria

Initial prior authorization for a wound care system may be considered for reimbursement for up to a 30-day period.

Recertification Criteria

Medically necessary prior authorized extensions may be considered for reimbursement for 30-day periods up to a maximum of four months when documentation supports continued significant improvement in wound healing. Wound care systems may be considered for reimbursement beyond four months of treatment on a case-by-case basis after review by the medical director or designee with documentation of medical necessity.

24.5.14.7 Prior Authorization

To request prior authorization for a wound system, the documentation listed below must be provided on the Statement of Initial Wound Therapy System In-Home Use Form on page B-91 for an initial or recertification request and submitted with the signed and dated Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. The original documentation must be maintained by the prescribing physician in the client's medical record. A copy of these documents must be maintained by the requesting provider.

- Accurate diagnostic information pertaining to the underlying diagnosis/condition and any other medical diagnoses/conditions, including the client's overall health status.
- The client's use of a pressure reducing mattress, when appropriate.
- Albumin level within the last 30 days:
  - If the albumin level is below 3.0, documentation must show that nutritional supplement is in place.
- Hemoglobin A1c obtained within last 30 days if the client has a diagnosis of diabetes mellitus.
- Appropriate medical history related to the current wound:
  - Documentation that the wound is free of necrotic tissue and infection, or if infection is present, that it is being treated with antibiotics, including the name of the antibiotic, dosage, frequency, and route of administration.
  - Wound measurements to include length, width, and depth, any tunneling and/or undermining.
  - For recertification, documentation that the wound is improving.
  - Wound color, drainage (type and amount), and odor if present.
- The prescribed wound care regimen, to include frequency, duration, and supplies needed.
- Identification of the caregiver who agrees to be available to assist client during this time and agreement of this person not to operate the negative pressure or the pulsatile jet irrigation system if used.
- Documentation that an RN who is certified in the use of the wound care system is performing the wound care when a negative pressure or pulsatile jet irrigation wound care system is used. All requirements for skilled nursing care must be met.

Wound care system supplies are limited to a maximum of:

- 15 dressing kits or supplies per wound per month unless documentation supports that the wound size requires more than one dressing kit for each dressing change or if the physician has ordered more frequent dressing changes.

When documentation supports evidence of high-volume drainage, defined as greater than 90 ml per day, a stationary pump with the largest capacity canister must be used. Extra canisters related to the equipment failure are not considered medically necessary.

Wound care systems and related supplies will not be prior authorized nor considered for reimbursement when:

- The client has one of the following contraindications:
  - A fistula to the body.
  - Wound ischemia.
  - Gangrene.
  - Skin cancer in the wound margins.
  - Presence of necrotic tissue, including bone (nonapplicable to the pulsatile jet irrigation wound care system).
  - Osteomyelitis (unless it is being treated; the treatment must be identified).
  - Less than six months to live.
- In the documented judgement of the treating physician, adequate wound healing has occurred and the wound care system is no longer required.
- No measurable wound healing has occurred over the previous 30-day period.
- A wound care system was used for four months or more in the inpatient setting before discharge, except when documentation supports continued significant improvement in wound healing.

- The wound care equipment and supplies are no longer being used by the client. Stand-by use equipment and supplies are not a benefit of Home Health Services.

24.5.14.8 Wound Care Procedures and Limitations

Procedure Code	Maximum Limitation
9-A4213	As needed
9-A4217	As needed
9-A4244	1 per month
9-A4245	Per box as needed
9-A4246	1 per month
9-A4247	1 per month
9-A4450	20 per month
9-A4452	20 per month
9-A4455	4 per month
9-A4461	As needed
9-A4930	As needed
9-A6000	15 per month
9-A6010	As needed
9-A6011	As needed
9-A6021	As needed
9-A6022	As needed
9-A6023	As needed
9-A6024	As needed
9-A6025	As needed
9-A6154	As needed
9-A6196	As needed
9-A6197	As needed
9-A6198	As needed
9-A6199	As needed
9-A6200	As needed
9-A6201	As needed
9-A6202	As needed
9-A6203	As needed
9-A6204	As needed
9-A6205	As needed
9-A6206	As needed
9-A6207	As needed
9-A6208	As needed
9-A6209	As needed
9-A6210	As needed
9-A6211	As needed
9-A6212	As needed
9-A6213	As needed
9-A6214	As needed
9-A6215	As needed
9-A6216	As needed
9-A6217	As needed
9-A6218	As needed
9-A6219	As needed
9-A6220	As needed
9-A6221	As needed
9-A6222	As needed
9-A6223	As needed
9-A6224	As needed
9-A6228	As needed
9-A6229	As needed
9-A6230	As needed
9-A6231	As needed
9-A6232	As needed
9-A6233	As needed
9-A6234	As needed
9-A6235	As needed
9-A6236	As needed
9-A6237	As needed
9-A6238	As needed
9-A6239	As needed
9-A6240	As needed
9-A6241	As needed
9-A6242	As needed
9-A6243	As needed
9-A6244	As needed
9-A6245	As needed
9-A6246	As needed
9-A6247	As needed
9-A6248	As needed
9-A6251	As needed
9-A6252	As needed
9-A6253	As needed
9-A6254	As needed
9-A6255	As needed
9-A6256	As needed
9-A6257	As needed
9-A6258	As needed
9-A6259	As needed
9-A6260	As needed
9-A6261	As needed
9-A6262	As needed
9-A6266	As needed
9-A6402	As needed

Procedure Code	Maximum Limitation
9-A6403	As needed
9-A6404	As needed
9-A6407	As needed
9-A6410	As needed
9-A6411	As needed
9-A6412	As needed
9-A6441	As needed
9-A6442	As needed
9-A6443	As needed
9-A6444	As needed
9-A6445	As needed
9-A6446	As needed
9-A6447	As needed
9-A6448	As needed
9-A6449	As needed
9-A6450	As needed
9-A6451	As needed
9-A6452	As needed
9-A6453	As needed
9-A6454	As needed
9-A6455	As needed
9-A6456	As needed
9-A4657	As needed
9-A6550	15 per month
9-T1999	As needed
L-E0231	1 per month
L-E0232	1 per month
L-E1399	1 per month (for use with Pulsatile Jet Irrigation Wound Care System)
L-E2402	1 per month

24.5.15 Durable Medical Equipment (DME) and Supplies

The Texas Medicaid Program defines DME as:

Medical equipment or appliances that are manufactured to withstand repeated use, ordered by a physician for use in the home, and required to correct or ameliorate a client's disability, condition, or illness.

Since there is no single authority, such as a federal agency, that confers the official status of "DME" on any device or product, HHSC retains the right to make such determinations with regard to DME benefits of the Texas Medicaid Program. DME benefits of the Texas Medicaid Program must have either a well-established history of efficacy or, in the case of novel or unique equipment, valid, peer-reviewed evidence that the equipment corrects or ameliorates a covered medical condition or functional disability.

Requested DME may be a benefit when it meets the Medicaid definition of DME.

The majority of DME and expendable supplies are covered Home Health Services.

If a service cannot be provided for a client younger than 21 years of age through Home Health Services, these services may be covered through THSteps-CCP if they are determined to be medically necessary.

To be reimbursed as a home health benefit:

- The client must be eligible for home health benefits.
- The criteria listed for the requested equipment must be met.
- The equipment requested must be medically necessary, and federal financial participation must be available.
- The client's health status would be compromised without the requested equipment.
- The requested equipment or supplies must be safe for use in the home.
- The client must be seen by a physician within one year of the DOS.

A completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form prescribing the DME and/or supplies must be signed and dated by a physician familiar with the client before requesting prior authorization for all DME equipment and supplies. All signatures must be current, unaltered, original, and handwritten. Computerized or stamped signatures will not be accepted. The completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must include the procedure codes and quantities for services requested. The completed, signed, and dated form must be maintained by the DME provider and the prescribing physician in the client's medical record. The completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form with the original signature must be maintained by the prescribing physician.

Prior authorization is required for most DME and services provided through Home Health Services. These services include accessories, modifications, adjustments, and repairs for the equipment.

The date last seen by the physician must be within the past 12 months unless a physician waiver is obtained. The physician's signature on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is only valid for 90 days before the initiation of services.

Obtain authorization within *three business days* of providing the service by calling TMHP Home Health Services Authorization Department or faxing the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. A determination will be made as to whether the equipment will be rented, purchased, repaired, modified, or denied based on the client's medical necessity.

To facilitate a determination of medical necessity and avoid unnecessary denials when requesting prior authorization, the physician must provide correct and complete information supporting the medical necessity of the equipment and/or supplies requested, including:

- Accurate diagnostic information pertaining to the underlying diagnosis/condition as well as any other medical diagnoses/conditions, to include the client's overall health status.
- Diagnosis/condition causing the impairment resulting in a need for the equipment and/or supplies requested.

The provider must have the client sign the DME Certification and Receipt Form on page B-35 for all purchased DME for Medicaid clients before submitting a claim for payment. *The client's signature means the DME is the property of the client.* The certification form also requires the name of the item and the date the client received the DME. The DME supplier should retain this form, not submit it with the claim.

The provider must keep all Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Forms and Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Forms on file. Providers must retain delivery slips or invoices and the signed and dated DME Certification and Receipt Form documenting the item and date of delivery for all DME provided to a client and must disclose them to HHSC or its designee on request.

- The DME must be used for medical or therapeutic purposes, and supplied through an enrolled DMEH provider in compliance with the client's POC.
- These records and claims must be retained for a minimum of five years from the DOS or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.

Note: *All purchased equipment must be new upon delivery to client. Used equipment may be utilized for lease, but when purchased, must be replaced with new equipment.*

HHSC/TMHP reserves the right to request the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and/or Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form at any time.

DME must meet the following requirements to qualify for reimbursement under Home Health Services:

- The client received the equipment as prescribed by the physician.
- The equipment has been properly fitted to the client and/or meets the client's needs.
- The client, the parent or guardian of the client, and/or the primary caregiver of the client, has received training and instruction regarding the equipment's proper use and maintenance.

DME must:

- Be medically necessary due to illness or injury or to improve the functioning of a body part, as documented by the physician in the client's POC or the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.
- Be prior authorized by the TMHP Home Health Services Prior Authorization Department for rental or purchase of supplies for most equipment. Some equipment does not require prior authorization. Prior authorization for equipment rental can be issued for up to six months based on diagnosis and medical necessity. If an extension is needed, requests can be made up to 60 days before the start of the new authorization period with a new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.
- Meet the client's existing medical and treatment needs.
- Be considered safe for use in the home.
- Be provided through an enrolled DMEH provider/supplier.

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this home health benefit will receive those services through THSteps-CCP.*

DME that has been delivered to the client's home and then found to be inappropriate for the client's condition will not be eligible for an upgrade within the first six months following purchase unless there had been a significant change in the client's condition, as documented by the physician familiar with the client. All adjustments and modifications within the first six months after delivery are considered part of the purchase price.

All DME purchased for a client becomes the Medicaid client's property upon receipt of the item. This property includes equipment delivered which will not be prior authorized or reimbursed in the following instances:

- Equipment delivered to the client before the physician signature date on the POC or Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form or Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.
- Equipment delivered more than three business days before obtaining prior authorization from the TMHP Home Health Services Prior Authorization Department and meets the criteria for purchase.

Additional criteria:

- The TMHP Home Health Services Prior Authorization Department will make the final determination whether DME will be rented, purchased, or repaired based on the client's duration and use needs.
- Periodic rental payments are made only for the lesser of either the period of time the equipment is medically necessary, or when the total monthly rental payments equal the reasonable purchase cost for the equipment.

- Purchase is justified when the estimated duration of need multiplied by the rental payments would exceed the reasonable purchase cost of the equipment or it is otherwise more practical to purchase the equipment.
- DME repair will be considered based on the age of the item and cost to repair it.
- A request for repair of DME must include a statement or medical information from the attending physician substantiating that the medical appliance or equipment continues to serve a specific medical purpose and an itemized estimated cost list from the vendor or DME provider of the repairs. Rental equipment may be provided to replace purchased medical equipment for the period of time it will take to make necessary repairs to purchased medical equipment.
- If a DME/medical supply provider is unable to deliver an authorized piece of equipment or supply, the provider should allow the client the option of obtaining the equipment or supplies from another provider.

Items and/or services addressed are reimbursed at a maximum fee determined by HHSC. If an item is manually priced, the MSRP must be submitted for consideration of rental or purchase with the appropriate procedure codes. Purchases and rentals are reimbursed at the MSRP minus a discount as determined by HHSC.

DME is anticipated to last a minimum of five years and may be considered for replacement when five years have passed and the equipment is no longer functional and repairable. The DME may then be considered for prior authorization. Replacement of equipment will be considered when loss or irreparable damage has occurred. A copy of the police or fire report when appropriate, with the measures to be taken to prevent reoccurrence, must be submitted.

Replacement, adjustments, modifications, or repairs will not be authorized in situations where the equipment has been abused or neglected by the client, the client's family, or the caregiver. A referral to the DSHS Medical Case Management Department will be made by TMHP Home Health Services Prior Authorization Department (or CCP Department, where appropriate) for clients younger than 21 years of age. Providers will be notified that the state will be monitoring this client's services.

Prior authorization is required for replacement. Replacement will be considered in at least one of the following situations:

- After the maximum limitation time has elapsed and the DME is no longer functional and/or repairable.
- When irreparable damage has occurred.

Documentation, which must accompany a request, includes a statement from the prescribing physician, which includes:

- A copy of the fire or police report.
- The cause of the loss or damage and what measures will be taken to prevent reoccurrence.

Those who supply DME equipment and supplies to Medicaid Managed Care clients must obtain a prior authorization form. Services and supplies for STAR+PLUS Medicaid Qualified Medicare Beneficiary (MQMB) clients should be billed to Medicare first. If denied, submit them to TMHP to consider. The STAR+PLUS health plan is not responsible for these services.

Cancelling an authorization

The client has the right to choose his DME/medical supply provider and change providers. If the client changes providers, TMHP must receive a change of provider letter with a new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. The client must sign and date the letter, which must include the name of the previous provider and the effective date for the change. The client is responsible for notifying the original provider of the change and the effective date. Prior authorization for the new provider can only be issued up to three business days before the date TMHP receives the change of provider letter and the new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.

Repairs

Repairs will not be authorized in situations where the equipment has been abused or neglected by the client, client's family, or caregiver.

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

For clients requiring wheelchair repairs only, the date last seen by physician does not need to be filled in on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.

Benefits of the Home Health Services Program such as medical equipment (rental, purchase, or repairs) includes, but is not limited to:

- Manual or powered wheelchairs: *noncustomized,* including medically justified seating, supports, and equipment, or *customized,* specifically tailored or individualized, wheelchairs, including appropriate medically justified seating, supports, and equipment not to exceed an amount specified by HHSC.

Example: *If a wheelchair is requested, the provider should define additional items needed, such as foot rests or crutch holders, removable arms, or special attachments.*

- Canes, crutches, walkers, and trapeze bars.
- Bed pans, urinals, bedside commode chairs, elevated commode seats, bath chairs/benches/seats, and bath tub rails that are not wall-mounted.
- Electric and nonelectric hospital beds, mattresses, and bed-side rails.
- Air flotation or air pressure mattresses and cushions.
- Reasonable and appropriate appliances for measuring blood pressure and blood glucose suitable to the client's medical situation to include replacement parts and supplies.

- Freestanding lifts for assisting the client to ambulate within their residence or to transfer the client from one piece of equipment to another.
- Pumps for feeding tubes and IV administration.
- Respiratory or oxygen-related equipment.

Payment may be authorized for repair of purchased DME. Maintenance of rental equipment (including repairs) is the supplier's responsibility. The toll-free number for the TMHP Home Health Services Prior Authorization Department is 1-800-925-8957. Requests for repairs must include the cost estimate, reasons for repairs, age of equipment, and serial number.

Refer to: "Physician Supervision—Plan of Care" on page 24-7.

"DME Certification and Receipt Form" on page B-35.

"Home Health Services Plan of Care (POC)" on page B-47.

"Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions (2 Pages)" on page B-42 and

"Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form" on page B-45.

"Procedure Codes That Do Not Require Prior Authorization" on page 24-67 for equipment that does not require prior authorization.

"Provider Enrollment" on page 1-2.

24.5.16 Augmentative Communication Device (ACD) System

ACD systems are a benefit of Home Health Services and require prior authorization. ACD systems for clients younger than 21 years of age who do not meet the criteria for home health services may be considered under THSteps-CCP.

Refer to: "ACD Procedure Codes and Limitations" on page 24-36 for more information.

24.5.16.1 ACD Systems

An ACD system, also known as an augmentative and alternative communication (AAC) device system, allows a client to overcome the disabling effects of severe communication impairment by representation of vocabulary or ideas and expression of messages and enables the client to meet their functional speaking needs. For the purpose of this policy, the term "ACD system" refers to the ACD and all medically necessary components and accessories. Permanent loss of speech is defined as a severe communication disorder with no functional means/intelligible sound to communicate basic needs or thoughts.

An ACD system is a benefit of the Texas Medicaid Program and may be considered for prior authorization as a Home Health Services benefit when the following home health services eligibility criteria are met:

- The client must be eligible for home health benefits.
- The criteria in this section must be met.
- The equipment requested must be medically necessary.
- The client's status would be compromised without the requested equipment.
- Federal financial participation must be available.
- The requested equipment or supplies must be safe for use in the home.

24.5.16.2 Prior Authorization and Required Documentation

Prior authorization is required for rental or purchase of an ACD system provided through Home Health Services. The prior authorization request should include all related accessories and/or supplies.

Before requesting prior authorization, a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form, prescribing the DME and/or supplies must be signed and dated by a physician familiar with the client. All signatures and dates must be current, original, unaltered, and handwritten. Computerized or stamped signatures will not be accepted. The date of the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form can be no more than three months before the service start date. Forms that are submitted more than three months before the start of service will result in an authorization rejection. A letter will be generated to the provider stating that the date of the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is prior to the three-month limit. The completed, signed, and dated Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must include the procedure codes and quantities for services requested and must be maintained by the DME provider and the prescribing physician in the client's medical record.

To facilitate a determination of medical necessity and avoid unnecessary denials when requesting prior authorization for an ACD system, the physician must provide correct and complete information supporting the medical necessity of the equipment and/or supplies requested, including:

- Diagnosis/condition causing impairment of communication.
- Accurate diagnostic information pertaining to any other medical diagnoses/conditions, to include the client's overall health status.

The following documentation must be submitted with the completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form:

- The physician familiar with the client will base his/her recommendation on the review of a formal written evaluation of cognitive and language abilities

completed by a speech language pathologist (SLP). The prior authorization criteria must be addressed in this evaluation. The prescribing physician will review the professional evaluation/assessment and base the prescription on the recommendations.

- The formal written ACD system evaluation completed, signed, and dated by a speech-language pathologist (SLP) must include a minimum of all of the following information:
  - Current communication impairment, including the type, severity, language skills, cognitive ability and anticipated course of the impairment.
  - A description of the functional communication goals expected to be achieved and treatment options, including the ability of the requested ACD system, accessories and/or software to meet the projected communication needs of the client, and the length of time it is expected to meet their needs (must be anticipated to meet the client's needs for a minimum of 5 years).
  - Anticipated changes, modifications or upgrades that will be needed to meet the future needs (up to 5 years) of the client, to include projected long and short term time frames.
  - A treatment plan that includes a training schedule for the selected device and components addressing the needs of the client and caregiver to ensure appropriateness and optimal use of the prescribed device.
  - Evaluation that the client possesses the cognitive, emotional and physical abilities to effectively use the selected device and any accessories to communicate, including cognitive, postural, mobility and sensory (visual and auditory) capabilities.
  - Evaluation of the residential, vocational, educational and other settings/situations requiring communication (e.g., transportation), alternative ACD system evaluated, with a consideration of the advantages/disadvantages of the device considered as well as their appropriateness for the client.
  - How the use of the ACD system will be implemented/integrated into various environments of use.
  - Medical status/condition and medical diagnosis that is underlying the severe expressive speech disability leading to the need for an ACD system.
  - An assessment of the client's daily communication needs and whether they could be met using other natural modes of communication.
  - Other forms of treatment that have been considered and ruled out.
  - The rationale for selection of a specific device and any accessories, including why the requested equipment is the most appropriate and cost effective for the particular client, and that the client's speech disability will benefit from the device ordered.

Note: *The Texas Medicaid Program may request additional information to clarify or complete a request for an ACD system and accessories.*

The SLP evaluation must be dated before the date on the physician's prescription (Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form).

An ACD system is expected to serve the client's needs for an extended period of time. Refer to "Replacement" on page 24-35 for additional information.

24.5.16.3 Procedure Codes for ACD Systems and Accessories

ACDs and Access Devices

A *digitized speech device*, sometimes referred to as a "whole message" speech output device, utilizes words or phrases that have been recorded by someone other than the ACD system user for playback upon command of the ACD system user. Use procedure codes J/L-E2500, J/L-E2502, J/L-E2504, and J/L-E2506 for the rental or purchase of a digitized speech device.

A *synthesized speech device* is a technology that translates a user's input into device-generated speech using algorithms representing linguistic rules. Users of synthesized speech ACD systems are not limited to pre-recorded messages, but can independently create messages as their communication needs dictate.

Some synthesized speech devices require that the user make *physical contact* with a keyboard, touch screen, or other display containing letters. Use procedure code J/L-E2508 for the rental or purchase of a synthesized speech device.

Other synthesized devices allow multiple methods of message formulation through letters, words, pictures, or symbols. Such devices also allow for multiple methods of access including direct physical contact with a keyboard or touch screen; and one or more tools that aid in direct selection, including joystick, head mouse, optical pointer, infrared and light pointers, scanning device, or morse code. These synthesized speech devices are reimbursed with procedure code J/L-E2510.

Synthesized speech language generating devices with *multiple* methods of message formulation and *multiple* methods of device access are reimbursed with procedure code J/L-E2510 and the corresponding modifier TG (Intermediate level) or TF (Complex/High tech level) as indicated below.

Reimbursement for the rental or purchase of synthesized speech generating devices that have multiple methods of message formulation and multiple methods of device access may be considered based on the following levels of access devices:

- Minimum level—basic access device, such as a joystick for clients with good gross and fine motor control (no modifier required).

- Medium level—gross motor control access devices, such as a switch or large button, for clients with good gross motor skills, but poor fine motor extremity skills (use modifier TF).
- Maximum level—fine motor and head control access devices, such as a laser or infrared pointer, for clients with good fine motor head control, but poor fine and gross motor extremity skills (use modifier TG).

Items included in the reimbursement for an ACD system and not reimbursed separately include, but are not limited to, the following:

- ACD.
- Basic essential software (except for software purchased specifically to enable a client owned computer or personal digital assistant [PDA] to function as an ACD system).
  - Requests for ACD software may be considered for prior authorization if the software is more cost effective than an ACD system.
  - If an ACD system is more cost-effective than adapting the client owned laptop PC or PDA, an ACD system will be considered for prior authorization instead of the ACD software.
  - If software is purchased, installation of the program and technical support are included in the reimbursement for the software. Rental of ACD system software is not a benefit. Speech generating software is identified with procedure code J-E2511.

  Note: *Either an ACD system or ACD software for a client-owned laptop or desktop PC or PDA may be authorized, but not both.*
- Batteries.
- Battery charger, power supplies, A/C, and/or other adapters.
- Interface cables.
- Adequate memory to allow for system expansion within a five year time frame.
- All basic operational training necessary to instruct the client and family/caregiver(s) in the use of the ACD system.
- Manufacturer's warranty.
- Interconnects.
- Sensors.
- Moisture guard.
- Access device when necessary.
- Mounting device when necessary.

24.5.16.4 ACD System Accessories

Accessories for rental or purchase are a benefit of Home Health Services if the criteria for ACD system authorization are met *and* the medical necessity of *each* accessory is clearly documented in the SLP written evaluation.

All accessories necessary for proper use of an ACD system, including those necessary for the potential growth/expansion of the ACD system (such as a memory card), should be included in the initial prescription for purchase.

The following accessories may be considered for reimbursement if the criteria for ACD system authorization are met *and* the medical necessity for *each* accessory is clearly documented in the written evaluation:

- Access devices for an ACD system include, but are not limited to, devices that enable selection of letters, words or symbols via direct selection or tools that aid in direct selection techniques such as optical head pointers, joysticks, and ACD scanning devices.
- Gross motor access devices, such as switches and buttons, may be considered for clients with poor head and hand control.
- Fine motor, head control access devices, such as laser or infrared pointers, may be considered for clients with poor hand control and good head control.
- Moisture guard.
- Extended warranty if cost beneficial.

Use procedure code J/L-E2599 when billing for accessories for speech generating devices.

Mounting systems are devices necessary to place the ACD system, switches and other access devices within the reach of the client. Mounting devices may be considered to attach an ACD system or access device to a wheelchair or table. The make, model, and purchase date of the wheelchair or table is required when requesting a wheelchair mounting device. One additional mounting device, separate form the one included in the system, may be considered for prior authorization for the same client. Use procedure code J/L-E2512 when billing for the rental or purchase of mounting systems when a second mount is medically necessary.

24.5.16.5 Noncovered ACD System Items

Items that are not related to the ACD system, or software components which are not necessary to operate the system, are not a benefit of the Texas Medicaid Program. These items include, but are not limited, to carrying cases and printers.

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit will receive these services through THSteps-CCP.*

24.5.16.6 Prior Authorization

All of the following criteria must be met in order to consider prior authorization of an ACD system. These criteria must be addressed in the written evaluation. The client must have:

- A severe communication disorder with no functional means/intelligible sound to communicate basic needs or thoughts.

- A minimum mental or developmental age of 24 months.
- The ability to see, hear, and feel sensation.
- The ability to follow two-step commands, take turns, and initiate an interaction.
- The ability to demonstrate performance, attention, desire, interest, flexibility, and independence.
- An understanding of cause and effect and object permanence.
- Someone available to communicate with or a situation to communicate in.
- A family/caregiver(s) willing to support the client in the use of the ACD system.

24.5.16.7 Trial Period/Rental/Purchase

In order to ensure and ascertain that the client's needs are met in the most cost effective manner, an ACD system will not routinely be prior authorized for purchase until the client has completed a 6-month trial period that included experience with the requested system. Prior authorization may be provided for rental during this trial period. All components, such as access devices, mounting devices and lap trays necessary for use, must be evaluated during this trial period.

In the situation where an ACD system is not available for rental, purchase can be considered with documentation that the client has had experience with the requested system at school or in another setting.

A trial period is not required when replacing an existing ACD system unless the client's needs have changed and another ACD system or access device is being considered.

To obtain prior authorization for ACD system rental, all of the following documentation must be submitted:

- A formal written evaluation completed by an SLP before requesting an ACD system rental.
- A Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form listing the prescribed ACD system, access device and accessories such as a mounting device, must be completed, signed, and dated by the physician.

Purchase

Purchase of an ACD system may be considered for prior authorization when all of the following ACD system criteria are met:

- A formal written evaluation/re-evaluation must be completed by an SLP before requesting an ACD system purchase. The evaluation/re-evaluation must include documentation that the client has had sufficient experience with the requested ACD system through trial/rental, school, or another setting.
- A Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form listing the prescribed ACD system, access device and accessories such as a mounting device, must be completed, signed and dated by the physician.

24.5.16.8 DME Certification

The signed and dated DME certification and Receipt Form is required and must be completed before reimbursement can be made for any DME delivered to a client. The certification form must include the date the client received the DME, the item(s) name, and the signatures of the provider and the client or primary caregiver. This form must be maintained by the DME provider in the client's record.

24.5.16.9 Reimbursement

Items and/or services addressed in this section are either reimbursed at a maximum fee determined by HHSC or through manual pricing. If an item is manually priced, the MSRP must be submitted for consideration of rental or purchase with the appropriate procedure codes. Purchases are reimbursed at MSRP minus a discount as determined by HHSC.

24.5.16.10 Nonwarranty Repairs

Nonwarranty repairs of an ACD system may be considered for prior authorization with documentation from the manufacturer explaining why the repair is not covered by the warranty. A request for prior authorization of ACD system repair(s) not covered by warranty must be submitted with the following procedure codes. Use procedure code 9-E1340 for non-warranty repairs. Use procedure code 9-A9900 for nonwarranty parts.

24.5.16.11 Replacement

An ACD system is anticipated to last a minimum of five years. Documentation must be submitted for the following situations:

- If requesting a replacement with the same ACD system or repair of the present ACD system, a statement must be submitted indicating that the client's abilities and/or communication needs are unchanged and/or no other currently available ACD system is better able to meet the client's needs.
- If requesting a different ACD system from the one lost or damaged, a new evaluation/assessment is required.
- When appropriate, a copy of the police or fire report listing the cause of the loss or damage, as well as, what measures will be taken to prevent reoccurrence.
- In situations where the equipment has been abused or neglected by the client, the client's family, or the caregivers, the Home Health Services Prior Authorization Department will make a referral to the DSHS THSteps Case Management Program for clients under 21 years of age. The provider will be notified that the state will be monitoring this client's services to evaluate the safety of the environment for both the client and equipment.

Prior authorization for replacement may be considered within five years or more from the purchase date or when the ACD system is no longer functional, and either cannot be repaired or it is not cost effective to repair.

Note: *ACD system replacements for clients under 21 years of age that do not meet the criteria in this section may be considered through THSteps-CCP.*

24.5.16.12 ACD Procedure Codes and Limitations

Procedure Code	Maximum Limitation
9-E1340	As needed, with documentation of warranty coverage
J-E2500	1 per 5 years
J-E2502	1 per 5 years
J-E2504	1 per 5 years
J-E2506	1 per 5 years
J-E2508	1 per 5 years
J-E2510	1 per 5 years
J-E2510-TF	1 per 5 years
J-E2510-TG	1 per 5 years
J-E2511	1 per 5 years
J-E2512	1 per 5 years
J-E2599	1 per 5 years
L-E2500	1 per month
L-E2502	1 per month
L-E2504	1 per month
L-E2506	1 per month
L-E2508	1 per month
L-E2510	1 per month
L-E2510-TF	1 per month
L-E2510-TG	1 per month
L-E2512	1 per month
L-E2599	As needed, with documentation of warranty coverage

24.5.17 Bath and Bathroom Equipment

Bath and bathroom equipment is DME that is included in a treatment protocol, serves as a therapeutic agent for life and health maintenance, and is required to treat an identified medical condition. Bath and bathroom equipment may be considered for reimbursement for those clients who have physical limitations that do not allow for bathing, showering, or bathroom use.

Note: *THSteps eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit may be considered under THSteps-CCP.*

The following criteria must be met to qualify for Home Health Services:

- The requested equipment must be medically necessary.
- The client must be eligible for home health benefits.
- The criteria listed in this policy for the requested supplies/equipment must be met.
- Federal financial participation must be available.
- The requested equipment must be safe to use in the home.

Bath seats are not considered for clients younger than one year of age or weighing less than 30 pounds. Prior authorization is required for all bath and bathroom equipment and related supplies, including any accessories, modifications, adjustments, replacements and repairs to the equipment. The bath and bathroom equipment must be able to accommodate a 20 percent change in the client's height and/or weight. To request prior authorization for bath or bathroom equipment, the following documentation must be provided:

- Diagnosis/condition.
- Accurate diagnostic information pertaining to the underlying diagnosis/condition, including the client's overall health status, any other medical needs, developmental level, and functional mobility skills and why regular bath or bathroom equipment will not meet the client's needs
- The age, height, and weight of the client.
- Assessment of the client's home to ensure the requested equipment can be safely accommodated.
- Anticipated changes in the client's needs, including anticipated modifications or accessory needs and the growth potential of any custom shower/bath equipment.

A completed, signed, and dated Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form prescribing the DME and/or supplies must be signed and dated by a prescribing physician who is familiar with the client before requesting authorization. All signatures must be current, unaltered, original, and handwritten. Computerized or stamped signatures will not be accepted. The completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must be maintained by the DME provider and prescribing physician in the client's record. The original signature must be maintained in the client's record.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation of the medical necessity of the requested equipment and/or supplies. The physician must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for the bath or bathroom equipment.

Rental of equipment includes all necessary supplies, adjustments, repairs, and replacement parts.

A determination as to whether the equipment will be rented, purchased, replaced, repaired, or modified will be made by HHSC or its designee based on the client's needs, duration of use, and age of the equipment.

Hand-Held Shower/Shower Wand

A hand held shower/shower wand is a shower head attached to a flexible tubing. Hand held showers/shower wands with attachments are limited to one every five years.

A hand-held shower/shower wand with attachments may be considered for prior authorization only if the client currently owns or meets the criteria for a bath/shower chair, tub stool/bench, or tub transfer bench. Prior authorization of a hand-held shower/shower wand includes all attachments and accessories.

Use procedure code J-E1399 when billing for a hand held shower/shower wand.

Hand held showers/shower wands with attachments are limited to one every five years.

Bath/Shower Chairs, Tub Stool/Bench, Tub Transfer Bench

A bath/shower chair, tub stool/bench, or tub transfer bench may be considered for those clients who cannot safely use a regular bath tub or shower. Bath/shower chairs, tub stool/benches and tub transfer benches are grouped into three levels of design to assist the client based on their physical condition and mobility status.

Bath/shower chairs, tub stool/bench, and tub transfer benches are limited to one every five years.

A bath/shower chair is a stationary or mobile seat with or without upper body/head support used to support a client who is unable to stand or sit independently in the shower or tub.

A tub stool/bench is a stationary seat/bench used to support a client who is unable to stand or sit independently in the shower or tub.

A tub transfer bench is a stationary bench that sits in the tub and extends outside the tub used to support a client who is unable to stand or sit independently in the shower or tub to sit and allows the client to scoot/slide over the side of the tub.

Level 1 Group

A level 1 device is defined as stationary equipment.

Level 1 devices may be considered if the client meets either of the following two criteria:

- Is unable to stand independently or is unstable while standing.
- Is unable to independently enter or exit the shower/tub due to limited functional use of the upper or lower extremities and one of the following:
  - Maintains the ability to ambulate short distances (with or without assistive device).
  - Has a condition that is defined as a short-term disability without a concomitant long-term disability (including, but not limited to postoperative status).

Use procedure code J-E0240 for level 1 group bath/shower chairs.

Level 2 Group

A level 2 device is defined as mobile equipment with or without a commode cut out. A level 2 device may be considered if the client has good upper body stability and one of the following:

- Has impaired functional ambulation, including, but not limited to lower body paralysis, osteoarthiritis.
- Is nonambulatory.

The client must have a shower that is adapted for rolling equipment; ramps are not acceptable for access to showers. Use procedure code J-E0240 with modifier TF (Intermediate Level) for level 2 group bath/shower chairs.

Level 3 Group

A level 3 device is a custom stationary or mobile chair with or without a commode cut out. A level 3 device may be considered if the client requires trunk and/or head/neck support or positioning to accommodate conditions that include, but are not limited to, spasticity or frequent/uncontrolled seizures.

A bath/shower chair may be prior authorized for clients who meet the level 1, 2, or 3 criteria. A custom bath/shower chair may be considered for reimbursement only if the client does not also have any type of commode chair. Use procedure code J-E0240 with the TG modifier (Complex/high level) for level 3 group bath/shower chairs.

A level 3 custom bath/shower chair may be prior authorized only if the client does not also have any type of commode chair. The client must have a shower that is adapted for rolling equipment; ramps will not be prior authorized for access to showers. A tub transfer bench may be considered if the client meets the Level 1 or 2 criteria. A tub stool/bench may be prior authorized for clients who meet the level 1 criteria. Use procedure code J-E0245 for a tub/stool bench. Use procedure code J-E0247 for a tub transfer bench.

A heavy duty tub transfer bench may be considered for clients who meet the level 1 or 2 criteria and who weigh more than 200 pounds. Use procedure code J-E0248 for a heavy duty tub transfer bench.

Bathroom Equipment

Non-fixed Toilet Rail, Bathtub Rail Attachment, and Raised Toilet Seat

Non-fixed toilet rails sit on the floor and attach to the commode to allow support while sitting/standing during use of the toilet. Non-fixed toilet rails are limited to two every five years.

A bathtub rail attachment is a rail that screws onto the side of the tub to provide support while climbing into or out of the tub. Bathtub rails are limited to one every five years.

A raised toilet seat is a device that adds height to the toilet seat. It is either fixed height or adjustable and is either attached to the toilet or is resting on the bowl. Raised toilet seats are limited to one every five years.

Non-fixed toilet rails, bathtub rail attachments, and raised toilet seats may be considered for prior authorization for a client who has decreased functional mobility and is unable to safely self-toilet or self-bathe without assistive equipment.

Use procedure code J-E0243, J-E0244, or J-E0246 for non-fixed toilet rails, bathtub rails or raised toilet seats.

Portable Sitz Bath

Portable sitz bath is used to immerse only the perineum and buttocks, that fits over commode seats. Portable sitz baths that fit over commode seats are limited to two per year.

A portable sitz bath, may be considered for prior authorization if the client requires any of the following:

- Cleaning, irrigation, or pain relief of a perianal wound.
- Relief of pain associated with the pelvic area (hemorrhoids, bladder, vaginal infections, prostate infections, herpes, testicle disorders).
- Muscle toning for bowel and bladder incontinence.

Use procedure codes J-E0160 or J-E0161 for portable sitz baths.

Bath Lifts

A bath lift is a client lift for use in the bathroom designed to accommodate the smaller space. The purchase of bath lifts are limited to one every five years. The rental of bath lifts are limited to one per month.

A bath lift may be considered for prior authorization if the client has:

- An inability to transfer to the bathtub/shower independently using assistive devices including but not limited to, a cane, walker, bathtub rails.
- The client requires maximum assistance by the caregiver to transfer to the bathtub/shower.
- The client's bathroom and tub/shower meet the manufacturer's recommended depth, width, and height for safe bath lift installation and operation.

Use procedure code J/L-E0625 for the purchase or rental of bath lifts.

The purchase of a lift sling is limited to one every five years. Use procedure code J-E0621 for the purchase of a lift sling.

Home adaptation for use of medical equipment is not a benefit of Home Health Services. The following are payable procedure codes for bath and bathroom equipment:

Procedure Code	Maximum Limitation
J-E0160	2 per year
J-E0161	2 per year
J-E0240	1 every 5 years
J-E0243	2 every 5 years
J-E0244	1 every 5 years
J-E0245	1 every 5 years
J-E0246	1 every 5 years
J-E0247	1 every 5 years
J-E0248	1 every 5 years
J-E0621	1 per year
J-E0625	1 every 5 years
J-E0630	1 every 5 years
J-E1399	1 every 5 years
L-E0625	1 per month

Bath and bathroom equipment that have been purchased are anticipated to last a minimum of five years and may be considered for replacement when five years have passed and/or the equipment is no longer repairable. The DME may then be considered for prior authorization. Replacement of equipment may also be considered when loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent a recurrence must be submitted.

Modifications, Adjustments, and Repairs

Modifications are the replacement of components because of changes in the client's condition, not replacement because the component is no longer functioning as designed.

All modifications/adjustments within the first six months after delivery are considered part of the purchase price.

Modifications to custom equipment may be prior authorized should a change occur in the client's needs, capabilities, or physical/mental status which cannot be anticipated. Documentation must include all projected changes in the clients mobility needs, the date of purchase, the serial number of the current equipment, and the cost of purchasing new equipment versus modifying current equipment. All modifications within the first six months after delivery are considered part of the purchase price.

Adjustments do not require supplies.

Adjustments made within the first six months after delivery will not be prior authorized. Adjustments made within the first six months after delivery are considered part of the purchase price.

A maximum of one hour of labor for adjustments may be prior authorized as needed after the first six months following delivery.

Repairs to client-owned equipment may be prior authorized as needed with documentation of medical necessity. Technician fees are considered part of the cost of the repair. Repairs require the replacement of components that are no longer functional.

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

Bathroom/toilet lift rentals may be prior authorized during the period of repair up to a maximum of four months per lifetime per client.

Prior authorization will not be considered for modifications, adjustments, or repairs to bath or bathroom equipment delivered to a client's home and then found to be inappropriate for the client's condition within the first six months after delivery. This applies unless there is a significant change in the client's condition that is documented by a physician familiar with the client.

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

In situations where the equipment has been abused or neglected by the client, the client's family, or the caregiver, a referral to the DSHS THSteps Case Management Department will be made by the Home Health Services Prior Authorization Department for clients under 21 years of age. Providers will be notified that the state will be monitoring this client's services to evaluate the safety of the environment for both the client and equipment.

Accessories

Equipment accessories including, but not limited to, pressure support cushions, may be prior authorized with documentation of medical necessity.

24.5.18 Blood Pressure Devices

Blood pressure devices are a payable benefit of Home Health Services when:

- Medically necessary and appropriate.
- Prescribed by a physician.
- The client has one of the following covered diagnoses: essential or secondary hypertension, hypertensive heart disease, hypertensive renal disease, chronic pulmonary heart disease, heart failure, nephritis or nephropathy, acute renal failure, or hypertension complicating pregnancy, childbirth, and the puerperium.

When billing for these devices use procedure codes 9-A4660 and 9-A4670

If the client is not eligible for home health services, blood pressure devices may be provided under THSteps-CCP for clients younger than 21 years of age.

Prior authorization is required for blood pressure devices. Electronic blood pressure devices are not a benefit through Home Health Services. Rental of electronic blood pressure devices may be prior authorized through THSteps-CCP for clients *younger than 12 months of age.*

Refer to: "Electronic Blood Pressure Monitoring Device" on page 43-53 for more information.

24.5.19 Breast Pumps

A breast pump is a benefit of Title XIX Home Health Services and requires prior authorization.

A manual breast pump may be considered for purchase only with the appropriate documentation supporting medical necessity.

The purchase of a breast pump is limited to one every three years. Use procedure codes J-E0602 or J-E0603 for the purchase of a manual or electronic breast pump.

An electric breast pump may be considered for purchase only with appropriate documentation supporting medical necessity and an explanation of why a manual breast pump was not effective. Supporting documentation may include an evaluation from a lactation consultant or RN, such as an experienced perinatal nurse.

Replacement of the breast pump will be considered when loss or irreparable damage has occurred, with a copy of the police or fire report when appropriate, and with the measures to be taken to prevent reoccurrence. Replacement will not be authorized in situations where the equipment has been abused or neglected by the client, the client's family, or the caregiver.

Procedure code J/L-E0604 for a hospital grade breast pump is not a benefit of Home Health Services.

Note: *Breast pumps are also available through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).*

24.5.20 Continuous Passive Motion (CPM) Device

A CPM device may be considered for prior authorization through Home Health Services. Reimbursement for a CPM device is considered after joint surgery, such as knee replacement, when prescribed by a physician and submitted with clinical documentation of medical necessity/appropriateness.

A CPM device is reimbursed on a daily basis and is limited to once per day. Reimbursement includes delivery, set-up and all supplies. Use procedure code L-E0935 when billing for a CPM machine.

Note: *THSteps eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit may be considered under THSteps-CCP.*

24.5.21 Intravenous (IV) Therapy Equipment and Supplies

The following equipment and supplies are used in the delivery of IV therapy and are a benefit of Home Health Services. Additional supply procedure codes may be considered with documentation of medical necessity:

Procedure Code		
9-A4206	9-A4207	9-A4208
9-A4209	9-A4212	9-A4222
9-A4245	9-A4247	9-A4300
9-A4305	9-A4306	9-A4450
9-A4452	9-A4930	9-A6206
9-A6207	9-A6257	9-A6258
9-A6402	9-A9900	9-S1015

Procedure Code		
J/L-E0776	J/L-E0779	J/L-E0780
J/L-E0781	J/L-E0791	

Types of IV access devices include but are not limited to:

- Peripheral IV lines.
- Central IV lines, including but not limited to, peripherally-inserted central catheters, subclavian catheters, and vena cava catheters.
- Central venous lines, including but not limited to, tunneled and peripherally inserted central venous catheters.
- Implantable ports, including but not limited to, access devices with subcutaneous ports.

Prior authorization of IV equipment and supplies may be considered when administration of the drug in the home is medically necessary and is appropriate in the home setting. IV equipment may be prior authorized for rental or purchase depending on the clinician's predicted length of treatment.

An IV infusion pump that has been purchased is anticipated to last a maximum of 5 years and may be considered for replacement when 5 years have passed and/or the equipment is no longer repairable. The DME may then be considered for prior authorization. Replacement of equipment may also be considered when loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent a reoccurrence must be submitted.

A completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form that prescribes the DME and/or medical supplies must be signed and dated by a prescribing physician who is familiar with the client before requesting authorization. All signatures must be current, unaltered, original, and handwritten. Computerized or stamped signatures will not be accepted. The completed, signed, and dated Home Health DME Prior Authorization Form must be maintained by the requesting provider and the prescribing physician. The original signature copy must be kept in the physician's medical record for the client.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation of the medical necessity of the equipment and/or supplies requested. The physician must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for the IV therapy equipment and supplies.

To request prior authorization for IV supplies and equipment, the following documentation must be provided:

- Diagnostic information pertaining to the underlying diagnosis/condition.
- A physician's order and documentation supporting medical necessity.
- The medication being administered, the duration of drug therapy, and the frequency of administration.

The following standards are used when considering prior authorization of IV supplies:

- The aseptic technique is acceptable for IV catheter insertion and site care; the sterile technique is not required:
  - Non-sterile gloves are acceptable for the insertion of a peripheral IV catheter and for changing any IV site dressing.
  - The sterile technique may be medically necessary. Examples of medical necessity include, but are not limited to, a client who is immuno-compromised.
- A peripheral IV site is rotated no more frequently than every 72 hours, but it is rotated at least weekly.
- The IV administration set (with or without dial flow regulator), extension set (with or without dial flow regulator), and any add-on devices are changed every 72 hours.
- One IV access catheter is used per insertion.
- Saline/heparin-locked catheters:
  - Use one syringe to flush the catheter before administration of an intermittent infusion to assess.
  - Use two syringes to flush the catheter after the intermittent infusion—one to clear the medication and one to infuse the anticoagulant or other medication used to maintain IV patency between doses, including, but not limited to, heparin.
- An injection port is cleaned before administering an intermittent infusion and capped after the infusion.
- IV catheter site care:
  - Disinfect the site with an appropriate antiseptic (including but not limited to 2 percent chlorhexidine-based preparation, tincture of iodine, or 70 percent alcohol).
  - Cover with sterile gauze, transparent dressing, or semi-permeable dressing.
  - Replace the dressing if it becomes damp, loosened, or visibly soiled.

Stopcocks increase the risk of infection and should not be routinely used for infusion administration. Routine use of in-line filters is not recommended for infection control.

Note: *Non-sterile/sterile gloves for use by a health-care provider in the home setting, such as an RN, LVN, or attendant, are not a benefit of Home Health Services.*

Stationary infusion pumps are electrical devices without a battery, or with a battery that requires frequent recharging (more frequently than every 4 hours), used to deliver an intravenous solution or parenteral drugs at a steady flow rate. Stationary infusion pumps may be a benefit when the infusion rate must be more consistent and cannot be obtained with gravity drainage.

Ambulatory infusion pumps are electrical devices that have an extended battery life (four hours or longer without recharging) used to deliver an intravenous solution or

parenteral drugs at a steady flow rate. Ambulatory infusion pumps may be a benefit when the length of infusion is greater than two hours, the client must be involved in activities away from home, and when the infusion rate must be more consistent and cannot be obtained with gravity drainage.

Elastomeric infusion pumps are non-electrical, single use, simplified devices that deliver parenteral drugs at a fixed volume and flow rate. Elastomeric infusion pumps may be a benefit for short-term use when the caregiver cannot administer the infusion via pump. Dial flow regulators, such as dial-a-flow, are incorporated into IV extension sets or IV tubing. They are non-electrical, single use, simplified devices that deliver parenteral drugs at a fixed volume and flow rate utilizing a dial system to set a flow rate.

If additional supplies are needed beyond the standards listed in this policy, prior authorization may be considered with documentation supporting medical necessity.

- For additional IV access catheters, supporting documentation should have evidence that includes, but is not limited to:
  - Dehydration.
  - Vein scarring.
  - Fragile veins, including but not limited to, clients who are infants or elderly.
- For more frequent IV site changes, supporting documentation should have evidence that includes, but is not limited to:
  - Phlebitis.
  - Infiltration.
  - Extravasation.
- For more frequent IV tubing or add-on changes, supporting documentation should have evidence that includes, but is not limited to:
  - Phlebitis.
  - IV catheter-related infection.
  - The administered infusion requires more frequent tubing changes.

Elastomeric devices and dial flow regulators are specialized infusion devices that may be considered for prior authorization when the device:

- Will be used for short-term medication administration (less than two weeks duration)
- Is expected to increase client compliance
- Will better facilitate drug administration
- Costs less than the cost pump rental/tubing
- The caregiver can not administer infusion via pump

Elastomeric devices may be reimbursed using procedure codes 9-A4305 and 9-A4306.

The following criteria must be met for prior authorization of a stationary infusion pump:

- An infusion pump is required to safely administer the drug.
- The standard method of administration of the drug is through prolonged infusion or intermittent infusion, and the infusion rate must be more consistent than can be obtained with gravity drainage.
- The drug being administered requires IV infusion (i.e., the drug cannot be administered orally, intramuscularly, or by push technique).

The following criteria must be met for prior authorization of an ambulatory infusion pump:

- An infusion pump is required to safely administer the drug.
- The standard method of administration of the drug is through prolonged infusion or intermittent infusion and the infusion rate must be more consistent than can be obtained with gravity drainage.
- The drug being administered requires IV infusion (i.e., the drug cannot be administered orally, intramuscularly, or via push technique).
- The infusion administration is more than two hours and the client is involved in activities away from home, including, but not limited to, physician visits.

Rental of an infusion pump may be prior authorized on a monthly basis for a maximum of four months per lifetime. Purchase of an infusion pump (ambulatory or stationary) may be prior authorized with documentation of medical necessity that supports repeated IV administration for a chronic condition.

For clients who require cardiovascular medications, infusion pumps will be rented, but not purchased.

Repairs to client-owned equipment may be prior authorized as needed with documentation of medical necessity. Technician fees are considered part of the cost of the repair. Providers are responsible for maintaining documentation in the client's medical record that specifies the repairs and supports medical necessity.

All repairs within the first six months after delivery are considered part of the purchase price. Additional documentation, such as the purchase date, serial number, and manufacturer's information, may be required.

IV therapy, supplies, and equipment are not considered a benefit when the infusion/medication being administered:

- Is not considered medically necessary to the treatment of the client's illness.
- Exceeds the frequency and/or duration ordered by the physician.
- Is a chemotherapeutic agent or blood product.
- Is not FDA-approved, unless the physician documents why the off-label use is medically appropriate and not likely to result in an adverse reaction. In order to consider coverage of an off-label (non-FDA approved)

use of a drug, documentation must include why a drug usually indicated for the specific diagnosis or condition has not been effective for the client.

In situations where the equipment has been abused or neglected by the client, the client's family, or the caregiver, a referral to the DSHS THSteps Case Management Department will be made by the Home Health Services Prior Authorization Department for clients under 21 years of age. Providers will be notified that the state will be monitoring the client's services to evaluate the safety of the environment for both the client and the equipment.

The completed, signed, and dated DME Certification and Receipt Form is required before reimbursement can be made for any DME delivered to a client. The certification form must include the name of the item, the date the client received the DME, and the signatures of the provider and the client or primary caregiver. This form must be maintained by the DME provider in the client's medical record.

Routine maintenance of rental equipment is included in the rental price.

24.5.22 Phototherapy Devices

Phototherapy devices for use in the home are a benefit of the Texas Medicaid Program for low-risk infants. Medium- to high-risk infants, as defined by the American Academy of Pediatrics (AAP), should be considered for other, more extensive treatment in an inpatient setting. Home phototherapy devices use light exposure with white, blue, or green lights to increase bilirubin excretion in the infant with elevated bilirubin levels. Home phototherapy services include parent/guardian education and obtaining laboratory specimens. Laboratories performing analysis of laboratory specimens may bill according to established procedures. Home phototherapy must be prior authorized under a provider identifier that is enrolled as a DME supplier. Home phototherapy devices require prior authorization and are provided only for the days that are medically necessary. Consideration for the rental of a home phototherapy device includes, but is not limited to, the following primary diagnoses:

Diagnosis Codes				
7740	7741	7742	77430	77431
77439	7744	7745	7746	7747

Authorization requirements include following the current guidelines and standards set by the AAP:

Indications for phototherapy in the home for infants 35 weeks gestation or greater				
	0-24 hours	25-48 hours	49-72 hours	>72 hours
Low Risk	6-10	10-16	13-18	16-21

Note: *Bilirubin levels are expressed in mg/dl*

- Lower risk infants are greater than or equal to 38 weeks gestation and well.
- Risk factors may include but are not limited to isoimmune hemolytic disease, G6PD deficiency, asphyxia, significant lethargy, temperature instability, sepsis, acidosis, or albumin <3.0 g/dl (if measured).

Documentation of medical necessity is required if the infant does not meet authorization requirements. Documentation of medical necessity includes:

- Serum bilirubin level (in mg/dl).
- Gestational age.
- Any known risk factors (for example: breast feeding, jaundice within the first 24 hours, blood group incompatibility).
- Physician's POC for intervention after seven days.
- Anticipated number of days the client will need the phototherapy light.
- Documentation of parental education regarding the importance of monitoring and follow-up.

Note: *The total serum bilirubin levels listed are guides for authorization only.*

Prior authorization may be given up to a maximum of seven days at a time with the documentation of medical necessity that is listed above. A new prior authorization is required for requests beyond seven days.

Home phototherapy devices will not be considered for prior authorization if the client has an open authorization for skilled nursing visits to address hyperbilirubenemia.

In accordance with AAP guidelines, the Texas Medicaid Program expects that there will be an ongoing assessment for risk of severe hyperbilirubenemia for all infants who receive home phototherapy.

Retroactive Eligibility

Newborn babies may not have a Medicaid number at the time that services are ordered by the physician and provided by the supplier. In these cases, authorization may be given retroactively for services rendered between the start date and the date that the client's Medicaid number becomes available.

- The provider is responsible for finding out the effective dates of client eligibility.
- The provider has 95 days from the date on which the client's Medicaid number becomes available (add date) to obtain authorization for services that were already rendered.

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

Rental of a phototherapy device is reimbursed as a daily global fee. The global fee includes skilled nursing visits (SNV) for client teaching, monitoring, and customary and routine laboratory work.

The SNV will be denied as part of the phototherapy device rental.

Note: *Providers may* not *bill for those days the phototherapy device is at the client's home and is* not *in use.*

Use procedure code L-E0202 for home phototherapy devices.

Note: *Services provided after the client's Medicaid number is available must be prior authorized within three business days.*

Note: *THSteps eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit may be considered under THSteps-CCP.*

Refer to: Section 24.3.1, "Eligibility."

24.5.23 Hospital Beds and Equipment

Hospital beds are defined as medical beds that are used by a client who has a medical condition that requires positioning the body in ways that are not feasible with an ordinary bed. Head/upper body elevation of less than 30 degrees does not require use of a hospital bed. Hospital beds and related equipment are considered for reimbursement for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Note: *If the client is not eligible for home health services, hospital beds may be provided under THSteps-CCP for clients younger than 21 years of age.*

Hospital beds require prior authorization.

Hospital beds may be considered for those clients who cannot safely use a regular bed. To request prior authorization for a hospital bed, the following documentation must be submitted:

- Accurate diagnostic information pertaining to the underlying medical diagnoses/conditions (e.g., gastrostomy feeding, suctioning, ventilator dependent, other respiratory equipment/ventilation assistance devices) to include the client's overall health status.
- The client's height and weight.
- The client's functional mobility status.
- The client's use of any pressure-reducing support surfaces, if applicable.

A hospital bed without side rails and/or mattress is not a benefit of Home Health Services. Side rails or mattresses may be considered for reimbursement for replacement only. A replacement mattress or side rails may be considered if a client's condition requires a replacement of an innerspring mattress or side rails and it is a client-owned hospital bed. A determination will be made by HHSC or its designee as to whether the equipment will be rented, purchased, repaired, or modified based on the client's needs, duration of use, and age of the equipment.

The following types of hospital beds are addressed in this policy:

- A fixed height hospital bed with manual head and leg elevation adjustments but no height adjustment.
- A variable height hospital bed with manual head and leg elevation adjustments and manual height adjustment.
- A semielectric bed with manual height adjustment and with electric head and leg elevation adjustments.
- A full electric bed has an electric head and leg adjustment, plus electric height adjustment.
- Heavy-duty hospital beds:
  - A heavy-duty, extra wide hospital bed is capable of supporting a client who weighs more than 350 pounds, but no more than 600 pounds *or*
  - A extra heavy-duty, extra wide hospital bed is capable of supporting a client who weighs more than 600 pounds.

A hospital bed is not one that is typically sold as furniture. A home furniture bed may consist of a frame, box spring and mattress. It is a fixed height and has no head or leg elevation adjustments.

A *fixed height bed* may be considered for prior authorization if the client requires the head of the bed to be elevated more than 30 degrees most of the time because of conditions such as congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been used and found to be ineffective.

Use procedure code J/L-E0250 when billing for a fixed height bed.

A *variable height hospital bed* may be considered for prior authorization if the client meets the criteria for a fixed height hospital bed and requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair, or standing position.

Use procedure code J/L-E0255 when billing for a variable height hospital bed.

A *semi-electric hospital bed* may be considered for prior authorization if the client meets the criteria for a variable height bed and requires frequent changes in body position and/or has an immediate need for a change in body position.

Use procedure code J/L-E0260 when billing for a semi-electric hospital bed.

A *fully electric hospital bed* may be considered if the manufacturer's product information and MSRP for manually priced items documentation is included for clients who cannot function without a fully electric bed. A fully electric bed may be considered for prior authorization if it is found to increase the client's ability to self-care and will not be authorized for the convenience of the caregiver.

Use procedure code J/L-E0265 when billing for a fully electric hospital bed.

A *heavy-duty, extra wide hospital bed* is capable of supporting a client who weighs more than 350 pounds, but no more than 600 pounds. A heavy-duty, extra wide hospital bed may be considered for prior authorization if the client meets the criteria for one of the other hospital beds.

Use procedure code J/L-E0303 when billing for a heavy-duty, extra wide hospital bed.

An *extra heavy-duty, extra wide hospital bed* is capable of supporting a client who weighs more than 600 pounds. An extra heavy-duty, extra wide hospital bed may be

considered for prior authorization if the client meets the criteria for one of the other hospital beds and whose weight meets the description of a heavy-duty hospital bed.

Use procedure code J/L-E0304 when billing for an extra heavy-duty, extra wide hospital bed.

Equipment

All equipment must be prior authorized.

A *trapeze bar attached to a bed* may be considered for reimbursement if the client needs this device to sit up, to change body position, for other medical reasons, or to get in or out of bed with documentation of medical necessity. Use procedure code J/L-E0910 or J/L-E0911 when billing for a trapeze bar attached to a bed.

Free standing trapeze equipment may be considered for reimbursement if the client does not have a covered hospital bed but the client needs this device to sit up to change body position for other medical reasons, or to get in or out of bed. Use procedure codes J/L-E0912 or J/L-E0940 when billing for free standing trapeze equipment.

An *over-bed table* may be considered for reimbursement if client is bed bound and needs the equipment for treatments. Use procedure code J-E0315 when billing for an over-bed table.

A safety enclosure (J/L-E0316) used to prevent a client from leaving the bed is not a benefit of the Home Health Services. A safety enclosure may be considered through THSteps-CCP.

Traction equipment, such as procedure codes J/L-E0890, J/L-E0947, and J/L-E0948, (excluding procedure codes J/L-E0910 and J/L-E0940 trapeze devices) are not a benefit of Home Health Services.

Pressure-Reducing Support Surfaces

Pressure-reducing support surfaces must be prior authorized.

A pressure-reducing support surface includes three separate groups of mattress/mattress-like equipment designed to assist in the healing of wounds. These devices are used in conjunction with conventional wound care therapy and/or to prevent the occurrence of said wounds in susceptible clients. Pressure-reducing support surfaces are designed to prevent skin breakdown or promote the healing of pressure ulcers by reducing or eliminating tissue interface pressure. Most of these devices reduce interface pressure by conforming to the contours of the body so that pressure is distributed over a larger surface area rather than concentrated on a more circumscribed location.

Pressure-reducing support surfaces are a benefit of Home Health Services on a case-by-case basis. To request prior authorization for a pressure-reducing support surface the following documentation must be provided:

- Client's overall health status and all other medical diagnosis/condition (e.g., history of decubitus).
- Documentation of the client's limited mobility or confinement to a bed.
- Previous use of pressure-reducing support surfaces with client outcome, (e.g., wound improvement, stasis, or degradation).
- Current wound therapy if any.
- Wound measurements to include location, length, width, depth, any undermining and/or tunneling, and odor if applicable.

Pressure-reducing support surfaces containing multiple components are categorized according to the clinically predominant component (usually the topmost layer of a multilayer product).

A support surface that does not meet the characteristics specified in the pressure-reducing support surface policy may be denied as not medically necessary.

Home Health Services will only cover alternating air mattresses and low-air-loss beds when they meet the definition of DME. Air mattresses that are not durable or made to withstand prolonged use do not meet the definition of DME.

For all types of pressure-reducing support surfaces, the support surface provided for the client should be one in which the client does not *bottom out*. The Centers for Medicare & Medicaid Services (CMS) defines "bottoming out" as when an outstretched hand, palm up, between the undersurface of the overlay or mattress and in an area under the bony prominence can readily palpate the bony prominence (coccyx or lateral trochanter). This bottoming out criterion should be tested with the client in the supine position with their head flat, in the supine position with their head slightly elevated (no more than 30 degrees), and in the sidelying position.

24.5.23.1 Criteria for Grouping Levels

Group 1 Support Surfaces

A group 1 Support Surface may be considered if the client is completely immobile without assistance, *or* either of the following first two criteria:

- The client has limited mobility, *or*
- The client has an existing pressure ulcer on the pelvis or trunk, *and*

And at least one of these four criteria:

- Impaired nutritional status
- Fecal or urinary incontinence
- Altered sensory perception
- Compromised circulatory status

Each of the support surfaces described below are considered a benefit of the Home Health Services Program when medical necessity criteria for Group 1 support surfaces are met.

*Pressure pads for mattresses/nonpowered pressure-reducing mattress overlay*s are designed to be placed on top of a standard hospital or home mattress. Pressure pads/nonpowered pressure-reducing mattress overlays

for mattresses with the following features may be considered for reimbursement with documentation of medically necessity:

- A gel or gel-like layer with a height of two inches or greater.
- An air mattress overlay with interconnected air cells that are inflated with an air pump and a cell height of three inches or greater.
- A water mattress overlay with a filled height of three inches or greater.
- A foam mattress overlay with *all* the following features:
  - Base thickness of two inches or greater and peak height of three inches or greater if it is a convoluted overlay (e.g., eggcrate) or an overall height of at least three inches if it is a nonconvoluted overlay.
  - Foam with a density and other qualities that provide adequate pressure reduction.
  - Durable, waterproof cover.

Nonpowered pressure-reducing mattresses are designed to be placed directly on a hospital bed frame. Nonpowered pressure-reducing mattresses, with the following features, may be considered for reimbursement with documentation supporting medical necessity:

- A foam mattress with *all* the following features may be considered with documentation supporting medical necessity. Documentation must include all of the following features:
  - A foam height of five inches or greater.
  - Foam with a density and other qualities that provide adequate pressure reduction.
  - Durable, waterproof cover.
  - Can be placed directly on a hospital bed frame.
- An air, water or gel mattress with *all* the following features may be considered for reimbursement:
  - A height of five inches or greater.
  - Durable, waterproof cover.

Powered pressure-reducing mattress overlay systems (alternating pressure or low air loss) are designed to be placed on top of a standard hospital or home mattress. A powered pressure reducing mattress overlay system, with *all* the following features, may be considered for reimbursement when documentation supports medical necessity:

- The system includes an air pump or blower which provides either sequential inflation and deflation of air cells, or a low interface pressure throughout the overlay.
- Inflated cell height of the air cells through which air is being circulated is 2.5 inches or greater.
- Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure provide adequate client lift, reduces pressure, and prevents bottoming out.
- The manufacturer's product information substantiates that the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces.

Group 2 Support Surfaces

A Group 2 support surface may be considered if the client has multiple stage II ulcers on the trunk or pelvis and has been on a comprehensive ulcer treatment program for at least the past month which has included the use of a Group 1 support surface.

The client must also have at least one of the following:

- The ulcers have remained the same or worsened over the past month.
- There are large or multiple stage III or IV pressure ulcers on the trunk or pelvis.
- A myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the last 60 days, and have been on a Group 2 or 3 support surface immediately before discharge from the hospital or a nursing facility (discharge within the past 30 days).

Each of the support surfaces described below are considered a benefit of the Home Health Services Program when medical necessity criteria for Group 2 support surfaces are met.

Powered pressure-reducing mattress (alternating pressure low air loss, or powered flotation without air loss) is designed to be placed directly on a hospital bed frame. This device with *all* the following features may be considered for reimbursement when documentation supports medical necessity:

- The system includes an air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress.
- Inflated cell height of the air cells through which air is being circulated is five inches or greater.
- Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattress), and air pressure to provide adequate client lift, reduce pressure, and prevent bottoming out.
- A surface designed to reduce friction and shear.

A *semi-electric hospital bed with fully integrated powered pressure-reducing mattress* that has all of the features described above may be considered for reimbursement when documentation supports medical necessity.

An *advanced nonpowered pressure-reducing mattress overlay* is designed to be placed on top of a standard hospital or home mattress. This device, with *all* the following features, may be considered for reimbursement when documentation supports medical necessity.

- Height and design of individual cells which provide significantly more pressure reduction than Group 1 overlay and prevent bottoming out.
- Total height of 3 inches or greater.
- A surface designed to reduce friction and shear.
- The manufacture product information substantiates that the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces.

A *powered pressure-reducing mattress overlay* (low air loss, powered flotation without low air loss, or alternating pressure) is designed to be placed on top of a standard hospital or home mattress designed to reduce friction and shear. This device, with *all* the following features, may be considered for reimbursement when documentation supports medical necessity:

- The system includes an air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the overlay.
- Inflated cell height of the air cells through which air is being circulated is 3.5 inches or greater.
- Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure to provide adequate client lift, reduce pressure and prevent bottoming out.

An *advanced nonpowered pressure-reducing mattress* is designed to be placed directly on a hospital bed frame. This device with *all* the following features may be considered for reimbursement when documentation supports medical necessity:

- Height and design of individual cells which provide significantly more pressure than a Group 1 mattress and prevent bottoming out.
- Total height of five inches or greater.
- A surface designed to reduce friction and shear.
- Documented evidence substantiates that the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces.

Sheepskin and lambs wool pads are considered a benefit of the Home Health Services Program under the same conditions as alternating pressure pads and mattresses (Group 2 pressure-reducing support surfaces).

Group 3 Support Surfaces

A Group 3 support surface may be considered if *all* the following criteria are met:

- Presence of a stage III or IV ulcer.
- Severely limited mobility rendering the client bed or chair bound.
- Without an air-fluidized bed, the client would be institutionalized.
- The client has been placed on a Group 2 support surface for at least a month before ordering the air-fluidized bed with the ulcer(s) not improving or worsening.
- There has been at least weekly assessment of the wound by the physician, a nurse or other licensed health-care professional and the treating physician has done a comprehensive evaluation of the client's condition within the week before ordering the air-fluidized bed.
- A trained adult caregiver is available to assist the client with activities of daily living, maintaining fluid balance, supplying dietary needs, aiding in repositioning and skin care, administering prescribed treatments, recognizing and managing altered mental status, and managing the air-fluidized bed system and its potential problems, such as leakage.
- The physician continues to reevaluate and direct the home treatment regimen monthly.
- All other alternative equipment has been considered and ruled out.

The existence of any one of the following conditions may result in noncoverage of the air-fluidized bed:

- Coexisting pulmonary disease (the lack of firm back support can render coughing ineffective and dry air inhalation thickens pulmonary secretions).
- Wounds requiring moist wound dressings that are not protected with an impervious covering such as plastic wrap or other occlusive material (if wet-to-dry dressings are being utilized, dressing changes must be frequent enough to maintain their effectiveness).
- For clients 21 years of age and older, the caregiver is unwilling or unable to provide the type of care required by the client on an air-fluidized bed.
- The home's structural support or electrical system cannot safely accommodate the air-fluidized bed.

The groups for pressure-reducing support surfaces used in this policy are defined as follows.

Initial prior authorization for a Group 3 pressure-reducing support surface will be for no more than 30 days. Prior authorized extensions may be considered for reimbursement in increments of 30-day periods, up to a maximum of four months, when documentation supports continued significant improvement in wound healing. Coverage beyond four months will be on a case-by-case basis after review by the medical director or designee.

An *air-fluidized bed* uses warm air under pressure to set small ceramic beads in motion, which simulate the movement of fluid. When the client is placed in the bed, the client's body weight is evenly distributed over a large surface area, which creates the sensation of floating. Air-fluidized beds may be considered for reimbursement when the medical necessity criteria for Group 3 support surfaces are met.

24.5.23.2 Decubitus Care Accessories

A bed blanket cradle (keeps bed covers from touching affected skin) may be considered for reimbursement when documentation supports medical necessity (e.g., diabetic ulcers, decubiti or burns, or gouty arthritis).

A heel or elbow protector may be considered for reimbursement when documentation supports medical necessity.

The staging of pressure ulcers used in this policy is as follows:

Stage I: Observable pressure related alteration of intact skin whose indicators are as follows:

- Compared to the adjacent or opposite area on the body may include changes in one of more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching).
- The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue or purple hues.

Stage II: Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.

Stage III: Full thickness skin loss involving damage to, or necrosis of, SQ/SC tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

Stage IV: Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.

Bed rails and frames that have been purchased are anticipated to last a minimum of 5 years and may be considered for replacement when 5 years have passed and/or the equipment is no longer functional and no longer repairable. The durable medical equipment may then be considered for prior authorization. Replacement of equipment will also be considered when loss or irreparable damage has occurred. A copy of the police or fire report when appropriate, and the measures to be taken to prevent reoccurrence must be submitted.

In situations where the equipment has been abused or neglected by the client, the client's family, or the caregiver, a referral to the DSHS THSteps Case Management unit will be made by the Home Health Services prior authorization unit for clients under 21 years of age. Providers will be notified that the State will be monitoring this client's services to evaluate the safety of the environment for both the client and equipment.

24.5.23.3 Hospital Beds and Equipment Procedure Code Table

Procedure Code	Maximum Limitation
J-E0184	1 every 5 years
J-E0185	1 every 5 years
J-E0186	1 every 5 years
J-E0187	1 every 5 years
J-E0198	1 every 5 years
J-E0199	1 every 5 years
J-E0250	1 every 5 years
J-E0255	1 every 5 years
J-E0260	1 every 5 years
J-E0265	1 every 5 years
J-E0271	1 every 5 years
J-E0303	1 every 5 years
J-E0304	1 every 5 years
J-E0305	1 every 5 years
J-E0310	1 every 5 years
J-E0315	1 every 5 years
J-E0371	1 every 5 years
J-E0372	1 every 5 years
J-E0373	1 every 5 years
J-E0910	1 every 5 years
J-E0911	1 every 5 years
J-E0912	1 evert 5 years
J-E0920	1 every 5 years
J-E0940	1 every 5 years
J-E0946	1 every 5 years
L-E0184	1 per month
L-E0185	1 per month
L-E0186	1 per month
L-E0187	1 per month
L-E0193	1 per month
L-E0194	1 per month
L-E0196	1 per month
L-E0197	1 per month
L-E0198	1 per month
L-E0250	1 per month
L-E0255	1 per month
L-E0260	1 per month
L-E0265	1 per month
L-E0277	1 per month
L-E0303	1 per month
L-E0304	1 per month
L-E0371	1 per month

Procedure Code	Maximum Limitation
L-E0372	1 per month
L-E0373	1 per month
L-E0910	1 per month
L-E0911	1 per month
L-E0912	1 per month
L-E0920	1 per month
L-E0940	1 per month
L-E0946	1 per month

24.5.24 Reflux Slings and Wedges

Home Health Services may cover reflux slings or wedges for clients who are younger than 12 months of age. These may be used as positioning devices for infants who require elevation after feedings when prescribed by a physician as medically necessary and appropriate. Reflux slings, wedges, or covers require prior authorization.

If the client is not eligible for home health services, reflux slings and wedges may be provided under THSteps-CCP. Use procedure code J-E1399 when billing for reflux slings and wedges.

24.5.25 Special Needs Car Seats and Travel Restraints

Special needs car seats and travel restraints are not services available under Home Health Services.

Refer to: "Special Needs Car Seats and Travel Restraints" on page 43-57 for details about coverage through THSteps-CCP.

24.5.26 Mobility Aids

Medical appliances and equipment including mobility aids such as canes, crutches, walkers, and wheelchairs are reimbursed to assist clients to move about in their environment.

Mobility aids are a benefit through Home Health Services when the following criteria are met:

- The client must be eligible for home health benefits.
- The criteria listed in this policy for the requested equipment must be met.
- The equipment requested must be medically necessary.
- Federal financial participation must be available.
- The client's mobility status would be compromised without the requested equipment.
- The requested equipment or supplies must be safe for use in the home.

Note: *A mobility aid for a client under 21 years of age is medically necessary when it is required to correct or ameliorate a disability or physical illness or condition.*

The following mobility aids are not a benefit of Home Health Services:

- Feeder seats, floor sitters, corner chairs and travel chairs are not considered medically necessary devices.
- Items included but not limited to tire pumps, a color for a wheelchair, gloves, back packs and flags are not considered medically necessary.
- Mobile standers are not a benefit of Title XIX Home Health Services.
- Vehicle lifts and modification.
- Permanent ramps, vehicle ramps and home modifications.

The Texas Medicaid Program does not reimburse separately for associated DME charges, including batter disposal fees or state taxes. Reimbursement for associated charges is included in the reimbursement for the specific piece of equipment. White canes for the blind are considered self help adaptive aids and are not a benefit of Home Health Services.

Note: *THSteps-eligible clients who have a medical need for services beyond the limits of this Home Health Services benefit may be considered under THSteps-CCP.*

Refer to: Section 24.3.1, "Eligibility."

24.5.26.1 Canes, Crutches, and Walkers

Canes, crutches, and/or walkers may be prior authorized as a home health service with documentation supporting medical necessity and appropriateness of the requested item. This documentation by a physician familiar with the client must include information on the clients impaired mobility.

24.5.26.2 Feeder Seats, Floor Sitters, Corner Chairs, and Travel Chairs

Feeder seats, floor sitters, corner chairs, and travel chairs are not considered medically necessary devices and are not a benefit of Texas Medicaid. If a child requires seating support and meets the criteria for a seating system, a stroller may be considered for reimbursement with prior authorization through THSteps-CCP or a wheelchair may be considered for reimbursement with prior authorization from TMHP Home Health Services Prior Authorization Department.

24.5.26.3 Wheelchairs

A wheelchair is a professionally manufactured seating system mounted on a four- or six-wheeled base, with a combination of tires and casters especially for the use of propelling the occupant.

A wheelchair may be considered for prior authorization for short-term use or purchase as a home health service with documentation supporting the medical necessity and appropriateness of the requested item. This documentation by a physician familiar with the client must include information on the client's impaired mobility and physical requirements.

In addition, one of the following information must be submitted with documentation of medical necessity:

- Why the client is unable to ambulate a minimum of 10 feet due to his/her condition (including AIDS, sickle cell anemia, fractures, a chronic diagnosis, or chemotherapy.
- If the client is able to ambulate further than 10 feet, why a wheelchair is required to meet the client's needs.
- A completed Wheelchair/Scooter/Stroller Seating Assessment Form with seating measurements that includes documentation supporting medical necessity, except when requesting a standard sling seat/sling back wheelchair.
- An itemized component list for custom manual or power wheelchairs.

A standard manual wheelchair may be prior authorized for rental or purchase if the client owns, or is requesting, a standard or custom power wheelchair.

A custom manual wheelchair may be prior authorized for rental or purchase if the client owns, or is requesting a custom power wheelchair.

Prior authorization for labor to create a molded seating system is limited to 15 hours or less.

Assessment of the accessibility of the client's residence must be completed and included in the prior authorization documentation to ensure that the wheelchair is usable in the home such as doors and halls wide enough, no obstructions.

24.5.26.4 Seating Assessment for Manual and Power Custom Wheelchairs

A seating assessment, which includes specifications for exact mobility/seating equipment and all necessary accessories, must be completed by a physician, licensed occupational therapist, or licensed physical therapist.

To request prior authorization for a custom manual/power wheelchair, a Wheelchair/Scooter/Stroller Seating Assessment Form must be completed by a physician or a licensed physical or occupational therapist using the procedure codes 1-97001 and 1-97003.

The following documentation must be provided:

- A seating evaluation and seating measurements, performed by a physician or a licensed occupational or physical therapist, which includes specifications for exact mobility/seating equipment, all necessary accessories, and how the client and/or family will be trained in the use of the equipment.
- Anticipated changes in the client's needs, anticipated modifications, or accessory needs, as well as the growth potential of the wheelchair. A wheelchair must have a growth potential, which must accommodate 20 percent of height and weight changes.
- Significant medical information pertinent to mobility and requested equipment including intellectual, postural, physical, sensory (visual and auditory), and physical status. Address trunk and head control, balance, arm and hand function, existence and severity of orthopedic deformities, as well as any recent changes in the client's physical and/or functional status, and any expected/potential surgeries that will improve or further limit mobility.
- A description of the current mobility/seating equipment, how long the client has been in the current equipment and why it no longer meets the client needs.
- Client's height, weight, and a description of where the equipment is to be used. Include the accessibility of client's residence.
- Manufacturer's retail pricing information, with itemized pricing including the description of the specific base, any attached seating system components and any attached accessories as well as the manufacturer's retail pricing information and itemized pricing for manually priced components.

If the wheelchair assessment form is completed by a physician, reimbursement is considered part of the physician office visit and will not be authorized using the above therapy procedure codes.

24.5.26.5 Manual Wheelchairs—Custom

Standard manual wheelchairs may be prior authorized for short-term rental or for purchase, if the client has a condition which does not require specialized seating.

Custom manual wheelchairs may be considered for prior authorization for a client who meets criteria for a manual wheelchair, has a condition that requires specialized seating, and cannot safely utilize a standard manual wheelchair.

24.5.26.6 Levels for Custom Manual and Powered Wheelchairs

Level 1 is a basic standard wheelchair (no modifier required).

Level 2 is a custom system with growth potential, including components for posture support (TF [Intermediate Level] modifier required).

Level 3 is a custom system that meets the Level 2 definition with the addition of a molded seating system, tilt and space and reclining capacities (TG [Complex, high level] modifier required).

24.5.26.7 Power Wheelchairs—Standard

Standard power wheelchairs may be considered for short-term rental up to 6 months or for purchase for a client who meets criteria for a wheelchair when the client has a condition that does not require specialized seating, and is unable to self-propel a manual wheelchair.

An attendant control is not a benefit of Home Health Services.

Prior authorization for a standard power wheelchair requires all documentation necessary for a custom manual wheelchair, as well as the following documentation:

- The client's physical and mental ability to receive and follow instructions related to responsibilities of using equipment. The client *must* be able to operate a power wheelchair independently. The therapist must provide written documentation that the client is physically and cognitively capable of managing a power wheelchair.
- How the power wheelchair will be operated such as joystick, head pointer, puff and go.
- The capability of the caregiver/client to care for the power wheelchair and accessories.
- The capability of the client to understand how the power wheelchair operates.

Rental of a manual wheelchair may be prior authorized when the client's power wheelchair is being repaired or replaced.

24.5.26.8 Power Wheelchairs—Custom

Custom power wheelchairs may be considered for a client who meets criteria for a power wheelchair, has a condition that requires specialized seating, and cannot safely utilize a standard power wheelchair.

An attendant control is not a benefit of the Home Health Services.

For safety, all power chairs are to include a stop switch.

Seat lift chairs and seat elevators or mechanisms, including those used for power wheelchairs, are not a benefit of the Texas Medicaid Program

Prior authorization for a custom power wheelchair requires all documentation necessary for a custom manual wheelchair, as well as the following:

- The client's physical and mental ability to receive and follow instructions related to responsibilities of using equipment. The client *must* be able to operate a power wheelchair independently. The therapist must provide written documentation that the client is physically and cognitively capable of managing a power wheelchair.
- How the power wheelchair will be operated such as joystick, head pointer, or puff and go.
- The capability of the caregiver/client to care for the power wheelchair and accessories.
- The capability of the client to understand how the power wheelchair operates.

An attendant control system is not a benefit of the Texas Medicaid Program. For safety, all power chairs are to include a stop switch.

Note: *Seat lift chairs, seat elevators, or mechanisms, including those used for power wheelchairs, are not a benefit of the Texas Medicaid Program.*

24.5.26.9 Scooters

A scooter is a professionally manufactured, three or four-wheeled motorized base with a professionally manufactured basic seating system for clients who have little or no positioning needs.

Scooters may be approved for a short term rental or initial three-month trial period based on documentation supporting the medical necessity and appropriateness of the device.

Scooters may be considered for reimbursement for ambulatory impaired clients with good head, trunk and arm/hand control, without a diagnosis of progressive illness such as progressive neuromuscular diseases such as amyotrophic lateral sclerosis.

Assessment of the accessibility of the client's residence must be completed and included in the prior authorization documentation to ensure that the scooter is usable in the home such as doors and halls wide enough, no obstructions.

All scooters must have a growth potential, which must accommodate 20 percent of height and weight changes.

To request prior authorization for a scooter the client must not own or be expected to require a power wheelchair within five years of the purchase of a scooter.

All documentation required for a standard power wheelchair must be provided, along with the following documentation:

- The client's physical and cognitive ability to receive and follow instructions related to the responsibilities of using the equipment.
- The ability of the client to physically and cognitively operate the scooter independently.
- The capability of the client to care for the scooter and understand how it operates.
- A completed Wheelchair/Scooter/Stroller Seating Assessment Form with seating measurements that includes documentation supporting medical necessity, except when requesting a standard sling seat/sling back wheelchair.

Custom seating for scooters is not a benefit of Home Health Services.

Repairs to scooters may be considered only for those scooters purchased by the Texas Medicaid Program.

24.5.26.10 Client Lift

A lift is a portable transfer system used to move a client from bed to chair and chair to bed.

A client lift will not be authorized for the convenience of a caregiver.

Hydraulic lifts are operated by the weight or pressure of a liquid.

Electric lifts is operated by electricity. An electric lift may be considered when a hydraulic lift will not meet the client's needs.

Barrier free lifts are not a benefit of Home Health Services.

24.5.26.11 Hydraulic Lift

Prior authorization for a hydraulic lift may be considered with the following documentation:

- The client must be unable to assist in his own transfers.
- The weight of the client and the weight capacity of the requested lift.
- The availability of a caregiver to operate the lift.
- Training by the provider to the client and the caregiver on the safe use of the lift.

24.5.26.12 Electric Lift

Prior authorization for an electric lift may be considered when the client meets criteria for a hydraulic lift and additional documentation explains why a hydraulic lift will not meet the client's needs.

24.5.26.13 Standers

A stander is a device used for the client with neuromuscular conditions who is unable to stand alone. Standers and standing programs can improve digestion, increase muscle strength, decrease contractures, increase bone density, and minimize decalcification.

Standers, including all accessories, require prior authorization.

Prior authorization may be considered for the standers with the following documentation:

- Diagnoses relevant to the requested equipment, including functioning level and ambulatory potential.
- Anticipated benefits of the equipment.
- Frequency and amount of time of a standing program.
- Anticipated length of time the client will require this equipment.
- Client's height/weight/age.
- Anticipated changes in the client's needs, anticipated modifications, or accessory needs, as well as the growth potential of the stander.

Standers, gait trainers, and parapodiums will not be authorized for a client within one year of each other.

24.5.26.14 Gait Trainers

Gait trainers are devices with wheels used to train clients with ambulatory potential. They provide the same benefits as the stander, in addition to assisting with gait training.

Prior authorization for the gait trainer may be considered with documentation supporting medical necessity and an assessment of the accessibility of the client's residence to ensure that the wheelchair is usable in the home (i.e., doors and halls wide enough, no obstructions) when a physician familiar with the client documents that the client has ambulatory potential and will benefit from a gait training program, and when the client meets the criteria for a stander.

Standers, gait trainers, and parapodiums/standing frames/braces/vertical standers that are covered through THSteps-CCP will not be authorized for a client within one year of each other.

24.5.26.15 Batteries and Battery Charger

A battery charger and initial batteries are included as part of the purchase of a power wheelchair.

Batteries and battery chargers will not be prior authorized for replacement within six months of delivery.

Replacement batteries or a battery charger may be considered for reimbursement under Home Health Services if they are no longer under warranty.

To request prior authorization for replacement batteries or a battery charger, the provider must document the date of purchase and serial number of the currently owned wheelchair as well as the reason for the replacement batteries or battery charger.

Documentation required supporting the need to replace the batteries or battery charger must include:

- Why the batteries are no longer meeting the client's needs, and/or
- Why the battery charger is no longer meeting the client's needs.

A maximum of one hour of labor may be considered for reimbursement to install new batteries. Labor is not reimbursed with the purchase of a new power wheelchair, or with replacement battery chargers.

24.5.26.16 Accessories

Accessories, modifications, adjustments, and repairs are benefits as outlined in this policy. All modifications, adjustments, and repairs within the first six months after delivery are considered part of the purchase price.

Equipment accessories, including pressure support cushions, may be prior authorized with documentation of medical necessity.

24.5.26.17 Modifications

Modifications are replacement of components due to changes in the client's condition, not replacement due to the component no longer functioning as designed.

Prior authorization may be considered for modifications to custom equipment should a change occur in the client's needs, capabilities, or physical/mental status, which cannot be anticipated.

Documentation must include the following:

- All projected changes in the client's mobility needs
- The date of purchase and serial number of the current equipment, and the cost of purchasing new equipment versus modifying current equipment. All modifications within the first six months after delivery are considered part of the purchase price.

24.5.26.18 Adjustments

Adjustments do not require supplies. A maximum of one hour of labor for adjustments may be considered for reimbursement through Home Health Services as needed after the first six months from delivery.

All adjustments within the first six months after delivery are considered part of the purchase price and will not be considered for prior authorization.

24.5.26.19 Repairs

Repairs require replacement of components that are no longer functional.

Repairs to client-owned equipment may be prior authorized as needed with documentation of medical necessity.

Repairs to client-owned equipment may be considered for reimbursement with prior authorization under Home Health Services.

Technician fees are considered part of the labor cost on the repair.

Providers are responsible for maintaining documentation in the client's medical record specifying repairs.

Rentals may be considered for reimbursement during the period of repair.

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

24.5.26.20 Replacement

A request for replacement of equipment and/or accessories may be considered for reimbursement and must include an order from the prescribing physician familiar with the client and an assessment by a physician, licensed occupational or physical therapist with documentation supporting why the current equipment is no longer meeting the client's needs.

Replacement, adjustments, modifications and repairs will not be authorized in situations where the equipment has been abused or neglected by the client, client's family, or caregiver.

24.5.26.21 Wheelchair Ramp—Portable and Threshold

A portable ramp is defined as a ramp that is able to be carried as needed to access a home, weighs no more than 90 pounds, and/or measures no more than 10 feet in length. A threshold ramp provides access over elevated thresholds.

One portable and one threshold ramp for wheelchair access may be considered for prior authorization when documentation supports medical necessity. The following documentation supporting medical necessity is required:

- The date of purchase and serial number of the client's wheelchair or documentation of a wheelchair request being reviewed for purchase.
- Diagnosis with duration of expected need.
- A diagram of the house showing the access points with the ground-to-floor elevation and any obstacles.

Ramps may be considered for rental for short term disabilities.

Ramps may be considered for purchase for long term disabilities.

Mobility aid lifts for vehicles, and vehicle modifications are not a benefit of the Texas Medicaid Program.

Note: *Permanent ramps, vehicle ramps and home modifications are not a benefit of the Texas Medicaid Program.*

24.5.26.22 Procedure Codes and Limitations for Mobility Aids

Procedure Code	Maximum Limit
Canes	
J-E0100	1 per 5 years
J-E0105	1 per 5 years
Crutches	
9-A4635	As needed
J-E0110	1 per 5 years
J-E0111	1 per 5 years
J-E0112	1 per 5 years
J-E0113	1 per 5 years
J-E0114	1 per 5 years
J-E0116	1 per 5 years
J-E0153	1 per 5 years
L-E0110	4 months maximum
L-E0111	4 months maximum
L-E0112	4 months maximum
L-E0113	4 months maximum
L-E0114	4 months maximum
L-E0116	4 months maximum
Walkers	
9-A4636	As needed
9-A4637	As needed
J-E0130	1 per 5 years
J-E0135	1 per 5 years
J-E0140	1 per 5 years
J-E0141	1 per 5 years
J-E0143	1 per 5 years
J-E0144	1 per 5 years
J-E0147	1 per 5 years
J-E0148	1 per 5 years
J-E0149	1 per 5 years
J-D0153	1 per 5 years
J-E0154	1 per 5 years

Procedure Code	Maximum Limit
J-E0155	1 per 5 years
J-E0157	1 per 5 years
J-E0158	1 per 5 years
J-E0159	1 per 5 years
L-E0130	4 months maximum
L-E0135	4 months maximum
L-E0141	4 months maximum
L-E0143	4 months maximum
L-E0144	4 months maximum
L-E0147	4 months maximum
L-E0148	4 months maximum
L-E0149	4 months maximum
Gait Trainers	
J-E8001	1 per day
Seating Assessments	
1-97001	As needed
1-97003	As needed
Wheelchairs	
J-E1050	1 per 5 years
J-E1060	1 per 5 years
J-E1070	1 per 5 years
J-E1083	1 per 5 years
J-E1084	1 per 5 years
J-E1085	1 per 5 years
J-E1086	1 per 5 years
J-E1087	1 per 5 years
J-E1088	1 per 5 years
J-E1089	1 per 5 years
J-E1090	1 per 5 years
J-E1093	1 per 5 years
J-E1100	1 per 5 years
J-E1110	1 per 5 years
J-E1130	1 per 5 years
J-E1140	1 per 5 years
J-E1150	1 per 5 years
J-E1160	1 per 5 years
J-E1161	1 per 5 years
J-E1170	1 per 5 years
J-E1171	1 per 5 years
J-E1172	1 per 5 years
J-E1180	1 per 5 years
J-E1190	1 per 5 years
J-E1195	1 per 5 years
J-E1200	1 per 5 years
J-E1220	1 per 5 years
J-E1220-TF	1 per 5 years
J-E1220-TG	1 per 5 years
J-E1229	1 per 5 years
J-E1231	1 per 5 years
J-E1232	1 per month
J-E1233	1 per month
J-E1234	1 per 5 years
J-E1235	1 per 5 years
J-E1236	1 per 5 years
J-E1237	1 per 5 years
J-E1238	1 per 5 years
J-E1240	1 per 5 years
J-E1250	1 per 5 years
J-E1260	1 per 5 years
J-E1270	1 per 5 years
J-E1280	1 per 5 years
L-E1050	1 per month
L-E1060	1 per month
L-E1070	1 per month
L-E1083	1 per month
L-E1084	1 per month
L-E1085	1 per month
L-E1086	1 per month
L-E1087	1 per month
L-E1088	1 per month
L-E1089	1 per month
L-E1090	1 per month
L-E1093	1 per month
L-E1100	1 per month
L-E1110	1 per month
L-E1130	1 per month
L-E1140	1 per month
L-E1150	1 per month
L-E1160	1 per month
L-E1161	1 per month
L-E1170	1 per month
L-E1171	1 per month
L-E1172	1 per month
L-E1180	1 per month
L-E1190	1 per month
L-E1195	1 per month
L-E1200	1 per month
L-E1231	1 per month
L-E1232	1 per 5 years

Procedure Code	Maximum Limit
L-E1233	1 per 5 years
L-E1234	1 per month
L-E1235	1 per month
L-E1236	1 per month
L-E1237	1 per month
L-E1238	1 per month
L-E1240	1 per month
L-E1250	1 per month
L-E1260	1 per month
L-E1270	1 per month
L-E1280	1 per month
Power Wheelchairs	
J-E1220-TF	1 per 5 years
J-E1220-TG	1 per 5 years
J-K0813	1 per 5 years
J-K0814	1 per 5 years
J-K0815	1 per 5 years
J-K0816	1 per 5 years
J-K0820	1 per 5 years
J-K0821	1 per 5 years
J-K0822	1 per 5 years
J-K0823	1 per 5 years
J-K0824	1 per 5 years
J-K0825	1 per 5 years
J-K0826	1 per 5 years
J-K0827	1 per 5 years
J-K0828	1 per 5 years
J-K0829	1 per 5 years
J-K0835	1 per 5 years
J-K0836	1 per 5 years
J-K0837	1 per 5 years
J-K0838	1 per 5 years
J-K0839	1 per 5 years
J-K0840	1 per 5 years
J-K0841	1 per 5 years
J-K0842	1 per 5 years
J-K0843	1 per 5 years
J-K0848	1 per 5 years
J-K0849	1 per 5 years
J-K0850	1 per 5 years
J-K0851	1 per 5 years
J-K0852	1 per 5 years
J-K0853	1 per 5 years
J-K0854	1 per 5 years

Procedure Code	Maximum Limit
J-K0855	1 per 5 years
J-K0856	1 per 5 years
J-K0857	1 per 5 years
J-K5058	1 per 5 years
J-K0859	1 per 5 years
J-K0860	1 per 5 years
J-K0861	1 per 5 years
J-K0862	1 per 5 years
J-K0863	1 per 5 years
J-K0864	1 per 5 years
J-K0868	1 per 5 years
J-K0869	1 per 5 years
J-K0870	1 per 5 years
J-K0871	1 per 5 years
J-K0877	1 per 5 years
J-K0878	1 per 5 years
J-K0879	1 per 5 years
J-K0880	1 per 5 years
J-K0884	1 per 5 years
J-K0885	1 per 5 years
J-K0886	1 per 5 years
J-K0890	1 per 5 years
J-K0891	1 per 5 years
J-K0898	1 per 5 years
J-K0899	1 per 5 years
L-K0813	1 per month
L-K0814	1 per month
L-K0815	1 per month
L-K0816	1 per month
L-K0820	1 per month
L-K0821	1 per month
L-K0822	1 per month
L-K0823	1 per month
L-K0824	1 per month
L-K0825	1 per month
L-K0826	1 per month
L-K0827	1 per month
L-K0828	1 per month
L-K0829	1 per month
L-K0835	1 per month
L-K0836	1 per month
L-K0837	1 per month
L-K0838	1 per month
L-K0839	1 per month

Procedure Code	Maximum Limit
L-K0840	1 per month
L-K0841	1 per month
L-K0842	1 per month
L-K0843	1 per month
L-K0848	1 per month
L-K0849	1 per month
L-K0850	1 per month
L-K0851	1 per month
L-K0852	1 per month
L-K0853	1 per month
L-K0854	1 per month
L-K0855	1 per month
L-K0856	1 per month
L-K0857	1 per month
L-K0859	1 per month
L-K0860	1 per month
L-K0861	1 per month
L-K0862	1 per month
L-K0863	1 per month
L-K0864	1 per month
L-K0868	1 per month
L-K0869	1 per month
L-K0870	1 per month
L-K0871	1 per month
L-K0877	1 per month
L-K0878	1 per month
L-K0879	1 per month
L-K0880	1 per month
L-K0884	1 per month
L-K0885	1 per month
L-K0886	1 per month
L-K0890	1 per month
L-K0891	1 per month
L-K0898	1 per month
L-K0899	1 per month
L-K5058	1 per month
Scooters	
J-E1230	1 per 5 years
J-K0800	1 per 5 years
J-K0801	1 per 5 years
J-K0802	1 per 5 years
L-E1230	1 per month
L-K0800	1 per month
L-K0801	1 per month
L-K0802	1 per month
Wheelchair Parts	
J-E0700	1 per year
9-E0705	1 per 5 years
J-E0942	1 per year
J-E0944	1 per year
J-E0945	1 per year
J-E0950	1 per year
J-E0951	2 per year
J-E0952	2 per year
J-E0955	1 per year
J-E0957	2 per year
J-E0958	1 per year
J-E0960	As needed
J-E0961	1 per year
J-E0969	1 per year
J-E0970	1 pair per year
J-E0971	1 pair per year
J-E0973	1 per year
J-E0974	1 per year
J-E0978	1 per year
J-E0980	1 per year
J-E0990	2 per year
J-E0992	1 per year
J-E0994	2 per year
J-E0995	2 per year
J-E1002	1 per 5 years
J-E1003	1 per 5 years
J-E1004	1 per 5 years
J-E1005	1 per 5 years
J-E1006	1 per 5 years
J-E1007	1 per 5 years
J-E1008	1 per 5 years
J-E1009	1 per 5 years
J-E1011	As needed
J-E1014	1 per 5 years
J-E1015	2 per year
J-E1016	2 per year
J-E1017	2 per year
J-E1018	2 per year
J-E1028	1 per 5 years
J-E1029	1 per 5 years
J-E1296	1 per 5 years
J-E1297	1 per 5 years

Procedure Code	Maximum Limit
J-E1298	1 per 5 years
J-E2201	1 per 5 years
J-E2202	1 per 5 years
J-E2203	1 per 5 years
J-E2204	1 per 5 years
J-E2205	1 per 3 years
J-E2206	1 per 3 years
J-E2207	1 per 5 years
J-E2208	1 per 5 years
J-E2209	1 per 5 years
J-E2210	1 per year
J-E2211	1 per 6 months
J-E2212	1 per 6 months
J-E2213	1 per 6 months
J-E2214	1 per 6 months
J-E2215	1 per 6 months
J-E2216	1 per 6 months
J-E2217	1 per 6 months
J-E2218	1 per 6 months
J-E2219	1 per 6 months
J-E2220	1 per 6 months
J-E2221	1 per 6 months
J-E2222	1 per 6 months
J-E2223	1 per 6 months
J-E2224	1 per 6 months
J-E2225	1 per 6 months
J-E2226	1 per year
J-E2291	1 per 3 years
J-E2292	1 per 3 years
J-E2293	1 per 3 years
J-E2294	1 per 3 years
J-E2310	1 per 5 years
J-E2311	1 per 5 years
J-E2321	1 per 5 years
J-E2323	1 per 5 years
J-E2324	1 per 5 years
J-E2325	1 per 5 years
J-E2326	1 per 5 years
J-E2327	1 per 5 years
J-E2328	1 per 5 years
J-E2329	1 per 5 years
J-E2330	1 per 5 years
J-E2340	1 per 5 years
J-E2341	1 per 5 years

Procedure Code	Maximum Limit
J-E2342	1 per 5 years
J-E2343	1 per 5 years
J-E2351	1 per 5 years
J-E2368	1 per 5 years
J-E2369	As needed
J-E2370	As needed
J-E2373	1 per 5 years
J-E2374	1 per 5 years
J-E2375	1 per 5 years
J-E2376	1 per 5 years
J-E2377	1 per 5 years
J-E2381	2 per year
J-E2382	1 pair per 5 years
J-E2383	1 pair per 5 years
J-E2384	1 pair per 5 years
J-E2385	1 pair per 5 years
J-E2386	1 pair per 5 years
J-E2387	1 pair per 5 years
J-E2388	1 pair per 5 years
J-E2389	1 pair per 5 years
J-E2390	1 pair per 5 years
J-E2391	1 pair per 5 years
J-E2392	1 pair per 5 years
J-E2393	1 pair per 5 years
J-E2394	1 pair per 5 years
J-E2395	1 pair per 5 years
J-E2396	1 pair per 5 years
J-E2611	1 per year
J-E2612	1 per year
J-E2613	1 per year
J-E2614	1 per year
J-E2615	1 per year
J-E2616	1 per year
J-E2617	1 per year
J-E2618	1 per 5 years
J-E2619	1 per year
J-E2620	1 per year
J-E2621	1 per year
L-E1020	1 per 5 years
L-E2207	1 per month
L-E2208	1 per month
L-E2209	1 per month

Procedure Code	Maximum Limit
Wheelchair/Pressure/Positioning Cushions	
J-E0190	1 per 5 years
J-E2601	1 per year
J-E2602	1 per year
J-E2603	1 per year
J-E2604	1 per year
J-E2605	1 per year
J-E2606	1 per year
J-E2607	1 per year
J-E2608	1 per year
J-E2609	1 per year
J-E2611	1 per year
J-E2612	1 per year
J-E2613	1 per year
J-E2614	1 per year
J-E2615	1 per year
J-E2616	1 per year
J-E2617	1 per year
J-E2618	1 per 5 years
J-E2619	1 per year
J-E2620	1 per year
J-E2621	1 per year
J-K0734	1 per year
J-K0735	1 per year
J-K0736	1 per year
J-K0737	1 per year
Batteries	
J-E2361	2 per year
J-E2363	2 per year
J-E2366	1 per 5 years
J-E2371	1 pair per 5 years
J-K0733	2 per year
Safety Equipment	
J-E0700	1 per year
J-E0705	1 per 5 years
J-E0942	1 per year
J-E0944	1 per year
J-E0945	1 per year
J-E0960	As needed
J-E0971	1 pair per year
J-E0974	1 per year
J-E0978	1 per year
J-E0980	1 per year
Lifts	
J-E0630	1 per 5 years
J-E0635	1 per 5 years
L-E0630	1 per month
L-E0635	1 per month
Miscellaneous	
9-A9900	As Needed
9-E1340	As Needed
J-E1399	As Needed
J-K0108	As Needed

24.5.27 Respiratory Equipment and Supplies

Respiratory equipment is defined as any device that assists a client's ventilation. Respiratory equipment and supplies may be provided in the home under Home Health Services.

The following respiratory equipment requires prior authorization:

- Intermittent positive pressure breathing device.
- Electrical percussor.
- Intrapulmonary percussive ventilation (IPV).
- High-frequency chest wall compression system (HFCWCS).
- Cough-stimulating device.
- Continuous positive airway pressure (CPAP) system.
- Bi-level positive airway pressure system without backup (such as BPAP S).
- Bi-level positive airway pressure system with backup (such as BiPAP ST).
- All home mechanical ventilation equipment.
- Home oxygen systems.
- Oral device/appliance.

Rental of equipment includes all necessary supplies, adjustments, repairs, and replacement parts.

Respiratory equipment is anticipated to last a minimum of 5 years.

For replacement of equipment due to loss by theft or fire, a copy of the police or fire report must be submitted with the measures to be taken to prevent reoccurrence.

In situations where the equipment has been abused or neglected by the client, the client's family, or the caregiver, a referral to the DSHS THSteps Case Management unit will be made by the Home Health Services unit for clients under the age of 21 years. Providers will be notified that the State will be monitoring this client's services to evaluate the safety of the environment for both the client and equipment.

The durable medical equipment (DME) provider/supplier must have the appropriate license and/or certification from DSHS regarding supplying of medical devices and oxygen.

Note: *Respiratory equipment and related supplies that are not considered a benefit under Home Health Services may be considered for reimbursement through THSteps-CCP for clients younger than 21 years of age, who are THSteps-CCP eligible (e.g., clients residing in residential treatment centers).*

24.5.27.1 Nebulizers

A nebulizer is a device with a compressor that delivers respiratory medications by inhalation in the form of a mist.

Medications for use with the nebulizer will not be reimbursed to a DME company. These medications may be considered under the Vendor Drug Program.

Nebulizers do *not* require prior authorization for the diagnoses listed below. Other diagnoses require prior authorization and may be considered based on review of documentation by HHSC or its designee.

Nebulizers may be reimbursed for purchase only, and that purchase is limited to one every five years.

Use procedure code J-E0570 for purchase of the nebulizer.

Diagnosis Codes				
1363	27700	27701	27702	27703
27709	4660	46611	46619	4801
486	488	4910	4911	49120
49121	4918	4919	4920	4928
49300	49301	49302	49310	49311
49312	49320	49321	49322	49381
49382	49390	49391	49392	4940
4941	4950	4951	4952	4953
4954	4955	4956	4957	4958
4959	496	5070	5071	5078
5533	7469	769	7707	78609
7861				

The following nebulizer supplies may be billed with the diagnosis codes listed above:

Procedure Codes		
9-A4617	9-A7003	9-A7004
9-A7006	9-A7007	9-A7009
9-A7011	9-A7013	9-A7015
9-A7016	9-A7018	

Ultrasonic nebulizers do not require prior authorization for the diagnoses listed below. Use procedure code J-E0575 when billing for the ultrasonic nebulizer.

The ultrasonic nebulizer will be reimbursed only for the following diagnosis codes:

Diagnosis Codes				
1363	27700	27701	27702	27703
27709				

Use procedure codes 9-A7009 or 9-A7017 when billing supplies with an ultrasonic nebulizer.

24.5.27.2 Vaporizers

The vaporizer is a machine that creates a mist, which is released into the air.

Vaporizers may be reimbursed for purchase only, and that purchase is limited to once every five years.

Use procedure code J-E0605 when billing for vaporizers.

Vaporizers do *not* require prior authorization for the diagnoses listed below. Vaporizers will be reimbursed for the following diagnoses only:

Diagnosis Codes				
462	4644	4650	4658	4659
4660	46611	46619		

24.5.27.3 Humidification Units

Humidification units for nonmechanically ventilated clients will be purchased when a purchase is determined to be more cost effective than leasing the device with supplies. Use procedure code J-E1399 when billing for humidification units for nonmechanically ventilated clients. Procedure code J-E1399 will be reimbursed with a maximum fee of $1,230.00 or MSRP less 18 percent, which ever is the lesser cost. Supplies to be used with client owned humidification units will be considered for purchase and must be billed with the appropriate HCPCS code for each item requested. Documentation of medical necessity must be included with submission of the request.

24.5.27.4 Secretion Clearance Devices

Incentive Spirometer

Incentive spirometers, including electronic spirometers, are not a benefit of the Home Health Services.

Intermittent Positive-Pressure Breathing (IPPB) Devices

Intermittent positive-pressure breathing is the application of positive pressure, frequently with aerosols or humidity, to a spontaneously breathing client, as a short-term treatment. Each treatment usually does not last more than 15 or 20 minutes.

IPPB devices require prior authorization.

The IPPB machine may be reimbursed for rental only, and that rental is limited to once per month for a maximum of four months per lifetime.

Rental of the IPPB device includes all supplies, such as humidification and tubing.

Use procedure code L-E0500 when billing for the IPPB.

Purchase of the IPPB device (J-E0500) is not a benefit.

The IPPB device may be authorized for the following diagnoses:

Diagnosis Codes				
27700	27701	27702	27703	27709
33510	33511	33519	3591	35921
35922	35923	35929	496	514
515	5162	5163	5185	

Other diagnoses may be considered based on review of documentation by HHSC or its designee.

Mucous Clearance Valve

The mucous clearance valve is a small handheld device that provides positive expiratory pressure (PEP) therapy for clients who have chronic obstructive pulmonary disease (COPD), chronic bronchitis, cystic fibrosis, atelectasis, or other conditions producing retained secretions.

The mucous clearance valve requires prior authorization.

The mucous clearance valve is age-restricted to 6 years of age and older.

The mucous clearance valve may be reimbursed for purchase only, and that purchase is limited to one every five years.

Use procedure code J-S8185 for the purchase of a mucous clearance valve.

The mucous clearance valve will be reimbursed for the following diagnosis codes only:

Diagnosis Codes				
27700	27701	27702	27703	27709
490	4910	4911	49120	49121
4918	4919	4920	4928	49300
49301	49302	49310	49311	49312
49320	49321	49322	49381	49382
49390	49391	49392	4940	4941
4950	4951	4952	4953	4954
4955	4956	4957	4958	4959
496				

Other diagnoses may be considered based on review of documentation by HHSC or its designee.

24.5.27.5 Electrical Percussor

An electrical percussor is a device that produces vibrations when applied to the chest wall. The purpose of this device is to improve the effectiveness of chest physiotherapy.

The electrical percussor device requires prior authorization.

The electrical percussor may be reimbursed for rental or purchase depending on the physician's predicted length of treatment. Purchase is limited to one every five years and rental is limited to once per month for a maximum of four months per lifetime.

In addition to the completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form, a description of all previous courses of therapy and why they did not adequately assist the client in airway mucus clearance is required to obtain authorization for an electrical percussor.

Use procedure codes J-E0480 and L-E0480 when billing for the percussor.

24.5.27.6 Chest Physiotherapy Devices

Either an IPV, cough-stimulating device, *or* the HFCWCS generator with vest will be prior authorized. These systems are *not* prior authorized simultaneously.

Note: *Chest physiotherapy to promote bronchial drainage that is performed by a therapist or any other health-care professional, including a private duty nurse, will not be authorized during the period of time that the HFCWCS, cough-stimulating device, or intrapulmonary percussion ventilation device is prior authorized.*

Prior authorization for the rental or purchase of equipment in this section requires a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and the *Medicaid Certificate of Medical Necessity for Chest Physiotherapy Devices* form completed by a physician familiar with the client.

High-Frequency Chest Wall Compression System

A High-Frequency Chest Wall Compression System (HFCWCS) is composed of an inflatable vest and an air-pulse generator. The generator produces high-frequency pressure pulses, which rapidly inflate and deflate the vest, creating oscillation of the chest wall.

Payment of the HFCWCS is limited to the following diagnosis codes:

Diagnosis Codes				
27700	27701	27702	27703	27709
33510	33511	33519	3591	496

Other diagnoses may be considered based on review of documentation by HHSC or its designee.

A HFCWCS is reimbursed only when it is demonstrated that other mechanical devices or chest physiotherapy by a caregiver and/or self have been ineffective.

The HFCWCS requires prior authorization. Requests may be considered for prior authorization for the initial three-month rental of a HFCWCS generator and vest. All of the following information must be provided:

- A description of all previous therapy courses that have been tried and why these treatments did not adequately assist the client in airway mucus clearance. This must include the information that the client has used

electrical percussor therapy for a minimum of four months before the request and that this therapy has been ineffective.

- A physician's statement of a trial of the HFCWCS in a clinic, hospital, or the home setting documenting the effectiveness and tolerance of the system, including a statement that the client has not exacerbated any gastrointestinal manifestations nor caused aspiration and exacerbation of pulmonary manifestations nor an exacerbation of seizure activity secondary to the use of the system.
- Diagnosis and background history including complications, medications used, history of any IV antibiotic therapy with dosage, frequency and duration, history of recent hospitalizations and/or history of school, work, or extracurricular activity absences due to diagnosis-related complications.
- Any recent illnesses and/or complications.
- Medical diagnosis or other limitations preventing the client/caregiver from doing chest physiotherapy.

Prior authorization for an extension of another three months rental may be considered with the above documentation.

Requests for authorization of the purchase of a HFCWCS generator may be considered based on the outcome of a six-month rental period and the following required documentation.

Documentation of vest tolerance and positive outcomes/results of therapy, including:

- Physician's description/assessment of the effectiveness such as decreased medication use, shorter hospital length of stay, decreased hospitalizations, and fewer school, work or extracurricular activity absences due to diagnosis related complications.
- The frequency and compliance graphs for the six-month period showing use of the system at least 50 percent of the maximum time prescribed by the physician for each day.
- Respiratory status, including any recent hospitalization.
- A statement that the client has not exacerbated any gastrointestinal manifestations nor caused aspiration and exacerbation of pulmonary manifestations nor an exacerbation of seizure activity secondary to the use of the system.

Rental cost of the HFCWCS applies toward the purchase price.

A HFCWCS generator purchase and vest purchase will be reimbursed only once per lifetime, due to the lifetime warranty provided by the manufacturer.

Requests for a vest replacement due to growth will be considered with appropriate documentation.

In addition to a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form documenting the medical necessity and appropriateness of the device, providers must submit a completed Medicaid Certificate of Medical Necessity for Chest Physiotherapy Devices Initial or Extended form. These signed and dated forms must be maintained by the provider and the prescribing physician in the client's medical record.

Use procedure code J/L-E0483 when billing for HFCWCS for either a rental or purchase.

Intrapulmonary Percussive Ventilation (IPV)

IPV offers a form of physiotherapy which is pneumatically delivered. The IPV delivers mini-bursts of gas into the lungs at a high-frequency with aerosol therapy and positive pressure. Its purpose is to mobilize secretions.

The IPV requires prior authorization.

The IPV may be reimbursed for monthly rental only and includes all accessories.

Use procedure code L-E0481 when requesting authorization for rental of the IPV.

The IPV may be reimbursed for the following cystic fibrosis diagnosis codes:

Diagnosis Codes				
27700	27701	27702	27703	27709
33510	33511	33519	3591	496

Other diagnoses will be considered based on review of documentation by HHSC or its designee.

The IPV is reimbursed only when it is demonstrated that an electric/pneumatic percussor or chest physiotherapy by a caregiver and/or self have not been effective.

The IPV may be approved initially for a three-month rental period based on the following required documentation:

- Diagnosis and background history including recent illnesses, complications, medications used, history of any IV antibiotic therapy with dosage, frequency and duration, history of recent hospitalizations and/or history of school, work, and extracurricular activity absences due to diagnosis related complications.
- Any medical reasons why the client/caregiver cannot do chest physiotherapy.
- A description of all previous therapy courses that have been tried and why these treatments did not adequately assist the client in airway mucus clearance. This must include information on why other treatments have not been tried, and that the client has used electrical percussor therapy for a minimum of four months before the request and that this therapy has been ineffective.

Requests for prior authorization of an extension must include documentation by a physician familiar with the client that indicates that the client is compliant with the use of the equipment and that the treatment is effective.

Either an IPV, cough stimulating device, or the high-frequency chest wall compression generator with vest will be authorized. These systems will not be authorized simultaneously.

In addition to a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form documenting the medical necessity and appropriateness of the device, providers

must submit a completed Medicaid Certificate of Medical Necessity for Chest Physiotherapy Devices Initial or Extended form.

Medicaid Certificate of Medical Necessity for Chest Physiotherapy Devices Initial or Extended form must be signed, dated, and maintained by the provider and the prescribing physician in the client's medical record.

Cough-Stimulating Device (Cofflator)

The cough-stimulating device assists clients in secretion clearance by applying positive pressure to the airway via mask, mouthpiece or tracheostomy adapter. It then cycles to negative pressure stimulating a cough response.

The cough-stimulating device requires prior authorization.

The cough-stimulating device may be reimbursed for monthly rental only and includes all supplies.

Use procedure code L-E0482 when requesting rental of a cough-stimulating device.

The cough-stimulating device may be reimbursed for those clients with chronic pulmonary disease and/or neuromuscular disorders that affect the respiratory musculature.

The cough-stimulating device may be approved initially for a three-month rental period based on the following required documentation:

- Diagnosis and background history including recent illnesses, complications, medications used, history of any IV antibiotic therapy with dosage, frequency and duration, history of recent hospitalizations, results of pulmonary function studies if applicable, and/or history of school/work/extracurricular activity absences due to diagnosis related complications.
- Medical reasons why the client/caregiver cannot do chest physiotherapy.
- A description of all previous therapy courses that have been tried and why these treatments did not adequately assist the client in airway mucus clearance. This must include information on why other treatments have not been tried, and that the client has used electrical percussor therapy for a minimum of four months before the request and that this therapy has been ineffective.

Requests for prior authorization of an extension must include documentation by the physician familiar with the client that the client is compliant with the use of the equipment and that the treatment is effective.

24.5.27.7 Positive Airway Pressure System Devices

In addition to the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form, a Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy Form must be completed by the physician familiar with the client and submitted by the provider for all positive pressure system devices.

24.5.27.8 Continuous Positive Airway Pressure (CPAP) System

A CPAP system is used to provide noninvasive positive air pressure through the nose with a mask or nasal pillows to prevent the collapse of the oropharyngeal walls during sleep. It is used primarily for the treatment of obstructive sleep apnea. Other conditions may be considered based on medical necessity.

The CPAP system requires prior authorization.

The CPAP system may be reimbursed for rental or purchase depending on the physician's predicted length of treatment. Purchase is limited to a maximum of once every five years with medical necessity. Reimbursement for rental is limited to once per month and includes all supplies and accessories.

Use procedure code J/L-E0601 when requesting authorization for the rental or purchase of the CPAP system.

Clients who have a current prior authorization for a CPAP/BiPAP S may continue to rent these items until the authorization period expires. After the current authorization period expires, then the criteria in the following paragraph applies to any further authorizations of CPAP/BiPAP. Providers must supply a new CPAP/BiPAP to clients at the beginning of the new authorization period.

The CPAP may be approved initially for a three-month rental period based on documentation supporting the medical necessity and appropriateness of the device.

CPAP may be approved initially for three months if the duration of the symptoms is at least six months and one of the following:

- The Sleep Study Respiratory Disturbance Index (RDI) or Apnea/Hypopnea Index (AHI) is greater than 15 per hour.
- The Sleep Study RDI or AHI is greater than 10 per hour with the lowest oxygen saturation during the study is less than 80 percent.

24.5.27.9 Pediatric CPAP Changes

One of the following oxygen saturation levels may be used for clients under 21 years of age:

- An oxygen saturation of 89 to 92 percent, taken at rest, breathing room air.
- An oxygen saturation less than 92 percent with documentation of medical necessity provided by a physician familiar with the client.

24.5.27.10 CPAP Prior Authorization Renewal

Prior authorization for purchase after the initial three-month rental period may be granted if the client is continuing to use the equipment at a minimum of four hours per night and symptoms are improved as documented by a physician familiar with the client. This documentation of compliance and effectiveness must be provided with a new completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical

Supplies Physician Order Form and a Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy form.

Rental of CPAP/BiPAP S includes all supplies. CPAP/BiPAP S may be rented up to a maximum of 13 months. The equipment is considered purchased after 13 months rental.

24.5.27.11 Bi-level Positive Airway Pressure System (BiPAP S) Without Backup

A BiPAP S is used to provide noninvasive inspiratory positive airway pressure and expiratory positive airway pressure through the nose with a mask to prevent the collapse of the oropharyngeal walls during sleep. This equipment is used primarily for obstructive sleep apnea.

The BiPAP S requires prior authorization.

The BiPAP S may be reimbursed for rental or purchase depending on the physician's predicted length of treatment. Purchase is limited to a maximum of once every five years with medical necessity. Reimbursement for rental is limited to once per month and includes all supplies.

The BiPAP S will not be authorized once a CPAP is purchased.

Use procedure code L/J-E0470 when requesting authorization for the rental or purchase of the BiPAP S.

Clients who have a current prior authorization for a CPAP/BiPAP S may continue to rent these items until the authorization period expires. After the current authorization period expires, then the criteria in the following paragraph applies to any further authorizations of CPAP/BiPAP. Providers must supply a new CPAP/BiPAP to clients at the time of purchase, if the item is purchased after a rental period.

The BiPAP S may be approved initially for a three-month rental period based on documentation supporting the medical necessity and appropriateness of the device.

The BiPAP S may be approved initially for three months if the following conditions are met:

- The client has demonstrated the inability to tolerate the CPAP system, *and*
- Duration of symptoms of at least six months, and
- The Sleep Study RDI or AHI is greater than 15 per hour, *or*
- The Sleep Study RDI or AHI greater than 10 per hour with the lowest oxygen saturation during study is less than 80 percent or oxygen saturation equal to or less than 92 percent for clients under 21 years of age.

Prior authorization for purchase after the initial three-month rental period may be granted if the client is continuing to use the equipment at a minimum of four hours per night and symptoms are improved as documented by a physician familiar with the client. This documentation of compliance and effectiveness must be provided with a new completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and a Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy form.

Rental of CPAP/BiPAP S includes all supplies. CPAP/BiPAP S may be rented up to a maximum of 13 months. The equipment is considered purchased after 13 months rental.

24.5.27.12 Bi-level Positive Airway Pressure System With Backup (BiPAP ST)

A BiPAP ST is used to provide timed noninvasive inspiratory positive airway pressure and expiratory positive airway pressure through the nose with a mask when BiPAP S has been proven ineffective or through a tracheostomy.

The BiPAP ST requires prior authorization.

The rental of a BiPAP ST may be reimbursed only once per month.

Purchase of the BiPAP ST is not a benefit.

The BiPAP ST may be approved initially for a three-month rental period based on documentation supporting the medical necessity and appropriateness of the device.

Use either procedure code L-E0471 or L-E0472 when requesting authorization for the rental of the BiPAP ST.

BiPAP ST may be approved initially for three months if the following conditions are met:

- A diagnosis of central sleep apnea, or a neuromuscular disease producing respiratory insufficiency, *and*
- Sleep study records central apnea greater than 5 RDI or AHI per hour, *or*
- Oxygen saturation equal to or less than 92 percent in clients under 21 years of age.
- The client has an arterial PO2 at or below 56 mm Hg, or an arterial oxygen saturation at or below 89 percent by transcutaneous oximetry associated with a diagnosis of neuromuscular respiratory insufficiency or failure (not COPD).

Continued authorization for rental after the initial three-month rental period may be granted if the client is continuing to use the equipment at a minimum four hours per night and has a transcutaneous saturation greater than 88 percent while using the equipment as documented by a physician familiar with the client or 92 percent or less for clients under 21 years of age. This documentation of compliance and effectiveness must be provided with the above documentation plus a new completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and a Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy form.

Home Mechanical Ventilation Equipment

Ventilators are used for clients who do not have adequate respiratory function. Continuous use ventilators are used for 12 or more hours per day. Intermittent use ventilators are used for less than 12 hours per day.

Mechanical ventilation is either provided by positive pressure ventilation (volume ventilator) or negative pressure ventilation (iron lung).

All ventilators require prior authorization.

The completed, signed, and dated Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must specify all ventilator settings and must be maintained by the DME provider and the prescribing physician in the client's medical record.

24.5.27.13 Volume Ventilators

A volume ventilator may operate, using room air and/or oxygen, in various phases, modes and variables, which are time controlled, pressure controlled, volume controlled or a combination of these. A volume ventilator may be operated in any of the following:

Ventilation Modes

- Control.
- Assist control.
- Synchronized intermittent mandatory ventilation (SIMV).
- CPAP.

Breath Types

- Spontaneous (client triggered and cycled).
- Ventilator assisted (client or machine triggered and/or cycled) (e.g., pressure support or pressure-assisted).
- Mandatory (machine triggered and/or machine cycled).

The volume ventilator is prior authorized for rental only for those clients who have a tracheostomy.

The monthly ventilator rental includes all ventilator supplies, such as (but not limited to):

- Internal filters.
- External filters.
- Ventilator circuits with an exhalation valve.
- High and low pressure alarms.
- All humidification systems including supplies and solutions (i.e., sterile/distilled water).
- Compressors and supplies.
- Tracheostomy filters/heat moisture exchangers.

Use procedure codes L-E0450, L-E0463, and L-E0464 when requesting prior authorization for the volume ventilator.

24.5.27.14 Negative Pressure Ventilators

A negative pressure ventilator decreases atmospheric pressure to a predetermined negative pressure immediately outside the chest or body to allow passive lung expansion from normal air pressure.

Negative pressure ventilators may be prior authorized for rental only for individuals who have the ability to speak, eat, drink and do not have a tracheostomy.

The ventilator rental includes all component parts (pillow, mattress, gaskets, etc.).

Use procedure code L-E0460 when requesting prior authorization for a negative pressure ventilator.

One of the following devices may be authorized with a portable negative pressure ventilator using procedure codes J/L-E0457 and J/L-E0459. These devices may be reimbursed for an initial three-month rental period.

The listed application devices may be purchased following the initial three-month rental period depending on the physician's predicted length of treatment and the client's compliance.

The purchase of a chest shell (cuirass) and chest wrap is limited to a maximum of one every five years. Reimbursement for rental is limited to once per month for a total of four months.

24.5.27.15 Ventilator Service Agreement

A ventilator service agreement may be prior authorized for a client who owns their own ventilator, when documentation supports medical necessity/appropriateness for continued ventilator usage.

A ventilator service agreement requires prior authorization, which must include submission of a completed Title XIX form and the ventilator service agreement. The completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must include all ventilator settings.

The completed, signed, and dated Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and the Ventilator Service Agreement form must be maintained by the provider and the prescribing physician in the client's medical record.

A ventilator service agreement may be reimbursed only once per month.

Use procedure code 9-A9900 when requesting the ventilator service agreement.

The client-owned ventilator must be functional at the time of the request for prior authorization and documentation must include the make, model number, serial number, and the date of ventilator purchase and all ventilator settings.

The ventilator service agreement contract may be considered for renewal every six months.

The provider must agree to include all of the following components in the ventilator service agreement:

- Ensure that all routine service procedures as outlined by the ventilator manufacturer are followed.
- Provide all internal filters, external filters, tracheostomy filters, and all ventilator circuits (with the exhalation valve) as a part of the ventilator service agreement.
- Provide a respiratory therapist and back-up ventilator on a 24-hour call basis.

- Provide monthly home visits by a certified respiratory therapist to verify proper functioning of the ventilator system and the client's status. The provider must maintain documentation on monthly visits.
- Provide a substitute ventilator while the manufacturer's recommended preventive maintenance is being performed on the client-owned ventilator.

Requests for a continued six-month authorization of a ventilator service agreement must include the above documentation and the following:

- The recommended preventive maintenance schedule for the ventilator make and model.
- Documentation of the monthly ventilator/client assessments.
- Documentation of all service performed during the previous service agreement.

24.5.27.16 Oxygen Therapy

Oxygen therapy is defined as supplemental oxygen administration for the purpose of relieving hypoxemia and preventing damage to the tissue cells as a result of oxygen deprivation.

All oxygen therapy and related equipment requires prior authorization.

Oxygen therapy home delivery systems may be reimbursed for rental only once per month.

Multiple oxygen delivery systems (e.g., liquid or gas) will not be authorized concurrently.

Moisture exchangers for use with non-mechanically ventilated clients may be considered for reimbursement when billed with procedure code 9-A9900.

Rental of oxygen equipment includes all supplies and refills.

Supplies and refills may be prior authorized for those clients that own their own oxygen systems.

One of the following clinical indications should be present when requesting approval for in-home oxygen therapy:

- Bronchopulmonary dysplasia and other respiratory diagnoses due to prematurity.
- Respiratory failure or insufficiency.
- Musculoskeletal weakness, such as that caused by Duchenne's or spinal muscle atrophy.
- Cluster headaches.
- Hypoxemia-related symptoms and findings that might be expected to improve with oxygen therapy (examples of these symptoms and findings are pulmonary hypertension, recurring congestive heart failure due to chronic corpumonale, erythrocytosis, impairment of the cognitive process, nocturnal restlessness, and morning headache).
- Severe lung disease, such as COPD, diffuse interstitial lung disease, whether known or unknown etiology such as cystic fibrosis, bronchiectasis or widespread pulmonary neoplasm.

Note: *In addition to the completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form, a Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy form must be completed by the physician familiar with the client and submitted by the provider.*

24.5.27.17 Initial Oxygen Therapy Medical Necessity Certification

Authorization of home oxygen therapy for the initial period of three months will be granted if the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and the Medicaid Certificate of Medical Necessity for CPAP or BiPAP or Oxygen Therapy form is completed and all of the following conditions are met:

- Symptoms have a duration of at least three months (or less with special circumstances).
- For clients under 21 years of age one of the following parameters must be used:
  - An oxygen saturation of 89 to 92 percent, taken at rest, breathing room air.
  - An oxygen saturation less than 92 percent with documentation of medical necessity provided by a physician familiar with the client.
- An arterial PO2 at or below 56 mm Hg, or an arterial oxygen saturation at or below 89 percent, taken at rest, breathing room air, or during sleep and associated with signs or symptoms reasonably attributed to hypoxemia.
- Hypoxemia associated with obstructive sleep apnea must be unresponsive to CPAP or BiPAP therapy before oxygen therapy can be approved. In these cases, coverage is provided only for use of oxygen during sleep, and then only one type of delivery system will be considered a benefit under the Home Health Services Program.
- Portable oxygen systems are considered a benefit of the Home Health Services Program when the medical documentation indicates that the client requires the use of oxygen in the home and would benefit from the use of a portable oxygen system when traveling outside the home environment. Portable oxygen systems are not considered a benefit of the Home Health Services Program when traveling outside the home environment for clients who qualify for oxygen usage based solely on oxygen saturation levels during sleep.
- A client who demonstrates an arterial PO2 at or above 56 mm Hg, or an arterial oxygen saturation at or above 89 percent, during the day while at rest and who subsequently experiences a decreased arterial PO2 of 55 mm Hg or below, or decreased arterial oxygen saturation of 88 percent or below during exercise. In this case supplemental oxygen can be provided if there is

evidence that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the client was breathing room air.

In-home oxygen therapy can be approved for cluster headaches with the documentation of the following clinical indications:

- Neurological evaluation with diagnosis, *and*
- Documented failed medication therapy.

Note: *Lab values are not indicated with this diagnosis.*

24.5.27.18 Oxygen Therapy Recertification

Authorization of oxygen therapy after an initial three-month rental period may be granted with the submission of a new completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and a new Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy form and the following:

- Documentation of continued need.
- Documentation of client compliance by the physician familiar with the client.

Note: *The initial Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy Form cannot be used for recertification purposes.*

24.5.27.19 Oxygen Therapy Home Delivery System Types

The oxygen concentrator systems are the preferred (standard) delivery system of in-home oxygen therapy. This type of system concentrates oxygen molecules from the ambient air, generating concentrations of up to 90 to 98 percent.

Use procedure code L-E1390 for the rental of an oxygen concentrator system.

The reimbursement payment for the rental of the procedure code L-E1390 includes, but is not limited to, cannula or mask, tubing, and humidification. These items will not be reimbursed separately.

If other types of oxygen therapy home delivery systems are required, documentation of medical necessity exception must be provided.

Other types of delivery systems include:

- Compressed gas cylinder systems (nonportable tanks) (L-E0424).
- Liquid oxygen reservoir systems (L-E0439).

Note: *The reimbursement for compressed gas cylinder and liquid oxygen reservoir systems includes all of the supplies that are noted in the procedure code description.*

- Portable oxygen systems—Portable oxygen therapy may be authorized if the medical necessity conditions are met, and the medical documentation indicates that the client requires the use of oxygen in the home and would benefit from the use of a portable oxygen system when traveling outside the home environment.
- Portable oxygen systems are not considered a benefit of the Home Health Services Program for clients who qualify for oxygen solely based on blood gas studies obtained during sleep.
- Use procedure codes L-E0431, L-E0434, and L-K0738 when billing for the portable oxygen systems. When procedure code L-K0738 is billed for the same dates of service as procedure code L-E0431, procedure code L-E0431 will be denied.
- Rental of the portable oxygen system includes all supplies and refills. Refills for a client-owned system must be obtained from a DSHS-licensed vendor.

24.5.27.20 Tracheostomy Tubes

A tracheostomy tube fits into a tracheal stoma and is used for those clients who have undergone surgical tracheostomy. The procedure codes and modifiers noted in the following tables may be used when requesting prior authorization for a tracheostomy tube. Prior authorization requests must provide sufficient information to support the determination of medical necessity for the requested item.

A tracheostomy tube may be reimbursed for purchase only and is limited to one per month. Authorization for a tracheostomy tube will be considered with procedure code 9-A7520, 9-A7521, or 9-A7522. Add modifier TF when billing a tracheostomy with specialized functions. Add modifier TG when billing a custom made tracheostomy. The manufacturer's retail pricing information and a physician statement addressing the reason the client cannot use a standard tracheostomy tube are required when requesting prior authorization.

Use procedure code 9-A4623 when requesting prior authorization for the tracheostomy tube inner cannula.

An inner cannula is limited to one per month and will not be prior authorized when a custom manufactured tracheostomy tube (9-A7520-TG or 9-A7521-TG) is requested.

24.5.27.21 Pulse Oximetry

Pulse oximeters are not a benefit of Home Health Services.

Authorization for reimbursement of sensor probes (reusable or disposable) may be considered only for those with a client owned pulse oximeter (e.g., purchased through another source).

Use procedure code 9-A4606 for reimbursement of sensor probes (reusable or disposable).

24.5.27.22 Procedure Codes and Limitations for Respiratory Equipment and Supplies

Procedure Code	Limitations
Nebulizers	
9-A4617	2 per month
9-A7003	2 per month
9-A7004	2 per month

Procedure Code	Limitations
9-A7006	2 per month
9-A7007	2 per month
9-A7011	Every 6 months
9-A7013	1 per month
9-A7015	2 per month
9-A7016	2 per month
9-A7018	4 per month
9-S8101	2 per month
J-E0570	Every 5 years
Ultrasonic Nebulizers	
9-A7009	Every 2 years
9-A7014	1 per year
J-E0575	Every 5 years
Vaporizers	
J-E0605	Every 5 years
Intermittent Positive-Pressure Breathing (IPPB) Device	
L-E0500	4 months per life
Mucous Clearance Valve (i.e., Flutter)	
J-S8185	Every 5 years
Chest Physiotherapy Devices	
9-A7025	Every 5 years
9-A7026	2 per year
J-E0480	Every 5 years
J-E0483	1 per lifetime
L-E0480	1 per month
L-E0481	1 per month
L-E0482	1 per month
L-E0483	1 per month
CPAP/BiPAP	
9-A7034	Every 3 months
9-A7035	Every 6 months
9-A7037	1 per month
9-A7038	Every 6 months
J-E0470	1 per 5 years
J-E0471	1 per 5 years
J-E0561	1 per 5 years
J-E0562	1 per 5 years
J-E0601	Every 5 years
J-K0553	1 per 3 months
J-K0554	2 per month
J-K0555	2 per month
L-E0470	1 per month
L-E0471	1 per month
L-E0561	1 per month
L-E0562	1 per month
L-E0601	1 per month
Home Mechanical Ventilator Equipment	
9-A4481	31 per month
9-A4483	31 per month
9-A4611	Every 5 years
9-A4612	Every 5 years
9-A4613	Every 5 years
9-A4614	2 per year
9-A4623	1 per month
9-A4629	31 per month
9-A7520	1 per month
9-A7520-TF	1 per month
9-A7520-TG	1 per month
9-A7521	1 per month
9-A7521-TF	1 per month
9-A7521-TG	1 per month
9-A7522	1 per month
9-A7522-TF	1 per month
9-A7522-TG	1 per month
9-A7525	4 per month
9-A7526	8 per month
9-L8501	2 per year
J-E0457	Every 5 years
J-E0459	1 per lifetime
J-S8189	Limited per policy
L-E0450	1 per month
L-E0457	1 per month
L-E0459	1 per month
L-E0460	1 per month
L-E0463	1 per month
L-E0464	1 per month
L-E0580	1 per month
Ventilator Maintenance Agreement	
9-A9900	1 per month
Oxygen Therapy	
9-A4615	Every 2 weeks
9-A4616	Every 3 months
9-A4618	4 per month
J-E0565	Every 5 years
J-E1353	1 per year
L-E0424	1 per month
L-E0431	1 per month
L-E0434	1 per month

Procedure Code	Limitations
L-E0439	1 per month
L-E0441	1 per month
L-E0442	1 per month
L-E0443	1 per month
L-E0444	1 per month
L-E0565	1 per month
L-E1390	1 per month
L-K0738	1 per month
Suction Pumps	
9-A4605	10 per month
9-A4624	90 per month
9-A4628	2 per month
9-A7000	4 per month
9-A7002	8 per month
J-E0600	Every 5 years
Miscellaneous	
9-A4606	4 per month
9-A4627	Every 6 months
J-S8999	1 per year
L-E1399	Limited by policy

When procedure code L-K0738 is billed with procedure code L-E0431, procedure code L-E0431 will be denied.

24.5.28 Procedure Codes That Do Not Require Prior Authorization

The procedure codes listed in the following table do *not* require prior authorization for clients receiving services under Home Health Services. Although prior authorization is not required, providers must retain a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form for these clients. For medical supplies not requiring prior authorization, a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form may be valid for a maximum of six months unless the physician indicates the duration of need is less. If the physician indicates the duration of need is less than six months, then a new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is required at the end of the duration of need. It is expected that reasonable, medically necessary amounts will be provided.

Use of these services is subject to retrospective review. This is not an all inclusive list.

Procedure Codes		
Nebulizer Supplies/Equipment*		
9-A4614	9-A4627	9-S8101
J-E0570	J-E0575	L-E0580
Incontinence Supplies**		
9-A4310	9-A4311	9-A4312
9-A4313	9-A4314	9-A4315
9-A4316	9-A4320	9-A4321
9-A4322	9-A4326	9-A4327
9-A4328	9-A4330	9-A4335
9-A4338	9-A4340	9-A4344
9-A4346	9-A4351	9-A4352
9-A4353	9-A4354	9-A4355
9-A4356	9-A4357	9-A4358
9-A4402	9-A4554	9-A5102
9-A5105	9-A5112	9-A5113
9-A5114	9-A5120	9-A5121
9-A5122	9-A5131	

*** Prior authorization is required for certain diagnoses and if limitations are exceeded. Refer to "Nebulizers" on page 24-58**
**** Prior authorization is required for some procedure codes if the maximum limitation is exceeded. Refer to "Incontinence Supplies and Equipment" on page 24-21**

24.5.29 Nutritional (Enteral) Products, Supplies, and Equipment

24.5.29.1 Nutritional Products and Supplies

Enternal nutritional products are those food products that are included in an enteral treatment protocol. They serve as a therapeutic agent for health maintenance and are required to treat an identified medical condition. Nutritional products, supplies, and equipment may be provided in the home under Home Health Services.

Enteral products, including nutritional formulas, food thickener, and related supplies and equipment, are a benefit under Home Health Services for clients 21 years of age and older who require tube feeding as their sole source of nutrition. Prior authorization is required for all enteral products, supplies, related DME, and services provided through Home Health Services. The prior authorization also includes all related accessories and/or supplies. Requests are reviewed for medically necessary amounts based on caloric needs as indicated by the client's physician. Enteral products for clients who can take nutrition by mouth and/or that are used as a supplement will not be prior authorized.

Nutritional products and supplies will not be reimbursed for clients receiving TPN. Any nutritional products and/or supplies are included as part of the reimbursement for TPN. Requests are reviewed for reasonable amounts.

Enteral products for clients who can take nutrition by mouth and/or that are used as a supplement will not be prior authorized.

To avoid unnecessary denials, the physician must provide correct and complete, signed, and dated information, including documentation of the medical necessity of the equipment and/or supplies requested. The physician must maintain documentation of medical necessity in the clients medical record. The requesting provider may be asked for additional information to clarify or complete a request for the nutritional products, supplies, or equipment.

To be reimbursed as a home health benefit:

- The client must be eligible for home health benefits.
- The criteria listed in this policy for the requested supplies/equipment must be met.
- The supplies/equipment requested must be medically necessary.
- Federal financial participation must be available.
- The client's nutritional status would be compromised without the requested enteral nutritional products/supplies/equipment.

Note: *For clients under 21 years of age who do not meet criteria through Home Health Services, products, supplies, and equipment may be considered through CCP.*

The completed, signed, and dated DME Certification and Receipt Form is required before reimbursement can be made for any DME delivered to a client. The certification form must include the name of the item, the date the client received the DME/products/supplies, and the signatures of the provider and the client or primary caregiver. This form must be maintained by the DME provider in the client's medical record.

To request prior authorization for nutritional formula/supplies/equipment, the following documentation must be provided:

- Accurate diagnostic information pertaining to the underlying diagnosis/condition as well as any other medical diagnoses/conditions, including the client's overall health status.
- Diagnosis/condition (including the appropriate ICD-9-CM code).
- A statement from the ordering physician noting that enteral nutritional products are the client's sole source of nutrition.
- Total caloric intake prescribed by the physician.
- Acknowledgement that the client has a gastrostomy or nasogastric tube.
- Necessary product information.

The DME may be considered for prior authorization when criteria for nutritional products are met.

Prior authorization may be given for up to twelve months. Prior authorization may be recertified with documentation supporting ongoing medical necessity for the nutritional products requested.

Comparability will be determined from information provided by the manufacturer of the nutritional products. Documentation must include both the diagnosis indicating the metabolic disorder and the nutritional product which must be for use in metabolic disorders.

24.5.29.2 Enteral Nutritional Products

All enteral nutritional products paid under the Texas Medicaid Program are paid based on units of 100 calories (as documented by the manufacturer) with the appropriate "B" code (as documented by the Statistical Analysis DME Regional Carrier [SADMERC] Product Classification List for Enteral Nutrition in effect at the time) and with the appropriate modifier based on the product's AWP less 10.5 percent (as documented by the Red Book).

It is the provider's responsibility to know the correct "B" code, the correct units of 100 calories, and the modifier for requesting prior authorization and for payment. Supporting documentation for these components must be maintained in the provider's records and be made available upon request by HHSC or TMHP. Payment is based on the lower of billed charges or the Medicaid allowed fee, with the Medicaid allowed fee based on the appropriate "B" code, modifier, and units of 100 calories.

It is the provider's responsibility to know when products are discontinued by the manufacturer, when container sizes change and when names change. Please submit requests for prior authorization and payment accordingly.

The Palmetto GBA SADMERC Product Classification List is located on its website (www.palmettogba.com).

Procedure Codes		
9-B4100 No modifier required	9-B4150 with modifiers U2, U3, U4, U5	9-B4152 with modifiers U2, U3, U6
9-B4153 with modifiers U5, U6, U7, U8, U9	9-B4154 with modifiers U1, U2, U3, U4, U5, U6, U7, U8, U9, UA, UB, UC, UD	9-B4155 with modifiers U2, U3, U4, U5, U8, UC
9-B4157 No modifier required		

Modifier	Fee Per Unit
U1	$0.30
U2	$0.50
U3	$0.70
U4	$0.85
U5	$1.05
U6	$1.70
U7	$2.00
U8	$2.50
U9	$3.00
UA	$4.00

Modifier	Fee Per Unit
UB	$5.00
UC	$6.00
UD	Manually priced

24.5.29.3 Enteral Feeding Pumps

Enteral feeding pumps with alarms are a benefit of Home Health Services for those clients who require enteral feeding. Enteral feeding pumps with alarms require prior authorization.

The Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form requesting enteral feeding pumps and supplies must be completed, signed, and dated by a physician familiar with the client before requesting prior authorization.

Sole source enteral equipment is a benefit of Home Health Services for clients regardless of age. When enteral nutrition is not the client's sole source of nutrition, enteral equipment is only a benefit for clients under 21 years of age.

Enteral feeding pumps may be leased or purchased with documentation that gravity or syringe feedings have caused complications or are otherwise not indicated. Complications may include, but are not limited to, the following:

- Reflux and/or aspiration.
- Severe diarrhea.
- Dumping syndrome.
- Administration rate of less than 100 ml/hr.
- Blood glucose fluctuations.
- Circulatory overload.
- Gastrostomy/jejunostomy tube used for feeding.

Enteral feeding pumps that have been purchased are anticipated to last a minimum of 5 years and may be considered for replacement when 5 years have passed and/or the equipment is no longer repairable. The DME may then be considered for prior authorization. Replacement of equipment may also be considered when loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent reoccurrence, must be submitted.

In situations where the equipment has been abused or neglected by the client, the client's family, or the caregiver, a referral to the DSHS THSteps Case Management Department will be made by the Home Health Services Prior Authorization Department for clients under 21 years of age. Providers will be notified that the state will be monitoring the client's services to evaluate the safety of the environment for both the client and equipment.

Enteral Supplies

Enteral supplies require prior authorization. Enteral feedings may require some or all the following supplies:

- Needleless syringes, any size.
- Enteral extension tubing.
- Gravity bags/nutritional containers.
- Irrigation syringes (bulb or piston).
- Feeding supply kits-Bolus, pump, and/or gravity.

Syringes without needles are considered reusable for enteral administration of medication. These syringes are limited to eight per month.

Irrigation syringes, bulb or piston, for enteral administration of nutritional products are limited to four per month.

Feeding supply kits are limited to one per day. Gravity bags and pump nutritional containers are included in the feeding supply kits and will not be reimbursed separately.

Sole source enteral feeding supplies are a benefit of Home Health Services for clients regardless of age. When enteral nutrition is not the client's sole source of nutrition, enteral feeding supplies are only a benefit for clients under 21 years of age.

A food scale is payable for clients on specific diets with foods measured in grams (e.g., ketogenic diets). This service requires prior authorization and has a maximum allowable fee of $60.

Medical nutritional products for clients 20 years of age and younger remain a benefit of THSteps-CCP.

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this home health benefit will receive those services through THSteps-CCP.*

The TMHP Home Health Services Prior Authorization Department will not issue authorization of enteral products/supplies/equipment if the client is receiving TPN/hyperalimentation. TPN/Hyperalimentation is reimbursed as a daily global fee to cover visits by an RN for teaching and monitoring the client, customary and routine laboratory work, and enteral supplies and equipment.

Refer to: "In-Home Total Parenteral (TPN)/ Hyperalimentation Supplier" on page 27-1.

Nasogastric and Gastrostomy/Jejunostomy Tubes

Nasogastric feeding tubes require prior authorization. Additional devices may be reimbursed if documentation submitted indicates medical necessity.

Nonobturated gastrostomy/jejunostomy tubes will be limited to two per year. Additional tubes may be reimbursed if documentation submitted indicates medical necessity, such as infection at gastrostomy site, leakage or occlusion. Obturated gastrostomy tube replacements are performed in the physicians office or outpatient setting and are not a benefit of Home Health Services.

24.5.30 Limitations, Exclusions

Payment cannot be made for any service, supply or equipment for which FFP is not available.

For clients who are younger then 21 years of age and who are eligible to receive THSteps services, refer to "THSteps-Comprehensive Care Program (CCP)" on page 43-33 to find which of these items are a benefit for THSteps-CCP.

Home Health Services does not cover the following:

- Adaptive strollers, travel seats, push chairs, car seats.
- Administration of non-FDA-approved medications/treatments or the supplies and equipment used for administration.
- Aids for daily living, such as toothpaste, spoons, forks, knives, and reachers.
- Allergy injections.
- Any services, equipment, or supplies furnished to a client who is a resident of a public institution or a client in a hospital, SN facility, or intermediate care facility.
- Any services or supplies furnished to a client before the effective date of Medicaid eligibility as certified by HHSC or after the date of termination of Medicaid eligibility.
- Any services or supplies furnished without prior approval by TMHP, except as listed.
- Any supplies or equipment used in a physician's office, or inserted by a physician (for example, low profile gastrostomy tube).
- Apnea monitors.
- Blood products (the administration or the supplies and equipment used to administer blood products).
- Cardiac telemetry monitoring.
- Chemotherapy administration or the supplies and equipment used to administer chemotherapy.
- Developmental therapy.
- Diapers and wipes for clients younger than 4 years of age.
- Drugs or biologicals (except as specifically provided for in this manual).
- Dynamic Orthotic Cranioplasty (DOC).
- Environmental equipment, supplies, or services, such as room dehumidifiers, air conditioners, heater/air conditioner filters, space heaters, fans, water purification systems, vacuum cleaners, treatments for dust mites, rodents, and insects.
- Homemaker services. Clients requiring this type of care should contact their local DSHS office for information about community-based programs for PHC, day activities, or other related services.
- Home whirlpool baths, spas, home exercisers/gym equipment, hemodialysis equipment, safety wall rails, toys/therapy equipment.
- Inpatient rehabilitation.
- Medical social services.
- Mental health psychiatric services.
- Nursing visits to administer long-term SQ/SC, IM, oral, or topical medications, such as insulin, vitamin B_{12}, or deferoxamine, or to set up medications such as prefill insulin syringes or medication boxes, on a long-term basis.
- Nutritional counseling.
- Orthotics, braces, prosthetics including but not limited to voice prosthetic, and artificial larynx.
- Parapodiums.
- Pneumocardiograms.
- PDN services.
- Respite care (caregiver relief).
- Seat lift mechanisms and seat lift chairs.
- Services payable by any health, accident, other insurance coverage, or by a private or other governmental benefit system or legally liable third party resource.
- Shipping, freight, delivery travel time.
- SN visits when:
  - The medication is not considered medically necessary to the treatment of the individual's illness or is not FDA-approved.
  - The administration of medication exceeds therapeutic frequency or duration by accepted standards of medical practice.
  - A medical reason does not prohibit the administration of the medication by mouth.
  - The client, a primary caregiver, a family member, and/or neighbor has previously been taught to administer SQ/SC, IM and IV injections medications and has demonstrated competency.
  - The purpose of the visit is to administer chemotherapeutic agents or blood products.
- Speech therapy.
- Structural changes to homes, domiciles, or other living arrangements.
- Vehicle mechanical and/or structural modifications, such as wheelchair lifts.
- Visits made primarily for performing housekeeping services are not considered a benefit of the Home Health Services Program. These requests should be referred to in-home and family support service at HHSC.

Refer to: "Texas Medicaid Program Limitations and Exclusions" on page 1-19.

24.6 Medicaid Relationship to Medicare

24.6.1 Possible Medicare Clients

It is the provider's responsibility to determine the type of coverage (Medicare, Medicaid, or private insurance) that the client is entitled to receive.

Home health providers should follow these guidelines:

- Clients younger than 65 of age years without Medicare Part A or B:
  - If the agency erroneously submits a SOC notice to Medicare and does not contact TMHP for authorization, TMHP does not assume responsibility for any services provided before contacting TMHP. The SOC date is no more than three business days before the date the agency contacts TMHP. Visits made before this date are not considered a benefit of the Home Health Services Program.
- Clients older than 65 years of age without Medicare Part A or Part B and clients with Medicare Part A or B regardless of age:
  - In filing home health claims, home health providers may be required to obtain Medicare denials before TMHP can approve coverage. When TMHP receives a Medicare denial, the SOC is determined by the date the agency requested coverage from Medicare. If necessary, the 95-day claims filing deadline is waived for these claims, provided TMHP receives notice of the Medicare denial within 30 days of the date on the denial letter from Medicare.
  - If the agency receives a Medicare denial letter and continues to visit the client without contacting TMHP by telephone, mail, or fax within 30 days from the date on the denial letter from Medicare, TMHP will provide coverage only for services provided from the initial date of contact with TMHP. The SOC date is determined accordingly. TMHP must have the Medicare Remittance Notice and final review decision letter before considering the request for authorization.

24.6.2 Benefits for Medicare/Medicaid Clients

For eligible Medicare/Medicaid clients, Medicare is the primary coinsurance and providers must contact Medicare first for authorization and reimbursement. Medicaid pays the Medicare deductible on Part B claims for qualified home health clients. Home health service authorizations may be given for HHA services, certain medical supplies, equipment, or appliances suitable for use in the home in one of the following instances:

- When an eligible Medicaid client (enrolled in Medicare) who does not qualify for home health services under Medicare because SN care, PT, or OT are not a part of the client's care.
- When the medical supplies, equipment, or appliances are not a benefit of Medicare Part B and are a benefit of Home Health Services.

Federal and state laws require the use of Medicaid funds for the payment of most medical services only after all reasonable measures have been made to use a client's third party resources or other insurance.

Note: *If the client has Medicare Part B coverage, contact Medicare for authorization requirements and reimbursement. If the service is a Part B benefit, do not contact TMHP for prior authorization. Texas Medicaid will only pay the coinsurance and deductible on the electronic crossover claim.*

TMHP will not authorize or reimburse the difference between the Medicare payment and the retail price for Medicare Part B eligible clients.

Refer to: "Third Party Resources (TPR)" on page 4-14.

24.6.3 Medicare/Medicaid Authorization

Contact TMHP for authorization of Medicaid services (based on medical necessity and benefits of Home Health Services) within 30 days of the date on the Medicare final denial letter.

Note: *For MQMB clients, do not submit authorization requests to TMHP if the Medicare denial reason states "not medically necessary." Medicaid only will consider authorization requests if the Medicare denial states "not a benefit" of Medicare.*

Qualified Medicare Beneficiaries (QMB) are not eligible for Medicaid benefits. The Texas Medicaid Program is only responsible for premiums, coinsurance, and/or deductibles on these clients. Providers should not submit prior authorization requests to the TMHP Home Health Services Prior Authorization Department these clients.

24.6.4 Medicare/Medicaid Authorization and Reimbursement

To ensure Medicare benefits are used first in accordance with Texas Medicaid Program regulations, the following procedures apply when requesting Medicaid authorization and payment of home health services for clients.

Contact TMHP for authorization of Medicaid services (based on medical necessity and benefits of Home Health Services) within 30 days of the date on the Medicare final denial letter. Fax a copy of the original Medicare final denial letter and the Medicare appeal review letter to the TMHP Home Health Services Prior Authorization Department for prior authorization.

A Medicare denial letter is not required when a client is eligible for Medicare/Medicaid and needs HHA visits only. However, a skilled supervisory nursing visit must be made on the same day as the initial HHA visit and at least every 60 days (on the same day a HHA visit is made) thereafter as long as no skilled need exists. A SN supervisory visit is reimbursable, but an SN visit made for the primary purpose of assessing a client's nursing care is not.

The SOC date will be the date of the first requested Medicare home health services visit as listed on the original Medicare denial letter.

Note: *Claims for STAR+PLUS MQMB clients (those with Medicare and Medicaid) should always be submitted to TMHP as noted on these pages. The STAR+PLUS health plan is not responsible for these services if Medicare denies the service as not a benefit.*

When the client is older than 65 years of age or appears otherwise eligible for Medicare such as blind and disabled, but has no Part A or Part B Medicare, the TMHP Home Health Services Prior Authorization Department uses regular prior authorization procedures. In this situation, the claim is held for a midyear status determined by HHSC. The maximum length of time a claim may be held in a "pending status" for Medicare determination is 120 days. After the waiting period, the claim is paid or denied. If denied, the EOB code on the R&S report indicates that Medicare is to be billed.

Refer to: "Home Health Skilled Nursing Services" on page 24-9.

24.7 Prohibition of Medicaid Payment to Home Health Agencies Based on Ownership

Medicaid denies home health services claims when TMHP records indicate that the physician ordering treatment has a significant ownership interest in, or a significant financial or contractual relationship with, the nongovernmental home health agency billing for the services. Federal regulation Title 42 CFR §424.22 (d) states that "a physician who has a significant financial or contractual relationship with, or a significant ownership in a nongovernmental home health agency may not certify or recertify the need for home health services care services and may not establish or review a plan of treatment."

A physician is considered to have a significant ownership interest in a home health agency if either of the following conditions apply:

- The physician has a direct or indirect ownership of five percent or more in the capital, stock, or profits of the home health agency.
- The physician has an ownership of five percent or more of any mortgage, deed of trust, or other obligation that is secured by the agency, if that interest equals five percent or more of the agency's assets.

A physician is considered to have a significant financial or contractual relationship with a home health agency if any of the following conditions apply:

- The physician receives any compensation as an officer or director of the home health agency.
- The physician has indirect business transactions, such as contracts, agreements, purchase orders, or leases to obtain services, supplies, equipment, space, and salaried employment with the home health agency.
- The physician has direct or indirect business transactions with the home health agency that, in any fiscal year, amount to more than $25,000 or five percent of the agency's total operating expenses, whichever is less.

When providing CCP services and general home health services, the provider must file these on two separate UB-04 CMS-1450 forms with the appropriate prior authorization number, and should send them to the appropriate address.

Claims denied because of an ownership conflict will continue to be denied unless the home health agency submits documentation indicating that the ordering physician no longer has a significant ownership interest in, or a significant financial or contractual relationship with, the home health agency providing services. Documentation should be sent to TMHP Provider Enrollment at the address indicated in "Written Communication with TMHP" on page xi.

24.8 Claims Information

Use only type of business (TOB) 331 in Form Locator (FL) 4 of the UB-04 CMS-1450. Other TOBs are invalid and result in claim denial.

Home Health services must be submitted to TMHP in an approved electronic format or on a CMS-1500 or a UB-04 CMS-1450 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 claim form. Providers may purchase UB-04 CMS-1450 and CMS-1500 claim forms from the vendor of their choice. TMHP does not supply them.

When completing a CMS-1500 or a UB-04 CMS 1450 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

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

"Claims Filing" on page 5-1 for general information about claims filing.

"UB-04 CMS-1450 Claim Filing Instructions" on page 5-30.

"CMS-1500 Claim Filing Instructions" on page 5-22 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

The prior authorization number must appear on the UB-04 CMS-1450 claim in Block 63 and in Block 23 of the CMS-1500. 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.

24.9 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-22
UB-04 CMS-1450 Claim Filing Instructions	5-30
TMHP Electronic Claims Submission	5-13
Communication Guide	A-1
DME Certification and Receipt Form	B-35
External Insulin Pump	B-39
Medicaid Certificate of Medical Necessity for Chest Physiotherapy Devices (High-Frequency Chest Wall Compression System [HFCWCS]; Intrapulmonary Percussive Ventilation Device [IPV]; Cough-Stimulating Device [Cofflator]-Initial Request)	B-52
Medicaid Certificate of Medical Necessity for Chest Physiotherapy Devices (High-Frequency Chest Wall Compression System [HFCWCS); Intrapulmonary Percussive Ventilation Device [IPV]; Cough-Stimulating Device [Cofflator]-Extended Request)	B-53
Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions (2 Pages)	B-42
Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form	B-44
Home Health Services Plan of Care (POC)	B-46
Home Health Services Plan of Care (POC) Instructions	B-47
Home Health Services Prior Authorization Checklist	B-48
Wheelchair Seating Evaluation Form (THSteps-CCP/Home Health Services) (next six pages)	B-117
Home Health Services DME/Medical Supplies Claim Example	D-16
Home Health Services SN Visit Claim Example	D-16
Home Health Services SN Visit and Physical Therapy Claim Example	D-17
Acronym Dictionary	F-1

Section

25

Hospital (Medical/Surgical Acute Care Facility)

25.1 General Information

25.1.1 Introduction

The information in this section is intended for traditional Texas Medicaid Program hospital (medical/surgical acute care facility) providers. The section provides information about the Texas Medicaid Program's benefits, policies, and procedures applicable to acute care hospitals in the inpatient and outpatient setting.

Note: *Although Medicaid Managed Care providers must provide all medically necessary Medicaid-covered services to eligible clients, these providers must refer to the respective health plan documentation for specific information about hospital services, claims filing, etc.*

Refer to: "PCCM" on page 7-23.

While this section contains some claims filing and appeals information, hospitals should continue to refer to "Claims Filing" on page 5-1 and "Appeals" on page 6-1 for more comprehensive information about these subjects. An effort has been made to provide comprehensive information about hospital services in this section; however, hospital providers are encouraged to review other sections of the manual for specific requirements for special programs such as the Texas Health Steps-Comprehensive Care Program (THSteps-CCP) and other pertinent material impacting health-care providers rendering care in the hospital setting.

Refer to: "Procedure Codes Requiring Prior Authorization" on page 36-140 for a list of procedures requiring prior authorization. Also, review the index and individual sections for other information about prior authorization requirements.

25.1.2 Provider Cost and Reporting

The method of determining reasonable cost is similar to that used by Title XVIII (Medicare). Hospitals must include inpatient and outpatient costs in the cost reports submitted annually. The provider must prepare one copy of the applicable Centers for Medicare & Medicaid Services (CMS) Cost Report Form.

If a change of ownership or provider termination occurs, the cost report is due within five months after the date of the change in ownership or termination. Any request for an extension of time to file should be made on or before the cost report due date and sent to TMHP Medicaid Audit at the address indicated under "Written Communication with TMHP" on page xi. For questions or assistance call TMHP Medicaid Audit at 1-512-514-3648.

Annual cost reports must be filed as follows:

- Submit one copy of the cost report to TMHP Medicaid Audit within five months of the end of the hospital's fiscal year along with any amount due to the Texas Medicaid Program.
- TMHP Medicaid Audit performs a desk review of the cost report and makes a tentative settlement with the hospital. A tentative settlement letter requests payment for any balance due to the Texas Medicaid Program or instructs TMHP to pay the amount due to the provider. Interim payment rates are changed at this time based on the cost report.
- Field audits are conducted when necessary.
- Medicaid final settlement is made after a copy of all the following information is received from the provider or the Medicare intermediary:
  - Audited or settled without audit Medicare Cost Report.
  - Medicare Notice of Amount of Program Reimbursement.
  - Medicare Audit Adjustment Report, if applicable.

Medicaid hospitals may request copies of their claim summaries for their cost reporting fiscal year. The summaries for tentative settlements include three additional months of claim payments for the fiscal year. The summaries for final settlements include ten months of claim payments for the fiscal year. TMHP Medicaid Audit uses this data to determine the tentative and final settlements and interim rates.

The Medicaid claim summary data are only generated once each month, and the logs are received by the 15th of the following month. Requests for tentative settlement logs are submitted within 30 days after the fiscal year-end. Final settlement log requests are submitted within nine months after the fiscal year-end.

The Medicaid logs can be requested through the provider's administrator account on the TMHP website at www.tmhp.com. Medicaid logs can also be requested by calling 1-512-506-6117 or by sending a written request to the following address:

Texas Medicaid & Healthcare Partnership
Medicaid Audit
PO Box 200345
Austin, TX 78720-0345

Allow 45 days for receipt of these logs.

25.1.3 Third Party Liability Reporting

Hospitals and providers enrolled in the Texas Medicaid Program are required to inform TMHP about circumstances that may result in third party liability for health-care claims. After receiving this information, TMHP pursues reimbursement from responsible third parties.

Hospitals and providers should mail or fax the Tort Response Form for accidents and Other insurance Form for Health Insurance to the following address:

Texas Medicaid & Healthcare Partnership
TPR Correspondence
Third Party Resources Unit PO Box 202948
Austin, TX 78720-9981
Fax: 1-512-490-4666

Refer to: "Third Party Resources (TPR)" on page 4-14 for more information.

Refer to: "Tort Response Form" on page B-113.
"Other Insurance Form" on page B-64.

25.1.4 Medicaid Relationship to Medicare

The Texas Medicaid Program makes coinsurance and deductible payments on valid, assigned Part A (hospital) and Part B (medical) Medicare claims.

Exception: *If the Medicare payment amount equals or exceeds the Medicaid payment rate, HHSC is not required to pay the Medicare Part A and/or Part B deductible/coinsurance/copay on a crossover claim.*

The Texas Medicaid Program provides 30 inpatient benefit days per spell of illness. When the 30 days coincide with the first 30 days of the Medicare benefit period and the client is eligible for *both* Medicare and Medicaid, the Texas Medicaid Program pays the:

- Inpatient hospital deductible under Medicare Part A.
- Medicare Part A deductible for the first three pints of whole blood or packed red cells.

When the client only has Medicare Part B coverage, the hospital must follow these guidelines:

- Submit to Medicare the charges for certain inpatient ancillary services on a Medicare Claim Form 1483 for payment under the client's Part B coverage. The ancillary charges include the following:
  - Diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests.
  - X-ray, radium, and radioactive isotope therapy, including materials and services of technicians.
  - Surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations.
  - Prosthetic devices (other than dental) that replace all or part of an internal body organ or member (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ or member including replacement or repairs of such devices (e.g., cardiac pacemakers, breast prostheses, maxillofacial devices, colostomy bags, and prosthetic lenses).
  - Leg, arm, back and neck braces, and artificial legs, arms, and eyes, including replacements and adjustments (if required) because of a change in the client's physical condition.
  - Physical therapy (PT) services.
  - Speech pathology services.
  - Dialysis treatments.
- Submit to TMHP the remaining Part A charges on a UB-04 CMS-1450 claim form (or its electronic equivalent) indicating in Block 80 that the client is eligible for Medicare Part B benefits only. The client's health insurance claim (HIC) number must appear on the Medicaid claim in Block 80. TMHP *must* receive these charges within 95 days of the last date of service on the claim.

Refer to: "Medicare Crossover Reimbursement" on page 2-7 for more information.

25.1.5 Nursing Facility Admission

The revised Client Assessment, Review, and Evaluation (CARE) Form 3652-A must be used for admissions to a nursing facility. There are instances in which hospital social workers and/or discharge nurses complete the CARE forms 3652-A, such as:

- If the client is in a long-term care acute center (LTAC).
- If the potential receiving nursing facility (NF) desires a better clinical picture of the client, a paper copy of the CARE form 3652-A is completed by the hospital staff before the client is accepted for admission into the nursing facility.

To order new forms, specify that the order is for the CARE Form 3652-A and mail the request to the following address:

Texas Department of Aging and Disability Services
PO Box 149030 (MC E-205, Provider Forms)
Austin, TX 78714-9030
Fax: 1-512-490-4666
www.dads.state.tx.us/handbooks
/mpm-ltcf/5000/5720.htm

25.1.6 Authorizations

All supporting documentation must be included with a request for authorization. Send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

25.2 Inpatient

25.2.1 Enrollment

To be eligible to participate in the Texas Medicaid Program, a hospital must be certified by Medicare, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process.

All providers of laboratory services must comply with the rules and regulations of the *Clinical Laboratory Improvement Amendments* (CLIA). Providers not complying with CLIA will not be reimbursed for laboratory services.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to*

provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

"Clinical Laboratory Improvement Amendments (CLIA)" on page 26-2 for more information about CLIA.

25.2.1.1 Hospital Eligibility Through Change of Ownership

Under procedures set forth by CMS and the U.S. Department of Health and Human Services (HHS), a change in ownership of a hospital does not terminate Medicare eligibility; therefore, Medicaid participation may be continued if the hospital obtains recertification as a Title XVIII (Medicare) hospital and a new Title XIX (Medicaid) agreement between the hospital and HHSC.

To obtain the Medicaid hospital participation agreement, call the TMHP Contact Center at 1-800-925-9126, Monday through Friday, 7 a.m. to 7 p.m, Central Standard Time.

25.2.1.2 Psychiatric Hospital/Facility (THSteps-CCP)

Refer to: "Psychiatric Hospital/Facility (Freestanding) (THSteps-CCP Only)" on page 43-83 for enrollment and other program information.

25.2.1.3 Hospital Ambulance

A hospital supplying ambulance services must enroll s*eparately* from the hospital.

Refer to: "Enrollment" on page 8-2 for ambulance enrollment requirements.

25.2.1.4 Certified Registered Nurse Anesthetist (CRNA) Services

CRNAs must enroll and bill according to the instructions given in "Certified Registered Nurse Anesthetist (CRNA)" on page 15-1. Hospitals *cannot* bill for CRNA services using their provider identifier.

25.2.1.5 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with Medicaid Managed Care to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

Refer to: "Medicaid Managed Care" on page 7-4 for more information.

25.2.1.6 Hospital Transplant Centers

Hospital providers can refer to "Enrollment" on page 25-4 for enrollment and other related information.

25.2.2 Reimbursement

Fee schedules for all services in this chapter are available on the TMHP website at www.tmhp.com/file library /file library/fee schedules.

25.2.2.1 Prospective Payment Methodology

Inpatient hospital stays except in children's hospitals and psychiatric facilities (THSteps-CCP) are reimbursed according to a prospective payment methodology based on diagnosis-related groups (DRGs). The reimbursement method itself does not affect inpatient benefits and limitations. Inpatient admissions must be medically necessary and are subject to the Texas Medicaid Program's utilization review (UR) requirements.

The DRG reimbursement includes all facility charges (for example, laboratory, radiology, and pathology). Hospital-based laboratories and laboratory providers who deliver referred services outside the hospital setting must obtain reimbursement for the technical portion from the hospital. The technical portion includes the handling of specimens and the automated or technician-generated reading and reporting of results. The technical services are not billable to Texas Medicaid clients.

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

Prior authorization is not required for psychiatric admissions to acute care hospitals for reimbursement; however, admissions must be medically necessary and are subject to retrospective UR by HHSC.

Reimbursement to acute care hospitals for inpatient services is limited to $200,000 per client, per benefit year (November 1 through October 31). Claims may be subject to retrospective review, which may result in recoupment.

This limitation does not apply to services related to certain organ transplants or services to THSteps clients when provided through CCP.

In accordance with legislative direction included in the 2006-2007 *General Appropriations Act* (Article II, Section 49, S.B. 1, 79th Legislature, Regular Session, 2005), a rate reduction will be applied to inpatient hospital services rendered to non-Medicare Supplemental Security Income (SSI) and SSI-related Medicaid clients. The rate reduction will affect hospital providers within the Bexar, Dallas, El Paso, Lubbock, Tarrant, Nueces, Harris, and Travis service areas that are reimbursed by DRG.

Effective September 1, 2007, a hospital that is either located in a county with 50,000 or fewer persons, is a Medicare-designated rural referral center (RRC) or sole community hospital (SCH) that is not located in a metropolitan statistical area (MSA) as defined by the U.S. Office of Management and Budget, or is a Medicare-designated critical access hospital (CAH), will be reimbursed the greater of the prospective payment system rate or a cost-reimbursement methodology authorized by the *Tax Equity and Fiscal Responsibility Act* of 1982 (TEFRA) using the most recent data.

A new provider is given a reimbursement inpatient interim rate of 50 percent until a cost audit has been performed. A default standard dollar amount (SDA) rate is assigned for newly enrolled providers or newly constructed facilities.

Payment is calculated by multiplying the SDA for the hospital's payment division indicator times the relative weight associated with the DRG assigned by Grouper.

Refer to: "Children's Hospitals" on page 25-7.

"Psychiatric Hospital/Facility (Freestanding) (THSteps-CCP Only)" on page 43-83 for more reimbursement information.

25.2.2.2 Client Transfers

When more than one hospital provides care for the same client, the hospital providing the most significant amount of care receives consideration for a full DRG payment. The other hospitals are paid a per diem rate based on the lesser of the mean length of stay for the DRG or eligible days in the facility. Services must be medically necessary and are subject to the Texas Medicaid Program's UR requirements.

HHSC performs a postpayment review to determine if the hospital providing the most significant amount of care received the full DRG. If the review reveals that the hospital providing the most significant amount of care did not receive the full DRG, an adjustment is initiated.

Client transfers within the same facility are considered one continuous stay and receive only one DRG payment. The Texas Medicaid Program does not recognize specialty units within the same hospital as separate entities; therefore, these transfers must be billed as one admission under the provider identifier. Readmissions to the same facility within 24 hours of a previous acute hospital or facility discharge are also considered one continuous stay and receive only one DRG payment.

Readmissions are considered a continuous stay regardless of the original or readmission diagnosis. The modifier PT may appear on the provider's Remittance and Status (R&S) report to indicate that the DRG payment was calculated on a per diem basis for an inpatient stay because of patient transfer. Admissions billed inappropriately are identified and denied during the UR process and may result in intensified review.

Note: *To ensure correct payor identification, providers that receive transfer patients from another hospital must enter the actual date that the client was admitted into each facility in Block 12 on the UB-04. Inpatient authorization requirements are based on the requirements that are specified by the program in which the client is enrolled on the date of the original admission. Providers must adhere to the authorization requirements for claims to be considered for reimbursement. Providers are reimbursed at the rate in effect on the date of admission.*

25.2.2.3 Observation Status to Inpatient Admission

When a client's status changes from observation to inpatient admission, the date of the inpatient admission is the date the client was placed on observation status. This rule always applies regardless of the length of time the client was in observation (less than 24 hours) or whether the date of inpatient admission is the following day. All charges including the observation room are billed on the inpatient claim (type of bill [TOB] 111).

25.2.2.4 Outliers

TMHP makes outlier payment adjustments to DRG hospitals for admissions that meet the criteria for exceptionally high costs or exceptionally long lengths of stay for clients younger than 21 years of age as of the date of the inpatient admission. If a client's admission qualifies for both a day and a cost outlier, the outlier resulting in the higher payment to the hospital is paid. The R&S report reflects the outlier reimbursement payment and defines the type of outlier paid.

Day Outliers

The following criteria must be met to qualify for a day outlier payment. Inpatient days must exceed the DRG day threshold for the specific DRG. Additional payment is based on inpatient days that exceed the DRG day threshold multiplied by 70 percent of the per diem amount of a full DRG payment. The per diem amount is established by dividing the full DRG payment amount by the arithmetic mean length of stay for the DRG.

Hospitals should use the following formula to calculate the day outliers. To calculate the day outlier payment amount, the number of outlier days must first be determined:

Number of Days Allowed-DRGs Threshold = Outlier Days

$$\frac{\text{SDA x DRG relative weight}}{\text{(Divided by) Mean length of stay}} \times \text{Outlier Days} \times 0.70 = \text{Day outlier amount}$$

Cost Outliers

To establish a *cost outlier,* TMHP determines the outlier threshold by using the full DRG payment amount multiplied by 1.5 *or* an amount determined by selecting the lesser of the universal mean of the current base year data multiplied by 11.14 *or* the hospital's SDA multiplied by 11.14. The calculation that yields the amount is used in calculating the actual cost outlier payment. The outlier threshold is subtracted from the amount of reimbursement for the admission established under TEFRA principles, and the remainder multiplied by 70 percent to determine the actual amount of the cost outlier payment.

Hospitals should use the following formulas to calculate the day outliers for dates of admission on or after September 1, 2002. Effective September 1, 2002, (date of admission) the Universal Mean is $3,328.89.

To calculate the cost outlier amount, the cost threshold must first be determined. Three calculations and two comparisons are necessary:

A) 11.14 x Universal Mean ($3,328.89) = $37,083.83

B) 11.14 x SDA = _____Comparison 1: Take lesser of number A or B.

C) 1.5 x DRG Relative Weight X SDA = _____ Comparison 2: Greater of number C and Comparison 1 is the cost threshold

Allowed amount x reimbursement rate = _____

Result of A minus cost threshold = _____

Result of B x0.70 = cost outlier amount

25.2.2.5 Children's Hospitals

Inpatient hospital stays in designated children's hospitals are reimbursed according to the TEFRA reimbursement principles on a reasonable cost basis. Designated children's hospitals are reimbursed on a percentage of the hospital's standard charges derived from the hospital's most recent tentative or final Medicaid cost report settlement.

To be designated as a children's hospital, the hospital must have a provider agreement with Medicare and be engaged in delivering services to patients who are predominantly younger than 18 years of age. A designated children's hospital is excluded from the Medicare/Medicaid prospective payment system per 42 *Code of Federal Regulations* (CFR) (Subsection) 412.23.

Note: *Children's hospitals that are reimbursed according to the TEFRA 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.*

25.2.2.6 Hospital Transplant Center Approval

In-State Facility Approval Process

All facilities choosing to participate in the Texas Medicaid Transplant Program will be monitored and approved by HHSC. The transplant facility should be approved by Medicare as a transplant center before applying to the Texas Medicaid Program unless the transplant facility is in a designated Children's Hospital. The Texas Medicaid Program will not reimburse for transplants in the hospitals that do not have current approval by HHSC. Exception(s) may be considered if the transplant type is not available in Texas.

All transplant facilities who wish to perform organ transplants for clients of the Texas Medicaid Program must have current certification and be in continuous compliance with the criteria set forth by the Organ Procurement and Transportation Network (OPTN) criteria, receive certification from the United Network for Organ Sharing (UNOS) or the National Marrow Donor Program (NMDP). The Texas Medicaid Program does not approve or reimburse transplants in facilities that are not certified and in "good standing" with these credentialing organizations.

Those facilities whose status of "good standing" has been suspended for any reason by the national credentialing bodies will not be approved by the Texas Medicaid Program to provide transplant services until this status has been restored.

The facility must notify HHSC within three working days of any change in compliance or certification status from UNOS and NMDP. Failure to notify HHSC within three working days of any changes in compliance or certification status may result in disapproval of current and pending transplant requests or recoupment of reimbursement. Submit notification information to:

Texas Health and Human Services Commission
1100 West 49th Street, H-310
Austin, TX 78756
Attn: Medicaid/CHIP Benefits–Transplant Facility Approvals

Out-of-State Facilities

The Texas Medicaid Program requires that all transplant facilities requesting approval to perform transplants for Texas Medicaid clients must provide proof of transplant facility certification. HHSC approval is dependent upon compliance with the transplant facility criteria of the OPTN and certification from the UNOS or the NMDP. In order for the Texas Medicaid Program to pay for an out-of-state transplant, the facility and professional providers must be enrolled as Texas Medicaid providers. The out-of state transplant facilities must submit documentation about relevant transplant facility UNOS or NMDP certification as required by HHSC.

Texas licensed physicians may request prior authorization for transplant services to be performed at out-of-state facilities when the:

- Facilities are nationally recognized as Centers of Excellence.
- Required organ transplants are not available in Texas.

- Services are medically necessary, reasonable, and federally allowable.
- The client is enrolled in the Texas Medicaid Program.

25.2.3 Benefits and Limitations

Inpatient hospital services include medically necessary items and services ordinarily furnished by a Medicaid hospital or by an approved out-of-state hospital under the direction of a physician for the care and treatment of patients. The Texas Medicaid Program also reimburses for medically necessary services in the outpatient setting to include day surgery and outpatient observation. Services must be medically necessary and are subject to the Texas Medicaid Program's UR requirements. Services must also be billed to TMHP per Medicaid policy and procedures.

Inpatient hospital services include the following:

- Bed and board in semiprivate accommodations or in an intensive care or coronary care unit including meals, special diets, and general nursing services; and an allowance for bed and board in private accommodations including meals, special diets, and general nursing services up to the hospital's charge for its most prevalent semiprivate accommodations. Bed and board in private accommodations are provided in full if required for medical reasons as certified by the physician. Additionally, the hospital must document the medical necessity for a private room such as the existence of a critical or contagious illness or a condition that could result in disturbance to other patients. This type of information should be included in Block 80 or attached to the claim.
- Whole blood and packed red cells reasonable and necessary for treatment of illness or injury if they are not available without cost.
- Maternity care (includes usual and customary care for all female clients).
- All medically necessary services and supplies ordered by a physician to include laboratory, radiology, and pathology.
- Newborn care (includes routine newborn care, routine screenings, and specialized nursery care for newborns with specific problems).

Circumstances requiring the mother and newborn to remain in the hospital longer than two days for a routine vaginal delivery or four days for a cesarean section must be documented. Continuation of hospitalization is a benefit for the infant when the mother is required to remain hospitalized for medical reasons and must be documented.

If a hospital discharge procedure code (1-99238 or 1-99239) is submitted for reimbursement with the same date of service as an inpatient neonatal critical care procedure code (1-99295 or 1-99296) or a pediatric critical care procedure code (1-99293 or 1-99294), the hospital discharge procedure code is denied and the critical care procedure code is considered for reimbursement.

Take-home drugs, self-administered drugs, or personal comfort items are not benefits of the Medicaid program nor THSteps-CCP, except when received by prescription through the Vendor Drug Program.

Reimbursement to hospitals for inpatient services is limited to the Medicaid spell of illness. The spell of illness is defined as 30 days of inpatient hospital care, which may accrue intermittently or consecutively. After 30 days of inpatient care is provided, reimbursement for additional inpatient care is not considered until the client has been out of an acute care facility for 60 consecutive days.

Exceptions to the spell of illness are the following:

- A prior-approved transplant that is medically necessary because of an emergent, life-threatening condition. This exception allows an additional 30 days of inpatient care that begins with the date of the transplant. For example, if the transplant occurs on the 15th day of an inpatient stay, the additional 30 days would allow a total of 45 days.
- THSteps-eligible clients when a medically necessary condition exists.
- Some Medicaid Managed Care clients. Refer to "Medicaid Managed Care" on page 7-4.

Medicaid reimbursement for services cannot exceed the limitations.

Reimbursement to acute care hospitals for inpatient services is limited to $200,000 per client, per benefit year (November 1 through October 31). Claims are reviewed retrospectively, and payments exceeding $200,000 are recouped. This limitation does not apply to services related to certain organ transplants or services to THSteps clients when provided through CCP.

Note: *Dollar or day limitations are not applicable for clients younger than 21 years of age.*

25.2.3.1 Hysterectomy Services

Medically necessary hysterectomies are reimbursable when the physician obtains an appropriate acknowledgment statement from the client. The Texas Medicaid Program does not reimburse for hysterectomies performed for the sole purpose of sterilization.

The physician's signature acknowledging the client's sterility is not required on the claim. The acknowledgment statement must be maintained in the physician's files and is subject to retrospective review. A modifier, PM or PS, must continue to be submitted on the claim or a copy of the signed certification may be attached to the paper claim.

When TMHP receives a valid acknowledgment statement, the client's eligibility file is updated to reflect receipt. Subsequent claims TMHP receives for the hysterectomy are referenced to the acknowledgment statement.

Refer to: "Hysterectomy Acknowledgment Form" on page B-50.

25.2.3.2 Newborn Services

Eligibility Process

A child is deemed eligible for the Texas Medicaid Program for up to 12 months of age if the mother is receiving Medicaid at the time of the child's birth, the child continues to live with the mother, and the mother continues to be eligible for Medicaid or would be eligible for Medicaid if she were pregnant. Therefore, it is not acceptable for a hospital to require a deposit for newborn care from a Medicaid client. The child's eligibility ends if the mother relinquishes her parental rights or if it is determined that the child is no longer part of the mother's household.

Hospitals should complete the HHSC Form 7484, "Hospital Report (Newborn Child or Children) HHSC Form 7484" on page B-49, to provide information about each child born to a mother eligible for Medicaid. If the newborn's name is known, the name must be on the form. *The use of Baby Boy or Baby Girl delays the assignment of a number.* Filing this form will expedite the assignment of a Medicaid client number for the newborn child. The form should not be completed for stillbirths. The form should be completed by the hospital within five days of the child's birth and should be sent to HHSC at the address identified on the form. The five-day time frame is not mandatory; however, prompt submission expedites the process of determining the child's eligibility. Hospitals should duplicate the form as needed. HHSC, DADS, and TMHP do not supply the forms.

Note: *Providers may call the HHSC Bureau of Vital Statistics at 1-800-452-9115 for details on how to transmit newborn information electronically.*

After receiving a completed form, HHSC verifies the mother's eligibility and within 10 days sends notices to the hospital, mother, caseworker, and attending physician if identified. The notice includes the child's Medicaid client number and the effective date of coverage. After the child has been added to the eligibility file, HHSC issues a Medicaid Identification Form (Form H3087).

Providers should submit address changes to the following address:

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

The attending physician's notification letter is sent to the address on file by license number at the Texas Medical Board. It is imperative the address be kept current to ensure timely notification of attending physicians. Physicians should submit address changes to the following address:

Texas Medical Board
Customer Information, MC-240
PO Box 2018
Austin, TX 78767-2018

Claims submitted for services provided to a newborn child eligible for Medicaid are filed using the newborn child's Medicaid client number.

Note: *When billing for a Medicaid Managed Care client, providers must adhere to the Medicaid Managed Care health plans' guidelines for newborn billing.*

Screening

A newborn hearing screening must be offered to all newborns as part of their newborn hospital stay. This screening procedure is not diagnostic and will not reimburse separately from the usual newborn delivery payment. Special investigations and examination codes are not appropriate for use with hearing screening of infants.

For more information about newborn hearing screening contact:

Department of State Health Services
1100 West 49th Street
Austin, TX 78756-3167
1-512-458-7726
www.dshs.state.tx.us/audio/default.shtm

All newborns who have abnormal screening results should be referred to a local Program for Amplification for Children in Texas (PACT) provider for follow-up care. PACT provides services and hearing aids for children 20 years of age and younger who have permanent hearing loss and are eligible for Medicaid. Obtain a current list of PACT providers at www.dshs.state.tx.us/audio/program.shtm or the following address:

DSHS
PACT Health Screening Branch
1100 West 49th Street, MC-1918
Austin, TX 78756-3199
1-800-252-8023

Refer newborns with suspected genetic disorders or with a positive newborn screening test for a genetic work-up as appropriate.

Refer to: "Genetic Services" on page 22-1.

Hepatitis B Immunizations

Newborns should be given the first dose of hepatitis B vaccine before discharge from the hospital or birthing center. Hepatitis B vaccine for newborns is provided by the Texas Vaccines for Children (TVFC) Program. Hospitals and birthing centers may obtain vaccine at no cost by enrolling in the TVFC Program. For more information on enrolling in the TVFC Program, refer to "Texas Vaccines for Children Program Packet" on page H-8 or call the DSHS Immunization Division toll-free at 1-800-252-9152.

The recommended administration of the hepatitis B vaccine to newborns before discharge from the hospital has been established as the standard of care and should not be considered as a reason to upcode to a different DRG. The reimbursement for the administration of hepatitis B vaccine to newborns is included in the DRG payment. The Texas Medicaid Program will not reimburse for the cost of the vaccine for newborns. Providers must enroll in the TVFC Program to obtain vaccine at no cost.

Consult the vaccine package insert for information on proper administration and dosing.

25.2.3.3 Psychiatric Services

Inpatient admissions for adults and children to acute care hospitals for psychiatric conditions are a benefit of the Texas Medicaid Program. Admissions must be medically necessary and are subject to the Texas Medicaid Program's retrospective UR requirements. The UR requirements are applicable regardless of the hospital's designation of the psychiatric unit versus medical/surgical unit.

Admissions for the single diagnosis of chemical dependency or abuse (such as alcohol, opioids, barbiturates, and amphetamines) without an accompanying medical complication are not a benefit of the Texas Medicaid Program. Additionally, admissions for chronic diagnoses such as mental retardation, organic brain syndrome, or chemical dependency or abuse are not a benefit for acute care hospitals without an accompanying medical complication or medical condition. The UB-04 CMS-1450 claim form must indicate all relevant diagnoses that necessitate the inpatient stay.

Additional coverage may be allowed for clients who are eligible for Medicaid and younger than 21 years of age through THSteps-CCP.

Note: *NorthSTAR is a managed care program in the Dallas service area that covers behavioral health services. Psychiatrists who provide behavioral health services to clients in NorthSTAR must be members of the NorthSTAR behavioral health organization (BHO).*

Refer to: "THSteps-Comprehensive Care Program (CCP)" on page 43-33 for more information.

"Medicaid Managed Care" on page 7-4 for more information or contact the client's BHO.

Providers rendering services to STAR and STAR+PLUS clients must contact the respective managed care plan.

25.2.3.4 Rehabilitation Services

Inpatient rehabilitation services are a benefit of the Texas Medicaid Program when provided in a general acute care hospital setting with an acute condition or an acute exacerbation of a chronic illness in which rehabilitation services are medically necessary in the usual course, treatment, and management of the illness.

All services must be documented as medically necessary and ordered by a physician. When submitting the claim, the hospital must include the physician's written treatment plan supporting the medical necessity of the hospitalization and services.

All rehabilitation services are subject to Medicaid benefit limitations including the spell of illness. Extensions beyond the regular scope of Medicaid may be offered under THSteps-CCP.

Refer to: "Physical Therapists/Independent Practitioners" on page 35-1 for more information.

"Benefits and Limitations" on page 43-72.

25.2.3.5 Organ/Tissue Transplant Services

Prior Authorization

Prior authorization for a transplant is *mandatory* and approved *only* if the physician indicates the transplant will be performed in an approved Texas Medicaid transplant facility. If the facility indicated on the original authorization request is not a Medicaid-approved transplant facility, the physician needs to designate a different approved facility before the authorization is given. Transplant facilities are reviewed for approval each year. TMHP issues prior authorizations for dates within the facility approval period.

Note: *If the client is a Medicaid Managed Care client, all prior authorizations for transplants will need to be obtained from the client's health plan.*

If the transplant has not been performed by the end of the authorization period, physicians need to apply for an extension. Fax inquiries for authorization extensions to TMHP Special Medical Prior Authorization at 1-512-514-4213. Prior authorization is required for the following services (this noninclusive list is subject to change):

- Stem cell transplant.
- Heart transplant.
- Single lung transplant with bronchial anastomosis.
- Double sequential lung transplant with bilateral bronchial anastomosis.
- Combined heart/lung transplant.
- Liver transplant.
- Kidney transplant.

The prior authorization number (PAN) must be entered in Block 63 (Treatment Authorization Code) of the UB-04 CMS-1450 claim form.

Cornea transplants do not require prior authorization.

Documentation supplied with the prior authorization request should include a complete history and physical, a statement of the client's current medical problems and status, and meet the criteria specified in the individual transplant policy for which the facility is requesting prior authorization.

If a solid organ transplant is not prior authorized, services directly related to the transplant within the three day preoperative and six weeks postoperative period also will be denied, regardless of who provides the service, (i.e., laboratory services, status-post visits, and radiology services). Services unrelated to the transplant surgery will be paid separately.

A transplant request signed by a physician associated with one of the Texas Medicaid Program approved transplant facilities is considered for prior authorization after the client has been evaluated and meets the guidelines of the institution's transplant protocol.

All supporting documentation must be included with the request for authorization. Send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

Heart Transplants

Heart transplant candidates must be limited to those clients who, based on sound patient selection criteria, would most likely benefit from the heart transplant procedure on a long-term basis. In order to be reimbursed by the Texas Medicaid Program, the facility must document a critical medical need with the New York Heart Association (NYHA) Class III or IV cardiac disease as shown below:

- *Class III.* Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity (e.g., mild exertion) causes fatigue, palpitation, dyspnea, or anginal pain.
- *Class IV.* Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.

Or the facility must document:

- Congenital heart disease.
- Valvular heart disease.
- Viral cardiomyopathy.
- Familial or restrictive cardiomyopathy.
- Heart transplant will result in a return to improved functional independence.
- Absence of comorbidities, such as:
  - Severe pulmonary hypertension.
  - End-stage renal, hepatic, or other organ dysfunction unrelated to primary disorder.
  - Uncontrolled human immunodeficiency virus (HIV) infection or acquired immunodeficiency syndrome (AIDS)-defining illness.
  - Multiple organ compromise secondary to infection, malignancy, or condition with no known cure.
- Documented compliance with other medical treatment regimens and plan of care. Documented compliance includes no active alcohol or chemical dependency that interferes with compliance to a medical regimen.

Documented psychiatric instability is a contraindication for transplant if severe enough to jeopardize incentive for adherence to medical regimen.

Prior authorization for a heart/lung transplant must follow criteria for both heart and lung transplants. Requests for a heart/lung transplant will be considered on an individual basis.

All heart transplant services provided by facilities and professionals must be prior authorized by HHSC or its designee.

Documentation supplied with the prior authorization request must address the criteria above and must be medically necessary, reasonable, and federally-allowable.

Liver Transplants

Authorization of liver transplantation requires documentation of life-threatening complications of acute liver failure or chronic end-stage liver disease.

Liver transplant candidates must be limited to those clients who, based on sound patient selection criteria, would most likely benefit from the liver transplant procedure on a long-term basis. In order to be reimbursed by the Texas Medicaid Program, the facility must document the following:

- A critical medical need with a likelihood of a successful clinical outcome.
- Liver disease in these categories:
  - Primary cholestatic liver disease.
  - Other cirrhosis: alcoholic, hepatitis C (non-A, non-B), hepatitis B.
  - Fulminant hepatic failure.
  - Metabolic diseases.
  - Malignant neoplasms.
  - Benign neoplasms.
  - Biliary atresia.
- Absence of comorbidities such as:
  - End-stage cardiac, pulmonary, or renal disease unrelated to primary disorder.
  - Multiple organ compromise secondary to infection, malignancy, or condition with no known cure.
- Documented compliance with other medical treatment regimens and plan of care. Documented compliance includes no active alcohol or chemical dependency that interferes with compliance to a medical regimen.

Documented psychiatric instability is a contraindication for transplant if it is severe enough to jeopardize incentive for adherence to medical regimen.

Payment for liver transplant professional services will be made under procedure code 2/8-47135 or 2/8-47136. These procedures include six months of professional postoperative care. Separate charges for a choledochojejunostomy (Roux-en-y) should be denied as part of the liver transplant. Parenteral immunosuppressant therapy is approved for a period of 12 months following the date of discharge from the hospital, conditional upon the Medicaid-eligibility of the client.

Two assistant surgeons will be allowed for liver transplant surgery using procedure codes 8-47135 and 8-47136.

Lung Transplants

Lung transplant candidates must be limited to those clients who, based on sound patient selection criteria, would most likely benefit from the lung (single or double)

transplant procedure on a long-term basis. In order to be reimbursed by the Texas Medicaid Program, the facility must document the following:

- A critical medical need with a likelihood of a successful clinical outcome.
- Symptoms at rest that are directly related to chronic pulmonary disease and which result in severe functional limitation.
- End-stage pulmonary diseases in these categories:
  - Obstructive lung disease.
  - Restrictive lung disease.
  - Cystic fibrosis.
  - Pulmonary hypertension.
- Absence of comorbidities such as:
  - End-stage renal, hepatic, or other organ dysfunction unrelated to primary disorder.
  - Multiple organ compromise secondary to infection, malignancy, or a condition with no known cure.
- Documented compliance with other medical treatment regimens and plan of care. Documented compliance includes no active alcohol or chemical dependency that interferes with compliance to a medical regimen.

Documented psychiatric instability is a contraindication for transplant if it is severe enough to jeopardize incentive for adherence to medical regimen.

Prior authorization for a heart/lung transplant must follow criteria for both heart and lung transplants. Requests for a heart/lung transplant will be considered on an individual basis.

Pancreas Transplant/Simultaneous Kidney-Pancreas Transplant

Based upon published research and clinical studies, pancreas transplants and simultaneous kidney-pancreas transplants have been determined to be a benefit of the Texas Medicaid Program. A pancreas transplant or simultaneous kidney-pancreas transplant for individual Medicaid clients is subject to prior authorization and must be performed in an institution approved as a kidney and pancreas transplant facility by the Texas Medicaid Program.

For benefit consideration under this policy for a pancreas transplant and simultaneous kidney-pancreas transplant, there must be documentation that aggressive conventional and/or standard therapies have failed.

Texas Medicaid Program approval is limited to facilities that are certified by United Network of Organ Sharing (UNOS) and have written documentation of agreement from the facility ethics and transplant committees in support of the specific transplant.

Pancreas Transplant Alone

For the pancreas alone transplant, Group 1 or Group 2 documentation is required:

Group 1

- Satisfactory kidney function (creatinine clearance greater than 40 mL/min).
- Type 1 diabetes with secondary diabetic complications that are progressive despite the best medical management.
- Secondary complications which must include at least two of the following:
  - Diabetic neuropathy.
  - Retinopathy.
  - Gastroparesis.
  - Autonomic neuropathy.
  - Extremely labile (brittle) insulin-dependent diabetes melliltus.

Group 2

- Recurrent, acute, and severe metabolic and potentially life-threatening complications requiring medical attention which incude:
  - Hypoglycemia.
  - Hyperglycemia.
  - Ketacidosis.
  - Failure of exogenous insulin-based management to achieve sufficient glycemic control (HbA1c of greater than 8.0) despite aggressive conventional therapy.
  - Insensibility to hypoglycemia.

Simultaneous Kidney and Pancreas Transplant

For the simultaneous kidney-pancreas transplant, Group 1 or Group 2 documentation is required:

Group 1

- Type 1 diabetes mellitus with secondary diabetic complications that are progressive despite the best medical management.
- Secondary complications which must include at least two of the following:
  - Diabetic neuropathy.
  - Retinopathy.
  - Gastroparesis.
  - Autonomic neuropathy.
  - Extremely labile (brittle) insulin-dependent diabetes mellitus.

Group 2

- Recurrent, acute, and severe metabolic and potentially life-threatening complications requiring medical attention which included:
  - Hypoglycemia.
  - Hyperglycemia.
  - Ketacidosis.
  - Failure of exogenous insulin-based management to achieve sufficient glycemic control (HbA1c of greater t than 8.0) despite aggressive conventional therapy.
  - Insensibility to hypoglycemia.
- End-stage renal disease that requires dialysis or is expected to require dialysis within the next 12 months.

The following contraindictions for transplant applies to both the pancreas and simultaneous kidney-pancreas transplant and are as follows:

- Inadequate cardiac status, pulmonary, or liver function.
- Ongoing or recurrent active infestions that are not effectively treated.
- Uncontrolled HIV/AIDS infection.
- Malignancy (except non-melanoma skin cancers).
- Documented psychiatric instability if severe enough to jeopardize incentive for adherence to medical regimen.
- Documentation of compliance with medical treatments regimen and plan of care, including no active alcohol or chemical dependency that interferes with compliance to a medical regimen.

If a pancreas transplant or simultaneous kidney-pancreas transplant has been prior authorized as medically necessary by the Commission or its designee because of an emergent, life-threatening situation, a maximum of 30 days of inpatient hospital services during a Title XIX spell of illness may be a benefit beginning with the actual first day of the transplant. This coverage is in addition to covered inpatient hospital days provided before the actual first day of the transplant. This 30 day period is considered a separate inpatient hospital admission for reimbursement purposes, but is included under one hospital stay.

Program Limitations

If a transplant has been prior authorized as medically necessary by HHSC or its designee because of an emergent, life-threatening situation, a maximum of 30 days of inpatient hospital services during Title XIX spell of illness may be a benefit, beginning with the actual first day of the transplant. This benefit is in addition to covered inpatient hospital days provided before the actual first day of the transplant. This 30-day period is considered a separate inpatient hospital admission for reimbursement purposes, but is included under one hospital stay. Physician services that HHSC or its designee determines to be reasonable and medically necessary are also a benefit during the 30-day period. Day limitations do not apply for clients younger than 21 years of age.

Expenses for a single inpatient hospital admission for an authorized transplant are not included in the annual $200,000.00 inpatient expenditure cap. Dollar limitations do not apply for clients younger than 21 years of age.

All program coverage limits are applied.

The above guidelines also apply to one subsequent re-transplant, because of rejection, as a lifetime benefit. A subsequent transplant is not included in the prior authorization for the initial transplant; it must be prior authorized separately.

Reimbursement for transplant is limited to an initial transplant as a lifetime benefit and one subsequent re-transplant because of rejection. Expenses incurred by a living donor will not be reimbursed.

Transplants are also a benefit under the Medicare program; therefore, for clients eligible for Medicare and Medicaid, the Texas Medicaid Program will pay only the deductible or coinsurance portion as applicable. Prior authorization must be obtained for Medicaid-only clients; authorization will not be given for Medicare/Medicaid-eligible clients. The Texas Medicaid Program will not pay a transplant service denied by Medicare for a Medicare-eligible client.

If a Medicaid client receives a transplant in a facility that is not approved by the Texas Medicaid Program, the client must be discharged from the facility to be considered to receive other medical and hospital benefits under the Texas Medicaid Program. Coverage for other services needed as a result of complications of the transplant may be considered when medically necessary, reasonable, and federally allowable. The Texas Medicaid Program will not pay for routine post-transplant services for transplant patients in facilities that are not approved by the Texas Medicaid Program. Services unrelated to the transplant surgery will be paid separately.

Benefits are not available for any experimental or investigational services (including xenotransplantation and artificial/bioartificial liver transplants), supplies, or procedures.

The DRG payment for the transplant includes procurement of the organ and services associated with the organ procurement. The Texas Medicaid Program does not pay for solid organs procured by a facility for supply to an organ procurement organization (OPO). The *Omnibus Budget Reconciliation Act* of 1986 (OBRA 86) Public Law 99-509 added Section 1138 of the *Social Security Act,* which defines conditions of participation for institutions in the organ procurement program. Organ procurement costs are not reimbursed to a hospital that fails to meet the conditions of participation. The specific guidelines may be found in the appropriate areas of 42 CFR Parts 405, 413, 441, 482, and 485. Documentation of organ procurement must be maintained in the hospital's medical record. Expenses incurred by a living donor for transplants will not be reimbursed separately.

Refer to: "Reimbursement" on page 2-2.

25.2.4 Utilization Review

UR activities of all Medicaid services provided by hospitals reimbursed under the DRG prospective payment system or TEFRA are required by Title XIX of the *Social Security Act*, Sections 19-02 and 19-03. The review activities are accomplished through a series of monitoring systems developed to ensure services are appropriate to need, of optimum quality and quantity, and rendered in the most cost-effective mode. Clients and providers are subject to UR monitoring. The monitoring focuses on the appropriate screening activities, medical necessity of all services, and quality of care as reflected by the choice of services provided, type of provider involved, and settings in which the care was delivered. This monitoring ensures the efficient and cost-effective administration of the Texas Medicaid Program.

UR may also occur by an examination of particular claims or services not within the usual screening review when a specific UR is requested by HHSC or the Texas Attorney General's Office.

25.2.4.1 Responsibilities

The HHSC Office of Inspector General (OIG)/UR Unit is responsible for retrospective review of inpatient DRG and TEFRA admissions. These reviews are accomplished through onsite visits or on a mail-in basis.

25.2.4.2 Utilization Review Process

The inpatient UR process for admissions reimbursed under the DRG prospective payment system consists of sampling medical records of paid Medicaid claims. The review process consists of three major components:

- *Admission review*. Determination of the medical necessity of the admission. For purposes of the Texas Medical Review Program (TMRP) and the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), medical necessity means the client has a condition requiring treatment that can be safely provided only in the inpatient setting.
- *Quality review*. Assessment of the quality of care provided to determine if it meets generally accepted standards of medical and hospital care practices or puts the client at risk of unnecessary injury or death. Quality of care review includes the use of discharge screens and generic quality screens.
- *DRG validation*. Determination that the critical elements necessary to assign a DRG are present in the medical record and the diagnosis and procedures are sequenced correctly. The critical elements are age, sex, admission date, discharge date, discharge status, principal diagnosis, secondary diagnosis (complications or comorbidity), and principal and secondary procedures.

The HHSC OIG UR Unit staff reviews the complete medical record to make decisions about the medical necessity of the admission, validity of the DRG, and quality of care. The medical record must reflect that any services reimbursed by the Texas Medicaid Program were ordered by the attending physician, certified nurse-midwife, or nurse practitioner.

Effective for dates of admission on or after September 1, 2006, the HHSC OIG UR Unit uses evidence-based guidelines to assist in performing retrospective UR of inpatient hospital claims for Medicaid clients. The evidence-based guidelines are Milliman Care Guidelines, which replace the physician-developed and physician-approved Medicaid hospital screening criteria addressed through a rule revision effective August 1, 2006. Reviews required by the TMRP, TEFRA, and the current LoneSTAR Select II contracting Program are included.

All services, supplies, or items billed are medically necessary for the client's diagnosis or treatment as certified on claim submission.

Refer to: "Provider Certification/Assignment" on page 1-9.

When an admission denial or a denial of continued stay is issued, or when a technical denial becomes final, all money is recouped from the hospital for the admission or the days of stay denied. When a DRG is reassigned as a result of UR, the payment to the hospital is adjusted.

If an inpatient admission is denied, but a physician's order is present documenting the client originally was placed in observation, the UR unit may authorize the rebilling of services rendered during the first 23 hours on an outpatient claim.

Admission Review

Review personnel assess the medical necessity of an admission by comparing documentation present in the medical record with elements in the TMRP Hospitalization Screening Criteria. For an admission to be approved, an indication for hospitalization and treatment criteria must be met. Cases that do not meet both screening criteria are referred to a physician consultant for determination of the medical necessity of the inpatient admission. If the TMRP Hospitalization Screening Criteria are met but the medical necessity of the admission is still questionable, the case is referred to a physician consultant for a determination. If a physician consultant determines the admission is not medically necessary, a denial is issued.

Effective for admissions on or after September 1, 2006, review personnel assess the medical necessity of an admission by comparing documentation present in the medical record using recognized evidence-based guidelines for inpatient screening criteria. Non-physician reviewers use the criteria as guidelines for the initial approval or for the referral of inpatient reviews for medical necessity decisions. Cases that do not meet initial approval are referred to a physician consultant for the determination of the medical necessity of the inpatient admission. If the criteria are met but the medical necessity of the admission is still questionable, the case is referred to a physician consultant for a determination. If a physician consultant determines the admission is not medically necessary, a denial is issued.

Compliance with the DRG prospective payment system and aspects of the review as stated above are evaluated quarterly. Identified problems may result in an educational visit or action such as recoupment or referral to HHSC OIG Medicaid Program Integrity (MPI) for determination of a sanction.

Readmission Review

If a hospital admission or readmission occurs within 30 days of a previous discharge from the same or a different hospital for the same or closely related diagnosis, or for a condition identified during the previous admission, it may be reviewed for medical necessity.

Transfers from one facility to another and readmissions are also subject to review.

Hospital-Based Ambulatory (HASC) Surgical Procedures

Inpatient admissions for surgical procedures listed as ambulatory surgical codes in the current fee schedule are denied if documentation does not support the need for the inpatient admission.

Quality Review

Each Medicaid case is evaluated for quality client care, adequacy of discharge planning, and medical stability of the client at discharge. To accomplish this review, CMS Generic Quality Screens and discharge screens included in the TMRP Hospitalization Screening Criteria are used. Potential quality of care issues are identified by the physician. HHSC contracts with physician consultants to review medical records for quality of care. Physician consultants, of the specialty related to the care rendered, may make clinical recommendations or determine corrective actions when deemed appropriate. Child and adolescent psychiatrists may make recommendations based on review of inpatient psychiatric services provided to Medicaid clients younger than 21 years of age. Failure to verify completion of any corrective action recommendation within the specified time frame may result in referral of the case to the HHSC OIG, MPI section, for possible payment hold (withholding Medicaid claims payments until verification of the completed corrective action has been received) and/or exclusion from the Texas Medicaid Program.

Diagnosis-Related Group Validation

Each medical record is reviewed to validate the elements critical to the DRG assignment. These elements are the client's age, sex, admission date, discharge date, discharge status, principal diagnosis, secondary diagnoses (complications or comorbidities), and principal and secondary procedures. Documentation of these critical DRG elements in the medical record is evaluated for the correlation to the information provided on the claim form.

The principal diagnosis is the diagnosis (condition) established after study to be chiefly responsible for causing the admission of the client to the hospital for care. The principal diagnosis must be treated or evaluated during this admission to the hospital.

The secondary diagnoses are conditions that affect client care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, increased nursing care and/or monitoring, *or* has clinically significant implications for future health-care needs.

The coding of diagnoses that have clinically significant implications for future health-care needs applies *only* to newborns and *must* be identified by the physician. Normal newborn conditions or routine procedures are not to be considered as complications or comorbidities for DRG assignment.

Refer to: "Texas Medicaid Program Limitations and Exclusions" on page 1-19.

If the principal diagnosis, secondary diagnoses (complications or co-morbidities), or procedures are not substantiated in the medical record; sequenced correctly; or have been omitted, codes may be deleted, changed, or added. All diagnosis/procedure coding changes potentially resulting in a DRG change are referred to a physician consultant. When it is determined that the diagnoses and procedures are substantiated and sequenced correctly, the information will be entered into the applicable version of the Grouper software for a DRG determination. The CMS-approved DRG software considers each diagnosis and procedure and the combination of all codes and elements to make a determination of the final DRG assignment. When the DRG is reassigned, the payment to the provider is adjusted.

25.2.4.3 Recommendations to Enhance Compliance with the Texas Medicaid Program Fee-for-Service Hospital Billing

The following information highlights an area for physician and hospital providers where collaboration in client care delivery exists but can improve. The Texas Medicaid Program, through its hospital UR activities, has identified this area for both compliance with provider responsibilities and the reduction of the submission of inappropriate inpatient hospital claims. To enhance compliance with Texas Medicaid fee-for-service hospital billing and decrease the submission of inappropriate inpatient hospital claims, adhere to the following suggestions:

- Physicians and hospital personnel, primarily case managers, UR, and billing staff, should become familiar with the Hospital Inpatient Screening Criteria used by the HHSC staff in performing reviews of hospital medical records related to paid, inpatient hospital claims. The criteria provide guidelines for review staff to assist with the determination of medical necessity of inpatient stays. The Medicaid Hospital Inpatient Screening Criteria are available on the HHSC website at www.hhs.state.tx.us/OIG/screen/SC_TOC.shtml.
- Initially admit clients in observation status if the physician feels that it is reasonable to expect that the client may be able to be discharged within 24 hours. If the client is initially admitted in observation status (per physician order), the stay is more than 24 hours, and the hospital submits an inpatient claim, the hospital is given the opportunity to rebill the first 24 hours of services on an outpatient claim if the inpatient claim is subsequently denied per retrospective UR.
- When a client is admitted to the hospital as an inpatient and is discharged in less than 24 hours, the hospital may request that the physician change the admission order from inpatient status to outpatient observation status. This billing practice is acceptable when the physician makes the changes to the admitting order before the hospital submits the claim for payment.
- This correction in admission status avoids errors in billing and the potential need for a more lengthy appeal process. If the physician admitting orders do not accurately reflect the services provided, the hospital inpatient claim may be denied and the inappropriate payment recovered from both the hospital and the admitting physician.

25.2.4.4 Hospitals Reimbursed Under TEFRA

For all Medicaid admissions identified for review, the TEFRA review process consists of the following major components:

- *Admission review*. Determination of the medical necessity of the admission. For purposes of the TMRP and TEFRA, medical necessity means the client has a condition requiring treatment that can be safely provided only in the inpatient setting.
- *Continued stay review*. Determination of the medical necessity of each day of stay.
- *Quality of care review*. Assessment of the quality of care provided to determine if it meets generally accepted standards of medical and hospital care practices or puts the client at risk of unnecessary injury or death. Quality of care review includes the use of discharge screens and generic quality screens.

TEFRA Hospitals are required to submit all charges.

HHSC OIG UR Unit staff review the complete medical record to make decisions about the medical necessity of the admission, continued stay, and quality of care.

25.2.4.5 Technical Denials (DRG Prospective Payment and TEFRA)

On Site Reviews

The following information describes on site reviews:

- If the complete medical record is not made available during the on site review, a preliminary technical denial is issued on site. The hospital is allowed 60 calendar days from the date of the exit conference to provide the complete medical record to HHSC. If the complete medical record is not received by HHSC within this specified time frame, a final technical denial is issued and payment is recouped.
- If a complete medical record is made available on site, but a copy is required for further review, and the copy is not received by HHSC within the specified time frame, a preliminary technical denial is issued by certified mail or fax machine. The hospital has 60 calendar days from the date of receipt of the notice to submit the complete medical record. If the complete medical record is not received by HHSC within this specified time frame, a final technical denial is issued and payment is recouped.

Note: *A notarized business record affidavit is required for paper and electronic copies of requested medical records. A provider failing to provide this documentation must resubmit the requested records with the affidavit.*

Refer to: "Retention of Records and Access to Records and Premises" on page 1-7.

Mail-In Reviews

If the complete medical record is not received by HHSC within the specified time frame, a preliminary technical denial is issued by certified mail or fax machine. The hospital has 60 calendar days from the date of receipt of the notice to submit the complete medical record. If the complete medical record is not received by HHSC within this specified time frame, a final technical denial is issued and payment is recouped.

Hospital inpatient claim payments that have been recouped because of a technical denial may not be rebilled on an outpatient claim.

Note: *A notarized business record affidavit is required for paper and electronic copies of requested medical records. A provider who fails to provide this documentation must resubmit the requested records with the affidavit.*

Refer to: "Retention of Records and Access to Records and Premises" on page 1-7.

25.2.4.6 Acknowledgment of Penalty Notice

Hospitals must have on file a signed acknowledgment from the physician stating that the physician received the following notice:

Notice to Physicians: *Medicaid payment to hospitals is based, in part, on each client's principal and secondary diagnoses and the major procedures performed on the client, as attested to by the client's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal or state funds, may be subject to fine, imprisonment, or civil penalty under applicable federal and state laws.*

The acknowledgment of penalty notice must be specific to the Texas Medicaid Program. Medicare penalty notices are not accepted.

25.2.4.7 Sanctions

Compliance with the DRG prospective payment system and aspects of the review as stated above are evaluated quarterly. Identified problems may result in an educational visit or action such as recoupment or referral to HHSC OIG MPI for determination of a sanction.

25.2.4.8 Utilization Review Appeals

Hospital providers may appeal adverse decisions by HHSC's UR Unit to the HHSC UR/Medical Appeals Unit. A UR/Medical Appeals decision is the final administrative decision of HHSC. Neither HHSC's UR Unit nor TMHP are responsible for UR appeals.

Refer to: "Utilization Review Appeals" on page 6-8.

25.2.5 Claims Information

Claims for inpatient hospital services must be submitted to TMHP in an approved electronic format or on the UB-04 CMS-1450 claim form. Providers may purchase UB-04 CMS-1450 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a UB-04 CMS-1450 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Hospitals may submit information only claims to TMHP when one of the following situations exists. Hospitals should use TOB 110 to file these claims:

- Inpatient 30-day spell of illness benefit is exhausted.
- Payment made by a third party resource/other insurance exceeds the Medicaid allowed amount.

Additional claims information can be found within individual topic areas in this section.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"UB-04 CMS-1450 Claim Filing Instructions" on page 5-30. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

25.2.5.1 Claim Filing Resources

Refer to the following sections and forms on the page numbers listed below when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
UB-04 CMS-1450 Claim Filing Instructions	5-30
TMHP Electronic Claims Submission	5-13
Communication Guide	A-1
Hospital Report (Newborn Child or Children) HHSC Form 7484	B-49
Hospital-Based ASC Claim Example	D-17
Hospital Inpatient Claim Example	D-18
Hospital Outpatient	D-18
Acronym Dictionary	F-1

25.3 Outpatient

25.3.1 Enrollment

To be eligible to participate in the Texas Medicaid Program, a hospital must be certified by Medicare, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process.

All providers of laboratory services must comply with the rules and regulations of CLIA. Providers not complying with CLIA will not be reimbursed for laboratory services.

Hospital Eligibility Through Change of Ownership

Under procedures set forth by CMS and HHS, a change in ownership of a hospital does not terminate Medicare eligibility; therefore, Medicaid participation may be continued if the hospital obtains recertification as a Title XVIII (Medicare) hospital and a new Title XIX (Medicaid) agreement between the hospital and HHSC.

Contact the TMHP Contact Center at 1-800-925-9126 to obtain the Medicaid hospital participation agreement.

25.3.1.1 Hospital Ambulatory Surgical Center

Refer to: "Day Surgery" on page 25-18.

"Ambulatory Surgical Center (ASC)" on page 9-1 for more information.

25.3.1.2 Hospital Ambulance

A hospital supplying ambulance services must enroll s*eparately* from the hospital.

Refer to: "Enrollment" on page 8-2 for ambulance enrollment requirements.

25.3.1.3 Certified Registered Nurse Anesthetist

Hospital-employed CRNAs must enroll and bill according to instructions in "Certified Registered Nurse Anesthetist (CRNA)" on page 15-1.

Note: *Hospitals cannot bill for CRNA services using their provider identifier.*

25.3.1.4 Medicaid Managed Care Enrollment

To be reimbursed for services provided to Medicaid Managed Care clients, hospital providers must enroll with the Medicaid Managed Care health plan in which the clients are enrolled.

Refer to: "Medicaid Managed Care" on page 7-4 for more information.

25.3.2 Reimbursement

Outpatient services are reimbursed on a reasonable cost based on a percentage of the hospital's most recent tentative Medicaid cost report settlement. Reimbursement for outpatient hospital services for high-volume providers is 84.48 percent of allowable cost. For the remaining providers, reimbursement for outpatient hospital services is 80.3 percent of allowable cost. High-volume providers are eligible for additional payments on traditional Medicaid and Primary Care Case Management (PCCM) claims. A high-volume outpatient hospital provider is defined as one that was paid at least $200,000 during calendar year 2004.

All clinical laboratory services are reimbursed at 60 percent of the prevailing charge except for those hospitals identified by Medicare as sole community hospitals. These hospitals are reimbursed at 62 percent of the prevailing charges for services provided to clients in

the outpatient setting and 60 percent to clients in the inpatient setting. Clinical pathology consultations continue to be allowed for reimbursement.

Refer to: "Provider Cost and Reporting" on page 25-3 for more information about the calculation of the interim rate.

"Clinical Laboratory Improvement Amendments (CLIA)" on page 26-2 for important information.

25.3.2.1 Day Surgery

Reimbursement for outpatient hospital surgery is limited to the lesser of the amount reimbursed to an ambulatory surgical center (ASC) for similar services, the hospital's actual charge, or the allowable cost determined by HHSC. Hospitals must bill *all* scheduled day surgeries under their provider identifier using TOB 131.

To avoid delays in claims processing payment, file scheduled outpatient surgical procedures using the hospital's provider identifier and appropriate type of service (TOS) F-Healthcare Common Procedure Coding System (HCPCS) procedure code. ASC/HASC providers indicate the appropriate TOS F-HCPCS facility procedure code in Block 44 of the UB-04 CMS-1450 claim form, instead of the *International Classification of Diseases Ninth Revision Clinical Modification* (ICD-9-CM) procedure code in Block 74 of the UB-04 CMS-1450 claim form.

File claims for emergency, unscheduled outpatient surgical procedures with separate charges (lab, radiology, anesthesia, and emergency room [ER]) for all services using TOB 131 and the hospital's provider identifier.

Reimbursement of ASC/HASC procedures is based on the CMS-approved Ambulatory Surgical Code Groupings (1 through 9 per CMS and Group 10 per HHSC) payment schedule. Providers are sent a list of these codes and payment categories after enrollment with the Texas Medicaid Program and when periodic updates occur. The rates implemented by the Texas Medicaid Program on April 1, 1995, remain in effect. To acquire a list of approved procedures, call the TMHP Contact Center at 1-800-925-9126. This information is also available on the TMHP website at www.tmhp.com. Click on **Fee Schedules**.

Refer to: "Day Surgery" on page 25-18 for more information on day surgery and outpatient observation.

"Procedure Codes Requiring Prior Authorization" on page 36-140.

ASC/HASC Global Services

The ASC/HASC payment represents a global payment and includes room charges and supplies. Covered services provided are billed as one inclusive charge. All facility services provided in conjunction with the surgery (for example, laboratory, radiology, anesthesia supplies, medical supplies) are considered part of the global payment and cannot be itemized or billed separately.

Routine X-ray and laboratory services, directly related to the surgical procedure being performed, are not reimbursed separately. All nonroutine laboratory and X-ray services, provided with emergency conditions, may be billed separately with documentation that the complicating condition arose after the initiation of the surgery.

No separate payment outside of the ASC/HASC reimbursement rate will be made for prosthetic devices. Medical and prosthetic devices such as implantable pumps and intraocular lenses, may be supplied by the ASC/HASC and implanted, inserted or otherwise applied during a covered surgical procedure.

Multiple surgeries

When multiple surgical procedures are performed on the same day, only the procedure with the highest surgical code grouping is reimbursed. Surgical procedures performed in the hospital's outpatient departments (emergency or treatment rooms) are to be billed under the hospital's provider identifier, using TOB 131 (outpatient claim).

Elective/Scheduled Day Surgeries

These procedures are for clients who are scheduled for a day surgery procedure and are not inpatient at the time the day surgery is performed. Providers must bill (TOB 131) the scheduled day surgery as an outpatient procedure using the provider identifier.

Complications following Elective/Scheduled Day Surgeries

If a condition of the scheduled day surgery requires additional care beyond the recovery period, the client may be placed in outpatient observation (stay less than 24 hours). The observation period must be billed on an outpatient claim (TOB 131) using the hospital's provider identifier. If the client requires inpatient admission following the observation stay, the admission date for the inpatient claim is the date the client was placed in observation. All charges for services provided from the time of observation placement (excluding the surgical procedure) should be included on the inpatient claim (TOB 111) using the hospital's provider identifier. The principal diagnosis to be used on the inpatient claim is the complication of the surgery that necessitated the extended stay. The day surgery procedure should still be billed as an outpatient procedure under the provider identifier. Specific guidelines for billing observation placement as an outpatient claim are found under "Hospital Outpatient Observation Room Services" on page 25-27.

Inpatient Admissions After Day Surgery

If a complication occurs for which the client requires inpatient admission immediately following the day surgery (no observation period), the day surgery must be billed as an outpatient procedure (TOB 131), using the hospital's provider identifier. The inpatient admission is to be billed as an inpatient claim (TOB 111), using the hospital's provider identifier. The principal diagnosis to be used on the inpatient claim is the complication of the surgery that necessitated the extended stay. The day surgery procedure should not be included on the inpatient claim. The inpatient admission *must* be medically necessary and is subject to retrospective review.

Emergency/Unscheduled Day Surgeries

These procedures are for clients who require an unscheduled (emergency) day surgery procedure and are not inpatient at the time the day surgery is performed.

If a client is first treated in the ER and then requires emergency surgery as an outpatient, claims for emergency, unscheduled outpatient surgical procedures should be filed itemizing each service, such as room charge, laboratory, radiology, anesthesia, and supplies. Providers must bill unscheduled day surgery procedures and emergency services as outpatient procedures. If a condition of the unscheduled day surgery requires additional care beyond the recovery period, the client may be placed on outpatient observation status. The observation period must be billed on the same outpatient claim.

Providers *must* bill the unscheduled day surgery procedures and emergency services as outpatient procedures (TOB 131) using the hospital's provider identifier. If a condition of the unscheduled day surgery requires additional care beyond the recovery period, the client may be placed on outpatient observation status (stay less than 24 hours). The observation period must be billed on the same outpatient claim (TOB 131) using the hospital's provider identifier. Specific guidelines for billing observation placement as an outpatient claim are found under "Hospital Outpatient Observation Room Services" on page 25-27.

Complications following Emergency/Unscheduled Day Surgery

If the client requires inpatient admission following the observation stay, the admission date for the inpatient claim is the date the client was placed in observation. All charges for services provided from the time of observation status (excluding surgical procedures and emergency services) should be included on the inpatient claim (TOB 111) using the hospital's provider identifier. The principal diagnosis to be used on the inpatient claim is the complication of the surgery that necessitated the extended stay. The day surgery and emergency services should not be included on the inpatient claim since they are to be billed (TOB 131) as outpatient procedures under the hospital's provider identifier. Specific guidelines for billing observation placement as an outpatient claim are found under "Hospital Outpatient Observation Room Services" on page 25-27.

ASA Physical Status and Heart Disease Classifications

If a client is admitted for a day surgery procedure—whether scheduled or emergency—and has either an American Society of Anesthesiologists (ASA) Classification of Physical Status of III, IV, or V or Classification of Heart Disease III or IV (refer to Texas Medicaid Hospital Screening Criteria), the procedure may be considered an inpatient procedure and billed on an inpatient claim (TOB 111) using the hospital's provider identifier. The reason for the surgery (principal diagnosis), any additional substantiated conditions, and the procedure must be included on one inpatient claim.

The ASA classifications of physical status consist of five classes:

- *Class I*. A patient who has no organic disease or in whom the disease is localized and causes no systemic disturbance.
- *Class II*. A patient exhibiting *mild* to moderate systemic disturbance that may or may not be associated with the surgical complaint and that interferes only moderately with the patient's regular activities and general physiologic equilibrium.

Example: *Non- or only slightly-limiting organic heart disease, mild diabetes, hypoglycemia, essential hypertension, or anemia; extreme obesity; chronic bronchitis.*

- *Class III*. A patient exhibiting *severe* systemic disturbance that may or may not be associated with the surgical complaint and that seriously interferes with the patient's activities.

Example: *Severely limiting organic heart disease, severe diabetes with vascular complications; moderate to severe degrees of pulmonary insufficiency; angina pectoris or healed myocardial infarction.*

- *Class IV*. A patient exhibiting *extreme* systemic disturbance that may or may not be associated with the surgical complaint, that interferes with the patient's regular activities, and that has already become life-threatening.

Example: *Organic heart disease with marked signs of cardiac insufficiency present (for example, cardiac decompensation); persistent anginal syndrome, or active myocarditis; advanced degrees of pulmonary, hepatic, renal, or endocrine insufficiency present.*

- *Class V*. The rare person who is *moribund* (in a dying state) before operation, whose preoperative condition is such that he or she is expected to die within 24 hours even though not subjected to the additional strain of operation.

Example: *Burst abdominal aneurysm with profound shock; major cerebral trauma with rapidly increasing intracranial pressure; massive embolus.*

The Classification of Heart Disease consists of four classes:

- *Class I*. No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea, or anginal pain.
- *Class II*. Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain.
- *Class III*. Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitation, dyspnea, or anginal pain.
- *Class IV*. Unable to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency, or of the anginal syndrome, may be present even at rest. If any physical activity is undertaken, discomfort occurs.

Inpatients may occasionally require a surgery that has been designated as an outpatient procedure. The physician must document the need for this surgery as an inpatient procedure before the procedure is performed. These claims are subject to retrospective review.

Incomplete Day Surgeries

When ASC/HASC providers bill the Texas Medicaid Program for an incomplete surgical procedure, the following information *must* be included on the claim:

- Modifier 73 or 74.
- Facilities must use either the following diagnosis codes or modifier to indicate an incomplete surgical procedure, TOS F:

Diagnosis Code	Description
V641	Surgical or other procedure not carried out because of contraindication
V642	Surgical or other procedure not carried out because of patient's decision
V643	Procedure not carried out for other reasons

Claims billed with diagnosis codes V641, V642, V643 and modifier 73 and 74 suspend for review of the medical documentation submitted with the claim. Providers must submit the operative report, the anesthesia report, and state why the operation was not completed.

Reimbursement to ASC/HASC facilities for canceled or incomplete surgeries because of patient complications, is made according to the following criteria, depending on the extent to which the anesthesia or surgery proceeded:

- Reimburse at 0 percent of ASC group payment schedule for a procedure that is terminated for nonmedical or medical reasons before the facility has expended substantial resources.
- Reimburse at 33 percent of ASC group payment schedule up to the administration of anesthesia.
- Reimburse at 50 percent of ASC group payment schedule after the administration of anesthesia but before incision.
- Reimburse at 100 percent of ASC group payment schedule after incision.

Surgeries canceled because of incomplete preoperative procedures are *not* reimbursed.

25.3.2.2 Revenue Codes (Outpatient Hospital)

UB-04 revenue codes must be used to bill outpatient hospital facility services. In some instances, a HCPCS procedure code is required in addition to the revenue code for accurate claims processing:

Revenue Code	Description	Comments
	Pharmacy	
B-250	General classification	
B-251	Generic drugs	
B-252	Non-generic drugs	
B-253	Take Home drugs	Not a benefit
B-254	Drugs incident to other diagnostic services	
B-255	Drugs incident to radiology	
B-256	Experimental drugs	Not a benefit
B-257	Nonprescription drugs	
B-258	IV solutions	
B-259	Other pharmacy	
B-451	Emergency room - *Emergency Medical Treatment and Active Labor Act of 1986* (EMTALA) emergency medical screening services	
B-630	Drugs requiring specific identification	HCPCS code required
B-631	Single source drug	HCPCS code required

*** HCPCS procedure code is required in addition to revenue code for accurate claims processing.**

Revenue Code	Description	Comments
	Pharmacy	
B-632	Multiple source drug	HCPCS code required
B-633	Restrictive prescription	HCPCS code required
B-634	Erythropoietin (EPO) less than 10,000 units	HCPCS code required
B-635	Erythropoietin (EPO) 10,000 or more units	HCPCS code required
B-636	Drugs requiring detailed coding	HCPCS code required
B-637	Self-administrable drugs	Not a benefit
	Intravenous (IV) Therapy	
B-260	General classification	
B-261	Infusion pump	
B-262	IV therapy/pharmacy services	
B-263	IV therapy/drug/supply delivery	
B-264	IV therapy/supplies	
B-269	Other IV therapy	
	Medical/Surgical Supplies and Devices	
B-270	General classification	
B-271	Nonsterile supply	
B-272	Sterile supply	
B-273	Take-home supplies	Not a benefit
B-274	Prosthetic/orthotic devices	HCPCS code required
B-275	Pacemaker	
B-276	Intraocular lens	
B-277	Oxygen–take-home	
B-278	Other implants	HCPCS code required
B-279	Other supplies/devices	HCPCS code required
B-620	Medical/surgical supplies	HCPCS code required
B-621	Supplies incident to radiology	
B-622	Supplies incident to other diagnostic services	
B-623	Surgical dressings	
B-624	Food and Drug Administration (FDA) investigational devices	Not a benefit
	Oncology	
B-280	General classification	
B-289	Other oncology	
	Laboratory	
B-300	General classification	HCPCS code required
B-301	Chemistry	HCPCS code required
B-302	Immunology	HCPCS code required
B-303	Renal client (home)	HCPCS code required
B-304	Nonroutine dialysis	HCPCS code required
B-305	Hematology	HCPCS code required
B-306	Bacteriology and microbiology	HCPCS code required
B-307	Urology	HCPCS code required

*** HCPCS procedure code is required in addition to revenue code for accurate claims processing.**

Revenue Code	Description	Comments
	Laboratory	
B-309	Other laboratory	HCPCS code required
	Laboratory Pathological	
B-310	General classification	HCPCS code required
B-311	Cytology	HCPCS code required
B-312	Histology	HCPCS code required
B-314	Biopsy	HCPCS code required
B-319	Other pathology	HCPCS code required
	Radiology–Diagnostic	
B-320	General classification	HCPCS code required
B-321	Angiocardiography	HCPCS code required
B-322	Arthrography	HCPCS code required
B-323	Arteriography	HCPCS code required
B-324	Chest X-ray	HCPCS code required
B-329	Other diagnostic radiology	HCPCS code required
	Radiology–Therapeutic	
B-330	General classification	HCPCS code required
B-331	Chemotherapy–injected	HCPCS code required
B-332	Chemotherapy–oral	HCPCS code required
B-333	Chemotherapy–radiation therapy	HCPCS code required
B-335	Chemotherapy–IV	HCPCS code required
B-339	Other therapeutic radiology	HCPCS code required
	Nuclear Medicine	
B-340	General classification	HCPCS code required
B-341	Diagnostic	HCPCS code required
B-342	Therapeutic	HCPCS code required
B-349	Other nuclear medicine	HCPCS code required
	Computed Tomography (CT) Scan	
B-350	General classification	HCPCS code required
B-351	Head scan	HCPCS code required
B-352	Body scan	HCPCS code required
B-359	Other CT scans	HCPCS code required
	Operating Room Services	
B-360	General classification	
B-361	Minor surgery	
B-369	Other operating room services	
	Anesthesia	
B-370	General classification	
B-371	Anesthesia incident to radiology	
B-372	Anesthesia incident to other diagnostic services	
B-374	Acupuncture	Not a benefit
B-379	Other anesthesia	
	Blood	

*** HCPCS procedure code is required in addition to revenue code for accurate claims processing.**

Revenue Code	Description	Comments
	Blood	
B-380	General classification	HCPCS code required
B-381	Packed red cells	HCPCS code required
B-382	Whole blood	HCPCS code required
B-383	Plasma	HCPCS code required
B-384	Platelets	HCPCS code required
B-385	Leucocytes	HCPCS code required
B-386	Other components	HCPCS code required
B-387	Other derivatives (cryoprecipitates)	HCPCS code required
B-389	Other blood	HCPCS code required
	Blood Storage and Processing	
B-390	General classification	
B-391	Blood administration	Not a benefit
B-399	Other blood storage and processing	Not a benefit
	Other Imaging Services	
B-400	General classification	HCPCS code required
B-401	Diagnostic mammography	HCPCS code required
B-402	Ultrasound	HCPCS code required
B-403	Screening mammography	HCPCS code required
B-404	Positron emission tomography	HCPCS code required
B-409	Other imaging services	HCPCS code required
	Respiratory Services	
B-410	General classification	
B-412	Inhalation services	
B-413	Hyperbaric oxygen therapy	
B-419	Other respiratory services	HCPCS code required
	Physical Therapy (PT)	
B-420	General classification	HCPCS code required
B-421	Visit charge	HCPCS code required
B-422	Hourly charge	HCPCS code required
B-423	Group rate	HCPCS code required
B-424*	Evaluation or re-evaluation	HCPCS code required
B-429	Other PT	HCPCS code required
	Occupational Therapy (OT)	
B-430	General classification	HCPCS code required
B-431	Visit charge	HCPCS code required
B-432	Hourly charge	HCPCS code required
B-433	Group rate	HCPCS code required
B-434	Evaluation or re-evaluation	HCPCS code required
B-439	Other OT	HCPCS code required
	Speech-Language Pathology	
B-440	General classification	HCPCS code required
B-441	Visit charge	HCPCS code required

*** HCPCS procedure code is required in addition to revenue code for accurate claims processing.**

Revenue Code	Description	Comments
	Speech-Language Pathology	
B-442	Hourly charge	HCPCS code required
B-443	Group rate	HCPCS code required
B-444*	Evaluation or re-evaluation	HCPCS code required
B-449	Other speech-language pathology	HCPCS code required
	Emergency Room	
B-450	General classification	
B-451	Emergency room - EMTALA screening	
B-456	Urgent care	
B-459	Other emergency room	
	Pulmonary Function	
B-460	General classification	HCPCS code required
B-469	Other pulmonary function	HCPCS code required
	Audiology	
B-470	General classification	HCPCS code required
B-471	Diagnostic	HCPCS code required
B-472	Treatment	HCPCS code required
B-479	Other Audiology	HCPCS code required
	Cardiology	
B-480	General classification	HCPCS code required
B-481	Cardiac cath lab	HCPCS code required
B-482	Stress test	HCPCS code required
B-489	Other cardiology	HCPCS code required
	Clinic	
B-510	General classification	
B-511	Chronic pain center	
B-512	Dental clinic	
B-513	Psychiatric clinic	
B-514	Obstetrics-Gynecology (OB-GYN) clinic	
B-515	Pediatric clinic	
B-516	Urgent Care clinic	
B-517	Family Practice clinic	
B-519	Other clinic	
	Freestanding Clinic	
B-520	General classification	
B-523	Family practice clinic	
B-526	Urgent care clinic	
B-529	Other freestanding clinic	
	Magnetic Resonance Technology (MRT)	
B-610	General classification	HCPCS code required
B-611	Magnetic resonance imaging (MRI) brain (including brainstem)	HCPCS code required
B-612	MRI spinal cord (including spine)	HCPCS code required

*** HCPCS procedure code is required in addition to revenue code for accurate claims processing.**

Revenue Code	Description	Comments
Magnetic Resonance Technology (MRT)		
B-619	Other MRT	HCPCS code required
Cast Room		
B-700	General classification	
B-709	Other cast room	
Recovery Room		
B-710	General classification	
B-719	Other recovery room	
Labor Room/Delivery		
B-720	General classification	
B-721	Labor	
B-722	Delivery	
B-723	Circumcision	
B-724	Birthing center	
B-729	Other labor room/delivery	
Electrocardiogram (EKG/ECG)		
B-730	General classification	HCPCS code required
B-731	Holter monitor	HCPCS code required
B-732	Telemetry	HCPCS code required
B-739	Other EKG/ECG	HCPCS code required
Electroencephalogram (EEG)		
B-740	General classification	HCPCS code required
B-749	Other EEG	HCPCS code required
Gastrointestinal Services		
B-750	General classification	
B-759	Other gastrointestinal	
Treatment or Observation Room		
B-760	General classification	
B-761	Treatment room	
B-762	Observation room	
B-769	Other treatment/observation room	
Preventive Care Services		
B-770	General classification	HCPCS code required
B-771	Vaccine administration	HCPCS code required
B-779	Other preventive care services	HCPCS code required
Lithotripsy		
B-790	General classification	HCPCS code required
B-799	Other lithotripsy	HCPCS code required
Other Diagnostic Services		
B-920	General classification	HCPCS code required
B-921	Peripheral vascular lab	HCPCS code required
B-922	Electromyelogram	HCPCS code required
B-923	Pap smear	HCPCS code required

*** HCPCS procedure code is required in addition to revenue code for accurate claims processing.**

Revenue Code	Description	Comments
	Other Diagnostic Services	
B-924	Allergy test	HCPCS code required
B-925	Pregnancy test	HCPCS code required
B-929	Other diagnostic service	HCPCS code required
*** HCPCS procedure code is required in addition to revenue code for accurate claims processing.**		

25.3.3 Benefits and Limitations

Outpatient hospital services are diagnostic, therapeutic, and rehabilitative services that are provided to clients by or under the direction of a physician in a licensed hospital setting.

Benefits do not include drugs and biologicals taken home by the client. Supplies provided by a hospital supply room for use in physicians' offices in the treatment of clients in the outpatient setting are not reimbursable.

Take-home drugs and supplies are a benefit in the outpatient setting for outpatients when supplied by prescription through the Vendor Drug Program.

Outpatient hospital services include those services performed in the ER, clinic, or observation room. In instances of sudden illness or injury, the client may receive treatment in the ER and be discharged, placed on observation status, or admitted as an inpatient. If a client goes from the ER to an observation room, the hospital is reimbursed only for the observation room charges: not the ER charges. If the client ultimately is admitted as an inpatient within 24 hours of treatment in the ER or clinic, the ER or clinic charges must be billed on the inpatient hospital claim form as an ancillary charge. The date of inpatient admission is the date the client initially was seen in the ER or clinic.

Outpatient hospital services must be itemized by date of service. Procedure repeated over a period of time should be billed for each separate date of service. Do *not* combine multiple dates of service on the same line detail.

The Texas Medicaid Program pays the clinic registration fee in lieu of other benefits when a hospital provides outpatient services without charge, and if the fee is less than what the Medicaid payment would be for the service.

Refer to: "Texas Medicaid Program Limitations and Exclusions" on page 1-19 for more information about noncovered items/services.

25.3.3.1 Emergency Department Services

An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to clients who present for immediate medical attention. The facility must be available 24 hours a day, 7 days a week. Hospital-based emergency departments are reimbursed for services based on a reasonable cost, based on the hospital's most recent tentative Medicaid cost report settlement. The reasonable cost is reduced by a percentage determined by the state.

Emergency department room charges may be billed using the following revenue codes:

Revenue Code	Description
B-450 *or* B451 *or* B456 *or* B-459	Emergency room *or* Emergency room–EMTALA emergency medical screening *or* Emergency room, urgent care *or* Emergency room–other
B-761	Treatment room
B-762	Observation room

Emergency department ancillary services include laboratory services, radiology services, respiratory therapy services, and diagnostic studies, such as EKGs, CT scans, and supplies. Ancillary services should be billed on a UB-04 CMS-1450 claim form using the appropriate procedure codes such as the Current Procedural Terminology (CPT) code or the HCPCS code indicating the procedures or services performed.

According to federal legislation, if any individual presents at the hospital's emergency department requesting an examination or treatment, the hospital must provide an appropriate medical screening examination and stabilization services within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether an emergency medical condition exists.

EMTALA medical screening code (B-451) may be considered for reimbursement when billed as a stand alone service and provided by a qualified medical professional as designated by the facility. Ancillary, professional, or facility services will not be considered for separate reimbursement. Services beyond screening (B-451) can be billed with the appropriate corresponding emergency services code (B-450).

Medicaid claims administrators and Medicaid Managed Care Organizations (MCOs) are prohibited from requiring prior authorization or primary care provider notification for emergency services including those that are needed to evaluate or stabilize an emergency medical condition or emergency behavioral health condition.

The Texas Medicaid Program provides that certain undocumented aliens and legalized aliens who require treatment of an emergency medical condition or emergency behavioral health condition are eligible to receive that treatment. After the emergency condition requiring care is stabilized and no longer an emergency, the coverage ends. If the alien continues to receive ongoing treatment after the emergency ceases, the ongoing treatment is not a benefit.

The Texas Medicaid Program provides for medical services for eligible clients while out-of-state. The attending physician or other provider must document that the client was treated for an emergency condition. Out-of-state emergency services are also a benefit when the client's health would be in danger if he or she were required to travel back to Texas.

Emergency department services are subject to retrospective review.

25.3.3.2 Hospital Outpatient Observation Room Services

Outpatient means a client is in an organized medical facility, and receives, professional services for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the client remains in the facility past midnight.

Some patients, while not requiring an inpatient hospital admission, may require an extended period of observation (less than 24 hours) in the hospital environment on an outpatient basis. The client is considered an outpatient if he or she remains in the hospital for less than 24 consecutive hours and is discharged to home from an outpatient observation status.

Observation services may be provided in any part of the hospital where a client can be assessed, examined, monitored, or treated.

If a physician's order for outpatient observation is present in the patient's medical record, per 1 TAC §371.206(b), the Texas Medicaid Program considers reimbursement to the hospital for outpatient observation services based on the facility's reimbursement rate.

Hospitals may bill medically necessary outpatient services provided during the initial period of observation on TOB 131. The hospital outpatient observation room service commences with the first clinical contact of the client by professional/licensed staff of the hospital.

Because the unit associated with the observation room charge (B-762) is considered to be *hours*, claims submitted with observation room *units* exceeding 23 hours are denied with explanation of benefits (EOB) code 643, Claim indicates outpatient charges in excess of 23 hours. Facilities should resubmit these outpatient claims as appeals with charges for the initial 23 hours only.

Any service *ordered within* the initial 24 hour period may be included on the outpatient claim *if a physician's order for the service is within* the observation period time frame but hospital scheduling limitations prevent the service from being performed before 23 hours has expired. Any services ordered *after* the initial 24 hours must *not* be included on the outpatient claim nor billed to the client.

To receive reimbursement for physician-*ordered* services that are medically necessary and *exceed* the 24-hour period from the initial point of contact, the claim may be submitted as an inpatient stay. All observation room charges, outpatient charges (except ambulatory surgical procedure codes as listed in the current ASC/HASC fee schedule), and ER charges for an inpatient claim are included in the reimbursement methodology and are not reimbursed separately (charges for an observation room on an inpatient claim should be coded with revenue code 760).

It is important to realize that any inpatient stay billed to the Texas Medicaid Program is subject to retrospective review by the HHSC UR Unit with the possibility for denial if the admission is determined not medically necessary. If the inpatient admission is denied as not medically necessary, HHSC UR may allow services rendered during the first 23 hours (less than 24 hours) to be rebilled to TMHP as an outpatient claim if a physician's order for outpatient observation is present in the hospital medical record (per Title 1 TAC §371.206[b]). The claim must be submitted to THMP within 120 days from the date of the UR notification letter.

The following documentation must accompany the revised bill:

- Revised UB-04 CMS-1450 claim form containing the required data for outpatient billing for medically necessary outpatient services.
- Copy of the UR notification letter indicating services may be rebilled.

When a client is admitted to the hospital as an inpatient and is discharged in less than 24 hours, the hospital may request that the physician change the admission order from inpatient status to outpatient observation status. This billing practice is acceptable under the Texas Medicaid Program when the physician makes the changes to the admitting order from inpatient status to outpatient observation status before the hospital submits the claim for reimbursement. A hospital is not allowed to convert a client from observation status to inpatient admission status without a physician's order.

25.3.3.3 Outpatient Total Parenteral Nutrition/Hyperalimentation

Outpatient total parenteral nutrition (TPN)/hyperalimentation is a benefit of the Texas Medicaid Program for eligible clients who require long-term nutritional support because of extensive bowel resection and/or severe advanced bowel disease in which the bowel cannot absorb nutrition.

Covered services must be medically necessary and prescribed by the physician. This service is not payable when oral/enteral intake will maintain adequate nutrition. TPN/hyperalimentation and lipids must be prior authorized.

Outpatient hospital TPN/hyperalimentation should be billed using the appropriate revenue code. Reimbursement to hospital outpatient departments furnishing in-home TPN services may not exceed the maximum yearly fee established by HHSC or its designee. Claims for TPN/hyperalimentation therapy administered as a nutritional supplement are denied.

25.3.3.4 Aerosol Treatment

Aerosol treatments, including vaporizers, humidifiers, nebulizers, and inhalers are a benefit of the Texas Medicaid Program. These treatments must be coded with revenue code B-412, Respiratory services–inhalation services.

The following diagnosis codes are payable for aerosol treatments:

Diagnosis Codes				
1363	27700	27701	27702	27703
27709	46611	46619	4801	486
488	4910	4911	49120	49121
49122	4918	4919	4920	4928
49300	49301	49302	49310	49311
49312	49320	49321	49322	49381
49382	49390	49391	49392	4940
4941	4950	4951	4952	4953
4954	4955	4956	4957	4958
4959	496	5070	5071	5078
51911	51919	5533	7707	99527

Medications used in aerosol therapy are reimbursed separately and must be billed using the appropriate HCPCS procedure code. Saline used in aerosol therapy is denied as part of the aerosol therapy.

Revenue code B-412, Inhalation services, billed for aerosol therapy in the recovery room after outpatient surgery (billed on an outpatient claim) is also allowable as it is a necessary adjunct to the postoperative recovery of a client who has undergone general anesthesia.

Revenue code B-412 includes the inhalers listed below and is payable in the outpatient setting (place of service [POS] 5) when it is the *only* therapy billed on that day:

- Beclomethasone dipropionate (*Vanceril* or *Beclovent* oral inhalers).
- Isoproterenol sulfate (*Iso-Autohaler, Luf-Iso Inhaler, Medihaler-Iso, Norisodrine Aerohaler*).
- Isoproterenol hydrochloride (*Iprenol, Vapo-Iso inhalers*).
- Albuterol (*Proventil* or *Ventolin inhalers*).
- Metaproterenol sulfate (*Alupent Metered Dose inhaler*, *Metaprel inhaler, Alupent* 10 mL, *Alupent* 30 mL).
- Epinephrine bitartrate (*Medihaler-Epi* and *Primatene Mist Suspension inhaler*).
- Phenylephrine bitartrate (*Duo-Medihaler*).
- Isoetharine mesylate inhalation aerosol (*Bronkometer*).
- Dexamethasone sodium phosphate (*Turbinaire* or *Respihaler*).

When revenue code B-412, Respiratory services–inhalation services, is billed on the same day for both aerosol therapy and inhalers, only one service is allowed, not both.

Pulse oximetry is considered part of an evaluation and management visit and will not be reimbursed separately. Demonstration and/or evaluation of client utilization of an aerosol generator, nebulizer, metered dose inhaler, or intermittent positive pressure breathing (IPPB) device will not be reimbursed separately.

IPPB treatments have been determined to be inappropriate for the treatment of most respiratory problems and are denied.

25.3.3.5 Pentamidine Aerosol

Aerosol pentamidine treatments will be reimbursed using procedure code 1-94642.

Additionally, the provider may also be reimbursed for the medication using procedure code 1-J2545.

Payment for aerosol pentamadine treatments is limited to the following diagnosis codes:

Diagnosis Codes				
042	07951	07952	07953	1363
48284	5186			

Aerosol pentamidine treatments are limited to one treatment every 28 days.

Oral trimethoprim-sulfamethoxazole is available from pharmacies for self administration at home. The use of oral trimethoprim-sulfamethoxazole is not a payable benefit of the insured portion of the Texas Medicaid Program.

25.3.3.6 Fluocinolone Acetonide

The fluocinolone acetonide (*Retisert*) intravitreal implant will be considered for reimbursement for ASCs and hospitals when services are rendered in the inpatient hospital and/or outpatient hospital settings for clients 12 years of age and older.

Procedure code 1-J7311 is only payable with a posterior uveitis diagnosis (36320) of more than six months in duration and only when the condition has been unresponsive to oral or systemic medication treatment. Prior authorization is required.

25.3.3.7 Pulmonary Function Studies

Pulmonary function studies include, but are not limited to, the following procedures:

Procedure Codes		
5/I/T-94010	5-94014	5-94015
5-94016	5/I/T-94060	5/I/T-94070
5/I/T-94150	5/I/T-94200	5/I/T-94240
5/I/T-94250	5/I/T-94260	5/I/T-94350
5/I/T-94360	5/I/T-94370	5/I/T-94375
5/I/T-94400	5/I/T-94450	5/I/T-94620
5/I/T-94621		

When multiple procedure codes are billed, the most inclusive code of the related codes will be paid and all other related codes will be denied.

When procedure code 5/I/T-94010 is billed with procedure code 5/I/T-94200, 5/I/T-94010 will be denied as part of 5/I/T-94200.

When procedure code 5/I/T-94010 is billed with 5/I/T-94060, 5/I/T-94010 will be denied as part of 5/I/T-94060.

When procedure code 5/I/T-94150 is billed with 5/I/T-94240, procedure code 5/I/T-94150 will be denied as part of 5/I/T-94240.

When procedure code 5/I/T-94200 is billed with 5/I/T-94060, procedure code 5/I/T-94200 will be denied as part of 5/I/T-94060.

When procedure codes 5/I/T-94010, 5/I/T-94200, and 5/I/T-94060 are billed with procedure code 5/I/T-94070, procedure codes 5/I/T-94010, 5/I/T-94200, and 5/I/T-94060 will be denied as part of 5/I/T-94070.

When procedure codes 5-94014 and 5-94015 are billed together, procedure code 5-94015 will be denied as part of 5-94014.

When procedure codes 5-94014, 5-94015, and 5-94016 are billed more than once per month they will suspend for review.

When procedure code 5/I/T-94621 is billed more than once per day by the same provider, the claim will suspend for review.

When unrelated pulmonary function studies are billed together, each will be paid.

25.3.3.8 Chemotherapy Administration

Hospitals must submit outpatient charges using the appropriate revenue codes for room charges, supplies, IV equipment, and pharmacy.

For chemotherapy administration, outpatient facilities should submit charges using the appropriate revenue codes, such as the revenue codes listed below:

Revenue Code	Description
B-264	IV therapy, IV therapy/supplies
B-450 *or* B456 *or* B-459	Emergency room *or* Emergency room, urgent care *or* Emergency room–other

Revenue Code	Description
B-510 *or* B-511 *or* B-512 *or* B-514 *or* B-515 *or* B-516 *or* B-517 *or* B-519	Clinic *or* Clinic–chronic pain center *or* Clinic–dental *or* Clinic; OB/GYN *or* Clinic; pediatric *or* Clinic, urgent care clinic *or* Clinic, family practice clinic *or* Clinic–other
B-761	Treatment room
B-762	Observation room

25.3.3.9 Bacillus Calmette-Guérin (BCG) Vaccine

Procedure code 1-J9031 is a benefit of the Texas Medicaid Program for the diagnosis codes listed below. Procedure code 1-90586 is also a benefit of the Texas Medicaid Program for the following diagnosis codes:

Diagnosis Codes				
1880	1881	1882	1883	1884
1885	1886	1887	1888	1889
1890	2337			

Procedure code 1-90585 is a benefit of the Texas Medicaid Program for diagnosis code V032. BCG vaccines will autodeny for all other diagnoses.

25.3.3.10 Tetanus Injections, Acute Care

Tetanus toxoid absorbed and tetanus immune globulin, human, are benefits of the Texas Medicaid Program.

Tetanus toxoid absorbed is an immunization used to prevent tetanus. It produces immunity to tetanus by promoting antibody production. The tetanus immune globulin provides a passive immunity for injuries that are over 24 hours old, extensively contaminated and/or for the client who has had less than two tetanus toxoid injections in a lifetime. Therefore, both of these injections can be given on the same day for the same injury event.

Tetanus toxoid and tetanus immune globulin should be billed with procedure codes 1-J1670 and 1-90703.

Tetanus toxoid and tetanus immune globulin injections are benefits for treating injuries such as puncture wounds, burns, or abrasions. These injections are diagnosis restricted.

Refer to: "Tetanus Injections, Acute Care" on page 36-71 for a complete list of covered diagnoses.

25.3.3.11 Deep Brain Stimulators

Implantation of neurostimulator electrodes for the treatment of intractable tremors, diagnosis code 3320, and 3331 are benefits. One of these diagnoses must appear on the claim for reimbursement to be considered. The actual deep brain stimulator device is a benefit only under the DRG or ASC/HASC reimbursement rate. No separate payment outside of the DRG or ASC/HASC reimbursement rate will be made for the device.

When billing for procedures related to the implantation of a deep brain stimulator, use the following codes. The types of service for which these codes are payable are listed with each code. TOS F should be used by the ASC/HASC.

Professional services for these codes are:

- Payable in the inpatient and outpatient settings.
- Subject to the global surgical fee policy, with three weeks precare and six weeks postcare days assigned.
- Subject to multiple surgery guidelines.

Procedure Codes	Types of Service
61880	2, 8, F
61885	2, F
61888	2, 8, F

The following procedure codes for the electronic analysis of the implanted neurostimulator pulse generator are payable without prior authorization:

Procedure Codes			
5-95970	5-95971	5-95972	5-95973
5-95974	5-95975	5-95978	5-95979

25.3.3.12 Neurostimulators

Neurostimulators are a benefit of the Texas Medicaid Program when medically necessary. All procedures require prior authorizations.

Refer to: "Neurostimulators" on page 36-32 for more information.

25.3.3.13 Hospital Laboratory Services

The American Medical Association (AMA) has discontinued the following general multichannel automated panel codes:

Discontinued Panel Codes			
5-80002	5-80003	5-80004	5-80005
5-80006	5-80007	5-80008	5-80009
5-80010	5-80011	5-80012	5-80013
5-80014	5-80015	5-80016	5-80017
5-80018	5-80019	5-G0058	5-G0059
5-G0060			

These panel codes were discontinued because the panel did not define exactly what tests are performed.

The new organ and disease panel codes 5-80048, 5-80051, 5-80053, 5-80069, and 5-80076 must be used instead of the general multichannel automated panel codes in the table above.

The CPT procedure codes in the table above should not be used as billing codes, but the payment amounts associated with pricing of these automated profiles will continue.

For example, if two automated profile tests are performed, the individual codes for the two automated tests must be billed instead of code 5-80002. For pricing, count the number of automated profile tests billed, and payment will be at the same rate as the former code 5-80002. CMS continues to provide updated pricing for the deleted profiles of automated tests.

The new organ or disease panels include the following codes:

5-80048 - Basic metabolic panel must include:			
5-82310	5-82374	5-82435	5-82565
5-82947	5-84132	5-84295	5-84520

5-80050 - General health panel must include:		
5-80053	5-85025 or 5-85027 and 5-85004 OR 5-85007 or 5-85009 and 5-85027	5-84443

5-80051 - Electrolyte panel must include:			
5-82374	5-82435	5-84132	5-84295

5-80053 - Comprehensive metabolic panel must include:			
5-82040	5-82247	5-82310	5-82374
5-82435	5-82565	5-82947	5-84075
5-84132	5-84155	5-84295	5-84450
5-84460	5-84520		

5-80055 - Obstetric panel must include:			
5-85025 or 5-85027 and 5-85004 OR 5-85007 or 5-85009 and 5-85027	5-86592	5-86762	5-86850
	5-86900	5-86901	5-87340

5-80061 - Lipid panel must include:		
5-82465	5-83718	5-84478

5-80069 - Renal function panel must include:			
5-82040	5-82310	5-82374	5-82435
5-82565	5-82947	5-84100	5-84132
5-84295	5-84520		

5-80074 - Acute hepatitis panel must include:			
5-86705	5-86709	5-86803	5-87340

5-80076 - Hepatic function panel must include:			
5-82040	5-82247	5-82248	5-84075
5-84155	5-84450	5-84460	

Outpatient and inpatient claims for laboratory services must reflect only tests actually performed by the hospital laboratory.

Exception: *Hospital laboratories may bill for all the tests performed on a specimen if some but not all the tests are done by another laboratory on referral from the hospital submitting the claim.*

The billing hospital must enter the name and provider identifier of the performing laboratory in Block 80 of the UB-04 CMS-1450 claim form and must enter the performing laboratory's provider identifier next to the service provided by the performing laboratory.

Hospitals may bill a handling fee procedure code (1-99001) for collecting and forwarding a specimen to a referral laboratory if the specimen is collected by venipuncture or catheterization. Only one handling fee may be charged per day, per client, unless specimens are sent to two or more different laboratories; this must be documented on the claim.

Laboratory tests generally performed as a panel (chemistries, complete blood count [CBC], urinalyses) must be billed with the appropriate HCPCS panel code. The policy applies to laboratory tests performed by a hospital laboratory.

Modifier 91

Modifier 91 should be used for *repeat* clinical diagnostic tests as follows:

- Modifier 91 must not be used when billing the initial procedure. It must be used to indicate the clinical diagnostic retest.
- If more than two services are billed on the same day by the same provider regardless of the use of modifier 91, the claim or detail is denied.
- If a clinical diagnostic retest is performed by the same provider on the same day and is billed without modifier 91, it is denied as a duplicate procedure.
- If a claim is denied for a quantity more than two or as a duplicate procedure, the times of these procedures/services must be documented on appeal.
- Modifier 91 is not required and must not be used when billing multiple quantities of a supply (for example, disposable diapers or sterile saline).

When appealing claims with modifier 91 for repeat procedures, providers must separate the details. One detail should be appealed without the modifier and one detail with the modifier, or documentation of times for each repeated procedure.

Modifier 76

The use of modifier 76 is limited as follows:

- Modifier 76 must not be used when billing the initial procedure, it must be used to indicate the non-clinical repeated procedure.
- If more than two services are billed on the same day by the same provider regardless of the use of modifier 76, the claim or detail is denied.
- If a repeated procedure performed by the same provider on the same day is billed without modifier 76, it is denied as a duplicate procedure.
- If a claim is denied for a quantity more than two or as a duplicate procedure, the times of these procedures/services must be documented on appeal.
- Modifier 76 is not required and must not be used when billing multiple quantities of a supply (for example, disposable diapers or sterile saline).

Certain procedure codes have been removed from modifier 76 auditing. These procedure codes have been identified as routinely being performed at the same time, more than twice per day for each antigen (e.g., agglutinins, febrile, [e.g., brucella, francisella, murine typhus, Q fever, Rocky Mountain spotted fever, scrub typhus], each antigen). Providers may still appeal claims for that have been denied for documentation of time. Most procedure codes initially requiring modifier 76 will continue to be audited for the 76 modifier.

When appealing claims with modifier 76 for repeat procedures, providers must separate the details. One detail should be appealed without the modifier and one detail with the modifier, or documentation of times for each repeated procedure.

Refer to: "Laboratory Paneling" on page 26-5 for more information about laboratory paneling procedures.

25.3.3.14 Helicobacter Pylori (H. Pylori)

The following procedure codes are benefits of the Texas Medicaid Program: 5-83009, 5-83013, 5-83014, 5-86677, and 5-87338.

These codes are considered to be clinical lab services and must be billed using TOS 5. The interpretation/professional component TOS I is not separately reimbursed.

Refer to: "Helicobacter Pylori (H. Pylori)" on page 36-40 for more information.

25.3.3.15 Colorectal Cancer Screening

The following procedure codes are benefits of the Texas Medicaid Program:

Procedure Codes		
2/F-G0104	2/F-G0105	2-G0121
4/I/T-G0106	4/I/T-G0120	

Procedure codes 2/F-G0104, 4/I/T-G0106, and 2-G0121 are limited to diagnosis codes V1272 and V7651.

Procedure codes 2/F-G0105 and 4/I/T-G0120 are limited to the following diagnosis codes:

Diagnosis Codes				
5550	5551	5552	5559	5560
5561	5562	5563	5568	5569
5589	V1005	V1006	V1272	V160
V1851				

Procedure code 4/I/T-G0122 is *not* a benefit of the Texas Medicaid Program.

Refer to: "Colorectal Cancer Screening" on page 36-29 for more information.

25.3.3.16 Pap Smears

Pap or estrogen smears are benefits of the Texas Medicaid Program. Pap smears completed for family planning purposes in the outpatient department should be billed using diagnosis code V2509. If a specimen is sent to an outside laboratory for processing, the outside laboratory must bill for the test. The hospital is not reimbursed for a collection or handling fee.

Refer to: "Cytopathology Studies—Gynecological, Pap Smears" on page 36-36 for more information on Pap smears.

25.3.3.17 Fetal Nonstress Testing and Contraction Stress Test

The following diagnosis codes are payable for *both* nonstress and contraction stress testing:

Diagnosis Codes				
30393	30403	30410	30411	30412
30413	30420	30421	30422	30423
30430	30431	30432	30433	30440
30441	30442	30443	30450	30451
30452	30453	30460	30461	30462
30463	30470	30471	30472	30473
30480	30481	30482	30483	30490
30491	30492	30493	5851	5852
5853	5854	5855	5856	5859
64210	64211	64212	64213	64214
64220	64221	64222	64223	64224
64230	64231	64232	64233	64240
64241	64242	64243	64244	64250
64251	64252	64253	64254	64260
64261	64262	64263	64264	64270
64271	64272	64273	64400	64403
64410	64413	64510	64513	64520
64523	64700	64701	64702	64703
64704	64710	64711	64712	64713
64714	64720	64721	64722	64723

Diagnosis Codes				
64724	64730	64731	64732	64733
64734	64740	64741	64742	64743
64744	64750	64751	64752	64753
64754	64760	64761	64762	64763
64764	64780	64781	64782	64783
64800	64801	64802	64803	65130
65131	65133	65140	65141	65143
65150	65151	65153	65160	65161
65163	65633	65650	65651	65653
65660	65661	65663	65840	65841
65843	V231	V232	V233	V235
V237	V2381	V2382	V2383	V2384
V2389	V239			

Nonstress Testing

Nonstress testing is a form of fetal monitoring in which transducers are applied to the mother's abdomen to monitor fetal heart rate. Tracings of this activity may be obtained from the fetoscope.

Nonstress testing conducted in the outpatient setting should be billed with revenue code B-729.

This revenue code is denied if it is billed more than once per day with the same provider. Procedure code 2-59025 and revenue code B-729 may be reimbursed on the same day, different provider, without appeal. Codes 2-59025 and B-729 billed more than once per day, same provider, will be denied. The provider must appeal with documentation supporting the performance of the test more than once on the same day/same provider.

Revenue code B-729 is payable for outpatient (POS 5) hospital settings and to hospital-based rural health clinics only. The inpatient hospital stay is payable under the hospital's reimbursement methodology.

The following diagnosis codes are payable only for nonstress testing (B-729):

Diagnosis Codes				
64110	64111	64113	64120	64121
64123	64130	64131	64133	64180
64181	64183	64190	64191	64193
65420	65421	65423	65570	65571
65573				

Contraction Stress Testing

The contraction stress test is performed to assess the condition of the fetus in utero. This test is done by monitoring the fetus' response to the stress of uterine contractions. Baseline recordings of the fetal heart rate are made by an electronic devise such as a Doppler. IV oxytocin is administered to produce uterine contractions. Fetal heart rate is measured during the contractions.

Sustained alterations of the heart rate beyond the contractions may indicate fetal distress and the need for further intervention.

Contraction stress testing conducted in the outpatient setting should be billed with revenue code B-729.

Revenue code B-729 is reimbursed on the same day/different provider, without appeal. This procedure code is denied if it is billed more than once per day with the same provider. Procedure code 2-59020 and revenue code B-729 may be reimbursed on the same day, different provider, without appeal. Codes 2-59025 and B-729 billed more than once per day, same provider, will be denied. The provider must appeal with documentation supporting the performance of the test more than once on the same day/same provider.

Revenue code B-729 is payable for outpatient hospital stays and to hospital-based rural health clinics only. The inpatient hospital stay is reimbursed under the hospital's DRG.

The following diagnosis codes are payable only for contraction stress testing (B-729):

Diagnosis Codes				
28241	28242	28249	28263	28264
28268	65613	65620	65621	65623
65803				

Refer to: "Nonstress Testing, Contraction Stress Testing" on page 36-84 for related physician services.

25.3.3.18 Hospital Radiology Services

Procedure codes 5-93000, T-93005, I-93010, 5-93040, T-93041, and I-94042 will be considered for reimbursement for electrocardiograms if submitted with one of the diagnosis codes in the chart below.

Diagnosis Codes				
03282	0362	03640	03641	03642
03643	07420	07421	07422	07423
0860	08881	0930	0931	09320
09321	09322	09323	09324	0938
09381	09382	09389	09883	09884
09885	11281	11503	11504	11513
11514	11593	11594	124	1303
135	1640	1641	1642	1643
1648	1649	19889	2127	25000
25001	25002	25003	25010	25011
25012	25013	25020	25021	25022
25023	25030	25031	25032	25033
25040	25041	25042	25043	25050
25051	25052	25053	25060	25061
25062	25063	25070	25071	25072
25073	25080	25081	25082	25083

Diagnosis Codes				
25090	25091	25092	25093	2512
2720	2721	2722	2723	2724
2725	2726	2727	2728	2750
2752	2753	27541	27542	2760
2761	2762	2763	2764	27650
27651	27652	2766	2767	2768
27730	27739	3062	3373	390
3910	3911	3912	3918	3919
392	3920	3929	393	3940
3941	3942	3949	3950	3951
3952	3959	3960	3961	3962
3963	3968	3969	3970	3971
3979	3980	3989	39890	39891
39899	4010	4011	4019	40200
40201	4021	40210	40211	40290
40291	40300	40301	40310	40311
40390	40391	40400	40401	40402
40403	40410	40411	40412	40413
40490	40491	40492	40493	40501
40509	40511	40519	41000	41001
41002	41010	41011	41012	41020
41021	41022	41030	41031	41032
41040	41041	41042	41050	41051
41052	41060	41061	41062	41070
41071	41072	41080	41081	41082
41090	41091	41092	4110	4111
4118	41181	41189	412	4130
4131	4139	4140	41400	41401
41402	41403	41404	41405	41406
41407	41410	41411	41412	41419
4142	4148	4149	4150	4151
41511	41512	41519	4160	4161
4168	4169	4170	4171	4178
4179	4200	42090	42091	42099
4210	4211	4219	4220	42290
42291	42292	42293	42299	4230
4231	4232	4233	4238	4239
4240	4241	4242	4243	42490
42491	42499	4250	4251	4252
4253	4254	4255	4257	4258
4259	4260	42610	42611	42612
42613	4262	4263	4264	42650
42651	42652	42653	42654	4266
4267	42681	42682	42689	4269

Diagnosis Codes				
4270	4271	4272	42731	42732
42741	42742	4275	42760	42761
42769	42781	42789	4279	4280
4281	42820	42821	42822	42823
42830	42831	42832	42833	42840
42841	42842	42843	4289	4290
4291	4292	4293	4294	4295
4296	42971	42979	42981	42982
42983	42989	4299	43300	43301
43310	43311	43390	43391	43400
43401	43410	43411	43490	43491
4359	4372	44100	44101	44103
4411	4412	4416	4417	4439
4440	4441	44421	44422	4460
4467	4580	45821	4589	4590
496	514	5173	5184	5185
51882	51884	51919	53081	57410
64201	64202	64203	64204	64251
64252	64253	64254	64850	64851
64852	64853	64854	65420	65423
66810	66811	66812	66813	66814
66971	67450	67451	67452	67453
67454	7100	7142	71941	7200
7231	7295	7336	7450	74510
74511	74512	74519	7452	7453
7454	7455	74560	74561	74569
7457	7458	7459	74600	74601
74602	74609	7461	7462	7463
7464	7465	7466	7467	74681
74682	74683	74684	74685	74686
74687	74689	7469	7470	74710
74711	74720	74721	74722	74729
7473	74740	74741	74742	74749
7580	7593	75982	78001	78002
78003	78009	7802	7804	78079
7808	7815	7823	7825	7850
7851	7852	7853	78550	78551
78552	78559	78600	78602	78605
78609	78650	78651	78652	78659
78701	78702	78703	7871	78900
78907	78960	7904	7905	7906
7932	79430	79431	79439	7991
8072	8073	8074	8600	8601
8602	8603	8604	8605	86100

Diagnosis Codes				
86101	86102	86103	86110	86111
86112	86113	8628	8629	90000
90001	90002	90003	9001	9010
9011	9012	9013	90140	90141
90142	90181	90182	90183	9221
9584	9607	9631	96509	9720
9721	9722	9723	9724	9725
9726	9727	9728	9729	9779
986	9893	9894	9895	9920
9921	9940	9941	9947	9948
9950	99522	99523	99527	99600
99601	99602	99603	99604	99609
99661	99671	99672	99683	9971
9980	99931	99939	9994	V151
V252	V421	V422	V426	V4321
V433	V4500	V4501	V4502	V4509
V4581	V4582	V472	V4983	V5331
V5332	V5339	V5844	V5869	V717
V7281	V7284			

Prior authorization or retrospective authorization is required for:

- Magnetic resonance imaging (MRI).
- Magnetic resonance angiography (MRA).
- Computed tomography imaging (CT).
- Computed tomography angiography (CTA).
- inpatient hospital MRI, MRA, CT, or CTA.

Prior authorization is required for all outpatient nonemergent CT, CTA, MRI, and MRA studies (i.e. those that are scheduled) before services are rendered. Authorization is not required for the emergency department. Retrospective authorization is required for outpatient emergent studies when the physician determines that a medical emergency that imminently threatens life or limb exists, and the medical emergency requires advanced diagnostic imaging (CT, CTA, MRI, or MRA). Providers must submit a retrospective authorization request no later than two business days after the study is completed.

The addition of post 3-D reconstruction (76376 and 76377) CT and MR studies must be prior authorized. No additional payment will be made without prior authorization. Obstetrical 3-D reconstruction ultrasound is not a benefit of the Texas Medicaid Program.

Refer to: "Radiology Services" on page 36-121, for further information.

All medically necessary radiology services provided to hospital clients must be ordered by the client's attending or consulting physician. These services must be documented in the client's medical record.

The diagnoses submitted on the claim form should reflect the medical necessity of services rendered. If a diagnosis is not available, TMHP accepts signs and symptoms. TMHP monitors the diagnoses indicated for the following procedures:

- Ambulatory electroencephalograms (A/EEG).
- EKG.
- Arteriography.
- Venography.
- Radiation therapy.
- Cardiac blood pool imaging.
- Chest X-rays.
- Computed tomography (CT) scans.
- Echography.
- Magnetic resonance angiogram (MRA).
- Mammography.
- Magnetic resonance imaging (MRI) mammography.
- Polysomnography.

Repeat Procedures/Modifier 76

The use of modifier 76 is limited as follows:

- Modifier 76 must not be used when billing the initial procedure. It must be used to indicate the repeated non-clinical procedure.
- If more than two services are billed on the same day by the same provider regardless of the use of modifier 76, the claim or detail is denied.
- If a repeated procedure performed by the same provider on the same day is billed without modifier 76, it is denied as a duplicate procedure.
- If a claim is denied for a quantity more than two or as a duplicate procedure, the times of these procedures/services must be documented on appeal.
- Modifier 76 is not required and must not be used when billing multiple quantities of a supply (e.g., disposable diapers or sterile saline).

When appealing claims with modifier 76 for repeat non-clinical procedures, providers must separate the details. One detail should be appealed without the modifier and one detail with the modifier, or documentation of times for each repeated procedure.

Certain procedure codes have been removed from modifier 76 auditing. These procedure codes have been identified as routinely being performed at the same time, more than twice per day for each antigen (e.g., agglutinins, febrile [e.g., Brucella, Francisella, Murine typhus, Q fever, Rocky Mountain spotted fever, scrub typhus], each antigen). Providers may still appeal claims that have been denied for documentation of time. Most procedure codes initially requiring modifier 76 will continue to be audited for the modifier 76.

25.3.3.19 Computed Tomography

Scout views and reconstruction are considered part of any CT procedure and are not reimbursed in addition to any other CT. Procedure codes 4-76375 and 4-76380, are denied when billed on the same day as any other CT. Procedure codes 4-76375 and 4-76380 are paid if billed as an independent procedure.

25.3.3.20 Strontium-89 Chloride

Supply of therapeutic radiopharmaceutical, strontium-89 chloride, per mci, is a benefit of the Texas Medicaid Program. Strontium-89 should be billed using procedure code 9-A9600 and is limited to a total of ten mci intravenously injected every 90 days, any provider.

Reimbursement of strontium-89 is restricted to the following diagnosis codes:

Diagnosis Codes				
1740	1741	1742	1743	1744
1745	1746	1748	1749	1750
1759	185	1985		

25.3.3.21 Technetium TC 99M Tetrofosmin

Procedure code 9-A9502 is a benefit without age restriction. It is payable in the office, inpatient, and outpatient settings. Payable providers are physicians, radiation treatment centers, and hospitals.

Inpatient settings are reimbursed under their DRG. Services provided in the outpatient hospital setting are paid at the Texas Medicaid Reimbursement Methodology (TMRM). The reimbursement for procedure code 9-A9502 can be found in the Physician's Fee Schedule on the TMHP website at www.tmhp.com/file library/file library /fee schedules.

25.3.3.22 Low Osmolar (Nonionic) Contrast Material (LOCM)

Reimbursement for radiological procedures, such as MRI or CT, with descriptions that specify "with contrast", include payment for high osmolar, LOCM and paramagnetic contrast materials.

These contrast materials will not be reimbursed separately.

Radiopharmaceuticals, when used for therapeutic treatment, may be considered for separate reimbursement.

25.3.3.23 Cardiac Blood Pool Imaging

Cardiac blood pool imaging (procedure codes 4/I/T-78472, 4/I/T-78473, 4/I/T-78481, 4/I/T-78483, 4/I/T-78494, and 4/I/T-78496) is a benefit for the following diagnosis codes:

Diagnosis Codes				
3526	3940	3941	3942	3949
3950	3951	3952	3959	3960
3961	3962	3963	3968	3969
3970	3971	3979	41000	41001
41002	41010	41011	41012	41020
41021	41022	41030	41031	41032
41040	41041	41042	41050	41051
41052	41060	41061	41062	41070
41071	41072	41080	41081	41082
41090	41091	41092	4110	4111
41181	41189	412	4130	4131
4139	41400	41401	41402	41403
41404	41405	41406	41407	41410
41411	41412	41419	4142	4148
4149	4150	41511	41519	4160
4161	4168	4169	4170	4171
4178	4179	4200	42090	42091
42099	4210	4211	4219	4220
42290	42291	42292	42293	42299
4230	4231	4232	4238	4239
4240	4241	4242	4243	42490
42491	42499	4250	4251	4252
4253	4254	4255	4257	4258
4259	4260	42610	42611	42612
42613	4262	4263	4264	42650
42651	42652	42653	42654	4266
4267	42681	42682	42689	4269
4270	4271	4272	42731	42732
42741	42742	4275	42760	42761
42769	42781	42789	4279	4280
4281	42820	42821	42822	42823
42830	42831	42832	42833	42840
42841	42842	42843	4289	4290
4291	4292	4293	4294	4295
4296	42971	42979	42981	42982
42989	4299	78099	7813	78650
78651	78652	78659	7991	V4321
V4581				

25.3.3.24 Gamma Knife Radiosurgery

The following diagnosis codes are payable for 2/F-61793:

Diagnosis Codes				
1700	1701	1702	1703	1704
1705	1706	1707	1708	1709
1710	1910	1911	1912	1913
1914	1915	1916	1917	1918

Diagnosis Codes				
1919	1944	1983	2251	2252
2254	2273	2370	2371	2530
2531	2550	25511	25512	25513
25514	25541	25542	3501	74760
74781				

25.3.3.25 Hospital Radiation Therapy Services

Outpatient radiation therapy is limited to a maximum of five facility services every seven days beginning with the first date of service.

Take-home drugs given during the course of therapy can be reimbursed separately through the Vendor Drug Program.

Freestanding radiation therapy facilities (specialty 98) and outpatient hospitals are reimbursed only for the technical component (TOS T) for services rendered in POS 5 for the services listed in the following procedure code tables.

The following radiation therapy services provided in an outpatient setting are allowed only once per day unless documentation of medical necessity supports the need for repeated services: therapeutic radiation treatment planning, therapeutic radiology simulation-aided field setting, teletherapy, brachytherapy isodose calculation, treatment devices, proton beam delivery/treatment, intracavity radiation source application, interstitial radiation source application, remote afterloading high intensity brachytherapy, radiation treatment delivery, localization, and radioisotope therapy.

Clinical Treatment Planning

Procedure Codes			
T-77280	T-77285	T-77290	T-77295
T-77299	T-77301		

Refer to: "Physician" on page 36-1 for further radiation therapy guidelines.

Medical Radiation Physics, Dosimetry, Treatment Devices, and Special Services

Procedure Codes			
T-77300	T-77305	T-77310	T-77315
T-77326	T-77327	T-77328	T-77332
T-77333	T-77334	T-77371	T-77372
T-77373	T-77399		

Clinical Brachytherapy

Procedure Codes			
F-55875	F-55876	F-57155	F-58346
T-77781	T-77782	T-77783	T-77784
T-77789	T-77799		

Radiation Treatment Delivery/Port Films

Procedure Codes			
T-77401	T-77402	T-77403	T-77404
T-77406	T-77407	T-77408	T-77409
T-77411	T-77412	T-77413	T-77414
T-77416	T- 77417	T-77418	T-77421
T-77422	T-77423		

Contrast Materials/Radiopharmaceuticals

Reimbursement for radiological procedures, such as MRI or CT, with descriptions that specify with contrast, include payment for high osmolar, LOCM and paramagnetic contrast materials. These contrast materials will not be reimbursed separately.

Radiopharmaceuticals, when used for therapeutic treatment, may be considered for separate reimbursement.

The following procedure codes may be billed for therapeutic radiopharmaceuticals:

Procedure Codes			
6-79403	9-A9517	9-A9543	9-A9699

The following services are *not* benefits of the Texas Medicaid Program:

Procedure Codes			
6-77321	6-77331	6-77336	6-77370
6-77470	6–77600	6-77620	6-77790

Radiation therapy services will be allowed once per day, unless documentation submitted with an appeal supports the need for the service to be provided more than once.

Clinical brachytherapy services include admission to the hospital and daily care. Initial and subsequent hospital care will be denied on the same day that clinical brachytherapy services are billed.

Texas Medicaid Program benefits include payment for the technical portion of radiation therapy services provided in an inpatient setting. Covered services include clinical treatment planning and management and clinical brachytherapy. Hospitals use revenue code B-333, Radiation therapy, on the UB-04 CMS-1450 claim form when submitting charges for these services.

25.3.3.26 Hyperbaric Oxygen Therapy (HBO)

HBO is a type of therapy that is intended to increase the environmental oxygen pressure to promote the movement of oxygen from the environment into the body tissues by means of pressurization that is greater than atmospheric pressure. Such treatment is performed in specially constructed hyperbaric chambers, which may hold one or several patients.

Note: *Although oxygen may be administered by mask, cannula, or tube in addition to the hyperbaric treatment, the use of oxygen by mask, etc., or applied topically is not considered hyperbaric treatment in itself.*

HBO will be limited to one session per day, any provider using procedure code 1-99183.

Outpatient hospital clinics and hospital-based rural health centers must use revenue code B-413, Respiratory services, HBO, (quantity of one) for reimbursement of the technical component.

The FDA-approved indications for the hyperbaric oxygen chamber (therapy) in accordance with the guidelines established by the Undersea and Hyperbaric Medical Society are as follows:

- Air or gas embolism.
- Carbon monoxide/smoke inhalation.
- Compromised skin grafts and flaps.
- Crush injuries/acute traumatic ischemias.
- Decompression sickness.
- Enhanced healing in selected problem wounds.
- Exceptional blood loss (anemia).
- Gas gangrene (clostridial myonecrosis).
- Intracranial abscess.
- Necrotizing soft tissue infections.
- Radiation tissue damage (osteoradionecrosis).
- Refractory osteomyelitis.
- Thermal burns.

When requesting reimbursement of HBO for the treatment of *air or gas embolism* the following diagnosis codes should be used:

Diagnosis Codes			
6396	67300	9580	9991

When requesting reimbursement of HBO for the treatment of *carbon monoxide/smoke inhalatio*n use diagnosis code 986.

When requesting reimbursement of HBO for the treatment of *compromised skin grafts and flap*s the following diagnosis codes should be used:

Diagnosis Codes				
99652	99660	99661	99662	99663
99664	99665	99666	99667	99668
99669	99670	99671	99672	99673
99674	99675	99676	99677	99678
99679	V423			

When requesting reimbursement of HBO for the treatment of *crush injuries/acute traumatic ischemia*s the following diagnosis codes should be used:

Diagnosis Codes				
8690	8691	8871	8873	8875
8877	8971	8973	8975	8977
9251	9252	9260	92611	92612
92619	9268	9269	92700	92701
92702	92703	92709	92710	92711
92720	92721	9273	9278	9279
92800	92801	92810	92811	92820
92821	9283	9288	9289	9290
9299	99690	99691	99692	99693
99694	99695	99696	99699	

When requesting reimbursement of HBO for the treatment of *decompression sickness* use diagnosis code 9933.

When requesting reimbursement of HBO for the treatment of *enhanced healing in selected problem wounds* the following diagnosis codes should be used:

Diagnosis Codes				
25070	25071	25072	25073	44023
44024	44381	44382	44389	4439
4540	4542	68600	68601	68609
70700	70701	70702	70703	70704
70705	70706	70707	70709	70710
70711	70712	70713	70714	70715
70719	7078	7079	9895	99859

When requesting reimbursement of HBO for the treatment of *exceptional blood loss (an*emia) the following diagnosis codes should be used:

Diagnosis Codes				
2851	78552	78559	9584	9980

When requesting reimbursement of HBO for the treatment of *gas gangrene (clostridial myonecrosis)* diagnosis codes 0383 and 0400 should be used.

When requesting reimbursement of HBO for the treatment of *necrotizing soft tissue infections* diagnosis codes 72886 and 7854 should be used.

When requesting reimbursement of HBO for the treatment of *radiation tissue damage (osteoradionecrisis)* the following diagnosis codes should be used:

Diagnosis Codes				
73010	73011	73012	73013	73014
73015	73016	73017	73018	73019
7854	9092	990		

When requesting reimbursement of HBO for the treatment of *refractory osteomyelitis* the following diagnosis codes should be used:

Diagnosis Codes				
73010	73011	73012	73013	73014
73015	73016	73017	73018	73019

When requesting reimbursement of HBO for the treatment of *thermal burns* the following diagnosis codes should be used:

Diagnosis Codes				
9400	9401	9402	9403	9404
9405	9409	94100	94101	94102
94103	94104	94105	94106	94107
94108	94109	94110	94111	94112
94113	94114	94115	94116	94117
94118	94119	94120	94121	94122
94123	94124	94125	94126	94127
94128	94129	94130	94131	94132
94133	94134	94135	94136	94137
94138	94139	94140	94141	94142
94143	94144	94145	94146	94147
94148	94149	94150	94151	94152
94153	94154	94155	94156	94157
94158	94159	94200	94201	94202
94203	94204	94205	94209	94210
94211	94212	94213	94214	94215
94219	94220	94221	94222	94223
94224	94225	94229	94230	94231
94232	94233	94234	94235	94239
94240	94241	94242	94243	94244
94245	94249	94250	94251	94252
94253	94254	94255	94259	94300
94301	94302	94303	94304	94305
94306	94309	94310	94311	94312
94313	94314	94315	94316	94319
94320	94321	94322	94323	94324
94325	94326	94329	94330	94331
94332	94333	94334	94335	94336
94339	94340	94341	94342	94343
94344	94345	94346	94349	94350
94351	94352	94353	94354	94355
94356	94359	94400	94401	94402
94403	94404	94405	94406	94407
94408	94410	94411	94412	94413
94414	94415	94416	94417	94418
94420	94421	94422	94423	94424
94425	94426	94427	94428	94430
94431	94432	94433	94434	94435
94436	94437	94438	94440	94441
94442	94443	94444	94445	94446
94447	94448	94450	94451	94452
94453	94454	94455	94456	94457

Diagnosis Codes				
94458	94500	94501	94502	94503
94504	94505	94506	94509	94510
94511	94512	94513	94514	94515
94516	94519	94520	94521	94522
94523	94524	94525	94526	94529
94530	94531	94532	94533	94534
94535	94536	94539	94540	94541
94542	94543	94544	94545	94546
94549	94550	94551	94552	94553
94554	94555	94556	94559	9460
9461	9462	9463	9464	9465
9470	9471	9472	9473	9474
9478	9479	94800	94810	94811
94820	94821	94822	94830	94831
94832	94833	94840	94841	94842
94843	94844	94850	94851	94852
94853	94854	94855	94860	94861
94862	94863	94864	94865	94866
94870	94871	94872	94873	94874
94875	94876	94877	94880	94881
94882	94883	94884	94885	94886
94887	94888	94890	94891	94892
94893	94894	94895	94896	94897
94898	94899	9490	9491	9492
9493	9494	9495		

HBO that exceeds one session per day, any provider will be denied.

25.3.3.27 Implantable Contraceptive Capsules

ASCs and HASCs billing for insertion or removal of implantable contraceptive capsules should use procedure code F-11975, F-11976, and F-11977.

Implantable contraceptive capsules are payable for the following diagnoses:

Diagnosis Codes				
99632	V2501	V2502	V2509	V251
V252	V2541	V2542	V2543	V2549
V255	V258	V259	V615	

25.3.3.28 Occupational and Physical Therapy Services

Refer to: "Physical Therapists/Independent Practitioners" on page 35-1 for more information about physical therapy.

"Occupational Therapy (OT) Services" on page 24-16 and "Occupational Therapy" on page 36-89, for more information about occupational therapy.

25.3.3.29 Osteopathic Manipulation Treatments (OMT)

OMT is a benefit of the Texas Medicaid Program for the acute phase of the acute musculoskeletal injury or the acute phase of an acute exacerbation of a chronic musculoskeletal injury including acute musculoskeletal injury with a neurological component. The acute modifier AT must be submitted with the claim for payment to be made.

The AT modifier is described as representing treatment provided for an acute condition, or an exacerbation of a chronic condition, which persists less than 180 days from the start date of therapy. If the condition persists for more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client's condition has not become chronic and the client has not reached the point of plateauing. Plateauing is defined as the point at which maximal improvement has been documented and further improvement ceases.

Use procedure codes 1-98925, 1-98926, 1-98927, 1-98928, and 1-98929 when billing for OMT to the head, cervical, thoracic, lumbar, sacral, pelvic, lower extremities, upper extremities, rib cage, abdominal, and visceral regions.

When multiples of procedure codes 1-98925, 1-98926, 1-98927, 1-98928, and 1-98929 are billed on the same day by the same provider, the most inclusive code is paid and the others denied.

Procedure code 1-97140 will deny as part of another service if billed on the same date of service as procedure codes 98925, 98926, 98927, 98928, or 98929.

25.3.3.30 Psychiatric Services

Each individual behavioral health practitioner is limited to a combined total of 12 hours of Medicaid reimbursement per day for behavioral health services. Each individual delegated to perform behavioral health services by a doctor of medicine (MD) or doctor of osteopathy (DO) is also limited to a combined total of 12 hours. MDs and DOs who delegate and providers who perform group therapy may possibly submit claims in excess of 12 hours in a given day.

Retrospective review may occur for both the total hours of services performed per day and for the total hours of services billed per day. If inappropriate payments are identified, the money will be recouped. Documentation requirements for all services billed are listed for each individual specialty in this manual.

Outpatient behavioral health services without prior authorization are limited to 30 encounters/visits per client per calendar year. An encounter/visit is defined as any and all outpatient behavioral health services rendered per hour by any provider, in the office, outpatient, nursing home, and home settings. This limitation includes encounters/visits by all practitioners.

The following services are not counted towards the 30-encounter/visit limitation:

- School Health and Related Services (SHARS) behavioral health rehab services.
- Mental Health and Mental Retardation (MHMR) services.
- Laboratory and radiology services.
- Pharmacological management (1-90862).

Services that exceed 30 encounters/visits per calendar year per client must be prior authorized. Prior authorization must be obtained before providing the 25th service in a calendar year. Prior authorization requests in increments of up to 10 additional encounters/visits may be considered. If the client changes providers during the year and the new provider is unable to obtain complete information on the client, prior authorization may be made when the request is accompanied by an explanation as to why the provider was not able to submit the prior authorization request by the 25th encounter/visit and before rendering services. This information must be submitted in addition to the usual medical necessity information.

It is recognized that a client may change providers in the middle of the year, and the new provider may not be able to obtain complete information on the client. In these instances, prior authorization may be made before rendering services when the request is accompanied by an explanation as to why the provider was unable to submit the prior authorization request by the client's 25th encounter/visit.

All authorization requests for extension of outpatient psychotherapy sessions beyond the annual 30-encounter/visit limitation are limited to 10 encounters/visits per request, and must be submitted on the Extended Outpatient/ Counseling Request Form. Requests must include the following:

- Client name and Medicaid number.
- Provider name and provider identifier.
- Clinical update, including current specific symptoms and response to past treatment, and treatment plan (measurable short term goals for the extension, specific therapeutic interventions to be used in therapy, measurable expected outcomes of therapy, length of treatment anticipated, and planned frequency of encounters/visits).
- Number and type of services requested and the dates (based on the frequency of visits) that the services will be provided.

- All areas of the request must be completed with the information required on the form. If additional room is needed providers may state "see attached." The attachment must contain the specific information required in that section of the form.

Prior authorization is not granted to providers who have seen a client for an extended period of time or from the start of the calendar year and who have not requested prior authorization before the 25th encounter/visit. It is recommended that a request for extension of outpatient behavioral health be submitted no sooner than 30 days before the date of service being requested, so that the most current information is provided.

The number of encounters/visits authorized is dependent on the client's symptoms and response to past treatment. If the client requires additional extensions, the provider must submit a new request for prior authorization at the end of each extension period. *The request for additional encounters/visits* must include new documentation addressing the client's current condition, treatment plan, and the therapist's rationale supporting the medical necessity for these *additional encounters/visits.* Prior authorization for an extension of outpatient behavioral health services is granted when the treatment is mandated by the courts for court-ordered services. A copy of the court order for outpatient treatment signed by the judge must accompany prior authorization requests.

Mail or fax the request to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

Use revenue code A-124 for inpatient psychiatric services. The following psychiatric services are not benefits of the Texas Medicaid Program:

- The services of a licensed chemical dependency counselor (LCDC), psychological associate (masters level psychologist), psychiatric nurse, or behavioral health worker.
- Psychiatric daycare.
- Recreational therapy.
- Biofeedback.
- Music/dance.
- Thermogenic therapy.

Outpatient psychiatric services for the diagnosis or treatment of a mental, psychoneurotic, or personality disorder are reimbursed at the hospital's designated reimbursement rate as determined by the annual cost settlement.

Note: *NorthSTAR is a managed care program in the Dallas service area that covers behavioral health services. Psychiatrists that provide behavioral health services to clients in NorthSTAR must be members of the NorthSTAR BHOs.*

Refer to: "Request for Extended Outpatient Psychotherapy/Counseling Form" on page B-83.

"Medicaid Managed Care" on page 7-4 for more information or contact the client's BHO.

25.3.3.31 Psychological and Neuropsychological Testing

Psychological or neuropsychological testing will be limited to a total of four hours per day per client, any provider. Documentation of medical necessity must be maintained in the client's chart. Each hour of therapy, psychological and/or neuropsychological testing counts as one of the 30-encounter/visit limit.

Refer to: "Psychological and Neuropsychological Testing" on page 38-6 for information on outpatient psychological and neuropsychological testing, including procedure codes and diagnosis code restrictions.

25.3.3.32 Sterilization Services

The Texas Medicaid Program benefits include payment for elective sterilization (performed solely for the purpose of rendering the individual incapable of bearing or fathering children) of eligible clients when providers comply with HHS regulations (42 CFR 441.250, Subpart F).

Payment of elective sterilization is *not* made if the client is:

- Younger than 21 years of age at the time the consent form is signed.
- Declared mentally incompetent for the purpose of sterilization (the individual may be adjudicated competent for the purpose of sterilization).
- Institutionalized in a correctional facility, mental hospital, or other rehabilitative facility.
- Giving consent during labor or childbirth, under the influence of alcohol or other drugs, or while seeking or obtaining an abortion.

If a client eligible for Medicaid decides not to be sterilized after entering the hospital, the hospital may be reimbursed for its services. The hospital must submit a valid consent form signed by the client. The physician's signature is not required.

TMHP must have a signed, valid sterilization consent form on file to reimburse elective sterilization procedures. Typewritten, blocked, or facsimile stamped signatures are not acceptable for signature requirements. When TMHP receives a valid consent form, the client's eligibility file is updated to reflect receipt. Subsequent claims received by TMHP for the sterilization covered by the consent are referenced to the valid consent and reimbursed even if they are not accompanied by a valid consent. It is to the provider's benefit to submit a consent form with claims for sterilization rather than relying on a fellow provider. A legible valid copy of the consent is acceptable.

The "Sterilization Consent Form Instructions (2 Pages)" on page B-94 and the HHS-approved form (supplied by TMHP) are the only acceptable forms. Providers may use

their own consent form as long as the form has the HHS-approved language and required fields. The only exception is if the provider obtains prior approval from HHS.

Refer to: "Elective Sterilization Services" on page 36-45.

"Sterilization and Sterilization-Related Procedures" on page 20-11 for elective sterilization services requirements and instructions.

25.3.4 Utilization Review

UR activities of all Medicaid services provided by hospitals reimbursed under the DRG prospective payment system or TEFRA are required by Title XIX of the *Social Security Act*, Sections 1902 and 1903. The review activities are accomplished through a series of monitoring systems developed to ensure services are appropriate to need, of optimum quality and quantity, and rendered in the most cost-effective mode. Clients and providers are subject to UR monitoring. The monitoring focuses on the appropriate screening activities, medical necessity of all services, and quality of care as reflected by the choice of services provided, type of provider involved, and settings in which the care was delivered. This monitoring ensures the efficient and cost-effective administration of the Texas Medicaid Program.

UR may also occur by an examination of particular claims or services not within the usual screening review when a specific UR is requested by HHSC or the Texas Attorney General's Office.

25.3.4.1 Responsibilities

TMHP is responsible for a comprehensive integrated review process to identify misuse and inappropriate billing patterns by outpatient hospitals and HASCs. All providers are subject to TMHP's UR monitoring. Providers are selected for review based on a comparison of their individual resource utilization with a peer group of similar specialty and geographic locality. The main goal of the required utilization control is to identify those providers whose practice patterns are aberrant from their peers and provide the necessary educational actions to help the provider achieve Texas Medicaid Program compliance. An analysis of UR data is completed by a registered nurse analyst for review by the medical director and staff. If the analyst substantiates that a provider's practice and billing patterns are inconsistent with the federal requirements and the Texas Medicaid Program's scope of benefits, a TMHP representative contacts the provider. The purpose of the contact is to discuss appropriate billing guidelines and to assist the provider in resolving the inappropriate billing patterns identified in the review.

TMHP uses the following criteria when reviewing all hospital outpatient medical records. Services must be:

- Medically necessary.
- Ordered by a physician, signed, and dated. Signature stamps are valid if initialed and dated by the physician.
- Billed in the quantities ordered and documented as provided.
- Program benefits.
- Specifically identified on the charge tickets or itemized statement submitted with the claim or by the HCPCS procedure code on the claim.
- Billed to the Texas Medicaid Program only after other medical insurance resources have been exhausted.

Refer to: "Medicaid Identification (Form H3087)" on page 4-10.

- Indicated by the documentation in the medical record.

The determination of TMHP's UR process may result in the following:

- Educational letters/visits.
- Mail-in of medical records for review.
- On-site medical record review (outpatient, ASC/HASC, or inpatient records *not* reviewed).
- Referral of questionable claims to HHSC or HHSC OIG.
- Recoupment.
- Prepayment review.

The intent of these actions is to ensure the most effective and appropriate use of available services and facilities and provide appropriate, cost-effective care to clients with Medicaid coverage.

25.3.5 Claims Information

Identification of outpatient charges must be in Block 43, if submitting by narrative description or in Block 44, if submitting by HCPCS code. The Texas Medicaid Program recommends the use of specific procedure codes for claim submission. Do *not* use the revenue code description in Block 43. The HCPCS narrative description must be identified on the claim. For example, when submitting charges for physical therapy, do not use the description associated with revenue code 420. To receive reimbursement for physical therapy services, providers must identify the specific modality used (for example, gait training).

Charges on claims must be itemized on the face of the UB-04 CMS-1450 claim form instead of submitting attachments or charge tickets. Additional claims information can be found within individual topic areas within this section.

Charges on claims must be itemized on the face of the UB-04 CMS-1450 claim form instead of submitting attachments or charge details. TMHP uses information attached to the claim for clarification purposes only. The UB-04 CMS-1450 claim form is designed to list 28 details. For claims with more than 28 details, submit additional UB-04 CMS 1450 claim forms. Surgery codes are included in the 28 details. If a claim contains more than 28 details, continue the claim on additional UB-04 CMS-1450 claim forms. Total each claim form as a stand-alone claim. If you do not total each page, your claim may be denied for being over the limitation, and must be resubmitted with 28 or less details.

Claims for outpatient hospital services must be submitted to TMHP in an approved electronic format or on the UB-04 CMS-1450 claim form. Providers may purchase UB-04 CMS-1400 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a UB-04 CMS-1450 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"UB-04 CMS-1450 Claim Filing Instructions" on page 5-30. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

25.3.5.1 Claim Filing Resources

Refer to the following sections and/or forms on the page numbers listed below when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
UB-04 CMS-1450 Claim Filing Instructions	5-30
TMHP Electronic Claims Submission	5-13
Communication Guide	A-1
Hospital Report (Newborn Child or Children) HHSC Form 7484	B-49
Sterilization Consent Form (English)	B-94
Sterilization Consent Form (Spanish)	B-96
Sterilization Consent Form Instructions	B-97
Hospital-Based ASC Claim Example	D-17
Hospital Inpatient Claim Example	D-18
Hospital Outpatient Claim Example	D-18
Acronym Dictionary	F-1

Section

26

Independent Laboratory

26.1 Enrollment

To enroll in the Texas Medicaid Program, the independent (freestanding) laboratory must do the following:

- Be independent from a physician's office or hospital.
- Meet staff, equipment, and testing capability standards for certification by HHSC.
- Have Medicare certification.
- Submit a current copy of the medical director's physician license, if the lab has physician involvement.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

26.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with Medicaid Managed Care to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

Refer to: "Medicaid Managed Care" on page 7-4 for more information.

26.2 *Clinical Laboratory Improvement Amendments* (CLIA)

26.2.1 CLIA Requirements

To be eligible for reimbursement by Medicare and Medicaid, all providers performing laboratory tests must:

- Pay a fee to the Centers for Medicare & Medicaid Services (CMS).
- Contact HHSC at 1-512-834-6650 to receive a CLIA registration and/or certification number. Submit CLIA applications to the following address:

  Health Facility Licensing and Certification Division
  HHSC
  1100 West 49th Street
  Austin, TX 78756

- Notify TMHP of the assigned CLIA number at the following address:

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

TMHP monitors claims submitted by *clinical* laboratories for CLIA numbers. Without a CLIA number on file with TMHP, claims for laboratory services will be denied.

26.2.2 CLIA Regulations

CMS implemented CLIA rules and regulations. The CLIA regulations were published in the February 28, 1992, *Federal Register* and have been amended several times since. The regulations are found at Title 42 *Code of Federal Regulations*, Part 493.

The CLIA rules and regulations are available on the CMS website at www.cms.gov.

CLIA regulations set standards designed to improve quality in all laboratory testing and include specifications for quality control (QC), quality assurance (QA), patient test management, personnel, and proficiency testing. These regulations concern all laboratory testing used for the assessment of human health or the diagnosis, prevention, or treatment of disease. Under CLIA 88, all clinical laboratories (including those located in physicians' offices), regardless of location, size, or type of laboratory, must meet standards based on the complexity of the test(s) they perform.

26.2.3 Limits of Waiver and Physician-Performed Microscopy Procedure (PPMP) CLIA Certificates

CLIA certificates may limit the holder to performing only certain tests. Medicaid bills must accurately reflect those services authorized by the CLIA program and no other procedures. Two types of certificates limit holders to only certain test procedures: *Waiver* and *PPMP* certificates. A list of those test procedures follows.

26.2.3.1 Waiver Certificate

Providers holding waiver CLIA certificates are authorized to perform only the following tests. The following tests granted waiver status under CLIA were updated beginning September 27, 2002. The QW modifier is a CLIA requirement for specific codes based on their complexity and must be included or claims will be denied.

Procedure Codes		
5-80061-QW	5-80101-QW	5-81002
5-81003-QW	5-81025	5-82010-QW
5-82044-QW	5-82055-QW	5-82120-QW
5-82270	5-82274-QW	5-82465-QW
5-82523-QW	5-82570-QW	5-82679-QW
5-82947-QW	5-82950-QW	5-82951-QW

Procedure Codes		
5-82952-QW	5-82985-QW	5-83001-QW
5-83002-QW	5-83026	5-83036-QW
5-83518-QW	5-83605-QW	5-83718-QW
5-83880-QW	5-83986-QW	5-84450-QW
5-84460-QW	5-84478-QW	5-84703-QW
5-85013	5-85014-QW	5-85018-QW
5-85576-QW	5-85610-QW	5-85651
5-86294-QW	5-86308-QW	5-86318-QW
5-86618-QW	5-86701-QW	5-87077-QW
5-87210-QW	5-87449-QW	5-87804-QW
5-87880-QW	5-G0107	

26.2.3.2 PPMP Certificates

Holders of PPMP certificates are authorized to perform all the procedures listed for waiver certificate in addition to the following tests:

Procedure Codes		
5-81000	5-81001	5-81015
5-81020	5-89190	5-Q0111
5-Q0112	5-Q0113	5-Q0115

26.3 Reimbursement

The Medicaid rates for independent laboratories are calculated in accordance with 1 TAC §355.8081 and §355.8610, and the *Deficit Reduction Act* (DEFRA) of 1984. By federal law, Medicaid payments for clinical laboratory services cannot exceed the Medicare payment for that service.

As the result of the *Tax Equity and Fiscal Responsibility Act* (TEFRA) of 1982, independent laboratories are not directly reimbursed by the Texas Medicaid Program when providing tests to clients registered as hospital inpatients. Reimbursement must be obtained from the hospital.

These services cannot be billed to the client.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

26.3.1 Texas Health Steps (THSteps) Outpatient Laboratory Services

The Medicaid service, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), is known in Texas as Texas Health Steps (THSteps).

Refer to: "Eligibility for a Medical Check Up" on page 43-7.

All required THSteps laboratory work is to be performed by the Department of State Health Services (DSHS) Laboratory Services Section. DSHS makes these services available free to all enrolled THSteps medical providers for THSteps clients. THSteps services provided in a private laboratory will not be reimbursed. The Laboratory Services Section is reimbursed at its cost for performing these tests.

Except for Pap smears, all required THSteps laboratory work that can be mailed at ambient temperature must be sent to the DSHS Laboratory Services Section using the business reply label provided to the following address:

DSHS Laboratory: Walter Douglass
PO Box 149163
Austin, TX 78714-9803

THSteps laboratory work requiring shipping overnight on cold packs through a courier service must be sent to the DSHS Laboratory Services Section at the following address:

DSHS Laboratory Services Section
1100 West 49th Street
Austin, TX 78756-3199
1-512-458–7318
Fax: 1-512-458-7294
Toll-free: 1-888-963-7111 ext. 7318.

Pap smear specimens must be sent to the following address:

Women's Health Laboratories
2303 SE Military Drive, Suite 1
San Antonio, TX 78223
Customer Service: 1-888-440-5002 or 1-210-531-4596
Fax: 1-210-531-4506

Claims for tests listed in the following table submitted by a THSteps medical provider or an outside laboratory for the same date of service as a THSteps medical check up will be denied and are subject to retrospective review and recoupment of inappropriate payments.

Laboratory Test Procedure Codes			
5-83020	5-83655	5-84203	5-85014
5-85018	5-86403	5-86592	5-86689
5-86701	5-87490	5-87590	I-88141
5-88142	5-88143	5-88147	5-88148
5-88150	5-88152	5-88153	5-88154
5-88164	5-88165	5-88166	5-88167
5-88174	5-88175		

Texas Health Steps (THSteps) medical providers may choose the laboratory to which they send THSteps laboratory specimens for blood test screening for hyperlipidemia or Type 2 diabetes (procedure codes 5-80061, 5-82465, 5-82947, 5-82952, 5-83718, and 5-84478).

Blood specimens for the above tests collected as part of the THSteps medical check up may be sent to the provider's laboratory of choice.

Laboratories that bill for these procedure codes on the same date of service as a medical check up visit can be reimbursed separately.

Providers who obtain and process these specimens in-house are not reimbursed separately.

26.4 Benefits and Limitations

The Texas Medicaid Program only covers professional and technical services that an independent laboratory is certified by Medicare to perform.

The Texas Medicaid Program pays up to the amount allowed for the total component for the same procedure, same client, same date of service, any provider.

- Providers who perform the technical service and interpretation must bill for the total component.
- Providers who perform only the technical service must bill for the technical component.
- Providers who perform only the interpretation must bill for the interpretation component.

Claims filed in excess of the amount allowed for the total component for the same procedure, same dates of service, same client, any provider, are denied. Claims are paid based on the order in which they are received.

For example, if a claim is received for the total component and TMHP has already made payment for the technical or interpretation component for the same procedure, same dates of service, same client, any provider, the claim for the total component will be denied as previously paid to another provider. The same is true if a total component has already been paid and claims are received for the individual components.

26.4.1 Reference Labs and Lab Handling Fees

An independent laboratory that forwards a specimen to another laboratory without performing any tests on that specimen may *not* bill for any laboratory tests. An independent laboratory may only bill the Texas Medicaid Program for tests referred to another laboratory (independent or hospital) if it performs at least one test (that is Medicare-certified to perform) and forwards a portion of the same specimen to another laboratory (reference laboratory) to have one or more tests performed.

In this instance, the referring laboratory may bill for tests it has performed and *all* tests it is to perform on the specimen. When billing, the *Yes* box in Block 20 of the CMS-1500 claim form must be marked, the name and provider identifier of the *reference lab* to where the specimens have been forwarded must be indicated in Block 32, and the provider identifier of the *reference lab* must be indicated in Block 24-K next to each procedure to be performed by the *reference lab*.

Only one handling fee may be charged per day, per client, unless specimens are sent to two or more different laboratories; this must be documented on the claim.

An independent laboratory that forwards a specimen to another laboratory (independent or hospital) may bill a handling fee (1-99001) for collecting and forwarding the specimen to the other laboratory if the specimen is collected by routine venipuncture or catheterization. Routine venipunctures or finger, heel, and ear sticks for collection of specimen(s) (2/5-36415) are not a benefit of the Texas Medicaid Program. Family planning agencies must use code 1-99000 with modifier FP to bill their laboratory handling charges for laboratory specimens sent out. As with the physician code 1-99000, only one handling fee may be charged for each laboratory to the agency that sends specimens, regardless of the number of specimens taken.

When family planning test specimens such as Pap smears are collected, providers must direct the laboratory to indicate the claim for the test is to be billed as a family planning service.

26.4.2 Repeated Procedures

26.4.2.1 Modifier 91

Modifier 91 should be used for repeat clinical diagnostic tests as follows:

- Modifier 91 must not be used when billing the initial procedure. It must be used to indicate the repeated procedure.
- If more than two services are billed on the same day by the same provider, regardless of the use of modifier 91, the claim or detail is denied.
- If a repeated procedure performed by the same provider on the same day is billed without modifier 91, it is denied as a duplicate procedure.
- If a claim is denied for a quantity more than two or as a duplicate procedure, the times of these procedures and services must be documented on appeal.
- Modifier 91 is not required and must not be used when billing multiple quantities of a supply (for example, disposable diapers or sterile saline).

For dates of service on or after April 3, 1998, certain procedure codes have been removed from modifier 91 auditing. These are procedure codes that have been identified as routinely being performed at the same time, more than twice per day for each antigen (e.g., agglutinins, febrile [e.g., Brucella, Francisella, Murine typhus, Q fever, Rocky Mountain spotted fever, scrub typhus], each antigen). Providers may still appeal claims that have been denied for documentation of time. Most procedure codes initially requiring modifier 91 will continue to be audited for modifier 91.

When appealing claims with modifier 91 for repeat procedures, providers must separate the details. One detail should be appealed without the modifier and one detail with the modifier, including documentation of times for each repeated procedure.

26.4.2.2 Modifier 76

Modifier 76 is limited as follows:

- Modifier 76 must not be used when billing the initial procedure. It must be used to indicate the repeated non-clinical procedure.

- If more than two services are billed on the same day by the same provider, regardless of the use of modifier 76, the claim or detail is denied.
- If a repeated procedure performed by the same provider on the same day is billed without modifier 76, it is denied as a duplicate procedure.
- If a claim is denied for a quantity more than two or as a duplicate procedure, the times of these procedures/services must be documented on appeal.
- Modifier 76 is not required and must not be used when billing multiple quantities of a supply (e.g., disposable diapers or sterile saline).

Certain procedure codes have been removed from modifier 76 auditing for dates of service on or after April 3, 1998. These procedure codes have been identified as routinely being performed at the same time, more than twice per day for each antigen (e.g., agglutinins, febrile [e.g., Brucella, Francisella, Murine typhus, Q fever, Rocky Mountain spotted fever, scrub typhus], each antigen). Providers may still appeal claims that have been denied for documentation of time. Most procedure codes initially requiring modifier 76 will continue to be audited for modifier 76.

When appealing claims with modifier 76 for repeat procedures, providers must separate the details. One detail should be appealed without the modifier and one detail with the modifier, including documentation of times for each repeated procedure.

26.4.3 Laboratory Paneling

A *panel* is defined as a group of tests that were performed together or in combination. Chemistry tests, urinalysis, and complete blood count (CBC) must be billed as a panel.

When paneling codes, the charge for the panel must reflect the total charge for the laboratory services.

26.4.3.1 Chemistry Tests

Laboratory Paneling

Medicare policy pertaining to laboratory paneling procedures was implemented by the Texas Medicaid Program. Organ and disease panel codes 5-80048, 5-80051, and 5-80053 must be used instead of the general multichannel automated panel codes.

Procedure code 5-84078 is considered a component of the multiple chemistry panels. Procedure code 5-85595 is considered a component of any hemogram with a platelet panel. Hemogram or CBC with platelet panel codes 5-85025 to 5-85027 must be billed when two or more components of a CBC and a platelet count are performed. When two or more components of a CBC and a platelet count are billed separately on the same day, all components are denied with explanation of benefits (EOB) 00559, "*These tests must be combined and billed as a CBC/panel. Resubmit with signed claim copy, R&S report copy, and appropriate code (5-85025 and 5-85027).*"

The following chemistry tests must be billed individually unless a complete panel is performed on the same day:

Procedure Codes		
5-82040	5-82150	5-82247
5-82248	5-82310	5-82373
5-82374	5-82435	5-82465
5-82550	5-82565	5-82945
5-82947	5-82948	5-82977
5-83090	5-83615	5-83663
5-83664	5-83690	5-83735
5-83921	5-84075	5-84078
5-84100	5-84132	5-84152
5-84155	5-84160	5-84295
5-84450	5-84460	5-84478
5-84520	5-84550	5-84591

26.4.3.2 Urinalysis

Procedure codes 5-82009, 5-82947, and 5-83986 are payable when billed on the same day as a urinalysis. If procedure code 5-84578 and 5-84583 are billed on the same day as any of the following urinalysis procedure codes, procedure codes 5-84578 and 5-84583 will be denied as part of the urinalysis:

Procedure Codes		
5-81000	5-81001	5-81002
5-81003	5-81005	5-81020

If procedure code 5-81015 is billed in addition to routine urinalysis codes 5-81000 or 5-81001, procedure code 5-81015 will be denied as part of 5-81000 or 5-81001. If procedure code 5-81015 is billed with urinalysis codes 5-81002 or 5-81003, both codes will be denied requiring paneling into either 5-81000 or 5-81001.

When performing bacterial urine culture with antibiotic sensitivities, use procedure code 5-87086.

26.4.4 Cancer Screening, Colorectal

The following procedure codes are benefits of the Texas Medicaid Program:

Procedure Codes		
5–G0103	2/F-G0104	2/F-G0105
4/I/T-G0106	4/I/T-G0120	2-G0121

Procedure codes 2/F-G0104, 2/F-G0105, 4/I/T-G0106, 4/I/T-G0120, and 2-G0121 are benefits of the Texas Medicaid Program if they are submitted with diagnosis code V1272.

Procedure code 4/I/T-G0122 is *not* a benefit of the Texas Medicaid Program.

Screening intervals are recommended once every 48 months for individuals 50 years of age and older. The screening colonoscopy is recommended once every 24 months for individuals at high risk for colorectal cancer.

High-risk individuals include people with one or more of the following:

- Close relative (sibling, parent, or child) who has had colorectal cancer or adenomatous polyposis.
- Family history of familial adenomatous polyposis.
- Family history of hereditary nonpolyposis colorectal cancer.
- Personal history of colorectal cancer.
- Inflammatory bowel disease, including Crohn's Disease, and ulcerative colitis.

Procedure codes 2/F-G0104 and 4/I/T-G0106 are not benefits of the Texas Medicaid Program if they are submitted with the following diagnosis codes:

Diagnosis Codes				
5550	5551	5552	5559	5560
5561	5562	5563	5568	5569
5582	5583	5589	V1005	V1006
V160	V1851			

26.4.5 Complete Blood Count (CBC)

The Texas Medicaid Program considers a baseline CBC appropriate for the evaluation and management of existing and suspected disease processes. Complete blood counts should be individualized and based on client history, clinical indications or proposed therapy and will not be reimbursed for screening purposes.

The following procedure codes will be denied as part of another service when billed with procedure code 85025 for the same date of service by the same provider:

Procedure Codes		
85004	85007	85008
85009	85013	85014
85018	85027	85032
85041	85048	85049

Procedure code 85004 will be denied as part of another service when billed with procedure code 85007, 85009, 85025, or 85027 for the same date of service by the same provider.

Procedure code 85007 will be denied as part of another service when billed with procedure code 85025 for the same date of service by the same provider.

Procedure code 85008 will be denied as part of another service when billed with the following procedure codes for the same date of service by the same provider:

Procedure Codes		
85004	85025	85027
85032	85048	85049

Procedure code 85009 will be denied as part of another service when billed with procedure code 85025 for the same date of service by the same provider.

Procedure code 85013, 85014, or 85018 will be denied as part of another service when billed with procedure code 85025 or 85027 for the same date of service by the same provider.

Procedure code 85027 will be denied as part of another service when billed with procedure code 85025.

Procedure code 85032 will be denied as part of another service when billed with procedure code 85025, 85027, 85041, 85048, or 85049.

Procedure codes 85041 will be denied as part of another service when billed with procedure code 85025 or 85027.

Procedure codes 85044 will be denied as part of another service when billed with procedure code 85045 or 85046.

Procedure code 85045 will be denied as part of another service when billed with procedure code 85046.

Procedure codes 85048 will be denied as part of another service when billed with procedure code 85025 or 85027.

Procedure code 85049 will be denied as part of another service when billed with procedure codes 85025 or 85027.

A CBC is a comprehensive service that includes components.

The components of a CBC are listed in the following table:

Procedure Codes		
5-85004	5-85007	5-85008
5-85009	5-85013	5-85014
5-85018	5-85041	5-85048
5-85049		

Procedure code 85049 may be reimbursed separately If this procedure code is billed for the same date of service as procedure codes 85025 or 85027, it will deny as part of another service.

Reticulocyte procedure codes 85044, 85045, and 85046 may be reimbursed in addition to a CBC.

26.4.6 Helicobacter Pylori (H. Pylori)

Procedure codes 5-83009, 5-83013, 5-83014, 5-86677, 5-87338, and 5-87339 are benefits of the Texas Medicaid Program.

These codes are considered to be clinical lab services and must be billed using type of service (TOS) 5. The interpretation/professional component TOS I is not separately reimbursed.

The following procedure codes are not payable on the same date of service by the same provider: 5-86677, 5-83009, 5-87338, and 5-83013 or 5-83014. Procedure codes 5-83013 and 5-83014 may be considered for reimbursement on the same day.

Procedure codes 5-83009 and 5-86677 are benefits of the Texas Medicaid Program with the following diagnosis codes:

Diagnosis Codes				
1510	1511	1512	1513	1514
1515	1516	1518	1519	53100
53101	53110	53111	53120	53121
53130	53131	53140	53141	53150
53151	53160	53161	53170	53171
53190	53191	53200	53201	53210
53211	53220	53221	53230	53231
53240	53241	53250	53251	53260
53261	53270	53271	53290	53291
53300	53301	53310	53311	53320
53321	53330	53331	53340	53341
53350	53351	53360	53361	53370
53371	53390	53391	53400	53401
53410	53411	53420	53421	53430
53431	53440	53441	53450	53451
53460	53461	53470	53471	53490
53491	53500	53501	53510	53511
53520	53521	53530	53531	53540
53541	53550	53551	53560	53561
5368	78901	78902	78906	

Procedure codes 5-83013, 5-83014, and 5-87338 are benefits of the Texas Medicaid Program with the diagnoses listed above and also for diagnosis code 04186.

Refer to: "Helicobacter Pylori (H. Pylori)" on page 36-40 for more information.

26.4.7 Microquantitative Sweat Test

Procedure code 5-89230 is a procedure used to diagnose cystic fibrosis (27700 and 27701). Procedure code 89230 is not restricted by diagnosis.

26.4.8 Organ or Disease Panels

Organ panels are specific laboratory studies that have been combined under a problem-oriented classification as an approach to diagnosis. The following list of panels includes all components that must be included to report the panel code.

Individual laboratory studies considered a part of a specific panel are denied when billed on the same day as the panel code by the same provider.

26.4.8.1 Basic Metabolic Panel (5-80048)

This panel must include the following:

Procedure Codes		
5-82310	5-82374	5-82435
5-82565	5-82947	5-84132
5-84295	5-84520	

26.4.8.2 General Health Panel (5-80050)

This panel must include the following:

- 5-80053 and 5-84443.
- One of the following combinations:
  - 5-85025 or (5-85004 and 5-85027).
  - 5-85027 and (5-85007 or 5-85009).

26.4.8.3 Electrolyte Panel (5-80051)

This panel must include the following: 5-82374, 5-82435, 5-84132, and 5-84295.

26.4.8.4 Comprehensive Metabolic Panel (5-80053)

This panel must include the following:

Procedure Codes		
5-82040	5-82247	5-82310
5-82374	5-82435	5-82565
5-82947	5-84075	5-84132
5-84155	5-84295	5-84460
5-84450	5-84520	

26.4.8.5 Obstetric Panel (5-80055)

This panel must include the following:

- 5-86592, 5-86762, 5-86850, 5-86900, 5-86901, and 5-87340.
- One of the following combinations:
  - 5-85025 or (5-85004 and 5-85027).
  - 5-85027 and (5-85007 or 5-85009).

26.4.8.6 Lipid Panel (5-80061)

This panel must include the following: 5-82465, 5-83718, and 5-84478.

26.4.8.7 Renal function Panel (5-80069)

This panel must include the following:

Procedure Codes		
5-82040	5-82310	5-82374
5-82435	5-82565	5-82947
5-84100	5-84132	5-84295
5-84520		

26.4.8.8 Acute Hepatitis Panel (5-80074)

This panel must include the following: 5-86709, 5-86705, 5-87340, and 5-86803.

26.4.8.9 Hepatic Function Panel (5-80076)

This panel must include the following:

Procedure Codes		
5-85040	5-82247	5-82248
5-84075	5-84155	5-84450
5-84460		

26.4.8.10 TORCH Antibody Panel (5-80090)

This panel must include the following: 5-86644, 5-86694, 5-86762, and 5-86777.

26.4.9 Ferritin and Iron Studies

Procedure codes 5-82728, 5-83540, 5-83550, 5-84466, and 5-85536, are payable for the following diagnoses:

Diagnosis Codes				
2750	2800	2801	2808	2809
2810	2811	2812	2819	28241
28242	28249	28264	28268	2828
2829	2839	2850	28521	28522
28529	2859	5360	5728	5738
5739	5793	5798	5799	5851
5852	5853	5854	5855	5856
5859	586	64820	64821	64822
64823	64824	70900	V560	V5631
V5632	V568			

If a ferritin and an iron study are billed on the same day, procedure code 5-82728 will be denied and procedure code 5-83540 will be paid. Ferritin and iron studies will be payable on the same day with the diagnosis of 2750.

Procedure codes 5-82728 and 5-83540 are payable on the same day, same provider, with the following diagnoses:

Diagnosis Codes				
28521	5851	5852	5853	5854
5855	5856	5859		

26.4.10 Laboratory Services for Clients on Dialysis

The Texas Medicaid Program provides reimbursement for laboratory services performed for clients on dialysis.

Charges for routine laboratory tests performed according to the established frequencies are included in the facility's dialysis charge billed to the Texas Medicaid Program regardless of where the tests were performed. Routine laboratory services performed by an outside laboratory are billed to the facility.

Nonroutine laboratory services for clients dialyzing in a facility and all lab work for clients on continuous ambulatory peritoneal dialysis (CAPD) may be billed separately from the dialysis charge. These services and recommended frequencies are listed in "Laboratory and Radiology Services" on page 40-4.

26.4.11 Transfusion Medicine

Procedure code 5-86890 is denied when billed by any provider for the same client for dates of service in excess of two times within four days. The use of modifier 76 does not prevent claim denials. Documentation may be submitted on appeal that supports the medical necessity and appropriateness of more than two predeposited autologous donations in four days.

26.4.12 Diagnosis Requirements

Independent laboratories and pathologists do not have to supply the Texas Medicaid Program with a diagnosis except when billing the following procedures:

Procedure Codes		
5-82728	5-83540	5-84233
5-86950	5-88230	5-88233
5-88235	5-88237	5-88239
5-88245	5-88248	5-88249
5-88261	5-88262	5-88263
5-88264	5-88280	5-88283
5-88285	5-88289	5-88271
5-88272	5-88273	5-88274
5-88275	5-89230	5-95950
5-95951	5-95953	5-95956

Claims submitted for the above procedures without a diagnosis are denied. *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) evaluation and management (E/M) codes must not be used as the primary diagnosis.

All *V* codes except those listed under "Coding" on page 5-15 may be used as a primary diagnosis if appropriate. Additionally, any laboratory services provided to clients eligible for emergency services only must have a diagnosis on the claim to ensure accurate claims processing.

26.4.13 Breast Cancer (BRCA)

26.4.13.1 BRCA Testing

Gene mutation analyses (procedure codes 5-S3820, 5-S3822, and 5-S3823) are benefits of the Texas Medicaid Program.

Breast cancer 1 (BRCA1) and breast cancer 2 (BRCA2) are responsible for keeping breast cells from growing too rapidly or in an uncontrolled way. Mutations within the gene interrupt this regulatory function and increase the risk of breast cancer.

Note: *Guidelines for BRCA mutation testing are based on guidelines established by the U.S. Preventative Services Task Force.*

The procedure codes that describe the three basic steps of testing for a BRCA mutation, b-hexasominidase (procedure code 5-83080), isolation and separation of DNA (procedure codes 5-83890, 5-83891, 5-83892, 5-83893, 5-83894, 5-83896, and 5-83897), molecular diagnostics (procedure codes 5-83898, 5-83900, 5-83901, 5-83902, 5-83907, 5-83908, 5-83909, and 5-83912), and mutation scanning or identification (procedure codes 5-83903, 5-83904, 5-83905, and 5-83906) are not a benefit for the following breast cancer diagnosis codes:

Diagnosis Codes				
1740	1741	1742	1743	1744
1745	1746	1748	1749	1750
1759	1820	1821	1828	1982
19881	2330			

BRCA1 and BRCA2 (procedure codes 5-S3820, 5-S3822, and 5-S3823) are limited to once per lifetime. Additional services may be considered on appeal.

26.4.13.2 Authorization Requirements

Prior authorization is required for gene mutation analysis (procedure codes 5-S3820, 5-S3822, and 5-S3823). There must be documentation of one or more of the following:

- For non-Ashkenazi Jewish women, these patterns include:
  - Two first-degree relatives with breast cancer, one of whom was diagnosed at age 50 or younger
  - A combination of three or more first- or second-degree relatives with breast cancer, regardless of age of diagnosis.
  - A combination of both breast and ovarian cancer among first- and second-degree relatives with ovarian cancer.
  - A first-degree relative with bilateral breast cancer.
  - A combination of two or more first- or second-degree relatives with ovarian cancer, regardless of diagnosis.
  - A first-or second-degree relative with both breast and ovarian cancer, at any age.
  - A history of breast cancer in a male relative.
- For women of Ashkenazi Jewish heritage, an increased-risk family history includes any first- or second-degree relative on the same side of the family with breast or ovarian cancer.

A written prior authorization request, signed and dated by the referring provider, must be submitted. All signatures must be current, unaltered, original and handwritten. Computerized or stamped signatures will not be accepted. The original signature copy must be kept in the physician's medical record for the client.

To complete the prior authorization process, a provider must send the request to the TMHP Special Medical Prior Authorization unit and include documentation of medical necessity. The request can be faxed to 1-512-514-4213 or mailed to:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization Department
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727

To facilitate a determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including accurate medical necessity of the services requested.

26.4.13.3 Prognostic Breast and Gynecological Cancer Studies

Prognostic breast and gynecological cancer studies are benefits of the Texas Medicaid Program when ordered by a physician for the purpose of determining the best course of treatment for a patient with breast/gynecological cancers.

Prognostic breast and gynecological cancer studies are divided into two categories: Receptor assays and Her-2/neu.

- Receptor Assays (procedure codes 5-84233 and 5-84234)—The estrogen receptor assay (ERA) and the progesterone receptor assay (PRA) are tests in which a tissue sample is exposed to radioactively tagged estrogen or progesterone. The presence of these receptors can have prognostic significance in breast and edometrial cancer.
- Her-2/neu (procedure codes 5-83890, 5-88237, 5-88239, 5-88271, 5-88274, 5-88291, 5-88342, 5-88360, 5-88361 and 5-88365)—Human epidermal growth factor receptor 2 (Her-2/neu) is responsible for the production of a protein that signals cell growth. The over-expression of Her-2/neu in breast cancer is associated with decreased overall survival and response to some therapies. Each procedure used in the analysis should be coded separately.

Reimbursement for receptor assays (procedure codes 5-84233, 5-84234, 5-88360, and 5-88361) are limited to claims with a diagnosis of breast or uterine cancer as listed in the following table. Receptor testing for other diagnoses will be denied.

Diagnosis Codes				
1740	1741	1742	1743	1744
1745	1746	1748	1749	1750
1759	1982	19881	2330	

The following procedure codes are limited to once per lifetime:

Procedure Codes		
5-83080	5-83890	5-83891
5-83892	5-83893	5-83894
5-83896	5-83897	5-83898
5-83900	5-83901	5-83902
5-83903	5-83904	5-83905
5-83906	5-83907	5-83908
5-83909	5-83912	

Gene mutation analyses (procedure codes 5-S3820, 5-S3822, and 5-S3823) will not be reimbursed on the same date of service as the following procedure codes:

Procedure Codes			
5-83080	5-83890	5-83891	5-83892
5-83893	5-83894	5-83896	5-83897
5-83898	5-83900	5-83901	5-83902
5-83903	5-83904	5-83905	5-83906
5-83907	5-83908	5-83909	5-83912

26.5 Claims Information

When family planning test specimens such as Pap smears are collected, providers must direct the laboratory to indicate the claim for the test is to be billed as a family planning service using diagnosis code V2509.

Providers must submit independent laboratory services to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers must purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"CMS-1500 Claim Filing Instructions" on page 5-22. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

26.5.1 Electronic Filing for Laboratory Providers

Referring provider information is always required on laboratory claims. Failure to submit this data will result in a claim rejection on the TMHP Electronic Data Interchange (EDI).

When the place of service is 6 and the billing provider identifier belongs to a laboratory, there is no need to submit the same provider identifier in the facility ID field. This notation causes the claim to suspend processing unnecessarily, and may cause a delay in the disposition of the claim.

For questions about the electronic fields, contact the commercial software vendor or the TMHP EDI Help Desk at 1-888-863-3638.

26.5.2 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
AIS (Automated Inquiry System)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-22
TMHP Electronic Claims Submission	5-13
Communication Guide	A-1
Independent Laboratory Claim Example	D-19
Acronym Dictionary	F-1

Section

27

In-Home Total Parenteral (TPN)/ Hyperalimentation Supplier

27.1 Enrollment

To enroll in the Texas Medicaid Program, providers of in-home TPN/hyperalimentation must be enrolled in Medicare (the intermediary is Palmetto).

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

27.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with Medicaid Managed Care to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

Refer to: "Medicaid Managed Care" on page 7-4 for more information.

27.2 Reimbursement

In-home TPN/hyperalimentation suppliers are reimbursed the lesser of either the provider's billed charges or the rate calculated in accordance with Title 1 *Texas Administrative Code* (TAC) §355.8087.

Procedure Code	Rate
1-S9364	$145 per day with an annual maximum limit of $53,000
1-S9365	
1-S9366	
1-S9367	
1-S9368	

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

27.3 Benefits and Limitations

In-home TPN/hyperalimentation is a benefit for eligible clients who require long-term support because of extensive bowel resection and/or severe advanced bowel disease in which the bowel cannot support nutrition. Texas Health Steps (THSteps)-Comprehensive Care Program (CCP) clients birth through 20 years of age with diagnoses other than those mentioned above require prior authorization through CCP. Covered services must be reasonable, medically necessary, appropriate, and prescribed by a physician. TPN/hyperalimentation is not available through the traditional Medicaid program when oral intake will maintain adequate nutrition.

TPN/hyperalimentation *must* be prior authorized. The request for prior authorization must be submitted by the physician prescribing the treatment and must include the following documentation to support the medical necessity of the TPN/hyperalimentation:

- A completed Medicaid Certificate of Medical Necessity for In-Home Total Parenteral Nutrition form that is signed and dated by the physician.
- A clear copy of the most recent laboratory results (to include potassium, calcium, albumin, and liver function studies).
- A clear copy of the total parenteral nutrition (TPN) formula/prescription, including amino acids and lipids, signed and dated by the physician. The administration of intravenous fluids and electrolytes cannot be billed as in-home TPN/hyperalimentation.

Requests must include all pertinent medical records as required by HHSC or TMHP to indicate the medical necessity of the long-term TPN/hyperalimentation. Prior authorization may be given for up to one year, subject to renewal every year with the submission of a supplemental report documenting continued medical necessity for the treatment.

Refer to: "Medical Necessity for In-Home Total Parenteral Hyperalimentation (TPN)" on page B-56.

Covered services include, but are not necessarily limited to, the following:

- TPN/hyperalimentation solutions and additives as ordered by the client's physician.
- Supplies and equipment, including refrigeration (if necessary), that are required for the administration of prescribed solutions and additives.
- Education of the client and/or caregivers regarding the in-home administration of TPN/hyperalimentation before the initial administration begins. Education must include the use and maintenance of required supplies and equipment.
- Visits by a registered nurse appropriately trained in the administration of TPN/hyperalimentation. The nurse must visit the client at least once per month to monitor the client's status and to provide ongoing education to the client and/or family members/support people about the administration of TPN/hyperalimentation.
- Enteral supplies, nutritional products, and equipment, if medically necessary, in *conjunction* with TPN/hyperalimentation.

Hospitals administering TPN/hyperalimentation in the hospital outpatient department should refer to "Outpatient Total Parenteral Nutrition/Hyperalimentation" on page 25-28 for the policies and billing instructions.

TPN/hyperalimentation is payable only once per day, per client. No more than a one-week supply of solutions and additives will be reimbursed if the solutions and additives are shipped and not used because of the client's loss of eligibility, change in treatment, or inpatient hospitalization. Any days that the client is an inpatient in a hospital or other medical facility or institution must be excluded from the daily billing. TPN may be reimbursed in the inpatient hospital setting using the reimbursement methodology of that facility. Payment for partial months will be prorated based on actual days of administration.

Lipids (9-B4185) will be denied if billed on the same date of service as any other TPN procedure code (1-S9364, 1-S9365, 1-S9366, 1-S9367, or 1-S9368).

All supporting documentation must be included with the request for authorization. Send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

27.4 Claims Information

In-home TPN/hyperalimentation services must be submitted to TMHP in an approved electronic format or on a CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"CMS-1500 Claim Filing Instructions" on page 5-22. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Reminder: *Claims for TPN/hyperalimentation must contain the nine-character prior authorization number in Block 23. Providers must consult with their vendor for the location of this field in the electronic claims format. The prescribing physician name and provider identifier must be in Block 17 and 17a or in the appropriate field of the provider's electronic software.*

27.4.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-22
TMHP Electronic Claims Submission	5-13
Communication Guide	A-1
In-Home Total Parenteral Nutrition Supplier Claim Example	D-19
Acronym Dictionary	F-1

Section

28

Licensed Clinical Social Worker (LCSW)

28.1 Enrollment

To enroll in the Texas Medicaid Program, whether as an individual or as part of a group, an LCSW must be licensed by the Texas State Board of Social Worker Examiners. LCSWs must also be enrolled in Medicare or obtain a pediatric practice exemption from TMHP Provider Enrollment. If a pediatric-based LCSW is enrolling as part of a Medicare-enrolled group, then the LCSW must also be enrolled in Medicare. Providers that hold a temporary license are not eligible to enroll in the Texas Medicaid Program.

LCSWs cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

28.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with Medicaid Managed Care to be reimbursed for services provided to Managed Care clients. Contact the individual health plan for enrollment information.

NorthSTAR is a managed care program in the Dallas service area that covers behavioral health services. LCSWs who practice in the Dallas service area must be enrolled in the NorthSTAR Behavioral Health Organization to provide services to NorthSTAR clients. Providers must not bill TMHP for services rendered to NorthSTAR clients.

Refer to: "Managed Care" on page 7-1 for more information.

28.2 Reimbursement

According to 1 TAC §355.8091, the Texas Medicaid Program rate for LCSWs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085.

Under 1 TAC §355.8261, a federally qualified health center (FQHC) is reimbursed according to its specific prospective payment system (PPS) rate per visit for LCSW services.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

Fee schedules for all services in this chapter are available on the TMHP website at www.tmhp.com/file library /file library/fee schedules.

28.3 Benefits and Limitations

LCSW counseling services are a benefit for clients suffering from a mental, psychoneurotic, or personality disorder, when performed in the office (place of service [POS] 1), home (POS 2), skilled nursing facility (SNF) (POS 4), outpatient hospital (POS 5), nursing facility (POS 8), or other location (POS 9). When billing for contracted LCSW counseling services provided to Texas Medicaid Program clients who are 20 years of age and younger and reside in a residential treatment facility, providers should use POS 9 (other location).

LCSWs must not bill for services provided by people under their supervision; only the licensed LCSW and Medicaid enrolled practitioner providing the service may bill the Texas Medicaid Program. LCSWs who are employed by or remunerated by another provider may not bill the Texas Medicaid Program directly for counseling services if that billing would result in duplicate payment for the same services.

Procedure codes 1-90806, 1-90847, and 1-90853 are allowable for services provided by an LCSW on an hourly basis. When billing or providing family counseling services (1-90847), note the following requirements for Medicaid reimbursement:

- The client must be present when family counseling services are provided.
- Family counseling is only reimbursable for one family member per session.

According to the definition of "family" provided by HHSC Household Determination Guidelines, only specific relatives are allowed to participate in family counseling services. These guidelines also address the roles of relatives in supervision and care of children with Temporary Assistance for Needy Families (TANF). The following specific relatives are included in family counseling services:

- Father or mother.
- Grandfather or grandmother.
- Brother or sister.
- Uncle, aunt, nephew, or niece.
- First cousin or first cousin once removed.
- Stepfather, stepmother, stepbrother, or stepsister.

When billing for family, group, or individual counseling services, the time spent with the client must be reflected on the claim form as follows:

- 30 minutes bills as 0.5 hour.
- 60 minutes bills as 1 hour.
- 90 minutes bills as 1.5 hours.
- 120 minutes bills as 2 hours.

The time indicated on the claim form must be the time actually spent with the client.

Each individual practitioner is limited to performing a combined total of 12 hours of behavioral health services per day. The claims processing system enforces the 12-hour system limitation for the following providers: advanced practice nurse (APN), PA, LMFT, LCSW, Psychologist, and LPC. Since physicians (doctor of medicine [MD] and doctors of osteopathy [DO]) can delegate and may possibly submit claims in excess of 12 hours in a given day, the claims system does not limit these providers to 12 hours per day. However physicians (MD and DO) and those to whom they delegate are still subject to the 12-hour limitation. Additionally providers who perform group therapy may possibly submit claims in excess of 12 hours in a given day due to the manner in which group therapy is billed. Retrospective review may occur for both the total hours of services performed per day and the total hours of services billed per day. If inappropriate payments are identified, the reimbursement is recouped.

In addition, all behavioral health procedure codes, whether or not they are currently included in the 12-hour system limitation, are subject to retrospective review and possible recoupment for all providers who deliver health services.

Note: *Documentation requirements for all services billed are listed for each individual specialty in this manual.*

The claims subject to the 12-hour provider limit are based on the provider identifier number submitted on the claim. The location where the services occur is not a basis for exclusion of hours. If a provider practices at multiple locations and has a different suffix for the various locations, but has the same provider identifier, all services identified for restriction to the provider's 12-hour limit are counted regardless of whether they were performed at different locations.

Claims submitted with a prior authorization number are not exempt from the 12-hour limitation.

The following table lists the behavioral health procedure codes included in the system limitation and shows the type of service/procedure code combinations, along with the time increments the system applies based on the billed procedure code.

The time increments applied are used to calculate the 12-hour per day limitation.

Procedure Codes Included in the 12-hour System Limitation

Procedure Code	Time Assigned by Procedure Code Description	Time Applied
1-90801	Not applicable	60 minutes
1-90802	Not applicable	60 minutes
1-90804	20-30 minutes	30 minutes
1-90805	20-30 minutes	30 minutes
1-90806	45-50 minutes	50 minutes
1-90807	45-50 minutes	50 minutes
1-90808	70-80 minutes	80 minutes
1-90809	70-80 minutes	80 minutes
1-90810	20-30 minutes	30 minutes
1-90811	20-30 minutes	30 minutes
1-90812	45-50 minutes	50 minutes
1-90813	45-50 minutes	50 minutes
1-90814	70-80 minutes	80 minutes
1-90815	70-80 minutes	80 minutes
1-90816	20-30 minutes	30 minutes
1-90817	20-30 minutes	30 minutes
1-90818	45-50 minutes	50 minutes
1-90819	45-50 minutes	50 minutes
1-90821	70-80 minutes	80 minutes
1-90822	70-80 minutes	80 minutes
1-90823	20-30 minutes	30 minutes
1-90824	20-30 minutes	30 minutes
1-90826	45-50 minutes	50 minutes
1-90827	45-50 minutes	50 minutes
1-90828	70-80 minutes	80 minutes
1-90829	70-80 minutes	80 minutes
1-90847	Not applicable	50 minutes
5-96101	60 minutes	60 minutes
1-96118	60 minutes	60 minutes

If a cutback occurs for procedure codes included in the system limitation, the quantity allowed per service session designated is rounded up to one decimal point or rounded down to one decimal point following standard rounding procedures (as shown in the following example):

Total Time	Rounded Time
11.71 hours 11.72 hours 11.73 hours 11.74 hours	11.7 hours
11.75 hours 11.76 hours 11.77 hours 11.78 hours 11.79 hours	11.8 hours

Formula Applied

For client L on the table below, 80 billed minutes are applied, but the provider only has 40 available minutes before reaching the 12-hour daily limit (720 minutes); therefore, only 40 minutes are considered for reimbursement. The 40 allowed minutes are divided into the 80 applied minutes to get an allowed unit of .5 for payment.

TPI Base	TPI Suffix	Client	Code Billed	Amount Applied*	Total Time Paid	Qty.
1234567	01	A	90807	50	50	1
1234567	02	B	90828	80	80	1
1234567	01	C	90807	50	50	1
1234567	03	D	90828	80	80	1
1234567	01	E	90807	50	50	1
1234567	01	F	90828	80	80	1
1234567	02	G	90807	80	80	1
1234567	01	H	90827	50	50	1
1234567	01	J	90828	80	80	1
1234567	02	K	90828	80	80	1
Final claim for the day			**Subtotal**	680 minutes		
1234567	**01**	**L**	**90828**	**80**	**40**	**.5**
			Total	760 billed mins. for one day	720 paid mins. for one day	

*** Time applied toward the 12-hour limit.**

Reminder: *The procedure codes listed above have time ranges built in so the quantity billed should be reflected in quantities of one versus the actual amount of time spent with the client, i.e., procedure code 90804 is for 20 to 30 minutes of time spent with the client. The provider would bill a quantity of one when submitting a claim.*

If a claim is adjusted and causes additional minutes to be available to the provider for that day, the system does not automatically reprocess any previously denied or cutback claims that would now be payable. It is up to the provider to request reprocessing of the denied or cutback claims.

Outpatient behavioral health services are limited to 30 encounters/visits per client, per calendar year (January 1 through December 31) regardless of provider, unless prior authorized. This limitation includes encounters/visits by all practitioners. School Health and Related Services (SHARS) behavioral rehabilitation services, MHMR services, laboratory, radiology, and medication monitoring services are not counted toward the 30-encounter/visit limitation. An encounter/visit is defined as each hour of therapy, psychological, and/or neuropsychological testing rendered per hour, per provider. Each Medicaid client is limited to 30 encounters/visits per calendar year.

It is anticipated that this limitation, which allows for six months of weekly therapy or 12 months of biweekly therapy, is adequate for 75 to 80 percent of clients. Clinicians should plan therapy with this limit in mind. However, it may be medically necessary for some clients to receive extended encounters/visits. In these situations, prior authorization is required. *A provider who sees a client regularly and anticipates that the client will require encounters/visits beyond the 30-encounter/visit limit must submit the request for prior authorization before the client's 25th encounter/visit.*

It is recognized that a client may change providers in the middle of the year, and the new provider may not be able to obtain complete information on the client. In these instances, prior authorization may be made before rendering services when the request is accompanied by an explanation as to why the provider was not able to submit the prior authorization request by the client's 25th encounter/visit.

All authorization requests for extension of outpatient psychotherapy sessions beyond the annual 30-encounter/visit limitation are limited to ten encounters/visits per request and must be submitted on the Extended Outpatient/Counseling Request Form. Requests must include the following:

- Client name and Medicaid number.
- Provider name and provider identifier.

- Clinical update, including specific symptoms and response to past treatment, treatment plan (measurable short term goals for the extension, specific therapeutic interventions to be used in therapy, measurable expected outcomes of therapy, length of treatment anticipated, and planned frequency of encounters/visits).
- Number, type of services requested, and the dates based on the frequency of encounters/visits that the services will be provided.

All areas of request must be completed with the information required by the form. If additional room is needed providers may state "see attached," but the attachment must contain the specific information required in that section of the form.

Refer to: "Request for Extended Outpatient Psychotherapy/Counseling Form" on page B-83

Prior authorization is not granted to providers who have been seeing a client for an extended period of time or from the start of the calendar year and who have not requested prior authorization before the 25th encounter/visit. *It is recommended that a request for extension of outpatient behavioral health services be submitted no sooner than 30 days before the date of service being requested, so that the most current information is provided.*

The number of encounters/visits authorized is dependent on the client's symptoms and response to past treatment. If the client requires additional extensions, the provider must submit a new request for prior authorization at the end of each extension period. *The request for additional encounters/visits must include new documentation addressing the client's current condition, treatment plan, and the therapist's rationale supporting the medical necessity for these additional encounters/visits.* Prior authorization for an extension of outpatient behavioral health services is granted when the treatment is mandated by the courts as a court-ordered service. A copy of the court order for outpatient treatment signed by the judge must accompany prior authorization requests.

Mail or fax the request to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

Providers can submit requests for extended outpatient psychotherapy/counseling through the TMHP website.

Refer to: "Prior Authorization Requests Through the TMHP Website" on page 5-4 for additional information, including mandatory documentation requirements and retention.

The following services are not covered by the Texas Medicaid Program (except where specifically indicated in other sections):

- Music or dance therapy.
- Services provided by a licensed chemical dependency counselor (LCDC), psychiatric nurse, mental health worker, or a psychologist assistant.
- Thermogenic therapy, recreational therapy, psychiatric daycare, and biofeedback.
- Hypnosis.
- *Adult activity* and *individual activity* (these types of services would be payable only if guidelines of group therapy are met and are termed group therapy).

Refer to: "Managed Care" on page 7-1 for more information, or contact the client's BHO. Do not bill TMHP for services rendered to NorthSTAR clients.

28.4 Documentation Requirements

Those services not supported by required documentation in the client's record are subject to recoupment.

Each client for whom services are billed must have the following documentation included in their records, and the documentation must comply with the standards indicated (below) in the first listed item:

- All entries must be documented clearly, legible to individuals other than the author, dated (month/day/year), and signed by the performing provider.
- Notations of the beginning and ending session times.
- All pertinent information regarding the client's condition to substantiate the need for services, including but not limited to the following:
  - Diagnosis (background, symptoms, impression).
  - Behavioral observations during the session.
  - Narrative description of the counseling session.
  - Narrative description of the assessment, treatment plan, and recommendations.

28.5 Claims Information

Providers must bill Medicare before Medicaid when clients are eligible for services under both programs. Medicaid's responsibility for the coinsurance and/or deductible is determined in accordance with Medicaid benefits and limitations. Providers must check the client's Medicare card for Part B coverage before billing the Texas Medicaid Program. When Medicare is primary, it is inappropriate to bill Medicaid without first billing Medicare. The Texas Medicaid Program is responsible for the coinsurance and deductible of Medicare-allowed services on a crossover basis only.

Refer to: "Part B" on page 2-7.

"Medicare Part B Crossovers" on page 4-13.

LCSW services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"CMS-1500 Claim Filing Instructions" on page 5-22. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

28.5.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Medicaid Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-22
TMHP Electronic Claims Submission	5-13
Communication Guide	A-1
Request for Extended Outpatient Psychotherapy/Counseling Form	B-83
Licensed Clinical Social Worker (LCSW) Claim Example	D-20
Acronym Dictionary	F-1

Section

29

Licensed Marriage and Family Therapist (LMFT)

29.1 Enrollment

To enroll in the Texas Medicaid Program, whether as an individual or as part of a group, an LMFT must be licensed by the Texas State Board of Examiners of Licensed Marriage and Family Therapists. LMFTs are covered as Medicaid-only providers. Therefore, enrollment in Medicare is not a requirement. LMFTs can enroll as part of a multi-specialty group whether or not they are enrolled in Medicare. Providers that hold a temporary license are not eligible to enroll in the Texas Medicaid Program.

LMFTs cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

29.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with Medicaid Managed Care to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

NorthSTAR is a managed care program in the Dallas service area that covers behavioral health services. LMFTs practicing in the Dallas service area must be enrolled in the NorthSTAR Behavioral Health Organization to provide services to NorthSTAR clients. Providers must not bill TMHP for services rendered to NorthSTAR clients.

Refer to: "Managed Care" on page 7-1 for more information.

29.2 Reimbursement

According to 1 TAC §355.8091, the Medicaid rate for LMFTs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085.

According to 1 TAC §355.8261, a federally qualified health center (FQHC) is reimbursed according to its specific prospective payment system (PPS) rate per visit for LMFT counseling services.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

Fee schedules for all services in this chapter are available on the TMHP website at www.tmhp.com/file library /file library/fee schedules..

29.3 Benefits and Limitations

LMFT counseling services are a benefit for clients suffering from a mental, psychoneurotic, or personality disorder when provided in the office, (place of service [POS] 1), the home (POS 2), skilled nursing facility (SNF) (POS 4), outpatient hospital (POS 5), nursing facility (POS 8), or other locations (POS 9). When billing for contracted LMFT counseling services provided to Texas Medicaid clients who are younger than 21 years of age and who reside in a residential treatment facility, providers should use POS 9 (other location).

LMFTs must not bill for services provided by people under their supervision; only the licensed LMFT and Medicaid enrolled practitioner providing the services may bill Medicaid. LMFTs employed or remunerated by another provider may not bill Medicaid directly for counseling service if the billing results in duplicate payment for the same services.

Procedure codes 1-90806, 1-90847, and 1-90853 are allowable for services provided by an LMFT on an hourly basis. When billing or providing family counseling services (1-90847), note the following requirements for Medicaid reimbursement:

- The client must be present when family/counseling services are provided.
- Family counseling is only reimbursable for one family member per session.

According to the definition of "family" provided by HHSC Household Determination Guidelines, only specific relatives are allowed to participate in family counseling services. These guidelines also address the roles of relatives in supervision and care of children with Temporary Assistance for Needy Families (TANF). The following specific relatives are included in family counseling services:

- Father or mother.
- Grandfather or grandmother.
- Brother or sister.
- Uncle, aunt, nephew, or niece.
- First cousin or first cousin once removed.
- Stepfather, stepmother, stepbrother, or stepsister.

When billing for family, group, or individual counseling services, the time spent with the client must be reflected on the claim form as follows:

- 30 minutes bills as 0.5 hour.

- 60 minutes bills as 1 hour.
- 90 minutes bills as 1.5 hours.
- 120 minutes bills as 2 hours.

The time indicated on the claim form must be the time actually spent with the client.

LMFTs must use modifier U8, to identify the provider of the service as an LMFT.

Each individual practitioner is limited to performing a combined total of 12 hours of behavioral health services per day. The claims processing system enforces the 12-hour system limitation for the following providers: advanced practice nurse (APN), PA, LMFT, LCSW, Psychologist, and LPC. Since physicians (doctor of medicine [MD] and doctors of osteopathy [DO]) can delegate and may possibly submit claims in excess of 12 hours in a given day, the claims system does not limit these providers to 12 hours per day. However physicians (MD and DO) and those to whom they delegate are still subject to the 12-hour limitation. Additionally providers who perform group therapy may possibly submit claims in excess of 12 hours in a given day due to the manner in which group therapy is billed. Retrospective review may occur for both the total hours of services performed per day and the total hours of services billed per day. If inappropriate payments are identified, the reimbursement is recouped.

In addition, all behavioral health procedure codes, whether or not they are currently included in the 12 hour system limitation, are subject to retrospective review and possible recoupment for all providers who deliver health services.

Note: *Documentation requirements for all services billed are listed for each individual specialty in this manual.*

The claims subject to the 12-hour provider limit are based on the provider identifier number submitted on the claim. The location where the services occur is not a basis for exclusion of hours. If a provider practices at multiple locations and has a different suffix for the various locations, but has the same provider identifier, all services identified for restriction to the provider's 12-hour limit are counted regardless of whether they were performed at different locations.

Claims submitted with a prior authorization number are not exempt from the 12-hour limitation.

The following table lists the behavioral health procedure codes included in the system limitation and shows the type of service/procedure code combinations, along with the time increments the system applies based on the billed procedure code.

The time increments applied are used to calculate the 12-hour per day limitation.

Procedure Codes Included in the 12-hour System Limitation

Procedure Code	Time Assigned by Procedure Code Description	Time Applied
1-90801	Not applicable	60 minutes
1-90802	Not applicable	60 minutes
1-90804	20–30 minutes	30 minutes
1-90805	20–30 minutes	30 minutes
1-90806	45–50 minutes	50 minutes
1-90807	45–50 minutes	50 minutes
1-90808	70–80 minutes	80 minutes
1-90809	70–80 minutes	80 minutes
1-90810	20–30 minutes	30 minutes
1-90811	20–30 minutes	30 minutes
1-90812	45–50 minutes	50 minutes
1-90813	45–50 minutes	50 minutes
1-90814	70–80 minutes	80 minutes
1-90815	70–80 minutes	80 minutes
1-90816	20–30 minutes	30 minutes
1-90817	20–30 minutes	30 minutes
1-90818	45–50 minutes	50 minutes
1-90819	45–50 minutes	50 minutes
1-90821	70–80 minutes	80 minutes
1-90822	70–80 minutes	80 minutes
1-90823	20–30 minutes	30 minutes
1-90824	20–30 minutes	30 minutes
1-90826	45–50 minutes	50 minutes
1-90827	45–50 minutes	50 minutes
1-90828	70–80 minutes	80 minutes
1-90829	70–80 minutes	80 minutes
1-90847	Not applicable	50 minutes
5-96101	60 minutes	60 minutes
1-96118	60 minutes	60 minutes

If a cutback occurs for procedure codes included in the system limitation, the quantity allowed per service session designated is rounded up to one decimal point or rounded down to one decimal point following standard rounding procedures (as shown in the following example):

Total Time	Rounded Time
11.71 hours 11.72 hours 11.73 hours 11.74 hours	11.7 hours
11.75 hours 11.76 hours 11.77 hours 11.78 hours 11.79 hours	11.8 hours

Formula Applied

For client L on the table below, 80 billed minutes are applied, but the provider only has 40 available minutes before reaching the 12-hour daily limit (720 minutes); therefore, only 40 minutes are considered for reimbursement. The 40 allowed minutes are divided into the 80 applied minutes to get an allowed unit of .5 for payment.

TPI Base	TPI Suffix	Client	Code Billed	Amount Applied*	Total Time Paid	Qty.
1234567	01	A	90807	50	50	1
1234567	02	B	90828	80	80	1
1234567	01	C	90807	50	50	1
1234567	03	D	90828	80	80	1
1234567	01	E	90807	50	50	1
1234567	01	F	90828	80	80	1
1234567	02	G	90807	80	80	1
1234567	01	H	90827	50	50	1
1234567	01	J	90828	80	80	1
1234567	02	K	90828	80	80	1
Final claim for the day			Subtotal	680 minutes		
1234567	**01**	**L**	**90828**	**80**	**40**	**.5**
			Total	760 billed mins. for one day	720 paid mins. for one day	

*** Time applied toward the 12-hour limit.**

Reminder: *The procedure codes listed above have time ranges built in so the quantity billed should be reflected in quantities of one versus the actual amount of time spent with the client, i.e., procedure code 90804 is for 20 to 30 minutes of time spent with the client. The provider would bill a quantity of one when submitting a claim.*

If a claim is adjusted and causes additional minutes to be available to the provider for that day, the system does not automatically reprocess any previously denied or cutback claims that would now be payable. It is up to the provider to request reprocessing of the denied or cutback claims.

Outpatient behavioral health services are limited to 30 encounters/visits per client, per calendar year (January 1 through December 31) regardless of provider, unless prior authorized. This limitation includes encounters/visits by all practitioners. School Health and Related Services (SHARS) behavioral rehabilitation services, MHMR services, laboratory, radiology, and medication monitoring services are not counted toward the 30-encounter/visit limitation. An encounter/visit is defined as each hour of therapy, psychological, and/or neuropsychological testing rendered per hour, per provider. Each Medicaid client is limited to 30 encounters/visits per calendar year.

It is anticipated that this limitation, which allows for six months of weekly therapy or 12 months of biweekly therapy, is adequate for 75 to 80 percent of clients. Clinicians should plan therapy with this limit in mind. However, it may be medically necessary for some clients to receive extended

encounters/visits. In these situations, prior authorization is required. *A provider who sees a client regularly and anticipates that the client will require encounters/visits beyond the 30-encounter/visit limit must submit the request for prior authorization before the client's 25th encounter/visit.*

It is recognized that there are times when a client may change providers in the middle of the year, and the new provider may not be able to obtain complete information on the client. In these instances, prior authorization may be made before rendering services, when the request is accompanied by an explanation as to why the provider was not able to submit the prior authorization request by the client's 25th encounter/visit.

All authorization requests for extension of outpatient psychotherapy sessions beyond the annual 30-encounter/visit limitation are limited to 10 encounters/visits per request and must be submitted on the Extended Outpatient/Counseling Request Form. Requests must include the following:

- Client name and Medicaid number.
- Provider name and provider identifier.
- Clinical update, including specific symptoms and response to past treatment.
- Treatment plan (measurable short term goals for the extension, specific therapeutic interventions to be used in therapy, measurable expected outcomes of therapy, length of treatment anticipated, and planned frequency of encounters/visits).
- Number, type of services requested, and the dates based on the frequency of encounters/visits that the services will be provided.

All areas of request must be completed with the required information. If additional room is needed, providers may state "see attached," but the attachment must contain the specific information required in that section of the form.

Refer to: "Request for Extended Outpatient Psychotherapy/Counseling Form" on page B-83

Prior authorization is not granted to providers who have been seeing a client for an extended period of time or from the start of the calendar year and who have not requested prior authorization before the 25th encounter/visit. It is recommended that a request for extension of outpatient behavioral health be submitted no sooner than 30 days before the date of service being requested, so that the most current information is provided.

The number of encounters/visits authorized is dependent on the client's symptoms and response to past treatment. If the client requires additional extensions, the provider must submit a new request for prior authorization at the end of each extension period. *The request for additional encounters/visits must include new documentation addressing the client's current condition, treatment plan, and the therapist's rationale supporting the medical necessity for these additional encounters/visits.* Prior authorization for an extension of outpatient behavioral health services is granted when the treatment is mandated by the courts as a court-ordered service. A copy of the court order for outpatient treatment signed by the judge must accompany prior authorization requests.

Mail or fax the request to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

Providers can submit requests for extended outpatient psychotherapy/counseling through the TMHP website.

Refer to: "Prior Authorization Requests Through the TMHP Website" on page 5-4 for additional information, including mandatory documentation requirements and retention.

The following services are not covered by the Texas Medicaid Program (except where specifically indicated in other sections):

- Music or dance therapy.
- Services provided by a licensed chemical dependency counselor (LCDC), psychiatric nurse, mental health worker, or psychologist assistant.
- Thermogenic therapy, recreational therapy, psychiatric day care, and biofeedback.
- Hypnosis.
- Adult activity and individual activity (these types of services would be payable only if guidelines of group therapy are met and are termed *group therapy*).

29.4 Documentation Requirements

Those services not supported by required documentation in the client's record are subject to recoupment.

Each client for whom services are billed must have the following documentation (which meets the standards indicated) included in their records:

- All entries are documented clearly and are legible to individuals other than the author, dated (month/day/year), and signed by the performing provider.
- Notations of the beginning and ending session times.
- All pertinent information regarding the client's condition to substantiate the need for services, including but not limited to the following:
  - Diagnosis.
  - Behavioral observations during the session.
  - Narrative description of the counseling session.
  - Narrative description of the assessment, treatment plan, and recommendations.

29.5 Claims Information

LMFT services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"CMS-1500 Claim Filing Instructions" on page 5-22. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

29.5.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Medicaid Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-22
TMHP Electronic Claims Submission	5-13
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Request for Extended Outpatient Psychotherapy/Counseling Form	B-83
Licensed Marriage and Family Therapist (LMFT) Claim Example	D-21
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Section

30

Licensed Professional Counselor (LPC)

30.1 Enrollment

To enroll in the Texas Medicaid Program, whether as an individual or as part of a group, an LPC must be licensed by the Texas Board of Examiners of Professional Counselors. LPCs are covered as Medicaid-only providers; therefore, enrollment in Medicare is not a requirement. LPCs can enroll as part of a multi-specialty group whether or not they are enrolled in Medicare. Providers that hold a temporary license are not eligible to enroll in the Texas Medicaid Program.

LPCs cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

30.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with Medicaid Managed Care to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

NorthSTAR is a managed care program in the Dallas service area that covers behavioral health services. LPCs who practice in the Dallas service area must be enrolled in the NorthSTAR Behavioral Health Organization to provide services to NorthSTAR clients. Providers must not bill TMHP for services rendered to NorthSTAR clients.

Refer to: "Managed Care" on page 7-1 for more information.

30.2 Reimbursement

According to 1 TAC §355.8091, the Medicaid rate for LPCs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service under 1 TAC §355.8085.

Under 1 TAC §355.8261 a federally qualified health center (FQHC) is reimbursed according to its specific prospective payment system (PPS) rate per visit for LPC services provided by an LPC.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

Fee schedules for all services in this chapter are available on the TMHP website at www.tmhp.com/file library /file library/fee schedules..

30.3 Benefits and Limitations

LPC services are a benefit to clients of any age when performed in the office (place of service [POS] 1), home (POS 2), skilled nursing facility (POS 4), outpatient hospital (POS 5), nursing facility (POS 8), or other location (POS 9) for clients suffering from a mental, psychoneurotic, or personality disorder. When billing for contracted LPC counseling services provided to Texas Medicaid clients who are younger than 21 years of age and reside in a residential treatment facility, providers should use other location (POS 9). LPCs must not bill for services provided by people under their supervision; only the licensed LPC and Medicaid enrolled practitioner providing the service may bill Medicaid. LPCs may only bill for services that they provide to Medicaid clients. LPCs who are employed by or remunerated by another provider may not bill Medicaid directly for counseling services if that billing would result in duplicate payment for the same

Procedure codes 1-90806, 1-90847, and 1-90853 are allowable for services provided by an LPC on an hourly basis. When billing or providing family counseling services (1-90847), note the following requirements for Medicaid reimbursement:

- The client must be present when family counseling services are provided.
- Family counseling is only reimbursable for one family member per session.

According to the definition of "family" provided by HHSC Household Determination Guidelines, only specific relatives are allowed to participate in family counseling services. These guidelines also address the roles of relatives in the supervision and care of children with Temporary Assistance for Needy Families (TANF). The following specific relatives are included in family counseling services:

- Father or mother.
- Grandfather or grandmother.
- Brother or sister.
- Uncle, aunt, nephew, or niece.
- First cousin or first cousin once removed.
- Stepfather, stepmother, stepbrother, or stepsister.

When billing for family, group, or individual counseling services, the time spent with the client must be reflected on the claim form as follows:

- 30 minutes bills as 0.5 hour.

- 60 minutes bills as 1 hour.
- 90 minutes bills as 1.5 hours.
- 120 minutes bills as 2 hours.

The time indicated on the claim form must be the time actually spent with the client.

Each individual practitioner is limited to performing a combined total of 12 hours of behavioral health services per day. The claims processing system enforces the 12-hour system limitation for the following providers: advanced practice nurse (APN), PA, LMFT, LCSW, Psychologist, and LPC. Since physicians (doctor of medicine [MD] and doctors of osteopathy [DO]) can delegate and may possibly submit claims in excess of 12 hours in a given day, the claims system does not limit these providers to 12 hours per day. However physicians (MD and DO) and those to whom they delegate are still subject to the 12-hour limitation. Additionally providers who perform group therapy may possibly submit claims in excess of 12 hours in a given day due to the manner in which group therapy is billed. Retrospective review may occur for both the total hours of services performed per day and the total hours of services billed per day. If inappropriate payments are identified, the reimbursement is recouped.

In addition, all behavioral health procedure codes, whether or not they are currently included in the 12-hour system limitation, are subject to retrospective review and possible recoupment for all providers who deliver health services.

Note: *Documentation requirements for all services billed are listed for each individual specialty in this manual.*

The claims subject to the 12-hour provider limit are based on the provider identifier number submitted on the claim. The location where the services occur is not a basis for exclusion of hours. If a provider practices at multiple locations and has a different suffix for the various locations, but has the same provider identifier, all services identified for restriction to the provider's 12-hour limit are counted regardless of whether they were performed at different locations.

Claims submitted with a prior authorization number are not exempt from the 12-hour limitation.

The following table lists the behavioral health procedure codes included in the system limitation and shows the type of service/procedure code combinations, along with the time increments the system applies based on the billed procedure code.

The time increments applied are used to calculate the 12-hour per day limitation.

Procedure Codes Included in the 12-hour System Limitation

Procedure Code	Time Assigned by Procedure Code Description	Time Applied
1-90801	Not applicable	60 minutes
1-90802	Not applicable	60 minutes
1-90804	20-30 minutes	30 minutes
1-90805	20-30 minutes	30 minutes
1-90806	45-50 minutes	50 minutes
1-90807	45-50 minutes	50 minutes
1-90808	70-80 minutes	80 minutes
1-90809	70-80 minutes	80 minutes
1-90810	20-30 minutes	30 minutes
1-90811	20-30 minutes	30 minutes
1-90812	45-50 minutes	50 minutes
1-90813	45-50 minutes	50 minutes
1-90814	70-80 minutes	80 minutes
1-90815	70-80 minutes	80 minutes
1-90816	20-30 minutes	30 minutes
1-90817	20-30 minutes	30 minutes
1-90818	45-50 minutes	50 minutes
1-90819	45-50 minutes	50 minutes
1-90821	70-80 minutes	80 minutes
1-90822	70-80 minutes	80 minutes
1-90823	20-30 minutes	30 minutes
1-90824	20-30 minutes	30 minutes
1-90826	45-50 minutes	50 minutes
1-90827	45-50 minutes	50 minutes
1-90828	70-80 minutes	80 minutes
1-90829	70-80 minutes	80 minutes
1-90847	Not applicable	50 minutes
5-96101	60 minutes	60 minutes
1-96118	60 minutes	60 minutes

If a cutback occurs for procedure codes included in the system limitation, the quantity allowed per service session designated is rounded up to one decimal point or rounded down to one decimal point following standard rounding procedures (as shown in the following example):

Total Time	Rounded Time
11.71 hours 11.72 hours 11.73 hours 11.74 hours	11.7 hours
11.75 hours 11.76 hours 11.77 hours 11.78 hours 11.79 hours	11.8 hours

Formula Applied

For client L on the table below, 80 billed minutes are applied, but the provider only has 40 available minutes before reaching the 12-hour daily limit (720 minutes); therefore, only 40 minutes are considered for reimbursement. The 40 allowed minutes are divided into the 80 applied minutes to get an allowed unit of .5 for payment.

TPI Base	TPI Suffix	Client	Code Billed	Amount Applied*	Total Time Paid	Qty.
1234567	01	A	90807	50	50	1
1234567	02	B	90828	80	80	1
1234567	01	C	90807	50	50	1
1234567	03	D	90828	80	80	1
1234567	01	E	90807	50	50	1
1234567	01	F	90828	80	80	1
1234567	02	G	90807	80	80	1
1234567	01	H	90827	50	50	1
1234567	01	J	90828	80	80	1
1234567	02	K	90828	80	80	1
Final claim for the day			Subtotal	680 minutes		
1234567	**01**	**L**	**90828**	**80**	**40**	**.5**
			Total	760 billed mins. for one day	720 paid mins. for one day	

*** Time applied toward the 12-hour limit.**

Reminder: *The procedure codes listed above have time ranges built in so the quantity billed should be reflected in quantities of one versus the actual amount of time spent with the client, i.e., procedure code 90804 is for 20 to 30 minutes of time spent with the client. The provider would bill a quantity of one when submitting a claim.*

If a claim is adjusted and causes additional minutes to be available to the provider for that day, the system does not automatically reprocess any previously denied or cutback claims that would now be payable. It is up to the provider to request reprocessing of the denied or cutback claims.

Outpatient behavioral health services are limited to 30 encounters/visits per client, per calendar year (January 1 through December 31) regardless of provider, unless prior authorized. This limitation includes encounters/visits by all practitioners. School Health and Related Services (SHARS) behavioral rehabilitation services, MHMR services, laboratory, radiology, and medication monitoring services are not counted toward the 30-encounter/visit limitation. An encounter/visit is defined as each hour of therapy, psychological, and/or neuropsychological testing rendered per hour, per provider. Each Medicaid client is limited to 30 encounters/visits per calendar year.

It is anticipated that this limitation, which allows for six months of weekly therapy or 12 months of biweekly therapy, is adequate for 75 to 80 percent of clients. Clinicians should plan therapy with this limit in mind. However, it may be medically necessary for some clients to receive extended encounters/visits. In these situations, prior authorization is required. *A provider who sees a client regularly and anticipates that the client will require encounters/visits beyond the 30-encounter/visit limit must submit the request for prior authorization before the client's 25th encounter/visit.*

It is recognized that a client may change providers in the middle of the year, and the new provider may not be able to obtain complete information on the client. In these instances, prior authorization may be made before rendering services when the request is accompanied by an explanation as to why the provider was not able to submit the prior authorization request by the client's 25th encounter/visit.

All authorization requests for extension of outpatient psychotherapy sessions beyond the annual 30-encounter/visit limitation are limited to ten encounters/visits per request, and must be submitted on the Extended Outpatient/Counseling Request Form. Requests must include the following:

- Client name and Medicaid number.
- Provider name and provider identifier.

- Clinical update, including current specific symptoms and response to past treatment, and treatment plan (measurable short term goals for the extension, specific therapeutic interventions to be used in therapy, measurable expected outcomes of therapy, length of treatment anticipated, and planned frequency encounters/visits).
- Number, type of services requested, and the dates based on the frequency of encounters/visits that the services will be provided.

All areas of request must be completed with the information required by the form. If additional room is needed providers may state "see attached," but the attachment must contain the specific information required in that section of the form.

Refer to: "Request for Extended Outpatient Psychotherapy/Counseling Form" on page B-83

Prior authorization is not granted to providers who have been seeing a client for an extended period of time or from the start of the calendar year and who have not requested prior authorization before the 25th encounter/visit. It is recommended that a request for extension of outpatient behavioral health be submitted no sooner than 30 days before the date of service being requested, so that the most current information is provided.

The number of encounters/visits authorized is dependent on the client's symptoms and response to past treatment. If the client requires additional extensions, the provider must submit a new request for prior authorization at the end of each extension period. *The request for additional encounters/visits must include new documentation addressing the client's current condition, treatment plan, and the therapist's rationale supporting the medical necessity for these additional encounters/visits*. Prior authorization for an extension of outpatient behavioral health services is granted when the treatment is mandated by the courts as a court-ordered service. A copy of the court order for outpatient treatment signed by the judge must accompany prior authorization requests.

Mail or fax the request to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

Providers can submit requests for extended outpatient psychotherapy/counseling through the TMHP website.

Refer to: "Prior Authorization Requests Through the TMHP Website" on page 5-4 for additional information, including mandatory documentation requirements and retention.

The following services are not covered by the Texas Medicaid Program (except where specifically indicated in other sections):

- Music or dance therapy.
- Services provided by a licensed chemical dependency counselor (LCDC), psychiatric nurse, mental health worker, or psychologist assistant.
- Thermogenic therapy, recreational therapy, psychiatric day care, and biofeedback.
- Hypnosis.
- *Adult activity and individual activity* (These types of services would be payable only if guidelines of group therapy are met and are termed group therapy).

30.4 Documentation Requirements

Those services not supported by required documentation in the client's record are subject to recoupment.

Each client for whom services are billed must have documentation that meets the following guidelines included in their records:

- All entries must be documented clearly and legible to individuals that meet the following guidelines than the author, dated (month/day/year), and signed by the performing provider.
- Notations of the beginning and ending session times.
- All pertinent information regarding the client's condition to substantiate the need for services, including, but not limited to the following:
  - Diagnosis (background, symptoms, impression).
  - Behavioral observations during the session.
  - Narrative description of the counseling session.
  - Narrative description of the assessment, treatment plan, and recommendations.

30.5 Claims Information

LPC services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"CMS-1500 Claim Filing Instructions" on page 5-22. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

30.5.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Medicaid Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-22
TMHP Electronic Claims Submission	5-13
Communication Guide	A-1
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Licensed Professional Counselor (LPC) Claim Example	D-21
Acronym Dictionary	F-1

Section

31

Maternity Service Clinic (MSC)

31.1 Enrollment

To enroll in the Texas Medicaid Program, MSCs must ensure that the provider providing the services is employed by or has a contractual agreement or formal arrangement with the clinic to assume professional responsibility for the services provided to clinic clients. To meet this requirement, a provider must see the client at least once, prescribe the type of care provided, and if the services are not limited by the prescription, periodically review the need for continued care. Medicare certification is not a prerequisite for MSC enrollment. A current copy of the supervising practitioner's physician license must be submitted at the time of enrollment.

An MSC must be a facility that is:

- Not an administrative, organizational, or financial part of a hospital.
- Organized and operated to provide maternity services to outpatients.
- Compliant with all applicable federal, state, and local laws and regulations.

An MSC wanting to bill and receive reimbursement for case management services to high-risk pregnant adolescents, women, and infants must meet the eligibility criteria specified in "Case Management for Children and Pregnant Women (CPW)" on page 12-1.

To bill and receive reimbursement for family planning services, family planning agencies, providers, advanced practice nurses (APNs), or physicians assistants (PAs) must use their provider identifier.

To bill and receive reimbursement for laboratory procedures, an MSC must meet the requirements for an independent laboratory.

All providers of laboratory services must comply with the rules and regulations of the *Clinical Laboratory Improvement Amendments* (CLIA). Providers not complying with CLIA are not reimbursed for laboratory services.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

"Independent Laboratory" on page 26-1.

"Clinical Laboratory Improvement Amendments (CLIA)" on page 26-2.

31.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with Medicaid Managed Care to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

Refer to: "Managed Care" on page 7-1 for more information.

31.2 Reimbursement

The Medicaid rates for MSCs for procedure codes in the following table for antepartum and postpartum care visits are calculated in accordance with 1 TAC §355.8201.

Procedure Codes		
2-59430	1-99201-TH	1-99202-TH
1-99203-TH	1-99204-TH	1-99205-TH
1-99211-TH	1-99212-TH	1-99213-TH
1-99214-TH	1-99215-TH	

The applicable rates are reported in the current physician fee schedule, which is available on the TMHP website at www.tmhp.com/file library/file library/fee schedules or by calling the TMHP Contact Center at 1-800-925-9126 to request a copy.

Refer to: "Reimbursement" on page 2-2 for more information on reimbursement.

31.3 Benefits and Limitations

MSCs are those medical services provided by registered nurses (RNs) and determined with or by a licensed physician to be reasonable and medically necessary for the care of a pregnant adolescent or woman during the prenatal period and subsequent 60-day postpartum period. MSC benefits do *not* include deliveries.

Covered clinic services include, but are not necessarily limited to: risk assessment, medical services, specific laboratory or screening services, case coordination/outreach, nutritional counseling, psychosocial counseling, family planning counseling, and client education about maternal and child health.

Medical services must be furnished on an outpatient basis by the physician, nurse practitioner, physician's assistant, or licensed professional nurse under the physician's supervision, and must be within the staff's scope of practice or licensure as defined by state law.

Although the physician does not necessarily have to be present at the clinic when services are provided, the physician must assume professional responsibility for the medical services provided at the clinic, and ensure through approval of the plan of care (POC) that the services are medically appropriate. The physician must spend as much time in the clinic as is necessary to ensure that clients are receiving medical services in a safe and efficient manner in accordance with accepted standards of medical practice.

The physician must see each client as soon as possible after she enters the MSC care and prescribe or approve the POC. The POC must be based on a risk assessment completed by the physician or licensed, professional clinic staff. MSCs must follow the procedures outlined throughout this manual. All service, frequency, and documentation requirements are applicable.

A minimum level of service must be provided by enrolled MSC providers to all Texas Medicaid clients as follows.

31.3.1 Initial Antepartum Care Visit Components

The following initial antepartum care visit components should be done as early as possible in the client's pregnancy.

31.3.1.1 History

History includes obstetric and gynecological, present pregnancy, medical/surgical, substance use, environmental, nutritional, psychosocial (including violence), and family/support system.

31.3.1.2 Physical Examination

Physical examination includes height, weight, blood pressure; head, neck, lymph, breasts, heart, lungs, back, abdomen, pelvis, rectum, extremities, and skin; and uterine size, fetal heart rate, and location.

31.3.1.3 Laboratory Tests

The initial hematocrit or hemoglobin and each subsequent hematocrit or hemoglobin is included in the visit fee and is not separately reimbursable to MSCs.

The laboratory services listed may not be billed using the MSC provider identifier. They may be ordered by MSC personnel and provided by a reference laboratory.

MSCs referring laboratory work are required to supply the reference laboratory with the client's Medicaid number, as well as the MSC provider identifier for laboratory work including but not limited to:

- Hemoglobin or hematocrit, or complete blood count (CBC).
- Urinalysis.
- Blood type and Rh.
- Antibody screen.
- Rubella antibody titer.
- Serology for syphilis.
- Hepatitis B surface antigen.
- Cervical cytology.
- Other laboratory tests.

The following tests may be performed at the initial antepartum care, as indicated:

- Pregnancy test.
- Gonorrhea test.
- Urine culture.
- Sickle cell test.
- Tuberculosis (TB) test.
- Human immunodeficiency virus (HIV) antibody screen.
- Chlamydia test.

Multiple marker screens for neural tube defects must be offered if the client initiates care between 16 and 20 weeks.

31.3.1.4 Assessment

Assessment includes pregnancy, general health, medical, and psychosocial.

31.3.1.5 Plan

Plan includes pregnancy, preventive health, medical, and referral as indicated.

31.3.1.6 Education/Counseling

Education/counseling includes pregnancy, delivery, nutrition, breast-feeding, family planning, and preventive health.

The complete physical examination may be completed at the second visit if the MSC's routine involves a two-stage initial evaluation.

31.3.2 Subsequent Antepartum Care Visits

The following is a recommended guide for the frequency of subsequent antepartum visits for a regular pregnancy:

- One visit every four weeks for the first 28 weeks of pregnancy.
- One visit every two to three weeks from 28 to 36 weeks of pregnancy.
- One visit per week from 36 weeks to delivery.

More frequent visits may be medically necessary. Physicians, certified nurse-midwives (CNMs), and MSCs are limited to 20 antepartum care visits per pregnancy and two postpartum care visits per pregnancy after discharge from the hospital, without documentation of a complication of pregnancy.

Each subsequent visit must include the following:

Interim History

- Problems.
- Maternal status.
- Fetal status.

Physical Examination

- Weight, blood pressure.
- Fundal height, fetal position and size, and fetal heart rate.
- Extremities.

Laboratory Tests

- Urinalysis for protein and glucose every visit.

The urinalysis for protein and glucose, hemoglobin, and hematocrit is included in the visit fee and is not separately reimbursable to MSCs.

- Hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy.
- Multiple marker screen for fetal abnormalities offered at 16 to 20 weeks of pregnancy.
- Repeat antibody screen for Rh negative women at 28 weeks (followed by Rho immune globulin administration if indicated).
- Screen for gestational diabetes at 24 to 28 weeks of pregnancy, one hour post 50 gram glucose load.
- Other laboratory tests as indicated by the medical condition of the client.

31.3.3 Risk Assessment

A systematic assessment of factors that may compromise the health outcome for the pregnant adolescent or woman, or the fetus must be performed for all prenatal clients at the initial visit. The risk assessment must be ongoing and modified as necessary.

The level of services provided to the client must be appropriate for the risk assessment. Services must be available on-site or through a referral. If the maternity clinic refers the client to a physician, CNM, and/or hospital that does not participate in the Texas Medicaid Program, the maternity clinic must inform the client in advance of the client's potential financial responsibility, according to the requirements of the Texas Medicaid Program.

31.3.3.1 Classification of Risk

Low risk

A client with a normal evaluation without substantial risk factors at the initial examination and each subsequent examination is low risk. The number of antepartum care visits does not usually exceed 20 and the number of usual postpartum visits is 2.

High risk

A client with an identified complication or risk factor that might adversely affect the mother or fetus is high risk. Examples of common high-risk pregnancy factors are listed in the following table with the appropriate diagnosis code, but not all high-risk factors are listed. Providers submitting charges for high-risk antepartum care must document the high-risk diagnosis on the claim form.

- Maternal client is younger than 17 years of age or older than 35 years of age (V2381, V2382, V2383, V2384).
- Nutritional problems:
  - Underweight—30 percent underweight before pregnancy (V2389). Calculations of weight are based on actual weight compared to the standard height/weight charts nationally.
  - Failure to gain weight appropriately (64680).
  - Weight loss greater than 10 pounds during pregnancy (V2389, 64890)

Diagnosis Codes				
30300	30390	30400	30410	30420
30430	30440	30450	30500	3180
3181	3182	59010	59011	630
64110	64120	64180	64190	64200
64210	64220	64230	64250	64260
64290	64310	64420	64510	64520
64630	64700	64710	64720	64830
64880	65100	65101	65103	65110
65113	65120	65121	65123	65130
65131	65133	65140	65141	65143
65150	65151	65153	65160	65161
65163	65170	65171	65173	65180
65181	65183	65190	65300	65301
65303	65310	65311	65313	65320
65321	65323	65330	65350	65360
65370	65420	65450	65520	65650
65700	65800	V231	V233	V234
V235	V2389			

31.3.4 Postpartum Care Visit

Postpartum care provided by MSCs must be billed using procedure code 2-59430. A maximum of two postpartum visits are allowed within 60 days postpartum period for those clients without documentation or a diagnosis of complication of pregnancy. However, it is preferable for the MSC to enroll as a family planning agency and bill the postpartum visits as family planning services.

31.3.5 Documentation Requirements

Each client must have a complete and accepted standard medical record with documentation for the initial visit with procedures, as well as each subsequent visit with procedures. Such records must be made available when requested by HHSC or TMHP for utilization and quality assurance reviews as required by federal regulations. The documentation record or a true copy or narrative abstract

must be sent to the hospital of delivery by the client's 35th week of pregnancy. The record must be made available to the client if the client transfers care to another institution. Records completed by licensed professional clinic staff under the direction of a physician must be signed by the supervising physician.

31.4 Claims Information

Hemoglobin, hematocrit, and urinalysis procedures are included in the charge for antepartum care. The urinalysis for protein and glucose, Hemoglobin, and Hematocrit is included in the visit fee and is not separately reimbursable to MSCs.

MSC services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"CMS-1500 Claim Filing Instructions" on page 5-22. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

31.4.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
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Section

32

Mental Health (MH) Mental Retardation (MR)

32.1 Enrollment

To enroll in the Texas Medicaid Program, MH providers must contact the Texas Department of State Health Services (DSHS) at 1-512-206-4830. Entities that provide services to clients with mental retardation must contact the Texas Department of Aging and Disability Services (DADS) at 1-512-438-3011 to be approved.

Local MR providers are eligible to enroll, with the approval of DADS, for MR service coordination**.** Local MH providers are eligible to enroll, with the approval of DSHS, for MH case management and MH rehabilitative services.

Community mental health centers (CMHC) can enroll in the Texas Medicaid Program without the approval of DADS, but must be enrolled in Medicare.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

32.1.1 Medicaid Managed Care Enrollment

MR service coordination, MH case management, and MH rehabilitative services providers are not required to enroll with Medicaid Managed Care. Claims for MR and MH services are submitted to TMHP for all Medicaid clients including Medicaid Managed Care clients.

Exception: *MH providers in the Dallas service area must join the NorthSTAR Behavioral Health Organizations (BHO) to provide services to NorthSTAR clients.*

NorthSTAR is a managed care program in the Dallas service area that covers behavioral health services. MH providers that provide behavioral health services to clients in NorthSTAR must be members of the NorthSTAR BHOs.

32.2 Reimbursement

Services are reimbursed according to a maximum allowable fee established by HHSC. Reimbursement is limited to the federal matching percentage of the maximum allowable fee and is subject to adjustment annually.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement and the federal matching percentage.

32.3 Benefits and Limitations

32.3.1 Service Coordination and Case Management

The Texas Medicaid Program provides the following service coordination and case management services:

- Service coordination for people with mental retardation or related condition (adult or child) per consumer, per month.
- Case management for people with serious emotional disturbance (child, 3–17 years of age).

- Case management for people with severe and persistent mental illness (adult, 18 years of age and older).

Service	Procedure Code	Modifier	Limitations
Individual Community Support Services			
Service Coordination for people with mental retardation or related condition (adult or child)	1-G9012		Once per calendar month
Routine case management (adult)	1-T1017	TF	32 units (8 hours) per calendar day for people 18 years of age or older.
Routine case management (child and adolescent)	1-T1017	TF and HA	32 units (8 hours) per calendar day for people less than 18 years of age.
Intensive case management (child and adolescent)	1-T1017	TG and HA	

An MR service coordination reimbursable *contact* is the provision of a service coordination activity by an authorized service coordinator during a face-to-face meeting with an individual eligible for service coordination. To bill and be paid for one unit of service coordination per month, at least one face-to-face meeting between the service coordinator and the eligible individual must occur during the month billed.

An MH case management reimbursable contact is the provision of a case management activity by an authorized case manager during a face-to-face meeting with an individual authorized to receive that specific type of case management. A billable unit of case management is 15 continuous minutes of contact.

Service coordination and case management services are not reimbursable when provided to a client eligible for Medicaid and receiving services through the Home and Community-Based Services (HCS) waiver. These services are included in the waiver. Claims submitted to TMHP for people receiving services under the HCS waiver are identified quarterly by DADS and payments are recouped.

The Texas Medicaid Program must *not* be billed for service coordination or case management services provided to people who are residents or inpatients of:

- Nursing facilities (for people not mandated by the *Omnibus Budget Reconciliation Act* [OBRA] of 1987).*
- Intermediate care facilities for mental retardation (ICF-MR).*
- State MR facilities.*
- State MH facilities.
- Title XIX participating hospitals including general medical hospitals.
- Private psychiatric hospitals.
- Medicaid-certified residence not already specified.
- Institutions for mental diseases such as a hospital, nursing facility, or other institution of more than 16 beds primarily engaged in providing diagnosis, treatment, or care of people with mental diseases including medical attention, nursing care, and related services.
- Jail or public institution.

*A contact by the service coordinator to assist in discharge planning from some of the above may be reimbursed, if provided within 180 days before discharge. Service coordination services provided to people who are on predischarge furlough to the community from a nursing facility, intermediate care facility, or state MR facility may be reimbursed. Service coordination services provided to people who are on trial placement from a state MR facility to the community may be reimbursed if the person remains eligible for Medicaid upon release from the facility and receives regular Medicaid coverage.

The Texas Medicaid Program must *not* be billed for MH case management services provided before the establishment of a diagnosis of mental illness and authorization of services.

Refer to: "Managed Care" on page 7-1 for more information or contact the client's BHO. Do not bill TMHP for MH case management services rendered to NorthSTAR clients.

32.3.2 MH Rehabilitative Services

The following rehabilitative services may be provided to individuals who satisfy the criteria of the MH priority population and who are determined to need rehabilitative services. These services may be provided to a person with a single severe mental disorder (excluding MR, pervasive developmental disorder, or substance use disorder) or a combination of severe mental disorders as defined in the latest edition of the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*:

Service	Procedure Code	Modifier	Limitations
Day program for acute needs	1-G0177		6 units (4.5 to 6 hours) per calendar day, in any combination, for people 18 years of age or older
Day program for acute needs, Assertive Community Treatment (ACT), or ACT alternative client	1-G0177	HK	
Medication training and support, adult, individual	1-H0034		8 units (2 hours) per calendar day in any combination, for people 18 years of age or older.
Medication training and support, adult, ACT or ACT alternative client, individual	1-H0034	HK	
Medication training and support, adult, group	1-H0034	HQ	
Medication training and support, adult, ACT or ACT alternative client, group	1-H0034	HK and HQ	
Medication training and support, child and adolescent, individual	1-H0034	HA	8 units (2 hours) per calendar day in any combination, for people less than 18 years of age.
Medication training and support, child and adolescent with other individual	1-H0034	HA and HR or UK	
Medication training and support, child and adolescent, group	1-H0034	HA and HQ	
Medication training and support, child and adolescent with other group	1-H0034	HA and HQ and HR or UK	
Crisis intervention services, adult	1-H2011		96 units (24 hours) per calendar day in any combination
Crisis intervention services, adult, ACT or ACT alternative client	1-H2011	HK	
Crisis intervention services, child and adolescent	1-H2011	HA	
Skills training and development, adult, individual	1-H2014		16 units (4 hours) per calendar day, in any combination, for people 18 years of age or older
Skills training and development, adult, group	1-H2014	HQ	
Skills training and development, child and adolescent, individual	1-H2014	HA	16 units (4 hours) per calendar day, in any combination, for people less than 18 years of age
Skills training and development, child and adolescent, with other, individual	1-H2014	HA and HR or UK	

Service	Procedure Code	Modifier	Limitations
Psychosocial rehabilitative services, individual	1-H2017		16 units (4 hours) per calendar day, in any combination, for people 18 years of age or older
Psychosocial rehabilitative services, ACT or ACT alternative client, individual	1-H2017	HK	
Psychosocial rehabilitative services, by RN, individual	1-H2017	TD	
Psychosocial rehabilitative services ACT or ACT alternative client, by registered nurse (RN), individual	1-H2017	HK and TD	
Psychosocial rehabilitative services, group	1-H2017	HQ	
Psychosocial rehabilitative services, ACT or ACT alternative client, group	1-H2017	HQ and HK	
Psychosocial rehabilitative services, by RN, group	1-H2017	HQ and TD	
Psychosocial rehabilitative services, ACT or ACT alternative client, by RN, group	1-H2017	HQ and HK and TD	
Psychosocial rehabilitative services, Individual, crisis	1-H2017	ET	96 units (24 hours) per calendar day, in any combination
Psychosocial rehabilitative services, ACT or ACT alternative client, Individual, crisis	1-H2017	HK and ET	

32.3.2.1 Rehabilitative Services Limitations

The Texas Medicaid Program must *not* be billed for rehabilitative services provided before the establishment of a diagnosis of mental illness and authorization of services; rehabilitative services provided to individuals who reside in an institution for mental diseases; rehabilitative services provided to general acute care hospital inpatients; vocational services; educational services; nursing facility residents who are not mandated to need services by OBRA of 1987; and services provided to individuals in jail or a public institution.

Refer to: 25 TAC, Part I, Chapter 419, Subchapter L and the Medicaid MH Rehabilitative Billing Guidelines for more information.

32.3.2.2 Billing Units

All claims for reimbursement for rehabilitative services are based on the actual amount of time the eligible individual or primary caregiver/legal guardian of an eligible individual is engaged in face-to-face contact with a service provider. The billable units are: individual, group (15 continuous minutes); day programs (45-60 continuous minutes).

32.4 Claims Information

MR coordination services and MH case management and rehabilitative services must be submitted to TMHP in an approved electronic claims format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply them.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"CMS-1500 Claim Filing Instructions" on page 5-22. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

32.4.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-22
TMHP Electronic Claims Submission	5-13
Communication Guide	A-1
Mental Health Case Management Claim Example	D-22
Acronym Dictionary	F-1

Section

33

Military Hospital

33.1 Enrollment

To enroll in the Texas Medicaid Program, a military hospital must be certified by Medicare, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process. Veterans Administration (VA) hospitals are eligible to receive Texas Medicaid payment only on claims that have crossed over from Medicare.

Military hospital providers must comply with the rules and regulations of the *Clinical Laboratory Improvement Amendments* (CLIA) rules and regulations. Providers who do not comply with CLIA will not be reimbursed for laboratory services.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

"Clinical Laboratory Improvement Amendments (CLIA)" on page 26-2.

33.1.1 Medicaid Managed Care Enrollment

Medicaid Managed Care health plans must reimburse military hospital providers for emergency services.

Refer to: "Managed Care" on page 7-1 for more information.

33.2 Reimbursement

Reimbursement is limited to claims submitted for emergency inpatient care only.

Allowed inpatient hospital stays are reimbursed according to a prospective payment methodology based on diagnosis-related groups (DRGs). The reimbursement method itself does not affect inpatient benefits and limitations. The Texas Medicaid Program requires that one claim be submitted for each inpatient stay with appropriate diagnosis and procedure code sequencing. Providers should submit only one claim per inpatient stay to Medicaid, regardless of the diagnosis, to ensure accurate payment. The DRG reimbursement includes all facility services that were provided to the client while registered as an inpatient.

Reimbursement to hospitals for inpatient services is limited to $200,000 per client, per benefit year (November 1 through October 31). This limitation does not apply to services related to certain organ transplants, services to clients younger than 21 years of age and covered by the Comprehensive Care Program (CCP), or to services for certain clients enrolled in Medicaid Managed Care.

Military hospitals should keep a Medicaid client as an inpatient only for the length of time necessary to stabilize that client. The Medicaid client, once stabilized, should be transferred to the nearest Medicaid acute care hospital facility for further treatment.

When more than one hospital provides care for the same client, the hospital that furnishes the most significant amount of care receives consideration for a full DRG payment.

The other hospital is paid a per diem rate based on the lesser of the mean length of stay for the DRG or eligible days in the facility. The DRG modifier PT on the Remittance and Status (R&S) report indicates per diem pricing related to a client transfer.

Client transfers within the same facility are considered one continuous stay and receive only one DRG payment. Medicaid does not recognize specialty units as separate entities; therefore, these transfers should be billed as *one* admission under the provider identifier. Admissions billed inappropriately are identified and denied during the utilization review process and may result in intensified review.

After all hospital claims have been submitted, TMHP performs a post-payment review to determine if the hospital furnishing the most significant amount of care received the full DRG. If the review reveals that the hospital furnishing the most significant amount of care did not receive the full DRG, an adjustment is initiated.

The inpatient DRG reimbursement includes payment for all radiology and laboratory services, including those sent to referral laboratories.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

"THSteps-Comprehensive Care Program (CCP)" on page 43-33.

33.3 Benefits and Limitations

33.3.1 Inpatient Services

Inpatient hospital services include medically necessary items and services ordinarily furnished by a Medicaid hospital or by an approved out-of-state hospital under the direction of a physician for the care and treatment of inpatient clients. Reimbursement to hospitals for inpatient services is limited to the Medicaid "spell of illness." The *spell of illness* is defined as "30 days of inpatient hospital care, which may accrue intermittently or consecutively." After 30 days of inpatient care have been provided, reimbursement for additional inpatient care is

not considered until the client has been out of an acute care facility for 60 consecutive days. Exceptions are made in the following instances:

- Texas Health Steps (THSteps)-eligible clients do not have a 30-day spell of illness limitation, if medically necessary conditions exist (covered under THSteps-CCP).
- Some Medicaid Managed Care clients do not have a 30-day spell of illness limitation.

Refer to: "Managed Care" on page 7-1 for more information.

Hospitals may submit *information only* claims to TMHP when one of the following situations exists:

- The inpatient 30-day spell of illness benefit is exhausted.
- Payment that has been made by a third party resource/other insurance exceeds the Medicaid allowed amount.

For clients older than 21 years of age and not enrolled in Medicaid Managed Care, an inpatient expenditure cap of $200,000 per benefit year (November 1 through October 31) exists. Claims are reviewed retrospectively, and payments exceeding $200,000 will be recouped.

It is appropriate to submit *information only* claims using TOB 110.

The following hospital services must be medically necessary and are subject to the utilization review requirements of the Texas Medicaid Program. Medicaid reimbursement for services cannot exceed the limitations of the Texas Medicaid Program.

Inpatient hospital services include the following items and services:

- Bed and board in semiprivate accommodations or in an intensive care or coronary care unit, including meals, special diets, and general nursing services; or an allowance for bed and board in private accommodations, including meals, special diets, and general nursing services up to the hospital's charge for its most prevalent semiprivate accommodations. Bed and board in private accommodations are provided in full if required for medical reasons, as certified by the physician. Additionally, the hospital must document the medical necessity for a private room, such as the existence of a critical or contagious illness or a condition that could result in disturbance to other patients. This type of information is included in Block 80 or attached to the claim.
- Whole blood and packed red cells that are reasonable and necessary for treatment of illness or injury, provided they are not available without cost.
- All medically necessary services or supplies ordered by a physician.

Medicaid benefits are not available for take-home or self-administered drugs or personal comfort items, except when received by prescription through the Vendor Drug Program.

Only inpatient claims that have an emergency diagnosis on the claim are considered for reimbursement.

33.3.2 Outpatient/Physician Services

Although Medicare reimburses for emergency outpatient and inpatient services, Medicaid does not reimburse for either outpatient or physician services. Military hospitals are not reimbursed for outpatient day surgery.

33.4 Utilization Review

For information about hospital utilization review procedures, refer to "Utilization Review Process" on page 25-14.

33.5 Claims Information

If type of bill (TOB) 110 is used to submit a claim, all charges must be noncovered and the claim will finalize with Explanation of Benefit (EOB) 217, "Payment reduced through hospital action."

It is appropriate to submit *information only* claims using TOB 110.

Military hospitals may submit total charges in one line with appropriate accommodation revenue codes. Emergency hospital services must be submitted to TMHP in an approved electronic format or on the UB-04 CMS-1450 claim form. Providers may purchase claim forms from the vendor of their choice. TMHP does not supply the forms.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

When completing a UB-04 CMS-1450 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claims supplements.

Instructions for completing paper claims are provided in "UB-04 CMS-1450 Claim Filing Instructions" on page 5-30. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Refer to: "Military Hospital (Emergency Inpatient)" on page D-23.

33.5.1 Claim Filing Resources

Refer to the following sections and/or forms when claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
UB-04 CMS-1450 Claim Filing Instructions	5-22
TMHP Electronic Claims Submission	5-13
Communication Guide	A-1
Military Hospital (Emergency Inpatient) Claim Example	D-23
Acronym Dictionary	F-1

Section

34

Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS)

34.1 Enrollment

To enroll in the Texas Medicaid program, an NP or CNS must be licensed as a registered nurse and recognized as an advanced practice nurse (APN) by the Texas Board of Nursing (BON). A registered nurse under the multi-state licensure compact can be licensed in another state but certified as an APN by the Texas BON for the state of Texas. The Texas Medicaid program accepts a signed letter of certification from the Texas BON as acceptable documentation of appropriate licensure and certification for enrollment.

Providers cannot be enrolled if their license is due to expire within 30 days.

All providers of laboratory services must comply with the rules and regulations of the *Clinical Laboratory Improvement Amendments* (CLIA). Providers not complying with CLIA are not reimbursed for laboratory services.

All APNs (including certified nurse-midwives [CNMs], certified registered nurse anesthetists [CRNAs], CNSs, and NPs) are enrolled within the categories of practice as determined by the Texas BON. CNSs and NPs must enroll as an APN; CNMs and CRNAs are allowed to enroll using their specific titles. Specific CNM and CRNA enrollment information may be found in the CNM and CRNA sections of this manual.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

"CLIA Requirements" on page 26-2.

"Enrollment" on page 14-2 for more information on certified nurse midwife enrollment.

"Enrollment" on page 15-2 for more information on certified registered nurse anesthetist enrollment.

34.1.1 Enrollment in Texas Health Steps (THSteps)

Family and pediatric NPs are allowed to enroll in the THSteps Program to provide medical check ups. Women's health care NPs can enroll as THSteps providers for adolescents. Specific information is found in the THSteps section of this manual.

Refer to: "Provider Enrollment" on page 43-5 for more information on enrollment procedures.

34.1.2 Medicaid Managed Care Enrollment

NPs and CNSs may be eligible to enroll with Medicaid Managed Care as primary care providers. Contact the individual Medicaid Managed Care health plan for enrollment information.

Refer to: "Managed Care" on page 7-1 for more information.

34.2 Reimbursement

According to 1 TAC §355.8281, the Medicaid rate for NPs and CNSs is 92 percent of the rate paid to a physician (doctor of medicine [MD] or doctor of osteopathy [DO]) for the same service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections. The current fee schedule is available on the TMHP website at www.tmhp.com/file library/file library /fee schedules. To request a hard copy, call the TMHP Contact Center at 1-800-925-9126.

Refer to: "Provider Enrollment" on page 1-2 for more information.

"Reimbursement Methodology" on page 2-2 for more information.

"TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on how to obtain electronic fee schedules from the TMHP website.

34.3 Benefits and Limitations

Services performed by NPs and CNSs are benefits if the services meet the following criteria:

- Are within the scope of practice for APNs, as defined by Texas state law.
- Are consistent with rules and regulations promulgated by the Texas BON or other appropriate state licensing authority.
- Are covered by the Texas Medicaid program when provided by a licensed physician (MD or DO).
- Are reasonable and medically necessary as determined by HHSC or its designee.

NPs and CNSs who are employed or remunerated by a physician, hospital, facility, or other provider must not bill the Texas Medicaid program for their services if the billing results in duplicate payment for the same services.

Benefit limitation information for services can be found in the physician services, THSteps medical (includes newborn exams), and family planning sections of this manual.

Laboratory (including pregnancy tests) and radiology services provided during pregnancy must be billed separately from antepartum care visits and received within 95 days from the date of service.

Note: *Payment to physicians for supplies is not a benefit of the Texas Medicaid Program. Costs of supplies are included in the reimbursement for office visits.*

Procedures billed by an NP or CNS are reviewed retrospectively for appropriateness. Independently enrolled NPs and CNSs with a valid Medicare provider number are eligible to receive payment of deductible and coinsurance amounts as appropriate on Medicare crossover claims.

Refer to: "Family Planning Services" on page 20-1 for more information.

"Physician" on page 36-1 for more information.

"THSteps Medical Check Up Facilities" on page 43-12 for more information on THSteps services.

34.4 Claims Information

APN services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"CMS-1500 Claim Filing Instructions" on page 5-22. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

34.4.1 Claim Filing Resources

Refer to the following sections or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-22
Family Planning Claim Billing	20-4
Communication Guide	A-1
Family Planning Claim Form	D-13
Acronym Dictionary	F-1

Section

35

Physical Therapists/Independent Practitioners

35.1 Enrollment

To enroll in the Texas Medicaid Program, licensed physical therapists must be enrolled in Medicare.

Providers cannot be enrolled if their license is due to expire within 30 days of application. A current license must be submitted.

The Medicare enrollment requirement is waived for therapists that only provide services to Texas Health Steps (THSteps)-eligible clients who are younger than 21 years of age and who do not receive Medicare benefits. These therapists must enroll as individuals. If providers are currently enrolled with the Texas Medicaid Program or plan to provide regular acute care services to clients with Medicaid coverage, enrollment in the THSteps-Comprehensive Care Program (CCP) is not necessary. All non-CCP physical therapy (PT) services must be billed with the current provider identifier.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

"THSteps-CCP Overview" on page 43-33 for more information about providing services to Medicaid/THSteps clients.

"Texas Medicaid (Title XIX) Home Health Services" on page 24-1 for more information about providing services to clients in the home setting.

35.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with Medicaid Managed Care to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

Refer to: "Managed Care" on page 7-1 for more information.

"Provider Enrollment" on page 1-2 for more information about enrollment procedures.

35.2 Reimbursement

The Medicaid rates for physical therapists and independent practitioners are calculated in accordance with 1 TAC §355.8081 and §355.8085. The applicable Medicaid rates are listed in the current physician fee schedule, which is available on the TMHP website at www.tmhp.com/file library/file library/fee schedules. To request a copy, call the TMHP Contact Center at 1-800-925-9126.

Refer to: "Reimbursement Methodology" on page 2-2 for more information.

35.2.1 Benefits and Limitations

PT is the use of physical agents such as heat, massage, electricity, traction, or exercises in the treatment of disease. Payments for PT are limited to acute disorders of the musculoskeletal system or exacerbations of chronic disorders necessitating PT to restore function. The acute modifier AT must be billed for payment to be made. The AT modifier represents treatment provided for an acute condition or an exacerbation of a chronic condition that persists less than 180 days from the start date of therapy. If the condition persists for more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client's condition has not become chronic and the client has not reached the point of plateauing.

Plateauing is defined as the point that maximum improvement has been documented and more improvement ceases.

Examples of what may be considered acute are as follows:

- A new injury.
- Therapy before or after surgery.
- Acute exacerbations of conditions such as rheumatoid arthritis.
- Interventions such as a newly implanted intrathecal pump to decrease spasticity or Botulinum Toxin Type A injections.

PT, including functional evaluations, must be provided according to the current written orders of a physician (within 60 days) and based on medical necessity. It may be performed by auxiliary personnel under the direct supervision of the physician or the independently practicing physical therapist.

Payment cannot be made to a provider or an independently practicing physical therapist who provides physical medicine to a resident of a nursing facility. These services must be made available to nursing facility residents on an *as needed* basis and must be provided directly by the staff of the facility or furnished by the facility through arrangements with outside qualified resources. Nursing facilities must refrain from admitting clients who need goal-directed therapy, if the facility is unable to provide these services.

The following procedure codes are limited to once per day:

Procedure Codes				
1-97012	1-97014	1-97016	1-97018	1-97022
1-97024	1-97028	1-97150		

The following procedure codes may be paid in multiple 15-minute quantities:

Procedure Codes				
1-97032	1-97033	1-97034	1-97035	1-97036
1-97039	1-97110	1-97112	1-97113	1-97116
1-97124	1-97139	1-97140	1-97530	1-97535
1-97537	1-97542	1-97760	1-97761	

Procedure codes 1-97535, 1-97537, 1-97542, and 1-97760 are only payable for clients younger than 21 years of age.

Procedure codes 1-97010, 1-97265, 1-97545, 1-97546, 1-97770, 1-97780, and 1-97781 are not a benefit.

Procedure codes 1-97750 and 1-97762 are comprehensive codes and include an office visit. If an office visit is billed for the same day by the same provider, the office visit will be denied as part of another procedure billed for the same day. Procedure code 1-97762 is only payable for clients 20 years of age or younger.

Procedure code 1-97001 is payable once per six months, any provider, same facility. Procedure code 1-97002, is payable once per month, any provider, same facility. Procedure codes 1-97001 and 1-97002 are not payable on the same day as the following procedure codes:

Procedure Codes				
1-97012	1-97014	1-97016	1-97018	1-97022
1-97024	1-97028	1-97032	1-97033	1-97034
1-97035	1-97036	1-97039	1-97110	1-97112
1-97113	1-97116	1-97124	1-97139	1-97140
1-97150	1-97530	1-97750	1-97760	1-97761
1-97762				

Procedure codes that may be billed in multiple quantities (i.e., 15 minutes each) are limited to a total of two hours per day of individual, group, or a combination of individual and group therapy.

PT services that are not benefits of the regular Texas Medicaid Program may be benefits under THSteps-CCP when they are provided to clients with musculoskeletal or neuromusculoskeletal conditions.

CCP is for Medicaid THSteps-eligible clients who are 20 years of age or younger. CCP eligibility ends on the day of the client's 21st birthday.

Refer to: "Texas Medicaid (Title XIX) Home Health Services" on page 24-1 for information about authorization requirements and coverage or noncoverage of physical medicine and rehabilitation codes in the home.

35.2.2 Physical Therapy Documentation Requirements

Authorization is not required for therapy services delivered to clients 20 years of age or younger, although authorization is recommended through THSteps-CCP for services delivered in the home. Clients 21 years of age and older receive PT through Home Health Services.

Submit the following documentation for claims payment:

- A physician's prescription:
  - Clients 20 years of age or younger who receive PT services often have chronic conditions that require ongoing medical supervision.
  - The prescription must address medical necessity.
  - A new prescription is required at least every six months.
- Therapy treatment plan:
  - The initial THSteps-CCP treatment plan must include a copy of a current evaluation and documentation of the treatment goals and anticipated measurable progress.
  - Renewal of THSteps-CCP therapy services requires a summary statement of the measurable progress during the previous treatment period and documentation of new treatment goals with anticipated measurable progress for the renewal period.
  - A treatment plan is valid for up to six months.

Refer to: "Home Health Services" on page 24-7 for information about PT services provided in the home setting.

"THSteps-Comprehensive Care Program (CCP)" on page 43-33 for information about PT, occupational therapy (OT), and speech language-pathology (SLP) services.

35.2.2.1 Provisions for Therapy Services Provided Through ECI Programs

Because the Texas Early Childhood Intervention (ECI) Program requires local ECI providers to follow quality assurance procedures and develop Individualized Family Service Plans (IFSP) for each child, THSteps-CCP does not require copies of therapy evaluations or periodic progress notes to be submitted with therapy claims. (Providers may request copies of the ECI Request for Initial/Renewal Outpatient Therapy form from TMHP.) However, the prescription requirements as stated above must be followed by ECI providers.

35.2.3 Rehabilitative Services

Rehabilitative Services is a program administered by TMHP to nursing facility clients who need rehabilitation. These services must be *prior authorized* through TMHP before the therapy is provided and paid by TMHP. Covered services include OT, PT, and SLP to clients who are eligible for Medicaid, with an acute onset of an illness or

injury, with the expectation that function will be improved measurably. For all rehabilitative services inquiries, call Rehabilitative Services at 1-800-792-1109.

35.3 Claims Information

Submit services provided by an independently practicing physical therapist to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms. Claims may be filed electronically in a CMS-1500 format as long as the nine-digit prior authorization number is reflected in the equivalent electronic field.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"CMS-1500 Claim Filing Instructions" on page 5-22. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

35.3.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-22
TMHP Electronic Claims Submission	5-13
Communication Guide	A-1
Physical Therapist Claim Example	D-26
Physical Therapists (THSteps-CCP Only) Claim Example	D-26
Acronym Dictionary	F-1

Section

36

Physician

36.1 Enrollment

36.1.1 Physicians and Doctors

To enroll in the Texas Medicaid Program to provide medical services, physicians (doctor of medicine [MD] and doctor of osteopathy [DO]) and doctors (doctor of dental medicine [DMD], doctor of dental surgery [DDS], doctor of optometry [OD], doctor of podiatric medicine [DPM], and doctor of chiropractic medicine [DC]) must be authorized by the licensing authority of their profession to practice in the state where the services are performed at the time they are provided.

Providers cannot be enrolled in the Texas Medicaid Program if their licenses are due to expire within 30 days. A current Texas license must be submitted.

Important: *Centers for Medicare & Medicaid Services (CMS) guidelines mandate that physicians who provide durable medical equipment (DME) products such as spacers or nebulizers are required to enroll as Texas Medicaid Program DME providers.*

All physicians except gynecologists, pediatricians, pediatric sub-specialists, pediatric psychiatrists, and providers performing only Texas Health Steps (THSteps) medical or dental check ups must be enrolled in Medicare before Medicaid enrollment. TMHP may waive the Medicare enrollment prerequisite for pediatricians or physicians whose type of practice and service may never be billed to Medicare.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information.

36.1.2 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with a Medicaid Managed Care health plan to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

Refer to: "Managed Care" on page 7-1 for more information on Medicaid Managed Care programs.

Important: *NorthSTAR is a managed care program in the Dallas service area that covers behavioral health services. Physicians that provide behavioral health services to clients in NorthSTAR must be a network provider of the NorthSTAR behavioral health organization (BHO), ValueOptions of Texas, Inc., to provide services to NorthSTAR clients.*

36.1.3 Comprehensive Health Center (CHC)

CHCs and/or physician-operated clinics are funded by federal grants. To apply for participation in the Texas Medicaid Program, they must be certified and participate as a health center under Medicare (Title XVIII).

CHC claims are paid according to each center's encounter rates as established by CMS. Medicaid payment to CHCs is limited to the Medicare deductible and/or coinsurance.

All providers supplying laboratory services in an office setting must be certified and registered with the Food and Drug Administration (FDA) in accordance with the *Clinical Laboratory Improvement Amendments* (CLIA).

Providers who do not comply with CLIA cannot be reimbursed for laboratory services.

Refer to: "CLIA Requirements" on page 26-2 and "Provider Enrollment" on page 1-2 for more information.

36.2 Reimbursement

The Texas Medicaid Program rates for physicians and certain other practitioners are calculated in accordance with TAC §355.8085. The current physician fee schedule is available on the TMHP website at www.tmhp.com /file library/file library/fee schedules.

Refer to: "Physician Services in Outpatient Hospital Setting" on page 2-5.

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

The following table identifies the services applicable to the 60 percent limitation when furnished in outpatient hospital settings:

Procedure Codes				
1-99201	1-99202	1-99203	1-99204	1-99205
1-99211	1-99212	1-99213	1-99214	1-99215
1-99281	1-99282	1-99283	1-99284	1-99285

These procedures are designated with note code "1" in the current physician fee schedule, which is available at www.tmhp.com. The following list shows the services excluded from the 60 percent limitation:

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

Because of TEFRA, Texas Medicaid Program reimbursement for a payable nonemergency office service performed in the outpatient department of a hospital is limited to 60 percent of the Texas Medicaid Program rate for that service. If the condition qualifies as an emergency, the 60 percent professional service reimbursement limit does not apply.

Note: *STAR, STAR+PLUS, and NorthSTAR programs may follow a different reimbursement methodology. Providers should check each plan's reimbursement policies.*

Refer to: "Reimbursement" on page 2-2 for more information.

"Anesthesia" on page 36-24 for information on anesthesia services that are reimbursed according to relative value units (RVUs).

"TMHP Website" on page 3-2 for more information on obtaining fee schedules.

Fee schedules for services in this chapter are available on the TMHP website at www.tmhp.com/file library /file library/fee schedules.

36.2.1 Supplies, Trays, and Drugs

Payment to physicians for supplies is not allowed under the Texas Medicaid Program. All supplies, including anesthetizing agents, inhalants, surgical trays, or dressings are included in the surgical payment on the day of surgery when the surgery is performed in the office or home setting.

Reimbursement for office visits includes overhead for supplies. If any of these items are submitted separately, they are denied as included in the surgical fee. If the supplies are submitted with a place of service (POS) other than the office, these supplies are denied as services that must be billed by the hospital, or as services that are included in nursing facility charges.

Silver nitrate applicators, used to treat granulated tissue around gastrostomy tubes and tracheostomies, are considered part of the office/hospital visit. Silver nitrate applicators are not a benefit for home use.

36.2.2 Prior Authorization

Prior authorization may be required for several Texas Medicaid Program benefits. For more information, call the TMHP Contact Center at 1-800-925-9126 with questions.

36.3 Benefits and Limitations

The Administrative Simplification provisions of the *Health Insurance Portability and Accountability Act* (HIPAA) of 1996 mandates the use of national coding and transaction standards. HIPAA requires that the American Medical Association's (AMA) Current Procedural Terminology (CPT) system be used to report professional services, including physician services. Correct use of CPT coding requires using the most specific code that matches the services provided based on the code's description. Providers must pay special attention to the standard CPT descriptions for the evaluation and management (E/M) services. The medical record must document the specific elements necessary to satisfy the criteria for the level of services as described in CPT. Reimbursement may be recouped when the medical record documents a different level of service from what is submitted on the claim. The level of service provided and documented must be medically necessary based on the clinical situation and needs of the patient.

To receive reimbursement, providers must document the service, the date rendered, pertinent information about the client's condition supporting the need for service, and the care given in the client's medical record.

Important: *If a provider bills for an office visit, documentation must appear in the client's medical record for that date of service (DOS).*

36.3.1 Supervision

Physician services include those reasonable and medically necessary services ordered and performed by physicians or under physicians' supervision that are within the scope of practice of their profession as defined by state law. For each encounter, unless an explicit exception is provided, the teaching/supervising physician must:

- Examine the patient.
- Confirm or revise the diagnosis of record.

- Confirm or revise a plan of care.
- Document these tasks in the appropriate medical records for the client before submitting claims.

If such documentation is not present in the appropriate medical record, any payment made may be recouped. The services are a benefit if provided in the office, client's home, hospital, nursing facility, or elsewhere.

Physician services must be performed by the teaching or supervising physician personally or by the person to whom the physician has delegated the responsibility. The level of supervision required may be direct or personal.

Physician assistants (PAs) and advanced practice nurses (APNs) who provide physician or facility services, must submit the appropriate procedure codes with the modifiers U7 or SA. These modifiers identity the services as performed by a PA or an APN. To provide Medicaid services, each nurse practitioner (NP), clinical nurse specialist (CNS), certified nurse-midwife (CNM), and certified registered nurse anesthetist (CRNA) must be licensed as a registered nurse and recognized as an APN by the Texas Board of Nursing (BON).

36.3.1.1 Teaching Attending Physician and Resident Physician

The roles of the teaching attending physician and resident physician occur in the context of an accredited graduate medical education (GME) training program.

The *attending* physician is the Medicaid-enrolled physician who is professionally responsible for the particular services that were provided and are being submitted for reimbursement; the physician must be affiliated and in good standing with an accredited GME program and must possess all appropriate licensure.

In all cases, the client's medical record must clearly document that the teaching attending physician provided identifiable supervision of the resident. As defined below, the supervision must be direct or personal depending on the setting and the clinical circumstances:

- *Personal supervision* means that the teaching attending physician must be in the building of the office or facility when and where the service is provided.
- *Direct supervision* means that the teaching attending physician must be physically present in the room when and where the service is being provided.

The teaching attending physician must provide direct supervision during all medically-complex situations, dangerous procedures, or major surgery. A service or procedure is complex or dangerous if deviation from the expected technique at the time the procedure or service is performed presents a medically-reasonable and immediate risk to the patient's life or health. This criterion applies regardless of the place or setting of care.

The teaching attending physician must provide medically appropriate, identifiable personal supervision for all other services that do not require direct supervision.

The following prerequisites apply when the teaching attending physician submits claims for services performed, in whole or in part, by the resident physician:

Prerequisites for the Inpatient Hospital Setting, the Outpatient Hospital Setting, and Surgical Services and Procedures
Services provided in an outpatient setting. For services provided in an outpatient setting, the teaching attending physician must demonstrate that personal supervision was provided. The following tasks must be performed and their completion must be documented in the patient's medical record before the claims are submitted for consideration of reimbursement: • Review the patient's history and physical examination. • Confirm or revise the patient's diagnosis. • Determine the course of treatment to be followed. *Exception for E/M services furnished in certain primary care centers.* Teaching attending physicians that meet the primary care exception under Medicare are allowed to bill for low-level and mid-level E/M services for residents. Facilities that meet the primary care exception under Medicare may bill the Texas Medicaid Program, Family Planning, or the Children with Special Health Care Needs (CSHCN) Services Program for new patient services (procedure codes 1-99201, 1-99202, and 1-99203) and established patient services (procedure codes 1-99211, 1-99212, and 1-99213). ***Note:*** *All services provided in an outpatient setting that do not qualify for the exception above require that the attending teaching physician examine the patient.*
Services provided in an inpatient setting. For services provided in an inpatient setting, the teaching attending physician must demonstrate that medically-appropriate supervision was provided. The following tasks must be performed and their completion must be documented in the patient's medical record before the claims are submitted for consideration of reimbursement. The documentation must be made in the same manner as required by federal regulations under Medicare: • Review the patient's history, review the resident's physical examination, and examine the patient within a reasonable period of time after the patient's admission and before the patient's discharge. • Confirm or revise the patient's diagnosis. • Determine the course of treatment to be followed. • Document the teaching attending physician's presence and participation in the major surgical or other complex and dangerous procedure or situation.
Surgical services and procedures. The teaching attending surgeon is responsible for the beneficiary's preoperative, operative, and postoperative care. The teaching attending physician must demonstrate that medically appropriate supervision was provided. The following tasks must be performed and their completion must be documented in the patient's medical record before the claims are submitted for consideration of reimbursement. The documentation must be made in the same manner as required by federal regulations under Medicare: • Review the patient's history, review the resident's physical examination, and examine the patient within a reasonable period of time after the patient's admission and before the patient's discharge. • Confirm or revise the client's diagnosis. • Determine the course of treatment to be followed. • Document the teaching attending physician's presence and participation in the major surgical or other complex and dangerous procedure or situation.
Important: Reimbursement may be reduced, denied, or recouped if the prerequisites are not documented in the medical record. The documentation must be made in the same manner as required by federal regulations under Medicare.

36.3.2 Substitute Physician

Physicians may bill for the service of a substitute physician who sees clients in the billing physician's practice under either an informal arrangement of less than 14 days or a formal renewable arrangement of up to 90 days.

The substitute physician is not required to enroll in the Texas Medicaid Program. The billing provider's name, address, and national provider identifier must appear in Block 33 of the claim form. The substitute physician's name and address must be documented on the claim in Block 19, *not* Block 33.

When a physician bills for a substitute physician, the modifier Q5 or Q6 must follow the procedure code in Block 24D for services provided by the substitute physician. The Q5 modifier is used to indicate an informal reciprocal arrangement (period not to exceed 14 continuous days) and the Q6 modifier is used to indicate a formal renewable locum tenens or temporary arrangement (up to 90 days).

When physicians in a group practice bill substitute physician services, the performing provider identifier of the physician for whom the substitute provided services must be in Block 24J.

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

36.3.3 Physician Assistants (PAs)

Refer to: "Physician Assistant (PA)" on page 37-1, for additional information.

36.3.4 Physician Evaluation and Management Services

E/M services are benefits of the Texas Medicaid Program. E/M services are divided into a broad set of categories and subcategories (for example: outpatient services, inpatient services). Medical documentation for E/M services must consist of the appropriate components as designated in the 1995 and 1997 *Physician Evaluation and Management* guidelines published by CMS and in the CPT manual.

36.3.4.1 Office or Other Outpatient Services

Outpatient services are defined as services rendered in an outpatient setting such as a physician office, ambulatory facility and/or other outpatient setting.

New And Established Patient Services

A new patient is defined as one who has not received any professional services from a physician or more than one physician of the same specialty within the same group practice within the past three years. Providers may use procedure codes 1-99201, 1-99202, 1-99203, 1-99204, and 1-99205 when submitting claims for new patient services provided in the office or in an outpatient or other ambulatory facility.

A new patient visit is limited to one every three years, per patient, per provider.

An established patient is one who has not received professional services from a physician or more than one physician of the same specialty within the same group practice within the last three years. Providers may use procedure codes 1-99211, 1-99212, 1-99213, 1-99214, and 1-99215 when submitting claims for established patient services provided in the office or in an outpatient or other ambulatory facility.

When a patient office visit is submitted with the same date of service as a THSteps medical check up or exception to periodicity visit, the office visit must be submitted as an established patient visit. If a new patient visit is submitted with the same date of service as a THSteps medical check up or exception to periodicity visit, then the new patient visit is denied.

Modifier 25 may be used to describe circumstances in which an office visit was provided at the same time as other separately identifiable services. Modifier 25 may be included with the evaluation code when the services rendered are provided for different diagnoses or are performed for different reasons. Both services must be documented as distinct and documentation must be maintained in the medical record and made available to the Texas Medicaid Program upon request.

If an established patient visit is submitted with the same date of service as a new patient visit in any setting by the same provider for any diagnosis, the established patient visit is denied as part of another procedure on the same day. New or established patient care visits are limited to one per day for the same provider regardless of diagnosis.

Office visits (1-99201, 1-99202, 1-99203, 1-99204, 1-99205, 1-99211, 1-99212, 1-99213, 1-99214, and 1-99215) provided on the same day as a planned procedure (minor or extensive), are included in the cost of the procedure and are not considered for reimbursement separately. An office visit provided for a separately identifiable service on the same day as a planned procedure is considered for reimbursement with medical documentation. The modifier 25 should be included with the E/M code to indicate that the evaluation was provided for a separately identifiable service.

Procedures that are included in E/M services are denied as part of another procedure when submitted with the same date of service, by the same provider, as an office visit (1-99201, 1-99202, 1-99203, 1-99204, 1-99205, 1-99211, 1-99212, 1-99213, 1-99214, and 1-99215) or outpatient consultation visit (3-99241, 3-99241, 3-99241, 3-99241, and 3-99245).

Charges for inconvenience or after hours services (1-99050, 1-99056, or 1-99060), by emergency department-based physicians or emergency department-based physician groups are not allowed.

Preventive Care Visits

Preventive health visits are available to clients from birth through 20 years of age through THSteps medical check ups. For clients 21 years of age and older, breast exams and Pap smears are available through programs related to women's health, including Texas Medicaid Program family planning services and the Women's Health Program.

Refer to: "Texas Health Steps (THSteps)" on page 43-1, "Family Planning Services" on page 20-1, and "Women's Health Program" on page 0-1 for more information about preventive health benefits.

Consultation Services

A consultation is an E/M service provided at the request of another provider for the evaluation of a specific condition or illness. To be considered for reimbursement as a consultation, the service must meet the following criteria:

- The referring provider must request the evaluation of a particular condition or illness in writing.
- The consulting provider must communicate his medical findings in writing with the referring provider.
- During a consultation, the consulting provider may initiate diagnostic and therapeutic services if necessary. If treatment is initiated and the patient returns for follow up care, an established patient visit should be submitted.
- The medical records maintained by both the referring and consulting providers must identify their counterpart and the reason for the consultation.

Note: *If the purpose of the referral is to transfer care, the service is not considered a consultation and may not be submitted for reimbursement as such.*

Providers may use procedure codes 3-99241, 3-99242, 3-99243, 3-99244, and 3-99245 when submitting claims for a new or established patient consultation provided in the office or in an outpatient or other ambulatory facility.

Note: *An initial psychiatric examination (procedure code 1-90801) is denied as part of another service when procedure codes 3-99241, 3-99242, 3-99243, 3-99244, and 3-99245 are submitted by the same provider within 30 days of the initial psychiatric examination.*

Refer to: "Psychiatric Services" on page 36-110 for more information about psychiatric services.

"Surgeons and Surgery" on page 36-131 for information about consultations and the global fee concept.

Emergency Department Services By Physicians

An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to patients who require immediate medical attention. The facility must be available to provide services 24 hours per day, 7 days a week.

According to federal legislation (*Emergency Medical Transportation and Labor Act*), if any individual arrives at the hospital emergency department requesting an examination or treatment, the hospital must provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether an emergency medical condition exists. The following definitions were developed to be consistent with CMS:

- *Antidumping Statute*. A hospital must provide to any person who seeks emergency services an appropriate medical screening examination sufficient to determine whether he or she has an emergency medical condition.
- *Emergency Medical Condition*. A medical condition is considered an emergency when it manifests itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical care could result in one of the following circumstances:
  - Placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
  - Causing serious impairment to bodily functions.
  - Causing serious dysfunction of any bodily organ or part.
- *Emergency Services*. Services are considered emergency services when hospital-based emergency department services are needed to evaluate or stabilize an emergency medical condition and/or emergency behavioral health condition.
- *Medical Screening Examination*. The process required to determine, with reasonable clinical confidence, that an emergency medical condition or an emergency behavioral health condition exists. The medical screening examination ranges from a brief history and physical examination to performing ancillary studies and procedures (such as, but not limited to, lumbar punctures, clinical laboratory tests, and computed tomography [CT] scans); the level of care depends on the patient's presenting symptoms. A medical screening examination is not an isolated event; it is an ongoing process. The medical records must reflect continued monitoring according to the patient's needs and must continue until the patient is stabilized or appropriately transferred. There should be evidence of whether the patient is stable or unstable.
- *No Prior Authorization Before Screening or Stabilization*. It is not appropriate for a hospital to request or a health plan to require prior authorization before the patient has received a medical screening examination to determine the presence or absence of an emergency medical condition or before the patient's emergency condition is stabilized.
- *Post-Stabilization Services*. In the case of an emergency medical condition or emergency behavioral health condition, post-stabilization services begin once the patient has been determined stable by the emergency department physician or discharged, transferred, or admitted to the hospital.
- *Routine Condition*. A health condition, including a behavioral health situation, is considered routine when it can be addressed by a routine office visit within the next several days after the emergency department visit.
- *Stabilization Services*. In the case of an emergency medical condition or an emergency behavioral health condition, to stabilize is to provide medical services to assure within reasonable medical probability that no deterioration of the condition is likely to result from or occur during discharge, transfer, or admission of the patient from the emergency department.

- *Triage*. The evaluation, by a nurse(s), of people presenting for health care to a medical facility that allows treatment of the most serious cases first.
- *Urgent Behavioral Health Situations*. Conditions that require attention and assessment within 24 hours but that do not place the patient in immediate danger to themselves or others, and the patient is able to cooperate with treatment.
- *Urgent Condition*. A health condition, including an urgent behavioral health situation, is considered urgent when it is not an emergency but is severe or painful enough to require medical treatment, evaluation, or treatment within 24 hours by a physician to prevent serious deterioration of the patient's condition or health.

Emergency department procedure codes are used to describe E/M services provided in the emergency department to new or established patients. Physicians may use procedure codes 1-99281, 1-99282, 1-99283, 1-99284, and 1-99285 when submitting claims for emergency department services provided in the emergency department.

If an emergency department visit is submitted with the same date of service, by the same provider, as an office visit, outpatient consultation, or nursing facility service (1-99304, 1-99305, 1-99306, 1-99307, 1-99308, 1-99309, and 1-99310) the emergency department visit may be considered for reimbursement and the office, consultation, and/or nursing facility visit is denied.

Emergency department visits are denied when submitted with the same date of service as an observation service (1-99217, 1-99218, 1-99219, and 1-99220) by the same provider.

Multiple emergency department visits on the same day, submitted by the same provider, must have the times for each visit documented on the claim form. More than one visit on the same day can also be indicated by adding the modifier 76 to the claim form. Medical documentation is required to support the charge of more than one emergency department visit with the same date of service.

Critical care provided on the same day as an emergency room visit may be submitted when the services are rendered during a separate encounter. Medical documentation is required to support the charge of critical care and emergency room visit with the same date of service.

Reimbursement for physicians in the emergency department is based on Section 104 of TEFRA. TEFRA requires that Medicaid limit reimbursement for those physicians' services furnished in hospital outpatient settings that also are ordinarily furnished in physician offices. The diagnoses list of emergent conditions is used to determine the appropriate reimbursement for these services. The reimbursement for each service is determined by establishing a charge base for each professional service and multiplying the charge base by 60 percent.

Refer to: "Hospital (Medical/Surgical Acute Care Facility)" on page 25-1 for information on emergency department services by facilities (room and ancillary).

Services Outside of Business Hours

Texas Medicaid limits reimbursement for after-hours charges to office-based providers rendering services after routine office hours.

An *office-based* provider may submit an after-hours charge in addition to a visit for providing services after his routine office hours. This should be submitted when a provider, in his clinical judgment, deems it medically necessary to interrupt his schedule to care for a patient with an emergent condition. A provider's routine office hours are those hours posted at the physician's office as the usual office hours. Medicaid reimburses office-based physicians an inconvenience charge when any of the following exists:

- The physician leaves the office or home to see a client in the emergency room.
- The physician leaves the home and returns to the office to see a client after the physician's routine office hours.
- The physician is interrupted from routine office hours to attend to another client's emergency outside of the office.

Providers may use procedure codes 1-99050, 1-99056, and 1-99060 to submit claims for services outside of business hours.

Observation Services

Hospital observation services (procedure codes 1-99217, 1-99218, 1-99219, and 1-99220) are professional services that span a period of more than 6 hours but less than 24 hours regardless of the hour of the initial contact and regardless of whether or not the patient remains under physician care past midnight.

Observation may take place in any patient care area of the hospital or outpatient setting.

Observation care discharge day management procedure code 1-99217 may be submitted to report services provided to a patient upon discharge from "observation status" if the discharge is after the date of admission. The following procedure codes are denied if submitted with the same date of service as procedure codes 1-99217, 1-99234, 1-99235, and 1-99236:

Procedure Codes		
1-99211	1-99212	1-99213
1-99214	1-99215	1-99218
1-99219	1-99220	

E/M services provided in any POS other than the inpatient hospital and submitted with the same DOS as a physician observation visit, by the same provider, is denied.

If a physician observation visit (procedure codes 1-99217, 1-99218, 1-99219, 1-99220, 1-99234, 1-99235, and 1-99236) is submitted with the same date of service as prolonged services (procedure codes 1-99354 and 1-99355) by the same provider, the prolonged services are denied as part of another procedure on the same day.

If dialysis treatment and physician observation visits are submitted with the same date of service by the same provider and the provider identifiers used indicate the

same specialty (other than nephrology or internal medicine), the dialysis treatment is paid and the physician observation visit is denied.

36.3.4.2 Inpatient Services

Providers may submit inpatient hospital, observation, and consultation services using the following procedure codes:

Hospital Services Procedure Codes		
1-99221	1-99222	1-99223
1-99231	1-99232	1-99233

Inpatient Observation Services Procedure Codes		
1-99234	1-99235	1-99236

Inpatient Consultation Services Procedure Codes*		
3-99251	3-99252	3-99253
3-99254	3-99255	

*** These procedure codes are used to submit claims for consultations provided to hospital inpatients, residents of nursing facilities or patients in a partial hospital setting. Regardless of the POS, the consultations must meet the criteria outlined in "Consultation Services" on page 36-12.**

If a hospital admission (procedure codes 1-99221, 1-99222, and 1-99223) and physician observation visits (procedure codes 1-99217, 1-99218, 99219, 1-99220, 1-99234, 1-99235, and 1-99236) are submitted with the same date of service by the same provider, the hospital admission is paid and the physician observation visit is denied.

If an initial hospital visit following admission (procedure codes 1-99221, 1-99222, and 1-99223) is submitted with the same date of service by the same provider as an emergency department visit (procedure codes 1-99281, 1-99282, 1-99283, 1-99284, and 1-99285), inpatient consultation (procedure codes 3-99251, 3-99252, 3-99253, 3-99254, and 3-99255), or an office visit, outpatient consultation (procedure codes 3-99241, 3-99242, 3-99243, 3-99244, and 3-99245), the initial hospital visit is paid and the other visits are denied.

If a subsequent hospital visit following admission (procedure codes 1-99231, 1-99232, and 1-99233) is submitted with the same date of service by the same provider as an emergency department visit, an office visit, or an outpatient consultation, the subsequent hospital visit is paid and the other visits are denied.

Only one initial hospital care visit may be considered for reimbursement to the same provider within a thirty day period regardless of diagnosis. Additional hospital visits within the thirty days are considered for reimbursement as subsequent care visits.

A subsequent hospital visit (procedure codes 1-99231, 1-99232, and 1-99233) may be considered for reimbursement with the same date of service to the same provider when critical care services (procedure codes 1-99291 and 1-99292) are submitted.

E/M services provided in a hospital setting following a major procedure provided by the same provider and/or in direct follow-up for postsurgical care are included in the surgeon's global surgical fee and are denied as included in another procedure.

A physician who did not perform the surgery and provides postoperative surgical care in the time frame that is included in the global surgical fee must submit the appropriate procedure code with modifier 55. This may only be done when the surgeon submits a charge for surgical care only and there was an agreement between the physicians to split the care of the patient.

Hospital Discharge

Discharge management procedure codes 1-99238 and 1-99239 submitted with the same date of service as the admission by the same provider are denied.

Discharge management submitted with the same date of service as an emergency room visit by the same provider is denied. If the discharge management and the emergency room visit are provided at a separate time, the discharge management may be considered for reimbursement on appeal.

Only one discharge management service will be considered for reimbursement per day.

Subsequent hospital visits submitted with the same date of service as discharge management by the same provider are denied.

Initial and/or subsequent hospital visit procedure codes (1-99221, 1-99222, 1-99223, 1-99231, 1-99232, 1-99233) submitted with the same date of service as hospital discharge day management are denied as part of another procedure billed on the same day.

Nursing Facility Services

Nursing facility services may be submitted using the following procedure codes:

Procedure Codes		
1-99304	1-99305	1-99306
1-99307	1-99308	1-99309
1-99310	1-99315	1-99316
1-99318		

Providers must use initial, subsequent, and annual nursing facility assessment procedure codes when submitting claims for services in a nursing facility. Initial nursing facility assessments include all services related to an admission to the nursing facility.

Comprehensive Initial nursing facility assessments (procedure codes 1-99304, 1-99305, and 1-99306) are limited to one every 6 months.

Prolonged services in the nursing facility involving direct (face-to-face) patient contact that is beyond the usual service (procedure codes 1-99304, 1-99305, 1-99306, 1-99307. 1-99308, 1-99309, and 1-99310) may be considered for reimbursement on the same day as a nursing facility visit.

Procedure code 1-99356 should be used to report the first hour of prolonged service and will be limited to one per day.

Procedure code 1-99357 should be used to report each additional 30 minutes and will be limited to a quantity of 3 units or one and one-half hours per day.

Prolonged physician services will not be considered for reimbursement in addition to an emergency room visit submitted with the same date of service.

Procedure codes 1-99315 and 1-99316 are payable to physicians when discharging a client from a nursing home (POS 8) or specialized nursing home (POS 4). Procedure codes 1-99315 and 1-99316 are not both payable on the same day, for the same client.

Initial nursing facility assessments (procedure codes 1-99304, 1-99305, and 1-99306) or subsequent nursing facility care procedure codes (1-99307, 1-99308, 1-99309, and 1-99310) or nursing facility discharge day management (procedure codes 1-99315-1-99316) submitted with the same date of service as initial hospital care (procedure codes 1-99221, 1-99222, and 1-99223) by the same provider are denied as part of another procedure submitted on the same day.

All E/M services, irrespective of the POS, provided in conjunction with the admission by the same provider, are considered part of the initial nursing facility care when performed on the same day as the admission.

Subsequent nursing facility care E/M procedure codes (1-99307, 1-99308, 1-99309, and 1-99310) are limited to one service per day regardless of diagnosis.

Domiciliary, Rest Home, or Custodial Care

The following domiciliary and rest home care procedure codes are used to report E/M services provided to new and established patients in a facility which provides room, board, and other personal assistance services:

Procedure Codes		
1-99324	1-99325	1-99326
1-99327	1-99328	1-99334
1-99335	1-99336	1-99337

Established client visits submitted with the same date of service as a new client visit by the same provider will be denied as part of another procedure. Established client visits are limited to one per day regardless of diagnosis.

Home Services

Home services are those services that are provided in a private residence. A subsequent/established patient home visit submitted with the same date of service as a new patient home visit by the same provider is denied as part of another procedure submitted on the same day, regardless of the diagnosis.

The following procedure codes may be submitted for new and established patient home visits:

Home Services	Procedure Codes
New Patient	1-99341
	1-99342
	1-99343
	1-99344
	1-99345
Established Patient	1-99347
	1-99348
	1-99349
	1-99350

New patient visits are limited to one every three years.

Subsequent home E/M procedure codes are limited to one per day regardless of diagnosis.

Concurrent Care

Concurrent care exists when services are provided to a patient by more than one physician on the same day during a period of hospitalization in the inpatient hospital setting. Concurrent care is appropriate when the level of care and the documented clinical circumstances requires the skills of different specialties to successfully manage the patient in accordance with accepted standards of good medical practice.

Concurrent care will not be considered for reimbursement to providers of the same specialty for the same or related diagnoses. Diagnoses are considered related when there is a three-digit match of the primary *International Classification of Diseases*, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis code. Denied concurrent care is considered on appeal when accompanied by documentation of medical necessity. Concurrent care is considered for reimbursement to providers of different specialties when providing services for unrelated diagnoses involving different organ systems.

Each appeal submitted for concurrent care must contain the following information:

- Documentation of the medical necessity for the physicians' services (care and treatment).
- Diagnosis and indication of the severity of the client's condition (acute or critical).
- Role of the physician in the care of the client including the name of the admitting physician.
- Specialty and/or subspecialty of each physician and any limitations of practice.

Claims appealed without clear documentation of medical necessity as described above are denied.

Important: *If the attending physician requests only a consultation, the request must be clearly stated in the orders.*

All concurrent care is subject to retrospective review. Documentation of medical necessity for concurrent care must be retained by the physician as required by federal law and should include, but is not limited to, documentation of:

- The orders for concurrent care or valid reasons for the request by the attending physician.
- The name of the requesting physician by the physician rendering concurrent care.

Claims Filing Deadlines

Claims submitted to TMHP by physicians for services provided during an inpatient hospital stay must be received by TMHP within 95 days of each date of service, not 95 days of the discharge date.

Reminder: *Inpatient claims must indicate the facility's provider identifier in Block 32 or in the appropriate field of electronic software.*

36.3.4.3 Prolonged Physician Services

Prolonged physician services may be rendered and are applicable in either an outpatient or inpatient setting.

Prolonged services may be provided in the office, outpatient hospital, or inpatient hospital settings and may involve direct (face-to-face) patient contact that is beyond the usual service and exceeds the time threshold of the E/M procedure code (see below) being submitted for the date of service.

Evaluation and Management Procedure Codes		
1-99201	1-99202	1-99203
1-99204	1-99205	1-99211
1-99212	1-99213	1-99214
1-99215	1-99221	1-99222
1-99223	1-99231	1-99232
1-99233	3-99245	3-99251
3-99252	3-99253	3-99254
3-99255	1-99341	1-99342
1-99343	1-99344	1-99355
1-99341	1-99342	1-99343
1-99344	1-99345	1-99347
1-99348	1-99349	1-99350

Prolonged services in the inpatient setting involving direct (face-to-face) patient contact that is beyond the usual service are considered for reimbursement with the same date of service as an initial hospital visit (procedure codes 1-99221, 1-99222, 1-99223, 3-99251, 3-99252, 3-99253, 3-99254, and 3-99255) or a subsequent hospital visit (procedure codes 1-99231, 1-99232, and 1-99233).

Prolonged physician services are not considered for reimbursement in addition to critical care and/or emergency room visits submitted with the same date of service.

Procedure codes 1-99354 and 1-99356 should be used in conjunction with the E/M code to report the *first hour* of prolonged service and will be *limited to one per day*.

Procedure codes 1-99355 and 1-99357 should be used to report each additional 30 minutes and will be limited to a quantity of 3 units or one and one-half hours per day.

Prolonged services of less than 30 minutes duration should not be reported separately.

Prolonged physician services and physician standby services without face-to-face contact (procedure codes 1-99358, 1-99359, and 1-99360 are not benefits of the Texas Medicaid Program.

36.3.5 Hospital Visits

36.3.5.1 Nonintensive Care

Hospital visits are limited to one per day for the same provider.

Only one initial hospital care visit may be considered for reimbursement to the same provider within a 30-day period regardless of diagnosis. Additional hospital visits within the 30 days are considered for reimbursement as subsequent care visits.

An initial hospital care visit submitted within three days of a new patient office, home, nursing facility, or skilled nursing facility (SNF) visit, for the same or similar diagnosis submitted by the same provider, should be submitted as a subsequent care visit.

Refer to: “Prolonged Physician Services” on page 36-16.

36.3.5.2 Critical Care

Critical care is a benefit of the Texas Medicaid Program. Critical care includes the care of critically ill patients that require the constant attention of the physician. The physician must be either at bedside or immediately available to the patient. The physician must devote his full attention to the patient and therefore, cannot render E/M services to any other patient during the same period of time. Critical care is usually given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, neonatal intensive care unit, or the emergency department care facility.

Procedure codes 1-99291 (the first 30-74 minutes) and 1-99292 (each additional 30 minutes beyond the first 74 minutes) should be used to submit claims for daily critical care services. Procedure code 1-99291 should be used only once for the first 30-74 minutes of critical care even if the time spent by the physician is not continuous on that day. Procedure code 1-99292 is allowed up to 6 units or 3 hours each day. If the number of units is not stated on the claim, a quantity of 1 is allowed.

Procedure codes 1-99293 (initial) and 1-99294 (subsequent) should be used to report inpatient pediatric critical care each day for the E/M of a critically ill infant or young child between 29 days and 24 months old.

The following procedure codes are denied as part of another service if submitted with the same date of service by the same provider as procedure codes 1-99291 and 1-99292. This is not an all-inclusive list:

Procedure Codes - Denied as Part of 1-99291 and 1-99292		
2-36000	2-36410	2-36415
2-36540	2-36600	2-43752
4/I/T-71010	4/I/T-71015	4/I/T-71020
1-90940	1-91105	1-92002
1-92004	1-92012	1-92014
2-92953	5-93040	T-93041
I-93042	5/I/T-93561	5/I/T-93562
1-94002	1-94003	1-94660
1-94662	5-94760	5-94761
5-94762	5/I-95833	1-99090

The following procedure codes are denied as part of another service if submitted with the same date of service by the same provider as procedure codes 1-99293 and 1-99294. This is not an all-inclusive list:

Procedure Codes - Denied as Part of 1-99293 and 1-99294		
2-31500	2-31502	2-36000
2-36400	2-36405	2-36406
2-36410	2-36415	2-36420
2-36430	2-36440	2-36510
2-36540	2-36555	2-36600
2-36620	2-36625	2-36640
2-36660	2-43752	2-51000
2-51005	2-51010	2-51701
2-51702	2-62270	2-62272
4/I/T-71010	4/I/T-71015	4/I/T-71020
1-91105	1-90760	1-90761
1-90765	1-90766	1-92953
5/I/T-93561	5/I/T-93562	1-94002
1-94003	5/I/T-94375	1-94640
1-94642	1-94660	1-94662
1-94664	5-94760	5-94761
5-94762	5/I/T-94375	1-99090

Services for a patient who is not critically ill and unstable but who happens to be in a critical care unit must be reported using subsequent hospital visit codes or hospital consultation codes.

Critical care and pediatric critical care (procedure codes 1-99291, 1-99292, 1-99293, and 1-99294) provided on the same day as a major surgery, by the same provider who performed the surgical procedure must be submitted with documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure.

Critical care (procedure codes 1-99291 and 1-99292) may be submitted only by the provider rendering the critical care service at the time of the crisis. Critical care involves high complexity decision-making to access, manipulate, and support vital system functions. While providers from various specialties (for example: cardiology, neurology) may be consulted to render an opinion and/or assist in the management of a particular portion of the care, only the provider managing the care of the critically ill patient during a life threatening crisis may submit the critical care procedure codes.

If initial critical care (procedure code 1-99291) is provided by different physicians who meet the initial 30-minute time requirement, and the care is provided at separate distinct times, the initial provider's claim is considered for reimbursement. The second provider's claim is denied but may be considered on appeal. The time spent by each physician cannot overlap - two physicians cannot bill critical care for care delivered at the same time to the same patient. Supporting medical record documentation must be provided by the second physician and must include the time in which the critical care was rendered. In addition, a statement must be submitted indicating the physician was the only provider managing the care of the critically ill patient during the life threatening crisis.

If the provider's time exceeds the 74 minute time threshold for procedure code 1-99291, procedure code 1-99292 may be submitted in addition to procedure code 1-99291 for each additional 30 minutes. Procedure code 1-99292 may not be submitted as a stand alone procedure code.

Inpatient pediatric critical (procedure codes 1-99293 and 1-99294) is a per-day charge. Only one physician can submit the procedure codes for pediatric critical care per day. If an inpatient E/M service is submitted with the same date of service as pediatric critical care by the same provider, the inpatient E/M is denied.

If the critical care services are provided to a neonatal, pediatric, or adult client in an outpatient setting such as an emergency room, and the services do not result in admission, providers should use procedure codes 1-99291 and 1-99292.

If a hospital discharge (procedure codes 1-99238 and 1-99239) is submitted with the same date of service as pediatric critical care (procedure codes 1-99293 and 1-99294), the hospital discharge is denied, and the critical care is considered for reimbursement.

If critical care (procedure codes 1-99291 and 1-99292) is provided to a patient at a distinctly separate time from another outpatient E/M service by the same provider, both services may be considered for reimbursement with supporting medical record documentation.

Prolonged physician service (procedure codes 1-99354, 1-99355, 1-99356, 1-99357) are denied when submitted with the same date of service as critical care (procedure codes 1-99291 and 1-99292) by the same provider.

Claims for seemingly improbable amounts of critical care on the same date may be subject to review to determine if the physician has filed a false claim.

Critical care procedure codes 1-99291 and 1-99292 are denied when submitted with the same date of service as neonatal intensive care codes 1-99295, 1-99296, 1-99298, 1-99299, or 1-99300.

36.3.5.3 Neonatal Critical Care

Intensive (Non-Critical) Low Birth Weight Services

Procedure codes 1-99298, 1-99299, and 1-99300 must be used when submitting services for those infants who are low birth weight, very low birth weight, or normal weight and who continue to require intensive observation, frequent services and interventions only available in the intensive care setting even though they no longer meet the definition of critically ill.

Procedure codes 1-99298, 1-99299, or 1-99300 should be submitted for subsequent neonatal intensive (non critical) low birth weight services care per day, irrespective of the time that the physician spends with the neonate or infant as appropriate for the present body weight and intensity of service required by the neonate or infant.

Critical Care

Neonatal critical care is the comprehensive care of the critically ill neonate. Neonatal critical care procedure codes (1-99295 and 1-99296) are comprehensive per diem (daily) care procedure codes for providers personally delivering or supervising the delivery of care of the critically ill neonate as an inpatient.

Refer to: "Critical Care" on page 36-16 for references to outpatient critical care services for neonatal, pediatric, and adult patients.

The following procedure codes for subsequent hospital visits and neonatal critical care services are limited to one per day, any provider:

Procedure Codes		
1-99231	1-99232	1-99233
1-99296	1-99298	1-99299
1-99300		

Procedure code 1-99295 should be submitted for the initial day of neonatal critical care irrespective of the time that the physician spends with the critically ill neonate or infant that is 28 days of age or younger.

Procedure code 1-99295 may be considered for reimbursement once per lifetime per critically ill neonate.

Procedure code 1-99296 should be submitted for subsequent neonatal critical care, irrespective of the time that the physician spends with the critically ill neonate or infant that is 28 days of age or younger. Procedure code 1-99296 may be considered for reimbursement once per day, per critically ill neonate (any provider) and is denied when submitted with the same date of service as 1-99295.

Procedure codes 1-99295 and 1-99296 may be used only during the period of time the neonate is considered critically ill. When the neonate is no longer considered critically ill, the E/M procedure codes for subsequent hospital care (1-99231, 1-99232, 1-99233) may be used.

Neonatal critical care and low birth weight services are inpatient, per day charges and only allowed once a day (same provider). No other inpatient E/M services will be considered for reimbursement with the same date of service when submitted by the same provider.

Separate charges for any of the following procedures submitted with the same date of service as neonatal intensive care (procedure codes 1-99295 and 1-99296) and intensive (non-critical) low birth weight services subsequent intensive care (procedure codes 1-99298, 1-99299, and 1-99300) are denied as part of another procedure:

Procedure Codes		
2-31500	2-31502	2-36000
2-36400	2-36405	2-36406
2-36410	2-36415	2-36420
2-36430	2-36440	2-36510
2-36540	2-36555	2-36600
2-36620	2-36625	2-36640
2-36660	2-43752	2-51000
2-51005	2-51010	2-51701
2-51702	2-62270	2-62272
4/I/T-71010	4/I/T-71015	4/I/T-71020
1-90760	1-90761	1-90765
1-90766	1-91105	1-92953
5/I/T-93561	5/I/T-93562	1-94002
1-94003	5/I/T-94375	1-94640
1-94642	1-94644	1-94645
1-94660	1-94662	5-94760
5-94761	5-94762	1-99090

The following procedures, when submitted with the same date of service by the same provider, may be considered for reimbursement at the full rate in addition to neonatal intensive care (this is not an all inclusive list):

Procedure Codes		
2-31720	2-31730	2-32000
2-32020	2-36450	2-36455
2-49080	2-49081	2-61000
2-61001		

The same provider may request reimbursement for no more than 28 days. After the 28th day, providers must submit pediatric critical care codes 1-99293 and 1-99294.

Pediatric critical care procedure codes 1-99293 and 1-99294 will be denied when billed by any provider with the same date of service as neonatal intensive or critical care procedure codes 1-99295, 1-99296, 1-99298, 1-99299, and 1-99300.

When critical care services are provided to a neonatal, pediatric, or adult patient in an outpatient setting (e.g., emergency room) and do not result in admission, the critical care should be submitted using procedure codes 1-99291 and 1-99292.

Refer to: "Critical Care" on page 36-18 for references to outpatient critical care services for neonatal, pediatric, and adult patients.

Services for a patient who is not critically ill and unstable but who happens to be in a critical care unit must be reported using subsequent hospital procedure codes or hospital consultation procedure codes.

Prolonged Services

Prolonged service procedure codes 1-99356 and 1-99357 are denied when submitted in addition to initial or subsequent neonatal critical care service (procedure codes 1-99295 and 1-99296).

Prolonged services are denied when submitted with the same date of service and by the same provider as low birth weight and very low birth weight subsequent intensive care procedure codes (1-99298, 1-99299, and 1-99300).

Hospital Discharge

Hospital discharge (procedure codes 1-99238 and 1-99239) are denied when submitted with the same date of service by the same provider as newborn care (procedure codes 1-99431, 1-99432, 1-99433, 1-99435, 1-99298, 1-99299, and 1-99300).

Newborn care procedure codes (1-99431, 1-99432, 1-99433, and 1-99435) and hospital discharge procedure codes (1-99238 and 1-99239) are denied when submitted with the same date of service as critical care procedure codes (1-99295 and 1-99296).

If a hospital discharge is submitted with the same date of service as inpatient neonatal or pediatric critical care, the hospital discharge is denied and the critical care is considered for reimbursement.

36.3.5.4 Referrals

A *referral* is defined as the transfer of the total or specific care of a patient from one physician to another; a referral does not constitute a consultation. These services should be submitted using the appropriate E/M visit code.

When a Texas Medicaid Program provider refers a Texas Medicaid Program client to another provider for additional treatment or services, the referring provider must forward notification of the client's eligibility and his provider identifier. The client must be made aware that the provider he/she is referred to does or does not participate in the Texas Medicaid Program. Some clients not eligible for Medicaid are eligible for family planning through Titles V and XX. These clients should be referred to contracted agency providers for family planning services.

Referral Requirements for Children with Disabilities

All health-care professionals are required by state and federal legislation to refer children younger than 3 years of age with developmental delays to early childhood intervention services provided under the authority of the Department of Assistive and Rehabilitative Services (DARS). Referrals must take place within two business days of identifying a delay in development.

DARS is a coordinated system of services available in every Texas county for children from birth to 3 years of age with developmental delays. DARS has served more than 27,000 children younger than 3 years of age through 70 local programs.

Referrals may be based on professional judgment or a family's concern. A medical diagnosis or a confirmed developmental delay is not required for referrals.

On referral, DARS programs determine eligibility based on screening and assessments. Children are eligible if they meet at least one of the following criteria:

- A delay in one or more areas of development.
- *Atypical development*. Children who perform within their appropriate age range on test instruments, but whose patterns of development are different from their peers.
- *A medically diagnosed condition*. Children who have a medically diagnosed condition with a high probability of resulting in developmental delay.

Families and professionals work together to plan appropriate services based on the unique needs of the child and the child's family.

Services that are provided at no cost to families may include:

- Physical, occupational, speech, and language therapy.
- Service coordination.
- Vision services.
- Special instruction.
- Nutrition services.
- Family counseling and education.
- Assistive technology (service and devices).

Providers can refer families for services by calling the local DARS program or the statewide DARS Care Line at 1-800-250-2246. Providers can also obtain brochures or more information by calling the DARS Care Line or visiting the DARS website at www.dars.state.tx.us.

36.3.6 Physician Services in a Long Term Care (LTC) Nursing Facility

The Department of Aging and Disability Services (DADS) requires initial certification and recertification of Medicaid clients in nursing facilities by physicians in accordance with guidelines set forth in federal regulations. Physician visits for certification and recertification are considered medically necessary, and are reimbursable by Medicaid whether performed in the physician's office or the nursing facility.

The *Omnibus Budget Reconciliation Act* (OBRA) of 1987 included legislation on Preadmission Screening and Resident Review (PASARR). PASARR requires that *all admissions to a Medicaid-certified distinct part of a nursing*

facility be screened for mental illness, mental retardation, or a related condition. This screening prevents inappropriate placement of clients in Medicaid-certified nursing facility beds.

DADS uses the Client Assessment Review and Evaluation (CARE) Form 3652-A to satisfy PASARR screening requirements. All individuals must have a preadmission screening completed before admission to the nursing facility. The screening is performed by the hospital or the nursing facility completing a CARE Form 3652-A with a purpose code *P*. Individuals whose CARE Forms have a *Y* checked in Item 34 must have a Level II screening conducted by DADS.

Physicians and hospitals may obtain written instructions on the completion and processing of the CARE form by visiting the following website at www.dads.state.tx.us /handbooks/instr/3000/F3652-A.

If the attending physician delegates health-care tasks to a qualified PA in an intermediate care/SNF, the physician services are covered if the supervision or delegation is consistent with the Texas Medical Board's rules and regulations. Services provided by PAs in intermediate care/SNFs must be consistent with the requirements of DADS agency rules [§§16.1906, 16.1912, 16.3017(c), and 16.3207(a)] as they relate to operating policies and procedures, client-patient care policies, conformance with physician orders, and drug orders. If the supervision of the delegated task is not appropriately documented in the patient's chart, any payment for services may be recouped.

Rehabilitation services (for example, physical therapy [PT], occupational therapy [OT], and speech-language pathology [SLP]) must be made available to nursing facility residents on an as-needed basis as ordered by the attending physician, and must be provided by the nursing facility staff or furnished by the facility through arrangements with outside qualified resources. Clients who need these services cannot be admitted to the nursing facility if the facility is unable to provide these services as needed. Payment for these services is included in the reimbursement made to the nursing facility; they may not be billed to TMHP. If these services cannot be furnished by the extended care facility, it is the facility's responsibility to provide transportation for the client to a provider to render these services. The Texas Medicaid Program must not be billed for the rehabilitation services or the transportation charges in these situations.

Physician visits to Medicaid patients confined in an extended care facility are not limited when they are seen for a diagnosis of illness or injury. The CMS-1500 claim form must document the medical necessity of the visit by listing the specific diagnosis in Block 21 or the appropriate electronic field.

Refer to: "Nursing Facility Services" on page 36-14 for additional information.

36.3.7 Telemedicine Services

Telemedicine is a benefit of the Texas Medicaid Program. Telemedicine is defined as a method of health-care service delivery used to facilitate medical consultations by physicians to health-care providers in rural or medically underserved areas (MUAs) for purposes of patient diagnosis or treatment that requires advanced telecommunications technologies, including interactive video consultation, teleradiology, and telepathology.

A *rural area* is defined as a county with a population of less than 50,000 people.

An *underserved area* is one that meets the definition of a MUA or medically underserved population (MUP) by the U.S. Department of Health and Human Services (HHS).

No separate reimbursement is made for the cost of telemedicine hardware and/or equipment, videotapes, and transmissions. Telephone conversations, chart reviews, email messages, and faxes alone do not constitute a telemedicine interactive video consultation and, therefore, are not considered for reimbursement. Only those services that involve direct *face-to-face* interactive video communication with the client, remote, and hub site providers are reimbursed; unless the service may currently be considered for reimbursement using telemedicine, without face-to-face contact, i.e., teleradiology and telepathology.

Telemedicine services are reimbursed only when provided through systems meeting minimum technical specification standards, as identified by HHSC, the Texas Utilities Commission, or as otherwise authorized.

In both the traditional and managed care systems, THSteps (Early and Periodic Screening, Diagnosis, and Treatment [EPSDT]) visits will not be considered for reimbursement if performed using telemedicine services. In the managed care system, THSteps visits, well child check ups, and adult preventive visits will not be reimbursed if performed using telemedicine services. Care provided for abnormalities identified during these preventive health visits may be reimbursed if the care is provided by using telemedicine services.

Information about the diagnosis, evaluation, or treatment of a client with Medicaid coverage by a person licensed or certified to perform the diagnosis, evaluation, or treatment of drug abuse or any medical or emotional disorder is confidential information that the provider may disclose only to authorized people. Only the client may give written permission for release of any pertinent information before client information can be released, and confidentiality must be maintained in all other aspects. The signed consent form or documentation of consent for release of information is to become part of the medical records at the remote site.

Reimbursement for telemedicine services is made only when *both* the hub site provider and remote site provider are acceptable Medicaid provider types for telemedicine services.

Reimbursement for the telemedicine services is made only to the following Texas Medicaid Program enrolled primary care provider using the GT (telemedicine) modifier with the appropriate E/M code. RHCs and federally qualified health center (FQHC) providers must use encounter procedure codes with modifiers AM (physician), SA (APN/CNM), and U7 (PA) in addition to the GT modifier (refer to the following):

- Physicians (MDs/DOs).
- PA.
- NP.
- CNS.
- CNM.

Hub site providers are limited to:

- Physician (MD), provider type 20.
- Physician (DO), provider type 19.

Remote site providers are limited to:

- Physician (MD), provider type 20.
- Physician (DO), provider type 19.
- NP, CNS, PA, provider type 10.
- CNM, provider type 33.
- FQHC, provider type 46.
- RHC, provider types 78 and 79.

To provide Medicaid services, each NP, CNS, CNM, and CRNA must be licensed as a registered nurse and recognized as an APN by the Texas BON.

The Healthcare Common Procedure Coding System (HCPCS) modifier code GQ (through an asynchronous telecommunications system) is not appropriate for the Texas Medicaid telemedicine program and should not be used.

The remote and hub site providers are to be reimbursed for telemedicine services. Reimbursement for telemedicine services is made at current Texas Medicaid Reimbursement Methodology (TMRM) for CPT E/M codes and encounter rates for RHCs and FQHCs. Providers billing for teleradiology and telepathology services are to use the appropriate CPT code and the modifier GT.

The use of these modifiers by providers certifies they have met the criteria set forth by HHSC and that they understand claims data may be monitored for program integrity and provider compliance. Visits, consultations, and encounters are reimbursed based on individual policy guidelines; for example, global fee policy, consultation policy, and so forth (including payable provider types and POSs). Office or outpatient consultations are limited to one consultation per six-month period, same provider. All other consultations during the period are changed to the appropriate outpatient or office E/M code.

Telemedicine services are reimbursable only in the following POSs:

- Practitioner's office (Hub site).
- Practitioner's office (Remote site).
- RHC.
- FQHC.
- Inpatient hospital.
- Outpatient hospital.
- Emergency room.
- ICF-MR state schools.

Nursing facilities, SNFs, and client homes *are not* approved POSs.

Use of telemedicine services in ICF-MR state schools is subject to policies established by HHSC and DADS.

36.3.7.1 Hub Site Provider

A hub site provider must be a physician at an accredited medical or osteopathic school located in Texas, or a physician at one of the following entities affiliated through a written contract or agreement with an accredited medical or osteopathic school located in Texas:

- Hospitals.
- Teaching hospitals.
- Tertiary centers.
- Health clinics.

The hub site physician provides consultation and the diagnosis, as well as develops the patient's plan of care and treatment.

Hub site providers may be reimbursed only for consultations through interactive video using the following procedure codes billed with the GT modifier:

Procedure Codes				
3-99241	3-99242,	3-99243	3-99244	3-99245
3-99251	3-99252	3-99253	3-99254	3-99255

The hub site physician's findings must be documented in writing in the client's medical records at the remote site. The client's medical records may be faxed to the remote site provider.

More than one medically necessary telemedicine consultation may be paid on the same day/time, same POS, if the consultations are billed by physicians of different specialties.

36.3.7.2 Remote Site Provider

Remote site providers must be primary care providers, such as physicians, PAs, NPs, CNSs, or CNMs, who provide visits/encounters in their offices, RHCs, or FQHCs and are able to bill the Texas Medicaid Program independently. Remote site providers must be located in rural or underserved areas. The remote site provider is responsible for carrying out or coordinating the plan of care and treatment after consulting with the hub site provider. Because the office visit or encounter must be through interactive video, the remote site provider must be present with the client during the performance of the interactive video telemedicine consultation. The signed

consent form or documentation of consent for release of information must remain in the medical records at the remote site.

Remote site providers may be reimbursed for an office visit (POS 1) using procedure codes 1-99201, 1-99202, 1-99203, 1-99204, 1-99205, 1-99211, 1-99212, 1-99213, 1-99214, and 1-99215 or encounter code 1-T1015 (FQHC, RHC) in POS 1 or 5, as applicable.

FQHC and RHC telemedicine encounter providers must submit their claims using the following modifiers. Use modifier AM, U7, or SA *in the first modifier field* on the claim form together with the modifier GT *in the second field* on the claim form.

If a prolonged physician service (procedure codes 1-99354 and 1-99355) or a special service (procedure code 1-99050) is provided in addition to a telemedicine office visit (procedure codes 1-99201, 1-99202, 1-99203, 1-99204, 1-99205, 1-99211, 1-99212, 1-99213, 1-99214, and 1-99215), these services should also be billed with modifier GT.

Telemedicine services are not a benefit when provided in nursing homes, SNFs, or the client's home.

36.3.8 Orthognathic Surgery

Orthognathic surgery is a benefit of the Texas Medicaid Program only when it is necessary for medical reasons, or when it is necessary as part of an approved plan of care in the Texas Medicaid Dental Program. Orthognathic surgery is administered and reimbursed as part of the medical/surgical benefit of the Texas Medicaid Program and not as part of the Texas Medicaid Dental Program.

Treatment of malocculsion is a benefit of the Texas Medicaid Dental Program. Orthognathic surgery is a benefit when it is necessary as part of the approved dental benefit.

Maxillary and/or mandibular facial skeletal deformities are associated with clearly abnormal masticatory malocclusion.

Orthognathic surgery may be considered medically necessary for the following client conditions:

- Producing signs or symptoms of masticatory dysfunction.
- Facial skeletal discrepancies associated with documented sleep apnea, airway defects, and soft tissue discrepancies.
- Facial skeletal discrepancies associated with documented speech impairments.
- Structural abnormalities of the jaws secondary to infection, trauma, neoplasia, or congenital anomalies.

Orthognathic surgery that is done primarily to improve appearance and not for reasons of medical necessity is considered cosmetic and is not a benefit of the Texas Medicaid Program.

Prior Authorization

The following orthognathic medical surgical services may be considered for reimbursement to oral and maxillofacial surgeons when mandatory prior authorization is received from the TMHP Medical Director or designee. A narrative explaining medical necessity must be provided with the authorization request.

Procedure Codes		
2/F-21010	2-21031	2-21032
2/8/F-21050	2/8/F-21060	2/F-21100
2-21110	2/8-21120	2/8/F-21121
2/8/F-21122	2/8/F-21123	2/8-21125
2/8/F-21127	2/8-21137	2/8-21138
2/8-21139	2/8-21145	2/8-21146
2/8-21147	2/8-21150	2/8-21151
2/8-21154	2/8-21155	2/8-21159
2/8-21160	2/8-21172	2/8-21175
2/8-21179	2/8-21180	2/8/F-21181
2/8-21182	2/8-21183	2/8-21184
2/8-21188	2/8-21193	2/8-21194
2/8-21195	2/8-21196	2/8-21198
2/8-21199	2/8/F-21206	2/F-21208
2/8/F-21209	2/8/F-21210	2/F-21215
2/8/F-21230	2/F-21235	2/8/F-21240
2/8/F-21242	2/8/F-21243	2/8/F-21244
2/F-21245	2/F-21246	2/8-21247
2/8-21255	2/8-21256	2/8-21260
2/8-21261	2/8-21263	2/8/F-21267
2/8-21268	2/F-21270	2/8/f-21275
2/F-21280	2/F-21282	2/F-21295
2/F-21296	2/8/F-21299	2/F-29800
2/F-29804	2/F-40840	2/F-40842
2/F-40843	2/F-40844	2/F-40845

36.4 Procedures and Services

36.4.1 Aerosol Treatment

Aerosol treatments including vaporizers, humidifiers, nebulizers, and inhalers are appropriate methods of treatment for certain *acute* medical problems and should be coded 1-94640, 1-94644, 1-94645, and revenue code B-412.

Medication(s) used in the aerosol therapy may be considered for separate reimbursement when billed by the physician.

The outpatient facility should bill with revenue code B-412 for aerosol treatments.

Revenue code B-412 includes the following medications delivered by inhaler and is payable in the outpatient setting (POS 5) when it is the only therapy service billed on that day:

- Beclomethasone dipropionate.
- Isoproterenol sulfate.
- Isoproterenol hydrochloride.
- Albuterol.
- Metaproterenol sulfate.
- Epinephrine bitartrate.
- Phenylephrine bitartrate.
- Isoetharine mesylate inhalation aerosol.
- Dexamethasone sodium phosphate.

When revenue code B-412, Respiratory services-inhalation services, is billed on the same day for both aerosol therapy and inhalers, only one service is allowed, not both.

Revenue code B-412 may be reimbursed separately when billed for aerosol treatment in the recovery room after outpatient surgery (billed on an outpatient claim) as it is necessary adjunct to the postoperative recovery of a client who has undergone general anesthesia.

Pulse oximetry (5-94760 and 5-94761) is considered part of an E/M visit and will not be reimbursed separately.

Procedure Code 5-94664, demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device will not be reimbursed separately.

IPPB treatments have been determined to be inappropriate for the treatment of most respiratory problems and are denied.

Payment for professional services for aerosol therapy is limited to the following diagnosis codes:

Diagnosis Codes				
1363	27700	27701	27702	27703
27709	46611	46619	4801	486
488	4910	4911	49120	49121
49122	4918	4919	4920	4928
49300	49301	49302	49310	49311
49312	49320	49321	49322	49381
49382	49390	49391	49392	4940
4941	4950	4951	4952	4953
4954	4955	4956	4957	4958
4959	496	5070	5071	5078
51911	51919	5533	7707	99527

Medications used in aerosol therapy, when billed by the physician, are reimbursed separately and should be billed using the appropriate HCPCS procedure code. A separate charge for saline used in aerosol therapy is denied as part of the aerosol therapy.

36.4.2 Allergy Services

The Texas Medicaid Program uses the following guidelines for reimbursement of allergy services.

Reminder: *Procedure codes 1-95120, 1-95125, 1-95130, 1-95131, 1-95132, 1-95133, and 1-95134 are no longer payable.*

36.4.2.1 Allergy Injections, Vials and Extracts

Allergen immunotherapy consists of the parenteral administration of allergenic extracts as antigens at periodic intervals, usually on an increasing dosage scale to a dosage which is maintained as maintenance therapy.

Preparation of the allergy vial or extracts is a benefit of the Texas Medicaid Program and should be submitted using the following procedure codes:

Procedure Codes—Preparation of Allergy Vial or Extract		
1-95145	1-95146	1-95147
1-95148	1-95149	1-95165
1-95170	1-95180	

The preparation of the allergy vial or extract must be submitted with an appropriate diagnosis code as follows:

Diagnosis Codes		
37214	38100	38101
38102	38103	38104
38105	38106	38110
38119	4770	4778
4779	49300	49301
49302	49310	49311
49312	49320	49321
49322	49390	49391
49392	7080	78607
7862	9895	

The quantity billed should represent the total number of cc in the vial. If the number of cc is not stated on the claim, a quantity of one is allowed.

When an injection is given from a vial, providers should use an administration-only procedure code (1-95115 or 1-95117).

An office visit, clinic visit, or observation room is not considered for reimbursement in addition to the fee for preparation of the allergy vial or administration, unless the visit was for a different (non-allergy related) diagnosis or re-evaluation of the patient's condition.

The following E/M procedure codes submitted with allergy testing or allergy immunotherapy are appropriate only if a significant, separately identifiable service is administered:

Procedure Codes				
1-99201	1-99202	1-99203	1-99204	1-99205
1-99211	1-99212	1-99213	1-99214	1-99215
1-99217	1-99218	1-99219	1-99220	

Single dose vials (procedure code 1-95144) are not a benefit of the Medicaid program.

Sublingual antigens are not a benefit of the Texas Medicaid Program.

36.4.2.2 Allergy Testing

The Texas Medicaid Program benefits include specific allergy testing and allergy immunotherapy for clients with clinically significant allergic symptoms. Allergy testing is focused on determining the allergens that cause a particular reaction and the degree of the reaction. Allergy testing also provides justification for recommendations of particular medicines, of immunotherapy, or of specific avoidance measures in the environment.

An initial evaluation of a new patient is considered for reimbursement in addition to allergy testing on the same day.

Established patient visits are not considered for reimbursement in addition to allergy testing on the same day. The allergy testing is considered for reimbursement and the visit is denied as part of another procedure on the same day.

Procedure codes 1-95027 and 1-95199 are not benefits of the Texas Medicaid Program and are denied if submitted for reimbursement.

The following allergy tests are benefits of the Texas Medicaid Program:

- *Percutaneous and intracutaneous skin test*. The skin test for IgE-mediated disease with allergenic extracts is used in the assessment of allergic clients. The test involves the introduction of small quantities of test allergens below the epidermis. Procedure codes 1-95004, 1-95010, 1-95015, 1-95024, and/or 1-95028 should be used to submit skin tests for consideration of reimbursement.
- *Patch or application tests*. Patch testing (procedure code 1-95044) is used for diagnosing contact allergic dermatitis.
- *Photo or photo patch skin test*. Procedure codes 1-95052 and 1-95056 may be used for photo or photo patch skin tests.
- *Ophthalmic mucous membrane or direct nasal mucous membrane tests*. Nasal or ophthalmic mucous membrane tests (procedure codes 1-95060 and 1-95065) are used for the diagnosis of either food or inhalant allergies and involve the direct administration of the allergen to the mucosa.
- *Inhalation bronchial challenge testing (not including necessary pulmonary function tests)*. Bronchial challenge testing with methacholine, histamine, or allergens (procedure codes 1-95070 and 1-95071) is used for defining asthma or airway hyperactivity when skin testing results are not consistent with the client's medical history. Results of these tests are evaluated by objective measures of pulmonary function.

The type and number of allergy tests performed should be indicated on the claim. When the number of tests is not specified, a quantity of one is allowed.

RAST/MAST Tests

Radioallergosorbent tests (RAST) and multiple antigen simultaneous tests (MAST) are benefits of the Texas Medicaid Program. RAST testing is a radioimmunoassay of the blood serum used to detect specific allergens. MAST is an RAST type test using an enzyme rather than a radioactive marker. RAST/MAST testing is usually performed by an independent lab; however, there are physicians who have the capability of performing these tests in their offices. Physicians who submit RAST/MAST tests performed in the office setting must use modifier SU to be considered for reimbursement. Without the use of the SU modifier, RAST/MAST testing submitted with POS 1 (office) is denied with the message, “Lab performed outside of office must be billed by the performing facility.”

RAST/MAST tests should be submitted using procedure codes 5-86003 and 5-86005.

Procedure code 5-86003 should be submitted with a quantity of one and is limited to twelve per year, same provider.

Procedure code 5-86005 should be submitted with a quantity of one and is limited to four (4) per year, same provider.

An allergy injection (1-95120, 1-95125, 1-95130, 1-95131, 1-95132, 1-95133 and 1-95134) is considered for reimbursement in addition to RAST/MAST testing when submitted with the same date of service. Allergy injections will be denied when billed on the same day as any other allergy testing.

36.4.3 Anesthesia

36.4.3.1 Anesthesia for Abortion

Use the procedure code 7-01965 for abortions.

36.4.3.2 Anesthesia for Sterilization

Use modifier FP, Family Planning, when reporting anesthesia services for a sterilization procedure.

The following procedure codes require modifier FP, in addition to the regular anesthesia modifier, if the service is sterilization:

CPT Anesthesia Codes		
7-00840	7-00920	7-00940
7-00851	7-00922	7-00950

36.4.3.3 Anesthesia for Labor and Delivery

Providers must bill the most appropriate procedure code for the service provided. Other time-based procedure codes cannot be submitted if 7-01960 or 7-01967 is the most appropriate procedure code.

Epidural Anesthesia by the Delivering Obstetrician

The Texas Medicaid Program reimburses the anesthesia services and the delivery at full allowance when provided by the delivering obstetrician.

The following procedure codes must be used for obstetrical procedures:

Procedure Codes		
2-59410	2-59515	2-59614
2/8-59622	2-62311	2-62319
7-01960	7-01961	7-01963
7-01967	7-01968	7-01969

Procedure codes 2-62311 and 2-62319 are reimbursed at an access-based maximum fee rate.

Procedure codes 7-01960 and 7-01967 are reimbursed at a flat fee and not by RVU. The time reported must be in minutes and should represent the total minutes between the start and stop times for these procedures, regardless of the time actually spent with the client. Providers are not required to report actual face-to-face minutes with the client for these procedure codes. Providers should refer to the definition of time in the CPT manual in the "Anesthesia Guidelines—Time Reporting" section.

Procedure code 7-01968 or 7-01969 may be considered for reimbursement when submitted with procedure code 7-01967. For a cesarean delivery following a planned vaginal delivery, the anesthesia administered during labor must be billed with procedure code 7-01967 and must indicate the time in minutes that represents the time between the start and stop times for the procedure. The additional anesthesia services administered during the operative session for a cesarean delivery must be submitted using procedure code 7-01968 or 7-01969 and must indicate the time spent administering the epidural and the actual face-to-face time spent with the client. The insertion and injection of the epidural are not considered separately for reimbursement.

All time must be documented in block 24D of the claim form or the appropriate field of the chosen electronic format.

For continuous epidural analgesia procedure codes (other than 7-01960 and 7-01967), the Texas Medicaid Program reimburses providers for the time when the physician is physically present and monitors the continuous epidural. Reimbursable time refers to the period between the catheter insertion and when the delivery commences.

Procedure code 1-99140 is not considered for reimbursement when submitted with diagnosis code 650, 66970, or 66971 if one of these diagnoses is documented on the claim as the referenced diagnosis. The referenced diagnosis must indicate the complicating condition.

Epidural Anesthesia by a Provider other than the Delivering Obstetrician

The following procedure codes must be used for epidural anesthesia when provided by a provider other than the delivering obstetrician:

Procedure Codes		
2-62311	2-62319	7-01960
7-01961	7-01963	7-01967
7-01968	7-01969	

Procedure codes 7-01960 and 7-01967 are reimbursed at a flat fee and not by RVU. The time reported must be in minutes and should represent the total minutes between the start and stop times for these procedures, regardless of the time actually spent with the client. Providers are not required to report actual face-to-face minutes with the client for these procedure codes. Providers should refer to the definition of time in the CPT manual in the "Anesthesia Guidelines—Time Reporting" section.

Procedure code 7-01968 or 7-01969 may be considered for reimbursement when submitted with procedure code 7-01967. For a cesarean delivery following a planned vaginal delivery, the anesthesia administered during labor must be billed with procedure code 7-01967 and must indicate the time in minutes that represents the time between the start and stop times for the procedure. The additional anesthesia services administered during the operative session for a cesarean delivery must be submitted using procedure code 7-01968 or 7-01969 and must indicate the time spent administering the epidural and the actual face-to-face time spent with the client. The insertion and injection of the epidural are not considered separately for reimbursement.

All time must be documented in block 24D of the claim form or the appropriate field of the chosen electronic format.

Procedure codes 2-62311 and 2-62319 must be used when the anesthesiologist or CRNA provides the epidural anesthesia during labor only. Procedure codes 2-62311 and 2-62319 are considered for reimbursement at an access-based maximum fee rate.

Procedure code 1-99140 is not considered for reimbursement when submitted with diagnosis code 650, 66970, or 66971 if one of these diagnoses is documented on the claim as the referenced diagnosis. The referenced diagnosis must indicate the complicating condition.

36.4.3.4 Anesthesia Provided by the Surgeon (Other than Labor and Delivery)

Local, regional, or general anesthesia provided by the operating surgeon is not reimbursed separately from the surgery. A surgeon billing for a surgery will not be reimbursed for the anesthesia when billing for the surgery, even when using the CPT modifier 47. The anesthesia service is included in the global surgical fee.

36.4.3.5 Base Units

Base units are the RVUs assigned by the Texas Medicaid Program to each anesthesia service billed.

36.4.3.6 Central Lines

Placement (insertion) of a central venous catheter is denied as part of another procedure when procedure 2-33970 is billed on the same day. Separate payment for the *insertion* of monitoring lines is not available. Reimbursement for the *insertion* of monitoring lines is included in the anesthesia fee when the time units are calculated.

Providers should refer to the 2007 Texas Medicaid Fee Schedule PRCR402c-100107, which is available on the TMHP website at www.tmhp.com, for the reimbursement rates for the following procedure codes:

Procedure Codes		
7-00851	7-01961	7-01963
7-01968	7-01969	

Procedure codes 7-01960 and 7-01967 are reimbursed at a flat fee for anesthesiologists. Providers must code the procedures in Block 24D of the CMS-1500 paper claim form with a valid CPT anesthesia code preceded by TOS indicator *7* for anesthesia.

36.4.3.7 Claim Filing

The Texas Medicaid Program reimburses anesthesiologists based on TEFRA. Anesthesiologists must identify the following information on their claims:

- Procedure performed (CPT anesthesia code in Block 24 of the CMS-1500 claim form).
- Person (physician or CRNA) administering anesthesia (modifiers must be used to designate this provider type).
- Time in minutes.
- Any other appropriate modifier (refer to “Modifiers” on page 5-18 for a complete listing).

36.4.3.8 Complicated Anesthesia

The following procedure codes are payable in addition to an anesthesia procedure or service: 1-99100, 1-99116, 1-99135, and 1-99140.

Procedure code 1-99140 is not reimbursed for diagnosis codes 650, Normal delivery, or 66970, cesarean delivery without mention of indication, when one of these diagnoses is documented as the referenced diagnosis on the claim. The referenced diagnosis must indicate the complicating condition. An emergency is defined as existing when delay in treatment of the client would lead to a significant increase in the threat to life or body part.

36.4.3.9 Pain Management

Acute pain is defined as pain caused by occurrences such as trauma, a surgical procedure, or a medical disorder manifested by increased heart rate, increased blood pressure, increased respiratory rate, shallow respirations, agitation or restlessness, facial grimace, or splinting.

Chronic pain is defined as persistent, often lasting more than six months; symptoms are manifested similarly to that of acute pain.

Postoperative refers to the time frame immediately following a surgical procedure in which a catheter is maintained in the epidural or subarachnoid space for the duration of the infusion of pain medication.

Epidural and Subarachnoid Infusion (not including Labor and Delivery)

Epidural and subarachnoid infusion for pain management is payable for acute, chronic, and postoperative pain management. Procedure code 1-01996 should be reported as a type of service (TOS) 1 (medical) instead of a TOS 7 (anesthesia).

Procedure code 1-01996 is limited to once per day and is denied when billed on the same day as a surgical/anesthesia procedure (TOS 2, 7, and 8). Procedure code 1-01996 billed longer than 30 days requires medical necessity documentation. Cancer diagnoses are excluded from the 30-day limitation.

Procedure code 1-01996 is payable to the following providers:

- Independent CRNA.
- Independent CRNA group.
- DO.
- MD.
- Physician group, DO.
- Physician group, MD.

Intrathecal Morphine Pumps

Treatment of intractable pain with an intrathecal morphine pump is a benefit with prior authorization. However, prior authorization is *not* required if used for the treatment of intractable cancer pain.

The request for prior authorization must include required information. The use of the Texas Medicaid Prior Authorization Request Form: Intrathecal Baclofen or Morphine Pump Section I form is not mandatory; however, the information requested on both pages of the form is required.

Providers are to mail or fax prior authorization requests to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

Pain management is a benefit of the Texas Medicaid Program. Prior authorization is required for procedure codes 2-62350, 2-62360, 2-62361, and 2-62362 unless used for the treatment of intractable cancer pain.

Procedure codes 2-62350, 2-62351, 2-62355, 2-62360, 2-62361, 2-62362, and 2-62365 billed on the same day as another surgical procedure performed by the same physician are paid according to multiple surgery guidelines.

Procedure codes 2-62350, 2-62351, 2-62355, 2-62360, 2-62361, 2-62362, and 2-62365 billed on the same day as an anesthesia procedure performed by the same physician are denied as included in the total anesthesia time.

Reimbursement to the physician for the surgical procedure is based on the assigned RVUs or maximum fee. Outpatient facilities are reimbursed at their reimbursement rate. Inpatient facilities are reimbursed under the assigned diagnosis-related group (DRG). No separate payment for the intrathecal pump is made.

Use the following codes when billing for the implantation/revision/replacement of the pump/catheter:

Procedure Codes		
2-62350	2-62351	2-62355
2-62360	2-62361	2-62362
2-62365		

Procedure codes 1-62367 and 1-62368 do not require prior authorization and are payable as a medical service (TOS 1) only.

Refer to: "Chemotherapy" on page 36-30 for more information about implanted pumps.

"Texas Medicaid Prior Authorization Request Form: Intrathecal Baclofen or Morphine Pump Sections I and II (2 Pages)" on page B-102

36.4.3.10 Multiple Procedures

When billing for anesthesia and other services on the same claim, the anesthesia charge must appear in the first detail line for correct reimbursement. Any other services billed on the same day must be billed as subsequent line items. Multiple surgical procedures billed on the same day by the same provider are subject to the multiple surgery guidelines.

When billing for multiple anesthesia services, TOS 7, performed on the same day or during the same operative session, use the procedure code with the higher RVU. For accurate reimbursement, apply the total minutes and dollars for *all* anesthesia services rendered on the a higher RVU code.

36.4.3.11 Reimbursement Methodology

Reimbursement for anesthesia services is determined by a calculation using the RVUs for a particular anesthesia procedure (Base Units) plus the quantity billed (anesthesia *Time Units* divided by 15) multiplied by the TMRM conversion factor for physicians. The formula is Base Unit + Time Units x TMRM. The following is an example of physician pricing:

Provider Type Description–Physician Pricing Example				
Modifier	=	120/15	=	8 (quantity billed)
Procedure Code	=	7-00851 (6 RVUs) 6.00 + 8	=	14.00
Time	=	14.00 x 18.21	=	$254.94 (physician reimbursement)

36.4.3.12 Services Incidental to Surgery and/or Anesthesia

Surgical and anesthesia services are benefits of the Texas Medicaid Program when they are medically necessary.

Certain services that are performed in conjunction with surgical or anesthesia procedures are considered incidental to the surgery or anesthesia and are denied as included in the surgical/anesthesia fee. The following table includes, but may not be limited to, services that are incidental to surgery or anesthesia:

Procedure Codes		
2-31500	2-36010	2-36420
2-36425	2-36430	2-36440
5-82800	5-82803	5-82805
5-82810	5-82820	1-90760
1-90761	1-90765	1-90766
1-90767	1-90768	4/I/T-93312
4-93313	4/I/T-93314	4/I/T-93315
4-93316	4/I/T-93317	5/I/T-93561
5/I/T-93562	1-94002	1-94003
5/I/T-94010	5/I/T-94060	5/I/T-94680
5/I/T-94681	5/I/T-94690	5-94760
5-94761	5/I/T-94770	T-93005
T-93017	T-93041	1-96521
1-96522	1-96523	1-99231
1-99232	1-99233	1-99291
1-99292		

Procedure codes 2-33967, 2-33970, 2-36013, and 2-36014 (not an all-inclusive list) are services that are incidental to the anesthesia fee.

The following table includes procedure codes that are *not* incidental to surgery or anesthesia procedures and may be considered for reimbursement separately in addition to the surgery or anesthesia service in the inpatient or outpatient setting:

Procedure Codes		
2/F-36555	2/F-36556	2/F-36557
2/F-36558	2/F-36560	2/F-36561

Procedure Codes		
2/F-36563	2/F-36565	2/F-36566
2/F-36568	2/F-36569	2-36620
2-36625	2-93503	

Should the need arise for the insertion of a monitoring line due to a separate incident not related to the original surgery after the post-operative recovery period, reimbursement may be considered on appeal with appropriate documentation. Reimbursement for monitoring lines submitted as the sole procedure performed is allowed.

Procedure codes 4/I/T-93312, 4/I/T-93313, 4/I/T-93314, 4/I/T-93315, 4/I/T-93316, and 4/I/T-93317 (Transesophageal echocardiography) may be considered for reimbursement on appeal with appropriate documentation when performed for diagnostic purposes with documentation of a formal report and when due to a separate incident not related to the original surgery after the post-operative recovery period.

Critical care procedure codes 1-99291 and 1-99292 performed due to a separate incident not related to the original surgery after the postoperative recovery period may be considered for reimbursement on appeal with appropriate documentation.

36.4.3.13 Supervision of Concurrent Anesthesia Procedures

Physicians must supply information on the number of concurrent anesthesia procedures being concurrently supervised through the use of the appropriate modifier. The name of each qualified person supervised and all concurrent procedures performed *do not* have to be submitted on the claim form. Physicians are responsible for maintaining the information that is subject to retrospective review.

The percentage of reduction for each modifier is shown in the following table:

Modifier	Description	Time Divided By	RVU Reduction
AA	Anesthesia services performed personally by the anesthesiologist [RVU + (Minutes/15)] X Conversion Factor = Allowed Amount	15 minutes	0 percent
AD	Medical supervision by a physician; more than four concurrent anesthesia procedures. The AD modifier is also used when a modifier is not submitted on the claim.	NA. Total time units for claim are set to one unit.	0 percent
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals [RVU + (Minutes/30)] X Conversion Factor = Allowed Amount	30 minutes	10 percent
QS	Monitored services. This informational modifier can be billed by a CRNA or physician and must have a pricing modifier billed with it for processing.	NA	NA
QY*	Medical direction of one CRNA by an anesthesiologist [RVU + (Minutes/15)] X Conversion Factor = Allowed Amount	15 minutes	0 percent
*** = Providers should continue to use the AA modifier until further notice.**			

36.4.3.14 Supervision of CRNA

TMHP reimburses an anesthesiologist for supervision of a CRNA. The services of the CRNA must be billed using a CRNA provider identifier.

In situations where the anesthesiologist supervises the CRNA and no concurrent procedures occur, the anesthesiologist or the CRNA should bill for the administration of anesthesia. Payment is not made to both providers when the modifier AA is used by the physician anesthesiologist.

CRNA services are reimbursed the lesser of the actual charge or 92 percent of the rate reimbursed to a physician anesthesiologist for the same service for covered procedures.

Time Units

Time Units is based on the time in minutes indicated on the claim by the provider. It is the result of the following calculation:

- Time in minutes as indicated on the claim by the provider.
- Divided by 15-minute or 30-minute increments.

The resulting *Time Units* value is added to the *Base Units* value to get the *Total Units* value.

The modifier indicated on the claim determines which time increment is used to divide the total anesthesia time billed.

Providers billing anesthesia time must refer to the CPT manual definition of time. The definition is provided under the title *Time Reporting*:

> "Anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area and ends when the anesthesiologist is no longer in personal attendance; that is, when the patient may be safely placed under the postoperative supervision."

Refer to: "Supervision of Concurrent Anesthesia Procedures" on page 36-28.

36.4.3.15 Anesthesia (General) for THSteps Dental Restoration

Anesthesia services for THSteps dental procedures must be billed using procedure code 7-00170 with modifier EP and diagnosis code 52100 in Block 21 of the CMS-1500 paper claim form.

Note: *Except for Primary Care Case Management (PCCM), THSteps Dental anesthesia services for clients in the STAR and STAR+PLUS health plans must be billed to the appropriate health plan, not to TMHP. PCCM providers submit claims to TMHP.*

36.4.4 Assessment of Higher Cerebral Function Testing

Physician Payment Reform has grouped assessment of higher cerebral function testing, procedure codes 5-96105, 5-96110, 5-96111, and 5-96115 into the payment for primary services; therefore, no separate payment is made for this testing.

Aphasia, developmental, and cognitive testing must be billed using the appropriate E/M or outpatient code. Procedure codes 5-96105, 5-96110, 5-96111, and 5-96115 are denied as part of the patient's evaluation, whether billed in conjunction with an E/M or outpatient code or as an independent procedure(s).

36.4.5 Cancer

36.4.5.1 Colorectal Cancer Screening

Screening colonoscopies and sigmoidoscopies are benefits of the Texas Medicaid Program. Screening refers to the testing of asymptomatic persons in order to assess their risk for the development of colorectal cancer. Screening has been shown to decrease mortality due to this cancer by detecting cancers at earlier stages and allowing the removal of adenomas, thus preventing the subsequent development of cancer.

The American Cancer Society and U.S. Preventive Services Task Force both recommend screening people at average risk for colorectal cancer beginning at age 50 by any of the following methods:

- A fecal occult blood test (FOBT)* or fecal immunochemical test (FIT) every year.
- Flexible sigmoidoscopy every 5 years.
- A FOBT* or FIT every year plus flexible sigmoidoscopy every 5 years, or (of these 3 options, the combination of FOBT or FIT every year plus flexible sigmoidoscopy every 5 years is preferable).
- Double-contrast barium enema every 5 years.
- Colonoscopy every 10 years.

**For FOBT, the take-home multiple sample method should be used.*

The American Cancer Society and U.S. Preventative Task Force recommends screening for people at high-risk for colorectal cancer once very two years.

Indications/characteristics of a high-risk individual:

- A close relative (sibling, parent or child) has had colorectal cancer or an adenomatous polyp.
- There is a family history of familial adenomatous polyposis.
- There is a family history of hereditary non-polyposis colorectal cancer.
- There is a personal history of adenomatous polyps.
- There is a personal history of colorectal cancer.
- There is a personal history of colonic polyps.
- There is a personal history of inflammatory bowel disease, including Crohn's disease and ulcerative colitis.

Colorectal screening services are considered for reimbursement when submitted using procedure codes 2/F-G0104, 2/F-G0105, 4/I/T-G0106, 4/I/T-G0120, and 2-G0121 by associated risk category based on the American Cancer Society and U.S. Preventative Services

Task Force frequency recommendations. Reimbursement for these procedure codes is considered when medical necessity is documented in the patient's record. Prior authorization is not required for this service.

Procedure code 4/I/T-G0122 is not a benefit of the Texas Medicaid Program.

Sigmoidoscopies

Procedure codes 2/F-G0104 and 4/I/T-G0106 are considered for reimbursement once every five years when submitted with diagnosis codes V1272 and V7651, as recommended by the American Cancer Society and the U.S. Preventive Services Task Force.

A screening barium enema may be substituted for a screening flexible sigmoidoscopy if the effectiveness has been established by the physician for substitution. Procedure code 4/I/T-G0106 may be used as an alternative to procedure code 2/F-G0104 respectively.

If during the course of screening flexible sigmoidoscopy, a lesion or growth is detected that results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a flexible sigmoidoscopy with biopsy or removal should reported rather than procedure code 2/F-G0104 or 4/I/T-G0106.

Colonoscopies: Average Risk

Procedure code 2-G0121 is considered for reimbursement once every ten years when submitted with diagnosis codes V1272 and V7651, as recommended by the American Cancer Society and U.S. Preventive Services Task Force for patients not meeting the criteria for high-risk.

If during the screening colonoscopy a lesion or growth is detected that results in a biopsy or removal of the growth, the procedure code for a colonoscopy with biopsy or removal of lesion should be reported rather than procedure code 2-G0121.

Colonoscopies: High-Risk

Procedure codes 2/F-G0105 and 4/I/T-G0120 are considered for reimbursement once every two years for patients meeting the definition of high-risk. Procedure codes 2/F-G0105 and 4/I/T-G0120 must be submitted with one of the following diagnosis codes:

Diagnosis Codes				
5550	5551	5552	5559	5560
5561	5562	5563	5568	5569
5589	V1005	V1006	V1272	V160
V1851				

A screening barium enema may be substituted for a screening colonoscopy if the effectiveness has been established by the physician for substitution. Procedure code 4/I/T-G0120 may be used as an alternative to procedure code 2/F-G0105 respectively.

If during the screening colonoscopy a lesion or growth is detected that results in a biopsy or removal of the growth, the procedure code for a colonoscopy with biopsy or removal of lesion should be reported rather than procedure code 2/F-G0105 or 4/I/T-G0120.

36.4.5.2 Chemotherapy

Chemotherapy infusion procedure codes listed in the following table are comprehensive codes that include all supplies, catheters, and solutions necessary to safely administer the necessary chemotherapeutic agents either by or under the supervision of the physician, but do not include the provision of the chemotherapeutic agents:

Procedure Codes			
1-96401	1-96402	1-96405	1-96406
1-96409	1-96411	1-96413	1-96420
1-96422	1-96521	1-96522	1-96523
1-96542	1-96549		

Chemotherapeutic infusion procedure codes are comprehensive codes that include all supplies, catheters, and solutions necessary to safely administer the necessary chemotherapeutic agents under the physician's direct supervision, but do not include the provision of chemotherapeutic agents. These procedure codes also include the appropriate invasive surgical procedure. As a result, a thoracentesis billed with 1-96440 is denied as part of 1-96440; a paracentesis billed with 1-96445 is denied as part of 1-96445; and a lumbar puncture billed with 1-96450 is denied as part of 1-96450.

These procedure codes (1-96440, 1-96445, and 1-96450) may be considered for reimbursement in addition to E/M codes billed on the same day, regardless of the POS billed.

Chemotherapeutic drugs and other injections given in the course of chemotherapy may be billed separately and considered for reimbursement using the appropriate procedure code(s).

Chemotherapeutic procedure codes may be considered for reimbursement in addition to E/M codes provided on the same day if the services occur in a sequential manner in POS 1, 2, or 5 for the following:

Procedure Codes		
1-96401	1-96402	1-96405
1-96406	1-96409	1-96411
1-96413	1-96420	1-96422
1-96521	1-96522	1-96523
1-96542	1-96549	

If the patient is hospitalized (POS 3), the physician should use the appropriate E/M codes. These chemotherapeutic procedure codes are denied as part of the daily hospital management codes in POS 3. If chemotherapy administration is the only service billed in POS 3, it is reimbursed.

Chemotherapy planning may be considered for reimbursement as a physician service.

When a chemotherapy planning program is billed by the same provider on the same date of service with office visits, consultations, hospital visits, and emergency room visits, the chemotherapy planning is considered for reimbursement, and the visits are denied as part of the chemotherapy planning.

Factors considered for planning chemotherapy treatment include, but are not limited to:

- The type of cancer.
- Where the cancer is located in the body.
- Whether the cancer has spread.
- Where the cancer has spread (if it has).
- The age and general health of the client.
- The frequency of chemotherapy treatment, and how long the treatment lasts, depending on factors that include, but are not limited to:
  - Type of cancer.
  - Drugs used.
  - How the cancer cells respond to the drugs.
  - Any side effects from the drugs.

Procedure code 2-51720 is used for Treatment of bladder lesion.

Chemotherapy Procedure Codes

Procedure code 2-51720 should be used for intravesical instillation of anti carcinogenic agents into the bladder including retention time.

The following surgical procedures necessary to place catheters and reservoirs for continuous anti carcinogenic agents must use one of the following appropriate surgical procedure codes:

Procedure Codes		
2/ 8-61210	2-61215	2-62350
2-62360	2-62361	2-62362

Note: *Prior authorization is not required for procedure codes 2-62350, 2-62360, 2-62361, and 2-62362 when used as a means for chemotherapy administration.*

Prolonged infusion of chemotherapeutic agents is considered for reimbursement when submitted with procedure codes 1-96413 and 1-96422.

Since physicians are allowed reimbursement for only "face to face" contact, the subsequent hours of infusion therapy are not considered for reimbursement separately. Procedure codes 1-96415, 1-96423, 1-96416, and 1-96425 are not benefits of the Texas Medicaid Program.

Chemotherapy administration by push technique (procedure codes 1-96409, 1-96411, and 1- 96420) and by infusion technique (procedure codes 1-96413, 1-96415, 1-96416, 1-96422, 1-96423, and 1-96425) are considered for reimbursement when submitted with the same date of service. Infusion technique submitted with procedure codes 1-96415, 1-96416, 1-96423, and 1-96425 is not a benefit.

Only one intravenous push administration (procedure code 1-96409) and only one intra-arterial push administration (procedure code 1-96420) is allowed per day, regardless of whether separate drugs are given.

Refer to: "Texas Medicaid Prior Authorization Request Form: Intrathecal Baclofen or Morphine Pump Sections I and II (2 Pages)" on page B-102.

36.4.5.3 Bacillus Calmette-Guérin (BCG) Intravesical for Treatment of Bladder Cancer

BCG intravesical, instillation (procedure code 1-J9031) and for bladder cancer for intravesical use (procedure code 1-90586) are benefits of the Texas Medicaid Program for the following diagnosis codes:

Diagnosis Codes				
1880	1881	1882	1883	1884
1885	1886	1887	1888	1889
1890	2337			

BCG vaccine (procedure code 1-90585) is considered for reimbursement when submitted with diagnosis code V032.

BCG intravesical vaccines will autodeny for all other diagnosis codes. Bladder instillation of anticarcinogenic agent (procedure code 2-51720) may be reimbursed separately when billed separately.

36.4.6 Casting, Splinting, and Strapping

When a casting, splinting, strapping, or traction device is submitted with the same date of service as the surgery, the surgery is considered for reimbursement and the casting, splinting, strapping, or traction device is denied as part of another procedure submitted with the same date of service if the following procedure codes are used:

Procedure Codes		
2-29000	2/F-29010	2/F-29015
2/F-29020	2/F-29025	2/F-29035
2/F-29040	2/F-29044	2/F-29046
2/F-29049	2/F-29055	2/F-29058
2/F-29065	2/F-29075	2/F-29085
2/F-29086	2-29105	2-29125
2-29126	2-29130	2-29131
2-29200	2-29220	2-29240
2-29260	2-29280	2/F-29305
2/F-29325	2/F-29345	2/F-29355
2-29358	2/F-29365	2/F-29405
2/F-29425	2/F-29435	2-29440
2/F-29445	2/F-29450	2-29505
2-29515	2-29520	2-29530
2-29540	2-29550	2-29580
2-29590		

The replacement of a cast, splint, or strapping, using the procedure codes in the table above, is not included in the original surgical fee and may be paid separately.

Payment for cast removal or repair will be denied if billed within six weeks of the initial cast application, splinting, or strapping by the same provider. The procedure codes for

cast removal listed in the table below may be paid to a provider other than the provider who applied the initial cast, splint, or strap.

Procedure Codes		
2-29700	2-29705	2-29710
2-29715	2-29720	2-29730
2-29740	2-29750	2-29788

When casting, splinting, strapping, or wedging is performed without surgery and the appropriate E/M code is billed, both may be paid using the following procedure codes:

Procedure Codes		
2-29000	2-29010	2-29015
2-29020	2-29025	2-29035
2-29040	2-29044	2-29046
2-29049	2-29055	2-29058
2-29065	2-29075	2-29085
2-29086	2-29105	2-29125
2-29126	2-29130	2-29131
2-29200	2-29220	2-29240
2-29260	2-29280	2-29305
2-29325	2-29345	2-29355
2-29358	2-29365	2-29405
2-29425	2-29435	2-29440
2-29445	2-29450	2-29505
2-29515	2-29520	2-29530
2-29540	2-29550	2-29580
2-29590	2-29700	2-29705
2-29710	2-29715	2-29720
2-29730	2-29740	2-29750
2-29788		

Supplies are not separately payable. This includes the procedure code 9-99070.

36.4.7 Neurostimulators

36.4.7.1 Central Nervous System Stimulators

The implantation of central nervous system electrical nerve stimulators is a benefit of the Texas Medicaid Program with documentation of medical necessity. It may be considered for reimbursement for the relief of chronic intractable pain. Conditions that may indicate chronic intractable pain include, but are not limited to the following:

- Amputation *ghost* pain:

Diagnosis Codes				
7092	7295	V493	V5841	V5842
V5843	V5844	V5849		

- Cancer with bone metastasis (too numerous to list).
- Causalgia of upper/lower limb:
  - Diagnosis codes 3544 and 35571.
- Herniated disc:

Diagnosis Codes				
7220	72210	72211	7222	72230
72231	72232	72239	7224	72251
72252	7226	72270	72271	72272

- Radiculitis:
  - Diagnosis codes 09489, 7234, and 7292.
- Spinal stenosis:

Diagnosis Codes				
7230	7231	7232	7233	7234
7235	7236	7237	7238	7239
72400	72401	72402	72409	

- Spinal surgery, using the following procedure codes:

Procedure Codes		
2-63001	2-63003	2-63005
2-63011	2-63012	2-63015
2-63016	2-63017	2-63020
2-63030	2-63035	2-63040
2-63041	2-63042	2-63043
2-63044	2-63045	2-63046
2-63047	2-63048	2-63050
2-63051	2-63055	2-63056
2-63057	2-63064	2-63066
2-63075	2-63076	2-63077
2-63078	2-63081	2-63082
2-63085	2-63086	2-63087
2-63088	2-63090	2-63091
2-63101	2-63102	2-63103
2-63170	2-63172	2-63173
2-63180	2-63182	2-63185
2-63190	2-63191	2-63194
2-63195	2-63196	2-63197
2-63198	2-63199	2-63200
2-63250	2-63251	2-63252
2-63265	2-63266	2-63267
2-63268	2-63270	2-63271
2-63272	2-63273	2-63275
2-63276	2-63277	2-63278
2-63280	2-63281	2-63282
2-63283	2-63285	2-63286
2-63287	2-63290	2-63295
2-63300	2-63301	2-63302

Procedure Codes		
2-63303	2-63304	2-63305
2-63306	2-63307	2-63308

- Tic douloureux (Trigeminal neuralgia):
  - Diagnosis codes 3501, 3502, and 05312.

The following types of central nervous system stimulators are benefits:

- Dorsal column (spinal cord) (2/F-63650, 2/8-63655, 2/F-63660, 2/F-63685, and 2/F-63688).
- Intracranial (2-61850, 2-61860, 2-61863, 2-61864, 2-61867, 2-61868, 2-61870, 2-61875, 2/8/F-61880, 2/F-61885, 2-61886, and 2/F-61888).

Documentation of the following must be submitted with claims for payment of the implantation of a *dorsal column stimulator:*

- Implantation of the stimulator is a last resort in a patient with chronic intractable pain. Other treatment modalities, including pharmacological, surgical, physical, and/or psychological therapies, have been tried and been shown to be unsatisfactory, unsuitable, or contraindicated for the patient.
- The patient has undergone careful screening, evaluation, and diagnosis by a multidisciplinary team before implantation. This screening should include psychological as well as physical evaluation.
- All the facilities, equipment, and professional and support personnel required for the proper diagnosis, treatment, training, and follow-up of the patient are available.
- Demonstration of pain relief with a temporarily implanted electrode preceded permanent implantation.

Separate payment for the device is not a benefit for the physician or hospital. It is included in the hospital or facility global payment group. Separate charges for the rental or purchase of the stimulator device (dorsal column, intracranial, deep brain, or vagal) are denied as not a benefit of the Texas Medicaid Program.

The *implantation of intracranial neurostimulators* is payable *only* for the following diagnoses and is subject to multiple surgery audit guidelines. When billing for intracranial neurostimulator implantation (2/F-61850, 2-61860, 2-61863, 2-61864, 2-61867, 2-61868, 2-61870, 2-61875, 2/8/F-61880, 2/F-61885, 2-61886, and 2/F-61888), the documentation required for dorsal column stimulators does *not* need to be submitted. When billing the following codes pertaining to the treatment of intractable pain with a dorsal column stimulator, prior authorization is not required: 2/F-63685 and 2/F-63688.

Documentation must be included in the client's records and is subject to retrospective review.

The following codes are payable through the Texas Medicaid Program without prior authorization for the electronic analysis of an implanted neurostimulator:

Procedure Codes		
5-95970	5-95971	5-95972
5-95973	5-95974	5-95975
5-95978	5-95979	

Payment will not be made for the implantation of central nervous system stimulators to treat motor function disorders such as multiple sclerosis. However, the implantation, revision, and removal of deep brain stimulators is a payable benefit for the treatment of intractable tremors because of diagnosis code 3320, or diagnosis code 3331.

However, if procedure codes 2/F-63685 or 2/F-63688 are billed for services provided in treating intractable seizures with a vagal nerve stimulator, they *do* require prior authorization.

Refer to: "Deep Brain Stimulators" on page 36-33 for more information about prior authorization.

36.4.7.2 Deep Brain Stimulators

Implantation of neurostimulator electrodes for the treatment of intractable tremors, diagnosis codes 3320 and 3331, are benefits. One of these diagnoses must appear on the claim for reimbursement to be considered. The actual deep brain stimulator device is payable only under the DRG or ASC/HASC reimbursement rate. No separate payment outside of the DRG or ASC/HASC reimbursement rate is made for the device.

Procedure codes 2/8/F-61880, 2/F-61885, and 2/8/F-61888 are:

- Payable in the inpatient and outpatient settings.
- Subject to the global surgical fee policy, with three-day pre-care and six week post-care periods assigned.
- Subject to multiple surgery guidelines.

36.4.7.3 Percutaneous/Transcutaneous Nerve Stimulators

Application of a surface (transcutaneous) neurostimulator is *not a benefit* of the Medicaid program. Implantation of percutaneous peripheral nerve stimulators and electrodes are *not a benefit* of the Texas Medicaid Program.

Purchase or rental of electrical nerve stimulators and associated supplies, such as leads/electrodes, rechargeable transcutaneous electrical nerve stimulator (TENS) battery packs, and form-fitting conductive garments, are *not a benefit* of the Texas Medicaid Program. Additionally, diagnostic assessments for use of a TENS or percutaneous electrical nerve stimulator (PENS) are not a benefit of the Medicaid program.

36.4.7.4 Sacral Nerve Stimulators

Sacral nerve stimulators are *not a benefit* of the Texas Medicaid Program.

36.4.7.5 Vagal Nerve Stimulators

The implantation, revision, programming/reprogramming, and removal of the vagal nerve stimulator device is a benefit for the Texas Medicaid Program clients with medically intractable partial onset seizures.

These procedures are payable for inpatient, ASC, and HASC. If performed in an ASC or HASC, the maximum reimbursement is determined by the payment grouping.

No separate payment for the device is made to either the hospital or the physician. Reimbursement for the device is included in the facility payment.

The following procedure codes are payable for the incision, implantation, revision, or removal of the vagal nerve stimulator: 2/F-61885, 2/F-64573, 2/F-64585, and 2/F-61888.

The following diagnosis codes must be billed for procedure codes 2/F-61885 and 2/F-61888 when requesting the vagal nerve stimulator: 34511, 34541, and 34551.

The following procedure codes are payable in an outpatient setting or physician office for the electronic analysis and programming/reprogramming of the implanted neurostimulator: 5-95970, 5-95971, 5-95972, 5-95973, 5-95974, 5-95975, 5-95978, and 5-95979. These procedure codes do not require prior authorization.

Clients with diagnoses with ominous prognoses or other limiting factors would not be considered appropriate candidates for the implantation of the vagal nerve stimulator (for example, clients with an absent left vagus nerve, severe mental retardation, cerebral palsy, stroke, progressive fatal neurologic diseases, or progressive fatal medical diseases).

Refer to: "THSteps-Comprehensive Care Program (CCP)" on page 43-33 for children younger than 21 years of age.

36.4.8 Cochlear Implants

Cochlear implants, when medically indicated, are benefits of the Texas Medicaid Program. A cochlear implant device (procedure code 2/F-69930) is an electronic instrument, part of which is implanted surgically to stimulate auditory nerve fibers, and part of which is worn externally to capture and amplify sound. These devices are available in single and multi-channel models. Cochlear implants are used to provide awareness and identification of sound and to facilitate communication for persons who are profoundly hearing impaired.

The device must be FDA-approved and the approved device must be age-appropriate for the client. The device and separate components include the cochlear device itself, headpiece/headset, microphone, transmitting coil, transmitter cable, external speech processor, zinc air batteries, AA alkaline batteries, recharger units, and rechargeable AA batteries. A total of 12 replacement rechargeable batteries are a benefit per year. Up to a maximum of 15 Zinc Air batteries or a maximum of 31 alkaline batteries per month are benefits.

Reimbursement is provided only for those patients who meet all of the following criteria:

- Diagnosis of total bilateral sensorineural deafness that cannot be mitigated by use of a hearing aid in clients whose auditory cranial nerve is stimulable.
- Cognitive ability to use auditory clues and a willingness to undergo an extended program of rehabilitation.
- Post-lingual deafness or pre-lingual deafness.
- Twelve months of age or older.
- Freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system.
- No contraindications to surgery.

The payment for the cochlear implant is limited to the following diagnosis codes:

Diagnosis Codes				
38910	38911	38912	38914	38915
38916	38918	38922		

Tuning and adjustment of the external device is included in the package of services.

Diagnostic analysis of the cochlear implant in the event of a malfunction may be considered for reimbursement using procedure codes 1-92601, 1-92602, 1-92603, 1-92604.

36.4.8.1 Speech Therapy Post Cochlear Implant

Payment for speech therapy (1-92507) is included as part of the cochlear implant procedure (2-69930). Speech therapy is a benefit of the Texas Medicaid Program under a six month global fee period, for a maximum of 12 visits. Additional speech therapy related to the cochlear implants may be prior-authorized for clients ages 1 through 20 under the THSteps-Comprehensive Care Program (CCP). Reimbursement for speech therapy will be made separately from the surgical fee for cochlear implant.

For clients 12 months of age to 21 years of age, speech therapy is reimbursed through the THSteps-CCP program. For clients 21 years of age and older, speech therapy is reimbursed through the Traditional Texas Medicaid Program when submitted by the hospital or the physician. The Traditional Medicaid Program reimburses a maximum of 12 visits within a 6 month period.

The speech therapy should be prescribed by a physician, provided as an outpatient hospital service, and billed by the hospital; or the therapy should be prescribed by a physician, performed by or under his personal supervision, and submitted by the physician. The service is included in the DRG when provided in an inpatient facility and rehabilitation setting.

Speech evaluations and speech therapy submitted directly by an independently-practicing speech pathologist or audiologist are denied and considered on appeal.

36.4.8.2 Auditory Brainstem Implant (ABI)

ABI (procedure code 2-S2235) is an adaptation of cochlear implant. It is a benefit of the Texas Medicaid Program for clients 12 years of age and older with a diagnosis of neurofibromatosis II.

The payment for auditory brain implant is limited to diagnosis code 23772.

36.4.8.3 Authorization Requirements

Additional therapy related to the cochlear implants may be authorized for clients 2 through 20 years of age under THSteps-CCP.

Replacement of rechargeable AA batteries must be prior-authorized.

36.4.8.4 Sound Processor Replacement Guidelines

Unless ordered by the physician, minimal usage of the processor for 12 months is required before replacement of the unit is considered. Documentation by the physician must explain the need for sound processor replacement. Replacement of a sound processor requires prior authorization with adjustment to reimbursement based on manufacturer trade in policy.

36.4.8.5 Equipment and Non-Rechargeable Batteries

Equipment and non-rechargeable batteries should be submitted using the following procedure codes:

Procedure Codes		
9/J-L8614	9-L8615	9-L8616
9-L8617	9-L8618	9-L8619
9-L8621	9-L8622	

36.4.9 Diagnostic Tests

36.4.9.1 Ambulatory Blood Pressure Monitoring

Ambulatory blood pressure monitoring is a covered benefit for patients when hypertension is suspected but not defined by history or physical. Ambulatory blood pressure monitoring has been shown to be effective when used in the differential diagnosis of hypertension not elucidated by conventional studies.

The monitoring unit is 24 hours. Benefits are limited to the following medical necessities:

- Blood pressure measurements taken in the clinic or office are greater than 140/90 mm Hg on at least three separate visits, with two separate measurements made at each visit.
- At least two separately documented blood pressure measurements taken outside of the clinic or office that are less than 140/90 mm Hg.
- There is no evidence of end-organ damage.

Indications for the use of this monitoring are for diagnostic purposes only and should not be used for maintenance monitoring.

Use procedure codes 5-93784, 5-93786, 5-93788, and/or 5-93790 to bill for ambulatory blood pressure monitoring. Ambulatory blood pressure monitoring is a benefit when submitted with diagnosis code 7962.

36.4.9.2 Ambulatory Electroencephalogram (A/EEG)

A/EEG monitoring or 24-hour ambulatory monitoring is a covered benefit for patients in whom a seizure diathesis is suspected but not defined by history, physical, and resting EEG where A/EEG has been shown to be effective when used in the differential diagnosis of syncope and transient cerebral ischemic attacks not elucidated by the conventional studies.

The monitoring unit is 24 hours. Benefits are limited to three units (each unit 24 hours) for each physician for the same client per six months when medically necessary.

Use the following procedure codes to bill A/EEG: 5/I/T-95950, 5/I/T-95951, 5/I/T-95953, and 5/I/T-95956.

Procedure codes 5/I/T-95950, 5/I/T-95951, 5/I/T-95953, and 5/I/T-95956 are related. When multiple procedure codes are billed on the same day, the most inclusive code is paid and all other codes are denied.

Procedure codes 5/I/T-95950, 5/I/T-95951, 5/I/T-95953, and 5/I/T-95956 are payable when billed with the following diagnosis codes:

Diagnosis Codes				
2930	2948	33111	33119	3315
33182	3332	34500	34501	34510
34511	3452	3453	34540	34541
34550	34551	34560	34561	34570
34571	34580	34581	34590	34591
64940	64941	64942	64943	64944
7790	7797	78032	78039	78097
85011	85012			

Other diagnosis codes may be considered on appeal with supporting medical documentation to the TMHP Medical Director.

36.4.9.3 Bone Marrow Aspiration, Biopsy

Procedure code 2-20220 is for bone biopsy and is inappropriate for billing of bone marrow aspiration or bone marrow biopsy.

Physicians may bill procedure code I-85097 if interpretation is for smear interpretation, or 5/I/T-88305 if interpretation is for preparation and interpretation of cell block. If both 5-85097 and 5-88305 are billed, 5-88305 is paid and 5-85097 is denied.

Physicians may bill procedure code 5-85097 or 5-88305 for preparation and interpretation of the specimen.

36.4.9.4 Computed Tomography (CT) Scan

Freestanding facilities may bill for CT scans using TOS T for the technical component only. The radiologist or neurologist who reads the scan may bill using the TOS I for interpretation only. Additionally, when the client is in the inpatient or outpatient setting, the radiologist or neurologist may bill using the TOS I for interpretation.

Scout views and reconstruction are considered part of any CT scan procedure and are not reimbursed in addition to any other CT scan.

Refer to: "Radiological and Physiological Laboratory and Portable X-Ray Supplier" on page 39-1 for additional information.

36.4.9.5 Cytopathology Studies—Gynecological, Pap Smears

Pap smears are a benefit of the Texas Medicaid Program for early detection of cancer. Family planning clients are eligible for annual Pap smears.

Procurement and handling of the Pap smear are considered part of the E/M of the client and are not reimbursed separately.

The following procedure codes are reimbursed only to pathologists and CLIA-certified laboratories (whose directors providing technical supervision of cytopathology services are pathologists):

Procedure Codes		
I-88141	5-88142	5-88143
5-88147	5-88148	5-88150
5-88152	5-88153	5-88154
5-88155	5-88164	5-88165
5-88166	5-88167	5-88174
5-88175		

These procedure codes are payable in the POS where the Pap smear is interpreted: POS 1 (office), POS 3 (inpatient), POS 5 (outpatient), or POS 6 (independent laboratory).

The interpretation portion of any gynecological cytopathology test must be reported using procedure code I-88141. It is inappropriate to use the following procedure codes to bill for the interpretation:

Procedure Codes		
I-88142	I-88143	I-88147
I-88148	I-88150	I-88152
I-88153	I-88154	I-88155
I-88164	I-88165	I-88166
I-88167	I-88174	I-88175

Procedure code I-88141 remains a benefit. Its reimbursement is restricted to laboratories and pathologists. It is reimbursed in addition to the technical component. The following procedure codes are payable for TOS 5 only:

Procedure Codes		
5-88142	5-88143	5-88147
5-88148	5-88150	5-88152
5-88153	5-88154	5-88164
5-88165	5-88166	5-88167
5-88174	5-88175	

Procedure code 5-88155 is a benefit but is not reimbursed when billed in addition to the following cytopathology procedure codes:

Procedure Codes		
5-88142	5-88143	5-88147
5-88148	5-88150	5-88152
5-88153	5-88154	5-88164
5-88165	5-88166	5-88167
5-88174	5-88175	

Procedure code 5-88144 is not a benefit because the procedure it describes has not been FDA-approved.

The Pap smears procedure codes (in the table below), are not reimbursed separately to either the physician or a laboratory when submitted with the same date of service as a THSteps medical check up visit (procedure codes S-99381, S-99382, S-99383, S-99384, S-99385, S-99391, S-99392, S-99393, S-99394, and S-99395).

Procedure Codes				
I-88141	5-88142	5-88143	5-88147	5-88148
5-88150	5-88151	5-88152	5-88153	5-88154
5-88155	5-88164	5-88165	5-88166	5-88167
5-88174	5-88175			

Refer to: "Cervical Cancer Screening" on page 43-31 for more information about THSteps and laboratory procedure benefits.

36.4.9.6 Cytopathology Studies—Other Than Gynecological

Procurement and handling of the specimen for cytopathology of sites other than vaginal, cervical, or uterine is considered part of the client's E/M and will not be reimbursed separately.

Procedure codes 5/I/T-88160, 5/I/T-88161, and 5/I/T-88162 are reimbursed only to pathologists and CLIA-certified laboratories (whose directors providing technical supervision of cytopathology services are pathologists). These procedure codes are reimbursed according to the POS where the cytopathology smear is interpreted.

The following procedures are payable in the office (POS 1), outpatient setting (POS 5), or independent laboratory (POS 6): 5-88160, 5-88161, and 5-88162.

The following procedures are payable to a pathologist in the outpatient (POS 5) and inpatient (POS 3) hospital: I-88160, I-88161, and I-88162.

- Procedure codes 5/I-88160 and/or 5/I-88161 are denied as part of 5/I-88162.
- Procedure code 5/I-88160 is denied as part of procedure code 5/I-88161.

36.4.9.7 Echoencephalography

Echoencephalography (4/I/T-76506) is medically indicated for the following conditions or diagnosis codes:

Diagnosis Codes				
0065	01300	01301	01302	01303
01304	01305	01306	01310	01311
01312	01313	01314	01315	01316
01320	01321	01322	01323	01324
01325	01326	01330	01331	01332
01333	01334	01335	01336	01340
01341	01342	01343	01344	01345
01346	01350	01351	01352	01353
01354	01355	01356	01360	01361
01362	01363	01364	01365	01366
01380	01381	01382	01383	01384
01385	01386	1700	1901	1910
1911	1912	1913	1914	1915
1916	1917	1918	1919	1920
1921	1943	1983	1984	1985
19889	2130	2241	2250	2251
2252	2270	2340	2348	2375
2376	2379	2380	2388	2392
2396	2397	2398	29010	3240
3249	325	3310	33111	33119
3312	3313	3314	3317	33181
33182	33189	3319	3480	3482
34830	34831	34839	3484	3485
37700	37701	37702	37703	37704
37710	37711	37712	37713	37714
37715	37716	37721	37722	37723
37724	37730	37731	37732	37733
37734	37739	37741	37742	37749
37751	37752	37753	37754	37761
37762	37763	37771	37772	37773
37775	430	431	4320	4321
4329	43400	43401	43410	43411

Diagnosis Codes				
43490	43491	436	4371	4373
67400	67401	67402	67403	67404
74100	74101	74102	74103	7420
7421	7422	7423	7424	74781
76500	76501	76502	76503	76504
76505	76506	76507	76510	76511
76512	76513	76514	76515	76516
76517	7670	76711	76719	7678
7712	77210	77211	77212	77213
77214	7722	7790	7797	78031
78039	7842	8500	85011	85012
8502	8503	8504	8505	8509
85100	85101	85102	85103	85104
85105	85106	85109	85110	85111
85112	85113	85114	85115	85116
85119	85120	85121	85122	85123
85124	85125	85126	85129	85130
85131	85132	85133	85134	85135
85136	85139	85140	85141	85142
85143	85144	85145	85146	85149
85150	85151	85152	85153	85154
85155	85156	85159	85160	85161
85162	85163	85164	85165	85166
85169	85170	85171	85172	85173
85174	85175	85176	85179	85180
85181	85182	85183	85184	85185
85186	85189	85190	85191	85192
85193	85194	85195	85196	85199
85200	85201	85202	85203	85204
85205	85206	85209	85210	85211
85212	85213	85214	85215	85216
85219	85220	85221	85222	85223
85224	85225	85226	85229	85230
85231	85232	85233	85234	85235
85236	85239	85240	85241	85242
85243	85244	85245	85246	85249
85250	85251	85252	85253	85254
85255	85256	85259	85300	85301
85302	85303	85304	85305	85306
85309	85310	85311	85312	85313
85314	85315	85316	85319	85400
85401	85402	85403	85404	85405
85406	85409	85410	85411	85412

Diagnosis Codes				
85413	85414	85415	85416	85419
95901				

36.4.9.8 Electrocardiogram (EKG)

An EKG is a recording of the heart's electrical activity. The EKG provides important information about the spread of excitation to the different chambers of the heart and helps diagnose cases of abnormal cardiac rhythm and myocardial damage.

EKG procedure codes 5-93000, T-93005, I-93010, 5-93040, T-93041, and I-93042 are payable for the following diagnosis codes:

Diagnosis Codes				
03282	0362	03640	03641	03642
03643	07420	07421	07422	07423
0860	08881	0930	0931	09320
09321	09322	09323	09324	09381
09382	09389	09883	09884	09885
11281	11503	11504	11513	11514
11593	11594	124	1303	135
1640	1641	1642	1643	1648
1649	19889	2127	25000	25001
25002	25003	25010	25011	25012
25013	25020	25021	25022	25023
25030	25031	25032	25033	25040
25041	25042	25043	25050	25051
25052	25053	25060	25061	25062
25063	25070	25071	25072	25073
25080	25081	25082	25083	25090
25091	25092	25093	2512	2720
2721	2722	2723	2724	2725
2726	2727	2728	2750	2752
2753	27541	27542	2760	2761
2762	2763	2764	27650	27651
27652	2766	2767	2768	27730
27739	3062	3373	390	3910
3911	3912	3918	3919	3920
3929	393	3940	3941	3942
3949	3950	3951	3952	3959
3960	3961	3962	3963	3968
3969	3970	3971	3979	3980
39890	39891	39899	4010	4011
4019	40200	40201	40210	40211
40290	40291	40300	40301	40310
40311	40390	40391	40400	40401
40402	40403	40410	40411	40412

Diagnosis Codes				
40413	40490	40491	40492	40493
40501	40509	40511	40519	41000
41001	41002	41010	41011	41012
41020	41021	41022	41030	41031
41032	41040	41041	41042	41050
41051	41052	41060	41061	41062
41070	41071	41072	41080	41081
41082	41090	41091	41092	4110
4111	41181	41189	412	4130
4131	4139	41400	41401	41402
41403	41404	41405	41406	41407
41410	41411	41412	41419	4142
4148	4149	4150	41511	41512
41519	4160	4161	4168	4169
4170	4171	4178	4179	4200
42090	42091	42099	4210	4211
4219	4220	42290	42291	42292
42293	42299	4230	4231	4232
4233	4238	4239	4240	4241
4242	4243	42490	42491	42499
4250	4251	4252	4253	4254
4255	4257	4258	4259	4260
42610	42611	42612	42613	4262
4263	4264	42650	42651	42652
42653	42654	4266	4267	42681
42682	42689	4269	4270	4271
4272	42731	42732	42741	42742
4275	42760	42761	42769	42781
42789	4279	4280	4281	42820
42821	42822	42823	42830	42831
42832	42833	42840	42841	42842
42843	4289	4290	4291	4292
4293	4294	4295	4296	42971
42979	42981	42982	42983	42989
4299	43300	43301	43310	43311
43390	43391	43400	43401	43410
43411	43490	43491	4359	4372
44100	44101	44103	4411	4412
4416	4417	4439	4440	4441
44421	44422	4460	4467	4580
45821	4589	4590	496	514
5173	5184	5185	51882	51884
51919	53081	57410	64201	64202
64203	64204	64251	64252	64253

Diagnosis Codes				
64254	64850	64851	64852	64853
64854	65420	65421	65423	66810
66811	66812	66813	66814	66971
67450	67451	67452	67453	67454
7100	7142	71941	7200	7231
7295	7336	7450	74510	74511
74512	74519	7452	7453	7454
7455	74560	74561	74569	7457
7458	7459	74600	74601	74602
74609	7461	7462	7463	7464
7465	7466	7467	74681	74682
74683	74684	74685	74686	74687
74689	7469	7470	74710	74711
74720	74721	74722	74729	7473
74740	74741	74742	74749	7580
7593	75982	78001	78002	78003
78009	7802	7804	78079	7808
7815	7823	7825	7850	7851
7852	7853	78550	78551	78552
78559	78600	78602	78605	78609
78650	78651	78652	78659	78701
78702	78703	7871	78900	78907
78960	79001	79009	7904	7905
7906	7932	79430	79431	79439
7991	8072	8073	8074	8600
8601	8602	8603	8604	8605
86100	86101	86102	86103	86110
86111	86112	86113	8628	8629
90000	90001	90002	90003	9001
9010	9011	9012	9013	90140
90141	90142	90181	90182	90183
9221	9584	9607	9631	96509
9720	9721	9722	9723	9724
9725	9726	9727	9728	9729
9779	986	9893	9894	9895
9920	9921	9940	9941	9947
9948	9950	99522	99523	99527
99600	99601	99602	99603	99604
99609	99661	99671	99672	99683
9971	9980	99931	99939	9994
V151	V252	V421	V422	V426
V4321	V433	V4500	V4501	V4502
V4509	V4581	V4582	V472	V4983

Diagnosis Codes				
V5331	V5332	V5339	V5844	V5869
V717	V7281	V7284		

EKG interpretations are payable. The EKG codes for which interpretation components are paid are I-93010 and I-93042.

36.4.9.9 Esophageal pH Probe Monitoring

Esophageal pH monitoring uses an indwelling pH microelectrode positioned just above the esophageal sphincter. The pH electrode and skin reference electrode are connected to a battery-powered pH meter and transmitter worn as a shoulder harness. The esophageal pH is monitored continuously and a strip chart is used to record the pH determinations. The patient is usually monitored for a 24-hour period. Esophageal pH monitoring is a medically appropriate adjunct procedure to help establish the presence or absence of gastroesophageal reflux.

The following diagnosis codes are payable for esophageal pH probe monitoring or gastroesophageal reflux study to evaluate esophageal reflux:

Diagnosis Codes				
5070	53010	53011	53012	53020
53021	53019	53081	53085	53086
53087	7700	77010	77087	77088
7833	78603	78605	78606	78607
78609				

Esophageal pH probe monitoring should be coded with the following procedure codes: 2/F-91034, 2/F-91035, and 4/I/T-78262.

36.4.9.10 Electromyography (EMG)

EMG is reimbursed by the Texas Medicaid Program using the following procedure codes:

Procedure Codes		
5/I/T-95860	5/I/T-95861	5/I/T-95863
5/I/T-95864	5/I/T-95867	5/I/T-95868
5/I/T-95869	5/I/T-95872	5/I/T-95875

Separate charges for more than one extremity EMG is combined and coded as the appropriate multiple extremity EMG code. A maximum of four EMGs may be paid on the same day to the same provider. More than four EMGs are denied with explanation of benefit (EOB) 00103, "Services exceed allowed benefit limitations."

EMG used for the treatment of pathological muscle abnormalities or other disorders of the musculoskeletal system are considered a PT procedure and are paid according to the PT guidelines.

36.4.9.11 Helicobacter Pylori (H. Pylori)

Testing for H. pylori using serology, stool, or breath is a benefit of the Texas Medicaid Program with the following clinical lab services (TOS 5) procedure codes: 5-83009, 5-83013, 5-83014, 5-86677, and 5-87338.

The interpretation/professional component (TOS I) is not considered separately for reimbursement.

H. pylori is accepted as an etiologic factor in duodenal ulcers, peptic ulcer disease, gastric carcinoma, and primary B cell gastric lymphoma. H. pylori testing can be indicated for symptomatic clients with a documented history of chronic/recurrent duodenal ulcer, gastric ulcer, or chronic gastritis. The history must delineate the failed conservative treatment for the condition.

H. pylori testing is not indicated or covered for any of the following:

- New onset uncomplicated dyspepsia.
- Dyspepsia responsive to conservative treatment (e.g., withdrawal of non-steroidal anti-inflammatory drugs [NSAID] and/or use of antisecretory agents).
- Screening for H. pylori in asymptomatic clients.
- Dyspeptic clients requiring endoscopy and biopsy.

H. pylori testing is not indicated under the following circumstances:

- There has been a negative endoscopy in the previous six weeks.
- An endoscopy is planned.
- H. pylori is of new onset and still being treated.

Serology testing is not indicated or covered for monitoring response to therapy. Serology testing is a benefit once per year when submitted for the same client by any provider with the appropriate diagnosis code.

If a follow-up breath or stool test is used to document eradication of H. pylori, medical record documentation must verify the history of the following previous complication(s):

- The client remains symptomatic after a treatment regimen for H. pylori.
- The client is asymptomatic after H. pylori eradication therapy but has a history of hemorrhage, perforation, or outlet obstruction from peptic ulcer disease.
- The client has a history of ulcer on chronic NSAID or anticoagulant therapy.

The following procedure codes will not be payable on the same date of service by the same provider: 5-86677, 5-83009, 5-87338, and either 5-83013 or 5-83014. Procedure codes 5-83013 and 5-83014 may be considered for reimbursement on the same day.

Reimbursement for the H. pylori serology, breath, and stool test is restricted to the following diagnosis codes:

Diagnosis Codes				
1510	1511	1512	1513	1514
1515	1516	1518	1519	53100
53101	53110	53111	53120	53121
53130	53131	53140	53141	53150
53151	53160	53161	53170	53171
53190	53191	53200	53201	53210
53211	53220	53221	53230	53231
53240	53241	53250	53251	53260
53261	53270	53271	53290	53291
53300	53301	53310	53311	53320
53321	53330	53331	53340	53341
53350	53351	53360	53361	53370
53371	53390	53391	53400	53401
53410	53411	53420	53421	53430
53431	53440	53441	53450	53451
53460	53461	53470	53471	53490
53491	53500	53501	53510	53511
53520	53521	53530	53531	53540
53541	53550	53551	53560	53561
5368				

Procedure codes 5-83013, 5-83014, and 5-87338 are also payable with diagnosis code 04186.

36.4.9.12 Screening and Diagnostic Studies of the Breast

The following breast imaging studies are benefits of the Texas Medicaid Program:

- *Screening mammogram*. Used to look for breast disease in women who are asymptomatic. (Note: The American Cancer Society recommends annual screening mammography for woman beginning at 40 years of age.)
- *Diagnostic mammogram.* Used to diagnose breast disease in those women or men who have breast symptoms or findings on physical exam.
- *Digital Mammography*. used to assist diagnosis and further localization of lesions and areas of suspicion when performing screening and diagnostic mammography.
- *Diagnostic breast ultrasound*. Used to evaluate breast abnormalities that are found with screening or diagnostic mammography.

Mammography: Screening, Diagnostic, and Digital

Mammography is an essential appropriate diagnostic radiology technique for breast cancer detection.

To maximize the diagnosis of breast cancer at the earliest time, the diagnostic radiology procedure of mammography must be used on a reasonable basis in a timely manner. Physical examination supplemented by patient self-examination remains the principle diagnostic modality for women with an examination every year.

After 35 years of age, the physical examination should be augmented by the diagnostic radiology procedure of mammography on the following nationally recognized schedule, even if no symptoms are present:

Age Category*	Description
Women 35 to 39	Baseline mammogram in conjunction with a professional breast examination
Women 40 and older	Mammogram every year in conjunction with a professional breast examination

***This schedule is recommended; however, claims received for this service are not monitored for frequency of testing.**

Mammography is payable with an appropriate diagnosis.

The use of mammography as an augmentation to the physical examination on the schedule above is limited to females.

Procedure code 4/I/T-77057 may be used for a screening mammogram, and procedure codes 4/I/T-77055 or 4/I/T-77056 may be used for a diagnostic mammogram.

Other breast diagnostic radiology procedures may be medically necessary based on existing signs and symptoms. When indicated, such procedures may be considered for reimbursement. However, the mammography codes 4/I/T-77055, 4/I/T-77056, and 4/I/T-77057 are denied when submitted with the same date of service as diagnostic radiological procedure codes 4/I/T-76098, 4/I/T-77031, 4/I/T-77032, 4/I/T-77053, and 4/I/T-77054.

Digital mammography may be considered for reimbursement in addition to screening and diagnostic mammography when submitted with procedure codes 4/I/T-77051 and 4/I/T-77052.

Ultrasound may be considered for reimbursement using procedure code 4/I/T-76645.

A mammogram may be indicated in a male client, based on medical necessity because of existing signs and symptoms. In such circumstances, the procedure codes 4/I/T-77055 and 4/I/T-77056 are considered for reimbursement.

A mammogram may be medically necessary based on existing signs and symptoms, and may be performed without regard to the above schedule when medically indicated.

36.4.9.13 Breast Cancer (BRCA)

BRCA Testing

Gene mutation analyses (procedure codes 5-S3820, 5-S3822, and 5-S3823) are benefits of the Texas Medicaid Program.

Breast cancer 1 (BRCA1) and breast cancer 2 (BRCA2) are responsible for keeping breast cells from growing too rapidly or in an uncontrolled way. Mutations within the gene interrupt this regulatory function and increase the risk of breast cancer.

Note: *Guidelines for BRCA mutation testing are based on guidelines established by the U.S. Preventative Services Task Force.*

Prior authorization is required for gene mutation analysis. For non-Ashkenazi Jewish women, there must be documentation of one or more of the following:

- Two first-degree relatives with breast cancer, one of whom was diagnosed at age 50 or younger.
- A combination of three or more first- or second-degree relatives with breast cancer, regardless of age of diagnosis.
- A combination of both breast and ovarian cancer among first-and second-degree relatives with ovarian cancer.
- A first-degree relative with bilateral breast cancer.
- A combination of two or more first- or second degree relatives with ovarian cancer, regardless of age of diagnosis.
- A first-or second-degree relative with both breast and ovarian cancer, at any age.
- A history of breast cancer in a male relative.

For women of Ashkenazi Jewish heritage, there must be documentation of an increased risk due to family history. An increased risk includes any first-degree relative (or second-degree relatives on the same side of the family) with breast or ovarian cancer.

A written authorization request, signed and dated by the referring provider must be submitted. All signatures must be current, unaltered, original and handwritten. Computerized or stamped signatures are not accepted. The original signature copy must be kept in the physician's medical record for the client.

To complete the prior authorization process, the provider must mail or fax the request to the TMHP Special Medical Prior Authorization Unit and include documentation of medical necessity.

To facilitate a determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including accurate medical necessity of the services requested.

Interpretation of gene mutation analysis results is not separately reimbursable. Interpretation is part of the physician E/M service.

The following procedure codes which describe the three basic steps for testing for a BRCA mutation are not considered for reimbursement when submitted with a breast cancer diagnosis code (1740, 1741, 1742, 1743, 1744, 1745, 1746, 1748, 1749, 1750, 1759, 1982, 19881, and 2330):

- B-hexasominidase (procedure code 5-83080).

- Isolation and separation of DNA (procedure codes 5-83890, 5-83891, 5-83892, 5-83893, 5-83894, 5-83896, and 5-83897).
- Molecular diagnostics (procedure codes 5-83898, 5-83900, 5-83901, 5-83902, 5-83907, 5-83908, 5-83909, and 5-83912).
- Mutation scanning or identification (procedure codes 5-83903, 5-83904, 5-83905, and 5-83906).

Claims filed using these procedure codes with a diagnosis of breast cancer may be reviewed on appeal.

BRCA1 and BRCA2 (procedure codes 5-S3820, 5-S3822, and 5-S3823) are limited to once per lifetime. Additional services may be considered on appeal.

Prognostic Breast and Gynecological Cancer Studies

Prognostic breast and gynecological cancer studies are benefits of the Texas Medicaid Program when ordered by a physician for the purpose of determining the best course of treatment for a patient with breast/gynecological cancers.

Prognostic breast and gynecological cancer studies are divided into two categories: Receptor assays and Her-2/neu.

- Receptor Assays (procedure codes 5-84233 and 5-84234) - The estrogen receptor assay (ERA) and the progesterone receptor assay (PRA) are tests in which a tissue sample is exposed to radioactively tagged estrogen or progesterone. The presence of these receptors can have prognostic significance in breast and edometrial cancer.
- Her-2/neu (procedure codes 5-83890, 5-88237, 5-88239, 5-88271, 5-88274, 5-88291, 5-88342, 5-88360, 5-88361 and 5-88365) - Human epidermal growth factor receptor 2 (Her-2/neu) is responsible for the production of a protein that signals cell growth. The over-expression of Her-2/neu in breast cancer is associated with decreased overall survival and response to some therapies. Each procedure used in the analysis should be coded separately.

Reimbursement for receptor assays (procedure codes 5-84233, 5-84234, 5-88360, and 5-88361) are limited to claims with a diagnosis of breast or uterine cancer as listed in the following table. Receptor testing for other diagnoses will be denied.

Diagnosis Codes				
1740	1741	1742	1743	1744
1745	1746	1748	1749	1750
1759	1820	1821	1828	1982
19881	2330			

Interpretation of receptor assays, and Her-2/neu results is not considered separately for reimbursement. Interpretation is part of the physician's E/M service.

Gene mutation analyses (procedure codes 5-S3820, 5-S3822, and 5-S3823) are not considered for reimbursement when submitted with the same date of service as the following procedure codes:

Procedure Codes		
5-83080	5-83890	5-83891
5-83892	5-83893	5-83894
5-83896	5-83897	5-83898
5-83900	5-83901	5-83902
5-83903	5-83904	5-83905
5-83906	5-83907	5-83908
5-83909	5-83912	

Claims filed using these procedure codes may be considered upon appeal.

The following procedure codes are limited to once per lifetime:

Procedure Codes		
5-83080	5-83890	5-83891
5-83892	5-83893	5-83894
5-83896	5-83897	5-83898
5-83900	5-83901	5-83902
5-83903	5-83904	5-83905
5-83906	5-83907	5-83908
5-83909	5-83912	

36.4.9.14 Myocardial Perfusion Imaging

Myocardial perfusion imaging, using radionuclides, is a noninvasive stress test that measures coronary blood flow (perfusion), especially to the left ventricle.

Myocardial perfusion imaging is a covered benefit of the Medicaid program when medically indicated. Myocardial perfusion imaging studies will be limited to one study per day. This service includes, but is not limited to, the following procedures: 4/I/T-78460, 4/I/T-78461, 4/I/T-78464, and 4/I/T-78465.

When multiple procedure codes are billed, the most inclusive code will be paid, and all other codes will be denied.

Myocardial perfusion imaging may be performed at rest and/or during stress using physical exercise or pharmacologicals. The following procedure codes may be used to bill for cardiovascular stress testing: 5-93015, T-93017, and I-93018.

36.4.9.15 Nerve Conduction Studies

Nerve conduction studies are indicated whenever a need exists to locate neurologic or muscular symptomatology more precisely in post-traumatic circumstances or general widespread conditions affecting the entire neuromuscular system.

Procedure codes 5-95900, 5-95903, 5-95904, 5-95934, and 5-95936 may be used to submit nerve conduction studies for consideration of reimbursement.

Procedure codes 5-95900, 5-95903, and/or 5-95904 are reimbursed in full for the first nerve study and half for each additional study, regardless of the number of studies. Procedure code 5-95934 and/or 5-95936 are reimbursed in full when performed with procedure codes 5-95900, 5-95903, and/or 5-95904 in addition to the reimbursement for the codes 5-95900, 5-95903, and 5-95904, as outlined previously. If 5-95934 and 5-95936 are billed in multiples, the first is reimbursed in full, and all additional studies are reimbursed at half the fee.

Nerve conduction studies repeated within a three-month period on the same client by the same provider are denied except for the following diagnosis codes:

Diagnosis Codes				
25060	25061	25062	25063	2650
2652	2692	2699	2771	27730
27739	27781	27782	27783	27784
27789	3525	3541	3552	3553
3558	3560	3564	3569	3572
3575	3576	3577	35781	35782
35789	35921	35922	35923	35929
7220	72210	72211	7222	7234
7292	7295			

36.4.9.16 Pediatric Pneumogram

A pneumogram is a 12-hour to 24-hour recording of breathing effort, heart rate, oxygen level, and airflow to the lungs during sleep. The study is useful in identifying abnormal breathing patterns, with or without bradycardia, especially in premature infants.

Use procedure code 5/I/T-94772 when billing for the pediatric pneumogram.

The following diagnosis codes are payable for a pediatric pneumogram in infants up through 11 months of age:

Diagnosis Codes				
5300	53010	53011	53012	53019
53081	7685	7686	7689	769
7707	77081	77082	77083	77084
77087	77088	77089	78603	78606
78607	78609			

EMGs, polysomnography, EEGs, and ECGs will be denied when billed on the same day as a pediatric pneumogram.

Pediatric pneumograms may be reimbursed on the same date of service as an apnea monitor (rented monthly) if documentation supports the medical necessity.

Pneumogram supplies are considered part of the technical component of the reimbursement and will be denied if billed separately.

A pediatric pneumogram will be limited to two services without prior authorization based on the diagnosis codes listed in the previous table. Additional studies may be considered under THSteps-CCP with documentation of medical necessity, and will require prior authorization.

36.4.10 Doppler Studies

A Doppler examination is a noninvasive procedure that detects blood flow velocity within an artery or vein. It is commonly used to detect stenosis or occlusion of an artery or vein.

Some of the specific studies done using the Doppler ultrasound are as follows:

- Cerebrovascular evaluation—usually includes a peripheral arterial flow study.
- Thrombosis evaluation—usually includes a peripheral venous vascular study.
- Plethysmography technique—Arterial and/or venous outflow studies, usually done as a pre-operative and post-operative evaluation.
- Evaluation of arteriovenous fistula or malformation.
- Evaluation of arteriovenous shunt.

Doppler studies include the patient care required to perform the studies, supervision and the interpretation of study results. Doppler studies are limited to specific diagnoses for specific procedure codes.

36.4.10.1 Noninvasive Diagnostic Studies

Doppler studies of the *extracranial arteries* (4/I/T-93875, 4/I/T-93880, and 4/I/T-93882) are limited to the following diagnosis codes:

Diagnosis Code				
36230	36231	36232	36233	36234
36284	36811	36812	3682	36840
36841	36842	36843	36844	36845
36846	36847	43310	43311	43320
43321	43330	43331	4352	4353
4358	4359	436	44100	44281
44321	44323	44329	44589	449
7802	7843	78552	7859	90000
90001	90002	90003	9961	

Doppler studies of the *intracranial arteries* (4/I/T-93886, 4/I/T-93888, 4/I/T-93890, 4/I/T-93892, and 4/I/T-93893) are limited to the following diagnosis codes:

Diagnosis Codes				
34830	34831	34839	3488	430
43400	43401	43410	43411	43490
4351	4352	4353	4358	4359
4370	4430	44381	4439	4471

Diagnosis Codes				
449	74781	74782	74783	74789
78552				

Doppler studies of the *extremity arteries* (4/I/T-93922, 4/I/T-93923, 4/I/T-93924, 4/I/T-93925, 4/I/T-93926, 4/I/T-93930, and 4/I/T-93931) are limited to the following diagnosis codes:

Diagnosis Codes				
4404	4439	4440	4441	44421
44422	44481	44489	4466	4467
4470	449	60782	60784	70710
70711	70712	70713	70714	70715
70719	7854	78552	90300	90301
9031	9032	9033	9034	9035
9038	9039	9040	9041	90440
90441	90450	90451	90453	92300
92301	92302	92303	92309	92310
92311	92320	92321	9233	9238
9239	92400	92401	92410	92411
92420	92421	9243	9244	9245
9248	9249	92700	92701	92702
92703	92709	92710	92711	92720
92721	9273	9278	9279	92800
92801	92810	92811	92820	92821
9283	9288	9289	9961	99690
99691	99692	99693	99694	99695
99696	99699			

Doppler studies of the *extremity veins* (4/I/T-93965, 4/I/T-93970, and 4/I/T-93971) are limited to the following diagnosis codes:

Diagnosis Codes				
4510	45111	45119	4512	45181
45182	45183	45184	45189	4519
4530	4531	4532	4533	45340
45341	45342	4538	4539	4548
45910	45911	45912	45913	45919
60784	70710	70711	70712	70713
70714	70715	70719	7823	78552
90300	90302	9033	9035	9038
9039	9042	9043	90440	90442
90450	90452	90454	9046	9047
9048	9049	92700	92701	92702
92703	92709	92710	92711	92720
92721	9273	9278	9279	92800
92801	92810	92811	92820	92821
9283	9288	9289	9961	99690

Diagnosis Codes				
99691	99692	99693	99694	99695
99696	99699	9972		

Procedure code 4/I/T-93325 is payable for the following diagnosis codes:

Diagnosis Codes				
3911	3940	3941	3942	3949
3950	3951	3952	3959	3960
3961	3962	3963	3968	3969
3970	3971	3979	39890	41406
41407	41411	4150	4160	4168
4178	4210	42291	4240	4241
4242	4243	42490	42491	42499
4251	4253	4254	4259	4280
7450	74510	74511	74512	7452
7453	7454	7455	74560	74561
74569	74600	74601	74602	74609
7461	7462	7463	7464	7465
7466	7467	74681	74682	74683
74685	7470	74710	74711	74722
7473	74741	74742	74749	7852
78552	9607	9961	99771	99772
99779	V433			

Procedure codes 4/I/T-93922 and 4/I/T-93923 are limited to diagnosis codes: 44501, 44502, and 78552.

Procedure codes 4/I/T-93924, 4/I/T-93925 and 4/I/T-93926 are limited to diagnosis codes 44502 and 78552.

Procedure codes 4/I/T-93930 and 4/I/T-93931 are limited to the following diagnosis codes: 44501 and 78552.

Multiple Doppler procedures (for example, studies of extra-cranial arteries and intracranial arteries) billed on the same day are reimbursed at full fee for the first, and half for each additional study irrespective of the number of services billed.

Procedure codes described as complete bilateral studies are inclusive codes. Right and left studies submitted with the same date of service will be considered for reimbursement as a quantity of one.

Procedure codes 4/I/T-93882, 4/I/T-93888, 4/I/T-93926, 4/I/T-93931, 4/I/T-93971, 4/I/T-93976, and 4/I/T-93979 are considered unilateral codes. Right and left studies are reimbursed at full and one-half fee.

Procedure codes 4/I/T-93320 and 4/I/T-93321 are reimbursable in addition to procedure codes 4/I/T-93307 and 4/I/T-93308.

Procedure code 4/I/T-93325 may be considered for reimbursement separately from transthoracic and transesophageal echocardiograph procedure codes 4/I/T-93312 and 4/I/T-93350, when billed on the same date of service, by the same provider.

Procedure code 4/I/T-93990 is considered part of the care of the dialysis patient and is not reimbursed separately.

36.4.11 Elective Sterilization Services

The Texas Medicaid Program benefits include payment for elective sterilization (performed solely for the purpose of rendering the individual incapable of bearing or fathering children) of eligible clients when providers comply with HHS regulations (42 *Code of Federal Regulations* [CFR] 441.250, Subpart F).

Refer to: Section 19.3.3 "Sterilization Consent Form and Instructions" on page 20-11 for further information.

Payment of elective sterilization is *not* made if the client meets any of the following criteria:

- Is younger than 21 years of age at the time the consent form is signed.
- Has been declared mentally incompetent for the purpose of sterilization (clients are presumed to be mentally competent unless adjudicated incompetent for the purpose of sterilization).
- Is institutionalized in a correctional facility, mental hospital, or other rehabilitative facility.
- Gave consent in labor or childbirth, under the influence of alcohol or other drugs, or while seeking or obtaining an abortion.

Note: *All Medicaid clients, electing sterilization services including those in a STAR or STAR+PLUS Program health plan, must sign a Sterilization Consent Form. The form must be submitted to the client's health plan.*

TMHP must have a signed, valid Sterilization Consent Form on file to reimburse an elective sterilization procedure. Typewritten, blocked, or facsimile stamped signatures are *not* acceptable for signature requirements. When a valid consent form is received by TMHP, the Medicaid client's eligibility file is updated to reflect receipt. Subsequent claims received by TMHP for the sterilization covered by the consent are referenced to the valid consent and reimbursed even if they are not accompanied by a valid consent. It is to the provider's benefit to submit a consent form with claims for sterilization rather than relying on a fellow provider. A legible, valid copy of the consent is acceptable.

Providers may copy onto their letterhead the Sterilization Consent Form. Providers may use their own consent form as long as the form has the HHS-approved language and required fields. Providers who want their own consent form must obtain approval from HHS.

A mechanism for processing Sterilization Consent Forms aimed at reducing the number of unnecessary denials for sterilization covered under family planning and billed to Medicaid is used by TMHP. Family planning providers may provide sterilization to their clients after a waiting period of 30 days, defined as 30 full 24-hour periods from the time in which formal consent was obtained from the client. The waiting period prevents the denial of sterilization claims for sterilization conducted on the 30th day, despite the fact that 30 full days (24-hour periods) passed from the time of written consent.

When a sterilization is performed at the time of a premature delivery, the time of the client's consent must be at least 72 hours before the actual delivery *and* 30 days before the expected date of delivery. (The consent form is valid for 180 days from the date of the client's signature.) If emergency abdominal surgery occurs, the time of the client's consent must be at least 72 hours before surgery.

These instructions must be followed when completing the HHS-approved consent form. All blanks should be completed unless otherwise specified.

- The client's nine-digit Medicaid number must be recorded in the blocks provided at the top of page 1.
- The first section of the consent form, *Consent to Sterilization*, must be completed in English or Spanish.
- The *Race and Ethnicity Designation* is optional.
- An interpreter must be provided if the consent form is not written in the language of the individual to be sterilized or the person obtaining consent does not speak the individual's language. If an interpreter is used, the *Interpreter's Statement* must be completed.
- The *Statement of the Person Obtaining Consent* must be completed by the person who explains the surgery and its implications, alternate methods of birth control, and the fact that the consent may be withdrawn at any time. The signature of the person obtaining consent must be completed at the time the consent is obtained. The signature must be an original signature, *not* a rubber stamp.
- The physician or the person obtaining consent must allow a witness of the client's choice (if desired) when the consent form is signed, and arrangements must be made for individuals with disabilities.
- The *Physician's Statement* must be completed. The physician must indicate that 30 days or 72 hours have passed between consent and surgery by crossing out paragraph number 1 or 2 as indicated on the consent form.
- The *Physician's Statement* must be signed and dated on or after the day of surgery in all circumstances. The signature must be an original signature, *not* a rubber stamp.
- When the sterilization is performed at the time of a premature delivery, the expected date of delivery must be recorded in the space provided on the consent form and must be 30 days from date of client's signature.

- When the sterilization is performed at the time of emergency abdominal surgery, the circumstances must be described in the space provided on the consent form. If the space is not sufficient, additional documentation may be attached to the consent form.
- The physician must review the consent form with the client shortly before surgery.
- The actual sterilization procedure performed must be identical to that for which the client gave informed, written consent. Each reference to the sterilization procedure on the consent form and the claim form (for example, salpingectomy cannot be interchanged with tubal ligation) must be identical.
- Sterilization Consent forms may be faxed to 1-512-514-4229. Follow the guidelines under "Faxing Forms" on page 36-50.

Refer to: "Sterilization Consent Form Instructions (2 Pages)" on page B-94.

"Sterilization Consent Form (English)" on page B-96.

36.4.12 Endoscopies

The following endoscopies are benefits of the Texas Medicaid Program:

- Bronchoscopy.
- Cystourethroscopy.
- Endoscopic retrograde cholangiopancreatography (ERCP).
- Lower gastrointestinal endoscopy (GED) (for example, colonoscopy).
- Upper GED (for example, esophagogastroduodenoscopy [EGD]).
- Sinus endoscopy.

Multiple diagnostic or operative endoscopies in the same or different body areas are often billed on the same day. If done by the same provider, they may be paid the full amount allowed for the major procedure and one-half the allowed amount for each additional procedure, following multiple surgical guidelines.

If the physician bills separate charges for multiple endoscopies that are considered part of a more inclusive procedure, HHSC or its designee reviews the individual charges and pays only the procedure with the more inclusive code.

Example: *Separate charges for an esophagoscopy, a gastroscopy, and a duodenoscopy are reviewed and paid as an EGD. A surgical endoscopy always includes the diagnostic endoscopy.*

36.4.13 Epidural/Subarachnoid Infusion for Chronic Spasticity

Epidural/subarachnoid infusion of baclofen (*Lioresal*) for chronic spasticity is a benefit of the Texas Medicaid Program. Prior authorization is required for procedure codes 2-62350, 2-62360, 2-62361, and 2-62362.

Refer to: "Texas Medicaid Prior Authorization Request Form: Intrathecal Baclofen or Morphine Pump Sections I and II (2 Pages)" on page B-102 for guidelines.

36.4.14 Extracorporeal Membrane Oxygenation (ECMO)

ECMO is payable only in POS 3 (inpatient hospital) and the client should be monitored in the neonatal or pediatric intensive care unit.

Procedure codes 2-36822, 2-33960, and 2-33961 may be used when requesting reimbursement for prolonged extracorporeal circulation for cardiopulmonary insufficiency.

Procedure code 2-33960 or 2-33961 is limited to one per day, any provider.

Reimbursement is considered for, but not limited to, the following clinical indications:

- Persistent pulmonary hypertension.
- Meconium aspiration syndrome.
- Respiratory distress syndrome.
- Adult respiratory distress syndrome.
- Congenital diaphragmatic hernia.
- Sepsis.
- Pneumonia.
- Pre- and post-operative congenital heart disease or heart transplantation.
- Reversible causes of cardiac failure.
- Cardiomyopathy.
- Myocarditis.
- Aspiration pneumonia.
- Pulmonary contusion.
- Pulmonary embolism.

Terminal disease with expectation of short survival, advanced multiple organ failure syndrome, irreversible central nervous system injury and severe immunosuppression are contra-indications to ECMO. Payment for ECMO services may be recouped if the services were provided in the presence of these conditions.

The initial 24 hours of ECMO should be submitted using procedure code 2-33960. Procedure code 2-33961 should be used for each additional 24 hours. Procedure code 2-33960 is denied as part of 2-33961 if submitted with the same date of service.

If insertion of cannula (procedure code 2-36822) for prolonged extracorporeal circulation for cardiopulmonary insufficiency is submitted with the same date of service as procedure code 2-33960 or 2-33961, by the same provider, the insertion of the cannula is denied, and the ECMO (procedure codes 2-33960 and 2-33961) is considered for reimbursement.

36.4.15 Gamma Knife Radiosurgery

The following diagnosis codes are payable for procedure code 2-61793. This procedure is payable to physicians for professional services only in the inpatient and outpatient settings.

Diagnosis Codes				
1700	1701	1702	1703	1704
1705	1706	1707	1708	1709
1710	1910	1911	1912	1913
1914	1915	1916	1917	1918
1919	1944	1983	2251	2252
2254	2273	2370	2371	2530
2531	2550	25511	25512	25513
25514	3501	7476	74781	

36.4.16 Genetic Services

Refer to: "Genetic Services" on page 22-1.

36.4.17 Gynecological and Reproductive Health Services

Gynecological examinations, contraceptives, surgical procedures, and treatments are benefits of the Texas Medicaid Program

The following gynecological procedures and services are benefits of the Texas Medicaid Program:

- Assays for the diagnosis of vaginitis.
- Diagnostic hysteroscopy.
- Elective abortion.
- Exam under anesthesia.
- Family planning annual examinations, other visits, and contraceptives.
- Hysterectomy.
- Hysteroscopic sterilization.
- Laminaria insertion.
- Surgery for masculinized female.

36.4.17.1 Assays for the Diagnosis of Vaginitis

Vaginitis assay procedure codes 5-87480, 5-87510, 5-87660, and 5-87800 are benefits of the Texas Medicaid Program.

If more than one of procedure codes 5-87480, 5-87510, 5-87660, or 5-87800 is submitted by the same provider for the same client with the same date of service, all of the procedure codes are denied. Only one procedure code (5-87480, 5-87510, 5-87660, or 5-87800) may be submitted for reimbursement, and providers must submit the most appropriate procedure code for the test provided:

- *Single organism test.* A single test must be submitted for reimbursement using the appropriate procedure code (5-87480, 5-87510, or 5-87660) that describes the organism being isolated.
- *Multiple organism test.* When testing for multiple vaginal pathogens, providers must submit procedure code 5-87800 for reimbursement. Procedure code 5-87800 is inclusive of procedure codes 5-87480, 5-87510, and 5-87660 and is the most appropriate code to request reimbursement for multiple tests.

If the claim is denied because more than one procedure code was submitted with the same date of service, the provider must appeal the denied claim with a statement indicating which procedure code is most appropriate and should be considered for reimbursement. Procedure codes 5-87800, 5-87480, 5-87510, and 5-87660 should not be submitted for reimbursement by the same provider with the same date of service for the same client on the same claim form or on separate claim forms.

Procedure code 5-87797 will be denied if it is submitted for the same date of service as procedure code 5-87800. Providers are reminded to code to the highest level of specificity with a diagnosis to support medical necessity when submitting procedure code 5-87797. Claims may be subject to retrospective review if they are submitted with diagnosis codes that do not support medical necessity.

If a positive test result was not treated, documentation must be present indicating why treatment was not rendered.

36.4.17.2 Diagnostic Hysteroscopy

Diagnostic hysteroscopy (procedure code 2-58555) is a benefit of the Texas Medicaid Program when submitted with one of the following diagnosis codes:

Diagnosis Codes				
2180	6210	62130	6215	6262
6264	6266	6268	6270	6271
7522	7523			

36.4.17.3 Elective Abortions

According to a revision of the Hyde Amendment, under P.L. 103–112, HHSC implemented the federal directive pertaining to Medicaid reimbursement for abortions. Federal funding is available to save the life of the mother and to terminate pregnancies resulting from rape or incest. Reimbursement is based on the physician's certification that the abortion was performed to save the

mother's life, to terminate a pregnancy resulting from rape, or to terminate a pregnancy resulting from incest. Prior authorization for abortions is no longer required.

In accordance with federal law, providers are required to use specific language regarding the reason the mother's condition is life-threatening. An abortion for a life-threatening condition *must* be due to a physical disorder, injury, or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would place the woman in danger of death unless an abortion was performed.

Reimbursement of an abortion is based on the physician's certification that the abortion was performed to save the life of the mother, to terminate pregnancy resulting from rape, or to terminate pregnancy resulting from incest.

One of the following statements signed by the physician is *mandatory* for any abortion performed. Substitute wording will not be accepted. One of these statements *must* accompany any claim for abortion to be considered for reimbursement:

- "I, (physician's name), certify that on the basis of my professional judgment, an abortion procedure is necessary because (client's full name, Medicaid number, and complete address) suffers from a physical disorder, injury, or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place her in danger of death unless an abortion is performed." (A signature is required.)
- "I, (physician's name), certify that on the basis of my professional judgment, an abortion procedure for (client's full name, Medicaid number, and complete address) is necessary to terminate a pregnancy that was the result of rape. I have counseled the client concerning the availability of health and social support services and the importance of reporting the rape to the appropriate law enforcement authorities." (A signature is required.)
- "I, (physician's name), certify that on the basis of my professional judgment, an abortion procedure for (client's full name Medicaid number, and complete address) is necessary to terminate a pregnancy that was the result of incest. I have counseled the client concerning the availability of health and social support services and the importance of reporting the incest to the appropriate law enforcement authorities." (A signature is required.)

A stamped or typed physician signature is not acceptable on the original certification statement. The physician's signature must be an original signature. A copy of the signed certification statement must be submitted with each claim for reimbursement. Faxes and electronic billing are not acceptable or available at this time. The physician must maintain the original certification statement in the client's files.

Abortion services must be billed with modifier W1 (endangerment of the mother's life), W2 (rape), or W3 (incest) to indicate the reason for the abortion.

Performing physicians, facilities, anesthesiologists, and CRNAs must submit modifier G7 with the appropriate procedure code when requesting reimbursement for abortion procedures that are within the scope of the rules and regulations of the Texas Medicaid Program. Modifier G7 must be entered next to the procedure code that identifies the abortion services.

Refer to: "Abortion Certification Statements Form" on page B-3 for a sample form.

"Family Planning Services" on page 20-1.

Drugs or devices to prevent implantation of the fertilized ovum and medical procedures necessary for the termination of an ectopic pregnancy are benefits of the Texas Medicaid Program.

Important: *To bill a Texas Medicaid client for a service that TMHP denies as not medically necessary, the billing provider must ensure that the client or client's guardian has signed an acknowledgment statement obtained by the physician who has contact with the client.*

36.4.17.4 Examination Under Anesthesia

Pelvic examination under anesthesia (procedure code 2-57410) is considered part of another gynecological surgery performed the same day.

If the examination was done as an independent procedure or at the time of a non-gynecological surgery, the procedure is considered for reimbursement.

36.4.17.5 Family Planning

Physicians, PAs, NPs, and CNSs are encouraged to provide family planning services to Texas Medicaid Program clients, especially pregnant and postpartum clients. No separate enrollment is required. Providers are reimbursed for family planning services through the Texas Medicaid Program and not through the Family Planning Program.

Family planning services are preventive health, medical, counseling, and educational services that help an individual to control fertility and achieve optimal reproductive and general health. When billing for these services, use modifier FP.

The federal contribution to Texas is enhanced by the use of modifier FP, which increases the total amount of funds available for reimbursement. Providers must give their reference laboratory a family planning diagnosis code for all eligible family planning laboratory work. Family planning drugs and supplies may be provided through providers' offices and billed to the program, or they may be provided by prescription through the Vendor Drug Program (VDP). These drugs and supplies are exempt from the three prescriptions-per-month rule.

For supplies unavailable through the VDP, clients may be able to obtain supplies through a family planning agency. Medicaid clients whose eligibility is limited may receive family planning services without referrals.

Reminder: *Physicians are encouraged to issue family planning prescriptions for periods of at least 6 months if it is medically appropriate to do so. If a physician orders a 6-month supply, pharmacies that participate in the VDP must fill the prescription for the 6-month period, not one month at a time.*

Refer to: "Family Planning Services" on page 20-1 for additional information about family planning services.

"Client Limited Program" on page 4-5.

Family Planning Annual Examinations

The family planning annual examination (procedure codes 1-99204 or 1-99214) consists of all of the following:

- A comprehensive health history and physical examination, including medical laboratory evaluations (as indicated).
- An assessment of the client's problems.
- Contraceptive counseling and management.

One family planning annual exam is allowed per fiscal year per client per provider.

When seeking reimbursement for a family planning annual examination, providers must include all of the following information on the claim:

- The FP modifier.
- Family planning diagnosis code V2509.
- Appropriate E/M procedure code—1-99204 for new clients or 1-99214 for established clients.

A new patient is defined as one who has not received any professional services from a physician or physician within the same group practice, of the same specialty within the past three years. An established patient is one who has received professional services from a physician or physician within the same group practice within the last three years.

Other Family Planning Office or Outpatient Visits

Providers may use procedure codes 1-99201, 1-99202, 1-99203, 1-99205, 1-99211, 1-99212, 1-99213, or 1-99215 (based on the complexity of the visit) with modifier FP and a family planning diagnosis code for other family planning services when billing the Texas Medicaid Program for patient services provided in the office or in an outpatient or other ambulatory facility.

Procedure codes 1-99201, 1-99202, 1-99203, 1-99205, 1-99211, 1-99212, 1-99213, and 1-99215 are allowed for routine contraceptive surveillance, family planning counseling and education, contraceptive problems, suspicion of pregnancy, genitourinary infections, and evaluation of other reproductive system symptoms.

During any visit for a medical problem or during a follow-up visit the following must occur:

- The client's relevant history must be updated.
- A physical exam, if indicated.
- Laboratory tests, if indicated.
- Treatment and/or referral, if indicated.
- Education/counseling or referral, if indicated.
- The scheduling of an office or clinic visit, if indicated.

Any other E/M office visit will not be considered for reimbursement when billed with the same date of service and by the same provider as the family planning annual exam or any other family planning office visit.

Providers may resubmit denied claims on appeal using modifier 25 to indicate the additional visit was for a procedure that is separate and distinct from the family planning visit. Documentation that supports the provision of a significant and separately identifiable E/M service must be maintained in the client's medical record and made available to the Texas Medicaid Program upon request.

Refer to: "Family Planning Services" on page 20-1 for additional information about family planning services.

Contraceptives

Implantable Contraceptive Capsules

Procedure code 1-S0180 may be reimbursed in addition to procedure code 2/F-11975 or 2/F-11977.

Progesterone-containing subdermal contraceptive capsules (*Norplant*) were previously used for birth control. Although subdermal contraceptive capsules are no longer approved by the FDA, the removal of the implanted contraceptive capsule (diagnosis code V2543) may be considered for reimbursement with procedure code 2/F-11976.

Refer to: "Implantable Contraceptive Capsules" on page 25-39 for more information.

Intrauterine Device (IUD) Insertion

Providers must use procedure codes 1-J7300, 1-J7302, and 2-58300 when submitting claims for the insertion of an IUD.

Procedure code 2-58300 may be considered for reimbursement separately from procedure code 1-J7302.

An IUD insertion or procurement of the IUD may be considered for reimbursement when billed with the same date of service as procedure code 2-58120. Procedure code 2-58210 is reimbursed at full allowance. Procedure codes 1-J7300 and 1-J7302 are considered for reimbursement at full allowance.

When a vaginal, cervical, or uterine surgery (e.g., cervical cauterization) is billed with the same date of service as the insertion of the IUD, the surgical procedure is paid at full allowance and the IUD insertion that was billed using procedure code 2-58300 is paid at half of the allowed amount.

Procedure code 1-J7302 may be considered for reimbursement for females 10 through 55 years of age when submitted for reimbursement with one of the following diagnosis codes:

Diagnosis Codes				
V2502	V2503	V2509	V251	V2540
V2542	V2549	V258	V259	V615

Procedure code 2/F-58300 must be billed with procedure code 1-J7300 or 1-J7302 for both the insertion and the removal of the device to be considered for reimbursement.

Procedure code 2/F-58300 may be considered for reimbursement when billed with the same date of service as an office visit.

IUD Removal

Procedure code 2/F-58301 may be considered for reimbursement when an IUD is extracted from the uterine cavity.

Procedure code 2/F-58301 will not be considered for reimbursement when submitted with the same date of service as an office visit.

When a vaginal, cervical, or uterine surgery procedure code is submitted with the same date of service as the removal of the IUD or the replacement of the IUD procedure code, the surgical procedure is paid at full allowance and the removal or the replacement of the IUD is denied.

36.4.17.6 Faxing Forms

All Medicaid providers may fax Sterilization Consent Forms to 1-512-514-4229 and Hysterectomy Acknowledgment Forms to 1-512-514-4218. Include the client's Medicaid number on the form. All consent forms should be faxed with a cover sheet that identifies the provider and includes the telephone number and address. If the fax is incomplete or the consent form is invalid, the form is returned by mail or fax for correction.

Completed consent forms that are faxed for adjustments or appeals are validated in the TMHP system. However, claims associated with the consent forms must be appealed through the mail to Appeals/Adjustments at the following address:

Texas Medicaid & Healthcare Partnership
Attn: Appeals/Adjustments
PO Box 2006200645
Austin, TX 78720-0645

36.4.17.7 Hysterectomy Services

Providers can use any of the following procedure codes to submit claims for hysterectomy procedures:

Procedure Codes		
2/8-51925	2/8-58150	2/8-58152
2/8-58180	2/8-58200	2/8-58210
2/8-58240	2/8-58260	2/8-58262
2/8-58263	2/8-58267	2/8-58270
2/8-58275	2/8-58280	2/8-58285
2/8-58290	2/8-58291	2/8-58292
2/8-58293	2/8-58294	2/8-58541
2/8-58542	2/8-58543	2/8-58544
2/8/F-58548	2/8/F-58550	2/8/F-58552
2/8/F-58553	2/8/F-58554	2/8/F-59135
2/8/F-59525		

Assistant surgeons may be reimbursed when assisting a surgeon performing a surgical laparoscopy with vaginal hysterectomy (procedure code 8-58541, 8-58542, 8-58543, 8-58544, 8-58548, 8-58550, 8-58552, 8-58553, or 8-58554).

Note: *All Medicaid clients receiving hysterectomy services, including those in a STAR or STAR+PLUS Program health plan, must sign a Hysterectomy Acknowledgment Form. The acknowledgment must be submitted to the client's health plan.*

The Texas Medicaid Program reimburses hysterectomies when they are medically necessary. The Texas Medicaid Program does not reimburse hysterectomies performed for the sole purpose of sterilization.

Hysterectomy services are considered for reimbursement when the claim is filed with a signed Hysterectomy Acknowledgment Form or documentation supporting that the Hysterectomy Acknowledgment Form could not be obtained or was not necessary.

Each individual provider involved in the hysterectomy procedure is requested to submit a copy of a valid Hysterectomy Acknowledgment Form rather than relying on another provider. The client's eligibility file is updated upon receipt of the signed Hysterectomy Acknowledgment Form. Subsequent claims for services related to the hysterectomy are referenced to the valid acknowledgment form.

A Hysterectomy Acknowledgment Form is not required if the performing physician certifies and signs the claim form or attachment that states at least one of the following circumstances existed before the surgery:

- The patient was already sterile before the hysterectomy, and the cause of the sterility is stated (e.g., congenital disorder, sterilized previously, or postmenopausal). Providers must use a post-menopause or sterilization diagnosis code on the claim form. If the provider submits a claim and does not attach the acknowledgment, the provider must maintain the signed statement in the client's records, and the physician's signature will not be required on the claim form. These records are subject to retrospective review.
- The patient requires a hysterectomy on an emergency basis because of a life-threatening situation. The physician must state the nature of the emergency and certify that it was determined that prior acknowledgment was not possible. Because the acknowledgment may be signed the day of or an hour

before surgery, an emergency situation requires that the patient be unconscious or under sedation and unable to sign the acknowledgment.

The Hysterectomy Acknowledgement Form contains the acknowledgment statement of sterility by patient which informs clients that a hysterectomy will leave them permanently incapable of bearing children.

According to federal and state regulations, reimbursement for a hysterectomy is available if the claim is filed with an acknowledgment statement, signed and dated by the client, that indicates the client was informed both orally and in writing before the surgery that the hysterectomy would leave her permanently incapable of bearing children.

The provider is responsible for maintaining the original, signed copy of the Hysterectomy Acknowledgement Form in the client's medical record when a claim is submitted for consideration of payment. These records are subject to retrospective review.

When a hysterectomy, whether abdominal or vaginal, is performed without a client's acknowledgement form:

- The hysterectomy procedure code is denied.
- The other surgical procedures are evaluated for their clinical relevance.
- Multiple procedures are processed according to the multiple surgery guidelines.

A hysterectomy acknowledgment statement is not required when one or more of the following circumstances exist:

- The client is already sterile.
- The client requires a hysterectomy on an emergency basis because of a life-threatening situation, and the physician determines that prior acknowledgment is not possible.

Although the hysterectomy acknowledgement statement is not required if the above criteria are met, the performing physician must certify that one or more of the circumstances existed prior to the surgery. This certification must be attached to the claim and signed by the performing provider.

For more information refer to 42 CFR 441.255 and 25 TAC Part 1, Chapter 29, Subchapter F, section 25.501.

Refer to: "Hysterectomy Acknowledgment Form" on page B-50.

36.4.17.8 Hysteroscopic Sterilization

Providers should use procedure code 2/F-58565 to submit claims for the fallopian tube occlusion sterilization. Procedure code 2/F-58565 is considered bilateral and excludes the occlusive sterilization system (micro-insert).

Procedure code 9-L8699 is considered for reimbursement of the occlusive sterilization device when it is billed with the UD modifier.

A hysterosalpingogram is recommended three months after a hysteroscopic sterilization procedure to ensure tubal occlusion. Procedure code 4/I/T-74740 is considered for reimbursement in this circumstance when billed with diagnosis code V252.

36.4.17.9 Laminaria

Insertion of a laminaria or dilateria (procedure code 2-59200) is a benefit of the Texas Medicaid Program.

36.4.17.10 Surgery For Masculinized Females

Masculinized females possess ovaries and are female by genetic sex but the external genitalia are not those of a normal female. Surgical correction of abnormalities of the external genitalia is the only indicated treatment for this disorder. Procedure codes 2-56805 and 2-57335 may be considered for reimbursement for female clients younger than 21 years of age when submitted for reimbursement with diagnosis code 2552 or 7527.

36.4.18 Ilizarov Device/Procedure

Use procedure codes 2/F-20692, 2/F-20693, 2/F-20694, and 2/F-20999 when billing for the Ilizarov procedure. A global fee payment methodology is applied and includes a global period of 180 days. Procedure codes 2/F-20692, 2/F-20693, 2/F-20694, and 2/F-20999 include the preconstruction, surgical application, adjustments to the device for up to six months, and the removal of the device. Payment for broken/replacement parts to the device is currently under HHSC legal review.

Providers who bill for other external fixator devices, such as the Monticelli device, should continue to use procedure codes 2-20690 or 2-20692, where applicable, when billing for the surgical applications.

36.4.19 Hyperbaric Oxygen Therapy (HBOT)

HBOT is a type of therapy that is intended to increase the environmental oxygen pressure to promote the movement of oxygen from the environment into the body tissues by means of pressurization that is greater than atmospheric pressure. Such treatment is performed in specially constructed hyperbaric chambers, which may hold one or several patients.

Note: *Although oxygen may be administered by mask, cannula, or tube in addition to the hyperbaric treatment, the use of oxygen by mask, or other device, or applied topically is not considered hyperbaric treatment in itself.*

Procedure code 1-99183 is limited to one session per day, any provider.

Outpatient hospitals should use revenue code B-413, Respiratory services–HBO, for reimbursement of the technical component.

The FDA-approved indications for the hyperbaric oxygen chamber (therapy) in accordance with the guidelines established by the Undersea and Hyperbaric Medical Society are as follows:

- Air or gas embolism.
- Carbon monoxide/smoke inhalation.
- Compromised skin grafts and flaps.
- Crush injuries/acute traumatic ischemias.
- Decompression sickness.
- Enhanced healing in selected problem wounds.
- Exceptional blood loss (anemia).
- Gas gangrene (clostridial myonecrosis).
- Necrotizing soft tissue infections.
- Radiation tissue damage (osteoradionecrosis).
- Refractory osteomyelitis.
- Thermal burns.

When requesting reimbursement of HBOT for the treatment of *air or gas embolism* use the following diagnosis codes: 6396, 67300, 9580, and 9991.

When requesting reimbursement of HBOT for the treatment of *carbon monoxide/smoke inhalation,* use diagnosis code 986.

When requesting reimbursement of HBOT for the treatment of *compromised skin grafts and flaps,* use the following diagnosis codes:

Diagnosis Codes				
99652	99660	99661	99662	99663
99664	99665	99666	99667	99668
99669	99670	99671	99672	99673
99674	99675	99676	99677	99678
99679	V423			

When requesting reimbursement of HBOT for the treatment of *crush injuries/acute traumatic ischemias,* use the following diagnosis codes:

Diagnosis Codes				
8690	8691	8871	8873	8875
8877	8971	8973	8975	8977
9251	9252	9260	92611	92612
92619	9268	9269	92700	92701
92702	92703	92709	92710	92711
92720	92721	9273	9278	9279
92800	92801	92810	92811	92820
92821	9283	9288	9289	9290
9299	99690	99691	99692	99693
99694	99695	99696	99699	

When requesting reimbursement of HBOT for the treatment of *decompression sickness,* use the diagnosis code 9933.

When requesting reimbursement of HBOT for the treatment of *enhanced healing in selected problem wounds,* use the following diagnosis codes:

Diagnosis Codes				
25070	25071	25072	25073	44023
44024	44381	44382	44389	4439
4540	4542	68600	68601	68609
70700	70701	70702	70703	70704
70705	70706	70707	70709	70710
70711	70712	70713	70714	70715
70719	7078	7079	9895	99859

When requesting reimbursement of HBOT for the treatment of *exceptional blood loss (anemia),* use the following diagnosis codes: 2851, 78552, 78559, 9584, and 9980.

When requesting reimbursement of HBOT for the treatment of *gas gangrene (clostridial myonecrosis),* use the following diagnosis codes: 0383 and 0400.

When requesting reimbursement of HBOT for the treatment of *necrotizing soft tissue infections,* use the following diagnosis codes: 72886 and 7854.

When requesting reimbursement of HBOT for the treatment of *radiation tissue damage (osteoradionecrisis),* use the following diagnosis codes:

Diagnosis Codes				
52689	73010	73011	73012	73013
73014	73015	73016	73017	73018
73019	7854	9092	990	

When requesting reimbursement of HBOT for the treatment of *refractory osteomyelitis,* use the following diagnosis codes:

Diagnosis Codes				
73010	73011	73012	73013	73014
73015	73016	73017	73018	73019

When requesting reimbursement of HBOT for the treatment of *thermal burns,* use the following diagnosis codes:

Diagnosis Codes				
9400	9401	9402	9403	9404
9405	9409	94100	94101	94102
94103	94104	94105	94106	94107
94108	94109	94110	94111	94112
94113	94114	94115	94116	94117
94118	94119	94120	94121	94122
94123	94124	94125	94126	94127
94128	94129	94130	94131	94132
94133	94134	94135	94136	94137
94138	94139	94140	94141	94142

Diagnosis Codes				
94143	94144	94145	94146	94147
94148	94149	94150	94151	94152
94153	94154	94155	94156	94157
94158	94159	94200	94201	94202
94203	94204	94205	94209	94210
94211	94212	94213	94214	94215
94219	94220	94221	94222	94223
94224	94225	94229	94230	94231
94232	94233	94234	94235	94239
94240	94241	94242	94243	94244
94245	94249	94250	94251	94252
94253	94254	94255	94259	94300
94301	94302	94303	94304	94305
94306	94309	94310	94311	94312
94313	94314	94315	94316	94319
94320	94321	94322	94323	94324
94325	94326	94329	94330	94331
94332	94333	94334	94335	94336
94339	94340	94341	94342	94343
94344	94345	94346	94349	94350
94351	94352	94353	94354	94355
94356	94359	94400	94401	94402
94403	94404	94405	94406	94407
94408	94410	94411	94412	94413
94414	94415	94416	94417	94418
94420	94421	94422	94423	94424
94425	94426	94427	94428	94430
94431	94432	94433	94434	94435
94436	94437	94438	94440	94441
94442	94443	94444	94445	94446
94447	94448	94450	94451	94452
94453	94454	94455	94456	94457
94458	94500	94501	94502	94503
94504	94505	94506	94509	94510
94511	94512	94513	94514	94515
94516	94519	94520	94521	94522
94523	94524	94525	94526	94529
94530	94531	94532	94533	94534
94535	94536	94539	94540	94541
94542	94543	94544	94545	94546
94549	94550	94551	94552	94553
94554	94555	94556	94559	9460
9461	9462	9463	9464	9465
9470	9471	9472	9473	9474
9478	9479	94800	94810	94811
94820	94821	94822	94830	94831
94832	94833	94840	94841	94842
94843	94844	94850	94851	94852
94853	94854	94855	94860	94861
94862	94863	94864	94865	94866
94870	94871	94872	94873	94874
94875	94876	94877	94880	94881
94882	94883	94884	94885	94886
94887	94888	94890	94891	94892
94893	94894	94895	94896	94897
94898	94899	9490	9491	9492
9493	9494	9495		

HBOT that exceeds one session per day, any provider, is denied.

36.4.20 Injections

Injections are reimbursed as access-based fees under the physician fee schedule in accordance with 1 TAC §355.8085. Texas Medicaid Program fee decisions for blood clotting factors, pneumococcal and hepatitis B, injections, infusion drugs furnished through an item of implanted DME, and new injections are based on 89.5 percent of the average wholesale price (AWP). New injections are those that received approval for marketing by the FDA within the past 12 months.

For certain, specific injections studied by the Office of Inspector General (OIG)/General Accounting Office (GAO), Medicaid fee decisions are based on the recommended percentages of AWP resulting from those studies (Table 1 in §20 of Chapter 17 of the *Medicare Claims Processing Manual*, Pub. 100–04). For the remaining injections not listed above, fee decisions are based on 106 percent of the average sales price (ASP).

HHSC reserves the option to use other data sources to determine fees for injections when AWP calculations are determined to be unreasonable or insufficient.

Prescriptions are covered under the Texas Medicaid VDP. The reimbursement methodology for pharmacy services is located at 1 TAC §§355.8541 through 355.8551.

Injection administration billed by a provider is reimbursed separately from the medication. Injection administration should be billed using procedure code 1-90772.

Injection administration is not payable to outpatient hospitals. Procedure code 1-90772 is limited to one per day, unless the claim clearly indicates the medications could not be mixed. Procedure code 1-90772 is paid in addition to an E/M or consultation visit to ensure that each injection receives one administration fee regardless of the dosage.

Providers billing injections for clients younger than 21 years of age are to bill using the appropriate national code.

Use oral medication in preference to injectable medication in the office and outpatient hospital unless one of the following applies:

- No acceptable oral equivalent is available.
- Injectable medication is the standard treatment of choice.
- The oral route is contraindicated.
- The patient has a temperature over 102 degrees Fahrenheit (documented on the claim and in the medical record) and a high blood level of antibiotic is needed quickly.
- The patient has demonstrated noncompliance with orally prescribed medication that is documented on the claim and in the medical record.
- Previously attempted oral medication regimens have proved ineffective as supported by the medical record.
- It is an emergency situation.

Injections into joints, bursae, tendon sheaths, or trigger points are only payable for acute conditions or acute flare-ups of chronic conditions. For reimbursement, modifier AT must be used to indicate acute conditions. If a steroid medication is injected in one of the above areas, modifier AT or KX must also be used on the charge for the drug to indicate an acute condition. When performed for a chronic condition, these procedures are denied.

The acute condition does not apply to allergy injections or medically necessary injections into joints, bursae, tendon sheaths, or trigger points when used to treat acute conditions or the acute flare-up of a chronic condition.

Oral medications are not a benefit of the Texas Medicaid Program except when given in the hospital or physician's office, or when obtained by prescription through the VDP. Take-home and self-administered drugs are not a Medicaid benefit except when provided to Medicaid clients through the VDP and should not be submitted to TMHP for payment.

Physicians billing for injectable antibiotic and steroid medications *must* indicate the appropriate modifier with the appropriate injection code. The code identifying the dose administered must be used for correct reimbursement. Multiples of codes should be billed if a code is not available to document the dose administered (for example, procedure code 1-J0290—use a quantity of 2 for 1,000 mg).

The ET and KX modifiers are acceptable. Use modifier KX to indicate:

- Oral route contraindicated or an acceptable oral equivalent is not available.
- Injectable medication is the accepted treatment of choice. Oral medication regimen has proven ineffective or is not applicable.
- The patient has a temperature over 102 degrees and a high level of antibiotic is needed immediately.
- Injection is medically necessary into joints, bursae, tendon sheaths, or trigger points to treat an acute condition or the acute flare-up of a chronic condition.

The Texas Vaccines for Children (TVFC) Program provides vaccines for Medicaid clients who are younger than 19 years of age, according to the Recommended Childhood Immunization Schedule (Advisory Committee on Immunization Practices [ACIP], American Academy of Pediatrics [AAP], and the American Academy of Family Physicians [AAFP]).

Refer to: "Vendor Drug Program" on page E-1 for more information.

"Immunizations" on page H-1.

"Immunizations" on page 43-24 for information on immunizations for infants and children.

36.4.20.1 Abatacept (*Orencia*)

Abatacept is a benefit of the Texas Medicaid Program for clients with moderately to severely active rheumatoid arthritis. These clients may also have an inadequate response to analgesics, NSAIDs, Cox-2 inhibitors, and/or one or more disease-modifying anti-rheumatic drugs (DMARDs), such as methotrexate or tumor necrosis factor (TNF) antagonists.

Providers must obtain prior authorization for procedure code 1-J0129 to request reimbursement for abatacept. The prior authorization requests must include medical necessity documentation that contains the following information:

- A diagnosis of rheumatoid arthritis (diagnosis code 7140, 7141, 7142, 71430, 7144, or 7149).
- Failure of sufficient response to standard treatment, such as analgesics, NSAIDs, and Cox-2 inhibitors.
- Inadequate response to one or more DMARDs, such as methotrexate or TNF antagonists.
- The number of anticipated injections and the dosage and number of vials per injection.

Prior authorization may be granted for up to 14 injections per client, per year. Prior authorization is a condition for reimbursement; it is not a guarantee of payment. Providers may fax or mail the prior authorization request to the TMHP Special Medical Prior Authorization Department at:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization Department
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

36.4.20.2 Alatrofloxacin Mesylate (*Trovan*)

The Texas Medicaid Program follows the recommendation of the FDA about the use of intravenous alatrofloxacin mesylate, (*Trovan*). Alatrofloxacin mesylate is not reimbursed when provided in settings other than inpatient

hospital. Alatrofloxacin mesylate should be reserved for use *only* in the treatment of patients who meet *all* the following treatment criteria:

- Have at least one of the following infections judged by the treating physician to be serious and life- or limb-threatening:
  - Nosocomial pneumonia.
  - Community-acquired pneumonia.
  - Complicated intra-abdominal infections (including postsurgical infections).
  - Gynecologic and pelvic infections.
  - Complicated skin and skin-structure infections (including diabetic foot infections).
- Receive initial therapy in an inpatient health-care facility.
- The treating physician believes that, given the new safety information, the benefit of the product to the patient outweighs the risk.

36.4.20.3 Alglucosidase Alfa (*Myozyme*)

Aglucosidase alfa is a benefit of the Texas Medicaid Program for clients of any age who are diagnosed with glycogenosis, or Pompe disease.

Providers must obtain prior authorization for procedure code 1-S0147 to request reimbursement for alglucosidase alfa. The prior authorization request must include medical necessity documentation that contains laboratory evidence of acid alpha-glucosidase (GAA) deficiency (i.e., below the laboratory-defined cut-off value as determined by the laboratory performing the GAA enzyme activity assay). Tissues used for the determination of GAA deficiency include blood, muscle, or skin fibroblasts.

Prior authorization is a condition for reimbursement; it is not a guarantee of payment. Providers may fax or mail prior authorization requests, including all required documentation, to the TMHP Special Medical Prior Authorization Department at:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization Department
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

36.4.20.4 Amifostine

The Texas Medicaid Program covers Amifostine for reduction of the cumulative renal toxicity associated with administration of cisplatin in patients with advanced ovarian cancer or *nonsmall* cell lung cancer with documentation of a creatinine clearance of 50 or less and where no other chemotherapeutic agent can be used. Amifostine for injection may be considered for reimbursement through the Texas Medicaid Program for the following indications: bone marrow toxicity, cisplatin-and cyclophosphamide-induced (prophylaxis), advanced solid tumors, head and neck carcinoma, malignant lymphoma, nonsmall cell lung cancer, myelodysplastic syndromes, nephrotoxicity, advanced ovarian carcinoma, melanoma, advanced solid tumors of nongerm cell origin, neurotoxicity, reduction in the incidence of mucositus in patients receiving radiation therapy, or radiation combined with chemotherapy, and to reduce in the incidence of xerostomia associated with post-operative radiation treatment of head and neck cancer, where the radiation port includes a substantial portion of the parotid glands. It may also be used to reduce the incidence of moderate-to-severe xerostomia in patients undergoing postoperative radiation treatment for head and neck cancers where the radiation port includes a substantial portion of the parotid glands. Use HCPCS procedure code 1-J0207.

36.4.20.5 Antihemophilic Factor

Reimbursement for the following antihemophilic factor procedure codes is limited to the diagnosis codes of coagulation defects, noted in the second table below.

Reimbursement is available when the antihemophilic product is administered by or under the personal supervision of a physician in POS 1, 2, or 5.

HCPCS Codes		
1-J7187	1-J7189	1-J7190
1-J7191	1-J7192	1-J7193
1-J7194	1-J7195	1-J7197
1-J7198	1-J7199	

Diagnosis Codes				
2860	2861	2862	2863	2864
2865	2866	2867	2869	V8302

Procedure codes 1-J7193 and 1-J7195 must be submitted with diagnosis code 2861 to be considered for reimbursement.

Procedure code 1-J7189 must be submitted with diagnosis code 2860, 2861, 2863, or 2869 to be considered for reimbursement.

36.4.20.6 BCG Vaccine

Procedure code 1-90585 is payable for diagnosis code V032.

Procedure code 1-J9031 and 1-90586 are payable for the following diagnosis codes:

Diagnosis Codes				
1880	1881	1882	1883	1884
1885	1886	1887	1888	1889
2337				

Procedure code 2-51720 may be reimbursed separately when submitted with the same date of service as the BCG vaccine procedure codes.

36.4.20.7 Programmable Pumps for Epidural or Intrathecal Infusion

Programmable pumps and devices are used as an invasive treatment for intractable pain, spasms, and some types of chemotherapy. The therapeutic effects are achieved by infusing a pharmaceutical agent into the epidural or intrathecal space. Epidural refers to the space of the spinal chord that is outside the protective membrane that holds the spinal cord. Intrathecal administration is a deeper injection and refers to the infusing of the drug directly into the fluid surrounding the spinal cord. Its mechanism of delivery is via a pump and implanted catheter. The catheter delivers the medication from a reservoir through the pump to the spinal cord on a continuous basis. Most common uses include providing aggressive management of chronic intractable pain and uncontrolled muscular spasms where all non-invasive techniques have either not been effective or were not practical.

Prior Authorization Documentation

Providers must request prior authorization for implantation of all programmable implantable devices (e.g., pumps, catheters, reservoirs) unless the devices are used as a means of chemotherapy administration. Requests for prior authorization must include all required information as indicated on the approved form: "Texas Medicaid Prior Authorization Request Form: Intrathecal Baclofen or Morphine Pump."

The following information is required and must be provided with the authorization request:

- The initial evaluation, including the age of the client at the onset of the signs and symptoms and including other visits that are directly related to the request (If requesting baclofen, specify the muscle groups affected and the degree of spasticity).
- Any hospitalizations and other diagnoses.
- The trial of the intrathecal medication that is to be used (e.g., baclofen, morphine sulfate, Dilaudid (hydromophone HCl) or fentanyl).
- The type of surgical implantation with a description of the device.
- The periodic follow-up plan of care including reloading of the pump and monitor changes in infusion rate.
- All pertinent lab/X-ray results.
- The client's weight (in Kilograms).
- The role/participation/compliance of the family and/or client.
- The follow up evaluation of any non-invasive treatments attempted including medications, dosage route, and frequency.
- The expected benefit of the procedure related to the follow-up assessment to evaluate the treatment goals.

Baclofen (*Lioresal*)

Procedure code 1-J0476 should be used to request reimbursement for intrathecal baclofen on a trial basis. Prior authorization is required for reimbursement of the Baclofen trial injection and pump, implantation, catheter insertion/revision/replacement.

Separate payment for the device is not covered for the physician or the hospital.

Opioid Drugs

Opioid agonists produce analgesia at the spinal cord level when administered in the intrathecal or epidural space. This technique may be used for the management of chronic intractable pain that is not controlled by less invasive techniques. The preservative free morphine sulfate, Dilaudid (hydromophone HCl) or fentanyl is administered every 8 to 12 hours in the epidural space through an indwelling catheter, which can be placed percutaneously or by limited laminectomy. The reservoir is attached to the proximal portion of the catheter, which is tunneled beneath the skin.

Implanted pumps for opioid infusions include, but are not limited to, the following types of intractable pain:

- Advanced carcinoma, primary or metastatic.
- Complex regional pain syndrome I & II (causalgia/RSD) refractory to other treatments.
- Post herpetic neuralgia.
- Failed back syndrome.
- Phantom limb pain.
- Arachnoiditis (proven with MRI/increased CSF protein levels).
- Spinal cord myelopathy (refractory to conservative measurements).

The patient with the diagnosis of cancer should have a life expectancy of at least three months and should be unresponsive to less invasive medical therapy, or less invasive medical therapy is no longer the most appropriate therapy.

In patients with non-malignant conditions of intractable pain, documentation in the patient's medical record must establish that the patient's pain failed to respond to all non-invasive methods of pain control.

Procedure code 1-01996 is limited to once per day and is denied when submitted with the same date of service as a surgical/anesthesia procedure (TOS 2, 7, or 8). Procedure code 1-01996 submitted more than 30 times in a 30-day period requires documentation of medical necessity (epidurals for cancer diagnoses are excluded from this 30-day limitation).

Anti-Spasmodic Drugs

Anti-spasmodic drugs are used to treat intractable spasticity by reducing transmission of impulses from the spinal cord to skeletal muscles, thereby decreasing frequency and severity of muscle spasms.

An implantable epidural/subarachnoid infusion pump and/or catheter for chronic spasticity is considered for reimbursement when used to administer anti-spasmodic

drugs intrathecally (e.g., baclofen) to treat chronic intractable spasticity in patients who have proven unresponsive to less invasive medical therapy as determined by the following criteria:

- As indicated by at least a 6-week trial, the patient cannot be maintained on non-invasive methods of spasm control, such as oral anti-spasmodic drugs, either because these methods fail to adequately control the spasticity or produce intolerable side effects.
- Prior to pump implantation, the patient must have responded favorably to a trial intrathecal dose of the anti-spasmodic drug.

Chemotherapeutic Drugs

Prior Authorization is not required for implantation, revision, repositioning, or replacement of programmable implanted pumps, catheters, or reservoirs (procedure codes 2/F-62350, 2/F-62351, 2/F-62360, 2/F-62361, and 2/F-62362) when used as a means for chemotherapy administration.

Refer to: "Chemotherapy" on page 36-30 for other specific information when administering chemotherapy.

Diabetic Drugs

Only external insulin pumps are benefits of the Texas Medicaid Program. Prior authorization is required for external diabetic insulin pumps.

Refer to: "Diabetic Supplies/Equipment" on page 24-18 for other specific information when providing diabetic supplies or equipment.

Implantation of Catheters, Reservoirs, and Pumps

When insertion of an implanted catheter and reservoir or pump for long-term medication administration is requested, one of the procedure codes in Table A and one of the procedure codes in Table B, below, may be considered for reimbursement when submitted with the same date of service.

Table A: Procedure Codes	
2/F-62350	2/F-62351

Table B: Procedure Codes		
2/F-62360	2/F-62361	2/F-62362

Procedure codes 2/F-62355 and 2/F-62365 do not require prior authorization. These procedure codes are considered for reimbursement according to multiple surgery guidelines when submitted with the same date of service as another surgical procedure performed by the same physician.

Procedure codes 2/F-62355 and 2/F-62365 are denied as included in the total anesthesia time when submitted with the same date of service as an anesthesia procedure by the same physician.

Procedure codes 1-62367 and 1-62368 are considered for reimbursement as a medical service (TOS 1) only.

Procedure codes 1-95990, 1-96521, and 1-96522 are considered for reimbursement when used for refilling an implantable pump.

Providers are to send prior authorization requests to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

Refer to: "Texas Medicaid Prior Authorization Request Form: Intrathecal Baclofen or Morphine Pump Sections I and II (2 Pages)" on page B-102.

36.4.20.8 Botulinum Toxin Type A

Procedure code 1-J0585 no longer requires prior authorization and is considered for reimbursement when submitted with one of the following diagnosis codes:

Diagnosis Codes				
3336	33381	33382	33383	33384
33389	3341	340	3410	3411
3418	3419	34211	34212	3430
3431	3432	3433	3434	3438
3439	34400	34401	34402	34403
34404	34409	3441	3442	34430
34431	34432	34440	34441	34442
3445	34460	34461	34481	34489
3449	3518	37800	37801	37802
37803	37804	37805	37806	37807
37808	37810	37811	37812	37813
37814	37815	37816	37817	37818
37820	37821	37822	37823	37824
37830	37831	37832	37833	37834
37835	37840	37841	37842	37843
37844	37845	37850	37851	37852
37853	37854	37855	37856	37860
37861	37862	37863	37871	37872
37873	37881	37882	37883	37884
37885	37886	37887	3789	47875
47879	5300	7235	72885	72982

If a quantity greater than 300 units of botulinim toxin is billed on the same day, supporting medical documentation must be maintained in the client's records for the dosage used and is subject to retrospective review.

EMGs and/or visits, that are billed in conjunction with the administration of botulinum toxin type A, do not require prior authorization and are subject to current reimbursement guidelines. Any supplies billed by the physician for the administration of botulinum toxin type A are not paid separately.

36.4.20.9 Chelating Agents

The following chelating agents are benefits of the Texas Medicaid Program:

- Dimercaprol may be submitted using procedure code 1-J0470.
- Edetate calcium disodium may be submitted using procedure code 1-J0600.
- Deferoxamine mesylate may be submitted using procedure code 1-J0895.
- Edetate disodium may be submitted using procedure code 1-J3520.

Dimercaprol

Procedure code 1-J0470 is a benefit when submitted with one of the following diagnosis codes:

Diagnosis Codes				
9840	9841	9848	9849	9850
9851	9858	9859		

Edetate calcium disodium

Procedure code 1-J0600 is a benefit when submitted with one of the following diagnosis codes: 9840, 9841, 9848, 9849, or 9858.

Deferoxamine mesylate (*Desferal*)

Deferoxamine mesylate is a drug that chelates iron by forming a stable complex that prevents the iron from entering into more chemical reactions. Deferoxamine mesylate is indicated for the treatment of acute iron intoxication and of chronic iron overload because of transfusion dependent anemias.

Procedure code 1-J0895 must be submitted with one of the following diagnosis codes to be considered for reimbursement of deferoxamine mesylate:

Diagnosis Codes				
0470	28241	28242	28249	28260
28261	28262	28263	28264	28268
28269	5851	5852	5853	5854
5855	5856	5859	586	9640
9730	9858	9859		

Edetate disodium

Procedure code 1-J3520 is a benefit when submitted with one of the following diagnosis codes: 27542 or 9721.

Procedure codes 1-J0470, 1-J0600, 1-J0895, and 1-J3520 are denied if they are submitted with any other diagnosis code than the codes listed above.

36.4.20.10 Cidofovir

Cidofovir is a benefit when used for the treatment of cytomegalovirus retinitis in clients with acquired immunodeficiency syndrome (AIDS). Use diagnosis code 36320, Chorioretinitis, unspecified with procedure code 1-J0740.

36.4.20.11 Cladribine (*Leustatin*)

Procedure code 1-J9065 is a benefit of the Texas Medicaid Program when billed with one of the diagnosis codes listed in the following table for hairy cell leukemia.

Diagnosis Codes				
20240	20241	20242	20243	20244
20245	20246	20247	20248	

Cladribine is denied for all other diagnosis codes.

36.4.20.12 Clofarabine

Prior authorization is required for treatment with clofarabine (1-J9027).

Clofarabine may be prior authorized for the treatment of relapsed or refractory acute lymphoblastic leukemia (20400).

- Prior authorization may be given for a maximum of 6 weeks.
- Prior authorization for treatment with Clofarabine should be obtained before, but must be obtained within three business days from the date of initiating treatment.

Prior authorization requests may be considered with documentation of the following:

- A diagnosis of refractory or relapsed acute lymphoblastic leukemia (20400), and
- A history of at least two prior failed chemotherapy regimens.

The prior authorization number must be submitted on the claim along with the number of units based, on the dosage given.

Failure to place the prior authorization number on the claim or to obtain prior authorization within the allotted timeframe will result in denied claims.

36.4.20.13 Liposomal Encapsulated Daunorubicin (*DaunoXome*)

Liposomal encapsulated daunorubicin for the treatment of advanced AIDS-related Kaposi's Sarcoma is reimbursable under the Texas Medicaid Program. Providers must use procedure code 1-J9999 and provide the drug name and dosage.

36.4.20.14 Denileukin Diftitox (*Ontak*)

Procedure code 1-J9160 is reimbursed by the Texas Medicaid Program for clients with advanced or recurrent cutaneous T-cell lymphoma (payable, but not limited to diagnosis codes 20210 and 20220) with the CD25 component of IL-2 and failure of at least one type of traditional therapy. Documentation of diagnosis and treatment must be submitted with the claim. Denileukin diftitox is reimbursed only when given in the office or outpatient setting.

36.4.20.15 Docetaxel

Procedure code 1-J9170 is covered if billed using one of the following diagnosis codes:

Diagnosis Codes				
1620	1622	1623	1624	1625
1628	1629	1740	1741	1742
1743	1744	1745	1746	1748
1749	1750	1759	1830	1970
1971	1972	1977	1982	1983
1985	1986	19881	19889	

36.4.20.16 Dolasetron Mesylate (*Anzemet*)

When billing for dolasetron mesylate, use procedure code 1-J1260.

36.4.20.17 Hematopoietic Agents

Providers requesting reimbursement for epoetin alfa for the treatment of anemia associated with end-stage renal disease (ESRD) may use procedure code 1-J0886. Providers requesting reimbursement for darbepoetin alfa for the treatment of anemia associated with ESRD may use procedure code 1-J0822. When submitting procedure code 1-J0822 or 1-J0886 for consideration of reimbursement, providers must enter in the comments section of the claim the client's most recent dated hematocrit levels that clearly indicate the client's hematocrit was *not* equal to or greater than 37 percent.

Erythropoietin Alfa (EPO)

Medicaid reimbursement is allowed for EPO injections administered to chronic renal disease patients, chronic end-stage renal disease predialysis patients who have an anemia with a Hematocrit of 36 percent or less, and for patients with human immunodeficiency virus (HIV) infection who are being treated with zidovudine (AZT). Payment is limited to the end-stage renal dialysis facility and the physician in the office. Only three injections are allowed per calendar week (Sunday through Saturday).

EPO is a glycoprotein that stimulates red blood cell formation and production of the precursor red blood cells of the bone marrow. EPO is indicated for:

- Anemia associated with chronic renal failure, including patients on dialysis (end-stage renal disease) and patients not on dialysis (in chronic end-stage renal disease patients, the increased blood, urea, nitrogen (BUN) impairs the production of erythropoietin, leading to a chronic anemia).
- Anemia related to therapy with AZT in HIV-infected patients.
- Anemia due to the effects of concomitantly administered chemotherapy in patients with non-myeloid malignancies.
- Anemia related to rheumatoid arthritis.

Procedure code 1-J0885 must be submitted with one of the following diagnosis codes to be considered for reimbursement:

Diagnosis Codes				
042	20300	20301	23872	23873
23874	23875	23876	23879	2733
2734	2800	2801	2808	2809
2810	2811	2812	2813	2814
2818	2819	2820	2821	2822
2823	28241	28242	28249	2825
28260	28261	28262	28263	28264
28268	28269	2827	2828	2829
2830	28310	28311	28319	2832
2839	28401	28409	2841	2842
2848	2849	2850	2851	28521
28522	28529	2858	2859	40300
40310	40390	40413	40493	5820
5821	5822	5824	58281	58289
5829	5851	5852	5853	5854
5855	5856	5859	586	7140
79001	99680	99811	V5811	V5812

Procedure code 1-J0886 must be submitted with one of the following diagnosis codes to be considered for reimbursement:

Diagnosis Codes				
40301	40311	40391	40402	40403
40412	40492	5851	5852	5853
5854	5855	5856	5859	586
58889	V451	V4983	V560	V5631
V5632	V568	V5844		

Important: *EPO given for a hematocrit of 37 percent or above is not a benefit of the Texas Medicaid Program.*

Darepoetin Alfa

Darbepoetin alfa is an erythropoiesis-stimulating protein closely related to erythropoietin. Darbepoetin stimulates erythropoiesis by the same mechanism as endogenous erythropoietin (EPO). Erythropoietin is produced in the kidney and released into the bloodstream in response to hypoxia. It interacts with progenitor stem cells to increase erythrocyte production.

Darbepoetin alfa may be considered for reimbursement when submitted using procedure codes 1-J0881 and 1-J0882. Darbepoetin is limited to 500 units per day (500mcg). The injection should be administered once a week if the patient is receiving Epoetin alfa 2 to 3 times weekly, and once every 2 weeks if the patient is receiving EPO alfa once per week.

Procedure code 1-J0881 must be submitted with one of the following diagnosis codes to be considered for reimbursement:

Diagnosis Codes				
042	20300	20301	23872	23873
23874	23875	23879	2800	2801
2808	2809	2810	2811	2812
2813	2814	2818	2819	2820
2821	2822	2823	28241	28242
28249	2825	28260	28261	28262
28263	28264	28268	28269	2827
2828	2829	2830	28310	28311
28319	2832	2839	28401	28409
28489	2849	2850	2851	28521
28522	28529	2858	2859	40301
40311	40391	40402	40403	40412
40413	40492	40493	585	586
7140	79001	99680	99811	V420
V451	V560	V5631	V568	V5811
V5812				

Procedure code 1-J0882 must be submitted with one of the following diagnosis codes to be considered for reimbursement:

Diagnosis Codes				
042	20300	20301	23872	23873
23874	23875	23879	2733	2800
2801	2808	2809	2810	2811
2812	2813	2814	2818	2819
2820	2821	2822	2823	28241
28242	28249	2825	28260	28261
28262	28263	28264	28268	28269
2827	2828	2829	2830	28310
28311	28319	2832	2839	28409
2848	2849	2850	2851	28521
28522	28529	2858	2859	7140
79001	99680	99811	V451	V560
V5631	V568	V5811	V5812	

36.4.20.18 Fluocinolone Acetonide (*Retisert*)

Procedure code 1-J7311 is a benefit of the Texas Medicaid Program. ASCs, HASCs, and hospitals may submit procedure code 1-J7311 for the fluocinolone acetonide intravitreal implant when services are rendered in the inpatient hospital and/or outpatient hospital settings for clients 12 years of age and older.

Procedure code 1-J7311 is only considered for reimbursement with a posterior uveitis diagnosis (36320) of more than six months in duration and only when the condition has been unresponsive to oral or systemic medication treatment. Prior authorization is required.

To request prior authorization, providers must submit requests to the Special Medical Prior Authorization Department by fax at 1-512-514-4213.

36.4.20.19 Galsulfase

Galsulfase injections are benefits of the Texas Medicaid Program. Procedure code 1-J1458 is limited to diagnosis code 2775. Procedure code 1-J1458 may be reimbursed to physicians and APNs when performed in an office setting, and to hospitals when performed in the outpatient or inpatient setting.

36.4.20.20 Gamma Globulin/Immune Globulin

Gamma globulin procedure codes 1-J1460, 1-J1470, 1-J1480, 1-J1490, 1-J1500, 1-J1510, 1-J1520, 1-J1530, 1-J1540, 1-J1550, 1-J1560, 1-J1562, 1-J1566, 1-J1567, 1-J7504, and 1-J7511 are benefits when billed with one of the following diagnosis codes:

Diagnosis Codes				
042	20410	27789	27900	27901
27902	27903	27904	27905	27906
27909	27910	27911	27912	27913
27919	2792	2793	2794	28409
28489	28730	28731	28732	28733
28739	3348	340	34541	3530
3570	35781	35782	35800	35801
3929	4461	5855	5856	586
64630	7103	7104	7140	79579
9895	V0179	V0182	V0189	V0260
V08	V4281	V4282	V4283	V4284
V4289				

The globulins listed in the following table are payable for clients younger than 3 years of age with a diagnosis of idiopathic thrombocytopenia (ITP) and a concurrent diagnosis of HIV/AIDS.

Procedure Codes		
1-J1460	1-J1470	1-J1480
1-J1490	1-J1500	1-J1510
1-J1520	1-J1530	1-J1540
1-J1550	1-J1560	1-J1566
1-J1567		

All claims with a primary diagnosis of HIV/AIDS suspend for manual review of a concurrent diagnosis of ITP. If the client does not meet the age criteria, requests are considered by the medical director, or designee, on a case by case basis.

Immune globulin or gamimune (procedure codes 1-J1566 and 1-J1567) is an immunoglobulin preparation. It also is a benefit for those diagnosis codes listed previously.

Procedure code 1-J1562 is denied if submitted by any provider with the same date of service as the following procedure codes:

Procedure Codes		
1-J1460	1-J1470	1-J1480
1-J1490	1-J1500	1-J1510
1-J1520	1-J1530	1-J1540
1-J1550	1-J1560	1-J1566
1-J1567	1-J7504	1-J7511

36.4.20.21 Gemcitabine HCl (*Gemzar*)

Gemcitabine HCl is a first-line treatment for patients with locally advanced or metastatic adenocarcinoma of the pancreas. Use and medical necessity of this chemotherapeutic agent should be determined by the provider in accordance with appropriate indications or approved criteria.

The quantity administered of procedure code 1-J9201 per 200 mg, must appear on the claim. For example, if a dose of 1,000 mg is administered, a quantity of 5 should appear on the claim.

36.4.20.22 Granisetron Hydrochloride

When requesting reimbursement for the granisetron hydrochloride injection (per 100 mcg), use procedure code 1-J1626. The quantity used, per 100 mcg, must appear on the claim. For example, if a dose of 800 mcg is administered, a quantity of 8 should appear on the claim.

Procedure code 1-J1626 is payable only for the following diagnosis codes: V580, V5811, V5812, V661, and V662.

36.4.21 Immunizations

36.4.21.1 Vaccine Coverage through the Texas Vaccines for Children (TVFC) Program

TVFC provides all routinely recommended ACIP vaccines to enrolled TVFC providers. All Medicaid eligible clients birth through 18 years of age are eligible for TVFC vaccine.

A distinction should be noted about proper billing. The billing codes in "Immunizations" on page 43-24 are to be used when the client is covered by the THSteps Program or the vaccine the client receives is provided through the TVFC Program.

36.4.21.2 Hepatitis A Vaccine

The hepatitis A vaccine is a benefit of the Texas Medicaid Program for children and adults who are at high risk of contracting the disease. The hepatitis A vaccine is routinely recommended for all Texas children who are 12 through 18 years of age. The hepatitis A vaccine is available through the TVFC program to vaccinate all recommended children.

36.4.21.3 Hepatitis B Vaccine

The Texas Medicaid Program covers the hepatitis B vaccine and the hepatitis B immune globulin (HBIG) for those clients who are not otherwise covered by TVFC Program.

Administration of the hepatitis B vaccine is indicated for immunization against infection caused by all known subtypes of the hepatitis B virus (HBV). The hepatitis B vaccine is medically necessary for patients who have been exposed to the HBV. This vaccine will not prevent hepatitis caused by other agents, such as hepatitis A, hepatitis C, or other viruses known to infect the liver.

The Texas Medicaid Program allows coverage of the hepatitis B vaccine for clients who are at high risk of contracting the disease.

Procedure codes 1-90740, 1-90746, and 1-90747 are payable for clients 19 years of age and older.

Procedure code 1-90772 is payable for the administration of the hepatitis B vaccines.

The immunization administration procedure codes 1-90471 and 1-90472 are not to be used for the administration of the hepatitis B vaccine.

Mentally retarded Medicaid-eligible individuals who reside in a private (nonstate) intermediate care facility for the mentally retarded (ICF-MR) are classified as having a continuing high risk for hepatitis B and an ongoing potential for exposure. When provided and billed by the attending physician, Medicaid will allow coverage of the hepatitis B vaccine for all inpatients of an ICF-MR (private) facility.

When the hepatitis B vaccine is provided to clients with end stage renal disease who are directly exposed, separate payment may be made as the vaccine and its administration are not included in dialysis services.

HBIG provides coverage for acute exposure to the hepatitis B virus.

Procedure code 1-90371 is payable for clients who are 19 years of age and older.

Procedure code 1-90371 is covered for diagnosis code V0179.

ACIP recommends the administration of the hepatitis B vaccine to newborns before they are discharged from the hospital. This is the accepted standard of care and will not be considered a reason to upcode to a different DRG.

The administration of the hepatitis B vaccine to newborns is included in the DRG payment and will not be reimbursed separately.

TVFC provides hepatitis B vaccine free of charge to physicians, hospitals, birthing centers and THSteps providers for administration to Medicaid-eligible clients who are from birth through 18 years of age. For Medicaid clients who are 19 through 20 years of age, providers must

purchase the vaccine. The Texas Medicaid Program will reimburse providers for the cost of the vaccine plus the administration fee.

36.4.21.4 Human Papillomavirus (HPV)

The HPV vaccine (procedure code 1-90649) is a benefit of the Texas Medicaid Program for clients 9 through 20 years of age.

Claims for the HPV vaccine will be considered for reimbursement to providers who administer the HPV vaccine to clients 19 through 20 years of age. The reimbursement fee for procedure code 1-90649 is $128.88. The appropriate administration CPT code will also be considered for reimbursement.

The HPV vaccine procedure code 1-90649 is informational for clients who are from 9 through 18 years of age. It is only considered for reimbursement to providers who administer the HPV vaccine to clients who are from 9 through 18 years of age when the vaccine is not available through the TVFC Program and and who bill using modifier U1. The appropriate administration CPT code will be considered for reimbursement. The vaccine CPT code must be included on the claim to receive reimbursement for the administration.

Providers must use the TVFC Program as the source for the HPV vaccine for TVFC-eligible clients when TVFC has HPV vaccine available. Providers must be enrolled in the TVFC Program to obtain HPV vaccines.

"Not available" is defined by the TVFC Program as:

- A new vaccine approved by ACIP that has not been negotiated or added to the TVFC program.
- Funding for a new vaccine that has not been established by the TVFC Program.
- A vaccine that has national supply and/or distribution issues.

Providers should submit claims with modifier U1 only if using privately purchased vaccine when the vaccine is not available through the TVFC Program.

36.4.21.5 Influenza Vaccine

The influenza vaccine is available through the TVFC for high-risk children who are from birth through 18 years of age. The influenza vaccine is a benefit of the Texas Medicaid Program for high-risk clients of any age when the clients are not covered by THSteps or by the TVFC Program or when the vaccine is not available through the TVFC.

For high-risk adults who are 21 years of age and older, the influenza vaccine is a benefit of the Texas Medicaid Program.

For clients who are birth through 18 years of age, the provider must obtain the vaccine through TVFC.

When the influenza vaccine is provided as part of a THSteps periodic visit, the vaccine is a benefit for clients who are from birth through 20 years of age through THSteps.

When the influenza vaccine is provided as part of an acute medical visit outside of a THSteps periodic visit, the vaccine is a benefit for clients who are from birth through 20 years of age through the Texas Medicaid Program.

When the influenza vaccine is not available through TVFC, the vaccine is a benefit for high-risk children and adolescents through the Texas Medicaid Program.

Providers are expected to follow the guidelines published in "Prevention and Control of Influenza: Recommendations of the Advisory Committee on Immunizations Practices (ACIP), 2007," which is available on the Centers for Disease Control and Prevention (CDC) website at www.cdc.gov/mmwr/preview/mmwrhtml/rr56e629a1.htm.

36.4.21.6 Pneumococcal Polysaccharide Vaccine

For individuals not covered by the THSteps or TVFC programs, the Texas Medicaid Program covers procedure code 1-90732 for high-risk clients who are 2 years of age and older, when it is medically necessary.

Pneumococcal polysaccharide vaccine is indicated for groups of individuals who have long-term health problems that lower the body's resistance to infection. The following indications for vaccination are in keeping with the recommendations of the CDC:

- Adults 65 years of age and older.
- Persons older than 2 years of age who have a long-term illness such as:
  - Alcoholism.
  - Cirrhosis.
  - Diabetes.
  - Heart disease.
  - Leaks of cerebrospinal fluid.
  - Lung disease.
  - Sickle cell disease.
- Persons older than 2 years of age who have an immunosuppressive disease or condition such as:
  - Damaged spleen or no spleen (asplenic).
  - HIV infection or AIDS.
  - Hodgkin's disease.
  - Kidney failure.
  - Lymphoma, leukemia.
  - Multiple myeloma.
  - Nephrotic syndrome.
  - Organ or bone marrow transplant.
- Persons older than 2 years of age who are taking medications or treatments that lower immunity such as:
  - Long-term steroids.
  - Certain cancer drugs.
  - Radiation therapy.

- Alaskan Natives and certain Native American populations.

The initial pneumococcal polysaccharide vaccine is limited to one per client per lifetime. Revaccination is recommended once in a lifetime 5 years after the initial dose for high-risk individuals who fall into the following categories:

- People 65 years of age and older who received their first dose when they were younger than 65 years of age, if 5 or more years have passed since that dose.
- People with any of the following conditions:
  - Damaged spleen or no spleen (asplenic).
  - Sickle-cell disease.
  - HIV infection or AIDS.
  - Cancer, leukemia, lymphoma, or multiple myeloma.
  - Kidney failure.
  - Nephrotic syndrome.
  - Organ or bone marrow transplant recipients.
  - Taking immunosuppressants (chemotherapy or long-term steroids).
- Children 10 years of age and younger may receive a second dose 3 years after the first dose. Those older than 10 years of age may receive it 5 years after the first dose.

Revaccination after a second dose is not a benefit of the Texas Medicaid Program.

Pneumococcal polysaccharide vaccine is not recommended for children younger than 2 years of age.

36.4.21.7 Pneumococcal 7 Valent Conjugate Vaccine

All TVFC-eligible children who are 2 months of age through 59 months of age may receive pneumococcal 7 valent conjugate vaccine from any provider that participates in the TVFC Program.

These children will not need a referral to an FQHC or RHC. Pneumococcal 7 valent conjugate vaccine is covered under TVFC. If a child does not meet TVFC criteria, coverage may be considered through THSteps-CCP with prior authorization. Providers must use procedure code 1-90669 when submitting claims for the pneumococcal 7 valent conjugate vaccine.

36.4.21.8 Hormone Injections

The following hormone procedure codes are a benefit of the Texas Medicaid Program when billed with a valid and applicable diagnosis code that indicates the client's physical condition:

Procedure Codes				
1-J0725	1-J0970	1-J1000	1-J1051	1-J1055
1-J1060	1-J1070	1-J1080	1-J1380	1-J1390
1-J1410	1-J1435	1-J3120	1-J3130	1-J3140
1-J3150	1-J9165			

Injectable Contraceptives

Medroxyprogesterone acetate injectable suspension (*Depo-Provera*) has been approved by the FDA as a method of contraception. Intramuscular injections of medroxyprogesterone acetate given at 90-day intervals has been proven to be a long-term method of preventing pregnancy. Medroxyprogesterone acetate injectable suspension is reimbursed by the Texas Medicaid Program to providers of family planning services.

Medroxyprogesterone acetate should be submitted using procedure code 1-J1055 for females 10 years through 55 years of age. One of the following diagnosis codes must be submitted for the claim to be considered for reimbursement:

Diagnosis Codes				
V2501	V2502	V2509	V2540	V2541
V2549	V255	V258	V259	V615

Medroxyprogesterone acetate/estradiol cypionate (*Lunelle*) has been approved by the FDA as a method of contraception. Intramuscular injections of medroxyprogesterone acetate/estradiol cypionate given at 28 to 30-day intervals has been proven to be a short-term method of preventing pregnancy and is limited to no more frequently than every 28 days.

Note: *Family planning services are available to females, 10 through 55 years of age.*

Growth Hormone

VDP services require prior authorization for outpatient prescriptions for biosynthetic growth hormone injections. Children with growth failure because of lack of adequate endogenous growth hormone secretion may be approved for therapy based on physician documentation of medical necessity.

Consideration for approval by the VDP is based on the following criteria:

- Physical stature less than the third percentile on the growth chart.
- Growth velocity 4 cm or less per year (5 through 10 years of age).
- Bone age a minimum of two years behind chronological age with epiphyses indicating growth potential.
- Evidence of deficient growth hormone production on two pharmacological provocative tests indicating growth hormone deficiency.
- Regular thyroid and other pituitary function studies (may be corrected with replacement therapy).
- Somatomedin C level or IGF/BP3.

Females with Turner's Syndrome may be approved for growth hormone therapy without evidence of deficient growth hormone production on provocative testing if the other criteria are met. Documentation of chromosomal abnormality must be submitted.

Nutropin therapy may be approved for the treatment of growth failure associated with chronic renal insufficiency up to the time of renal transplantation with physician

documentation of diagnosis and growth failure. Approval may be granted for up to a 12-month period. If an extension of benefits is requested, the provider must submit a progress report indicating growth and maturation.

Providers are to send requests for prior approval of somatrem (*Protropin*) and somatropin (*Nutropin, Humatrope, Saizen, Genotropin*) to the following address:

Vendor Drug
Drug Use Review Unit
1100 West 49th Street
Austin, TX 78756-3174
Fax: 1-512-338-6462

36.4.21.9 Ibutilide Fumarate

Procedure code 1-J1742 is a covered benefit of Medicaid. This procedure code is covered for diagnosis codes 42731 and 42732.

No other diagnosis codes are considered for reimbursement for this procedure code.

36.4.21.10 Idarubicin/Idamycin PFS Injection

Idarubicin hydrochloride is available in ready-to-use 5-mg, 10-mg, and 20-mg powder dosages. The new powder form is payable under the existing procedure code 1-J9211. When submitting a claim for this drug, specify the used quantity and/or dose.

36.4.21.11 Idursulfase (*Elaprase*)

Idursulfase is a benefit of the Texas Medicaid Program for the treatment of clients with Hunter syndrome (mucopolysaccharidosis II or MPS II). To be considered for reimbursement, claims must be submitted with procedure code 1-C9232 and diagnosis code 2775.

36.4.21.12 Imitrex

Imitrex should be billed using procedure code 1-J3030. Reimbursement is limited to:

Diagnosis Codes				
34600	34601	34610	34611	34620
34621	34680	34681	34690	34691

Procedure code 1-J3030 is denied for all other diagnosis codes.

Only use procedure code 1-J3030 when the drug is administered in the physician's office or the outpatient hospital by a physician or under the physician's direct supervision. Take-home medication for self-administration is a benefit of the Texas Medicaid Program *only* when provided to clients with Medicaid coverage through the VDP.

36.4.21.13 Immunosuppressive Drugs

Coverage is allowed for FDA-approved intravenous immunosuppressive drugs used for immunosuppression after an approved Texas Medicaid Program organ transplant procedure. Benefits are limited to the one-year period following the date of the beneficiary's discharge from the hospital after an approved Texas Medicaid Program organ transplant, conditional on the client's Medicaid eligibility.

Intravenous immunosuppressive drugs administered by physicians or under their personal supervision are reimbursable to physicians in a physicians office, in the home setting, SNF, and a nonskilled nursing facility. These IV drugs may be reimbursed to the outpatient facility where they were administered. Immunosuppressive drugs administered in the inpatient hospital setting are included in the DRG reimbursement.

Coverage of immunosuppressive drugs includes, but is not limited to:

Procedure Codes		
1-J0480	1-J7501	1-J7504
1-J7505	1-J7511	1-J7516
1-J7525		

Procedure codes 1-J0480 and 1-J7511 are restricted to the following diagnosis codes: V420 and V5844.

Oral self-administered immunosuppressive drugs may be payable through the VDP.

36.4.21.14 Infliximab (*Remicade*)

Infliximab is a benefit for clients with an inadequate response to methotrexate therapy. Procedure code 1-J1745 is reimbursed for the following diagnosis codes:

Diagnosis Codes				
5550	5551	5552	5559	5560
5561	5562	5563	5565	5566
5568	5569	5651	56981	6960
6961	7140	7141	7142	71430
7200				

Documentation supporting the client's inadequate response to methotrexate-only therapy must be maintained in the client's file. The documentation is subject to retrospective review.

36.4.21.15 Interferon Injections

The following interferon procedure codes are payable when billed with a covered diagnosis:

Procedure Codes		
1-J1825	1-J9212	1-J9213
1-J9214	1-J9215	1-J9216
1-Q3025	1-Q3026	

The following diagnosis codes are payable for interferon injection procedure codes 1-J9213, 1-J9214, 1-J9215, and 1-J9216:

Diagnosis Codes				
07030	07031	07051	07052	07053
07054	07059	07070	07071	07810
1530	1531	1532	1533	1534
1535	1536	1537	1538	1539
1720	1721	1722	1723	1724
1725	1726	1727	1728	1729
1730	1731	1732	1733	1734
1735	1736	1737	1738	1739
1760	1761	1762	1763	1764
1765	1768	1769	1800	1801
1808	1809	1880	1881	1882
1883	1884	1885	1886	1887
1888	1889	1890	1891	1970
1975	1980	1981	19882	20000
20001	20002	20003	20004	20005
20006	20007	20008	20020	20021
20022	20023	20024	20025	20026
20027	20028	20080	20081	20082
20083	20084	20085	20086	20087
20088	20200	20201	20202	20203
20204	20205	20206	20207	20208
20210	20211	20212	20213	20214
20215	20216	20217	20218	20220
20221	20222	20223	20224	20225
20226	20227	20228	20240	20241
20242	20243	20244	20245	20246
20247	20248	20280	20281	20282
20283	20284	20285	20286	20287
20288	20300	20301	20310	20311
20380	20381	20510	20511	2121
2303	2331	2337	2339	2367
2384	23879	2394	2395	2592
28730	2890	28952	28981	28982
28989	2899	57140	57141	57149
V1052				

Interferon injections are also covered for the following diagnoses:

- Procedure codes 1-J1825, 1-Q3025, and 1-Q3026 are payable only for diagnosis 340.
- Procedure code 1-J9212 is payable only for diagnosis 07054.

Nipent procedure code 1-J9268 may be submitted with one of the following diagnosis codes for the treatment of adult patients with alpha interferon-refractory hairy cell leukemia:

Diagnosis Codes				
20240	20241	20242	20243	20244
20245	20246	20247	20248	

Interferon injections for all other diagnosis codes are denied.

36.4.21.16 Intralesional Injection(s)

Procedure codes 2-11900 and 2-11901 for intralesional injections must be submitted with one of the following diagnosis codes:

Diagnosis Codes				
0780	0850	0851	0852	0853
0854	0855	0859	135	6953
6960	6961	6962	6963	6964
6965	6968	7014	7015	70583
7060	7061	9400	9401	9402
9403	9404	9405	9409	94100
94101	94102	94103	94104	94105
94106	94107	94108	94109	94110
94111	94112	94113	94114	94115
94116	94117	94118	94119	94120
94121	94122	94123	94124	94125
94126	94127	94128	94129	94130
94131	94132	94133	94134	94135
94136	94137	94138	94139	94140
94141	94142	94143	94144	94145
94146	94147	94148	94149	94150
94151	94152	94153	94154	94155
94156	94157	94158	94159	94200
94201	94202	94203	94204	94205
94209	94210	94211	94212	94213
94214	94215	94219	94220	94221
94222	94223	94224	94225	94229
94230	94231	94232	94233	94234
94235	94239	94240	94241	94242
94243	94244	94245	94249	94250
94251	94252	94253	94254	94255
94259	94300	94301	94302	94303
94304	94305	94306	94309	94310
94311	94312	94313	94314	94315
94316	94319	94320	94321	94322
94323	94324	94325	94326	94329
94330	94331	94332	94333	94334

Diagnosis Codes				
94335	94336	94339	94340	94341
94342	94343	94344	94345	94346
94349	94350	94351	94352	94353
94354	94355	94356	94359	94400
94401	94402	94403	94404	94405
94406	94407	94408	94410	94411
94412	94413	94414	94415	94416
94417	94418	94420	94421	94422
94423	94424	94425	94426	94427
94428	94430	94431	94432	94433
94434	94435	94436	94437	94438
94440	94441	94442	94443	94444
94445	94446	94447	94448	94450
94451	94452	94453	94454	94455
94456	94457	94458	94500	94501
94502	94503	94504	94505	94506
94509	94510	94511	94512	94513
94514	94515	94516	94519	94520
94521	94522	94523	94524	94525
94526	94529	94530	94531	94532
94533	94534	94535	94536	94539
94540	94541	94542	94543	94544
94545	94546	94549	94550	94551
94552	94553	94554	94555	94556
94559	9460	9461	9462	9463
9464	9465	9470	9471	9472
9473	9474	9478	9479	94800
94810	94811	94820	94821	94822
94830	94831	94832	94833	94840
94841	94842	94843	94844	94850
94851	94852	94853	94854	94855
94860	94861	94862	94863	94864
94865	94866	94870	94871	94872
94873	94874	94875	94876	94877
94880	94881	94882	94883	94884
94885	94886	94887	94888	94890
94891	94892	94893	94894	94895
94896	94897	94898	94899	9490
9491	9492	9493	9494	9495

36.4.21.17 Irinotecan

When billing for irinotecan, use procedure code 1-J9206. The quantity administered, per 20 mg, must be present on the claim. For example, if a dose of 200 mg is administered, a quantity of 10 should appear on the claim.

36.4.21.18 Iron Injections

To submit claims for iron injections, use procedure codes 1-J1750, 1-J1751, 1-J1752, 1-J1756, and 1-J9216.

Iron Dextran

Procedure codes 1-J1751 and 1-J1752 are benefits when submitted with one of the following diagnosis codes for renal diseases or conditions:

Diagnosis Codes				
5800	5804	58081	58089	5809
5810	5811	5812	5813	58181
58189	5819	5820	5821	5822
5824	58281	58289	5829	5830
5831	5832	5834	5836	5837
58381	58389	5839	5845	5846
5847	5848	5849	5856	586
587	5880	5881	58881	58889
5889	5890	5891	5899	59000
59001	59010	59011	5902	5903
59080	59081	5909	591	5920
5921	5929	5930	5931	5932
5933	5934	5935	5936	59370
59371	59372	59373	59381	59382
59389	5939			

Procedure codes 1-J1751 and 1-J1752 are covered for the following diagnosis codes for active hemorrhage:

Diagnosis Codes				
4480	4560	4590	5307	53082
53100	53101	53110	53111	53120
53121	53140	53141	53150	53151
53160	53161	53200	53201	53210
53211	53220	53221	53240	53241
53250	53251	53260	53261	53300
53301	53310	53311	53320	53321
53340	53341	53350	53351	53360
53361	53400	53401	53410	53411
53420	53421	53440	53441	53450
53451	53460	53461	53501	53511
53521	53531	53541	53551	53561
56202	56203	56212	56213	56985
5780	5781	5789	7724	

Procedure codes 1-J1751 and 1-J1752 are covered for the following diagnosis codes for anemia:

Diagnosis Codes				
2800	2801	2808	2809	64820
64821	64822	64823	64824	

Sodium Ferric Gluconate Complex in Sucrose (*Ferrlecit*)

Procedure code 1-J2916 is a benefit for the treatment of iron deficiency anemia in patients undergoing chronic hemodialysis who are receiving supplemental EPO therapy. Sodium ferric gluconate complex is covered for the following diagnosis codes: 28521 and 5856.

Iron Sucrose (*Venofer*)

Procedure code 1-J1756 is a benefit of The Texas Medicaid Program for the treatment of iron deficiency anemia in patients undergoing chronic hemodialysis who are receiving supplemental EPO therapy. The following diagnosis codes are payable: 28521 and 5856.

36.4.21.19 Joint Injections and Trigger Point Injections

Injections into joints should be coded using procedure codes 2-20600, 2-20605, 2-20610, and 2-20612.

Trigger point injections should be coded using procedure codes 2/F-20526, 2/F-20550, 2/F-20551, 2/F-20552, and 2/F-20553.

These procedures are valid only in the treatment of acute problems. Procedures for chronic diagnosis codes are denied. The provider must use the AT modifier to indicate an acute condition.

36.4.21.20 Leuprolide Acetate (*Lupron Depot*)

Leuprolide acetate is a synthetic gonadotropin-releasing hormone that has been found to be effective when administered at monthly intervals in order to treat endometriosis and in the palliative treatment of prostatic cancer at the following doses:

Diagnosis	Dosage	Availability/Kits
Treatment of endometriosis	3.75 mg	Monthly
Palliative treatment of prostatic cancer	7.5 mg	Monthly
	22.5 mg	3-month kit
	30 mg	4-month kit
	65 mg implant	Annually

Procedure codes 1-J9217, 1-J1950, or 1-J9219 should be used when submitting Leuprolide Acetate for consideration of reimbursement.

Procedure code 1-J9217 is considered for reimbursement when administered monthly for the following diagnosis codes: 185, 19882, 2334, and 2591.

Procedure code 1-J9217 is denied when submitted for reimbursement more than once per month and for other than the diagnosis codes listed above.

Procedure code 1-J1950 is limited to once per month and the following diagnosis codes:

Diagnosis Codes				
2180	2181	2182	2189	6170
6171	6172	6173	6174	6175
6176	6178	6179		

Procedure code 1-J1950 is denied with submitted for reimbursement more than once a month and for other than the above-listed diagnoses.

Procedure code 1-J9218 is a benefit of the Texas Medicaid Program when administered by a physician in the office setting (POS 1). One of the following diagnosis codes must be submitted on the claim: 185, 19882, or 2334.

Procedure code 1-J9218 is denied for other than the diagnosis codes listed above.

Procedure code 1-J9219 is considered for reimbursement once per year in the office and outpatient settings (POS 1 and 5) when submitted with one of the following diagnosis codes: 185 or 2334.

Procedure code 1-J9219 is denied when submitted for reimbursement more than once per year and for diagnosis codes other than those listed above.

The 3-month kit (22.5 mg) and the 4-month kit (30 mg) may be submitted for reimbursement with one of the following diagnosis codes: 18500, 19882, or 23340.

36.4.21.21 Linezolid

Linezolid, a new class of antibiotic, is a benefit of the Texas Medicaid Program. The FDA-recommended uses of linezolid include:

- The treatment of vancomycin-resistant enterococcus faecium infections.
- Nosocomial pneumonia.
- Complicated and uncomplicated skin and skin structure infections.
- Community-acquired pneumonia.

Oral forms of linezolid are covered through the VDP.

Note: *Linezolid intravenous injection is covered only in the inpatient setting as a part of the DRG payment.*

36.4.21.22 Melphalan Hydrochloride

Procedure code 1-J9245 is reimbursed by the Texas Medicaid Program when billed for the following diagnosis codes:

Diagnosis Codes				
1740	1741	1742	1743	1744
1745	1746	1748	1749	1750
1759	1830	1860	1869	20300
20301				

Procedure code 1-J9245 is denied for all other diagnosis codes.

36.4.21.23 Omalizumab

Omalizumab is an injectable drug that is FDA approved for the treatment of clients 12 years of age and older with severe asthma. Omalizumab is a benefit to Medicaid-eligible clients when medically necessary and must be prior authorized. THSteps-eligible clients under age 12 years will be considered on an exception basis through CCP.

When requesting prior authorization, the exact dosage must be included with the request using procedure code 1-J2357. Doses and dosing frequency are determined by body weight and by serum IgE level (IU/mL) measured before the start of the treatment. Each prior authorization of omalizumab is based on provider documentation with the following medical necessity criteria:

- Diagnosis of asthma.
- 12 years of age or older.
- Documentation of positive skin test or RAST to a perennial (not seasonal) aeroallergen within the past 36 months.
- Total IgE level greater than 30 IU/ml but less than 700 IU/ml within the past 12 months.
- Documentation of appropriate dose of inhaled steroid prescribed (roughly equivalent to greater than or equal to 660 microgram/day of fluticasone [adult] or comparable dose of other inhaled steroid; based on the National Asthma Educational Prevention Program Expert Panel).
- Documentation of patient compliance with inhaled steroid regimen.
- Clinical evidence of inadequate asthma control. This evidence may include:
  - Dependence upon continuous systemic steroids, maximal inhaled steroid regimen with frequent systemic steroid pulses.
  - Significantly declining pulmonary function test, or frequent hospitalizations for severe asthma exacerbations in the face of adequate maximal standard therapy and patient has to have been on daily therapy for persistent asthma for at least one year, with daily use of beta agonist.
- A pulmonary function test (performed within the last year) must demonstrate a forced expiratory volume (FEV) 1.0 less than 80 percent of predicted in conjunction with FEV 1.0/FVC ratio<0.7 of pulmonary function test; and results demonstrating on the same test a 12 percent or greater post-bronchodilator improvement of FEV 1.0.
- Pulmonary function tests must have been performed within the prior 12 months and be documented for all clients when requesting prior authorization for omalizumab. Exceptions may be considered with documentation of medical reasons as to why the test cannot be performed, and with documentation of an absence of exclusion criteria (client is not currently smoking, client is not pregnant/intending pregnancy, client is not breast-feeding).

Prior authorization approvals for omalizumab are for intervals of three months at a time. Clients must be fully compliant with their omalizumab regimen in order to qualify for any additional authorizations. The provider must submit a statement documenting full compliance with the requests for each renewal. After nine continuous months of omalizumab authorizations, the requesting provider must submit documentation of satisfactory clinical response to omalizumab in order to qualify for any additional authorizations. Prior authorizations will be considered on an individual basis for lapses in treatment with provider documentation.

Providers may not bill separately for an office visit if the only reason for the visit was the omalizumab injection.

36.4.21.24 Paclitaxel

Procedure code 1-J9265 is covered for the following diagnosis codes:

Diagnosis Codes				
1588	1620	1622	1623	1624
1625	1628	1629	1740	1741
1742	1743	1744	1745	1746
1748	1749	1750	1759	1760
1761	1762	1763	1764	1765
1768	1769	1830	1832	1833
1834	1835	1838	1839	1880
1881	1882	1883	1884	1885
1886	1887	1888	1889	1950
1986	19881			

Procedure code 1-J9264 is not restricted by diagnosis, however, a valid and applicable diagnosis code that indicates the client's physical condition is required for reimbursement consideration.

36.4.21.25 Pentagastrin

Pentagastrin billed in conjunction with gastric function studies is considered separately for reimbursement.

36.4.21.26 Porfimer (*Photofrin*)

Procedure code 1-J9600 is a covered benefit and limited to the following diagnosis codes:

Diagnosis Codes				
1500	1501	1502	1503	1504
1505	1508	1509	1978	

36.4.21.27 Rho(D) Immune Globulin

Use procedure codes 1-J2790 and 1-J2792, as applicable, when billing for Rho(D) Immune Globulin.

36.4.21.28 Rituximab

Rituximab is payable using procedure code 1-J9310. A valid and applicable diagnosis code that indicates the client's physical condition is required for reimbursement consideration.

Inpatient settings may be reimbursed under a DRG methodology. Outpatient facilities may be reimbursed at their reimbursement rate.

36.4.21.29 Filgrastim, Pegfilgrastim (G-CSF), and Sargramostim (GM-CSF)

Filgrastim and pegfilgrastim are granulocyte colony stimulating factors (G-CSFs). Sargramostim is a granulocyte-macrophage colony stimulating factor (GM-CSF). GM-CSF and G-CSF stimulate neutrophil production after autologous bone marrow transplant and significantly reduce the duration and impact of neutropenia. Use procedure codes 1-J1440, 1-J1441, 1-J2505, or 1-J2820 with the number of units administered.

One of the following diagnosis codes must be submitted with the appropriate procedure code for the claim to be considered for reimbursement:

Diagnosis Codes				
1400	1401	1403	1404	1405
1406	1408	1409	1410	1411
1412	1413	1414	1415	1416
1418	1419	1420	1421	1422
1428	1429	1430	1431	1438
1439	1440	1441	1448	1449
1450	1451	1452	1453	1454
1455	1456	1458	1459	1460
1461	1462	1463	1464	1465
1466	1467	1468	1469	1470
1471	1472	1473	1478	1479
1480	1481	1482	1483	1488
1489	1490	1491	1498	1499
1500	1501	1502	1503	1504
1505	1508	1509	1510	1511
1512	1513	1514	1515	1516
1518	1519	1520	1521	1522
1523	1528	1529	1530	1531
1532	1533	1534	1535	1536
1537	1538	1539	1540	1541
1542	1543	1548	1550	1551
1552	1560	1561	1562	1568
1569	1570	1571	1572	1573
1574	1578	1579	1580	1588
1589	1590	1591	1598	1599
1600	1601	1602	1603	1604

Diagnosis Codes				
1605	1608	1609	1610	1611
1612	1613	1618	1619	1620
1622	1623	1624	1625	1628
1629	1630	1631	1638	1639
1640	1641	1642	1643	1648
1649	1650	1658	1659	1700
1701	1702	1703	1704	1705
1706	1707	1708	1709	1710
1712	1713	1714	1715	1716
1717	1718	1719	1720	1721
1722	1723	1724	1725	1726
1727	1728	1729	1730	1731
1732	1733	1734	1735	1736
1737	1738	1739	1740	1741
1742	1743	1744	1745	1746
1748	1749	1750	1759	1760
1761	1762	1763	1764	1765
1768	1769	179	1800	1801
1808	1809	181	1820	1821
1828	1830	1832	1833	1834
1835	1838	1839	1840	1841
1842	1843	1844	1848	1849
185	1860	1869	1871	1872
1873	1874	1875	1876	1877
1878	1879	1880	1881	1882
1883	1884	1885	1886	1887
1888	1889	1890	1891	1892
1893	1894	1898	1899	1900
1901	1902	1903	1904	1905
1906	1907	1908	1909	1910
1911	1912	1913	1914	1915
1916	1917	1918	1919	1920
1921	1922	1923	1928	1929
193	1940	1941	1943	1944
1945	1946	1948	1949	1950
1951	1952	1953	1954	1955
1958	1960	1961	1962	1963
1965	1966	1968	1969	1970
1971	1972	1973	1974	1975
1976	1977	1978	1980	1981
1982	1983	1984	1985	1986
1987	19881	19882	19889	1990
1991	20000	20001	20002	20003
20004	20005	20006	20007	20008

Diagnosis Codes				
20010	20011	20012	20013	20014
20015	20016	20017	20018	20020
20021	20022	20023	20024	20025
20026	20027	20028	20030	20031
20032	20033	20034	20035	20036
20037	20038	20040	20041	20042
20043	20044	20045	20046	20047
20048	20050	20051	20052	20053
20054	20055	20056	20057	20058
20060	20061	20062	20063	20064
20065	20066	20067	20068	20070
20071	20072	20073	20074	20075
20076	20077	20078	20080	20081
20082	20083	20084	20085	20086
20087	20088	20100	20101	20102
20103	20104	20105	20106	20107
20108	20110	20111	20112	20113
20114	20115	20116	20117	20118
20120	20121	20122	20123	20124
20125	20126	20127	20128	20140
20141	20142	20143	20144	20145
20146	20147	20148	20150	20151
20152	20153	20154	20155	20156
20157	20158	20160	20161	20162
20163	20164	20165	20166	20167
20168	20170	20171	20172	20173
20174	20175	20176	20177	20178
20190	20191	20192	20193	20194
20195	20196	20197	20198	20200
20201	20202	20203	20204	20205
20206	20207	20208	20210	20211
20212	20213	20214	20215	20216
20217	20218	20220	20221	20222
20223	20224	20225	20226	20227
20228	20230	20231	20232	20233
20234	20235	20236	20237	20238
20240	20241	20242	20243	20244
20245	20246	20247	20248	20250
20251	20252	20253	20254	20255
20256	20257	20258	20260	20261
20262	20263	20264	20265	20266
20267	20268	20270	20271	20272
20273	20274	20275	20276	20277
20278	20280	20281	20282	20283

Diagnosis Codes				
20284	20285	20286	20287	20288
20290	20291	20292	20293	20294
20295	20296	20297	20298	20300
20301	20310	20311	20400	20401
20410	20411	20420	20421	20480
20481	20490	20491	20500	20501
20510	20511	20520	20521	20530
20531	20580	20581	20590	20591
20600	20601	20610	20611	20620
20621	20680	20681	20690	20691
20700	20701	20710	20711	20720
20721	20780	20781	20800	20801
20810	20811	20820	20821	20880
20881	20890	20891	2300	2301
2302	2303	2304	2305	2306
2307	2308	2309	2310	2311
2312	2318	2319	2320	2321
2322	2323	2324	2325	2326
2327	2328	2329	2330	2331
2332	23330	23331	23332	23339
2334	2335	2336	2337	2339
2340	2348	2349	28481	28489
28801	28802	28803	28804	7767
9631	99685	V4281	V4282	V5811
V5812	V622			

36.4.21.30 Strontium-89 Chloride

Supply of therapeutic radiopharmaceutical, strontium-89 chloride, per mci, is a benefit of the Texas Medicaid Program. Strontium-89 should be billed using procedure code 9-A9600 and is limited to a total of ten mci intravenously injected every 90 days, any provider.

Reimbursement of strontium-89 is restricted to the following diagnosis codes:

Diagnosis Codes				
1740	1741	1742	1743	1744
1745	1746	1748	1749	1750
1759	185	1985		

Reimbursement of strontium-89 is limited to hospital facilities, freestanding radiation treatment centers (POS 5), and the office setting (POS 1). Metastron (strontium-89) provided in the inpatient setting (POS 3) is part of the DRG reimbursement, and no separate payment is made.

36.4.21.31 Tetanus Injections, Acute Care

Tetanus toxoid adsorbed and tetanus immune globulin, human are benefits of the Texas Medicaid Program.

Tetanus toxoid adsorbed is an immunization used to prevent tetanus. It produces immunity to tetanus by promoting antibody production. The tetanus immune globulin provides a passive immunity for injuries that are over 24 hours old, extensively contaminated, and/or for the client who has had less than two tetanus toxoid injections in a lifetime. Therefore, both of these injections can be given on the same day for the same injury event.

Tetanus toxoid absorbed and tetanus immune globulin should be billed with the following procedure codes: 1-90703 and 1-J1670.

Tetanus toxoid and tetanus immune globulin injections are covered for injuries, such as puncture wounds, burns, or abrasions. These injections are diagnosis-restricted to the codes listed in the following table:

Diagnosis Codes				
80000	80001	80002	80003	80004
80005	80006	80009	80010	80011
80012	80013	80014	80015	80016
80019	80020	80021	80022	80023
80024	80025	80026	80029	80030
80031	80032	80033	80034	80035
80036	80039	80040	80041	80042
80043	80044	80045	80046	80049
80050	80051	80052	80053	80054
80055	80056	80059	80060	80061
80062	80063	80064	80065	80066
80069	80070	80071	80072	80073
80074	80075	80076	80079	80080
80081	80082	80083	80084	80085
80086	80089	80090	80091	80092
80093	80094	80095	80096	80099
80100	80101	80102	80103	80104
80105	80106	80109	80110	80111
80112	80113	80114	80115	80116
80119	80120	80121	80122	80123
80124	80125	80126	80129	80130
80131	80132	80133	80134	80135
80136	80139	80140	80141	80142
80143	80144	80145	80146	80149
80150	80151	80152	80153	80154
80155	80156	80159	80160	80161
80162	80163	80164	80165	80166
80169	80170	80171	80172	80173
80174	80175	80176	80179	80180
80181	80182	80183	80184	80185

Diagnosis Codes				
80186	80189	80190	80191	80192
80193	80194	80195	80196	80199
8020	8021	80220	80221	80222
80223	80224	80225	80226	80227
80228	80229	80230	80231	80232
80233	80234	80235	80236	80237
80238	80239	8024	8025	8026
8027	8028	8029	80300	80301
80302	80303	80304	80305	80306
80309	80310	80311	80312	80313
80314	80315	80316	80319	80320
80321	80322	80323	80324	80325
80326	80329	80330	80331	80332
80333	80334	80335	80336	80339
80340	80341	80342	80343	80344
80345	80346	80349	80350	80351
80352	80353	80354	80355	80356
80359	80360	80361	80362	80363
80364	80365	80366	80369	80370
80371	80372	80373	80374	80375
80376	80379	80380	80381	80382
80383	80384	80385	80386	80389
80390	80391	80392	80393	80394
80395	80396	80399	80400	80401
80402	80403	80404	80405	80406
80409	80410	80411	80412	80413
80414	80415	80416	80419	80420
80421	80422	80423	80424	80425
80426	80429	80430	80431	80432
80433	80434	80435	80436	80439
80440	80441	80442	80443	80444
80445	80446	80449	80450	80451
80452	80453	80454	80455	80456
80459	80460	80461	80462	80463
80464	80465	80466	80469	80470
80471	80472	80473	80474	80475
80476	80479	80480	80481	80482
80483	80484	80485	80486	80489
80490	80491	80492	80493	80494
80495	80496	80499	80500	80501
80502	80503	80504	80505	80506
80507	80508	80510	80511	80512
80513	80514	80515	80516	80517
80518	8052	8053	8054	8055

Diagnosis Codes				
8056	8057	8058	8059	80600
80601	80602	80603	80604	80605
80606	80607	80608	80609	80610
80611	80612	80613	80614	80615
80616	80617	80618	80619	80620
80621	80622	80623	80624	80625
80626	80627	80628	80629	80630
80631	80632	80633	80634	80635
80636	80637	80638	80639	8064
8065	80660	80661	80662	80669
80670	80671	80672	80679	8068
8069	80700	80701	80702	80703
80704	80705	80706	80707	80708
80709	80710	80711	80712	80713
80714	80715	80716	80717	80718
80719	8072	8073	8074	8075
8076	8080	8081	8082	8083
80841	80842	80843	80849	80851
80852	80853	80859	8088	8089
8090	8091	81000	81001	81002
81003	81010	81011	81012	81013
81100	81101	81102	81103	81109
81110	81111	81112	81113	81119
81200	81201	81202	81203	81209
81210	81211	81212	81213	81219
81220	81221	81230	81231	81240
81241	81242	81243	81244	81249
81250	81251	81252	81253	81254
81259	81300	81301	81302	81303
81304	81305	81306	81307	81308
81310	81311	81312	81313	81314
81315	81316	81317	81318	81320
81321	81322	81323	81330	81331
81332	81333	81340	81341	81342
81343	81344	81345	81350	81351
81352	81353	81354	81380	81381
81382	81383	81390	81391	81392
81393	81400	81401	81402	81403
81404	81405	81406	81407	81408
81409	81410	81411	81412	81413
81414	81415	81416	81417	81418
81419	81500	81501	81502	81503
81504	81509	81510	81511	81512
81513	81514	81519	81600	81601

Diagnosis Codes				
81602	81603	81610	81611	81612
81613	8170	8171	8180	8181
8190	8191	82000	82001	82002
82003	82009	82010	82011	82012
82013	82019	82020	82021	82022
82030	82031	82032	8208	8209
82100	82101	82110	82111	82120
82121	82122	82123	82129	82130
82131	82132	82133	82139	8220
8221	82300	82301	82302	82310
82311	82312	82320	82321	82322
82330	82331	82332	82340	82341
82342	82380	82381	82382	82390
82391	82392	8240	8241	8242
8243	8244	8245	8246	8247
8248	8249	8250	8251	82520
82521	82522	82523	82524	82525
82529	82530	82531	82532	82533
82534	82535	82539	8260	8261
8270	8271	8280	8281	8290
8291	8300	8301	83100	83101
83102	83103	83104	83109	83110
83111	83112	83113	83114	83119
83200	83201	83202	83203	83204
83209	83210	83211	83212	83213
83214	83219	83300	83301	83302
83303	83304	83305	83309	83310
83311	83312	83313	83314	83315
83319	83400	83401	83402	83410
83411	83412	83500	83501	83502
83503	83510	83511	83512	83513
8360	8361	8362	8363	8364
83650	83651	83652	83653	83654
83659	83660	83661	83662	83663
83664	83669	8370	8371	83800
83801	83802	83803	83804	83805
83806	83809	83810	83811	83812
83813	83814	83815	83816	83819
83900	83901	83902	83903	83904
83905	83906	83907	83908	83910
83911	83912	83913	83914	83915
83916	83917	83918	83920	83921
83930	83931	83940	83941	83942
83949	83950	83951	83952	83959

Diagnosis Codes				
83961	93969	83971	83979	8398
8399	8400	8401	8402	8403
8404	8405	8406	8407	8408
8409	8410	8411	8412	8413
8418	8419	84200	84201	84202
84209	84210	84211	84212	84213
84219	8430	8431	8438	8439
8440	8441	8442	8443	8448
8449	84500	84501	84502	84503
84509	84510	84511	84512	84513
84519	8460	8461	8462	8463
8468	8469	8470	8471	8472
8473	8474	8479	8480	8481
8482	8483	84840	84841	84842
84849	8485	8488	8489	8500
85011	85012	8502	8503	8504
8505	8509	85100	85101	85102
85103	85104	85105	85106	85109
85110	85111	85112	85113	85114
85115	85116	85119	85120	85121
85122	85123	85124	85125	85126
85129	85130	85131	85132	85133
85134	85135	85136	85139	85140
85141	85142	85143	85144	85145
85146	85149	85150	85151	85152
85153	85154	85155	85156	85159
85160	85161	85162	85163	85164
85165	85166	85169	85170	85171
85172	85173	85174	85175	85176
85179	85180	85181	85182	85183
85184	85185	85186	85189	85190
85191	85192	85193	85194	85195
85196	85199	85200	85201	85202
85203	85204	85205	85206	85209
85210	85211	85212	85213	85214
85215	85216	85219	85220	85221
85222	85223	85224	85225	85226
85229	85230	85231	85232	85233
85234	85235	85236	85239	85240
85241	85242	85243	85244	85245
85246	85249	85250	85251	85252
85253	85254	85255	85256	85259
85300	85301	85302	85303	85304
85305	85306	85309	85310	85311

Diagnosis Codes				
85312	85313	85314	85315	85316
85319	85400	85401	85402	85403
85404	85405	85406	85409	85410
85411	85412	85413	85414	85415
85416	85419	8600	8601	8602
8603	8604	8605	86100	86101
86102	86103	86110	86111	86112
86113	86120	86121	86122	86130
86131	86132	8620	8621	86221
86222	86229	86231	86232	86239
8628	8629	8630	8631	86320
86321	86329	86330	86331	86339
86340	86341	86342	86343	86344
86345	86346	86349	86350	86351
86352	86353	86354	86355	86356
86359	86380	86381	86382	86383
86384	86385	86389	86390	86391
86392	86393	86394	86395	86399
86400	86401	86402	86403	86404
86405	86409	86410	86411	86412
86413	86414	86415	86419	86500
86501	86502	86503	86504	86509
86510	86511	86512	86513	86514
86519	86600	86601	86602	86603
86610	86611	86612	86613	8670
8671	8672	8673	8674	8675
8676	8677	8678	8679	86800
86801	86802	86803	86804	86809
86810	86811	86812	86813	86814
86819	8690	8691	8700	8701
8702	8703	8704	8708	8709
8710	8711	8712	8713	8714
8715	8716	8717	8719	87200
87201	87202	87210	87211	87212
87261	87262	87263	87264	87269
87271	87272	87273	87274	87279
8728	8729	8730	8731	87320
87321	87322	87323	87329	87330
87331	87332	87333	87339	87340
87341	87342	87343	87344	87349
87350	87351	87352	87353	87354
87359	87360	87361	87362	87363
87364	87365	87369	87370	87371
87372	87373	87374	87375	87379

Diagnosis Codes				
8738	8739	87400	87401	87402
87410	87411	87412	8742	8743
8744	8745	8748	8749	8750
8751	8760	8761	8770	8771
8780	8781	8782	8783	8784
8785	8786	8787	8788	8789
8790	8791	8792	8793	8794
8795	8796	8797	8798	8799
88000	88001	88002	88003	88009
88010	88011	88012	88013	88019
88020	88021	88022	88023	88029
88100	88101	88102	88110	88111
88112	88120	88121	88122	8820
8821	8822	8830	8831	8832
8840	8841	8842	8850	8851
8860	8861	8870	8871	8872
8873	8874	8875	8876	8877
8900	8901	8902	8910	8911
8912	8920	8921	8922	8930
8931	8932	8940	8941	8942
8950	8951	8960	8961	8962
8963	8970	8971	8972	8973
8974	8975	8976	8977	90000
90001	90002	90003	9001	90081
90082	90089	9009	9010	9011
9012	9013	90140	90141	90142
90181	90182	90183	90189	9019
9020	90210	90211	90219	90220
90221	90222	90223	90224	90225
90226	90227	90229	90231	90232
90233	90234	90239	90240	90241
90242	90249	90250	90251	90252
90253	90254	90255	90256	90259
90281	90282	90287	90289	9029
90300	90301	90302	9031	9032
9033	9034	9035	9038	9039
9040	9041	9042	9043	90440
90441	90442	90450	90451	90452
90453	90454	9046	9047	9048
9049	9050	9051	9052	9053
9054	9055	9056	9057	9058
9059	9060	9061	9062	9063
9064	9065	9066	9067	9068
9069	9070	9071	9072	9073

Diagnosis Codes				
9074	9075	9079	9080	9081
9082	9083	9084	9085	9086
9089	9090	9091	9092	9093
9094	9095	9099	9100	9101
9102	9103	9104	9105	9106
9107	9108	9109	9110	9111
9112	9113	9114	9115	9116
9117	9118	9119	9120	9121
9122	9123	9124	9125	9126
9127	9128	9129	9130	9131
9132	9133	9134	9135	9136
9137	9138	9139	9140	9141
9142	9143	9144	9145	9146
9147	9148	9149	9150	9151
9152	9153	9154	9155	9156
9157	9158	9159	9160	9161
9162	9163	9164	9165	9166
9167	9168	9169	9170	9171
9172	9173	9174	9175	9176
9177	9178	9179	9180	9181
9182	9189	9190	9191	9192
9193	9194	9195	9196	9197
9198	9199	920	9210	9211
9212	9213	9219	9220	9221
9222	92231	92232	92233	9224
9228	9229	92300	92301	92302
92303	92309	92310	92311	92320
92321	9233	9238	9239	92400
92401	92410	92411	92420	92421
9243	9244	9245	9248	9249
9251	9252	9260	92611	92612
92619	9268	9269	92700	92701
92702	92703	92709	92710	92711
92720	92721	9273	9278	9279
92800	92801	92810	92811	92820
92821	9283	9288	9289	9290
9299	9300	9301	9302	9308
9309	931	932	9330	9331
9340	9341	9348	9349	9350
9351	9352	936	937	938
9390	9391	9392	9393	9399
9400	9401	9402	9403	9404
9405	9409	94100	94101	94102
94103	94104	94105	94106	94107

Diagnosis Codes				
94108	94109	94110	94111	94112
94113	94114	94115	94116	94117
94118	94119	94120	94121	94122
94123	94124	94125	94126	94127
94128	94129	94130	94131	94132
94133	94134	94135	94136	94137
94138	94139	94140	94141	94142
94143	94144	94145	94146	94147
94148	94149	94150	94151	94152
94153	94154	94155	94156	94157
94158	94159	94200	94201	94202
94203	94204	94205	94209	94210
94211	94212	94213	94214	94215
94219	94220	94221	94222	94223
94224	94225	94229	94230	94231
94232	94233	94234	94235	94239
94240	94241	94242	94243	94244
94245	94249	94250	94251	94252
94253	94254	94255	94259	94300
94301	94302	94303	94304	94305
94306	94309	94310	94311	94312
94313	94314	94315	94316	94319
94320	94321	94322	94323	94324
94325	94326	94329	94330	94331
94332	94333	94334	94335	94336
94339	94340	94341	94342	94343
94344	94345	94346	94349	94350
94351	94352	94353	94354	94355
94356	94359	94400	94401	94402
94403	94404	94405	94406	94407
94408	94410	94411	94412	94413
94414	94415	94416	94417	94418
94420	94421	94422	94423	94424
94425	94426	94427	94428	94430
94431	94432	94433	94434	94435
94436	94437	94438	94440	94441
94442	94443	94444	94445	94446
94447	94448	94450	94451	94452
94453	94454	94455	94456	94457
94458	94500	94501	94502	94503
94504	94505	94506	94509	94510
94511	94512	94513	94514	94515
94516	94519	94520	94521	94522
94523	94524	94525	94526	94529

Diagnosis Codes				
94530	94531	94532	94533	94534
94535	94536	94539	94540	94541
94542	94543	94544	94545	94546
94549	94550	94551	94552	94553
94554	94555	94556	94559	9460
9461	9462	9463	9464	9465
9470	9471	9472	9473	9474
9478	9479	94800	94810	94811
94820	94821	94822	94830	94831
94832	94833	94840	94841	94842
94843	94844	94850	94851	94852
94853	94854	94855	94860	94861
94862	94863	94864	94865	94866
94870	94871	94872	94873	94874
94875	94876	94877	94880	94881
94882	94883	94884	94885	94886
94887	94888	94890	94891	94892
94893	94894	94895	94896	94897
94898	94899	9490	9491	9492
9493	9494	9495	9500	9501
9502	9503	9509	9510	9511
9512	9513	9514	9515	9516
9517	9518	9519	95200	95201
95202	95203	95204	95205	95206
95207	95208	95209	95210	95211
95212	95213	95214	95215	95216
95217	95218	95219	9522	9523
9524	9528	9529	9530	9531
9532	9533	9534	9535	9538
9539	9540	9541	9548	9549
9550	9551	9552	9553	9554
9555	9556	9557	9558	9559
9560	9561	9562	9563	9564
9565	9568	9569	9570	9571
9578	9579	9580	9581	9582
9583	9584	9585	9586	9587
9588	95901	95909	95911	95912
95913	95914	95919	9592	9593
9594	9595	9596	9597	9598
9599				

36.4.21.32 Anti-thymocyte Globulin (Rabbit) (*Thymoglobulin*)

Anti-thymocyte globulin (rabbit) (procedure code 1-J7511) is a benefit of the Texas Medicaid Program. Anti-thymocyte globulin (rabbit) is approved by the FDA for treatment of inpatients with a diagnosis of renal transplant acute rejection.

36.4.21.33 Thyrotropin Alpha for Injection (*Thyrogen*)

Procedure code 1-J3240 is a benefit of the Texas Medicaid Program. The injection is reimbursed when billed with one of the following diagnosis codes:

Diagnosis Codes				
1613	193	2310	2348	2356
2374	2397	2409	24200	24220
V1087				

36.4.21.34 Topotecan

Use procedure code 1-J9350 to bill Topotecan. It is payable if used for the treatment of lung cancer, or for females with metastatic ovarian carcinoma after failure of first-line or subsequent chemotherapy, for the following diagnosis codes only:

Diagnosis Codes				
1623	1624	1625	1628	1629
1830	1986			

36.4.21.35 Trastuzumab

Procedure code 1-J9355 is a benefit. Reimbursement for this drug is considered when it is used as a single agent for the treatment of clients with metastatic breast cancer whose tumors overexpress the Her-2 protein and who have received one or more chemotherapy regimens for their metastatic disease.

Trastuzumab is also payable when:

- Used in combination with paclitaxel for the treatment of clients with metastatic breast cancer whose tumors overexpress the Her-2 protein and who have not received chemotherapy for their metastatic disease.
- Used as part of a treatment regimen containing doxorubicin, cyclophosphamide, and paclitaxel for the adjuvant treatment of clients with Her-2-overexpressing, node-positive breast cancer.

Use Herceptin only on patients whose tumors have Her-2 protein overexpression.

When billing for procedure code 1-J9355, one of the following appropriate diagnosis codes must appear on the claim:

Diagnosis Codes				
1740	1741	1742	1743	1744
1745	1746	1748	1749	1750
1759				

Procedure code 1-J9355 is payable in the office, home, outpatient hospital, and nursing home. If a provider requests that a CCP client receive this drug in the home, prior authorization must be obtained through the TMHP CCP Department. Trastuzumab, intravenous, per 10 mg, is paid to physicians, PAs, NPs, CNSs, and medical suppliers. Inpatient facilities are reimbursed under their DRG, and outpatient facilities are reimbursed at their reimbursement rate.

When billing for the test used to determine whether a client overexpresses the Her-2 protein, use procedure code 5-83950. This test is payable in the office, inpatient/outpatient hospital, and independent laboratory. Diagnosis of overexpression of the Her-2 protein must be made before the Texas Medicaid Program will consider reimbursement for trastuzumab. This test is payable only once in a client's lifetime for the same provider. An additional test by the same provider requires more information to support the medical necessity.

36.4.21.36 Valrubicin Sterile Solution for Intravesical Instillation (*Valstar*)

Procedure code 1-J9357 is reimbursed for clients with the diagnosis of bladder cancer in situ who have been treated unsuccessfully with BCG therapy and have an unacceptable morbidity or mortality risk if immediate cystectomy should be performed. Documentation of diagnosis and treatment must be submitted with the claim. Valrubicin is reimbursed only when given in the office or outpatient setting.

36.4.21.37 Vitamin B_{12} (Cyanocobalamin)

Vitamin B_{12} or cyanocobalamin is a water-soluble B-Complex vitamin that helps maintain the myelin sheath that surrounds the nerves. It is needed for the production of red blood cells and the metabolism of fatty acids, carbohydrates, and proteins. Vitamin B_{12} or cyanocobalamin is essential for DNA synthesis, cell division, and growth in children.

Use procedure code 1-J3420 when requesting reimbursement of vitamin B_{12} (cyanocobalamin) injections.

Reimbursement of Vitamin B_{12} (cyanocobalamin) injections is limited to the following diagnosis codes:

Diagnosis Codes				
25060	25061	25062	25063	2810
3572	5793	5798	5799	64820
V152				

36.4.22 Laboratory Services

Texas Medicaid Program benefits are provided for professional and technical services ordered by a physician and provided under the personal supervision of a physician in a setting other than a hospital (inpatient or outpatient). All laboratory services must be documented in the patient's medical record as medically necessary and referenced to an appropriate diagnosis. Medicaid does not reimburse baseline or screening laboratory studies.

If a physician performs more than 100 laboratory tests per year for other providers in their laboratory, the laboratory must be certified by Medicare, and the provider must enroll as an independent laboratory with TMHP. A physician laboratory is defined as one owned by the physician, located in the office area, and the laboratory where the physician performs or personally supervises laboratory tests daily. Personal supervision means the physician must be in the building of the office or facility when and where the service is provided.

All required THSteps laboratory work is to be performed by the DSHS Laboratory Services Section. DSHS makes these services available free to all enrolled THSteps medical providers for THSteps medical check ups only. THSteps services provided in a private laboratory will not be reimbursed. The Laboratory Services Section is reimbursed at its cost for performing these tests.

Exception: *THSteps laboratory specimens for blood test screening for hyperlipidemia or Type 2 diabetes may be sent to the provider's laboratory of choice.*

Except for Pap smear screenings for hyperlipidemia or Type 2 diabetes, all required THSteps laboratory specimens that can be mailed at ambient temperature must be sent through the U.S. Postal Service using the provided business reply labels to the DSHS Laboratory Services Section at:

DSHS Laboratory Services Section
Walter Douglass
PO Box 149163
Austin, TX 78714-9803
Fax: 1-512-458-7294
Telephone: 1-512-458-7318
Toll-free: 1-888-963-7111 Ext. 7318

THSteps laboratory work that requires overnight shipping on cold packs through a courier service must be sent to the DSHS Laboratory Services Section at:

DSHS Laboratory Services Section
1100 West 49th Street, MC-1947
Austin, TX 78756-3199

Pap smear specimens must be sent to the following address:

Women's Health Laboratories
2303 SE Military Drive
San Antonio, TX 78223
1-210-531-4596; Fax: 1-210-531-4506
Toll-free: 1-888-440-5002

Refer to: "Laboratory Services" on page 43-28 for more information.

Only physicians may bill for laboratory tests that are actually provided in their office. Any test sent to an outside laboratory should not be billed on the physician's claim. The laboratory bills Medicaid directly for the tests it performs. A physician may bill a laboratory handling fee (1-99000) if the specimen is obtained by venipuncture or catheterization *and* sent to an outside lab. The identity of the laboratory must be listed on the claim form.

The laboratory handling fee covers the expense of obtaining and packaging the specimen to a reference laboratory. Providers may be reimbursed one laboratory handling fee a day per client, unless *multiple* specimens are obtained and sent to *different* laboratories. When billing for a laboratory handling fee, the physician must document that a specimen was sent to a reference laboratory in Block 20 of the CMS-1500 claim form and indicate the reference laboratory name and address or provider identifier in the appropriate field of the electronic claim form or Block 32 of the CMS-1500 paper claim form. The physician is required to forward the client's name, address, Medicaid number, and diagnosis, if appropriate, with the specimen to the reference laboratory so the laboratory may bill the Texas Medicaid Program for its services.

A physician may bill only one laboratory handling fee per client visit unless the specimen is divided and sent to different laboratories or different specimens are collected and sent to different labs. The claim must indicate the name and/or address of each laboratory to which a specimen is sent for more than one laboratory handling fee to be paid. This limitation does not apply to THSteps medical check up providers who must submit specimens to the DSHS Laboratory.

Interpretation of laboratory tests for patients is considered part of the physician's professional services (hospital, office, or emergency room visits) and should not be billed separately.

Laboratory tests generally considered part of a laboratory panel (chemistries, complete blood counts [CBCs], urinalyses [UAs] and performed on the same day must be billed as a panel regardless of the method used to perform the tests [automated or manual]).

Hospital reimbursements (i.e., inpatient DRG reimbursement) include payment for all pathology and laboratory services, including those sent to referral laboratories. Hospital-based and referral laboratory providers must obtain reimbursement for the technical portion from the hospital. The technical portion includes the handling of specimens and the automated or technician-generated reading and reporting of results. These services are not billable to Medicaid-covered clients. Physician interpretations, that are requested of a consulting pathologist and require professional reading and reporting of results, may be billed to the Texas Medicaid Program separately as a professional charge.

All providers of laboratory services must comply with the rules and regulations of CLIA. Providers not complying with CLIA cannot be reimbursed for laboratory services.

The *Deficit Reduction Act* (DEFRA) of 1984 limited reimbursement of clinical laboratory services provided by a physician laboratory or an independent laboratory to a national fee schedule.

Refer to: "Laboratory Paneling" on page 26-5 for claims processing instructions.

"Clinical Laboratory Improvement Amendments (CLIA)" on page 26-2.

"Reimbursement" on page 2-2.

36.4.22.1 Blood Counts

The Texas Medicaid Program considers a baseline CBC appropriate for the E/M of existing and suspected disease processes. CBCs should be individualized and based on client history, clinical indications or proposed therapy and will not be reimbursed for screening purposes.

A CBC is a comprehensive service that includes components. A CBC is billed with one of the following procedure codes: 5-85025, 5-85027, and 5-85032.

The components of a CBC are listed in the following table. Any of these procedure codes billed for the same date of service as a CBC procedure code will deny as part of another service:

Procedure Codes		
5-85004	5-85007	5-85008
5-85009	5-85013	5-85014
5-85018	5-85041	5-85048
5-85049		

The following procedure codes will be denied as part of another service when billed with procedure code 5-85025 for the same date of service by the same provider:

Procedure Codes		
5-85004	5-85007	5-85008
5-85009	5-85013	5-85014
5-85018	5-85027	5-85032
5-85041	5-85048	5-85049

Procedure code 5-85004 is denied as part of another service when billed with procedure code 5-85007, 5-85009, 5-85025, or 5-85027 for the same date of service by the same provider.

Procedure code 5-85008 is denied as part of another service when billed with the following procedure codes for the same date of service by the same provider:

Procedure Codes		
5-85004	5-85025	5-85027
5-85032	5-85048	5-85049

Procedure code 5-85013, 5-85014, or 5-85018 is denied as part of another service when billed with procedure code 5-85025 or 5-85027 for the same date of service by the same provider.

Procedure code 5-85032 is denied as part of another service when billed with procedure code 5-85025, 5-85027, 5-85041, 5-85048, or 5-85049.

Procedure code 5-85044 is denied as part of another service when billed with procedure code 5-85045 or 5-85046.

Procedure code 5-85045 is denied as part of another service when billed with procedure code 5-85046.

Procedure codes 5-85041, 5-85048, and 5-85049 will be denied as part of another service when billed with procedure code 5-85025 or 5-85027.

Procedure code 5-85049 may be reimbursed separately in addition to procedure codes 5-85014, 5-85018, and 5-85032.

The following reticulocyte procedure codes may be reimbursed in addition to a CBC: 5-85044, 5-85045, and 5-85046.

36.4.22.2 Clinical Lab Panel Implementation

The AMA has discontinued the following general multichannel automated panel codes because the panel did not define exactly what tests were performed:

Procedure Codes		
5-80002	5-80003	5-80004
5-80005	5-80006	5-80007
5-80008	5-80009	5-80010
5-80011	5-80012	5-80016
5-80018	5-80019	5-G0058
5-G0059	5-G0060	

A new Medicare policy pertaining to laboratory paneling procedures was implemented by the Texas Medicaid Program. The new organ and disease panel codes 5-80048, 5-80051, and 5-80053 must be used instead of the general multichannel automated panel codes above.

The new organ or disease panels include the following codes:

5-80048 – Basic metabolic panel includes:		
5-82310	5-82374	5-82435
5-82565	5-82947	5-84132
5-84295	5-84520	

5-80051 – Electrolyte panel includes:		
5-82374	5-82435	5-84132
5-84295		

5-80053 – Comprehensive metabolic panel includes:		
5-82040	5-82247	5-82310
5-82374	5-82435	5-82565
5-82947	5-84075	5-84132
5-84155	5-84295	5-84450
5-84460	5-84520	

36.4.22.3 Clinical Pathology Consultations

Procedure codes 3-80500 and 3-80502 should be used for clinical pathology consultations.

Providers may be reimbursed for clinical pathology consultation when the claim indicates the following information:

- The request is initiated by the client's attending physician and includes the name and address or provider identifier of the physician requesting the consultation.
- The request relates to a test result that lies outside the normal or expected range in view of the condition of the patient.
- The patient's diagnosis.
- The clinical test(s) requiring the consultation.
- A written narrative report describing the findings of the consultation, which will also be included in the client's medical record.

If the claim does not include *all* of this information, the clinical pathology consultation will be denied.

Clinical pathology consultations cannot be paid for surgical and anatomical pathology services or any other pathology services payable in an inpatient hospital (POS 3) and an outpatient hospital (POS 5) (e.g., bone marrows, gross and microscopic exam, etc.).

A pathology consultation must always involve *medical interpretive judgment* that ordinarily requires a physician. Routine conversations held between a pathologist and attending physicians about test orders or results are not consultations.

Generally, only one clinical pathology consultation should be allowed per day by the same provider. Additional consultations per day, with supporting documentation of medical necessity, will be considered for payment on an individual basis.

Certain procedures are not usually performed by a pathologist, such as the following procedure codes used for office, outpatient, or inpatient consultations:

Procedure Codes		
3-99241	3-99242	3-99243
3-99244	3-99245	3-99251
3-99252	3-99253	3-99254
3-99255		

Therefore, if these procedures should be billed by this specialty type, the procedure code will autodeny with the message, "This procedure not covered for this provider specialty." Payment will be considered on an individual appeal basis if a pathologist can document the medical necessity of performing these procedures.

The specialties designated for pathologists are listed in the following table:

Specialty	Description
21	Pathology (DO)
22	Pathology (MD)

36.4.22.4 Cytogenetics Testing for Leukemia and Lymphoma

Cytogenetics testing is a group of laboratory tests involving the study of chromosomes. This does not refer to genetic services.

Clinical evidence supports the significance of cytogenetics evaluation in the diagnosis, prognosis, and treatment of acute leukemias and lymphomas, especially in children. The detection of the well-defined recurring genetic abnormalities often enables a correct diagnosis with important prognostic information that affects the treatment protocol.

Reimbursement for cytogenetics testing is limited to the following diagnosis codes:

Diagnosis Codes				
20030	20031	20032	20033	20034
20035	20036	20037	20038	20040
20041	20042	20043	20044	20045
20046	20047	20048	20050	20051
20052	20053	20054	20055	20056
20057	20058	20060	20061	20062
20063	20064	20065	20066	20067
20068	20070	20071	20072	20073
20074	20075	20076	20077	20078
20270	20271	20272	20273	20274
20275	20276	20277	20278	20280
20281	20282	20283	20284	20285
20286	20287	20288	20290	20291
20292	20293	20294	20295	20296
20297	20298	20400	20401	20410
20411	20420	20421	20480	20481
20490	20491	20500	20501	20510
20511	20520	20521	20530	20531
20580	20581	20590	20591	20600
20601	20610	20611	20620	20621
20680	20681	20690	20691	20700
20701	20710	20711	20720	20721
20780	20781	20800	20801	20810
20811	20820	20821	20880	20881
20890	20891	2533	2572	2590
2594	27549	27911	29900	29901
31400	31401	31500	31501	31502
31509	3151	3152	31531	31532
31534	31539	3154	3155	3158
3159	317	3180	3181	3182
319	37641	52400	52401	52402
52403	52404	52405	52406	52407
52409	6060	6061	6260	6261
6280	6289	6299	630	631

Diagnosis Codes				
632	65500	65501	65503	65510
65511	65513	65520	65521	65523
65950	65951	65953	65960	65961
65963	7400	7401	7402	74100
74101	74102	74103	74190	74191
74192	74193	7420	7421	7422
7423	7424	74251	74253	74259
7428	7429	74300	74303	74306
74310	74311	74312	74320	74321
74322	74330	74331	74332	74333
74334	74335	74336	74337	74339
74341	74342	74343	74344	74345
74346	74347	74348	74349	74351
74352	74353	74354	74355	74356
74357	74358	74359	74361	74362
74363	74364	74365	74366	74369
7438	7439	74400	74401	74402
74403	74404	74405	74409	7441
74421	74422	74423	74424	74429
7443	74441	74442	74443	74446
74447	74449	7445	74481	74482
74483	74484	74489	7449	7450
74510	74511	74512	74519	7452
7453	7454	7455	74560	74561
74569	7457	7458	7459	74600
74601	74602	74609	7461	7462
7463	7464	7465	7466	7467
74681	74682	74683	74684	74685
74686	74687	74689	7469	7470
74710	74711	74720	74721	74722
74729	7473	74740	74741	74742
74749	7475	74760	74761	74762
74763	74764	74769	74781	74782
74783	74789	7479	7480	7481
7482	7483	7484	7485	74860
74861	74869	7488	7489	74900
74901	74902	74903	74904	74910
74911	74912	74913	74914	74920
74921	74922	74923	74924	74925
7500	75010	75011	75012	75013
75015	75016	75019	75021	75022
75023	75024	75025	75026	75027
75029	7503	7504	7505	7506
7507	7508	7509	7510	7511

Diagnosis Codes				
7512	7513	7514	7515	75160
75161	75162	75169	7517	7518
7519	7520	75210	75211	75219
7522	7523	75240	75241	75242
75249	75251	75252	75261	75262
75263	75264	75265	75269	7527
75281	75289	7529	7530	75310
75311	75312	75313	75314	75315
75316	75317	75319	75320	75321
75322	75323	75329	7533	7534
7535	7536	7537	7538	7539
7540	7541	7542	75430	75431
75432	75433	75435	75440	75441
75442	75443	75444	75450	75451
75452	75453	75459	75460	75461
75462	75469	75470	75471	75479
75481	75482	75489	75500	75501
75502	75510	75511	75512	75513
75514	75520	75521	75522	75523
75524	75525	75526	75527	75528
75529	75530	75531	75532	75533
75534	75535	75536	75537	75538
75539	7554	75550	75551	75552
75553	75554	75555	75556	75557
75558	75559	75560	75561	75562
75563	75564	75565	75566	75567
75569	7558	7559	7560	75610
75611	75612	75613	75614	75615
75616	75617	75619	7562	7563
7564	75650	75651	75652	75653
75654	75655	75656	75659	7566
75670	75671	75679	75681	75682
75683	75689	7569	7570	7571
7572	75731	75732	75733	75739
7574	7575	7576	7578	7579
7580	7581	7582	75831	75832
75833	75839	7584	7585	7586
7587	75881	75889	7589	7590
7591	7592	7593	7594	7595
7596	7597	75981	75982	75983
75989	7599	V184	V195	V198
V2631	V2632	V2633	V280	

Cytogenetics testing is payable with the following procedure codes:

Procedure Codes		
Tissue Cultures		
5-88230	5-88233	5-88235
5-88237	5-88239	
Chromosome Analysis		
5-88245	5-88248	5-88249
5-88261	5-88262	5-88263
5-88264	5-88280	5-88283
5-88285	5-88289	
Molecular Cytogenetics		
5-88271	5-88272	5-88273
5-88274	5-88275	
Interpretation and Report		
5-88291		

A provider may be reimbursed for any combination of the following procedure codes when submitted for the same client on the same day:

- One tissue culture procedure code: 5-88230, 5-88233, 5-88235, 5-88237, or 5-88239.
- One molecular cytogenetic study procedure code: 5-88272, 5-88273, 5-88274, or 5-88275.
- One chromosome analysis procedure code from each of the following subcategories:
  - Chromosome Analysis—Breakage Syndromes (subcategory) procedure code: 5-88245, 5-88248, or 5-88249.
  - Chromosome Analysis—Cell Counts (subcategory) procedure code: 5-88261, 5-88262, 5-88263, or 5-88264.

More than one procedure code from any of the above individual categories/subcategories submitted for the same date of service will be denied as part of another service. Six procedures per category/subcategory are allowed within 365 days.

If an additional chromosome analysis procedure is required, a provider must use one of the following procedure codes: 5-88280, 5-88283, 5-88285, 5-88289, or 5-88271. More than one additional analysis procedure code submitted for the same client for the same date of service will be denied as part of another service.

Multiple deoxyribonucleic acid (DNA) probe studies (procedure code 5-88271) may be considered for reimbursement on the same day with a limitation of six days per year. Claims may be reviewed retrospectively to ensure that the DNA probe study is medically necessary and appropriate.

Procedure code 5-88235 is for female patients only.

36.4.22.5 Maternal Serum Alpha-Fetoprotein (MSAFP)

MSAFP may be reimbursed once per pregnancy per provider for all pregnant women eligible for Medicaid. For additional services, payment is allowed with documentation attached to the claim.

Refer to: "Genetic Services" on page 22-1 for genetic follow-up to a positive MSAFP.

36.4.23 Mastectomy and Breast Reconstruction

Mastectomy is a benefit of the Texas Medicaid Program when performed by a physician in an outpatient or inpatient hospital setting.

Reimbursement is provided for the following mastectomy procedure codes:

Procedure Codes		
2/F-19301	2/F-19302	2/F-19303
2/F-19304	2/F-19305	2/F-19306
2/F-19307	2/8-S2066	2/8-S2067

Mastectomy is a medically necessary procedure for a diagnosis of malignant breast cancer. Mastectomy is a benefit of the Texas Medicaid Program and is diagnosis-restricted. Reimbursement for a mastectomy is provided when billed with a diagnosis listed in the following table:

Diagnosis Codes				
1740	1741	1742	1743	1744
1745	1746	1748	1749	1750
1759	19881	2330	V103	

Breast reconstruction following a medically necessary mastectomy is a benefit of the Texas Medicaid Program when the following criteria are met:

- The client is Medicaid-eligible at the time of the breast reconstruction.
- The physician has documented a plan addressing the recommended breast reconstruction in the client's chart.

Breast reconstruction following a medically necessary mastectomy is diagnosis-restricted to the codes listed in the previous table.

Procedure Codes		
2/8/F-19340	2/8/F-19342	2/F-19350
2/8/F-19357	2/8/F-19361	2/8/F-19364
2/8/F-19366	2/8/F-19367	2/8/F-19368
2/8/F-19369		

Reimbursement is provided for complications of breast reconstruction, if any, when the complications occur during the time the client is eligible for the breast reconstruction benefit.

Procedure codes 2/F-19370, 2/F-19371, and 2/F-19380 may be used when billing for surgical intervention of complications following reconstructive breast surgery.

Breast reconstruction may be completed as multiple, staged procedures, such as tissue expansion followed by implants, and nipple/areola reconstruction.

Breast reconstruction may be completed using either saline or silicone implants or tissue transfers such as TRAM, latissimus dorsi, or gluteal flaps.

Surgery on the unaffected breast to achieve symmetry is not a benefit of the Texas Medicaid Program.

An external breast prosthesis is not a benefit of the Texas Medicaid Program.

The professional billing for Medicaid clients who are members of PCCM will be processed using the same diagnosis restrictions that apply to mastectomy and breast reconstruction for Medicaid fee-for-service clients. However, the associated hospitalizations are subject to concurrent review, and therefore hospitals must notify PCCM of admissions within the time frames for all of their hospital notification requirements.

36.4.24 Obstetrics/Prenatal Care

Medicaid reimburses antepartum care, deliveries (to include cesarean sections performed by physicians), and postpartum care as individual procedures. Providers may choose one of the following options for billing maternity services:

- Providers may itemize each service individually on *one* claim form and file at the time of delivery. The filing deadline is applied to the date of delivery.
- Providers may itemize each service individually and submit claims as the services are rendered. The filing deadline is applied to each individual date of service.

Providers who only provide antepartum care and choose to submit antepartum visit charges on one claim form have the filing deadline applied to the estimated date of confinement (EDC) that must be stated in Block 24D of the CMS-1500 claim form.

Laboratory (including pregnancy tests) and radiology services provided during pregnancy must be billed separately and claims must be received by TMHP within 95 days of the date of service.

Use modifier TH with all antepartum procedure codes.

Initial prenatal visits are payable with the following procedure codes with modifier TH: 1-99201, 1-99202, 1-99203, 1-99204, and 1-99205. These procedure codes for initial prenatal visits are limited to one per pregnancy, same provider. If billed more frequently than every seven months, documentation must support that the visits are for two different pregnancies. High risk pregnancy visits should be billed based on level of care and complexity of the visit using the appropriate procedure code with the TH modifier.

Antepartum care visits are payable for the following procedure codes with modifier TH: 1-99211, 1-99212, 1-99213, 1-99214, 1-99215, 1-99341, 1-99342, 1-99343, 1-99344, and 1-99345.

The initial antepartum visit is limited to one per client, per pregnancy, per provider.

The following is a recommended guide for the frequency of antepartum visits for a low-risk pregnancy:

- One visit every four weeks for the first 28 weeks.
- One visit every two to three weeks from 28 to 36 weeks.
- One visit every week at greater than 36 weeks to delivery.

In POS 1 (office), 5 (outpatient), and 7 (birthing center), physicians (obstetricians, family practice physicians, and maternal-fetal medicine specialists), CNMs, and maternity service clinics (MSCs) are limited to 20 antepartum care visits per pregnancy and two postpartum care visits after discharge from the hospital. Routine pregnancies are anticipated to require around 11 visits per pregnancy, and high-risk pregnancies are anticipated to require around 20 visits per pregnancy.

More frequent visits may be necessary for high-risk pregnancies. High-risk obstetrical visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician's files and is subject to retrospective review.

Antepartum and postpartum care visits billed in an inpatient hospital (POS 3) are denied as part of another procedure when billed within the three days before delivery or the six weeks after delivery. The inpatient intrapartum and postpartum care are included in the fee for the delivery or cesarean section and should not be billed separately.

Postpartum care provided after discharge must be billed using procedure code 2-59430 with modifier TH. A maximum of two postpartum visits are allowed.

If a client is admitted to the hospital during the course of her pregnancy, the diagnosis necessitating the admission should be the primary diagnosis listed on the claim. Use of the appropriate E/M, antepartum, or postpartum procedure codes is necessary for appropriate reimbursement.

If the physician in the office sees a client for a diagnosis unrelated to the pregnancy, the nonpregnancy diagnosis must be listed as the primary diagnosis on the claim and the services referenced appropriately. Use of the appropriate E/M, antepartum, or postpartum procedure code is necessary for appropriate reimbursement.

The following are the delivery and cesarean section procedure codes physicians must use to bill the Texas Medicaid Program: 2-59409, 2-59410, 2/8-59515, 2-59614, and 2/8-59622.

Delivering physicians who perform regional anesthesia or nerve block do not receive additional reimbursement because these charges are included in the reimbursement for the delivery except as outlined under "Anesthesia for

Labor and Delivery" on page 36-25. The Texas Medicaid Program reimburses the anesthesia services and the delivery at full allowance when provided by the delivering obstetrician. Procedure codes 2-62311 and 2-62319 are reimbursed at an access-based maximum fee rate. Both obstetrics related anesthesia procedure codes 7-01960 and 7-01967 will be considered for reimbursement with a flat fee rate. Providers should continue to report time in minutes for procedure codes 7-01960 and 7-01967; however the time reported will represent minutes between the start time and stop time for these procedures. Procedure code 7-01968 must indicate the time spent administering the epidural and actual time spent with the client. Insertion and injection of the epidural are not reimbursed separately when billed with the CPT anesthesia delivery codes (2-59410, 2-59515, 2-59614, or 2/8-59622). Medicaid reimburses only one delivery or cesarean section procedure code per client in a seven month period; reimbursement includes multiple births.

Procedure code 1-99140 is not considered for reimbursement when submitted with diagnosis code 650 for a normal delivery or with diagnosis code 66970 or 66971 for a cesarean delivery when one of these diagnosis codes is documented on the claim as the referenced diagnosis. The referenced diagnosis must indicate the complicating condition. An emergency is defined as a situation when delay in treatment of the client poses a significant health threat to a client's life, bodily organ, or body part.

Hospital admissions resulting from conditions or comorbidities complicating labor should be billed using the appropriate CPT E/M care codes. These codes are not subject to the three-day pre-care period but are not payable on the date of delivery or the following six-week post-care period.

Refer to: "Anesthesia" on page 36-24 for complete information about anesthesia for obstetrical procedures.

36.4.24.1 Ultrasound of the Pregnant Uterus

Ultrasound of the pregnant uterus is a benefit of the Texas Medicaid Program when medically indicated. Ultrasound of the pregnant uterus may be paid separately when billed by physicians.

Ultrasound may be indicated for suspected genetic defects, high risk pregnancy, fetal growth retardation, or gestational age conformation. Medical documentation supporting the medical necessity and appropriateness of additional ultrasounds *must* be present in the client's chart and is subject to retrospective review.

The total component of the codes listed in the following table may be considered for reimbursement in the office and outpatient settings. The professional component may be considered for reimbursement in the office or outpatient setting, when billed by a different provider or by the same provider in a different POS with documentation that supports the need for both visits. The professional component is considered part of a hospital or consultation visit, when provided in the inpatient setting. The technical component may be considered for reimbursement in the office and outpatient settings.

The following procedures may be billed for ultrasound of the pregnant uterus:

Procedure Codes		
4/I/T-76801	4/I/T-76802	4/I/T-76805
4/I/T-76810	4/I/T-76811	4/I/T-76812
4/I/T-76815	4/I/T-76816	4/I/T-76817
4/I/T-76818	4/I/T-76819	4/I/T-76820
4/I/T-76821		

The modifier TS may be billed with procedure codes 4/I/T-76811 and 4/I/T-76812 to indicate follow-up ultrasounds.

When multiple ultrasound procedure codes are billed on the same day, the most inclusive code is paid and all other codes are denied. Fetal biophysical profile (4/I/T-76818 and 4/I/T-76819) may be reimbursed separately when billed with 4/I/T-76805, 4/I/T-76810, 4/I/T-76811, 4/I/T-76812, 4/I/T-76815, or 4/I/T-76816 on the same day.

Physicians, such as fetal-maternal specialists, caring for high-risk clients are anticipated to perform an increased number of follow-up ultrasounds. Medical documentation supporting the medical necessity and appropriateness of additional ultrasounds must be present in the client's chart and is subject to retrospective review.

36.4.24.2 External Cephalic Version

External cephalic version is the external manipulation of a fetus to alter its position in the uterus to make it more favorable for delivery.

Procedure code 2-59412 is payable in the inpatient hospital (POS 3) or outpatient hospital (POS 5) setting when billed as an independent procedure performed by a physician at least one day before delivery. Procedure code 2-59412 billed on the same day as a delivery by the same provider is denied.

Emergency room and subsequent hospital care visit procedure codes billed the same day as external cephalic version by the same provider are denied.

36.4.24.3 Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis

Procedure code 2-59000 is the procedure of inserting a needle into the uterus through the abdominal wall for the purpose of withdrawing amniotic fluid, which is used to assess fetal health and maturity.

Procedure code 2-59012 is the procedure of entering the pregnant uterus and amniotic sac, identifying the umbilical cord, and obtaining a blood sample from a vein in the umbilical cord.

Procedure code 2-36460 is the procedure of accessing a fetal blood vessel to transfuse the fetus in utero.

In addition to the physician performing the amniocentesis, cordocentesis, or FIUT, another physician may assist with echography control.

Procedure code 2-59001 is diagnosis-restricted to the following codes: 65700, 65701, and 65703.

FIUT, cordocentesis, and ultrasonic guidance are payable benefits of the Texas Medicaid Program when billed with the following appropriate diagnosis code: 65610, 65613, 65620, and 65623.

The Medical Director reviews cordocentesis requests for diagnosis codes other than those listed above, on a case by case basis.

Procedure code 4/I/T-76946 or 4/I/T-76941 is reimbursed separately when billed by a different physician. Ultrasonic guidance is denied as part of the amniocentesis, cordocentesis, or FIUT procedure when it is billed on the same day by the same provider as one of the other procedures.

Cordocentesis or umbilical blood sampling is included in the global fee for procedure code 2-36460.

FIUT is reimbursed as a global fee and, therefore, includes all other services provided by the same physician, including umbilical blood sampling or cordocentesis.

No other fetal surgery is a benefit of the Texas Medicaid Program.

36.4.24.4 Fetal Fibronectin

Procedure code 5-82731 is a benefit of the Texas Medicaid Program and may be considered for reimbursement when the pregnancy is greater than 24 through 33 completed weeks of gestational age on the date the service was provided.

Fetal fibronectin is limited to threatened preterm labor using diagnosis code 64400 or 64403.

36.4.24.5 Certified Nurse-Midwife (CNM)

Deliveries performed in a home (POS 2) by a CNM without prior authorization are denied. A written prior authorization request must be submitted during the client's third trimester of pregnancy. Documentation must include a statement signed by a licensed physician who has examined the client during the third trimester and determined that at the time of examination the client is not at high risk and is suitable for a home delivery.

36.4.24.6 Nonstress Testing, Contraction Stress Testing

Nonstress testing is a form of fetal monitoring in which transducers are applied to the mother's abdomen to monitor fetal heart rate. Tracings of this activity may be obtained from the fetalscope itself.

The contraction stress test is performed to assess the condition of the fetus in utero. This is done by monitoring the fetus' response to the stress of uterine contractions. Baseline recordings of the fetal heart are made by Doppler. Then IV oxytocin is administered to produce uterine contractions. Fetal heart rate is then measured during the contractions. Slowing of the heart rate beyond the contractions may indicate problems with the fetus.

The following diagnosis codes are payable for *both* nonstress and contraction stress testing:

Diagnosis Codes				
30393	30403	30410	30411	30412
30413	30420	30421	30422	30423
30430	30431	30432	30433	30440
30441	30442	30443	30450	30451
30452	30453	30460	30461	30462
30463	30470	30471	30472	30473
30480	30481	30482	30483	30490
30491	30492	30493	5851	5852
5853	5854	5855	5856	5859
64210	64211	64212	64213	64214
64220	64221	64222	64223	64224
64230	64231	64232	64233	64240
64241	64242	64243	64244	64250
64251	64252	64253	64254	64260
64261	64262	64263	64264	64270
64271	64272	64273	64400	64403
64410	64413	64510	64513	64520
64523	64700	64701	64702	64703
64704	64710	64711	64712	64713
64714	64720	64721	64722	64723
64723	64724	64730	64731	64732
64733	64734	64740	64741	64742
64743	64744	64750	64751	64752
64753	64754	64760	64761	64762
64763	64764	64780	64781	64782
64783	64800	64801	64802	64803
65130	65131	65133	65140	65141
65143	65150	65151	65153	65160
65161	65163	65633	65650	65651
65653	65660	65661	65663	65840
65841	65843	V231	V232	V233
V2341	V2349	V235	V237	V2381
V2382	V2383	V2384	V2389	V239

When billing for 2-59025 performed because of decreased fetal movement, use the following diagnosis codes:

Diagnosis Codes				
64110	64111	64113	64120	64121
64123	64130	64131	64133	64180
64181	64183	64190	64191	64193

Diagnosis Codes				
64520	64521	64523	65570	65571
65573				

Procedure code 2-59020 is also payable for the following diagnosis codes:

Diagnosis Codes				
28241	28242	28249	28263	28264
28268	65613	65620	65621	65623
65803				

Nonstress testing is only payable to a physician when this service is performed in the office (POS 1) and should be billed with procedure code 2-59025.

The contraction stress test is payable to a physician when performed in an inpatient hospital (POS 3) or outpatient hospital (POS 5) setting and should be billed with procedure code 2-59020 and the appropriate POS code.

Procedure codes 2-59020 and 2-59025 can be reimbursed on the same day, different provider, without appeal. Procedure codes 2-59020 and 2-59025, billed more than once per day, same provider, are denied. The provider must appeal with documentation that supports the performing of the test more than once on the same day by the same provider.

Procedure code 2-59025 is payable to physicians, NPs, CNSs, PAs, CNMs, and County Indigent Health Care Program (CIHCP) providers in the office setting only. Procedure code 2-59020 is payable to physicians, NPs, CNSs, PAs, CNMs, and CIHCP providers in the inpatient and outpatient settings only.

Fetal monitoring and fetal stress testing are payable for outpatient hospital stays and to hospital-based RHCs only with revenue code B-729, Labor room delivery-other. The inpatient hospital stay is reimbursed under the hospital's DRG.

To prevent repeat unintended or unwanted pregnancies, physicians are urged to include family planning services or referrals in the maternity care of the client. Genetic diagnosis and counseling is also available through Medicaid for clients suspected of having a genetic disorder for informed reproductive decision making.

Refer to: "Family Planning Services" on page 20-1 for more information.

36.4.24.7 Screening of Pregnant Women for Syphilis, HIV, and Hepatitis B Required

Hepatitis B

Texas Health and Safety Code, Chapter 81, Subchapter E, §81.090, requires serologic testing during pregnancy for syphilis, HIV, and hepatitis B. The TAC addresses the mandated role of health-care providers, hospitals, laboratories, schools, and others to report patients who are suspected of having a notifiable condition (25 TAC, Part 1, and Chapter 97).

The specific references to perinatal hepatitis B are summarized as follows:

- Providers and hospitals must screen all pregnant women for the hepatitis B surface antigen (HBsAg) at their first prenatal visit and at delivery (25 TAC, Part 1, Chapter 97, Subchapter F §97.135).
- Perinatal hepatitis B and all HBsAg-positive mothers must be reported to DSHS (25 TAC, Part 1, Chapter 97, Subchapter A, §97.3).

Perinatal hepatitis B transmission is highly preventable when pregnant women are screened for HBsAg prenatally and at delivery for each pregnancy. Infants born to HBsAg positive mothers must receive HBIG and the hepatitis B birth dose within 12 hours of birth. Additionally, they must complete the hepatitis B vaccine series and post-vaccination serology 1 to 3 months after completion of the vaccine series to determine seroconversion. An infant who does not seroconvert must receive a second vaccine series and post-vaccine serology. DSHS health service regions and local health departments provide case management services for infants born to HBsAg-positive women, household members and sexual contacts of the infected mother. Case management includes administration of the hepatitis B vaccine, serology testing and educational services.

Approximately 90 percent of infants who acquire hepatitis B virus infection from perinatal transmission become chronically infected. If immunoprophylaxis is not administered at birth, 25 percent of these infants will die from liver-related diseases such as cirrhosis, liver failure, and hepatocellular carcinoma.

For further information on the DSHS Perinatal Hepatitis B Prevention Program, please contact the Perinatal Hepatitis B Prevention Program Coordinator by phone at 1-512-458-7447. Program resources such as information brochures, reporting forms and manual, are available at www.texasperinatalhepb.org.

Immunotherapy for infants born to HBsAg-positive women includes administration of 0.5 mL HBIG and 0.5 mL hepatitis B vaccine, within 12 hours of delivery. Subsequent doses of hepatitis B vaccine should be administered to the infant at 1 and 6 months of age. When the infant is 12 months old, a post-vaccine serology test should be performed to determine the success or failure of the vaccine intervention. Physicians should request that the laboratory test the infant's blood for anti-HBs and HBsAg. A positive anti-HBs test result and a negative HBsAg test result show the infant is protected against HBV. A negative anti-HBs and a positive HBsAg show the infant is infected with HBV and should be referred for clinical follow-up. For infants whose blood test is negative for anti-HBs and HBsAg, administration of a second series of vaccine is indicated. A second post-vaccine serology test should be performed two months after completion of the second series.

The DSHS Perinatal Hepatitis B Prevention Program provides hepatitis B vaccine and post-vaccine serology tests for infants born to HBsAg-positive women. HBIG is provided to hospitals for infants, on a case-by-case basis.

Prevaccination susceptibility testing and hepatitis B vaccine for susceptible sexual and nonsexual household contacts of HBsAg-positive pregnant women is provided through DSHS regional and local health department clinics.

For more information on the Perinatal Hepatitis B Prevention Program, including a program protocol, reporting forms, fax sheets for physicians, and hospital reporting forms for HBsAg-positive pregnant women, providers should call the Perinatal Hepatitis B Coordinator at 1-800-252-9152.

Pregnant women must be tested for HIV unless they object. If the patient objects to the HIV antibody test, the attending health-care provider must make a note in the patient's record that:

- The HIV test was offered.
- The patient declined testing.
- A referral to an anonymous testing site was made.
- The patient was provided with appropriate literature.

36.4.25 Newborn Services

Newborn services are a benefit of the Texas Medicaid Program. The newborn period is defined in the CPT manual as the time following birth through 28 days of age. Based on this definition a provider may bill no more than 28 days of neonatal intensive care visits. After the 28th day, providers must bill using the pediatric critical care procedure codes.

Note: *For E/M services for newborns, refer "Physician Evaluation and Management Services" on page 36-11.*

36.4.25.1 Apnea Monitors

Apnea monitors, to measure chest movement and heart rate, are a benefit of THSteps-CCP for infants. Apnea monitors used in the home will be paid for two months without prior authorization for infants with one of the following diagnosis codes:

Diagnosis Codes				
53010	53011	53012	53019	53020
53021	53081	7707	77081	77082
77083	77084	77089	78603	V198

When billing for apnea monitors, use procedure code L-E0619.

All apnea monitors provided to THSteps-CCP clients must be capable of recording apneic episodes.

The POS for apnea monitors is in the client's home.

Prior authorization is required for rental of an apnea monitor, if one of the following conditions exist:

- The child is older than 4 months of age.
- The initial two-month rental period has expired.

Prior authorization must be obtained in writing and must include *all* of the following items:

- A completed THSteps-CCP Prior Authorization Request Form, signed and dated by the physician.
- Documentation to support the medical necessity and appropriateness of the apnea monitor.
- A physician interpretation, signed and dated by the physician, of the most recent two-month's apnea monitor downloads.

Apnea monitors will not be authorized, if the documentation does not support medical necessity.

Procedure code 1-94774 may be used by the physician to bill for the interpretation of the apnea monitor recordings.

Electrodes and lead wires for the apnea monitor are a benefit only if the apnea monitor is owned by the client. If the apnea monitor is rented, the electrodes and lead wires are considered part of the rental fee. The electrodes and lead wires may be considered for purchase with the procedure codes 9-A4556 and 9-A4557 only with documentation of medical necessity and a statement from the physician that the client owns the monitor.

Refer to: "Apnea Monitor" on page 43-51 for authorization of apnea monitors through THSteps-CCP.

36.4.25.2 Circumcisions

The Texas Medicaid Program provides reimbursement for circumcisions billed with procedure codes 2-54150 and 2-54160 (for clients birth through 28 days old) or 2-54161 (for clients 29 days old and older).

Circumcisions performed on clients older than 1 year of age must be documented with medical necessity.

36.4.25.3 Claims Filing Instructions, Eligibility Requirements

Claims submitted for services provided to a newborn child that is eligible for Medicaid should be filed using the newborn child's Medicaid client number. *Filing a claim for a newborn client under the mother's client number may cause a delay in claim payment.* For information on the newborn's eligibility status, call TMHP at 1-800-925-9126. Claims with charges for newborn care must be submitted separately from claims with charges for the mother eligible for Medicaid.

Exception: *Services for a newborn's unsuccessful resuscitation may be billed under the mother's Medicaid number using procedure code 1-99499.*

Note: *Newborns are enrolled in the same STAR Program health plan that the mother is enrolled in, if the mother is eligible for Medicaid and enrolled in the plan on the date of birth. Check with individual health plans on the billing of newborn claims.*

Also, the Medicaid claim filing deadline is based on claim receipt within 95 days of the date of service *or* 95 days of the date the client's eligibility information is added to TMHP's eligibility file (in the case of retroactive eligibility). Retroactive eligibility occurs when an individual has been approved for Medicaid coverage but has not yet been assigned a Medicaid client number at the time of services.

The *add date* is the date the client's eligibility was added to the eligibility file. Client eligibility information is available through the Automated Inquiry System (AIS).

A newborn child is eligible for Medicaid for up to one year if all the following conditions are met:

- The mother is receiving Medicaid at the time of the child's birth.
- The child continues to live with the mother.
- The mother continues to be eligible for Medicaid or would be eligible for Medicaid, if she were pregnant. It is not acceptable for a provider to require a deposit for newborn care from a client. The child's eligibility ceases, if the mother relinquishes her parental rights or it is determined that the child is not a member of her household.

To provide information about each child born to a mother eligible for Medicaid, FQHCs, hospitals, birthing centers, and FQHCs with birthing centers should complete "Hospital Report (Newborn Child or Children) HHSC Form 7484" on page B-49 and submit it to DADS Data Control within five days of the child's birth. The use of *Baby Boy* or *Baby Girl* delays the assignment of a number. *Filing this form expedites the assignment of a Medicaid number for the newborn child.* Do not complete this form for stillbirths.

The facility should complete this form within five days of the child's birth and send it to DADS at the address referenced on the form. This five-day time frame is not mandatory; however, prompt submission expedites the process of determining the child's eligibility. Facilities should duplicate the form as needed; duplicates are *not* supplied by HHSC, DADS, or TMHP.

On receipt of a completed Form 7484, DADS Data Control verifies the newborn's eligibility and within ten workdays, sends notices to the mother, caseworker, hospital, birthing center, and attending physician, if identified. The notice includes the child's Medicaid client number and the effective date of coverage. After the child has been added to the HHSC eligibility file, HHSC issues a Medicaid Identification Form (Form H3087).

The attending physician's notification letter is sent to the address on file by license number at the Texas Medical Board. It is imperative that this address be kept current to ensure timely notification of attending physicians. Physicians should submit address changes to the following address:

Texas Medical Board
Customer Information, MC-240
PO Box 2018
Austin, TX 78767-2018

Refer to: "Automated Inquiry System (AIS)" on page xiii.

36.4.25.4 THSteps Newborn Examination

Newborn examinations that are billed with procedure codes 1-99431 and 1-99432 may be counted as a THSteps periodic medical check up if all necessary components are completed and documented in the medical record. Providers may submit a claim to TMHP using their acute care provider identifier. Providers do not have to be enrolled as THSteps providers to bill these newborn codes.

If a brief newborn examination is performed that does not fulfill periodic check up criteria, the provider may bill 1-99431 with modifier 52 (reduced services) or 1-99432 with modifier 52 (reduced services) using their acute care provider identifier. Providers do not have to be enrolled as THSteps providers to bill these procedure codes.

A THSteps newborn screening exam includes family and neonatal history:

- Physical exam, including length, weight, and head circumference.
- Vision and hearing screening.
- Health education.
- State-required newborn hereditary/metabolic laboratory testing.
- Hepatitis B immunization.

Refer to: "Newborn Examination" on page 43-9 for a list of the required componenets for an initial THSteps exam.

"Texas Health Steps (THSteps)" on page 43-1 for more information.

36.4.25.5 Newborn Screening

Health and Safety Code, Chapter 33, *Vernon's Texas Codes Annotated*, requires all newborns to be screened for certain disorders as recommended by the American College of Medical Genetics (ACMG). TAC, Title 25, Chapter 37, requires that the screening panel includes galactose-1-phosphate uridyltransferase deficiency, sickling hemoglobinopathies (sickle cell disease, hemoglobin SC disease, sickle beta thalassemia), 21-hydroxylase deficiency, hypothyroidism, argininosuccinic acidemia, citrullinemia, homocystinuria, maple syrup urine disease, phenylketonuria, tyrosinemia type I, carnitine uptake defect, long-chain hydroxyacyl-CoA dehydrogenase deficiency, medium-chain acyl-CoA dehydrogenase deficiency, trifunctional protein deficiency, very-long-chain acyl-CoA dehydrogenase deficiency, organic acidemias, including 3-methylcrotonyl-CoA carboxylase deficiency, beta-ketothiolase deficiency, glutaric acidemia type I, hydroxymethylglutaric aciduria, isovaleric acidemia, methylmalonic acidemia (Cbl A and Cbl B forms), methylmalonic acidemia (mutase deficiency form), multiple carboxylase deficiency, and propionic acidemia; and biotinidase deficiency. Two screens are required to be done. The first screen is collected at 24-48 hours of age or before leaving the hospital if the baby is discharged in the first 24 hours of life. The second screen is collected at one to two weeks of age, usually at a THSteps two-week check up, but maybe in the hospital if the baby is not yet discharged. The newborn screening collections kits are obtained from the NBS Laboratory Supply

(1-512-458-7661). For more information on the newborn screening program, providers may call 1-800-252-8023 or visit www.dshs.state.tx.us/newborn.

36.4.25.6 Newborn Hearing Screening

Health and Safety Code, Chapter 47, *Vernon's Texas Codes Annotated* requires facilities where births occur to offer all newborns a hearing screening as a part of their newborn hospital stay. Procedures for newborn hearing screening provided for infants born outside of a birthing facility, not admitted to a birthing facility for newborn assessment and monitoring after birth, and performed during the initial THSteps visit are considered part of the initial newborn medical check up and are not reimbursed as separate procedures. Providers who are not enrolled in THSteps must refer the infant to an enrolled THSteps provider for an initial THSteps medical check up. For more information on newborn hearing screening, providers may contact:

Texas Early Hearing Detection and Intervention
PO Box 149347, MC-1918
Austin, TX. 78714-9347
1-512-458-7111, Ext. 2600
www.dshs.state.tx.us/audio

Note: *This procedure is a screening, not diagnostic, and will not be reimbursed separately from the usual newborn delivery payment. Special investigations and examination codes are not appropriate for use with hearing screening of infants.*

All newborns who have abnormal screening results should be referred to a local Program for Amplification for Children of Texas (PACT) provider for follow-up care. PACT provides services and hearing aids for children ages birth through 20 years who have permanent hearing loss and are Medicaid-eligible.

Traditional Medicaid providers are reimbursed for the diagnosis and treatment of abnormal hearing screen follow-up when a local PACT provider is not available. Providers should use the following procedure codes when billing for follow-up of diagnosis of abnormal hearing screens: 5/I/T-92585, 5/I/T-92587, and 5/I/T-92588.

Procedure code 5-92586 is considered a diagnostic, not a screening, test.

For a complete list of PACT providers, contact:

Program for Amplification for Children of Texas (PACT)
PO Box 149347, MC-1918
Austin, TX. 78714-9347
1-512-458-7724
www.dshs.state.tx.us/audio

36.4.25.7 Critical Care

Neonatal critical care is the comprehensive care of the critically ill neonate.

Neonatal intensive care procedure codes are comprehensive per diem (daily) care codes for physicians who personally deliver and supervise the delivery of health care by the neonatal intensive care team to the neonate or infant and may be billed only once per day per neonate or infant. These procedure codes may be used only during the period of time that the neonate or infant is considered to be critically ill. After the neonate or infant is no longer considered to be critically ill, use the E/M codes for subsequent hospital care (1-99231, 1-99232, 1-99233, and 1-99300).

Refer to: "Neonatal Critical Care" on page 36-18 and "Hospital Visits" on page 36-16 for more details.

36.4.25.8 Newborn Resuscitation

Newborn resuscitation includes providing positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output. Providers should use procedure code 1-99440 when submitting claims for resuscitation care of high risk newborns.

Newborn resuscitation procedure code 1-99440 is considered for reimbursement when submitted with the same date of service as neonatal critical care procedure codes 1-99295 and 1-99296.

If both mother and baby require resuscitation at the time the anesthesiologist administers the anesthesia, both services may be considered for reimbursement. Newborn resuscitation must be submitted only on the infant's claim.

Use procedure code 1-99436 to attend a cesarean section or high-risk newborn. When using this procedure code for stand-by for a high-risk newborn, documentation of the maternal high-risk condition in Block 21 of the CMS-1500 claim form is recommended.

Refer to: "Risk Assessment" on page 31-4 for information about maternal high-risk conditions.

36.4.25.9 Potential SSI/Medicaid Eligibility for Premature Infants

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

Federal regulations state that infants with birth weights less than 1,200 grams are considered to meet the SSI disability criteria.

The SSA issued a new policy to local SSA offices to make presumptive SSI disability decisions and payments for these children, making it possible for a child to receive SSI and Medicaid benefits while waiting for a final disability determination to be made by Disability Determination Services.

The child's parent or legal guardian must file an SSI application with the SSA. It is in the child's best interest that the application with the SSA be filed as soon as possible after birth. The SSA accepts a birth certificate with the child's birth weight or a hospital medical summary as evidence for the presumptive disability decision.

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

36.4.25.10 Routine Care

Routine newborn care during the initial hospital/birthing center stay is defined as care given to a newborn immediately after birth. Services should be submitted using procedure codes 1-99431, 1-99433, and 1-99435.

Physicians must submit separate charges for each day of care. Procedure codes 1-99431, 1-99432, 1-99433, and 1-99435 are limited to one code per day, per provider. The claim must not reflect any diagnosis other than *well newborn* diagnosis listed in the table below:

Diagnosis Codes				
V3000	V3001	V301	V302	V3100
V3101	V311	V312	V3200	V3201
V321	V322	V3300	V3301	V331
V332	V3400	V3401	V341	V342
V3500	V3501	V351	V352	V3600
V3601	V361	V362	V3700	V3701
V371	V372	V3900	V3901	V391

Initial newborn care (procedure codes 1-99431 and 1-99435) are considered for reimbursement once per lifetime, any provider, when provided in the hospital.

Initial newborn care (procedure codes 1-99432 and 1-99435) are considered for reimbursement once per lifetime, any provider when provided in a birthing center.

Normal newborn care (procedure code 1-99432) provided in other than the hospital or birthing room setting may be considered for reimbursement once per lifetime, any provider. Subsequent visits should be submitted using an appropriate visit procedure code based on the POS (i.e., office visit or subsequent hospital care if the infant is admitted to the hospital).

Procedure code 1-99435 may be considered for reimbursement when newborns are admitted and discharged on the same day from the hospital or birthing center. If procedure codes 1-99431 and 1-99435 are submitted with the same date of service, procedure code 1-99431 is denied and procedure 1-99435 is considered for reimbursement.

If the patient is re-admitted within the first 30 days of life, the provider should submit an initial admit code.

Subsequent hospital care (procedure code 1-99433) is considered for reimbursement once per day in the hospital. Procedure code 1-99433 is not considered for reimbursement in the birthing center. If procedure code 1-99431 is submitted with the same date of service as 1-99433, procedure code 1-99433 is denied and procedure code 1-99431 is considered for reimbursement.

For a single visit for complete normal newborn services regardless of place of birth, use procedure 1-99435.

If procedure code 1-99436 is submitted with the same date of service as an outpatient E/M procedure code (1-99201, 1-99202, 1-99203, 1-99204,1-99205, 1-99211, 1-99212, 1-99213, 1-99214, or 1-99215), the outpatient E/M service is denied. Payment may be considered on appeal with supporting documentation.

36.4.26 Noncoronary Percutaneous Transluminal Angioplasty (PTA)

PTA is a procedure involving insertion of a balloon catheter into a narrowed or occluded vessel; by inflating the balloon, the artery is recanalized and dilated. Several recognized subdivisions of PTA have become standard as recognized surgical procedures in lieu of other more invasive surgical procedures.

A repeat PTA within 90 days may be reviewed retrospectively for documentation of medical necessity for the repeat.

Noncoronary PTA is a covered benefit of the Texas Medicaid Program. PTA services should be billed using the following procedure codes:

Procedure Codes		
2/F-35470	2/F-35471	2/F-35472
2/F-35473	2/F-35474	2/F-35475
2/F-35476	2/F-92997	2/F-92998

36.4.27 Nuclear Medicine

Procedure codes 4/I/T-78890 and 4/I/T-78891 are benefits of the Texas Medicaid Program.

When procedure code 4/I/T-78890 is billed with 4/I/T-78891, procedure code 4/I/T-78890 is denied as part of 4/I/T-78891. Only one procedure code is paid per day when multiples of the same code are billed on the same day.

Refer to: "Hospital Visits" on page 36-16 for specific details.

36.4.28 Occupational Therapy

OT is a payable benefit to physicians and outpatient and inpatient hospitals. OT *must be billed with the modifier AT and must be provided according to the current (within 60 days) written orders of a physician and must be medically*

necessary. OT is billed with CPT procedure codes. These procedure codes are subject to the guidelines outlined in the PT section:

CPT Code	Frequency
1-97012	Once per day
1-97014	Once per day
1-97016	Once per day
1-97018	Once per day
1-97022	Once per day
1-97024	Once per day
1-97026	Once per day
1-97028	Once per day
1-97032	Two hours maximum
1-97033	Two hours maximum
1-97034	Two hours maximum
1-97035	Two hours maximum
1-97036	Two hours maximum
1-97039	Two hours maximum
1-97110	Two hours maximum
1-97112	Two hours maximum
1-97113	Two hours maximum
1-97116	Two hours maximum
1-97124	Two hours maximum
1-97139	Two hours maximum

OT-Only Codes

CPT Code	Frequency
1-97003	Once every six months
1-97004	Once per month

OT prescribed primarily as an adjunct to psychotherapy is not a benefit.

Refer to: "Physical Therapists/Independent Practitioners" on page 35-1 and "Home Health Services" on page 24-7 and "Claims Information" on page 43-62 for authorization and requirements, and coverage or noncoverage of the above 2000 CPT Physical Medicine and Rehabilitation codes.

36.4.28.1 Limitations

OT must be billed with the modifier AT and must be provided according to the current (within 60 days) written orders of a physician and must be medically necessary. OT is to be billed with CPT procedure codes.

The AT modifier is described as representing treatment provided for an acute musculoskeletal or neuromuscular condition, or an acute exacerbation of a chronic musculoskeletal or neuromuscular condition, that persists fewer than 180 days from the start date of therapy. If the condition persists for more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client's condition has not become chronic and the client has not reached the point of plateauing.

Plateauing is defined as the point at which maximal improvement has been documented and more improvement ceases.

Procedure codes 1-97012, 1-97014, 1-97018, 1-97022, 1-97024, 1-97026, 1-97028, and 1-97150 are limited to one per day. The following procedure codes may be paid in multiple 15-minute quantities:

Procedure Codes		
1-97032	1-97033	1-97034
1-97035	1-97036	1-97039
1-97110	1-97112	1-97113
1-97116	1-97124	1-97139
1-97140	1-97530	1-97535
1-97537	1-97760	1-97761

Procedure code 1-97760 is only payable for clients younger than 21 years of age. Procedure code 1-97010 is not a benefit.

Procedure codes that may be billed in multiple quantities (e.g., 15 minutes each) are limited to a total of two hours per day of individual, group, or a combination of individual and group therapy.

Procedure code 1-97762 and 1-97750 are comprehensive codes and include an office visit. If an office visit is billed the same day by the same provider, the office visit is denied as part of another procedure billed the same day. Procedure codes 1-97535, 1-97537, 1-97542, and 1-97762 are only payable for clients younger than 21 years of age.

Procedure code 1-97004 is payable once per month, any provider, same facility. These codes are not payable on the same day as the following codes:

Procedure Codes		
1-97012	1-97014	1-97018
1-97022	1-97024	1-97026
1-97028	1-97032	1-97033
1-97034	1-97035	1-97036
1-97039	1-97110	1-97112
1-97113	1-97116	1-97124
1-97139	1-97140	1-97150
1-97530	1-97750	1-97760
1-97761	1-97762	

36.4.29 Ophthalmology

When an ophthalmologist sees a patient for a minor condition, such as conjunctivitis, that does not require a complete eye exam, providers are to use the appropriate office E/M code.

Providers are to use the following eye exam procedure codes with a diagnosis of ophthalmological disease or injury. If the client is seen by an ophthalmologist for a diagnosis of refractive error or to rule out a refractive error, the code 1-S0620 or 1-S0621 must be billed. Refractions are limited for clients younger than 21 years of age to once every state fiscal year (SFY) (September 1 through August 31).

For clients younger than 21 years of age, this limitation may be exceeded, if any of the following situations apply and the claim documentation supports the situation:

- A diopter change of 0.5 or more.
- A school nurse, teacher, or parent requests the eye exam.
- Medical necessity.

Clients 21 years of age and older are allowed one eye exam for refractive error once every 24 months. For example, if the exam for refractive error occurs in May 2001, the client older than 21 years of age is eligible for another exam in June 2003.

If a client is eligible for Medicare and Medicaid, the eye exam for a diagnosis of eye disease, injury, or aphakia (1-92002, 1-92004, 1-92012, or 1-92014) must be billed to Medicare in accordance with Medicare filing procedures. The refractive portion of the exam must be billed to Medicaid within 95 days of the eye refraction with a medical diagnosis. Medicare does *not* cross over the refractive portion of the eye exam to the Texas Medicaid Program.

When billed correctly, providers receive three payments:

- Medicare's allowance for the eye exam.
- A Medicare/Medicaid payment crossover for the allowed deductible and coinsurance on the eye exam.
- A Medicaid-only payment for the refractive portion of the exam.

Procedure code 1-92015 is used when billing for just the refraction on a client who is eligible for Medicaid and has Medicare. Use procedure code 1-92015 when the refraction is the only service performed when evaluating a patient with ocular disease.

A new patient eye examination in any POS is changed to an established patient eye exam if history shows that the same physician has furnished a medical service (TOS 1), surgical service (TOS 2), or consultation (TOS 3) within two years. Services coded as new patient eye exams in excess of this limitation are changed as follows:

If billed as:	Change to:
1-92002	1-92012
1-92004	1-92014

Unless specifically designated by CPT as a unilateral code, all ophthalmological services listed are considered bilateral and should not be billed as a quantity of two. However, procedure codes 1-92225, 1-92226, 1-92230, and 1-92235 are considered unilateral codes and are paid as a quantity of two, if both eyes are evaluated.

36.4.29.1 Complete Eye Exams

New Patient

Procedure Codes		
1-92002	1-92004	1-99201
1-99202	1-99203	1-99204
1-99205	1-S0620	

Established Patient

Procedure Codes		
1-92012	1-92014	1-92015
1-99211	1-99212	1-99213
1-99214	1-99215	1-S0621

Procedure codes 1-92015, 1-92020, 1-92060, and 1-92100 are not considered for reimbursement separately when submitted with the same date of service as an office visit/eye examination.

Note: *Procedure code 1-92015 may be considered separately for reimbursement when used to submit the refractive portion of the examination for clients eligible for both Medicare and Medicaid. Refer to* *"Medicare/Medicaid" on page 45-7.*

Evaluation and Management Office Visit or Consultation Billed in Addition to the Eye Examination

When an E/M office visit or consultation is billed in addition to the eye examination, the most inclusive code is paid and the other denied.

Services Billed in Addition to an Evaluation and Management Service or Eye Examination

The following services are not reimbursed when billed with an office visit/eye examination on the same date of service. Procedure codes 1-92015, 1-92020, 1-92060, and 1-92100 are considered part of the office visit/eye examination.

If no code exists for the additional procedure provided, use the appropriate 1-99201 or 1-99211 visit code.

Procedure code 1-92015 may be considered separately for reimbursement if it is used to bill for the refractive portion of an examination for clients who are eligible for both Medicare and Medicaid.

Procedure code 1-99173 will deny as part of another procedure/service billed on the same day (e.g., THSteps medical check up or E/M service).

Special Ophthalmological Services Reimbursed When Billed the Same Day as General Ophthalmological Services

The following special ophthalmological services are reimbursed when billed in addition to a general ophthalmological service, for the same date of service:

Procedure Codes		
1-92018	1-92019	1-92025
1-92081*	1-92082*	1-92083*
1-92120	1-92135	1-92140
*** Procedure codes that are considered bilateral.**		

A new or established patient office visit or ophthalmological medical examination is denied, if any of the following ophthalmological/ophthalmoscopy services are performed on the same day:

Procedure Codes		
1-92225	1-92226	1-92230
1-92235	1-92240	1-92250*
1-92260*	1-92265*	1-92270*
1-92275*	5/T/I-95930*	1-92285*
1-92286*	1-92287*	
*** Procedure codes that are considered bilateral.**		

Procedure code 1-92230 is not paid in addition to 1-92235.

Valid Diagnosis Codes for Evaluation and Management Services, Consultation Codes, or Medical Eye Examinations

Client E/M services, medical eye examinations, and consultations are payable when indicated and billed for the following diagnosis codes:

Diagnosis Codes				
05320	05321	05322	05329	05440
05441	05442	05443	05444	05449
0760	0761	0769	0770	0771
0772	0773	0774	0778	0903
0905	0906	0907	0909	09150
09151	09152	09840	09841	09842
09843	09849	11502	11512	11592
1301	1302	1900	1901	1902
1903	1904	1905	1906	1907
1908	1909	2240	2241	2242
2243	2244	2245	2246	2247
2248	2249	2340	36000	36001
36002	36003	36004	36011	36012
36013	36014	36019	36020	36021
36023	36024	36029	36030	36031
36032	36033	36034	36040	36041
36042	36043	36044	36050	36051

Diagnosis Codes				
36052	36053	36054	36055	36059
36060	36061	36062	36063	36064
36065	36069	36081	36089	3609
36100	36101	36102	36103	36104
36105	36106	36107	36110	36111
36112	36113	36114	36119	3612
36130	36131	36132	36133	36181
36189	3619	36201	36202	36203
36204	36205	36206	36207	36210
36211	36212	36213	36214	36215
36216	36217	36218	36221	36229
36230	36231	36232	36233	36234
36235	36236	36237	36240	36242
36243	36250	36251	36252	36253
36254	36255	36256	36257	36260
36261	36262	36263	36264	36265
36266	36752	36753	36789	36800
36801	36802	36803	36810	36811
36812	36813	36814	36815	36816
3682	36830	36831	36832	36833
36834	36840	36841	36842	36843
36844	36845	36846	36847	36851
36852	36853	36854	36855	36859
36860	36861	36862	36863	36869
3688	3689	36900	36901	36902
36903	36904	36905	36906	36907
36908	36910	36911	36912	36913
36914	36915	36916	36917	36918
36920	36921	36922	36923	36924
36925	3693	3694	36960	36961
36962	36963	36964	36965	36966
36967	36968	36969	36970	36971
36972	36973	36974	36975	36976
3698	3699	37000	37001	37002
37003	37004	37005	37006	37007
37020	37021	37022	37023	37024
37031	37032	37033	37034	37035
37040	37044	37049	37050	37052
37054	37055	37059	37060	37061
37062	37063	37064	3708	3709
37100	37101	37102	37103	37104
37105	37110	37111	37112	37113
37114	37115	37116	37120	37121
37122	37123	37124	37130	37131

Diagnosis Codes				
37132	37133	37140	37141	37142
37143	37144	37145	37146	37148
37149	37150	37151	37152	37153
37154	37155	37156	37157	37158
37160	37161	37162	37170	37171
37172	37173	37181	37182	37189
3719	37200	37201	37202	37203
37204	37205	37210	37211	37212
37213	37214	37215	37220	37221
37222	37230	37231	37233	37239
37240	37241	37242	37243	37244
37245	37250	37251	37252	37253
37254	37255	37256	37261	37262
37263	37264	37271	37272	37273
37274	37275	37281	37289	3729
37300	37301	37302	37311	37312
37313	3732	37331	37332	37333
37334	3734	3735	3736	3738
3739	37400	37401	37402	37403
37404	37405	37410	37411	37412
37413	37414	37420	37421	37422
37423	37430	37431	37432	37433
37434	37441	37443	37444	37445
37446	37450	37451	37452	37453
37454	37455	37456	37481	37482
37483	37484	37485	37486	37487
37489	3749	37500	37501	37502
37503	37511	37512	37513	37514
37515	37516	37520	37521	37522
37530	37531	37532	37533	37541
37542	37543	37551	37552	37553
37554	37555	37556	37557	37561
37569	37581	37589	37600	37601
37602	37603	37604	37610	37611
37612	37613	37621	37622	37630
37631	37632	37633	37634	37635
37636	37640	37641	37642	37643
37644	37645	37646	37647	37650
37651	37652	3766	37681	37682
37689	3769	37700	37701	37702
37703	37704	37710	37711	37712
37713	37714	37715	37716	37721
37722	37723	37724	37730	37731
37732	37733	37734	37739	37741

Diagnosis Codes				
37742	37743	37749	37751	37752
37753	37754	37761	37762	37763
37771	37772	37773	37775	3779
74300	74303	74306	74310	74311
74312	74320	74321	74322	74330
74331	74332	74333	74334	74335
74336	74337	74339	74341	74342
74343	74344	74345	74346	74347
74348	74349	74351	74352	74353
74354	74355	74356	74357	74358
74359	74361	74362	74363	74364
74365	74366	74369	7438	7439
8700	8701	8702	8703	8704
8708	8709	8710	8711	8712
8713	8714	8715	8716	8717
8719	9180	9181	9182	9189
9210	9211	9212	9213	9219
9300	9301	9302	9308	9309
9400	9401	9402	9403	9404
9405	9409			

Eye examinations for aphakia and disease or injury to the eye are not subject to any of the limitations listed above and are payable even if the Medicaid ID form does not have a checkmark under the Eye Exam column.

36.4.29.2 Blepharoplasty Procedures

Procedure codes 2-67901, 2-67902, 2-67903, 2-67904, 2-67906, 2-67908, and 2-67909 are payable for children up to 21 years of age without prior authorization when performed for one of the following diagnosis codes: 74361, 74362, or 74390.

Procedure codes 2-67901, 2-67902, 2-67903, 2-67904, 2-67906, and 2-67908 do not require prior authorization for clients 21 years of age or older when billed for the following diagnosis codes: 37431, 37432, 37433, and 37434.

Blepharoplasty and eyelid repair for adults 21 years of age and older requires mandatory prior authorization. The following information from the physician is required at the time of the request for blepharoplasty or eyelid repair for procedure codes 2-15820, 2-15821, 2-67901, 2-67902, 2-67903, 2-67904, 2-67906, 2-67908, 2-67909, 2-67911, 2-67961, 2-67966, 2-67971, 2-67973, 2-67974, and 2-67975:

- A brief history and physical evaluation.
- Photographs of the eyelid problem.
- Visual field measurements.
- ICD-9-CM diagnosis(es).

The following blepharoplasty procedures do *not* require prior authorization: 2-67916, 2-67917, 2-67923, and 2-67924.

All supporting documentation must be included with the request for authorization. Send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

36.4.29.3 Corneal Topography

Procedure code 1-92025 is a benefit of the Texas Medicaid Program. An initial or established visit/consultation is payable on the same day as corneal topography. These visits remain subject to the global surgery fee guidelines. If the topography is performed within the global surgical pre- and post-care days of the following ophthalmic procedures, the topography is denied as part of the procedure.

Procedure Codes		
2-65270	2-65272	2-65273
2-65275	2-65280	2-65285
2-65286	2-65400	2-65420
2-65426	2-65430	2-65435
2-65436	2-65450	2-65600
2-65710	2-65730	2-65750
2-65755	2-65880	2-66600
2-66605	2-66625	2-66630
2-66635	2-66820	2-66821
2-66830	2-66840	2-66850
2-66852	2-66920	2-66930
2-66940	2-66983	2-66986

Interpretations are payable in the office and outpatient and inpatient settings. The technical component is only reimbursed in the office setting. Depending on the POS billed, a maximum of two interpretations (one for each eye) and one technical component *or* one total component and one additional interpretation (if topography was performed on both eyes) may be reimbursed. Only one corneal topography may be billed per eye, per day, by any provider.

Prior authorization is required for procedure code 1-92025 when used for the fitting of contact lenses for diagnosis codes 36720, 36722, and 74341. Prior authorization criteria must be met for both corneal topography and contact lenses. Procedure code 1-92025 also must be prior authorized when using diagnosis code 74341 for any reason.

Providers are to send prior authorization requests to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

Topography is payable *without prior authorization* for conditions identified by the following diagnosis codes:

Diagnosis Codes				
37000	37001	37002	37003	37004
37005	37006	37007	37100	37101
37102	37103	37104	37120	37121
37122	37123	37140	37142	37146
37148	37149	37160	37161	37162
37170	37171	37172	37173	37240
37241	37242	37243	37244	37245
37281	37289	8710	8711	9402
9403	9404	99651	V425	V4561
V4569				

36.4.29.4 Corneal Transplants

Corneal transplants are benefits of the Texas Medicaid Program. Corneal transplants are subject to global surgery fee guidelines. Procedure codes 2-65710, 2-65730, 2-65750, and 2-65755 are used for this surgery.

Bioengineered cornea transplants remain investigational at this time and are not considered for reimbursement under the Texas Medicaid Program.

Procurement of the cornea is not reimbursed separately.

36.4.29.5 Echography Ophthalmic, A & B Scan

Procedure codes 4/I/T-76511, 4/I/T-76512, 4/I/T-76516, and 4/I/T-76519 are reimbursed for the following diagnosis codes. Ophthalmic A-scan (4/I/T-76511, 4/I/T-76516, or 4/I/T-76519) is reimbursed on the same day as ophthalmic B-scan (4/I/T-76512) when each meets the following diagnosis criteria:

Diagnosis Codes				
36600	36601	36602	36603	36604
36609	36610	36611	36612	36613
36614	36615	36616	36617	36618
36619	36620	36621	36622	36623
36630	36631	36632	36633	36634
36641	36642	36643	36644	36645
36646	36650	36651	36652	36653
3668	3669	37100	37101	37102
37103	37104	37110	37111	37112
37113	37114	37115	37116	37120

Diagnosis Codes				
37121	37122	37123	37124	37130
37131	37132	37133	37140	37141
37142	37143	37144	37145	37146
37148	37149	37150	37151	37152
37153	37154	37155	37156	37158
37160	37162	37170	37171	37172
37173	37181	37182	37189	3719
37931	37932	37933	37934	37939
74330	74331	74332	74333	74334
74335	74336	74337	74339	

36.4.29.6 Echography Ophthalmic Biometry, A-Mode

Procedure codes 4-76511, 4-76516, and 4-76519 are payable for the following diagnosis codes:

Diagnosis Codes				
36600	36601	36602	36603	36604
36609	36610	36611	36612	36613
36614	36615	36616	36617	36618
36619	36620	36621	36622	36623
36630	36631	36632	36633	36634
36641	36642	36643	36644	36645
36646	36650	36651	36652	36653
3668	3669	37100	37101	37102
37103	37104	37105	37110	37111
37112	37113	37114	37115	37116
37120	37121	37122	37123	37124
37130	37131	37132	37133	37140
37141	37142	37143	37144	37145
37446	37148	37149	37150	37151
37152	37153	37154	37155	37156
37158	37160	37162	37170	37171
37172	37173	37181	37182	37189
3719	37931	37932	37933	37934
37939	74330	74331	74332	74333
74334	74335	74336	74337	74339

36.4.29.7 Echography Scan, Ophthalmic

Procedure codes 4/I/T-76510, 4/I/T-76511, 4/I/T-76512, 4/I/T-76513, and 4/I/T-76999 are payable for the following diagnosis codes or conditions:

Diagnosis Codes				
1900	1901	1984	2240	2241
2340	2388	2389	25050	25051
25052	25053	36100	36101	36102
36103	36104	36105	36106	36107
36110	36111	36112	36113	36114
36119	3612	36130	36131	36132
36133	36181	36189	3619	36201
36202	36203	36204	36205	36206
36207	36210	36211	36212	36213
36214	36215	36216	36217	36218
36221	36229	36230	36231	36232
36233	36234	36237	36240	36241
36242	36243	36250	36251	36252
36253	36254	36255	36256	36260
36261	36262	36263	36264	36265
36266	36270	36271	36272	36273
36274	36275	36276	36277	36281
36282	36283	36284	36285	36289
36340	36341	36342	36343	36361
36362	36363	36370	36371	36372
36441	36481	36489	36641	37921
37926	37992			

36.4.29.8 Eye Surgery by Laser

All procedures are limited to reimbursement once every 90 days for the same eye with the exception of infants from birth to 23 months of age. Procedures performed on infants from birth to 23 months of age are not subject to any frequency restrictions.

36.4.29.9 The Anterior Segment of the Eye–The Lens

Reimbursement for Yttrium Aluminum Garnet (YAG) laser surgery (2-66821) is limited to the following diagnosis codes: 36650, 36652, and 36653.

The Anterior Segment of the Eye–The Cornea

Laser surgery to the cornea by Laser-Assisted in Situ Keratomileusis (LASIK) or photorefractive keratectomy (PRK) for the purpose of correcting nearsightedness (myopia), farsightedness (hyperopia), or astigmatism is not a benefit of the Texas Medicaid Program.

Reimbursement for laser surgery to the cornea, procedure codes 2-65450, 2-65855, and 2-65860 is limited to once every 90 days for the same eye and is restricted to the following diagnosis codes:

Diagnosis Codes				
36500	36501	36502	36503	36504
36510	36511	36512	36513	36514
36515	36520	36521	36522	36523
36524	36531	36532	36541	36542
36543	36544	36551	36552	36559
36560	36561	36562	36563	36564

Diagnosis Codes				
36565	36581	36582	36583	36589
3659				

The Anterior Segment of the Eye–The Iris, Ciliary Body

Laser surgery to the anterior segment of the eye–the iris, ciliary body will be reimbursed only when billed with one of the following procedure codes:

Procedure Codes		
2-66600	2-66605	2-66710
2-66711	2-66761	2-66762
2-66770		

Reimbursement for procedure codes 2-66600, 2-66605, 2-66710, 2-66711, 2-66761, 2-66762, and 2-66770 is limited to once every 90 days for the same eye and is restricted to the following diagnosis codes:

Diagnosis Codes				
36400	36401	36402	36403	36404
36405	36410	36411	36421	36422
36423	36424	3643	36500	36501
36502	36503	36504	36510	36511
36512	36513	36514	36515	36520
36521	36522	36523	36524	36531
36532	36541	36542	36543	36544
36551	36552	36559	36560	36561
36562	36563	36564	36565	36581
36582	36583	36589	3659	

Claims for iridectomy (2-66600 or 2-66605) are not reimbursed when billed for the same date of service as a trabeculectomy (2-66170 or 2-66172). These claims are considered for review when filed on appeal with documentation of medical necessity. The iridectomy is considered part of a trabeculectomy. An iridectomy billed with any other eye surgery on the same day suspends for review.

An iridectomy is also considered part of certain types of cataract extractions. An iridectomy (2-66600 or 2-66605) is not reimbursed when billed for the same date of service as the cataract surgeries listed in the following table. The iridectomy is considered part of the cataract surgery. These claims are considered for review when filed on appeal with documentation of medical necessity.

Procedure Codes		
2-65920	2-66840	2-66850
2-66852	2-66920	2-66930
2-66940	2-66983	2-66984
2-66985	2-66986	

Posterior Segment of the Eye–Retina or Choroid

Laser surgery to the retina or choroid will be reimbursed only when billed with one of the following procedure codes:

Procedure Codes		
2-67105	2-67107	2-67108
2-67110	2-67112	2-67145
2-67210	2-67220	2-67221
2-67225	2-67228	2/F-G0183
2/F-G0186		

Reimbursement for procedure codes, listed in the previous table, is restricted to the following diagnosis codes:

Diagnosis Codes				
1905	25050	25051	25052	25053
36100	36101	36102	36103	36104
36105	3612	36131	36132	36133
36181	36189	3619	36201	36202
36203	36204	36205	36206	36207
36210	36211	36212	36213	36214
36215	36216	36217	36218	36221
36229	36230	36231	36232	36233
36234	36235	36236	36237	36240
36241	36242	36243	36250	36251
36252	36253	36254	36255	36256
36257	36260	36261	36262	36263
36264	36265	36266	36281	

When billed for the same date of service, same eye, different provider procedure codes 2-66821, 2-67005, 2-67010 and 2-69990 will deny as part of procedure code 2-67031.

When billed for the same date of service, same eye, any provider procedure code 2-67031 will deny as part of any of the following procedure codes: 2-67036, 2-67120, 2-67121, 2-67208, 2-67218, 2-67108, 2-67110, 2-67227, and 2-67228.

When billed for the same date of service, same eye, any provider, only one of the following procedure codes is reimbursed: 2/F-67220, 2-67221, 2/F-G0183, 2/F-G0184, or 2/F-G0186.

The Posterior Segment of the Eye, Vitreous–Vitrectomy

Laser surgery to the vitreous will be reimbursed only when billed with one of the following procedure codes: 2-67031, 2-67039, and 2-67040.

Reimbursement for procedure codes 2-67031, 2-67039, and 2-67040 is limited to once every 90 days for the same eye and is restricted to the following diagnosis codes:

Diagnosis Codes				
25050	25051	25052	25053	36000
36001	36002	36003	36004	36012
36050	36051	36052	36053	36054
36055	36059	36060	36061	36062
36063	36064	36065	36069	36100
36101	36102	36103	36104	36105
36106	36107	36130	36132	36207
36212	36252	36254	36256	36281
36362	36370	36371	36372	36520
37923	37924	37925	37926	37929
37932	37934	8710	8711	8712
8713	8714	8715	8716	8717
8719	99653	99882		

- When billed for the same date of service, same eye, any provider procedure codes 2-67500 and 2-69990 are denied as part of 2-66821.
- Procedure code 2-66821 is denied as part of 2-66830, 2-67031, and 2-67228.
- Procedure codes 2-66820, 2-66984, 2-66985, and 2-67036 will pay according to multiple surgery guidelines when billed with procedure code 2-66821.
- When billed for the same date of service, same eye, different provider procedure codes 266821, 2-67005, 2-67010, and 2-69990 will deny as part of 2-67031.
- When billed for the same date of service, same eye, any provider procedure code 2-67031 will deny as part of any of the following procedure codes: 2-67036, 2-67120, 2-67121, 2-67208, 2-67218, 2-67108, 2-67110, 2-67227, and 2-67228.

All laser eye surgeries are payable only to the following provider types:

Provider Type	Description
03	CIHCP
19	Physician (DO)
20	Physician (MD)
21	Physician group (DO)
22	Physician group (MD)

36.4.29.10 Eye Surgery by Incision

The following restrictions apply to vitrectomy and cataract surgeries:

- Procedure codes 2-66500, 2-66505, 2-66600, 2-66605, 2-66625, 2-66630, and 2-66635 are denied as part of another procedure when billed with procedure codes 2-66170 or 2-66172 on the same eye for the same date of surgery.
- When cataract extraction and vitrectomy are billed on the same date of service for clients 8 years of age and under, the vitrectomy will pay at full TMRM allowance and the cataract extraction will pay at 50 percent per multiple surgical procedure payment guidelines.
- Procedure code 2-66020 is denied as part of another procedure when billed with any related eye surgery procedure code.
- Procedure code 2-67036 is reimbursed when billed alone.
- Procedure code 2-67036 is denied as part of another procedure when billed with procedure codes 2-67038, 2-67039, 2-67040, and/or 2-67108.
- Procedure codes 2-67039 and 2-67040 are combined and reimbursed as procedure code 2-67108 when billed by the same provider for the same date of service.
- For clients 8 years of age or younger, the following procedure codes, performed on the same eye, will be considered for payment per multiple surgery guidelines:

Procedure Codes		
2-66840	2-66850	2-66852
2-66920	2-66930	2-66940
2-66983	2-66984	2-67005
2-67010	2-67015	2-67025
2-67027	2-67028	2-67030
2-67031	2-67036	2-67038
2-67039	2-67040	

- For clients older than 8 years of age, the following procedure codes will be paid when performed on the same eye:

Procedure Codes		
2-67005	2-67010	2-67015
2-67025	2-67027	2-67028
2-67030	2-67031	2-67036
2-67038	2-67039	2-67040

- For clients older than 8 years of age, the following procedure codes will be denied as part of the codes listed above, when performed on the same eye:

Procedure Codes		
2-66840	2-66850	2-66852
2-66920	2-66930	2-66940
2-66983	2-66984	

Vitrectomy procedure codes 2/F-67036, 2/F-67038, 2/F-67039, and 2/F-67040 are diagnosis-restricted to the following codes:

Diagnosis Codes				
25050	25051	25052	25053	36000
36001	36002	36003	36004	36012
36050	36051	36052	36053	36054
36055	36059	36060	36061	36062
36063	36064	36065	36069	36100
36101	36102	36103	36104	36105
36106	36107	36130	36132	36202
36203	36204	36205	36206	36207
36212	36252	36254	36256	36281
36362	36370	36371	36372	36520
37923	37924	37925	37926	37929
37932	37934	8710	8711	8712
8713	8714	8715	8716	8717
8719	99653	99882		

Cataract procedure codes 2/F-66983, 2/F-66984, 2/F-66985, and 2/F-66986 are diagnosis-restricted to the following codes:

Diagnosis Codes				
36551	36600	36601	36602	36603
36604	36609	36610	36611	36612
36613	36614	36615	36616	36617
36618	36619	36620	36621	36622
36623	36630	36631	36632	36633
36634	36641	36642	36643	36644
36645	36646	36650	36651	36652
36653	3668	3669		

36.4.29.11 Intraocular Lens (IOL)

An IOL (9-V2630, 9-V2631, and 9-V2632) is reimbursed only to physicians in the office setting (POS 1). Providers must submit a copy of the manufacturer's invoice for the IOL to TMHP with their claim. Reimbursement for the lens is limited to the actual acquisition cost for the lens (taking into account any discount) plus a handling fee not to exceed 5 percent of the acquisition cost.

Medicaid does not reimburse physicians who supply IOLs to ASCs/HASCs; payment for the IOL is included in the facility fee.

Reimbursement for an IOL is limited to the following provider types:

Provider Type	Description
03	CIHCP
19	Physician (DO)
20	Physician (MD)
21	Physician group (DO)
22	Physician group (MD)

Reimbursement for the surgical procedure necessary to implant an IOL remains unchanged.

36.4.29.12 Intravitreal Drug Delivery System

Procedure codes 2/F-67027 and 2/F-67121 pertain to the procurement, implantation, and removal of an intravitreal drug delivery system (e.g., a ganciclovir implant). They are set to autodeny when billed concurrently.

The following diagnosis codes are valid for procedure code 2/F-67027: 0785 and 36320.

36.4.29.13 Iridectomy/Iridotomy/Trabeculectomy

If separate charges are billed for an iridectomy (2-66600, 2-66605, 2-66625, 2-66630, and 2-66635), or iridotomy (2-66500 and 2-66505), and a trabeculectomy (2-66170) on the same day, only the trabeculectomy is paid.

36.4.29.14 Ophthalmic Ultrasound Foreign Body Localization

Procedure code 4-76529 is payable for the following diagnosis codes:

Diagnosis Codes				
36050	36051	36052	36063	36054
36055	36059	36060	36061	36063
36064	36065	36069	3766	8704
8715	8716	9300	9301	9302
9308	9309			

36.4.29.15 Ophthalmological Services Billed with a Diagnosis of Cataract

Claims submitted with the following procedure codes and the diagnosis of cataract(s) are denied because they are not routinely medically indicated:

Procedure Codes		
1-92020	1-92060	1-92081
1-92082	1-92083	1-92100
1-92120	1-92225	1-92226
1-92230	1-92235	1-92250
1-92260	1-92265	1-92270
1-92275	1-92285	1-92286
1-92287	5-95930	

36.4.30 Organ/Tissue Transplants

Organ/tissue transplants that include bone marrow, peripheral stem cell, heart, lung, liver, kidney, pancreas/simultaneous kidney-pancreas, or combined heart/lung are a benefit of the Texas Medicaid Program.

Organ/tissue transplants are reimbursed only when performed in an institution that is fully qualified by the Texas Medicaid Program to perform transplant services.

If a Medicaid client receives a transplant in a facility not approved by the Texas Medicaid Program, the patient must be discharged from the facility to be considered to receive other medical and hospital benefits under the Texas Medicaid Program. Coverage for other services needed as a result of complications of the transplant may be considered when medically necessary, reasonable, and federally allowable.

Texas Medicaid will not pay for routine post-transplant services for transplant patients in facilities not approved by the Texas Medicaid Program.

Transplants are covered by the Medicare program; therefore, for clients eligible for both Medicare and Medicaid, Medicaid will pay the deductible or coinsurance portion only as applicable. Medicaid will not pay a transplant service denied by Medicare for a Medicare-eligible client.

If a transplant has been prior authorized as medically necessary by HHSC or its designee because of an emergent, life-threatening situation, a maximum of 30 days of inpatient hospital services during a Title XIX spell of illness may be covered beginning with the actual first day of the transplant. This coverage is in addition to covered inpatient hospital days provided before the actual first day of the transplant. This 30-day period is considered a separate inpatient hospital admission for reimbursement purposes, but is included under one hospital stay. Physician services that HHSC or its designee determines to be reasonable and medically necessary also are covered during the 30-day period. Day limitations do not apply for clients younger than 21 years of age.

Coverage is limited to one transplant per organ system (or organ systems for combined transplants) per lifetime except for one subsequent retransplant due to organ rejection.

Expenses for a single inpatient hospital admission for a prior authorized transplant are not included in the annual $200,000 inpatient expenditure cap. Dollar limitations do not apply for clients younger than 21 years of age. Expenses incurred by a living donor will not be reimbursed separately.

Refer to: "Organ/Tissue Transplant Services" on page 25-10 for more information about the transplant facility approval criteria.

36.4.30.1 Pancreas Transplant/Simultaneous Kidney-Pancreas Transplant

Based on published research and clinical studies, pancreas/simultaneous kidney-pancreas transplants have been determined to be a benefit of the Texas Medicaid Program. A pancreas/simultaneous kidney-pancreas transplant for individual Medicaid clients is subject to prior authorization and must be performed in an institution approved as a pancreas/simultaneous kidney-pancreas transplant facility by the Texas Medicaid Program.

Note: *Islet cell transplant is considered experimental and investigational and is not a benefit of the Texas Medicaid Program.*

A pancreas/simultaneous kidney-pancreas transplant must be documented as the client being unresponsive to more conventional and/or standard therapies to be considered for coverage.

Prior authorization is required for a pancreas/simultaneous kidney-pancreas transplant and must follow criteria for both pancreas and simultaneous kidney-pancreas transplant.

Guidelines for Coverage of a Pancreas/Simultaneous Kidney-Pancreas Transplant

Pancreas/simultaneous kidney-pancreas transplant candidates must be limited to those patients who, based on sound patient selection criteria, would most likely benefit from the transplant procedure on a long-term basis. Documentation at the time of authorization is required in order to be considered for reimbursement by the Texas Medicaid Program.

Pancreas Transplant Alone

For a transplant of the pancreas alone, documentation must be submitted that shows all of the following:

- A satisfactory kidney function (creatinine clearance greater than 40 mL/min).
- Type 1 diabetes with secondary diabetic complications that are progressive despite the best medical management and meet at least one of the following below:
  - Secondary complications which must include at least two of the following:
    - Diabetic neuropathy.
    - Retinopathy.
    - Gastroparesis.
    - Autonomic neuropathy.
    - Extremely labile (brittle) insulin-dependent diabetes melliltus.
  - Recurrent, acute and severe metabolic and potentially life-threatening complications requiring medical attention which include:
    - Hypoglycemia.
    - Hyperglycemia.
    - Ketacidosis.
    - Failure of exogenous insulin-based management to achieve sufficient glycemic control (HbA1c of greater than 8.0) despite aggressive conventional therapy.
    - Insensibility to hypoglycemia.

Simultaneous Kidney-Pancreas Transplant

For a simultaneous kidney-pancreas transplant, documentation must be submitted that shows that the client has type 1 diabetes mellitus with secondary diabetic complications that are progressive despite the best medical management. Additionally, the documentation must show at least one of the following:

- Secondary complications which must include at least two of the following:
  - Diabetic neuropathy.
  - Retinopathy.
  - Gastroparesis.
  - Autonomic neuropathy.
  - Extremely labile (brittle) insulin-dependent diabetes melliltus.
- Recurrent, acute and severe metabolic and potentially life-threatening complications requiring medical attention which include:
  - Hypoglycemia.
  - Hyperglycemia.
  - Ketacidosis.
  - Failure of exogenous insulin-based management to achieve sufficient glycemic control (HbA1c of greater than 8.0) despite aggressive conventional therapy.
  - Insensibility to hypoglycemia.
- End-stage renal disease that requires dialysis or is expected to require dialysis within the next 12 months.

The following contraindications for the transplant applies to both pancreas and simultaneous kidney-pancreas transplant and are as follows:

- Inadequate cardiac status, pulmonary or liver function.
- Ongoing or recurrent active infections that are not effectively treated.
- Uncontrolled HIV/AIDS infection.
- Malignancy (except non-melanoma skin cancers).
- Documented psychiatric instability if severe enough to jeopardize incentive for adherence to medical regimen.

Documentation of compliance with medical treatments regimen and plan of care.

Documented compliance includes no active alcohol or chemical dependency that interferes with compliance to a medical regimen.

36.4.30.2 Stem Cell Transplants

1) Allogeneic and autologous stem cell transplantation is a covered benefit of the Texas Medicaid Program when prior authorized and performed in an approved stem cell transplantation facility. Stem cell transplantation is a process in which stem cells are obtained from either a client's or donor's bone marrow, peripheral blood, or umbilical cord blood for intravenous infusion. The transplant can be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy and/or radiotherapy used to treat various malignancies, and also can be used to restore function in clients having an inherited or acquired deficiency or defect.
2) Benefits are not available for any experimental or investigational services, supplies, or procedures.
3) Coverage of stem cell transplantation is limited to the following procedure codes: 2-38240, 2-38241, 2-38242, and 2-38999. The unlisted procedure code 2-38999 should be used to indicate an umbilical cord blood transplant.
4) *Allogenic* stem cell transplantation is a covered benefit for the following diagnosis codes with associated restrictions referenced in paragraph six.

Diagnosis Codes				
1890	1916	20000	20001	20002
20003	20004	20005	20006	20007
20008	20010	20011	20012	20013
20014	20015	20016	20017	20018
20020	20021	20022	20023	20024
20025	20026	20027	20028	20030
20031	20032	20033	20034	20035
20036	20037	20038	20040	20041
20042	20043	20044	20045	20046
20047	20048	20050	20051	20052
20053	20054	20055	20056	20057
20058	20060	20061	20062	20063
20064	20065	20066	20067	20068
20070	20071	20072	20073	20074
20075	20076	20077	20080	20081
20082	20083	20084	20085	20086
20087	20088	20100	20101	20102
20103	20104	20105	20106	20107
20108	20110	20111	20112	20113
20114	20115	20116	20117	20118
20120	20121	20122	20123	20124
20125	20126	20127	20128	20140
20141	20142	20143	20144	20145
20146	20147	20148	20150	20151
20152	20153	20154	20155	20156
20157	20158	20160	20161	20162
20163	20164	20165	20166	20167
20168	20170	20171	20172	20173
20174	20175	20176	20177	20178
20190	20191	20192	20193	20194
20195	20196	20197	20198	20200
20201	20202	20203	20204	20205
20206	20207	20208	20278	20280

Diagnosis Codes				
20281	20282	20283	20284	20285
20286	20287	20288	20290	20291
20292	20293	20294	20295	20296
20297	20298	20401	20501	20510
20601	20701	20801	27912	2792
28241	28242	28249	28260	28261
28262	23263	28242	28264	28268
28269	28401	28409	2841	2842
28481	28489	2849	74259	75652
See ICD-9-CM: Neoplasm by site, malignant				

5) *Autologous* stem cell transplantation is a covered benefit for the following diagnosis codes with associated restrictions referenced in paragraph 6.

Diagnosis Codes				
1860	1869	1890	1916	19882
20000	20001	20002	20003	20004
20005	20006	20007	20008	20010
20011	20012	20013	20014	20015
20016	20017	20018	20020	20021
20022	20023	20024	20025	20026
20027	20028	20030	20031	20032
20033	20034	20035	20036	20037
20038	20040	20041	20042	20043
20044	20045	20046	20047	20048
20050	20051	20052	20053	20054
20055	20056	20057	20058	20060
20061	20062	20063	20064	20065
20066	20067	20068	20070	20071
20072	20073	20074	20075	20076
20077	20080	20081	20082	20083
20084	20085	20086	20087	20088
20100	20101	20102	20103	20104
20105	20106	20107	20108	20110
20111	20112	20113	20114	20115
20116	20117	20118	20120	20121
20122	20123	20124	20125	20126
20127	20128	20140	20141	20142
20143	20144	20145	20146	20147
20148	20150	20151	20152	20153
20154	20155	20156	20157	20158
20160	20161	20162	20163	20164
20165	20166	20167	20168	20170
20171	20172	20173	20174	20175
20176	20177	20178	20190	20191

Diagnosis Codes				
20192	20193	20194	20195	20196
20197	20198	20200	20201	20202
20203	20204	20205	20206	20207
20208	20278	20280	20281	20282
20283	20284	20285	20286	20287
20288	20290	20291	20292	20293
20294	20295	20296	20297	20298
20300	20401	20501	20601	20701
20801	28481	28489		
See ICD-9-CM: Neoplasm by site, malignant				

6) Associated restrictions for diagnosis codes referenced in the two above tables are:

- Medulloblastoma is only allowed for recurrent disease or relapse after a first remission following initial therapy.
- The following diagnosis codes are a type of Non-Hodgkin's lymphoma:

Diagnosis Codes				
20000	20001	20002	20003	20004
20005	20006	20007	20008	20010
20011	20012	20013	20014	20015
20016	20017	20018	20020	20021
20022	20023	20024	20025	20026
20027	20028	20080	20081	20082
20083	20084	20085	20086	20087
20088	20200	20201	20202	20203
20204	20205	20206	20207	20208
20290	20291	20292	20293	20294
20295	20296	20297	20298	

- Stem cell transplant is allowed for Hodgkin's diagnosis in advanced disease state with failure of conventional therapy.
- Other lymphomas refers to T-cell lymphomas, which are a type of non-Hodgkin's lymphoma. Coverage is allowed after recurrence of disease.
- Coverage of lymphoid leukemia is allowed for acute lymphoblastic or acute lymphocytic leukemias in remission.
- Wiskott-Aldrich syndrome is an x-linked disorder affecting lymphocyte and platelet function.
- Coverage of combined immunity deficiency is allowed only for severe combined immunodeficiency (SCID), which is a condition of absent or defective lymphoid stem cells.
- Thalassemias and sickle-cell anemia are transfusion-dependent red blood cell disorders that require greater than one transfusion per year.
- Coverage of aplastic anemia is allowed for severe

aplastic anemia, and includes Fanconi's anemia, an autosomal recessive hereditary aplastic anemia.

- Coverage of other congenital anomalies of the spinal cord is allowed only for myelodysplasia.
- Coverage of secondary malignant neoplasm of other specified sites–genital organs, is allowed only for testicular cancer.
- Coverage of multiple myeloma is allowed only for chemotherapy-responsive cases.

7) Stem cell transplantation for breast cancer is not a benefit of the Texas Medicaid Program.

8) All stem cell transplants require mandatory prior authorization by HHSC or its designee and must be performed in an approved Texas Medicaid stem cell transplant facility. Prior authorization is effective from the date of the prior authorization approval letter until the end of the transplant facility's approval period. If the transplant has not been performed by the end of the authorization period, the facility and physician need to apply for an extension.

9) Documentation supplied with the prior authorization request should include:

- A complete history and physical.
- A current statement of the medical problems present.
- The status of the client, including the expected long-term prognosis for the client from the proposed procedure.

10) Coverage is limited to an initial transplant and one subsequent retransplant due to rejection, for a total of two transplants per lifetime regardless of payor. The subsequent stem cell transplant must be prior authorized separately. A subsequent transplant is not included in the prior authorization for the initial transplant.

11) Peripheral or umbilical cord blood stem cell transplantation may be authorized in lieu of bone marrow transplantation (BMT), but should not be approved when performed simultaneously.

12) If a stem cell transplant has been prior authorized, a maximum of 30 days of inpatient hospital services during a Title XIX spell of illness may be covered beginning with the actual first day of the transplant. This coverage is in addition to covered inpatient hospital days provided before the actual first day of the transplant. This 30-day period is considered a separate inpatient hospital admission for reimbursement purposes, but is included under one hospital stay.

13) Bone marrow harvesting (2-38230) or peripheral stem cell harvesting (2-38205) in conjunction with Allogeneic bone marrow transplants are not a separate payable benefit of the Texas Medicaid Program, and are considered part of the allogeneic stem cell transplant service (procedure code 2-38240).

14) Bone marrow harvesting (2/F-38230) or peripheral stem cell harvesting (2/F-38206) for Autologous stem cell transplants are a benefit of the Texas Medicaid Program and require mandatory prior authorization by HHSC or its designee.

15) Autologous harvesting of stem cells (single or multiple sessions) is reimbursed to the facility when prior authorized by HHSC or its designee and performed in the outpatient setting (POS 5). Harvesting of stem cells performed in the inpatient setting (POS 3) is included in the DRG and will not be reimbursed separately.

16) Physician services for the harvesting and/or storage of umbilical cord stem cells are not a benefit of the Texas Medicaid Program.

17) Donor expenses are included in the global fee for the transplant recipient and are not a separately payable benefit of the Texas Medicaid Program.

18) The reimbursement to DRG hospitals for a stem cell transplant includes the cost of the procurement of the stem cells and the associated services. Documentation must be maintained to identify where the stem cells were obtained.

19) Stem cell transplants for very rare conditions and diseases may be considered on a case by case basis. Documentation for prior authorization must be submitted to HHSC or its designee to determine whether the transplant is medically necessary and appropriate.

36.4.30.3 Heart Transplants

Under current Texas Medicaid Program policy, procedures are considered to be medically necessary and reasonable, based on safety and efficacy, demonstrated by scientific evidence and by controlled clinical studies.

Based on published research and clinical studies, heart transplants have been determined to be a benefit of the Texas Medicaid Program. A heart transplant for individual Medicaid clients is subject to prior authorization and must be performed in an institution approved as a heart transplant facility by the Texas Medicaid Program.

A heart transplant to a client for primary heart dysfunction must be documented as the client being unresponsive to more conventional and/or standard therapies to be considered for coverage.

Prior authorization is required for a heart/lung transplant and must follow criteria for both heart and lung transplants. Requests for a heart/lung transplant are considered individually.

Guidelines for Coverage of a Heart Transplant

Heart transplant candidates must be limited to those patients who, based on sound patient selection criteria, would most likely benefit from the heart transplant procedure on a long-term basis. To be reimbursed by the Texas Medicaid Program, the facility must document the following considerations:

- New York Heart Association (NYHA) Class Stage III or IV cardiac disease.
- Congenital heart disease.
- Valvular heart disease.
- Viral cardiomyopathies.
- Familial and restrictive cardiomyopathies.
- A heart transplant will result in a return to improved functional independence.
- An absence of comorbidities such as:
  - Severe pulmonary hypertension.
  - End-stage renal, hepatic or other organ dysfunction unrelated to primary disorder.
  - Active, uncontrolled HIV infection or AIDS-defining illness.
  - Multiple organ compromise secondary to infection, malignancy, or condition with no known cure.

Documented compliance with other medical treatments, regimen, and plan of care.

Documented compliance includes no active alcohol or chemical dependency that interferes with compliance to a medical regimen.

Documented psychiatric instability is a contraindication for transplant if severe enough to jeopardize incentive for adherence to medical regimen.

36.4.30.4 Intestinal Transplants

Intestinal transplantation currently is not a benefit of the Texas Medicaid Program.

36.4.30.5 Liver Transplants

Under current Texas Medicaid Program policy, procedures are considered to be medically necessary and reasonable, based on safety and efficacy, demonstrated by scientific evidence and by controlled clinical studies.

Based on published research and clinical studies, liver transplants have been determined to be a benefit of the Texas Medicaid Program for Medicaid-eligible clients. A liver transplant for individual Medicaid clients is subject to prior authorization and must be performed in an institution approved as a liver transplant facility by the Texas Medicaid Program.

Guidelines for Coverage

Authorization of liver transplantation requires documentation of life threatening complications of acute liver failure or chronic end-stage liver disease.

Liver transplant candidates must be limited to those patients who, based on sound patient selection criteria, would most likely benefit from the liver transplant procedure on a long-term basis. To be reimbursed by the Texas Medicaid Program, the facility must document the following considerations:

- A critical medical need with a likelihood of a successful clinical outcome.
- Liver disease in one of the following categories:
  - Primary cholestatic liver disease.
  - Other cirrhosis:
    - Alcoholic.
    - Hepatitis C, non-A, non-B, and Hepatitis B.
  - Fulminant hepatic failure.
  - Metabolic diseases.
  - Malignant neoplasms.
  - Benign neoplasms.
  - Biliary atresia.
- An absence of comorbidities such as:
  - End-stage cardiac, pulmonary, or renal disease unrelated to primary disorder.
  - Multiple organ compromise secondary to infection, malignancy, or condition with no known cure.

Documented compliance with other medical treatments, regimen, and plan of care.

Documented compliance includes no active alcohol or chemical dependency that interferes with compliance to a medical regimen.

Documented psychiatric instability is a contraindication for transplant if severe enough to jeopardize incentive for adherence to medical regimen.

Payment for liver transplant professional services is made under procedure code 2/8-47135 or 2/8-47136. These procedures include six months of professional postoperative care. Separate charges for procedure code 2/8-47780 are denied as part of the liver transplant. Parenteral immunosuppressant therapy is approved for a period of 12 months following the date of discharge from the hospital, conditional upon the client's Medicaid eligibility.

Services unrelated to the liver transplant surgery are paid separately.

Two assistant surgeons are allowed for liver transplant surgery using procedure codes 8-47135 or 8-47136.

36.4.30.6 Lung Transplants

Under current Texas Medicaid Program policy, procedures are considered to be medically necessary and reasonable, based on safety and efficacy, demonstrated by scientific evidence and by controlled clinical studies.

Based on published research and clinical studies, lung transplants (single lung with bronchial anastomosis or double sequential lung with bilateral bronchial anastomosis) have been determined to be a benefit of the Texas Medicaid Program. A lung transplant for individual Medicaid clients is subject to prior authorization and must be performed in an institution approved as a lung transplant facility by the Texas Medicaid Program.

A lung transplant to a client must be documented as unresponsive to more conventional and/or standard therapies to be considered for coverage.

Prior authorization is required for a heart/lung transplant and must follow criteria for both heart and lung transplants. Requests for a heart/lung transplant are considered on an individual basis.

Guidelines for Coverage of a Lung Transplant

Lung transplant candidates must be limited to those patients who, based on sound patient selection criteria, would most likely benefit from the lung (single or double) transplant procedure on a long-term basis. To be reimbursed by the Texas Medicaid Program, the facility must document the following considerations:

- A critical medical need with a likelihood of a successful clinical outcome.
- Symptoms at rest directly related to chronic pulmonary disease and resultant severe functional limitation.
- Lung transplantation may be authorized with documentation of end-stage pulmonary diseases in these categories:
  - Obstructive lung disease.
  - Restrictive lung disease.
  - Cystic Fibrosis.
  - Pulmonary hypertension.
- An absence of comorbidities such as:
  - End-stage renal, hepatic, or other organ dysfunction unrelated to primary disorder.
  - Multiple organ compromise secondary to infection, malignancy, or condition with no known cure.

Documented compliance with other medical treatments, regimen, and plan of care.

Documented compliance includes no active alcohol or chemical dependency that interferes with compliance to a medical regimen.

Documented psychiatric instability is a contraindication for transplant if severe enough to jeopardize incentive for adherence to medical regimen.

Organ Procurement

The appropriate DRG reimbursement coverage to the approved institution for a prior authorized transplant procedure includes procurement of the organ and services associated with the organ procurement as specified by HHSC or its designee. Documentation of organ procurement must be maintained in the hospital medical records. *Organ procurement costs are not payable to a physician.*

Physician services for the procurement of peripheral stem cells are not reimbursable.

36.4.30.7 Prior Authorization

It is the requesting physician and facility's responsibility to receive prior authorization through TMHP Special Medical Prior Authorization.

HHSC or its designee must prior authorize all transplant services provided by facilities and professionals. Documentation supplied with the prior authorization request must address the criteria listed for each type of transplant above, and must be medically necessary, reasonable, and federally allowable.

If prior authorization is not obtained for a solid organ transplant, services directly related to the transplant within the three-day preoperative and six-week postoperative period are also denied regardless of who provides the services (e.g, laboratory services, status post visits, radiology services). Claims for transplant clients are placed on active review when the transplant was not prior authorized so that the services related to the transplant can be monitored.

Coverage is limited to one transplant per organ system (or organ systems for combined transplants) per lifetime except for one subsequent retransplant because of organ rejection. A subsequent transplant is not included in the prior authorization for the initial transplant; therefore, it must be prior authorized separately.

A transplant request signed by a physician associated with one of the Texas Medicaid Program-approved transplant facilities is considered for prior authorization after the client has been evaluated and meets the guidelines of the institution's transplant protocol. Additional documentation may be required, which is addressed in the previous specific organ/tissue information.

The Texas Medicaid Program does not pay for transplants or post-transplant services in a nonqualifying facility, nor are physician charges reimbursed for transplants in a nonqualifying facility.

Benefits are not available for any experimental or investigational services, supplies, or procedures. Expenses incurred by a living donor for transplants will not be reimbursed separately.

All supporting documentation must be included with the request for authorization. Providers are to send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

36.4.31 Osteopathic Manipulative Treatment (OMT) Services

OMT performed by a provider licensed to perform OMT is a covered benefit of the Texas Medicaid Program for the acute phase of the acute musculoskeletal injury or the acute phase of an acute exacerbation of a chronic musculoskeletal injury with a neurological component. Reimbursement is contingent on correct documentation of the condition. The acute modifier AT must be submitted with the claim for payment to be made.

The following procedure codes are payable when billing for OMT to the head, cervical, thoracic, lumbar, sacral, pelvic, lower extremities, upper extremities, rib cage, abdominal, and visceral regions: 1-98925, 1-98926, 1-98927, 1-98928, and 1-98929.

When multiples of procedure codes 1-98925, 1-98926, 1-98927, 1-98928, and 1-98929 are billed on the same day by the same provider, the most inclusive code is paid and the others are denied. An initial or subsequent care visit or consultation may be paid in addition to OMT billed on the same day.

Procedure code 1-97140 will deny as part of another service if billed on the same date of service as procedure codes 1-98925, 1-98926, 1-98927, 1-98928, or 1-98929.

36.4.32 Pentamadine, Aerosol

Aerosol pentamidine treatments will be reimbursed using procedure code 1-94642.

Additionally, the provider may also be reimbursed for the medication using procedure code 1-J2545.

Payment for aerosol pentamidine treatments is limited to the following diagnosis codes:

Diagnosis Codes				
042	07951	07952	07953	1363
48284	5186			

Oral trimethoprim-sulfamethoxazole is available from pharmacies for self administration at home. The use of oral trimethoprim-sulfamethoxazole is not a payable benefit of the insured portion of the Texas Medicaid Program.

Aerosol pentamidine treatments are limited to one treatment every 28 days.

36.4.33 Percutaneous Transluminal Coronary Interventions

Percutaneous transluminal coronary interventions are a therapeutic option for clients with arteriosclerotic heart disease. The procedure codes listed below are reimbursed by the Texas Medicaid Program:

Procedure Codes		
2/F-92973	2/F-92980	2/F-92981
2/F-92982	2/F-92984	2/F-92995
2/F-92996	2/F-G0290	2/F-G0291

When any of the following procedure codes are performed on the same vessel as intracoronary vessel stenting, any provider, only the stenting procedure will be considered for reimbursement: 2/F-92973, 2/F-92982, 2/F-92984, 2/F-92995, and 2/F-92996.

Angioplasty, atherectomy, or thrombectomy performed on different coronary vessels will be reimbursed separately. When different coronary vessels are not indicated, only the stenting procedure will be paid.

36.4.34 Physical Therapy Services

PT is the use of physical agents such as heat, massage, electricity, traction, or exercises in the treatment of disease. Payments for PT are limited to acute disorders of the musculoskeletal system or exacerbations of chronic disorders necessitating physical medicine to restore function. The acute modifier AT must be billed for payment to be made.

PT must be provided according to the current (within 60 days) written orders of a physician and must be medically necessary. PT is to be billed with CPT procedure codes.

Examples of what may be considered *acute* are as follows:

- A new injury.
- Therapy before or after surgery, acute exacerbations of conditions, such as rheumatoid arthritis.
- Interventions such as a newly implanted intrathecal pump to decrease spasticity or botulinum toxin type A injections.

Physical medicine, including functional evaluations, must be provided according to the current (within 60 days) written orders of a physician and based on medical necessity. It may be performed by auxiliary personnel under the direct supervision of the physician or the independently practicing physical therapist.

36.4.34.1 Limitations

Procedure codes 1-97012, 1-97014, 1-97018, 1-97022, 1-97024, 1-97026, 1-97028, and 1-97150 are limited to one per day. The following procedure codes may be paid in multiple 15-minute quantities:

Procedure Codes		
1-97032	1-97033	1-97034
1-97035	1-97036	1-97039
1-97110	1-97112	1-97113
1-97116	1-97124	1-97139
1-97140	1-97530	1-97535
1-97537	1-97760	1-97761

Procedure code 1-97760 is only payable for clients younger than 21 years of age. Procedure code 1-97010 is not a benefit.

Procedure codes that may be billed in multiple quantities (e.g., 15 minutes each) are limited to a total of two hours per day of individual, group, or a combination of individual and group therapy.

Procedure codes 1-97762 and 1-97750 are comprehensive codes and include an office visit. If an office visit is billed the same day by the same provider, the office visit is denied as part of another procedure billed the same day. Procedure codes 1-97535, 1-97537, 1-97542, and 1-97762 are only payable for clients younger than 21 years of age.

Procedure code 1-97001 is payable once per six months, any provider, same facility. Procedure code 1-97002 is payable once per month, any provider, same facility. These codes are not payable on the same day as the following procedure codes:

Procedure Codes		
1-97012	1-97014	1-97018
1-97022	1-97024	1-97026
1-97028	1-97032	1-97033
1-97034	1-97035	1-97036
1-97039	1-97110	1-97112
1-97113	1-97116	1-97124
1-97139	1-97140	1-97150
1-97530	1-97750	1-97760
1-97761	1-97762	

Refer to: "Occupational Therapy" on page 36-89 for additional CPT codes.

36.4.34.2 Nursing Facility

Separate payment cannot be made to a physician or an independently practicing physical therapist who provides physical medicine to a resident of a nursing facility. These services must be made available to nursing facility residents as needed and must be provided directly by the staff of the facility or furnished by the facility through arrangements with outside qualified resources as part of the daily care. Nursing facilities should refrain from admitting clients who need goal-directed therapy if the facility is unable to provide these services.

36.4.35 Podiatrist Services

Podiatry services are a benefit of the Texas Medicaid Program.

36.4.35.1 Clubfoot Casting

CPT code 2-29450 is payable to a physician in the management of clubfoot when no surgery has been performed. The physician may bill the appropriate E/M code with a casting code and be reimbursed for both. CPT code 2-29750 is payable to a physician in addition to the initial casting or strapping procedure.

Unilateral casting should be billed as cast code 2-29450. Procedure code 2-29750 is payable in addition to the initial casting or strapping procedure.

Use modifiers LT (left) and RT (right) with all procedures, as appropriate.

Casting for a diagnosis of clubfoot is covered if the client is from birth to 3 years of age and has one of the following conditions:

Diagnosis Codes				
73671	75450	75451	75452	75453
75459	75460	75461	75462	75469
75470	75471	75479		

36.4.35.2 Echography/Ultrasound of Extremity

The following procedure codes are payable to podiatrists. Claim processing is subject to modifier 76 auditing: 4/I/T-76880 and 4/I/T-76999.

Reimbursement is based on TMRM. If the technical (TOS T) and/or interpretation (TOS I) components are billed by any provider for the same date of service as the total component (TOS 4), the total component of the corresponding procedure is denied.

For example, if T-76880 and 4-76880 are billed by any provider, on the same day, the total component code, 4-76880 is denied.

36.4.35.3 Flat Foot Treatment

Reimbursement for treatment of deformities of the foot and lower extremity that includes flat foot as a component of the deformity may be considered when the client presents with significant pain in the foot, leg, or knee, resulting in a loss of or decrease in function, along with a secondary condition such as valgus deformity or plantar fasciitis.

Treatment of flat foot (flexible pes planus) that is solely cosmetic in nature is not a benefit of the Texas Medicaid Program.

36.4.35.4 Nerve Conduction Studies Performed by Podiatrist

Podiatrists (DPM) may be reimbursed for nerve conduction studies for foot and ankle diagnosis codes. Bill nerve conduction studies using the following codes: 5-95900, 5-95903, 5-95904, 5-95934, and 5-95936.

Procedure codes 5/I-95900, 5/I-95903, and/or 5/I-95904 are reimbursed at full for the first nerve study and half for each additional study irrespective of the number of studies.

Procedure code 5/I/T-95934 or 5/I/T-95936 are reimbursed at full fee when performed on the same date of service as procedure codes 5/I/T-95900, 5/I/T-95903 or 5/I/T-95904.

If 5/I/T-95934 and 5/I/T-95936 are billed in multiples, the first study is reimbursed at full fee and all additional studies at half fee.

Nerve conduction studies repeated within a three-month period on the same client by the same provider are denied except for the following diagnosis codes:

Diagnosis Codes				
25060	2650	2652	2692	2699
2771	27730	27739	27781	27782
27783	27784	27789	3525	3541
3552	3553	3558	3560	3564
3569	3572	3575	3576	3577
35921	35922	35923	35924	35929
7220	7221	7222	7234	7292
7295				

Podiatrists must use modifiers LT (left), RT (right), or AT when appropriate. Specific toe modifiers should also be used when appropriate.

36.4.35.5 Nursing Facility

Podiatry services provided in a skilled, intermediate, or extended care nursing facility are a benefit of the Texas Medicaid Program.

When more than one client receives services on the same day, reimbursement for podiatry services rendered in a nursing facility will be reduced as follows and billed with the modifiers noted below.

Modifiers	Reimbursement Reduction Amount
TT	$1.50
UN	50 percent
UP	33 percent
UQ	25 percent
UR	20 percent
US	16.67 percent

36.4.35.6 Routine Foot Care

Routine foot care must be medically necessary and billed with the following procedure codes. No specific diagnosis restrictions exist. The following procedures are limited to one service every six months per client, regardless of provider specialty: 2-11055, 2-11056, 2-11057, 2-11719, and 2-G0127.

Use modifiers TT, UN, UP, UQ, UR, and US for services rendered in a nursing facility when multiple patients are seen.

36.4.35.7 Vascular Studies Performed by Podiatrist

The following procedure codes are payable when billed by podiatrists:

Procedure Codes		
4/I/T-93922	4/I/T-93925	4/I/T-93926
4/I/T-93965	4/I/T-93970	4/I/T-93971

36.4.35.8 X-Ray Procedures by Podiatrist

A podiatrist may be reimbursed for the following X-ray and noninvasive diagnostic procedures:

Procedure Codes		
4/I/T-73600	4/I/T-73610	4/I/T-73620
4/I/T-73630	4/I/T-73650	4/I/T-73660

36.4.36 Polysomnography

Polysomnography is distinguished from sleep studies by the inclusion of sleep staging that includes a one to four lead electroencephalogram (EEG), electro-oculogram (EOG), and a submental EMG.

Additional parameters of sleep include, but are not limited to:

- ECG.
- Airflow.
- Ventilation and respiratory effort.
- Gas exchange by oximetry.
- Extremity/motor activity movement.
- Extended EEG monitoring.
- Penile tumescence.
- Gastroesophageal reflux.
- Continuous blood pressure monitoring.
- Snoring.
- Body positions.

For a sleep study to be reported as a polysomnography, sleep must be recorded and staged. Use the following procedure codes to bill for polysomnography studies: 5/I/T-95805, 5/I/T-95808, 5/I/T-95810, and 5/I/T-95811

Sleep studies (5/I/T-95806 and 5/I/T-95807) are not a benefit of the Texas Medicaid Program.

When multiple procedure codes are billed on the same day, the most inclusive code is paid and all other codes denied.

Providers are no longer required to obtain prior authorization when billing procedure codes 5/I/T-95810 and 5/I/T-95811 for PCCM clients.

Polysomnography (5/I/T-95808, 5/I/T-95810, 5/I/T-95811) is allowed for the following diagnosis codes:

Diagnosis Codes				
3073	30740	30741	30742	30743
30744	30745	30746	30747	30748
32700	32710	32711	32712	32713
32714	32715	32719	32720	32721
32722	32723	32724	32725	32726
32727	32729	32730	32731	32732
32733	32734	32735	32736	32737
32739	32740	32741	32742	32743

Diagnosis Codes				
32744	32749	32751	32759	3278
3332	33399	34700	34701	34710
34711	51883	78050	78051	78052
78053	78054	78055	78056	78057
78059	78609	7990		

Multiple sleep latency test (5/I/T-95805) is restricted to the following diagnosis codes:

Diagnosis Codes				
34700	34701	34710	34711	78050
78051	78052	75053	78054	78055
78056	78057	78058	78059	

36.4.37 Prostate Surgeries

A transurethral resection of the prostate (TURP) is the most common procedure performed to treat benign prostatic hyperplasia (BPH). A TURP may be billed with the following procedure codes:

Procedure Codes		
2/F-52601	2/F-52606	2/F-52612
2/F-52614	2/F-52620	2/F-52630
2/F-52640		

If a physician bills separate charges for any of the TURP procedure codes listed above, and any of the following procedure codes on the same date of service, the charges for the services listed below will be denied as part of the TURP procedure.

Procedure Codes		
2/F-52000	2/F-52204	2/F-52214
2/F-52275	2/F-52276	2/F-52281
2/F-52310	2/F-52315	2/F-52351
2/F-52354	2/F-53020	

36.4.38 Psychiatric Pharmacological Management Services

Procedure codes 1-M0064 and 1-90862 may be billed for pharmacological management services.

Procedure code 1-M0064 indicates the client is stable but pharmacologic regimen oversight is necessary.

A brief visit for the sole purpose of monitoring or changing drug prescriptions (1-M0064) refers to a lesser level of drug monitoring such as monitoring, simple dosage adjustment, or changing drug prescriptions where the client is evaluated during a face-to-face visit and treated in the office setting.

Procedure code 1-90862 is defined as the assessment and management of psychopharmacological agents with no more than minimal medical psychotherapy.

Pharmacological management (1-90862) is not intended to refer to a brief evaluation of the client's state, simple dosage adjustment, or long-term medication. Pharmacological management refers to the in-depth management of psychopharmacological agents which are medications with serious side effects and represents a very skilled aspect of care for a client who is determined to be mentally or physically unstable. It is intended for use for clients who are being managed primarily by psychotropics, antidepressants, electroconvulsive therapy (ECT), and/or other types of psychopharmacologic medications.

Pharmacological management must be provided during a face-to-face visit with the client and any psychotherapy must be less than 20 minutes.

The focus of a pharmacological management visit is the use of medication for relief of client's signs and symptoms of mental illness. When the client continues to experience signs and symptoms of mental illness necessitating discussion beyond minimal psychotherapy in a given day, the focus of the service is broader and is considered psychotherapy rather than pharmacological management.

Procedure codes 1-90862 and 1-M0064 describe a physician service and cannot be delegated to a nonphysician or *incident to* a physician's service. APNs whose scope of license permit them to prescribe may use these codes if they perform the service. The service must only be billed if the physician or APN actually performs the service. To provide Texas Medicaid Program services, each NP, CNS, CNM, and CRNA must be licensed as a registered nurse and recognized as an APN by the Texas BON.

The Texas Medicaid Program does not reimburse for 1-90862 or 1-M0064 for actual administration of medication or for observation of the patient taking an oral medication. Administration and supply of oral medication are noncovered services.

All documentation must support that the service was reasonable and medically necessary for the billed diagnosis.

Documentation of medical necessity for pharmacological management (1-90862) must address all of the following information in the client's medical record in legible format:

- Date.
- Diagnosis.
- Medication history.
- Current symptoms and problems to include presenting mental status and/or physical symptoms that indicate the client requires a medication adjustment (current presenting mental status or physical symptoms that indicate the client is in an unstable state of mind or body).
- Problems, reactions, and side effects, if any, to medications and/or ECT.
- Description of optional minimal psychotherapeutic intervention (less than 20 minutes), if any.
- Any medication modifications.

- The reasons for medication adjustments/changes or continuation.
- Desired therapeutic drug levels, if applicable.
- Current laboratory values, if applicable.
- Anticipated physical and behavioral outcome(s).

Documentation of medical necessity for a brief office visit for the sole purpose of monitoring or changing drug prescriptions (1-M0064) must address all of the following information in the client's medical record:

- The client is evaluated and determined to be stable, but continues to have a psychiatric diagnosis that needs close monitoring of therapeutic drug levels, or
- The client requires evaluation for prescription renewal, a new psychiatric medication, or a minor medication dosage adjustment, and
- Provider has documented the medication history in the client's records with current signs and symptoms, new medication modifications with anticipated outcome.

Pharmacological management procedure codes 1-90862 and 1-M0064 will not be reimbursed for the same date of service. If the two procedure codes are billed for the same date of service by any provider, 1-M0064 will deny as part of 1-90862.

E/M services include pharmacological management. Procedure codes 1- 90862 and 1-M0064 should not be billed in addition to the E/M service. Pharmacological management (1-M0064 or 1-90862), will be denied as part of any E/M service billed for the same date of service by the same provider.

If the primary reason for the office visit is for psychotherapy, then the specific psychotherapy procedure code should be billed. Pharmacological management codes 1-M0064 or 1-90862, will be denied as part of any psychotherapy service that is billed for the same date of service, by the same provider.

Pharmacological management procedure codes (1-90862 and 1-M0064) will not count against the 30-encounter annual limitation for outpatient behavioral health services.

The treating provider must document the medical necessity of the chosen treatment and list the diagnosis code that most accurately describes the condition of the client that necessitated the need for the pharmacological management on the claim and in the client's medical record. The medical record (hospital or outpatient records, reports, or progress notes) should be clear and concise, documenting the reason(s) for the pharmacological management treatment and the outcome.

Pharmacological management procedure codes 1-90862 and 1-M0064 are not payable more than one service per day, per client, by any provider in any setting. Procedure code 1-M0064 is limited to the office setting.

If behavioral health pharmacological services are needed beyond the current diagnosis and frequency limitations, the claim may be appealed with additional documentation to demonstrate the medical necessity.

The following diagnosis codes are the *only* payable diagnosis codes for billing pharmacological management procedure codes 1-M0064 or 1-90862.

Diagnosis Codes				
2900	29010	29011	29012	29013
29020	29021	2903	29040	29041
29042	29043	2908	2909	2910
2911	2912	2913	2914	2915
29181	29182	29189	2919	2920
29211	29212	2922	29281	29282
29283	29284	29285	29289	2929
2930	2931	29381	29382	29384
29389	2939	2940	29410	29411
2948	2949	29500	29501	29502
29503	29504	29505	29510	29511
29512	29513	29514	29515	29520
29521	29522	29523	29524	29525
29530	29531	29532	29533	29534
29535	29540	29541	29542	29543
29544	29545	29550	29551	29552
29553	29554	29555	29560	29561
29562	29563	29564	29565	29570
29571	29572	29573	29574	29575
29580	29581	29582	29583	29584
29585	29590	29591	29592	29593
29594	29595	29600	29601	29602
29603	29604	29605	29606	29610
29611	29612	29613	29614	29615
29616	29620	29621	29622	29623
29624	29625	29626	29630	29631
29632	29633	29634	29635	29636
29640	29641	29642	29643	29644
29645	29646	29650	29651	29652
29653	29654	29655	29656	29660
29661	29662	29663	29664	29665
29666	2967	29680	29681	29682
29689	29690	29699	2970	2971
2972	2973	2978	2979	2980
2981	2982	2983	2984	2988
2989	2990	2991	30000	30001
30002	30009	30010	30011	30012
30013	30014	30015	30016	30019
30020	30021	30022	30023	30029
3003	3004	3005	3006	3007
30081	30082	30089	3009	3010
30110	30111	30112	30113	30120

Diagnosis Codes				
30121	30122	3013	3014	30150
30151	30159	3016	3017	30181
30182	30183	30184	30189	3019
3020	3021	3022	3023	3024
30250	30251	30252	30253	3026
30270	30271	30272	30273	30274
30275	30276	30279	30281	30282
30283	30284	30285	30289	3029
30300	30301	30302	30303	30390
30391	30392	30393	30400	30401
30402	30403	30410	30411	30412
30413	30420	30421	30422	30423
30430	30431	30432	30433	30440
30441	30442	30443	30450	30451
30452	30453	30460	30461	30462
30463	30470	30471	30472	30473
30480	30481	30482	30483	30490
30491	30492	30493	30500	30501
30502	30503	30520	30521	30522
30523	30530	30531	30532	30533
30540	30541	30542	30543	30550
30551	30552	30553	30560	30561
30562	30563	30570	30571	30572
30573	30580	30581	30582	30583
30590	30591	30592	30593	3060
3061	3062	3063	3064	30650
30651	30652	30653	30659	3066
3067	3068	3069	3070	3071
30720	30721	30722	30723	3073
30740	30741	30742	30743	30744
30745	30746	30747	30748	30749
30750	30751	30752	30753	30754
30759	3076	3077	30780	30781
30789	3079	3080	3081	3082
3083	3084	3089	3090	3091
30921	30922	30923	30928	30929
3093	3094	30981	30982	30983
30989	3100	3101	311	31200
31201	31202	31203	31210	31211
31212	31213	31220	31221	31222
31223	31230	31231	31232	31234
31235	31239	3124	31281	31282
31289	3129	3130	3131	31321
31322	31323	3133	31381	31382

Diagnosis Codes				
31383	31389	3139	31400	31401
3141	3142	3148	3149	31500
31501	31502	31509	3151	3152
31531	31532	31539	3154	3155
3158	3159	316		

36.4.39 Psychiatric Services

Each individual practitioner is limited to performing a combined total of 12 hours of behavioral health services per day. The claims processing system will enforce the 12-hour system limitation for the following providers: APN, PA, LMFT, LCSW, psychologist, and LPC. Since physicians (MD and DO) can delegate and may possibly submit claims in excess of 12 hours in a given day, the claims system will not limit these providers to 12 hours per day. However, physicians (MD and DO) and those to whom they delegate are still subject to the 12-hour limitation. Providers who perform group therapy may possibly submit claims in excess of 12 hours in a given day because of the manner in which group therapy is billed. Retrospective review may occur for both the total hours of services performed per day and the total hours of services billed per day. If inappropriate payments are identified, the reimbursement will be recouped.

All behavioral health procedure codes, whether or not they are currently included in the 12-hour system limitation, are subject to retrospective review and possible recoupment for all providers who deliver health services.

Note: *Documentation requirements for all services billed are listed for each individual specialty in this manual.*

The claims subject to the 12-hour provider limit will be based on the provider identifier submitted on the claim. The location in which the services occur will not be a basis for the exclusion of hours. If a provider practices at multiple locations and has a different suffix for the various locations but has the same provider identifier, all services identified for restriction to the provider's 12-hour limit will be counted regardless of whether they were performed at different locations.

Court-ordered behavioral health services submitted with modifier H9 will be excluded from the 12-hour limitation.

Claims submitted with a prior authorization number will not be exempt from the 12-hour limitation.

The following table lists the behavioral health procedure codes that are included in the system limitation and shows the TOS and procedure code combinations and the time increments that the system will apply based on the billed procedure code.

The time increments applied will be used to calculate the 12-hour-per-day limitation.

Procedure Codes included in the 12-hour System Limitation		
Procedure Code	**Time Assigned by Procedure Code Description**	**Time Applied**
1-90801	Not applicable	60 minutes
1-90802	Not applicable	60 minutes
1-90804	20–30 minutes	30 minutes
1-90805	20–30 minutes	30 minutes
1-90806	45–50 minutes	50 minutes
1-90807	45–50 minutes	50 minutes
1-90808	70–80 minutes	80 minutes
1-90809	70–80 minutes	80 minutes
1-90810	20–30 minutes	30 minutes
1-90811	20–30 minutes	30 minutes
1-90812	45–50 minutes	50 minutes
1-90813	45–50 minutes	50 minutes
1-90814	70–80 minutes	80 minutes
1-90815	70–80 minutes	80 minutes
1-90816	20–30 minutes	30 minutes
1-90817	20–30 minutes	30 minutes
1-90818	45–50 minutes	50 minutes
1-90819	45–50 minutes	50 minutes
1-90821	70–80 minutes	80 minutes
1-90822	70–80 minutes	80 minutes
1-90823	20–30 minutes	30 minutes
1-90824	20–30 minutes	30 minutes
1-90826	45–50 minutes	50 minutes
1-90827	45–50 minutes	50 minutes
1-90828	70–80 minutes	80 minutes
1-90829	70–80 minutes	80 minutes
1-90847	Not applicable	50 minutes
5-96101	60 minutes	60 minutes
1-96118	60 minutes	60 minutes

If a cutback occurs for procedure codes included in the system limitation, the quantity allowed per service session designated will be rounded up to one decimal point or rounded down to one decimal point following standard rounding procedures.

For example:

Total Time	Rounded Time
11.71 hours, 11.72 hours, 11.73 hours, 11.74 hours	11.7 hours
11.75 hour, 11.76 hours, 11.77 hours, 11.78 hours, 11.79 hours	11.8 hours

Formula Applied:

For client L on the table below, 80 billed minutes are applied, but the provider only has 40 available minutes before reaching the 12-hour daily limit (720 minutes); therefore, only 40 minutes are considered for reimbursement. The 40 allowed minutes are divided into the 80 applied minutes to get an allowed unit of .5 for payment.

TPI Base	TPI Suffix	Client	Code Billed	Amt. Applied*	Total Time Paid	Qty.
1234567	01	A	90807	50	50	1
1234567	02	B	90828	80	80	1
1234567	01	C	90807	50	50	1
1234567	03	D	90828	80	80	1
1234567	01	E	90807	50	50	1
1234567	01	F	90828	80	80	1
1234567	02	G	90807	80	80	1
1234567	01	H	90827	50	50	1
1234567	01	J	90828	80	80	1
1234567	02	K	90828	80	80	1
Final claim for the day			**Subtotal**	680 mins.		
1234567	01	L	90828	80	40	.5
			Total	760 billed mins. for one day	720 paid mins. for one day	
*** Time applied towards the 12-hour limit**						

Reminder: *The procedure codes listed above have time ranges built in so that the quantity billed should be reflected in quantities of one versus the actual amount of time spent with the client (i.e., procedure code 90804 is for 20 to 30 minutes of time spent with the client). The provider would bill a quantity of one when submitting a claim.*

If a claim is adjusted and the adjustment causes additional minutes to be available to the provider for that day, the system will not automatically reprocess any previously denied or cutback claims that would now be payable. It will be up to the provider to request reprocessing of the denied or cutback claims.

Claims submitted for psychological evaluation or for testing performed by a qualified provider at the request of the Department of Family and Protective Services (DFPS) or by court order will not be counted against the benefit limitations. These claims must be submitted with the following information:

- The provider must submit the claim with the procedure codes and modifier H9.
- If psychological services are court-ordered, the claim must include a copy of the court order for outpatient treatment that was signed by the judge and documentation of medical necessity.
- If psychological services are directed by DFPS, the claim must include the name and telephone number of the DFPS employee who gave the direction, the reason for the DFPS request, and documentation of medical necessity.

Outpatient behavioral health services are limited to 30 encounters/visits per client, per calendar year (January 1 through December 31) regardless of provider, unless prior authorized. *This limitation includes encounters/visits by all practitioners.* School Health and Related Services (SHARS) behavioral rehabilitation services, mental health mental retardation (MHMR) services, laboratory, radiology, and medication monitoring services are not counted toward the 30-encounter/visit limitation. An encounter/visit is defined as each hour of therapy, psychological, and/or neuropsychological testing rendered per hour, per provider. Each Medicaid client is limited to 30 encounters/visits per calendar year.

If a provider determines that additional services are medically necessary within the calendar year, prior authorization must be obtained before providing the 25th service.

Note: *Psychiatrists and psychologists in the Dallas service area must be enrolled as a network provider in the NorthSTAR BHO network to provide services to NorthSTAR clients. NorthSTAR is a managed care program in the Dallas service area that covers behavioral health services. Physicians that provide behavioral health services to clients in NorthSTAR must be a network provider of the NorthSTAR BHO to provide services to NorthSTAR clients.*

It is anticipated that this limitation, which allows for 6 months of weekly therapy or 12 months of biweekly therapy, is adequate for 75 to 80 percent of clients. Clinicians should plan therapy with this limit in mind. However, it may be medically necessary for some clients to receive extended encounters/visits. In these situations, prior authorization is required.

A provider who sees a client regularly and anticipates that the client will require encounters/visits beyond the 30-encounter/visit limit must submit the request for prior authorization before the client's 25th encounter/visit. This request for prior authorization helps ensure the client does not miss any necessary encounters/visits with the mental health provider by having prior authorization in place before providing the 25th service. It will also assist the provider with timely and accurate claims payment.

It is recognized that sometimes a client may change providers in the middle of the year, and the new provider may not be able to obtain complete information on the client. In these instances, prior authorization may be made before rendering services when the request is accompanied by an explanation as to why the provider was not able to submit the prior authorization request by the client's 25th encounter/visit. This information must be submitted in addition to the usual medical necessity information required with every request.

Prior authorization will not be granted to providers who have been seeing a client for an extended period of time or from the start of the calendar year and who have not requested prior authorization before the 25th encounter/visit. *It is recommended that a request for extension of outpatient behavioral health be submitted no sooner than 30 days prior to the date of service being requested, so that the most current information is provided.*

All authorization requests for extension of outpatient psychotherapy sessions beyond the annual 30-encounter limitation are limited to 10 encounters/visits per request and must be submitted on the Request for Extended Outpatient Psychotherapy/Counseling Form. Requests must include the following:

- Client name and Medicaid number.
- Provider name and provider identifier.
- Clinical update, including current specific symptoms and response to past treatment, and treatment plan (measurable short term goals for the extension, specific therapeutic interventions to be used in therapy, measurable expected outcomes of therapy, length of treatment anticipated and planned frequency of encounters/visits).
- Number, TOSs requested, and the dates based on the frequency of encounters/visits that the services will be provided.
- All areas of request must be completed with the information required by the form if additional room is needed providers may state "see attached" but the attachment must contain the specific information required in that section of the form.

The number of encounters/visits authorized is dependent on the client's symptoms and response to past treatment. If the client requires additional extensions, the provider must submit a new request for prior authorization at the end of each extension period. *The request for additional encounters/visits must include new documentation addressing the client's current condition, treatment plan, and the therapist's rationale supporting the medical necessity for these additional encounters/visits.* Prior authorization for an extension of outpatient behavioral health services is granted when the treatment is mandated by the courts for court-ordered services. A copy of the court order for outpatient treatment signed by the judge must accompany prior authorization requests.

Mail or fax the request to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

Providers can submit requests for extended outpatient psychotherapy/counseling on the TMHP website.

Refer to: "Prior Authorization Requests Through the TMHP Website" on page 5-4 for additional information to include mandatory documentation requirements and retention.

Treatment for chronic diagnosis codes such as mental retardation are not covered by Medicaid.

Psychological testing (5-96101) and neuropsychological testing (1-96118) are covered services for the following diagnosis codes only:

Diagnosis Codes				
0360	0361	03681	04503	04510
04523	04593	0460	0461	0462
0463	0468	0469	0470	0471
0478	0479	048	0490	0491
0498	0499	05821	05829	2900
29010	29011	29012	29013	29020
29021	2903	29040	29041	29042
29043	2908	2909	2911	2912
2915	29189	2919	2920	29211*
29212*	2922	29281	2929	2930
2931	29381	29382	29383*	29384
29389	2939	2940	29410	29411
2948	2949	29500	29501	29502
29503	29504	29505	29510	29511
29512	29513	29514	29515	29520
29521	29522	29523	29524	29525
29530	29531	29532	29533	29534
29535	29540	29541	29542	29543
29544	29545	29550	29551	29552
29553	29554	29555	29560	29561

Diagnosis Codes				
29562	29563	29564	29565	29570
29571	29572	29573	29574	29575
29580	29581	29582	29583	29584
29585	29590	29591	29592	29593
29594	29595	29600	29601	29602
29603	29604	29605	29606	29610
29611	29612	29613	29614	29615
29616	29620	29621	29622	29623
29624	29625	29626	29630	29631
29632	29633	29634	29635	29636
29640	29641	29642	29643	29644
29645	29646	29650	29651	29652
29653	29654	29655	29656	29660
29661	29662	29663	29664	29665
29666	2967	29680	29681	29682
29689	29690	29699	2970	2971
2972	2973	2978	2979	2980
2981	2982	2983	2984	2988
2989	29900	29901	29910	29911
29980	29981	29990	29991	30000
30001	30002	30009	30010	30011
30012	30013	30014	30015	30016
30019	30020	30021	30022	30023
30029	3003	3004	3006	3007
30081	30082	30089	3009	3010
30110	30113	30120	30122	3013
3014	30150	30151	30159	3016
3017	30181	30182	30183	30184
30189	3019	3020	3021	3022
3023	3024	30250	30251	30252
30253	3026	30270	30271	30272
30273	30274	30275	30276	30279
30281	30282	30283	30284	30285
30289	3029	30390	30400	30500
30501	30502	30503	30520	30521
30522	30523	30530	30531	30532
30533	30540	30541	30542	30543
30550	30551	30552	30553	30560
30561	30562	30563	30570	30571
30572	30573	30580	30581	30582
30583	30591	30592	30593	3080
3081	3082	3083	3084	3089
3090	3091	30921	30922	30923
30924	30928	30929	3093	3094

Diagnosis Codes				
30981	30982	30983	30989	3099
3100	3101	3102	3108	311
31200	31201	31202	31203	31210
31211	31212	31213	31220	31221
31222	31223	31230	31231	31232
31233	31234	31235	31239	3124
31281	31282	31289	3129	3130
3131	31321	31322	31323	3133
31381	31382	31383	31389	3139
31400	31401	3141	3142	3148
3149	31531	31532	31534	3154
3155	3158	3159	317	3180
3181	3182	319	3200	3201
3202	3203	3207	32081	32082
32089	3209	3210	3211	3212
3213	3214	3218	3220	3221
3222	3229	32301	32302	3231
3232	32302	32341	32342	32351
32352	32361	32362	32363	32371
32372	32381	32382	3239	3240
3241	3249	3300	3301	3302
3203	3308	3309	3310	33111
33119	3312	3313	3314	3315
3317	33181	33182	3319	33392
340	34500	34501	34510	34511
3452	3453	34540	34541	34550
34551	34560	34561	34570	34571
34580	34581	34590	34591	3480
3481	34830	34831	34839	38845
430	431	4320	4321	4329
43300	43301	43310	43311	43320
43321	43330	43331	43380	43381
43390	43391	43400	43401	43410
43411	43490	43491	4350	4351
4352	4353	4358	4359	436
4370	4371	4372	4373	4374
4375	4376	4377	4378	4379
4380	43810	43811	43812	43819
43820	43821	43822	43830	43831
43832	43840	43841	43842	43850
43851	43852	43853	4386	4387
43881	43882	43883	43884	43885
43889	4389	7685	7686	77210
77211	77212	77213	77214	7722

Diagnosis Codes				
7790	78031	78032	78039	79901
79902	8500	85011	85012	8502
8503	8504	8505	8509	85100
85101	85102	85103	85104	85105
85106	85109	85110	85111	85112
85113	85114	85115	85116	85119
85120	85121	85122	85123	85124
85125	85126	85129	85130	85131
85132	85133	85134	85135	85136
85139	85140	85141	85142	85143
85144	85145	85146	85149	85150
85151	85152	85153	85154	85155
85156	85159	85160	85161	85162
85163	85164	85165	85166	85169
85170	85171	85172	85173	85174
85175	85176	85179	85180	85181
85182	85183	85184	85185	85186
85189	85190	85191	85192	85193
85194	85195	85196	85199	85200
85201	85202	85203	85204	85205
85206	85209	85210	85211	85212
85213	85214	85215	85216	85219
85220	85221	85222	85232	85224
85225	85226	85229	85230	85231
85232	85233	85234	85235	85236
85239	85240	85241	85242	85243
85244	85245	85246	85249	85250
85251	85252	85253	85254	85255
85256	85259	85300	85301	85302
85303	85304	85305	85306	85309
85310	85311	85312	85313	85314
85315	85316	85319	85400	85401
85402	85403	85404	85405	85406
85409	986	9941	9947	V110
V111	V112	V113	V170	V401
V402	V6282	V6283	V6284	V695
V7101	V7102	V790	V791	V792
V793	V798			
*** Only payable for procedure code 1-96118.**				

If separate charges for an office visit and psychological testing or psychotherapy are billed on the same day, the office visit is denied as part of another procedure on the same day unless the diagnosis referenced to the office visit indicates a physical condition *unrelated* to the psychiatric diagnosis. In this instance the office visit is paid separately.

Report psychotherapy of less than 20 minutes duration using the appropriate E/M code.

Procedure codes 1-90801 and 1-90802 are limited to once per day per client, any provider, regardless of the number of professionals involved in the interview, and once per year per provider (same provider) in any setting.

An interactive interview (1-90802) may be covered to the extent it is medically necessary. Examples of medical necessity include, but are not limited to, clients whose ability to communicate is impaired by an expressive or receptive language impairment from various causes, such as conductive or sensorineural hearing loss, deaf mutism, or aphasia.

A diagnostic interview (1-90801, 1-90802) may be incorporated into an E/M service provided the required elements of the E/M service are fulfilled. A diagnostic interview (1-90801 or 1-90802) will be denied as part of any E/M service when billed for the same date of service by the same provider.

Procedure code 1-90802 billed on the same day as 1-90801 by the same provider is denied as part of another procedure billed on the same day.

If procedure code 1-90801 or 1-90802 is billed, the following psychiatric therapeutic procedure codes performed the same day by the same provider are denied as part of the initial psychiatric exam.

Procedure Codes		
1-90804	1-90805	1-90806
1-90807	1-90808	1-90809
1-90810	1-90811	1-90812
1-90813	1-90814	1-90815
1-90816	1-90817	1-90818
1-90819	1-90821	1-90822
1-90823	1-90824	1-90826
1-90827	1-90828	1-90829
1-90845	1-90847	1-90853
1-90857	1-90865	

If procedure code 1-90801 or 1-90802 is billed on the same day as 1-99221, 1-99222, and 1-99223 by the same provider, the initial hospital visit is denied as part of another procedure on the same day.

Documentation for diagnostic interview examinations (1-90801, 1-90802) must include:

- Reason for referral/presenting problem.
- Prior History, including prior treatment.
- Other pertinent medical, social, and family history.
- Clinical observations and mental status examinations.
- Complete *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (DSM-IV-TR) diagnosis.

- Recommendations, including expected long term and short term benefits.
- For the interactive diagnostic interview (1-90802), the medical record must indicate the adaptations utilized in the session and the rationale for employing these interactive techniques.

Outpatient psychotherapy (1-90847, 1-90853, 1-90857, and 1-90804) billed on the same date of service as narcosynthesis (1-90865) will be denied.

If the following psychotherapy or psychoanalysis codes are billed on the same day as a subsequent hospital visit (1-99231, 1-99232, 1-99233, 1-99238, and 1-99239) by the same provider, the subsequent hospital visit is denied as part of another procedure billed on the same day.

Procedure Codes		
1-90804	1-90805	1-90806
1-90807	1-90808	1-90809
1-90810	1-90811	1-90812
1-90813	1-90814	1-90815
1-90816	1-90817	1-90818
1-90819	1-90821	1-90822
1-90823	1-90824	1-90826
1-90827	1-90828	1-90829
1-90845	1-90847	1-90853

A hospital visit subsequent care (1-99231, 1-99232, 1-99233, 1-99238, and 1-99239) may be considered for reimbursement on the same day as ECT. Hospital subsequent care for diagnoses unrelated to the ECT will be considered on appeal.

Psychotherapy (with and without E/M) is coded by the following:

Procedure Codes		
1-90804	1-90805	1-90806
1-90807	1-90808	1-90809
1-90810	1-90811	1-90812
1-90813	1-90814	1-90815
1-90816	1-90817	1-90818
1-90819	1-90821	1-90822
1-90823	1-90824	1-90826
1-90827	1-90828	1-90829
1-90847	1-90853	1-90857

Psychoanalysis should be coded 1-90845.

If the following psychotherapy procedure codes are billed on the same day as psychoanalysis (1-90845), psychotherapy is denied.

Procedure Codes		
1-90804	1-90805	1-90806
1-90807	1-90808	1-90809
1-90810	1-90811	1-90812
1-90813	1-90814	1-90815
1-90816	1-90817	1-90818
1-90819	1-90821	1-90822
1-90823	1-90824	1-90826
1-90827	1-90828	1-90829
1-90853	1-90857	

The following psychiatric services are *not* covered by the Texas Medicaid Program:

- Adult and individual activities.
- Biofeedback.
- Daycare.
- Hypnosis.
- Intensive outpatient program services.
- Marriage counseling.
- Music or dance therapy.
- Psychiatric day treatment program services.
- Psychiatric services for chronic diagnoses such as mental retardation.
- Recreational therapy.
- Services provided by a licensed chemical dependency counselor (LCDC), psychiatric nurse (RN or licensed vocational nurse [LVN]), mental health worker, or psychological associate.
- Thermogenic therapy.

Medicare deductibles or coinsurance for inpatient stays in psychiatric hospitals are not payable for clients 22 to 64 years of age. This limitation does not apply to psychiatric services rendered in a general acute care hospital.

Procedure codes 1-90846 and 1-90849 are *not* reimbursed by the Texas Medicaid Program.

When billing or providing family therapy/counseling services, note the following requirements for Medicaid reimbursement:

- The client must be present when family therapy/counseling services are provided.
- Family therapy/counseling is reimbursable only for one family member per session.

According to the definition of family provided by DADS Household Determination Guidelines, only specific relatives are allowed to participate in family counseling services. These guidelines also address the roles of relatives in supervision and care of Temporary Assistance to Needy Families (formerly Aid to Families with Dependent Children [AFDC]) children. The following specific relatives are included in family counseling services:

- Father or mother.
- Grandfather or grandmother.
- Brother or sister.
- Uncle, aunt, nephew, or niece.

- First cousin or first cousin once removed.
- Stepfather, stepmother, stepbrother, or stepsister.

When individual, group, or family psychotherapy is billed by any provider on the same day, each type of session is paid. When multiples of each type of session are billed, the most inclusive code from each type of session is paid and the others are denied.

Refer to: "Request for Extended Outpatient Psychotherapy/Counseling Form" on page B-83.

36.4.39.1 Documentation Required

Each client for whom services are billed must have the following documentation included in their record:

- All entries, clearly documented and legible to individuals other than the author, date (month/day/year), and signed by the performing provider.
- Notations of the beginning and ending session times.
- All pertinent information on the patient's condition to substantiate the need for services, including, but not limited to:
  - The name of test(s) (e.g., WAIS-R, Rorschach, MMPI).
  - Background observations during the session.
  - Narrative descriptions of the test findings.
  - The diagnosis (symptoms, impressions).
  - The treatment plan and recommendations.
  - The explanation to substantiate the necessity of retesting, if testing is repeated.

In addition to these documentation requirements, the following must be a part of each client's record for which services are billed:

- Narrative description of the counseling session.
- Narrative description of the assessment, treatment plan, and recommendations.

36.4.39.2 Psychological and Neuropsychological Testing

Psychological testing (5-96101) and neuropsychological testing (1-96118) are limited to a total of four hours per day and eight hours per calendar year per client for any provider. Providers must maintain documentation supporting the medical necessity for each test in the client's record.

If the client requires more than four hours of psychological or neuropsychological testing per day or more than eight hours per calendar year, prior authorization is required. Additional documentation must be submitted that supports the medical necessity for the additional hours requested. This includes a record of all of the tests previously performed and a complete history that reflects the need for each test requested.

Each hour of examination, therapy, psychological and/or neuropsychological testing will count toward the 12 hours per day limitation as well as one visit/encounter towards the 30 visit/encounter limit.

Procedure codes 5-96101 and 1-96118 include the testing, interpretation, and report, and will not be reimbursed separately. Providers must bill the preponderance of each quarter hour of testing and indicate that number of units on the claim form. Document the number of hours in Block 24G of the CMS-1500 claim form.

Procedure code 1-96118 will be denied when billed on the same day as procedure code 5-96101 by any provider.

Procedure code 5-96101 or 1-96118 is payable on the same day as procedure code 1-90801 or 1-90802.

APNs are not eligible providers and will not be reimbursed for psychological and neuropsychological testing. Behavioral health testing may be performed during an assessment by an APN, and should be billed as part of another service.

Procedure codes 5-96101 and 1-96118 performed by a physician or psychologist are covered services only for the following diagnosis codes:

Diagnosis Codes				
0360	0361	03681	04503	04510
04523	04593	0460	0461	0462
0463	0468	0469	0470	0471
0478	0479	048	0490	0491
0498	0499	2900	29010	29011
29012	29013	29020	29021	2903
29040	29041	29042	29043	2908
2909	2910	2911	2912	2913
2914	2915	29189	2919	2920
29211	29212	2922	29281	29282
29283	29284	29285	29289	2929
2930	2931	29381	29382	23983
28384	29389	2939	2940	29410
29411	2948	2949	29500	29501
29502	29503	29504	29505	29510
29511	29512	29513	29514	29515
29520	29521	29522	29523	29524
29525	29530	29531	29532	29533
29534	29535	29540	29541	29542
29543	29544	29545	29550	29551
29552	29553	29554	29555	29560
29561	29562	29563	29564	29570
29565	29571	29572	29573	29574
29575	29580	29581	29582	29583
29584	29585	29590	29591	29592
29593	29594	29595	29600	29601
29602	29603	29604	29605	29606

Diagnosis Codes				
29610	29611	29612	29613	29614
29615	29616	29620	29621	29622
29623	29624	29625	29626	29630
29631	29632	29633	29634	29635
29636	29640	29641	29642	29643
29644	29645	29646	29650	29651
29652	29653	29654	29655	29656
29660	29661	29662	29663	29664
29665	29666	2967	29680	29681
29682	29689	29690	29699	2970
2971	2972	2973	2978	2979
2980	2981	2982	2983	2984
2988	2989	29900	29901	29910
29911	29980	29981	29990	29991
30000	30001	30002	30009	30010
30011	30012	30013	30014	30015
30016	30019	30020	30021	30022
30023	30029	3003	3004	3006
3007	30081	30082	30089	3009
3010	30110	30111	30112	30113
30120	30121	30122	3013	3014
30150	30151	30159	3016	3017
30181	30182	30183	30184	30189
3019	3020	3021	3022	3023
3024	30250	30251	30252	30253
3026	30270	30271	30272	30273
30274	30275	30276	30279	30281
30282	30283	30284	30285	30289
3029	30390	30400	30500	30501
30502	30503	30520	30521	30522
30523	30530	30531	30532	30533
30540	30541	30542	30543	30550
30551	30552	30553	30560	30561
30562	30563	30570	30571	30572
30573	30580	30581	30582	30583
30590	30591	30592	30593	3080
3081	3082	3083	3084	3089
3090	3091	30921	30922	30923
30924	30928	30929	3093	3094
30981	30982	30983	30989	3099
3100	3101	3102	3108	311
31200	31201	31202	31203	31210
31211	31212	31213	31220	31221
31222	31223	31230	31231	31232

Diagnosis Codes				
31233	31234	31235	31239	3124
31281	31282	31289	3129	3130
3131	31321	31322	31323	3133
31381	31382	31383	31389	3139
31400	31401	3141	3142	3148
3149	31531	31532	3154	3155
3158	3159	317	3180	3181
3182	319	3200	3201	3202
3203	3207	32081	32082	32089
3209	3210	3211	3212	3213
3214	3218	3220	3221	3222
3229	32301	32302	3231	3232
32341	32342	32351	32352	32361
32362	32363	32371	32372	32381
32382	3239	3240	3241	3249
3300	3301	3302	3303	3308
3309	3310	33111	33119	3312
3313	3314	3317	33181	33182
33189	3319	33392	340	34500
34501	34510	34511	3452	3453
34540	34541	34550	34551	34560
34561	34570	34571	34580	34581
34590	34591	3480	3481	34830
34831	34839	430	431	4320
4321	4329	43300	43301	43310
43311	43320	43321	43330	43331
43380	43381	43390	43391	43400
43401	43410	43411	43490	43491
4350	4351	4352	4353	4358
4359	436	4370	4371	4372
4373	4374	4375	4376	4377
4378	4379	4380	43810	43811
43812	43819	42820	43821	43822
43830	43831	43832	43840	43841
43842	43850	43851	43852	43853
4386	4387	43881	43882	43884
43885	46889	4389	7685	7686
77210	77211	77212	77213	77214
7722	7790	78031	78032	78039
79901	79902	8500	85011	85012
8502	8503	8504	8505	8509
85100	85101	85102	85103	85104
85105	85106	85109	85110	85111
85112	85113	85114	85115	85116

Diagnosis Codes				
85119	85120	85121	85122	85123
85124	85125	85126	85129	85130
85131	85132	85133	85134	85135
85136	85139	85140	84141	84142
85143	85144	85145	85146	85149
85150	85151	85152	85153	85154
85155	85156	85159	85160	85161
85162	85163	85164	85165	85166
85169	85170	85171	85172	85173
85174	85175	85176	85179	85180
85181	85182	85183	85184	85185
85186	85189	85190	85191	85192
85193	85194	85195	85196	85199
85200	85201	85202	85203	85204
85205	85206	85209	85210	85211
85212	85213	85214	85215	85216
85219	85220	85221	85222	85223
85224	85225	85226	85229	85230
85231	85232	85233	85234	85235
85236	85239	85240	85241	85242
85243	85244	85245	85246	85249
85250	85251	85252	85283	85254
85255	85256	85259	85300	85301
85302	85303	85304	85305	85306
85309	55310	85311	85312	82313
85314	85315	85316	85319	85400
85401	85402	85403	85404	85405
85406	85409	986	9941	9947
V110	V111	V112	V113	V170
V401	V402	V6282	V6283	V6284
V695	V7101	V7102	V790	V791
V792	V793	V798		

36.4.40 Radiation Therapy

Radiation treatment management is reported in units of five fractions or treatment sessions, regardless of the actual time period in which the services are furnished. The services need not be furnished on consecutive days. Multiple fractions representing two or more treatment sessions furnished on the same day may be counted separately as long as a distinct break has occurred in therapy sessions, and the fractions are of the character usually furnished on different days. Procedure code 6-77427 is also reported if three or four fractions are beyond a multiple of five at the end of a course of treatment. One or two fractions beyond a multiple of five at the end of a course of treatment are not reported separately. The professional services furnished during treatment management typically consists of review of port films, review of dosimetry, dose delivery, and treatment parameters; review of patient treatment setup; and examination of the patient for medical E/M (e.g., assessment of the patient's response to treatment, coordination of care and treatment, and review of imaging and/or lab test results).

If a provider submits claims for dates of service that exceed five fractions in a seven-day period of time, the claim will suspend for manual review. If the provider has documented the dates/times the fractions were administered, supporting more than five fractions were provided in this seven-day period, the claim may be reimbursed. If the times are not supplied, the claim is denied for documentation of dates/times.

The professional component (TOS I) and the technical component (TOS T) are not reimbursed when billed with the total component (TOS 6). The total component includes the professional and technical components.

Radiation therapy (6-77427) may be reimbursed for the following provider types:

Provider Type	Description
19	Physician (DO)
20	Physician (MD)
21	Physician Group (DO Only)
22	Physician Group (MD Only and Multispeciality)
43	Radiation Treatment Centers
60	Hospital—Long Term, Limited, or Specialized Care
61	Hospital—Private Full Care
62	Hospital—Private, O/P Service/Emergency Care Only
79	Rural Health Clinic—Hospital Based

36.4.40.1 Clinical Treatment Planning

The professional component (TOS I) is payable for services rendered in the freestanding radiation therapy facility (POS 5), outpatient hospital (POS 5), and inpatient hospital (POS 3). Physicians billing for client services rendered in a facility recognized by Medicaid as a radiation treatment center (POS 1) or their offices (POS 1) are reimbursed for total components (TOS 6).

Procedure Codes		
6/I-77261	6/I-77262	6/I-77263
6/I-77280	6/I-77285	6/I-77290
6/I-77295	6/I-77299	6/I-77301

36.4.40.2 Clinical Treatment Management

Physicians billing for client services rendered in a facility recognized by Medicaid as a radiation treatment center (POS 1) or their offices (POS 1) are reimbursed for the total component (TOS 6).

The following procedure codes are payable as the total component (TOS 6) for services performed in POS 1: 6-77427, 6-77431, 6-77435, and 6-77499.

36.4.40.3 Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services, and Proton Beam Treatment Delivery

Procedure Codes		
6/I-77300	6/I-77305	6/I-77310
6/I-77315	6/I-77326	6/I-77327
6/I-77328	6/I-77332	6/I-77333
6/I-77334	6/I-77399	6-77520
6-77522	6-77523	6-77525

36.4.40.4 Clinical Brachytherapy

Procedure Codes		
2/F-55875	2/F-55876	2/F-57155
2/F-58346	6/I-77750	6/I-77761
6/I-77762	6/I-77763	6/I-77776
6/I-77777	6/I-77778	6/I-77781
6/I-77782	6/I-77783	6/I-77784
6/I-77789	6/I-77799	

36.4.40.5 Radiation Treatment Delivery/Port Films

Procedure Codes		
T-77401	T-77402	T-77403
T-77404	T-77406	T-77407
T-77408	T-77409	T-77411
T-77412	T-77413	T-77414
T-77416	T-77417	T-77418
T-77421	T-77422	T-77423

Only the technical component (TOS T) is payable to physicians for the following services when rendered in a facility recognized by Medicaid as a radiation treatment center (POS 1) or in the physician's office (POS 1).

36.4.40.6 Freestanding Radiation Therapy Facilities/Outpatient Facilities

Freestanding radiation therapy facilities (specialty 98) and outpatient hospitals are reimbursed only for the technical component (TOS T) for services rendered in POS 5 for the following services:

Procedure Codes		
Clinical Treatment Planning		
T-77280	T-77285	T-77290
T-77295	T-77299	
Medical Radiation Physics, Dosimetry, Treatment Devices and Special Services		
T-77300	T-77305	T-77310
T-77315	T-77326	T-77327
T-77328	T-77332	T-77333
T-77334	T-77371	T-77372
T-77373	T-77399	
Radiation Treatment Delivery/Port Films		
T-77401	T-77402	T-77403
T-77404	T-77406	T-77407
T-77408	T-77409	T-77411
T-77412	T-77413	T-77414
T-77416	T-77417	T-77418
T-77421	T-77422	T-77423
Clinical Brachytherapy		
T-77781	T-77782	T-77783
T-77784	T-77789	T-77799

The following services are not benefits of the Texas Medicaid Program:

Procedure Codes		
77321	77331	77336
77370	77470	77600
77605	77610	77615
77620	77790	

The following services are allowed once per day, unless documentation submitted with an appeal supports the need for the service to be provided more than once: therapeutic radiation treatment planning, therapeutic radiology simulation-aided field setting, teletherapy, brachytherapy isodose calculation, treatment devices, proton beam delivery/treatment, intracavity radioelement application, interstitial radioelement application, remote afterloading high intensity brachytherapy, radiation treatment delivery, localization, and radioisotope therapy.

The following clinical brachytherapy procedure codes include admission to the hospital and daily care. Initial and subsequent hospital care is denied on the same day that clinical brachytherapy services are billed.

Procedure Codes		
6/I-77750	6/I-77761	6/I-77762
6/I-77763	6/I-77776	6/I-77777
6/I-77778	6/I-77781	6/I-77782
6/I-77783	6/I-77784	6/I-77789
6/I-77799		

A consultation on the same day as clinical treatment planning and clinical brachytherapy is included in the therapeutic radiology procedure.

Laboratory and diagnostic radiologic services provided in an office (POS 1) are reimbursed to physicians as a total component. Freestanding radiation therapy facilities (specialty 98) will also be reimbursed for the total component for these services in POS 5. Injectable medications given during the course of therapy in any setting are reimbursed separately.

Routine follow-up care by the same physician on the day of any therapeutic radiology service is denied. Medical services within program limitations may be paid on appeal when documentation supports the medical necessity of the visit because of services unrelated to the radiation treatment or radiation treatment complication. Procedure code 2/F-19298 is a benefit of the Texas Medicaid Program.

No separate payment is made for any of the following procedure codes provided on the same day as radiation therapy by the same provider:

Procedure Codes		
2-16000	2-16025	2-16030
2-36425	B-413	2-51701
2-51702	2-51703	1-99183
1-99211	1-99212	1-99213
1-99214	1-99215	3-99241
3-99242	3-99243	3-99244
3-99245	1-99281	1-99282
1-99283	1-99284	1-99285

No separate payment is made for established office (1-99211, 1-99212, 1-99213, 1-99214, and 1-99215) or outpatient visits (1-99281, 1-99282, 1-99283, 1-99284, and 1-99285) within 90 days after radiation treatment by the same provider.

Procedure code T-77295 (three-dimensional) is payable to freestanding therapy facilities (specialty 98) and outpatient hospitals (POS 5). Reimbursement for freestanding radiation treatment centers is at 28.32 RVUs. Outpatient hospitals are reimbursed at their reimbursement rate. This code is payable on Medicare crossover claims. T-77295 is payable once per day.

The following codes are denied when billed on the same day as T-77295: T-77305, T-77310, and T-77315.

High energy neutron beam radiation therapy (T-77422 and T-77423) is payable only for diagnosis codes 1420, 1421, 1422, 1428, and 1429.

Texas Medicaid Program benefits include payment for the technical portion of radiation therapy services provided in an inpatient setting. Covered services include clinical treatment planning and management, and clinical brachytherapy. Hospitals use revenue code 333, Radiation therapy, on the UB-04 CMS-1450 claim form when submitting charges for these services.

36.4.41 Radiology Services

In compliance with HHS regulations, physicians (MDs and DOs), group practices, and clinics may not bill for radiology services provided outside their offices. These services must be billed directly by the facility/provider that performs the service.

This restriction does not affect radiology services performed by physicians or under their personal supervision in their offices. The radiology equipment must be owned by physicians and be located in their office to allow for billing of TOS 4 (complete procedure) or TOS T with modifier TC to the Texas Medicaid Program. If physicians are members of a clinic that owns and operates radiology facilities, they may bill for these services. However, if physicians practice independently and share space in a medical complex where radiology facilities are located, they may not bill for these services even if they own or share ownership of the facility, unless they personally supervise and are responsible for the operation of the facilities on a daily basis.

Providers billing for three or more of the same laboratory or radiology procedures on the same day must indicate the time the procedure was performed to indicate that it is not a duplicate service. The use of modifiers 76 and 77 does not remove the requirement of indicating the times services were rendered. The original claim will be denied but can be appealed with the documentation of procedure times.

When billing for services in an inpatient or outpatient hospital setting, the radiologist may only bill the professional interpretation or procedures (modifier 26). This also applies when providing services to a client who is in an inpatient status even if the client is brought to the radiologist's office for the service. The hospital is responsible for all facility services (the technical component) even if the service is supplied by another facility/provider.

A separate charge for an X-ray interpretation billed by the attending or consulting physician is not allowed concurrently with that of the radiologist. Interpretations are considered part of the attending or consulting physician's overall work-up and treatment of the patient.

Providers other than radiologists are sometimes under agreement with facilities to provide interpretations in specific instances. Those specialties may be paid if a radiologist does not bill for the professional component of X-ray procedures.

If duplicate billings are found between radiologists and the other specialties, the radiologist may be paid, and the other provider is denied.

Abdominal flat plates (AFP) or kidneys, ureters, bladder (KUB) codes 4-74000, 4-74010, and 4-74020 are frequently done as preliminary X-rays before other, more complicated X-ray procedures. If a physician bills separately for an AFP or KUB and more complicated procedures, the charges are combined and the more complex procedure may be paid. If, however, the claim specifically states the AFP or KUB was done first and the results required additional X-rays, each procedure may be paid separately.

Oral preparations for X-rays are included in the charge for the X-ray procedure when billed by a physician. Separate charges for the oral preparation are denied as part of another procedure on the same day.

Separate charges for injectable radiopharmaceuticals used in the performance of specialized X-ray procedures may be paid. If a procedure code is not indicated, an unlisted code must have a drug name, route of administration, and dosage written on the claim.

36.4.41.1 Cardiac Blood Pool Imaging

Cardiac blood pool imaging (4/I/T-78472, 4/I/T-78473, 4/I/T-78481, 4/I/T-78483, 4/I/T-78494, and 4/I/T-78496) is a covered benefit for the following diagnosis codes:

Diagnosis Codes				
3526	3940	3941	3942	3949
3950	3951	3952	3959	3960
3961	3962	3963	3968	3969
3970	3971	3979	41000	41001
41002	41010	41011	41012	41020
41021	41022	41030	41031	41032
41040	41041	41042	41050	41051
41052	41060	41062	41070	41071
41072	41080	41081	41082	41090
41091	41092	4110	4111	41181
41189	412	4130	4131	4139
41400	41401	41402	41403	41404
41405	41406	41407	41410	41411
41412	41419	4142	4148	4149
41511	41519	4160	4161	4168
4169	4170	4171	4178	4179
4200	42090	42091	42099	4210
4211	4219	4220	42290	42291
42292	42293	42299	4230	4231
4232	4238	4239	4240	4241
4242	4243	42490	42491	42499
4250	4251	4252	4253	4254
4255	4257	4258	4259	4260
42610	42611	42612	42613	4262
4263	4264	42650	42651	42652
42653	42654	4266	4267	42681
42682	42689	4269	4270	4271
4272	72731	42732	42741	42742
4275	42760	42761	42769	42781
42789	4279	4280	4281	42810
42821	42822	42823	42830	42831
42832	42833	42840	42841	42842
42843	4289	4290	4291	4292
4293	4294	4295	4296	42971
42979	42981	42982	42989	4299
78099	7813	78650	78651	78652
78659	7991	V4321	V4581	

36.4.41.2 Chest X-Rays

All providers including radiologists billing for chest X-rays must supply a diagnosis code.

Screening, baseline, or rule-out studies do not qualify for reimbursement; however, the following diagnosis codes are payable:

Diagnosis Codes				
01100	01101	01102	01103	01104
01105	01106	01110	01111	01112
01113	01114	01115	01116	01120
01121	01122	01123	01124	01125
01126	01130	01131	01132	01133
01134	01135	01136	01140	01141
01142	01143	01144	01145	01146
01150	01151	01152	01153	01154
01155	01156	01160	01161	01162
01163	01164	01165	01166	01170
01171	01172	01173	01174	01175
01176	01180	01181	01182	01183
01184	01185	01186	01190	01191
01192	01193	01194	01195	01196
01200	01201	01202	01203	01204
01205	01206	01210	01211	01212
01213	01214	01215	01216	01220
01800	01801	01802	01803	01804
01805	01806	01880	01881	01882
01883	01884	01885	01886	01890
0310	0330	0331	0338	0339
042	0551	07950	07951	07952
07953	07959	11144	1124	135
1363	1620	1622	1623	1624
1625	1628	1629	1630	1631
1638	1639	1640	1641	1642
1643	1648	1649	1650	1658
1659	1714	1740	1741	1742
1743	1744	1745	1746	1748
1749	1750	1759	1951	1961
1970	1971	1972	1973	2310
2311	2312	2318	2319	2330

Diagnosis Codes				
2391	2393	28262	2959	3061
34400	3530	3910	3911	3912
3918	3919	3920	393	3940
3941	3942	3949	3950	3951
3952	3959	3960	3961	3962
3963	3968	3969	3970	3971
3979	3980	39890	39891	39899
4010	4011	4019	40200	40201
40210	40211	40290	40291	40300
40301	40310	40311	40390	40391
40400	40401	40402	40403	40410
40411	40412	40413	40490	40491
40492	40493	41000	41001	41002
41010	41011	41012	41020	41021
41022	41030	41031	41032	41040
41041	41042	41050	41051	41052
41060	41061	41062	41070	41071
41072	41080	41081	41082	41090
41091	41092	4110	4111	41181
41189	412	4130	4131	4139
41400	41401	41402	41403	41404
41405	41406	41407	41410	41411
41412	41419	4148	4149	4150
41511	41519	4160	4161	4168
4169	4170	4171	4178	4179
4200	42090	42091	42099	4210
4211	4219	4220	42290	42291
42292	42293	42299	4230	4231
4232	4238	4239	4240	4241
4242	4243	42490	42491	42499
4250	4251	4252	4253	4254
4255	4257	4258	4259	4260
42610	42611	42612	42613	4262
4263	4264	42650	42651	42652
42653	42654	4266	4267	42681
42682	42689	4269	4270	4271
4272	42731	42732	42741	42742
4275	42760	42761	42769	42781
42789	4279	4280	4281	42820
42821	42822	42823	42830	42831
42832	42833	42840	42841	42842
42843	4289	4290	4291	4292
4293	4294	4295	4296	42971
42979	42981	42982	42989	4299

Diagnosis Codes				
43900	44100	44101	44102	44103
4411	4412	4416	4417	4644
4660	46611	46619	4800	4801
4802	4803	4808	4809	481
4820	4821	4822	48230	48231
48232	48239	48240	48241	48249
48281	48282	48283	48284	48289
4829	4830	4831	4838	4841
4843	4845	4846	4847	4848
485	486	4870	4871	4878
490	4910	4911	49120	49121
49122	4918	4919	4920	4928
49300	49301	49302	49310	49311
49312	49320	49321	49322	49381
49382	49390	49391	49392	4940
4941	4950	4951	4952	4953
4954	4955	4956	4957	4958
4959	496	500	501	502
503	504	505	5060	5061
5062	5063	5064	5069	5070
5071	5078	5080	5081	5088
5089	5100	5109	5110	5111
5118	5119	5120	5121	5128
5130	5131	514	515	5160
5161	5162	5163	5168	5169
5171	5172	5173	5178	5180
5181	5182	5183	5184	5185
5186	51881	51882	51883	51884
51889	51900	51901	51902	51909
51911	51919	5192	5193	5194
5198	5199	5300	53010	53011
53012	53019	53020	53021	5303
5304	5305	5306	5307	53081
53082	53083	53084	53085	53086
53087	53089	5309	5533	57400
57401	57410	57411	57420	57421
57430	57431	57440	57441	57450
5770	5820	5821	5822	5824
58281	58289	5829	586	66800
66801	66802	66803	66804	66810
66811	66812	66813	66814	7450
74510	74511	74512	74519	7452
7453	7454	7455	74560	74561
74569	7457	7458	7459	74600

Diagnosis Codes				
74601	74602	74609	7461	7462
7463	7464	7465	7466	7467
74681	74682	74683	74684	74685
74686	74687	74689	7469	7470
74710	74711	74720	74721	74722
74729	7473	74740	74741	74742
74749	7483	7484	7485	74860
74861	74869	7488	7489	7503
7504	7562	7563	7566	7682
7683	7684	7685	7686	7689
769	7700	77010	77011	77012
77013	77014	77015	77016	77017
77018	7702	7703	7704	7705
7706	7707	77081	77082	77083
77084	77085	77086	77089	7709
78001	78002	78009	7802	78031*
78039*	78057	7806	78071	78079
7808	7825	7852	78600	78601
78602	78603	78605	78606	78607
78609	7861	7862	7863	7864
78650	78651	78652	78659	7866
7867	7868	7869	78900*	7931
7932	7942	79430	79431	79439
7955	79901	79902	7991	80700
80701	80702	80703	80704	80705
80706	80707	80708	80709	80710
80711	80712	80713	80714	80715
80716	80717	80718	80719	8072
8073	8074	8075	8076	81000
81001	81002	81003	81010	81011
81012	81013	8185	83130	8600
8601	8602	8603	8604	8605
86100	86101	86102	86103	86110
86111	86112	86113	86120	86121
86122	86130	86131	86132	8620
8621	86221	86222	86229	86231
86232	86239	8628	8629	8750
8751	9192	9221	9228	9248*
9340	9341	9348	9349	9351
9352	938	94100	94101	94102
94103	94104	94105	94106	94107
94108	94109	94110	94111	94112
94113	94114	94115	94116	94117
94118	94119	94120	94121	94122

Diagnosis Codes				
94123	94124	94125	94126	94127
94128	94129	94130	94131	94132
94133	94134	94135	94136	94137
94138	94139	94140	94141	94142
94143	94144	94145	94146	94147
94148	94149	94150	94151	94152
94153	94154	94155	94156	94157
94158	94159	9470	9471	9472
9473	9591	9598*	9651	9711
9941	99550	99551	99552	99553
99554	99555	99559	99560	99561
99562	99563	99564	99565	99566
99567	99568	99569	9957	99580
99581	99673	9971	9973	9991
V011	V103	V420	V421	V422
V433	V451	V4581	V460	V560
V568	V711	V712	V760	V7610

***Claims for clients 12 years of age and older may be appealed with documentation of medical necessity.**

36.4.41.3 Diagnosis Requirements

Physicians enrolled and practicing as radiologists are not routinely required to send a diagnosis with their request for payment except when providing the following services:

- Arteriograms.
- Venography.
- Chest X-rays.
- Cardiac blood pool imaging.
- Echography.

Radiologists are required to identify the referring provider by full name and address or provider identifier in Block 17 of the CMS-1500 claim form. Radiology procedures submitted by all other physician specialties must reference a diagnosis with every procedure billed. As with all procedures billed to the Texas Medicaid Program, baseline screening and/or comparison studies are not a benefit.

36.4.41.4 Contrast Materials/Radiopharmaceuticals

Reimbursement for radiological procedures, such as MRI or CT, with descriptions that specify “with contrast,” include payment for high osmolar, low osmolar contrast material (LOCM) and paramagnetic contrast materials. These contrast materials will not be reimbursed separately.

Radiopharmaceuticals used for therapeutic treatment may be considered for separate reimbursement.

Procedure codes 6/I/T-79403, 9-A9517, 9-A9543, and 9-A9699 may be billed for therapeutic radiopharmaceuticals.

36.4.41.5 Magnetic Resonance Angiography (MRA)

MRA is a technique that allows noninvasive visualization and study of blood vessels through either two- or three-dimensional image reconstruction. Although MRA in the study of the blood vessels of the heart, lungs, abdomen, pelvis, spine, and extremities is continuing to develop, it is most advanced in the evaluation of cerebrovascular disease especially in the assessment of arterial occlusive disease in patients at risk of stroke.

Refer to: Section 39, "Radiological and Physiological Laboratory and Portable X-Ray Supplier" on page 39-1 for additional information and authorization requirements.

MRA of the Head and Neck

MRAs of the chest, abdomen, and pelvis (procedure codes 4/I/T-70544, 4/I/T-70545, 4/I/T-70546, 4/I/T-70547, 4/I/T-70548, and 4/I/T-70549) may be reimbursed as a benefit of the Texas Medicaid Program.

MRA of Other Areas

The following MRA studies (with contrast materials) are a benefit of the Texas Medicaid Program:

MRA Studies	
4/I/T-71555	4/I/T-72159
4/I/T-72198	4/I/T-73225
4/I/T- 73725	4/I/T-74185

Refer to: The CPT and ICD-9-CM manuals for code descriptions.

36.4.41.6 Magnetic Resonance Imaging (MRI)

MRIs are reimbursed by the Texas Medicaid Program when medically necessary.

MRI procedures that specify *with contrast* include payment for para-magnetic contrast; therefore, LOCM is not reimbursed separately.

When an MRI and a CT scan of the *same body area* are performed on the same day, the CT scan is paid and the MRI is denied as part of an overlapping diagnostic procedure. Additional MRIs and/or CT scans of *entirely different body areas* performed on the same day are paid with documentation of medical necessity.

A freestanding MRI facility may bill using the modifier TC for the technical portion only. The radiologist or neurologist who reads the MRI may bill using the modifier 26 for interpretation only whether the client is in the inpatient or outpatient setting.

Refer to: Section 39, "Radiological and Physiological Laboratory and Portable X-Ray Supplier" on page 39-1 for additional information and authorization requirements.

36.4.41.7 Technetium TC 99M-Tetrofosmin

Procedure code 9-A9502 is a benefit, without age restriction. It is payable in the office, inpatient, and outpatient settings.

Payable providers include:

- Physicians.
- Radiation treatment centers.
- Inpatient/outpatient hospitals.

Inpatient settings are reimbursed under their DRG. Outpatient hospitals are reimbursed at their reimbursement rate.

36.4.42 Reduction Mammoplasties

Procedure code 2/8/F-19318 is the removal of breast tissue and is a benefit of the Texas Medicaid Program when prior authorized. At least one of the following criteria must be met:

- Evidence of a restrictive pulmonary defect.
- Evidence of severe neck and/or back pain with incapacitation from the pain.
- Evidence of ulnar pain/paresthesia from thoracic nerve root compression.

In addition to the above criteria, documentation must indicate:

- A minimum of 500 grams of tissue is expected to be removed from each breast.
- The client, if 40 years of age or older, has had a mammogram within the past year that was negative for cancer.

The following services are *not* a benefit of the Texas Medicaid Program:

- Reduction mammaplasty for cosmetic purposes (such as the equalization of breast size).
- Reduction mammaplasty for gynecomastia (enlargement of breast tissue in the male).
- Augmentation mammaplasty to increase breast size.

For prior authorization of reduction mammaplasty, the following documentation must be submitted:

- Referring letter from the client's primary care physician.
- Completed Medicaid Certificate of Medical Necessity for Reduction Mammaplasty form, signed and dated by the physician (see "Medicaid Certificate of Medical Necessity for Reduction Mammaplasty" on page B-55).
- Relevant documentation of the client's medical condition, including summaries of:
  - Pulmonary function studies.
  - Failed treatments for neck/back/ulnar pain.
  - Results of a weight reduction program with the amount of weight lost.
- Preoperative photographs (front and lateral views).

- The estimated amount of tissue to be removed from each breast.

The physician is required to maintain the following documentation in the client's clinical records:

- A complete history and physical.
- Pulmonary function studies results.
- Past treatments, therapies, and outcomes for pain control and weight reduction.

For reimbursement purposes on a bilateral procedure, the full allowed amount will be paid to the surgeon and assistant surgeon for the first breast reduction and one half the allowed amount will be paid for the second reduction. Facilities are paid for one surgical procedure.

Procedure code 2/8/F-19318 is to be used to bill for reduction mammaplasty.

When submitting for prior authorization, requests *must* be sent to TMHP Special Medical Prior Authorization. Sending requests directly to the TMHP Medical Director delays the processing of the request. Providers are to mail prior authorization requests for reduction mammaplasty for traditional Medicaid and PCCM clients to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax 1-512-514-4213

36.4.43 Renal Disease

36.4.43.1 Cytogam

Procedure code 1-J0850 is reimbursable by the Texas Medicaid Program. Cytogam is indicated for the attenuation of primary cytomegalovirus disease in seronegative kidney transplant recipients who receive a kidney from a seropositive donor. Payment of cytogam is limited to diagnosis code V420, Status post kidney transplant. Cytogam is payable in POS 1 (office) and POS 5 (outpatient facility) only.

Refer to: "Organ/Tissue Transplant Services" on page 25-10 for information on kidney transplants.

36.4.43.2 Dialysis Patients

Physician reimbursement for supervision of patients on dialysis is based on a monthly capitation payment (MCP) calculated by Medicare. The MCP is a comprehensive payment that covers all physician services associated with the continuing medical management of a maintenance dialysis patient for treatments received in the facility. An original onset date of dialysis treatment must be included on claims for all renal dialysis procedures in all POSs except inpatient hospital. The original onset date must be the same date entered on the 2728 form sent to the Social Security office.

Physician Supervision of Dialysis Patients

Use procedure codes 1-90918, 1-90919, 1-90920, 1-90921, 1-90922, 1-90923, 1-90924, or 1-90925 when billing for physician supervision for outpatient dialysis regardless of POS. The procedure codes should be billed as follows:

- When a full month of supervision has been provided, use procedure codes 1-90918, 1-90919, 1-90920, or 1-90921. The date of service must reflect the first day of the month that supervision was provided and the quantity is 1.
- When supervision is for less than a full month (for example, the patient is hospitalized or is out of the area), use procedure codes 1-90922, 1-90923, 1-90924, or 1-90925. This code represents a per day charge used to bill the supervision when a full month is not provided. The dates of service must indicate each day that supervision was provided and the quantity must be the same as the number of days listed for the month.
- Physician services during a dialysis session including supervisory services to the patient in connection with complicated and uncomplicated session (such as routine predialysis examination and physician attendance during a dialysis treatment where the patient has a serious ailment such as pulmonary edema).
- Office visits for the routine evaluation of patient progress, or for treatment of renal disease complications including evaluation of diagnostic tests and procedures.
- All physician services rendered by the attending physician in the course of office visits where the primary purpose is either the routine monitoring or the follow-up of complications of dialysis; follow up of complications includes services involved in prescribing therapy for illnesses unrelated to renal disease if the treatment occurs without increasing the number of physician-patient contacts beyond those occurring at dialysis, regular monitoring sessions, or visits for treatment of renal complications.

The following services may be provided in conjunction with dialysis but are considered nonroutine and may be billed separately:

- Declotting of shunts.
- *Physician services to inpatients.* The physician should bill procedure codes 1-90922, 1-90923, 1-90924, or 1-90925 for each date of outpatient supervision and bill the appropriate hospital E/M code for individual services provided on the hospitalized days.
- *Dialysis at an outpatient facility other than the usual dialysis setting for a patient of a physician who bills the MCP.* The physician must bill procedure codes 1-90922, 1-90923, 1-90924, or 1-90925 for each date supervision is provided. The physician may not bill for days that the patient dialyzed elsewhere.
- *Physician services beyond those that are related to the treatment of the patient's renal condition that cause the number of physician-patient contacts to increase.* Physi-

cians may bill on a fee-for-service basis if they supply documentation on the claim that the illness is not related to the renal condition and that additional visits are required.

Use procedure codes 1-90935, 1-90937, 1-90945, and 1-90947 for inpatient dialysis services when the physician is present during dialysis treatment. The nephrologist must be physically present and involved during the course of the dialysis. These codes are not payable for a cursory visit by the nephrologist; hospital visit codes must be used for a cursory visit.

The hospital E/M procedure codes 1-90935, 1-90937, 1-90945, and 1-90947 are for complete care of the patient; hospital visits cannot be billed on the same day as these codes. However, if the physician only sees the patient when they are not dialyzing, the physician should bill the appropriate hospital visit code. The inpatient dialysis code should not be submitted for payment.

36.4.43.3 Epoetin Alfa (Erythropoietin; EPO)

EPO is a glycoprotein that stimulates red blood cell formation and production of the precursor red blood cells of bone marrow. EPO is indicated for anemia associated with chronic renal failure, including patients on dialysis (ESRD) and patients not on dialysis. In chronic ESRD patients, the increased BUN impairs the production of erythropoietin, leading to a chronic anemia.

EPO procedure codes used to bill for treatment of anemia associated with ESRD patients receiving dialysis are for a quantity of 1 for every 1,000 units. The exact dose should be stated on the claim.

Example: *If a client has an HCT of 34 percent with a diagnosis of ESRD and is given 5,000 units of EPO, bill a quantity of 5 with procedure code 1-J0886.*

EPO is limited to three injections per calendar week (Sunday through Saturday).

Refer to: "Erythropoietin Alfa (EPO)" on page 36-59 for more information on EPO.

EPO is payable in the following POSs:

POS	Description
1	Office
5	Outpatient hospital

36.4.43.4 Laboratory Services for Dialysis Patients

The Texas Medicaid Program provides reimbursement for laboratory services performed for dialysis patients.

Charges for *routine laboratory service*s performed according to the established frequencies listed under "Laboratory and Radiology Services" on page 37-4 are included in the facility's dialysis charge billed to Medicaid regardless of where the tests were performed. Routine laboratory services performed by an outside laboratory are billed to the facility.

*Nonroutine laboratory service*s for people dialyzing in a facility and all laboratory work for people on continuous ambulatory peritoneal dialysis (CAPD) may be billed separately from the dialysis charge.

36.4.43.5 Self-Dialysis Patients

Physician reimbursement for supervision of patients on self-dialysis is made after completion of the patient's training. If the training is not completed, payment is proportionate to the amount of time spent in training. Payment for training may be made in addition to payment under the MCP for physician supervision of an in-facility maintenance dialysis patient. Use procedure codes 1-90989 and 1-90993 for dialysis training regardless of the type of training performed. These procedure codes must be billed as specified:

- When complete dialysis training is provided, procedure code 1-90989 is billed. Providers are to use modifier AT when using this procedure code.The date of service indicates the date training was completed, and the quantity is 1.
- When dialysis training is not completed, bill procedure code 1-90993. The date of service must list each day that a session of training was provided and the quantity must indicate the number of training sessions provided.

The amount of reimbursement of subsequent training is determined by prorating the physician's payment for initial training sessions. The amount of payment for each additional training session does not exceed $20.

Physician Supervision

All physician services required to create the capacity for self-dialysis must include:

- Direction of and participation in training of dialysis patients.
- Review of family and home status and environment, and counseling and training of family members.
- Review of training progress.

Initial Training

The following services are included in the physician charge for supervision of a client on self-dialysis:

- Physician services rendered during a dialysis session including those backup dialyses that occur in outpatient facility settings.
- Office visits for the routine evaluation of patient progress, including the interpretation of diagnostic tests and procedures.
- Physician services rendered by the attending physician in the course of an office visit, the primary purpose of which is routine monitoring or the follow-up of complications of dialysis, including services involved in prescribing therapy for illnesses unrelated to renal disease, which may be appropriately treated without increasing the number of contacts beyond those occurring at regular monitoring sessions or visits for treatment of renal complications.

- General support services (for example, arranging for supplies).

Subsequent Training

No additional payment is made after the initial self-dialysis training course unless subsequent training is required for one of the following reasons:

- A change from the client's treatment machine to one the client had not been trained to use in the initial training course.
- A change in setting.
- A change in dialysis partner.

The physician must document the reason for additional training sessions on the CMS-1500 paper claim form.

Dialysis equipment and supplies used by the client who dialyzes in the home are not benefits of the Texas Medicaid Program, including the lease or purchase of dialysis machines and disposable supply kits.

36.4.44 Sign Language Interpreting Services

Sign language interpreting services are benefits of the Texas Medicaid Program. Providers must use procedure code 1-T1013 with modifier U1 for the first hour of service, and modifier UA for each additional 15 minutes of service. Procedure code 1-T1013 billed with modifier U1 is limited to once per day, per provider, and procedure code 1-T1013 billed with modifier UA is limited to a quantity of 28 per day.

Sign language interpreting services are available to Medicaid clients who are deaf or hard of hearing or to a parent or guardian of a person receiving Medicaid if the parent or guardian is deaf or hard of hearing.

Physicians in private or group practices with fewer than 15 employees may be reimbursed for this service. The physician will be responsible for arranging and paying for the sign language interpreting services to facilitate the medical services being provided. The physician will then seek reimbursement from the Texas Medicaid Program for providing this service. Procedure code 1-T1013 is reimbursed at $70.00 with modifier U1 and $8.75 with modifier UA.

Sign language interpreting services must be provided by an interpreter who possesses one of the following certification levels (i.e., levels A through H) issued by either the DARS, Office for Deaf and Hard of Hearing Services, Board for Evaluation of Interpreters (BEI) or the National Registry of Interpreters for the Deaf (RID).

Certification Levels:

- BEI Level I/Ii and BEI OC: B (Oral Certificate: Basic).
- BEI Basic and RID NIC (National Interpreter Certificate) Certified.
- BEI Level II/IIi, RID CI (Certificate of Interpretation), RID CT (Certificate of Transliteration), RID IC (Interpretation Certificate), and RID TC (Transliteration Certificate).
- BEI Level III/IIIi, BEI OC: C (Oral Certificate: Comprehensive), BEI OC: V (Oral Certificate: Visible), RID CSC (Comprehensive Skills Certificate), RID IC/TC, RID CI/CT, RID RSC (Reverse Skills Certificate), and RID CDI (Certified Deaf Interpreter).
- BEI Advanced and RID NIC Advanced.
- BEI IV/IVi, RID MCSC (Master Comprehensive Skills Certificate), and RID SC: L (Specialist Certificate: Legal).
- BEI V/VI.
- BEI Master; and RID NIC Master.

Interpreting services include the provision of voice-to-sign, sign-to-voice, gestural-to-sign, sign-to-gestural, voice-to-visual, visual-to-voice, sign-to-visual, or visual-to-sign services for communication access provided by a certified interpreter.

The physician requesting interpreting services must maintain documentation verifying the provision of interpreting services. Documentation of the service must be included in the patient's medical record and must include the name of the sign language interpreter and the interpreter's certification level. Documentation must be made available if requested by HHSC or its designee.

36.4.45 Skin Therapy

Skin therapy is a benefit of the Texas Medicaid Program and may be reimbursed with the following procedure codes:

Procedure Codes		
1-96900	1-96910	1-96912
1-96913	2-96920	2-96921
2-96922	2-96999	2-17000
2-17003	2-17004	2-17106
2-17107	2-17108	2-17110
2-17111	2-17250	2-17260
2-17261	2-17262	2-17263
2-17264	2-17266	2-17270
2-17271	2-17272	2-17273
2-17274	2-17276	2-17280
2-17281	2-17282	2-17283
2-17284	2-17286	2-17311
2-17312	2-17313	2-17314
2-17315	2-17340	2-17999
2-11900	2-11901	

Claims for incision and drainage of acne when the diagnosis states there is infection or pustules may be paid.

Procedure codes 1-96900, 1-96910, 1-96912, 1-96913, 2-96920, 2-96921, and 2-96922 are covered benefits for the following diagnosis codes:

Diagnosis Codes				
0780	0850	0851	0852	0853
0854	0855	0859	1032	20210
20211	20212	20213	20214	20215
20216	20217	20218	37453	69010
69011	69012	69018	6908	6910
6918	6920	6921	6922	6923
6924	6925	6926	69272	69273
69275	69281	69282	69283	69284
69289	6929	6930	6931	6938
6939	6940	6941	6942	6943
6944	6945	69460	69461	6948
6949	6953	6960	6961	6962
6963	6964	6965	6968	7060
7061	70901			

Procedure codes 1-96910 and/or 1-96912 will be denied when billed with 1-96913.

If billed with an office visit, an emergency room visit, or consult, 1-96900, 1-96910, or 1-96912 will be denied as part of the visit or consult.

If 1-96913 is billed with an office visit, emergency room visit or consult, the visit will be denied as part of the treatment.

Procedure codes 2-11900 and 2-11901 are covered benefits for the following diagnosis codes:

Diagnosis Codes				
0780	0850	0851	0852	0853
0854	0855	0859	135	6953
6960	6961	6962	6963	6964
6965	6968	7014	7015	70583
7060	7061	9400	9401	9402
9403	9404	9405	9409	94100
94101	94102	94103	94104	94105
94106	94107	94108	94109	94110
94111	94112	94113	94114	94115
94116	94117	94118	94119	94120
94121	94122	94123	94124	94125
94126	94127	94128	94129	94130
94131	94132	94133	94134	94135
94136	94137	94138	94139	94140
94141	94142	94143	94144	94145
94146	94147	94148	94149	94150
94151	94152	94153	94154	94155
94156	94157	94158	94159	94200

Diagnosis Codes				
94201	94202	94203	94204	94205
94209	94210	94211	94212	94213
94214	94215	94219	94220	94221
94222	94223	94224	94225	94229
94230	94231	94232	94233	94234
94235	94239	94240	94241	94242
94243	94244	94245	94249	94250
94251	94252	94253	94254	94255
94259	94300	94301	94302	94303
94304	94305	94306	94309	94310
94311	94312	94313	94314	94315
94316	94319	94320	94321	94322
94323	94324	94325	94326	94329
94330	94331	94332	94333	94334
94335	94336	94339	94340	94341
94342	94343	94344	94345	94346
94349	94350	94351	94352	94353
94354	94355	94356	94359	94400
94401	94402	94403	94404	94405
94406	94407	94408	94410	94411
94412	94413	94414	94415	94416
94417	94418	94420	94421	94422
94423	94424	94425	94426	94427
94428	94430	94431	94432	94433
94434	94435	94436	94437	94438
94440	94441	94442	94443	94444
94445	94446	94447	94448	94450
94451	94452	94453	94454	94455
94456	94457	94458	94500	94501
94502	94503	94504	94505	94506
94509	94510	94511	94512	94513
94514	94515	94516	94519	94520
94521	94522	94523	94524	94525
94526	94529	94530	94531	94532
94533	94534	94535	94536	94539
94540	94541	94542	94543	94544
94545	94546	94549	94550	94551
94552	94553	94554	94555	94556
94559	9460	9461	9462	9463
9464	9465	9470	9471	9472
9473	9474	9478	9479	94800
94810	94811	94820	94821	94822
94830	94831	94832	94833	94840
94841	94842	94843	94844	94850

Diagnosis Codes				
94851	94852	94853	94854	94855
94860	94861	94862	94863	94864
94865	94866	94870	94871	94872
94873	94874	94875	94876	94877
94880	94881	94882	94883	94884
94885	94886	94887	94888	94890
94891	94892	94893	94894	94895
94896	94897	94898	94899	9490
9491	9492	9493	9494	9495

Intralesional injection(s) may be considered for reimbursement in addition to an office visit.

36.4.46 Speech-Language Therapy

Speech and language evaluations are used to assess the therapeutic needs of patients having speech and/or language difficulties as a result of disease or trauma. The assessments are usually performed before the initiation of speech therapy. Bill using procedure code 1-92506.

Procedure code 1-92506 is payable only once per six months, any payable speech therapy provider, same facility. Procedure code 1-S9152 (Reassessment), may be used for re-evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status, is payable once per month, any payable speech therapy provider, same facility. Procedure codes 1-92507 and 1-92508 are not payable on the same day as a speech evaluation or re-evaluation. Bill using procedure code 1-92506 with a quantity of 1.

SLP therapy is reimbursed only for acute or subacute pathological or traumatic conditions of the head or neck that would affect speech production. For clients younger than 21 years of age, therapy not covered by the Texas Medicaid Program is available through THSteps-CCP with documentation of the medical necessity/appropriateness. Reimbursement for speech therapy includes VitalStim therapy for dysphagia. The Texas Medicaid Program will not separately reimburse for VitalStim therapy for clients with dysphagia.

To be covered under the Texas Medicaid Program, speech-language therapy must be prescribed by a physician, provided as an inpatient or outpatient hospital service, and billed by the hospital, or prescribed by a physician performed by or under the physician's personal supervision, and billed by the physician.

The therapy may be performed by either a speech-language pathologist (SLP) or audiologist if they are on staff at the hospital or under the personal supervision of a physician. Speech evaluations and speech-language therapy billed directly by an independently practicing SLP or audiologist are payable under THSteps-CCP to children younger than 21 years of age and eligible for Medicaid.

Use procedure code 1-92507 or 1-92508 for each half-hour session. If the claim does not state the amount of time spent on the session, a quantity of 1 is paid. SLP sessions are limited to one hour per day.

Evaluation and treatment of swallowing and oral function for feeding is a benefit of the Texas Medicaid Program:

- For clients birth through 21 years of age, the services are reimbursed through THSteps-CCP.
- For clients 21 years of age and older, the services are reimbursed through the traditional Medicaid program and must be limited to acute conditions or exacerbations of chronic conditions. The modifier AT must be used to indicate the necessity of an acute condition, and it must appear on the claim.
- For clients 21 years of age and older, the services must be either:
  - Prescribed by a physician, provided as an outpatient hospital service, and billed by the hospital.
  - Prescribed by a physician, performed by the physician or under the physician's personal supervision, and billed by the physician.
- The service is considered included in the DRG when provided in an inpatient and rehabilitation facility.

Procedure codes 1-92526 and 1-92610 may be billed for evaluation and treatment of swallowing and oral function for feeding.

Refer to: "Speech-Language Pathologists (THSteps-CCP Only)" on page 43-90.

36.4.46.1 Speech Therapy and Aural Rehabilitation Post Cochlear Implant

Cochlear implants are reimbursable for clients 12 months of age and older. Reimbursement for speech therapy and aural rehabilitation is made separately from the surgical fee for cochlear implants.

For clients 12 months to 21 years of age, speech therapy and aural rehabilitation are reimbursed through THSteps-CCP.

For clients 21 years of age and older, speech therapy and aural rehabilitation are reimbursed through the traditional Medicaid program when billed by the hospital or the physician. The traditional Medicaid program reimburses a maximum of 12 visits within a six-month period. Payment for speech therapy (1-92507) is included as part of the cochlear implant procedure (2-69930).

The speech therapy and aural rehabilitation should be prescribed by a physician, provided as an outpatient hospital service and billed by the hospital, or prescribed by a physician, performed by or under their personal supervision, and billed by the physician.

The service is considered included in the DRG when provided in an inpatient facility and rehabilitation setting.

Speech evaluations and speech therapy billed directly by an independently practicing speech pathologist or audiologist autodeny and are considered on appeal only by the TMHP Medical Director.

36.4.47 Surgeons and Surgery

36.4.47.1 Primary Surgery

A primary surgeon is reimbursed for services provided in the inpatient hospital, outpatient hospital setting, and ASC/HASC Center.

If the same physician bills a surgical fee for one procedure (TOS 2) and an assistant surgeon's fee for the second procedure (TOS 8) on the same day, full allowed reimbursement is paid for the TOS 2 procedure and half the allowed reimbursement is paid for the TOS 8 procedure.

Regarding cosurgery, if a procedure code is not payable to an assistant surgeon (TOS 8), it is only payable to a primary surgeon (TOS 2).

36.4.47.2 Anesthesia Administered by Surgeon

If the physician bills for a surgical procedure and anesthesia for the same procedure, the surgery is paid and the anesthesia is denied as part of the surgical procedure. An exception to this policy is an epidural during labor and delivery.

Refer to: "Anesthesia" on page 36-24 for more information.

36.4.47.3 Assistant Surgeon

Assistant surgeons are reimbursed 16 percent of the TMRM fee for the surgical procedures performed.

Medicaid follows the TEFRA regulations for assistant surgeons in teaching hospitals. TEFRA states that an assistant surgeon will not be paid in a hospital classified by Medicare as a teaching facility with an approved graduate training program in the performing physician's specialty. One of the following situations must be present and documented on the claim:

- No qualified resident was available (modifier 82 may be used to document this exception).
- There were exceptional medical circumstances such as an emergency or life-threatening situation requiring immediate attention (modifiers 80 and KX).
- The primary surgeon has a policy of never, without exception, involving a resident in the preoperative, operative, or postoperative care of a patient (modifiers 80 and KX).
- The surgical procedure was complex and required a team of physicians (modifiers 80 and KX).

Use of these modifiers is not required but expedites claims processing. Therefore, it is *recommended* that these modifiers be used in conjunction with the procedure code rather than a narrative statement when these specific circumstances exist.

All claims for assistant surgeon services must include in Block 32 of the CMS-1500 claim form the name and address *or* provider identifier of the hospital in which the surgery was performed. If the physician seeks an exception to this TEFRA regulation based on unavailability of a qualified resident, the following certification statement must appear on or attached to the claim form:

> "I understand that section 1842(b)(6)(D) of the *Social Security Act* generally prohibits reasonable charge payment for the services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were medically necessary, and that no qualified residents were available to perform the services. I further understand that these services are subject to postpayment review by TMHP."

A surgeon billing for a surgery and an assistant surgery fee on the same day (for the same client) may be reimbursed if two separate procedures are performed. Full payment is allowed for the surgery and the assisted surgical procedure is paid at half the allowed amount (16 percent of the TMRM fee for the surgical procedure performed).

Surgical procedures that do not ordinarily require the services of an assistant are denied when billed with a TOS 8 (assistant surgery). Procedures identified by Medicare as noncovered assisted surgical procedures are denied. One assistant surgeon is reimbursed for surgical procedures when appropriate. Two assistant surgeons are allowed for liver transplant surgery only.

Assistant surgeons must have the client's Medicaid number and when required the prior authorization number for claims payment. TMHP recommends that the surgeon provides this information to the assistant surgeon as soon as possible.

Physicians billing for assistant surgery on electronic and paper claims must include a facility provider identifier. When billing for assistant services, providers should bill the most appropriate assistant surgeon modifier.

PAs functioning as an assistant during surgery should be billed on the same claim as the surgery when the PA is not separately enrolled as a provider. Supervising physicians as defined by the Texas Medical Board may bill Medicaid for services performed by the PA they supervise. Use modifier AS for assistant at surgery services rendered by the PA. The claim must include the PA's name and license number. Only procedures currently allowed for assistant surgeons are payable.

PAs actively enrolled as a Medicaid provider with an assigned provider identifier may bill assistant surgery services on a separate claim form using the PA's individual provider identifier and modifiers U7 and 80.

36.4.47.4 Bilateral Procedures

When a bilateral procedure is performed and an appropriate bilateral code is not available, a unilateral code must be used. The unilateral code must be billed twice with a quantity of 1 for each code. For all procedures, use

modifiers LT (left) and RT (right) as appropriate. For example, bilateral application of short leg cast is billed as follows:

Procedure Code	Modifier
2/F-29405	LT
2/F-29405	RT

36.4.47.5 Biopsy

A biopsy refers to the surgical excision of tissue for pathological examination.

If a surgeon bills separate charges for a surgical procedure and a biopsy on the same organ or structure on the same day, the charges are reviewed and reimbursed only for the service with the higher of the allowed amounts.

36.4.47.6 Capsulotomy

A capsulotomy is the incision of the fibrous tissues surrounding a joint. This procedure is considered part of the joint surgery.

If a surgeon bills separate charges for a capsulotomy and another joint surgery on the same day, the charges are reviewed and reimbursed only for the service with the higher of the allowed amounts.

If a capsulotomy is billed alone, use the appropriate capsulotomy procedure code.

36.4.47.7 Cosurgery

Cosurgery (two surgeons) is reimbursed when the skills of two surgeons (usually with different skills) are required in the management of a specific surgical procedure. Cosurgery is for a surgery where the two surgeons' separate contributions to the successful outcome of the procedure are considered to be of equal importance. Prior authorization is no longer required, nor will it be issued for cosurgery.

Note: *No additional reimbursement will be made for an assistant surgeon.*

When billing for services provided during a cosurgery, each surgeon (usually of different specialties) must bill using the same CPT code(s), along with CPT modifier 62. Each surgeon is reimbursed 58 percent of the highest paying procedure and 29 percent of each secondary procedure. No cosurgery payment is made for claims submitted without CPT modifier 62. In instances where the surgeons do not use CPT modifier 62, the first claim received at TMHP for the service is considered that of the primary surgeon, and the subsequent claim is denied as a previously paid service.

36.4.47.8 Global Fees

The Texas Medicaid Program reimburses surgeons, assistant surgeons, and anesthesiologists based on a global fee concept. The global fee concept means that the fee paid for the surgical procedure includes *varying* preoperative and postoperative care based on the complexity of the procedure.

No distinction is made between emergency and nonemergency procedures because the required package of services is the same.

Surgical procedures are reimbursed as a comprehensive global fee for the performance of the procedure. The method of accomplishing the surgical procedure is the election of the surgeon, who may elect to incorporate new technology in the procedure because it offers advantages. However, the global fee remains the fee for the procedure, with additional payment not afforded because of surgeon preference as to the technology selected for completion of the procedure. Separate charges for the use of special equipment or other modifications during surgery are denied.

Consultations or visits denied within the pre-care of a surgery may be considered an appeal with documentation establishing the medical necessity for exceeding the global surgical fee limitations.

The reimbursement for minor surgeries (for example, elbow arthroscopy, conjunctiva biopsy) include all routine care related to the surgery three days preoperatively and seven days postoperatively.

Major surgeries (for example, gastrostomy, hysterectomy, and cataract extraction) include all routine care pertaining to the surgery three days preoperatively including admissions and consultations and all routine postoperative care for six weeks in any POS.

Extensive surgical procedures (for example, total hip replacement) include all routine care related to the surgical procedure three days preoperatively and for a period of 180 days postoperatively regardless of the POS of the pre and postoperative procedures.

Simple diagnostic (for example, paracentesis) and minor surgical procedures (for example, repair of a superficial wound up to 2.5 cm) do not include any preoperative or postoperative care restrictions. If the procedure is performed in the office or home, refer to "Office or Other Outpatient Services" on page 36-11.

If the simple diagnostic procedure is performed in an inpatient hospital setting, a visit is not paid on the same day unless it is for a distinctly separate diagnosis. Modifier 25 may be used to describe circumstances in which an office visit was provided at the same time as other separately identifiable services (e.g., THSteps visits, minor procedure). Both services must be documented as distinct and documentation must be maintained in the medical record and made available to the Texas Medicaid Program upon request. This modifier may be appended to the evaluation code when the services rendered meet the following conditions:

- Are distinct.
- Are provided for different diagnoses.
- Are performed for different reasons.

Postoperative complications necessitating readmission to the hospital during the postoperative package of service (that exceeds 72 hours of observation for a complication of the surgical procedure) may be reimbursed outside the package of service on appeal to the TMHP Medical Director. Documentation of the medical appropriateness of the protracted medical stay is required with submission of the appeal.

All supplies (trays, dressings, casting and splinting supplies, and local anesthetics) are considered part of the surgical procedure and should not be billed separately to Medicaid or the client.

Refer to: "Paper Appeals" on page 6-3 for information about submitting appeals.

36.4.47.9 Global Surgery Concurrent Care

Medicaid reimbursement for surgical procedures is based on the concept of a global fee for a package of services related to the surgical procedure. This package of services includes all preoperative and postoperative care. In situations where a single physician/surgeon does not provide the package of services, the following steps must be followed to ensure the accurate processing and reimbursement of services:

1) The preoperative care provided by the surgeon/anesthesiologist should not be billed separately because it is included in the reimbursement for the surgical procedure.
2) Surgeons who do not provide the postoperative care for a patient *must* bill the surgery code with modifier 54. This modifier allows reimbursement of the surgeon at 80 percent of the performing provider's allowed amount.
3) The physician who provides the postoperative care *without* having performed the surgery may bill the appropriate visit code but must use CPT modifier 55. CPT modifier 55 indicates that the physician did not perform the surgery and is only providing the preoperative or postoperative care.
4) Routine postoperative anesthesiology care by the anesthesiologist is included in the package of services by the anesthesiologist.

36.4.47.10 Multiple Surgeries

Medicaid payment for multiple surgeries is based on the following guidelines:

- When two surgical procedures are performed on the same day, the primary procedure (such as the higher paying procedure) is paid at the full TMRM allowance. Secondary procedures performed on the same day are paid at half of the TMRM allowance when medically justified.
- Surgical procedures performed at different operative sessions on the same day are paid at the full TMRM allowance for each primary procedure at each session.
  - Vaginal deliveries followed by tubal ligations are considered different operative sessions and are paid at full allowance for each primary procedure at a different session (i.e., both vaginal delivery and tubal ligation are paid at full allowance).
- Procedure code 2/8-58611 performed in conjunction with a cesarean section is reimbursed at full allowance in cases where the allowance already represents half of the primary procedure.
- When a surgical procedure and a biopsy on the same organ or structure is done on the same day, the charges will be reviewed and reimbursement will be made only for the service with the higher of the allowed amounts.

36.4.47.11 Office Procedures

CMS has identified certain surgical procedures that are more appropriately performed in the office setting rather than as outpatient hospital, ASC/HASC procedures. The following list of surgical procedure codes should be billed in POS 1 (physician's office). The medical necessity and/or special circumstances that dictate that these surgical procedures be performed in a POS other than the office must be documented on the claim. These surgical procedures are evaluated on a retrospective basis that may cause recoupment and/or adjustment of the original claim payment.

Excision benign lesions	Excision malignant lesions	Manipulation (urethral)
2-11400	2-11600	2-53600
2-11401	2-11601	2-53601
2-11402	2-11602	2-53620
2-11403	2-11603	2-53621
2-11404	2-11604	2-53660
2-11420	2-11620	2-53661
2-11421	2-11621	
2-11422	2-11622	
2-11423	2-11623	
2-11440	2-11624	
2-11441	2-11640	
2-11442	2-11641	
2-11443	2-11642	
2-11444	2-11643	
	2-11644	
Simple repairs	**Endoscopy**	**Biopsy (tongue)**
2-28010	2-31505	2-41100
2-28011		
Lesions (penile)	**Lesions (eyelid)**	
2-54060	2-67801	

36.4.47.12 Orthopedic Hardware

Reimbursement for the orthopedic hardware (e.g., buried wire, pin, screw, metal band, nail, rod, or plate) is part of the surgeon's global fee or the facility's payment group. The hardware is not reimbursed separately to either the surgeon or the facility.

The removal of orthopedic hardware is not payable to the same provider who inserted it, if removed within the global operative care period of the original insertion.

Services for removal of orthopedic hardware may be reimbursed separately after the global post operative care period.

36.4.47.13 Second Opinions

Texas Medicaid Program benefits include payment to physicians when eligible clients request second opinions about specific problems. The claim should be coded with the appropriate office or hospital visit codes, and the notation "Client Initiated Second Opinion" should be identified in Block 24D of the CMS-1500 claim form.

Refer to: "Consultation Services" on page 36-12.

36.4.47.14 Team Surgery

Team surgery is no longer reimbursed by the Texas Medicaid Program. Surgeons and assistant surgeons participating in a team surgery procedure should bill for the procedure(s) personally performed and are reimbursed based on the multiple surgery guidelines.

In instances where one surgeon performs the approach procedure, another surgeon performs the definitive procedure, and another surgeon performs the reconstruction/repair procedure, each surgeon reports only the code for the specific procedure performed. Each procedure is reimbursed at full allowance.

Refer to: "Assistant Surgeon" on page 36-131.

"Multiple Surgeries" on page 36-133 for more information.

36.4.48 Suture of Wounds

Wounds are defined as a break or laceration of soft parts of body structures (i.e., skin) caused by violence or trauma to tissues. Wounds occur to all parts of the body and can be caused by accidents or under aseptic conditions, such as a surgical incision. The repair of wounds is defined as simple, intermediate, or complex. Simple repair involves the dermis and subcutaneous tissue and requires a one-layer closure. Intermediate repair requires some layered closure of deeper layers of subcutaneous tissue and superficial fascia. Complex repair involves more layered closure, debridement, extensive undermining, stints, or retention sutures. Wound closures may use sutures, staples, and/or wound adhesives.

Wound closures should be billed using the following procedure codes:

Procedure Codes		
Repair Simple		
2-12001	2-12002	2-12004
2/F-12005	2/F-12006	2/F-12007
2-12011	2-12013	2-12014
2-12015	2/F-12016	2/F-12017
2/8/F-12018	2/F-12020	2/F-12021
Repair Intermediate		
2/F-12031	2/F-12032	2/F-12034
2/F-12035	2/F-12036	2/8/F-12037
2/F-12041	2/F-12042	2/F-12044
2/F-12045	2/F-12046	2/F-12047
2-12051	2-12052	2-12053
2/F-12054	2/F-12055	2/F-12056
2/8/F-12057		
Repair Complex		
2/F-13100	2/F-13101	2/8/F-13102
2/F-13120	2/F-13121	2/8/F-13122
2/F-13131	2/F-13132	2/8/F-13133
2/F-13150	2/F-13151	2/F-13152
2/8/F-13153	2/F-13160	

Multiple wounds on the same day will be paid the full-allowed amount for the major (largest) wound and one-half the allowed amount for each additional laceration.

No separate payment will be made for incision closures billed in addition to a surgical procedure when the closure is part of that surgical procedure.

No separate payment will be made for supplies in the office.

For the hospital-based emergency department, see the policy on "Supplies, Trays, and Drugs" on page 36-8.

36.4.49 Therapeutic Apheresis

Therapeutic apheresis does not require mandatory prior authorization. Payment for procedure code 2/F-36511, 2/F-36512, 2/F-36513, or 2/F-36514 is limited to the following diagnosis codes:

Diagnosis Codes				
20300	20310	20311	20380	20381
20400	20401	20410	20411	20420
20421	20480	20481	20490	20491
20500	20501	20510	20511	20520
20521	20530	20531	20580	20581
20590	20591	20600	20601	20610
20611	20620	20621	20680	20681
20690	20691	20700	20701	20710

Diagnosis Codes				
20711	20720	20721	20780	20781
20800	20801	20810	20811	20820
20821	20880	20881	20890	20891
2384	23871	2720	2730	2731
2733	28260	28261	28262	28263
28264	28268	28269	2828	2830
28310	28311	28319	2863	2866
28730	28731	28732	28733	28739
2884	28869	2890	28951	28952
2896	2897	2898	28981	28989
2899	3570	3571	3572	3573
3574	3575	3576	3577	3578
35800	35801	390	3918	44620
44621	44629	4466	4476	4478
570	5718	5724	5731	5732
5733	57431	57441	5800	5804
5810	5811	5812	5813	58181
58189	5819	5820	5821	5822
5824	5830	5831	5832	5834
5836	5837	58381	58389	5839
6944	6951	7100	701	7101
7103	7104	71430	71431	71432
71433	7140	7141	7142	

Procedure codes 2/F-36515 and 2/F-36516 may be considered for reimbursement when billed for the low density lipoprotein (LDL) apheresis (such as *Liposorber* LA 15) or the protein A immunoadsorption (such as *Prosorba*) columns.

- The protein A immunoadsorption column is indicated for use in either of the following cases:
  - Clients who have a platelet count of less than 100,000 mm3.
  - Adult clients with signs and symptoms of moderate to severe rheumatoid arthritis with long-standing disease who have failed, or are intolerant to, DMARDs.
- Therapeutic apheresis using the protein A immunoadsorption column may be reimbursed for the following diagnosis codes:

Diagnosis Codes				
2720	28730	28731	28732	28733
28739	7140	7141	7142	

- The LDL apheresis column is indicated for use in clients with severe familial hypercholesterolemia whose cholesterol levels remain elevated despite a strict diet and ineffective or untolerated maximum drug therapy. Coverage is considered for the following high-risk population, for whom diet has been ineffective and maximum drug therapy has either been ineffective or not tolerated:
  - Functional hypercholesterolemia homozygotes with LDL-C > 500 mg/dL.
  - Functional hypercholesterolemia heterozygotes with LDL-C $\geq$ 300 mg/dL.
  - Functional hypercholesterolemia heterozygotes with LDL-C $\geq$ 200 mg/dL and documented coronary heart disease.
- Baseline LDL-C levels are to be obtained after the client has had, at a minimum, a six-month trial on an American Heart Association (AHA) Step II diet or equivalent and maximum tolerated combination drug therapy designed to reduce LDL-C. Baseline lipid levels are to be obtained during a two- to four- week period and should be within 10 percent of each other, indicating a stable condition.
- Therapeutic apheresis using the LDL apheresis column may be reimbursed for diagnosis code 2720, Familial hypercholesterolemia.

Apheresis services represents one 30-minute time interval of personal physician involvement in the apheresis. Apheresis is limited to three 30-minute time intervals per procedure. The actual time must be reflected on the claim, or a unit of 1, 2, or 3 must be indicated. If the time (or unit) is not indicated, payment is based on one 30-minute time interval.

Apheresis is denied for all other diagnosis codes. Other diagnosis codes can be reviewed by the TMHP Medical Director or designee on appeal with documentation of medical necessity.

Laboratory work before and during the apheresis procedure is covered when apheresis is performed in the outpatient setting (POS 5). Laboratory work billed in conjunction with apheresis performed in the inpatient setting (POS 3) is included in the DRG reimbursement and is not paid separately.

36.4.50 Therapeutic Phlebotomy

Therapeutic phlebotomy is a treatment whereby a prescribed amount of blood is withdrawn for medical reasons. Conditions that cause an elevation of the red blood cell volume or disorders that cause the body to accumulate too much iron may be treated by therapeutic phlebotomy.

Therapeutic phlebotomy is a benefit of the Texas Medicaid Program and may be billed using procedure code 1-99195. This procedure code should be used only for the therapeutic form of phlebotomy and not for diagnostic reasons.

Reimbursement of therapeutic phlebotomy is limited to the following diagnosis codes:

Diagnosis Codes				
2384	2750	2771	2859	2890
2896	7764			

Therapeutic phlebotomy will autodeny for all other diagnosis codes.

36.4.51 Ventilation Assist and Management for the Inpatient

Use the following procedure codes and guidelines for reimbursement of ventilation assist and management: 1-94002 and 1-94003. Procedure codes 1-94002 and 1-94003 apply to hospital care only. Respiratory care billed in any other POS will be denied.

Use the ventilation assist and management subsequent code (1-94003) when respiratory support must be established for a patient in the postoperative period in the hospital (POS 3). Subsequent days of ventilation assistance are payable when documentation indicates a respiratory problem.

When the use of a ventilator is required as part of a major surgery, initial ventilation assist and management will be denied. It should be billed as ventilation assist and management subsequent code 1-94003.

Procedure codes 1-94002 and 1-94003 apply only to hospital care for critically ill patients. They do not apply to routine recovery room ventilation services. Separate support service charges billed on the same day as ventilatory support are denied (for example, initiation or maintenance of intravenous therapy or infusions, total parenteral nutrition (TPN)/hyperalimentation; arterial or venous punctures; interpretations of arterial blood gases; pulmonary function tests and management of the hemodynamic functions of the patient; intensive care visits; subsequent hospital visits; or any other hospital visit).

Use ventilation assist and management and initiation of pressure or volume preset ventilators for assisted or controlled breathing–first day (1-94002) when respiratory support must be established for a patient. It is a *one-time charge* per hospitalization that may be paid when the claim documents that a respiratory problem exists (for example, respiratory distress, asphyxia). After the first day, use subsequent days (1-94003).

Ventilation assist and management procedures 1-94002 and 1-94003 are not payable when billed by the same provider on the same date of service as the procedure codes listed below:

Procedure Codes		
1-99221	1-99222	1-99223
1-99231	1-99232	1-99234
1-99235	1-99236	1-99238
1-99239	1-99251	1-99252
1-99253	1-99254	1-99255
1-99291	1-99292	1-99293
1-99294	1-99295	1-99296
1-99298	1-99299	1-99300
1-99360		

Procedure code 1-94003 will be denied when billed for the same date of service as 1-94002.

36.5 Doctor of Dentistry Practicing as a Limited Physician

Claims information for a Doctor of Dentistry practicing as a limited physician outlines guidelines for the Doctor of Dentistry Practicing as a Limited Physician. The THSteps dental program is *not* addressed in these guidelines.

36.5.1 Medicaid Managed Care Enrollment

Services provided by a Doctor of Dentistry Practicing as a Limited Physician must be billed to the member's health plan if the client is in the STAR or STAR+PLUS Programs. Providers must enroll with each STAR and STAR+PLUS health plan to be reimbursed for services provided to STAR and STAR+PLUS Program members.

Note: *To be reimbursed for services provided to STAR and STAR+PLUS Program members, genetic providers must enroll with each STAR and STAR+PLUS health plan in which their patients are enrolled.*

36.5.1.1 Mandatory Prior Authorization Due to Life-Threatening Medical Condition

Reimbursement for general dental services by any provider, irrespective of the medical or dental qualifications of the provider, is not a Medicaid benefit for Medicaid clients 21 years of age and older (who do not reside in an ICF-MR facility).

The TMHP Medical Director or designee may allow an exception for a dental condition causally related to a life-threatening medical condition. *Mandatory prior authorization is required* and the dental diagnoses *must* be secondary to a life-threatening medical condition.

Examples of dental procedures that may be authorized for a *general dentist* who is enrolled as a *limited physician* are:

- Extractions.
- Alveolectomies (in limited situations).
- Incision and drainage.
- Curettement.

Examples of dental procedures that may be authorized for an *oral and maxillofacial surgeon* who is enrolled as a *limited physician* are:

- Extractions.
- Alveolectomies (in limited situations).
- Incision and drainage.
- Curettement maxillofacial surgeries to correct defects caused by accident or trauma.
- Surgical corrections of craniofacial dysostosis.

Note: *Therapeutic procedures such as restorations, dentures, and bridges are not a benefit of the program and will not be authorized.*

36.5.2 Guidelines for Requesting Mandatory Prior Authorization

The *limited physician* dentist must request the mandatory prior authorization, and the request must include:

- A treatment plan that clearly outlines the dental condition as related to the life-threatening medical condition.
- Narrative describing the current medical problem, client status, and medical need for requested services.
- The client name and Medicaid number.
- The *limited physician* dentist's provider identifier.
- The name and address of the facility.
- CPT procedure codes.
- The history and physical.
- The *limited physician* dentist's signature.

Note: *The "limited physician" dentist who will perform the procedure(s) must submit the request for prior authorization.*

All supporting documentation must be included with the request for authorization. Providers are to send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 512-514-4213

36.5.3 Reimbursement for Doctor of Dentistry Practicing as a Limited Physician

Services performed by a dentist (DDS or DMD) practicing as a limited physician are reimbursed according to the TMRM in accordance with 1 TAC §355.8085. The TMRM is based on the resource-based relative value scale (RBRVS). TMRM is a flat fee structure applicable on a statewide basis, with *no* geographical or specialty differences. All the following information is required to bill *limited physician* services:

- CMS-1500 claim form.
- Approved CPT procedure codes (refer to "CPT Procedure Codes" on page 36-138).
- Approved diagnosis codes (refer to "Diagnosis Codes" on page 36-137).
- *Limited physician* provider identifier.
- Authorization number when prior authorization is required.

For services provided to THSteps clients birth through 20 years of age, Doctor of Dentistry providers should first use American Dental Association (ADA) procedure codes, the ADA claim form, and the provider identifier. CPT codes may be used when an appropriate ADA procedure code is not available.

Refer to: "Reimbursement" on page 2-2.

36.5.3.1 Benefits and Limitations

Services by a dentist (DDS or DMD) are covered by the Texas Medicaid Program in accordance with OBRA of 1987 (public law 100-203), if the services are furnished within the dentist's scope of practice as defined by Texas state law and would be covered under the Texas Medicaid Program when provided by a licensed physician (MD or DO).

36.5.3.2 Diagnosis Codes

The following table lists diagnosis codes (ICD-9-CM) that may be billed by a Doctor of Dentistry practicing as a Limited Physician:

Diagnosis Codes				
0542	1120	1400	1401	1403
1404	1405	1406	1408	1409
1410	1411	1412	1413	1414
1415	1416	1418	1419	1420
1421	1422	1428	1429	1430
1431	1438	1439	1440	1441
1448	1449	1450	1451	1452
1453	1454	1455	1456	1458
1459	1460	1461	1462	1463
1464	1465	1466	1467	1468
1469	1490	1498	1602	1700
1701	1730	1733	1950	2100
2101	2102	2103	2104	2105
2106	2107	2120	2130	2131
2160	2163	22801	2300	2320
2323	2350	2380	3501	3510
470	4730	4780	5225	5227
52400	52401	52402	52403	52404
52405	52406	52407	52409	52410
52411	52412	52419	52420	52421
52422	52423	52424	52425	52426
52427	52428	52429	52450	52451
52452	52453	52454	52455	52456
52457	52459	52460	52461	52462
52463	52464	52469	52470	52471
52472	52473	52474	52475	52476
52479	52481	52482	52489	5249
5272	5273	5274	5275	5276
5277	5278	5279	5281	5282
5283	5284	5285	5286	52871
52872	52879	5290	5291	5292
5293	5294	5295	5298	6820
6828	6829	70900	71509	71518
71528	71618	71690	73810	73811

Diagnosis Codes				
73812	73819	74441	74442	74900
74901	74902	74903	74904	74910
74911	74912	74913	74914	74920
74921	74922	74923	74924	74925
7500	7810	78194	78199	8020
8021	80220	80221	80222	80223
80224	80225	80226	80227	80228
80229	80230	80231	80232	80233
80234	80235	80236	80237	80238
80239	8024	8025	8026	8027
8028	8029	80300	80301	80302
80303	80304	80305	80306	80309
80310	8481	87320	87321	87322
87323	87329	87330	87331	87332
87333	87339	87340	87341	87342
87343	87344	87349	87350	87351
87352	87353	87354	87359	87360
87361	87362	87363	87364	87365
87369	87370	87371	87372	87373
87374	87375	87379	8744	8745
9062	920	9350	95909	99811
99812	99813	99851	99859	

36.5.3.3 Evaluation and Management Procedure Codes

The following procedure codes listed in the "Evaluation and Management" section of the Physicians' CPT must be used with the appropriate ICD-9-CM codes listed in "Diagnosis Codes" on page 36-137.

Procedure Codes		
1-99201	1-99202	1-99203
1-99204	1-99205	1-99211
1-99212	1-99213	1-99214
1-99215	1-99217	1-99218
1-99219	1-99220	1-99221
1-99222	1-99223	1-99231
1-99232	1-99233	1-99234
1-99235	1-99236	1-99238
1-99239	1-99281	1-99282
1-99283	1-99284	1-99285
1-99291	1-99292	1-99293
1-99294	1-99295	1-99296
1-99297	1-99298	1-99299
1-99300	1-99304	1-99305
1-99306	1-99307	1-99308

Procedure Codes		
1-99309	1-99310	1-99315
1-99316	1-99318	1-99324
1-99325	1-99326	1-99327
1-99328	1-99334	1-99335
1-99336	1-99337	1-99341
1-99342	1-99343	1-99344
1-99345	1-99347	1-99348
1-99349	1-99350	1-99354
1-99355	1-99356	1-99357
1-99401	1-99402	1-99429
1-99431	1-99432	1-99433
1-99435	1-99436	1-99440
1-99499		

36.5.3.4 CPT Procedure Codes

The following CPT procedure codes are a benefit when:

- Accompanied by the appropriate diagnosis code.
- The dentist is qualified and licensed to perform the procedures.

Descriptions of these codes can be found in the current edition of CPT.

CPT Procedure Codes		
2-10060	2-10061	2-10120
2-10121	2-10140	2-10160
2-10180	2-11000	2-11001
2-11040	2-11041	2-11042
2-11043	2-11044	2-11440
2-11441	2-11442	2-11443
2-11444	2-11446	2-11640
2-11641	2-11642	2-11643
2-11644	2-11646	2-12011
2-12013	2-12014	2-12015
2-12016	2-12017	2-12018
2-12051	2-12053	2-12054
2-12055	2-12056	2-12057
2-13131	2-13132	2-13150
2-13151	2-13152	2-13133
2-13153	2-14040	2-14041
2-14060	2-14061	2-15004
2-15005	2-15120	2-15121
2-15240	2-15241	2-15260
2-15261	2-15400	2-15850
2-15851	2-15852	2-20000
2-20005	2-20200	2-20220

***Code is not a benefit for clients 21 years of age and older.**

CPT Procedure Codes		
2-20240	2-20520	2-20600
2-20605	2-20670	2-20680
2-20693	2-20694	2-20900
2-20902	2-20912	2-21015
2-21025	2-21026	2-21029
2-21030	2-21034	2-21040
2-21041	2-21044	2-21045
2-21070	2-21082*	2-21083*
2-21116	2-21310	2-21315
2-21320	2-21325	2-21330
2-21335	2-21336	2-21337
2-21338	2-21339	2-21340
2-21343	2-21344	2-21345
2-21346	2-21347	2-21348
2-21355	2-21356	2-21360
2-21365	2-21366	2-21385
2-21386	2-21387	2-21390
2-21395	2-21400	2-21401
2-21406	2-21407	2-21408
2-21421	2-21422	2-21423
2-21431	2-21432	2-21433
2-21435	2-21436	2-21440
2-21445	2-21450	2-21451
2-21452	2-21453	2-21454
2-21461	2-21462	2-21465
2-21470	2-21480	2-21485
2-21490	2-21499	2-29999
2-30130	2-30140	2-30400
2-30410	2-30420	2-30430
2-30435	2-30450	2-30520
2-30580	2-30600	2-30620
2-30630	2-30801	2-30802
2-30930	2-31020	2-31030
2-40490	2-40500	2-40510
2-40520	2-40525	2-40527
2-40530	2-40650	2-40652
2-40654	2-40700	2-40701
2-40702	2-40800	2-40801
2-40804	2-40805	2-40806
2-40808	2-40810	2-40812
2-40814	2-40816	2-40818
2-40819	2-40820	2-40830
2-40831	2-41000	2-41005

***Code is not a benefit for clients 21 years of age and older.**

CPT Procedure Codes		
2-41006	2-41007	2-41008
2-41009	2-41010	2-41015
2-41016	2-41017	2-41018
2-41100	2-41105	2-41108
2-41110	2-41112	2-41113
2-41114	2-41115	2-41116
2-41120	2-41130	2-41250
2-41251	2-41252	2-41520
2-41800	2-41805	2-41806
2-41822	2-41823	2-41825
2-41826	2-41827	2-41830
2-41850	2-41899	2-42000
2-42100	2-42104	2-42106
2-42107	2-42120	2-42160
2-42280	2-42281	2-42200
2-42205	2-42210	2-42215
2-42220	2-42225	2-42226
2-42227	2-42235	2-42260
2-42280	2-42300	2-42305
2-42310	2-42320	2-42330
2-42335	2-42340	2-42400
2-42405	2-42408	2-42409
2-42410	2-42415	2-42420
2-42425	2-42440	2-42450
2-42500	2-42505	2-42550
2-42600	2-42650	2-42665
2-42700	2-42720	2-42725
2-42810	2-42900	2-42960
2-42961	2-42962	2-42970
2-61575	2-61576	2-64400
2-64600	2-64722	2-64736
2-64738	2-64740	2-92511
5-88305	5-88331	5-88332

***Code is not a benefit for clients 21 years of age and older.**

36.5.3.5 CPT Codes Requiring Mandatory Prior Authorization

The following CPT codes may be payable to an *oral and maxillofacial surgeon* when *mandatory prior authorization* is received from the TMHP Medical Director or designee. A narrative explaining medical necessity must be provided with the authorization request.

CPT Procedure Codes		
2-21010	2-21031	2-21032
2/8/F-21050	2/8/F-21060	2/F-21100*
2-21110*	2/8-21120	2/8/F-21121

CPT Procedure Codes		
2/8/F-21122	2/8/F-21123	2/F-21125
2/8/F-21127	2/8-21137	2/8-21138
2/8-21139	2/8-21145	2/8-21146
2/8-21147	2/8-21150	2/8-21151
2/8-21154	2/8-21155	2/8-21159
2/8-21160	2/8-21172	2/8-21175
2/8-21179	2/8-21180	2/8/F-21181
2/8-21182	2/8-21183	2/8-21184
2/8-21188	2/8-21193	2/8-21194
2/8-21195	2/8-21196	2/8-21198
2/8-21199	2/8/F-21206	2/F-21208
2/8/F-21209	2/8/F-21210	2/F-21215
2/F-21230	2/F-21235	2/8/F-21240
2/8/F-21242	2/8/F-21243	2/8/F-21244
2/F-21245	2/F-21246	2/8-21247
2/8-21255	2/8-21256	2/8-21260
2/8-21261	2/8-21263	2/8/F-21267
2/8-21268	2/F-21270	2/8/F-21275
2/F-21280	2/F-21282	2/F-21295
2/F-21296	2/8/F-21299	2/F-29800
2/F-29804	2/F-40840	2/F-40842
2/F-40843	2/F-40844	2/F-40845

Refer to: "Guidelines for Requesting Mandatory Prior Authorization" on page 36-137 for more instructions about submitting your request for prior authorization.

36.5.3.6 Radiographs by a Doctor of Dentistry Practicing as a Limited Physician

When a Doctor of Dentistry Practicing as a Limited Physician uses appropriate radiograph equipment to produce required radiographs, the following procedure codes are eligible for reimbursement when accompanied by an appropriate diagnosis:

Procedure Codes		
4-70100	4-70110	4-70120
4-70130	4-70140	4-70150
4-70160	4-70170	4-70190
4-70200	4-70250	4-70260
4-70300	4-70310	4-70320
4-70328	4-70330	4-70332
4-70336	4-70350	4-70355
4-70370	4-70371	4-70380
4-70390	4-73100	

36.5.3.7 Dental Anesthesia by a Doctor of Dentistry Practicing as a Limited Physician

A Doctor of Dentistry Practicing as a Limited Physician who is licensed by the Texas State Board of Dental Examiners (TSBDE) practicing in Texas, who has obtained an Anesthesia Permit from the TSBDE in accordance with Title 22 TAC §§108.30 through 108.35, may be reimbursed for anesthesia services on clients having dental/oral and maxillofacial surgical procedures in the dental office or hospital in accordance with all applicable rules for physician administration and supervision of anesthesia services.

Dentists providing sedation/anesthesia services must have the appropriate permit from TSBDE for the level of sedation/anesthesia provided.

The following anesthesia services are payable to dentists as physician services when accompanied by a payable diagnosis:

Procedure Codes		
7-00100	7-00102	7-00160
7-00162	7-00164	7-00170
7-00190	7-00192	1-99100
1-99116	1-99135	1-99140

36.5.4 Claims Information for Doctor of Dentistry Practicing as a Limited Physician

Claims for services by a Doctor of Dentistry Practicing as a Limited Physician must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form using the appropriate provider identifier. All THSteps and ICF-MR services by a dentist must be submitted on an ADA claim form or ADA electronic claim format. Providers must purchase ADA or CMS-1500 claim forms from the vendor of their choice. TMHP does not supply them.

36.6 Procedure Codes Requiring Prior Authorization

The following list is *not all-inclusive* and is subject to change:

Procedure Codes		
7-00580	7-00796	K-00830
K-00831	K-00832	K-00833
K-00834	K-00835	K-00836
K-00837	K-00838	K-00844
7-00868	K-00870	K-00871
K-00872	K-00873	K-00874
K-00886	K-00887	K-02095
K-02491	K-02769	K-02773
K-02779	K-02940	K-03350
K-03360	K-03750	K-04100
K-04101	K-04102	K-04103

Procedure Codes		
K-04104	K-04105	K-04106
K-04191	K-05051	K-05059
K-05561	K-05569	K-06494
K-06495	K-06496	K-06497
K-07631	K-07639	K-07641
K-07642	K-07643	K-07644
K-07645	K-07646	K-07650
K-07661	K-07662	K-07663
K-07664	K-07665	K-07666
K-07667	K-07668	K-07669
K-08530	K-08531	K-08532
K-08683	K-09979	2/F-15820
2/F-15821	2/8/F-15822	2/8/F-15823
2/8/F-19318	2-21010	2/8-21031
2/8/F-21032	2/8/F-21050	2/8/F-21060
2/8-21100	2/8-21120	2/8/F-21121
2/8/F-21122	2/8/F-21123	2/8-21125
2/8/F-21127	2/8-21137	2/8-21138
2/8-21139	2/8-21141	2/8-21143
2/8-21145	2/8-21146	2/8-21147
2/8-21150	2/8-21151	2/8-21154
2/8-21155	2/8-21159	2/8-21160
2/8-21172	2/8-21175	2/8-21179
2/8-21180	2/8-21181	2/8-21182
2/8-21183	2/8-21184	2/8-21188
2/8-21193	2/8-21194	2/8-21195
2/8-21196	2/8-21198	2/8-21199
2/8-21206	2/8-21208	2/8-21209
2/8-21210	2/8-21215	2/8-21230
2/8-21235	2/8-21240	2/8-21241
2/8-21242	2/8-21243	2/8-21244
2/8-21245	2/8-21246	2/8-21247
2/8-21255	2/8-21256	2/8-21260
2/8-21261	2/8-21263	2/8-21267
2/8-21268	2/8-21270	2/8-21275
2/8-21280	2/8-21282	2/8-21295
2/8-21296	2/8-21299	2/8/F-29800
2/8/F-29804	2/8-32851	2/8-32852
2/8-32853	2/8-32854	2/8-33935
2/8-33945	2/8-38230	2/8-38240
2/8-38241	2/F-40840	2/F-40842
2/F-40843	2/F-40844	2/F-40845
2/8-41899	2/8-47135	2/8-47136
2/8-50360	2/8-50365	2/8-50380

Procedure Codes		
2-62350	2-62360	2-62361
2-62362	2/8-63685	2/8-63688
2/8-64573	2/8-64585	2/8/F-67900
2/8/F-67901	2/8/F-67902	2/8/F-67903
2/8/F-67904	2/8/F-67906	2/8/F-67908
2/8/F-67909	2/8/F-67911	2/8/F-67961
8-67961	8/F-67966	8/F-67971
8/F-67973	8/F-67974	2/8/F-67975
2/8/F-69300	9-92326	1-99503
W-D3346	W-D3347	W-D3348
W-D5951	W-D5952	W-D5953
W-D5954	W-D5955	W-D5958
W-D5959	W-D5960	W-D7260
W-D7280	W-D7286	W-D8080
W-D8110	W-D8120	W-D8999
W-D9930	5-Q0068	1-S9364
1-S9365	1-S9366	1-S9367
1-S9368	9-V2500	9-V2501
9-V2502	9-V2510	9-V2511
9-V2512		

Prior authorization is mandatory for these services (this list is noninclusive and subject to change):

- Abdominal lipectomies and panniculectomies.
- Baclofen and/or morphine pump implantation/revision/replacement.

Blepharochalasis/blepharoplasty/blepharoptosis repair (not required for procedure codes 2-67901, 2-67902, 2-67903, 2-67904, 2-67906, 2-67908, and 2-67909 for clients younger than 21 years of age with a diagnosis of 74361, 74362, or 7439). Procedure codes 2-67901, 2-67902, 2-67903, 2-67904, 2-67906, and 2-67908 do not require prior authorization for clients older than 21 years of age with diagnosis codes 37431, 37432, 37433, and 37434.

- Breast reduction.
- Communication devices (CCP only).
- Contact lenses (except postsurgical prosthetic contact lenses or emergency corneal bandage lenses or for the diagnosis of aphakia).
- Corneal topography performed by an optometrist.
- Corneal topography performed by an ophthalmologist.
- Customized DME (CCP only).
- Freestanding psychiatric facility (CCP only).
- Freestanding rehabilitation facility (CCP only).
- Heart transplants.
- Home delivery by a CNM.
- In-home respiratory services provided by a certified respiratory care practitioner.

- Kidney transplants.
- Liver transplants.
- Lung transplants.
- Maxillofacial/craniofacial surgery (excludes procedure code 2-61550 for cosurgery).
- Most home health services.
- Oral surgery—jaw deformities.
- Orthodontic services.
- Outpatient/in-home TPN/hyperalimentation.
- Outpatient mental health services in excess of 30-encounters per client per calendar year to enrolled practitioners.
- Private duty nursing (CCP only).
- Pancreas/simultaneous kidney-pancreas transplant.
- Stem cell transplants.
- Temporomandibular joint surgery.
- Treatment of life-threatening oral infections.
- Vagal nerve stimulator.
- Vestibuloplasty.

The following procedures do *not* require prior authorization:

- Cleft palate repair.
- Cochlear implantation.
- Contact lens(es) or replacement contact lens(es) for diagnosis of aphakia.
- Implant of a dorsal column spinal cord stimulator inserted to treat chronic intractable pain.
- Surgical removal of lesions, when medically necessary; use modifier KX, specific required documentation on file when excision/destruction is because of at least one of the following signs or symptoms: inflamed, growing, infected, bleeding, irritated, itching, limiting motion/function, or diagnosis 7020, actinic keratosis.
- Home Health Services/DME supplies for in-home use require prior authorization through Home Health Services.

Refer to: "THSteps-Comprehensive Care Program (CCP)" on page 43-33

"Corneal Topography" on page 36-94.

"Certified Respiratory Care Practitioner (CRCP) Services" on page 16-1.

"Texas Medicaid (Title XIX) Home Health Services" on page 24-1.

36.7 Claims Information

Claims for physician and doctor services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply them.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills and itemized statements are not accepted as claim supplements.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information about electronic claims submission.

"Claims Filing" on page 5-1 for general information about claims filing.

"CMS-1500 Claim Filing Instructions" on page 5-22. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

36.7.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-22
Example of CMS-1500 claim form	5-24
TMHP Electronic Claims Submission	5-13
State and Federal Offices Communication Guide	A-1
Abortion Certification Statements Form	B-3
Hysterectomy Acknowledgment Form	B-50
Request for Extended Outpatient Psychotherapy/Counseling Form	B-83
Sterilization Consent Form (English)	B-94
Sterilization Consent Form (Spanish)	B-96
Sterilization Consent Form Instructions	B-97
Anesthesia Claim Example	D-5
Dialysis Training Claim Example	D-11
Office Visit with Lab and Radiology Claim Example	D-24
Radiation Therapy Claim Example	D-28
Surgery Claim Example	D-34
Acronym Dictionary	F-1

Section

37

Physician Assistant (PA)

37.1 Enrollment

To enroll in the Texas Medicaid Program, a PA must be licensed and recognized as a PA by the Texas Medical Board. The Texas Medicaid Program accepts a signed letter of certification from the Texas Medical Board as acceptable documentation of appropriate licensure and certification for enrollment.

Providers cannot be enrolled if their license is due to expire within 30 days.

Enrollment as an individual provider is not mandatory. PAs currently treating clients and billing under the supervising physician's number can continue this billing arrangement.

All PA services must be delivered according to protocols developed jointly within the scope of practice and state law governing PAs.

All providers of laboratory services must comply with the rules and regulations of the *Clinical Laboratory Improvement Amendments* (CLIA). Providers not complying with CLIA are not reimbursed for laboratory services.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

"CLIA Requirements" on page 26-2.

PAs may enroll as providers of Texas Health Steps (THSteps) medical check ups. Specific information may be found in the THSteps section of this manual. PAs should have expertise or additional education in the areas of comprehensive pediatric assessment.

Refer to: "Provider Enrollment" on page 43-5 for more information about enrollment as a THSteps provider.

37.1.1 Medicaid Managed Care Enrollment

PAs may be eligible to enroll with Medicaid Managed Care as primary care providers. Contact the individual Medicaid Managed Care health plan for enrollment information.

Refer to: "Managed Care" on page 7-1 for more information.

37.2 Reimbursement

According to 1 TAC §355.8093, the Medicaid rate for PAs is 92 percent of the rate paid to a physician (doctor of medicine [MD] or doctor of osteopathy [DO]) for the same service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections. Services performed by a PA and billed under a physician's or RHC's provider identifier are reimbursed according to the Texas Medicaid Reimbursement Methodology (TMRM) for physician services.

Fee schedules are available on the TMHP website at www.tmhp.com/file library/file library/fee schedules. To request a hard copy, call the TMHP Contact Center at 1-800-925-9126.

Procedures billed by PAs are reviewed retrospectively for medical necessity. Independently enrolled PAs with a valid Medicare provider number are eligible to receive payment of deductible and coinsurance amounts as appropriate on Medicare crossover claims.

Refer to: "Provider Enrollment" on page 1-2 for more information.

"TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on how to obtain electronic fee schedules from the TMHP website.

37.3 Benefits and Limitations

Services performed by PAs are covered if the services meet the following criteria:

- Are within the scope of practice for PAs, as defined by Texas state law.
- Are consistent with rules and regulations promulgated by the Texas Medical Board or other appropriate state licensing authority.
- Are covered by the Texas Medicaid Program when provided by a licensed physician (MD or DO).
- Are reasonable and medically necessary as determined by HHSC or its designee.

Services provided to Medicaid clients must be documented in the client's medical record to include:

- Services provided.
- Date of service.
- Pertinent information about the client's condition supporting the need for service.
- The individual practitioner of the service.

PAs who are employed or remunerated by a physician, hospital, facility, or other provider must not bill the Texas Medicaid Program for their services if the billing results in duplicate payment for the same services.

Laboratory (including pregnancy tests) and radiology services provided during pregnancy must be billed separately from antepartum care visits and claims must be received within 95 days from the date of service.

Additional information about benefit limitation for services can be found in the Physician, THSteps, and Family Planning sections of this manual.

Note: *Payment to providers for supplies is not a benefit of the Texas Medicaid Program. Costs of supplies are included in the reimbursement for office visits.*

Refer to: "Family Planning Services" on page 20-1

"Physician" on page 36-1.

"Texas Health Steps (THSteps)" on page 43-1.

37.4 Claims Information

Claims for PA services must include modifier U7 on the claim details to indicate that the client was treated by a PA.

PA services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

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

Section 5, "Claims Filing" for general information about claims filing.

"CMS-1500 Claim Filing Instructions" on page 5-22 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

37.4.1 Claim Filing Resources

Refer to the following sections or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-22
Family Planning Claim Billing	20-4
Communication Guide	A-1
Family Planning Claim Form	D-13
Acronym Dictionary	F-1

Section

38

Psychologist

38.1 Enrollment

To enroll in the Texas Medicaid Program, whether as an individual or as part of a group, a psychologist must be licensed by the Texas State Board of Examiners of Psychologists. Psychologists must also be enrolled in Medicare or obtain a pediatric practice exemption from TMHP Provider Enrollment. If a pediatric-based psychologist is enrolling as part of a Medicare-enrolled group, then the psychologist must also be enrolled in Medicare.

Psychologists cannot be enrolled if they have a license that is due to expire within 30 days. A current license must be submitted. The Texas Medicaid Program accepts temporary licenses for psychologists.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

"Provider Enrollment" on page 43-5 for more information about enrollment in the THSteps Program.

38.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with Medicaid Managed Care to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

Psychologists who practice in the Dallas service area must be enrolled as a network provider in the NorthSTAR Behavioral Health Organization's (BHO) network to provide services to NorthSTAR enrollees.

NorthSTAR is a managed care program in the Dallas service area that covers behavioral health services. Providers must not bill TMHP for services rendered to NorthSTAR clients.

Refer to: "Managed Care" on page 7-1 for more information.

38.2 Reimbursement

The Medicaid rates for psychologists are calculated in accordance with 1 TAC §355.8081 and §355.8085.

A federally qualified health center (FQHC) is reimbursed for psychological services according to its specific Prospective Payment System (PPS) rate per visit calculated in accordance with 1 TAC §355.8261.

A freestanding psychiatric hospital/facility is reimbursed for psychological services in accordance with 1 TAC §355.8063.

Refer to: "Federally Qualified Health Center (FQHC)" on page 21-1 for more information.

"Psychiatric Hospital/Facility (Freestanding) (THSteps-CCP Only)" on page 43-83 for more information.

"Reimbursement Methodology" on page 2-2 for more information.

38.3 Benefits and Limitations

Psychologists licensed by the Texas State Board of Examiners of Psychologists and enrolled as Medicaid providers are authorized to perform counseling and testing for mental illness/debility. Treatment does *not* include the practice of medicine.

The services of a psychological associate (masters level psychologists), licensed chemical dependency counselor (LCDC), social worker, psychiatric nurse, or mental health worker are not covered by the Texas Medicaid Program and cannot be billed under a psychologist's provider identifier.

Psychologists must not bill for services performed by people under their supervision. For mental health services, only the licensed psychologist and Medicaid-enrolled provider actually performing the service may bill the Texas Medicaid Program. Services provided by a licensed clinical social worker (LCSW), licensed professional counselor (LPC), or licensed marriage and family therapist (LMFT) are reimbursable directly to the LCSW, LPC, or LMFT.

Each individual practitioner is limited to performing a combined total of 12 hours of behavioral health services per day. The claims processing system enforces the 12-hour system limitation for the following providers: advanced practice nurse (APN), PA, LMFT, LCSW, psychologist, and LPC. Since physicians (doctor of medicine [MD] and doctors of osteopathy [DO]) can delegate and may possibly submit claims in excess of 12 hours in a given day, the claims system does not limit these providers to 12 hours per day. However, physicians (MD and DO) and those to whom they delegate are still subject to the 12-hour limitation. Additionally, providers who perform group therapy may possibly submit claims in excess of 12 hours in a given day due to the manner in which group therapy is billed. Retrospective review may occur for both the total hours of services performed per day and the total hours of services billed per day. If inappropriate payments are identified, the reimbursement is recouped.

In addition, all behavioral health procedure codes, whether or not they are currently included in the 12-hour system limitation, are subject to retrospective review and possible recoupment for all providers who deliver health services.

Note: *Documentation requirements for all services billed are listed for each individual specialty in this manual.*

The claims subject to the 12-hour provider limit are based on the provider identifier number submitted on the claim. The location where the services occur is not a basis for exclusion of hours. If a provider practices at multiple locations and has a different suffix for the various locations, but has the same provider identifier, all services identified for restriction to the provider's 12-hour limit are counted regardless of whether they were performed at different locations.

Court-ordered behavioral health-billed services submitted with modifier H9 are excluded from the 12-hour limitation.

Claims submitted with a prior authorization number are not exempt from the 12-hour limitation.

The following table lists the behavioral health procedure codes included in the system limitation and shows the type of service/procedure code combinations, along with the time increments the system applies based on the billed procedure code.

The time increments applied are used to calculate the 12-hour per day limitation.

Procedure Codes Included in the 12-hour System Limitation		
Procedure Code	**Time Assigned by Procedure Code Description**	**Time Applied**
1-90801	Not applicable	60 minutes
1-90802	Not applicable	60 minutes
1-90804	20-30 minutes	30 minutes
1-90805	20-30 minutes	30 minutes
1-90806	45-50 minutes	50 minutes
1-90807	45-50 minutes	50 minutes
1-90808	70-80 minutes	80 minutes
1-90809	70-80 minutes	80 minutes
1-90810	20-30 minutes	30 minutes
1-90811	20-30 minutes	30 minutes
1-90812	45-50 minutes	50 minutes
1-90813	45-50 minutes	50 minutes
1-90814	70-80 minutes	80 minutes
1-90815	70-80 minutes	80 minutes
1-90816	20-30 minutes	30 minutes
1-90817	20-30 minutes	30 minutes
1-90818	45-50 minutes	50 minutes
1-90819	45-50 minutes	50 minutes
1-90821	70-80 minutes	80 minutes
1-90822	70-80 minutes	80 minutes
1-90823	20-30 minutes	30 minutes
1-90824	20-30 minutes	30 minutes
1-90826	45-50 minutes	50 minutes
1-90827	45-50 minutes	50 minutes
1-90828	70-80 minutes	80 minutes
1-90829	70-80 minutes	80 minutes
1-90847	Not applicable	50 minutes
5-96101	60 minutes	60 minutes

Procedure Codes Included in the 12-hour System Limitation		
1-96118	60 minutes	60 minutes

If a cutback occurs for procedure codes included in the system limitation, the quantity allowed per service session designated is rounded up to one decimal point or rounded down to one decimal point following standard rounding procedures (as shown in the following example):

Total Time	Rounded Time
11.71 hours 11.72 hours 11.73 hours 11.74 hours	11.7 hours
11.75 hours 11.76 hours 11.77 hours 11.78 hours 11.79 hours	11.8 hours

Formula Applied

For client L on the table below, 80 billed minutes are applied, but the provider only has 40 available minutes before reaching the 12-hour daily limit (720 minutes); therefore, only 40 minutes are considered for reimbursement. The 40 allowed minutes are divided into the 80 applied minutes to get an allowed unit of .5 for payment.

TPI Base	TPI Suffix	Client	Code Billed	Amount Applied*	Total Time Paid	Qty.
1234567	01	A	90807	50	50	1
1234567	02	B	90828	80	80	1
1234567	01	C	90807	50	50	1
1234567	03	D	90828	80	80	1
1234567	01	E	90807	50	50	1
1234567	01	F	90828	80	80	1
1234567	02	G	90807	80	80	1
1234567	01	H	90827	50	50	1
1234567	01	J	90828	80	80	1
1234567	02	K	90828	80	80	1
Final claim for the day			Subtotal	680 minutes		
1234567	**01**	**L**	**90828**	**80**	**40**	**.5**
			Total	760 billed mins. for one day	720 paid mins. for one day	

*** Time applied toward the 12-hour limit.**

Reminder: *The procedure codes listed above have time ranges built in so the quantity billed should be reflected in quantities of one versus the actual amount of time spent with the client, i.e., procedure code 90804 is for 20 to 30 minutes of time spent with the client. The provider would bill a quantity of one when submitting a claim.*

If a claim is adjusted and causes additional minutes to be available to the provider for that day, the system does not automatically reprocess any previously denied or cutback claims that would now be payable. It is up to the provider to request reprocessing of the denied or cutback claims.

Claims submitted for psychological evaluation or testing performed by a qualified provider at the request of the Department of Family and Protective Services (DFPS), or by a court order, are not counted against the benefit limitations. These claims must be submitted with the following information:

- The provider must submit the claim using modifier H9 with the procedure code(s) billed.

- If psychological services are court-ordered, the claim must include a copy of the court order for outpatient treatment signed by the judge, and documentation of medical necessity.
- If psychological services are directed by DFPS, the claim must include the name and telephone number of the DFPS employee who provided the direction, the reason for the DFPS request, and documentation of medical necessity.

Outpatient behavioral health services are limited to 30 encounters/visits per client, per calendar year (January 1 through December 31) regardless of provider, unless prior authorized. This limitation includes encounters/visits by all practitioners. School Health and Related Services (SHARS) behavioral rehabilitation services, MHMR services, laboratory, radiology, and medication monitoring services are not counted toward the 30-encounter/visit limitation. An encounter/visit is defined as each hour of therapy, psychological, and/or neuropsychological testing rendered per hour, per provider. Each Medicaid client is limited to 30 encounters/visits per calendar year.

It is anticipated that this limitation, which allows for six months of weekly therapy or 12 months of biweekly therapy, is adequate for 75 to 80 percent of clients. Clinicians should plan therapy with this limit in mind. However, it may be medically necessary for some clients to receive extended encounters/visits. In these situations, prior authorization is required. *A provider who sees a client regularly and anticipates that the client will require encounters/visits beyond the 30-encounter/visit limit must submit the request for prior authorization before the client's 25th encounter/visit.*

It is recognized that a client may change providers in the middle of the year, and the new provider may not be able to obtain complete information on the client. In these instances, prior authorization may be made before rendering services when the request is accompanied by an explanation as to why the provider was unable to submit the prior authorization request by the client's 25th encounter/visit.

All authorization requests for extension of outpatient psychotherapy sessions beyond the annual 30-encounter/visit limitation are limited to 10 encounters/visits per request and must be submitted on the Extended Outpatient Psychotherapy/Counseling Request Form. Requests must include the following:

- Client name and Medicaid number.
- Provider name and provider identifier.
- Clinical update, including current specific symptoms and response to past treatment, and treatment plan (measurable short term goals for the extension, specific therapeutic interventions to be used in therapy, measurable expected outcomes of therapy, length of treatment anticipated, and planned frequency of encounters/visits).
- Number and type of services requested and the dates (based on the frequency of encounters/visits) that the services will be provided.
- All areas of the request must be completed with the information required on the form. If additional room is needed providers may state "see attached." The attachment must contain the specific information required in that section of the form.

Prior authorization is not granted to providers who have seen a client for an extended period of time or from the start of the calendar year and who have not requested prior authorization before the 25th encounter/visit. It is recommended that a request for extension of outpatient behavioral health be submitted no sooner than 30 days before the date of service being requested, so that the most current information is provided.

The number of encounters/visits authorized is dependent on the client's symptoms and response to past treatment. If the client requires additional extensions, the provider must submit a new request for prior authorization at the end of each extension period. *The request for additional encounters/visits must include new documentation addressing the client's current condition, treatment plan, and the therapist's rationale supporting the medical necessity for these additional encounters/visits.* Prior authorization for an extension of outpatient behavioral health services is granted when the treatments are mandated by the courts as court-ordered services. A copy of the court order for outpatient treatment signed by the judge must accompany prior authorization requests.

Mail or fax the request to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

Providers can submit requests for extended outpatient psychotherapy/counseling through the TMHP website.

Refer to: "Prior Authorization Requests Through the TMHP Website" on page 5-4 for additional information, including mandatory documentation requirements and retention.

The Texas Medicaid Program does not cover treatment for chronic diagnoses such as mental retardation and organic brain syndrome.

Psychiatric daycare is not a covered service.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement methodologies.

"Managed Care" on page 7-1.

"Request for Extended Outpatient Psychotherapy/Counseling Form" on page B-83.

"Licensed Clinical Social Worker (LCSW)" on page 28-1.

"Licensed Professional Counselor (LPC)" on page 30-1.

"Licensed Marriage and Family Therapist (LMFT)" on page 29-1 for more information.

38.3.1 Psychological and Neuropsychological Testing

Procedure codes 5-96101 and 1-96118 are covered services for the following diagnoses only:

Diagnosis Codes				
0360	0361	03681	04503	04510
04523	04593	0460	0461	0462
0463	0468	0469	0470	0471
0478	0479	048	0490	0491
0498	0499	05821	05829	2900
29010	29011	29012	29013	29020
29021	2903	29040	29041	29042
29043	2908	2909	2911	2912
2915	29189	2919	2920	29211*
29212*	2922	29281	2929	2930
2931	29381	29382	29383*	29384
29389	2939	2940	29410	29411
2948	2949	29500	29501	29502
29503	29504	29505	29510	29511
29512	29513	29514	29515	29520
29521	29522	29523	29524	29525
29530	29531	29532	29533	29534
29535	29540	29541	29542	29543
29544	29545	29550	29551	29552
29553	29554	29555	29560	29561
29562	29563	29564	29565	29570
29571	29572	29573	29574	29575
29580	29581	29582	29583	29584
29585	29590	29591	29592	29593
29594	29595	29600	29601	29602
29603	29604	29605	29606	29610
29611	29612	29613	29614	29615
29616	29620	29621	29622	29623
29624	29625	29626	29630	29631
29632	29633	29634	29635	29636
29640	29641	29642	29643	29644
29645	29646	29650	29651	29652
29653	29654	29655	29656	29660
29661	29662	29663	29664	29665
29666	2967	29680	29681	29682
29689	29690	29699	2970	2971
2972	2973	2978	2979	2980
2981	2982	2983	2984	2988
2989	29900	29901	29910	29911
29980	29981	29990	29991	30000
30001	30002	30009	30010	30011
30012	30013	30014	30015	30016
30019	30020	30021	30022	30023
30029	3003	3004	3006	3007
30081	30082	30089	3009	3010
30110	30113	30120	30122	3013
3014	30150	30151	30159	3016
3017	30181	30182	30183	30184
30189	3019	3020	3021	3022
3023	3024	30250	30251	30252
30253	3026	30270	30271	30272
30273	30274	30275	30276	30279
30281	30282	30283	30284	30285
30289	3029	30390	30400	30500
30501	30502	30503	30520	30521
30522	30523	30530	30531	30532
30533	30540	30541	30542	30543
30550	30551	30552	30553	30560
30561	30562	30563	30570	30571
30572	30573	30580	30581	30582
30583	30591	30592	30593	3080
3081	3082	3083	3084	3089
3090	3091	30921	30922	30923
30924	30928	30929	3093	3094
30981	30982	30983	30989	3099
3100	3101	3102	3108	311
31200	31201	31202	31203	31210
31211	31212	31213	31220	31221
31222	31223	31230	31231	31232
31233	31234	31235	31239	3124
31281	31282	31289	3129	3130
3131	31321	31322	31323	3133
31381	31382	31383	31389	3139
31400	31401	3141	3142	3148
3149	31531	31532	31534	3154
3155	3158	3159	317	3180
3181	3182	319	3200	3201
3202	3203	3207	32081	32082
32089	3209	3210	3211	3212
3213	3214	3218	3220	3221
3222	3229	32301	32302	3231
3232	32341	32342	32351	32352
32361	32362	32363	32371	32372

***Only payable for procedure code 1-96118**

Diagnosis Codes				
32381	32382	3239	3240	3241
3249	3300	3301	3302	3303
3308	3309	3310	33111	33119
3312	3313	3314	3315	3317
33181	33182	3319	33392	340
34500	34501	34510	34511	3452
3453	34540	34541	34550	34551
34560	34561	34570	34571	34580
34581	34590	34591	3480	3481
34830	34831	34839	38845	430
431	4320	4321	4329	43300
43301	43311	43320	43321	43330
43331	43380	43381	43390	43391
43400	43401	43410	43411	43490
43491	4350	4351	4352	4353
4358	4359	436	4370	4371
4372	4373	4374	4375	4376
4377	4378	4379	4380	43810
43811	43812	43819	43820	43821
43822	43830	43831	43832	43840
43841	43842	43850	43851	43852
43853	4386	4387	43881	43882
43883	43884	43885	43889	4389
7685	7686	77210	77211	77212
77213	77214	7722	7790	78031
78032	78039	79901	79902	8500
85011	85012	8502	8503	8504
8505	8509	85100	85101	85102
85103	85104	85105	85106	85109
85110	85111	85112	85113	85114
85115	85116	85119	85120	85121
85122	85123	85124	85125	85126
85129	85130	85131	85132	85133
85134	85135	85136	85139	85140
85141	85142	85143	85144	85145
85146	85149	85150	85151	85152
85153	85154	85155	85156	85159
85160	85161	85162	85163	85164
85165	85166	85169	85170	85171
85172	85173	85174	85175	85176
85179	85180	85181	85182	85183
85184	85185	85186	85189	85190
85191	85192	85193	85194	85195
***Only payable for procedure code 1-96118**				

Diagnosis Codes				
85196	85199	85200	85201	85202
85203	85204	85205	85206	85209
85210	85211	85212	85213	85214
85215	85216	85219	85220	85221
85222	85223	85224	85225	85226
85229	85230	85231	85232	85233
85234	85235	85236	85239	85240
85241	85242	85243	85244	85245
85246	85249	85250	85251	85252
85253	85254	85255	85256	85259
85300	85301	85302	85303	85304
85305	85306	85309	85310	85311
85312	85313	85314	85315	85316
85319	85400	85401	85402	85403
85404	85405	85406	85409	986
9941	9947	V110	V111	V112
V113	V170	V401	V402	V6282
V6283	V6284	V695	V7101	V7102
V790	V791	V792	V793	V798
***Only payable for procedure code 1-96118**				

Psychological testing (procedure code 5-96101) and neuropsychological testing (procedure code 1-96118) are limited to a total of four hours per day and eight hours per calendar year per client for any provider. Providers must maintain documentation in the client's chart that supports the medical necessity for each test.

If the client requires more than four hours of psychological or neuropsychological testing per day or more than eight hours per calendar year, prior authorization is required. Documentation must be submitted that supports the medical necessity for the additional hours requested. This includes a record of all of the tests that were previously performed and a complete history that reflects the need for each requested test.

Each hour of examination, therapy, psychological, and/or neuropsychological testing counts toward the 12-hours-per-day limitation and as one visit/encounter towards the 30 visit/encounter limit.

Procedure codes 5-96101 and 1-96118 include the testing, interpretation, and report and are not reimbursed separately. Providers must bill the preponderance of each quarter hour of testing and indicate that number of units on the claim form. Document the number of hours in Block 24G of the CMS-1500 claim form.

Procedure code 1-96118 is denied when billed on the same day as procedure code 5-96101 by any provider.

Procedure code 5-96101 or 1-96118 is payable on the same day as procedure code 1-90801 or 1-90802.

The following is a list of psychiatric-related procedure codes:

Procedure Codes		
1-90801	1-90802	1-90804
1-90805	1-90806	1-90807
1-90808	1-90809	1-90810
1-90811	1-90812	1-90813
1-90814	1-90815	1-90816
1-90816	1-90817	1-90818
1-90819	1-90821	1-90822
1-90823	1-90824	1-90826
1-90827	1-90828	1-90829
1-90845	1-90847	1-90853
1-90857	1-90862	1-90865
1-90870	1-90899	5-96101

38.3.2 Outpatient Behavioral Health Services

38.3.2.1 Psychiatric Diagnostic Interviews

Psychiatric diagnostic interview examination (1-90801) and interactive psychiatric diagnostic interview examination (1-90802) are limited to once per day per client, any provider, regardless of the number of professionals involved in the interview, and once per year per provider (same provider) in any setting.

An interactive interview (procedure code 1-90802) may be covered to the extent it is medically necessary. Examples of medical necessity include, but are not limited to clients whose ability to communicate is impaired by an expressive or receptive language impairment from various causes, such as conductive or sensorineural hearing loss, deaf mutism, or aphasia.

A diagnostic interview may be incorporated into an evaluation and management (E/M) service provided the required elements of the E/M service are fulfilled.

A diagnostic interview examination (procedure codes 1-90801, 1-90802) is denied as part of any E/M service when billed for the same date of service by the same provider.

Documentation for diagnostic interview examinations must include:

- Reason for referral/presenting problem.
- Prior history, including prior treatment.
- Other pertinent medical, social, and family history.
- Clinical observations and mental status examinations.
- Complete *Diagnostic and Statistical Manual of Mental Disorders* - Fourth Edition, Text Revision (DSM-IV-TR) diagnosis.
- Recommendations, including expected long term and short term benefits.
- For the interactive diagnostic interview (procedure code 1-90802), the medical record must indicate the adaptations utilized in the session and the rationale for employing these interactive techniques.

38.3.3 Therapy

When multiple counseling codes are billed by the same provider on the same day, only the most inclusive code is paid.

If procedure code 1-90802 and 1-90801 are billed on the same day by the same provider, 1-90802 is denied as part of another procedure billed on the same day. Procedure codes 1-90801 and 1-90802 are limited to once per day per client by any provider, regardless of the number of professionals involved in the interview, and once per year per provider (same provider) in any setting.

If procedure code 1-90801 or 1-90802 is billed, the following procedure codes are denied as part of the initial psychiatric exam if billed on the same day by the same provider:

Procedure Codes		
1-90804	1-90806	1 90808
1-90810	1-90812	1-90814
1-90816	1 90818	1-90821
1-90823	1-90826	1-90828
1-90845	1-90847	1 90853
1-90857		

Procedure codes 1-90846 and 1-90849 are *not* reimbursed by the Texas Medicaid Program. Outpatient psychotherapy (procedure codes 1-90804, 1-90847, 1-90853, and 1-90857) billed on the same date of service as narcosynthesis (procedure code 1-90865) or psychoanalysis (procedure code 1-90845) is denied.

When billing or providing procedure code 1-90847, note the following requirements for Medicaid reimbursement:

- The client must be present when family therapy/counseling services are provided.
- Family therapy/counseling is only reimbursable for one family member per session.

Counseling performed by a licensed psychologist must be billed using the following procedure codes:

Procedure Codes		
1-90801	1-90802	1-90804
1 90806	1 90808	1-90810
1-90812	1-90814	1-90847
1-90853	1-90857	

Psychoanalysis must be billed using procedure code 1-90845.

Counseling is denied if any of the procedure codes in the table below are billed on the same day as procedure code 1-90845.

Procedure Codes		
1 90804	1-90806	1-90808
1-90810	1-90812	1 90814
1-90816	1-90818	1-90821
1-90823	1 90826	1-90828
1-90847	1-90853	1-90857

When individual, group, or family counseling is billed by any provider on the same day, each type of session is paid. When multiples of each type of session are billed, the most inclusive is paid and the others are denied.

When billing for contracted therapy services provided to Medicaid clients who are younger than 21 years of age and reside in a residential treatment facility, use place of service (POS) 9 (other location).

According to the definition of "family" provided by HHSC Household Determination Guidelines, only specific relatives are allowed to participate in family counseling services. These guidelines also address the roles of relatives in supervision and care of Temporary Assistance for Needy Families. The following specific relatives are included in family counseling services:

- Father or mother.
- Grandfather or grandmother.
- Brother or sister.
- Uncle, aunt, nephew, or niece.
- First cousin or first cousin once removed.
- Stepfather, stepmother, stepbrother, or stepsister.

The following psychiatric services are not covered by the Texas Medicaid Program (except where specifically indicated in other sections):

- Services provided by an LCDC, psychiatric nurse, mental health worker, or psychologist assistant.
- Thermogenic therapy, recreational therapy, psychiatric daycare, and biofeedback, music or dance therapy.
- Hypnosis.
- Adult activity and individual activity (these types of services would be payable only if guidelines of group therapy are met and are termed group therapy).

Procedure codes 1-90846 and 1-90849 are not benefits of the Texas Medicaid Program for any provider.

38.4 Documentation Requirements

Services not supported by required documentation in the client's record and medical necessity are subject to recoupment.

Each client for whom services are billed must have the following documentation (which meets the standards indicated) included in their record:

- All entries are clearly documented and legible to individuals other than the author, date (month/day/year), and signed by the performing provider.
- Notations of the beginning and ending session times for counseling and/or each test administered.
- All pertinent information regarding the client's condition to substantiate the need for services, including but not limited to the following:
  - Name of test(s) (e.g., Wechsler Adult Intelligence Scale–Revised [WAIS-R], Rorschach, Minnesota Multiphasic Personality Inventory [MMPI]).
  - Background and history of client and reason for testing.
  - Behavioral observations during the session.
  - Narrative description of the counseling session or test findings.
  - Diagnosis (symptoms, impressions).
  - Treatment plan and recommendations.
  - Explanation to substantiate the necessity of retesting, if applicable.

38.5 Claims Information

Services provided by an independently practicing licensed psychologist must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"CMS-1500 Claim Filing Instructions" on page 5-22. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Providers must bill Medicare before Medicaid. Medicaid's responsibility for the coinsurance and/or deductible is determined in accordance with Medicaid benefits and limitations. Providers must check the client's Medicare card for Part B coverage before billing the Texas Medicaid Program. When Medicare is primary, it is inappropriate to bill Medicaid without first billing Medicare. The Texas Medicaid Program is responsible for the coinsurance and deductible of Medicare-allowed services on a crossover basis only.

Refer to: "Part B" on page 2-7.

"Medicare Part B Crossovers" on page 4-13.

38.5.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-22
TMHP Electronic Claims Submission	5-13
Communication Guide	A-1
Psychiatric Hospital Inpatient Admission Form	B-76
Request for Extended Outpatient Psychotherapy/Counseling Form	B-83
Psychologist Claim Example	D-28
Acronym Dictionary	F-1

Section

39

Radiological and Physiological Laboratory and Portable X-Ray Supplier

39.1 Enrollment

To enroll in the Texas Medicaid Program, radiological and physiological laboratories and portable X-ray suppliers must be enrolled in Medicare. Both radiological and physiological laboratories must be directed by a physician.

All mammography providers, including those providing stereotactic biopsies, must be certified by the Bureau of Radiation Control (BRC). Providers must submit a certificate containing their BRC certification number, dates of issue and expiration, type of service, and Medicaid and Children with Special Health Care Needs (CSHCN) Services Program provider identifiers. For more information, contact TMHP Provider Enrollment:

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

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

39.1.1 Medicaid Managed Care Enrollment

Radiological, physiological laboratory, and portable X-ray suppliers may be eligible to enroll in the Medicaid Managed Care programs as primary care providers. Certain providers may be required to enroll with a Medicaid Managed Care health plan to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

Refer to: "Managed Care" on page 7-1.

39.2 Reimbursement

The Medicaid rates for radiological and physiological laboratory and portable X-ray supplier providers are calculated in accordance with 1 TAC §355.8081 and §355.8085. The applicable Medicaid rates are listed in the current physician fee schedule, which is available on the TMHP website at www.tmhp.com/file library /file library/fee schedules. These services are *not* payable when the client is in an inpatient setting, as they are included in the diagnosis related group (DRG) payment.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

39.3 Benefits and Limitations

Medicaid pays only up to the amount allowed for the total component for the same procedure, same client, same date of service, and any provider. Providers who perform the technical service and interpretation must bill for the total component. Providers who perform only the technical service must bill for the technical component; those who perform only the interpretation must bill for the interpretation component. Claims filed in excess of the amount allowed for the total component for the same procedure, same dates of service, same client, and any provider are denied. Claims are paid based on the order in which they are received.

For example, if a claim is received for the total component and TMHP has already made payment for the technical and/or interpretation component for the same procedure, same date of service, same client, and any provider, the claim for the total component will be denied as previously paid to another provider. The same is true if a total component has already been paid and claims are received for the individual components.

The following procedure codes are payable to radiological laboratories, physiological laboratories, and portable X-ray suppliers.

Descriptions of the following procedure codes can be found in the *Physician's Common Procedural Terminology* (CPT) Manual:

Procedure Codes		
4/I/T-70030	4/I/T-70100	4/I/T-70110
4/I/T-70120	4/I/T-70130	4/I/T-70134
4/I/T-70140	4/I/T-70150	4/I/T-70160
4/I/T-70170	4/I/T-70190	4/I/T-70200
4/I/T-70210	4/I/T-70220	4/I/T-70240
4/I/T-70332	4/I/T-70336	4/I/T-70350
4/I/T-70355	4/I/T-70360	4/I/T-70370
4/I-70371	4/I/T-70373	4/I/T-70380
4/I/T-70390	4/I/T-70450	4/I/T-70480
4/I/T-70486	4/I/T-70490	4/I/T-70496
4/I/T-70498	4/I/T-70540	4/I/T-70542
4/I/T-70543	4/I/T-70544	4/I/T-70545
4/I/T-70546	4/I/T-70547	4/I/T-70548
4/I/T-70549	4/I/T-70551	4/I/T-70552
4/I/T-70553	4/I/T-71010	4/I/T-71015
4/I/T-71020	4/I/T-71021	4/I/T-71022

Procedure Codes		
4/I/T-71023	4/I/T-71030	4/I/T-71034
4/I/T-71035	4/I/T-71100	4/I/T-71101
4/I/T-71110	4/I/T-71111	4/I/T-71120
4/I/T-71130	4/I/T-71250	4/I/T-71275
4/I/T-71550	4/I/T-71551	4/I/T-71552
4/I/T-72010	4/I/T-72020	4/I/T-72040
4/I/T-72050	4/I/T-72052	4/I/T-72069
4/I/T-72070	4/I/T-72072	4/I/T-72074
4/I/T-72080	4/I/T-72090	4/I/T-72100
4/I/T-72110	4/I/T-72114	4/I/T-72120
4/I/T-72125	4/I/T-72128	4/I/T-72131
4/I/T-72141	4/I/T-72146	4/I/T-72148
4/I/T-72156	4/I/T-72157	4/I/T-72158
4/I/T-72170	4/I/T-72190	4/I/T-72191
4/I/T-72192	4/I/T-72195	4/I/T-72196
4/I/T-72197	4/I/T-72198	4/I/T-72200
4/I/T-72202	4/I/T-72220	I-72291
I-72292	4/I/T-73000	4/I/T-73010
4/I/T-73020	4/I/T-73030	4/I/T-73050
4/I/T-73060	4/I/T-73070	4/I/T-73080
4/I/T-73090	4/I/T-73092	4/I/T-73100
4/I/T-73110	4/I/T-73120	4/I/T-73130
4/I/T-73140	4/I/T-73200	4/I/T-73206
4/I/T-73218	4/I/T-73219	4/I/T-73220
4/I/T-73221	4/I/T-73222	4/I/T-73223
4/I/T-73225	4/I/T-73500	4/I/T-73510
4/I/T-73520	4/I/T-73530	4/I/T-73540
4/I/T-73542	4/I/T-73550	4/I/T-73560
4/I/T-73562	4/I/T-73564	4/I/T-73565
4/I/T-73590	4/I/T-73592	4/I/T-73600
4/I/T-73610	4/I/T-73620	4/I/T-73630
4/I/T-73650	4/I/T-73660	4/I/T-73700
4/I/T-73706	4/I/T-73718	4/I/T-73719
4/I/T-73720	4/I/T-73721	4/I/T-73722
4/I/T-73723	4/I/T-73725	4/I/T-74000
4/I/T-74010	4/I/T-74020	4/I/T-74022
4/I/T-74150	4/I/T-74175	4/I/T-74181
4/I/T-74182	4/I/T-74183	4/I/T-74185
4/I/T-74190	4/I/T-74210	4/I/T-74220
4/I/T-74230	4/I/T-74240	4/I/T-74241
4/I/T-74245	4/I/T-74250	4/I/T-75635
4-75952	4/I/T-75989	4/I/T-76010
4/I/T-76100	4/I/T-76101	4/I/T-76102
4/I/T-76350	4/I/T-76376	4/I/T-76377

Procedure Codes		
4/I/T-76380	4/I/T-76390	4/I/T-76496
4/I/T-76497	4/I/T-76498	4/I/T-76499
4/I/T-76506	4/I/T-76510	4/I/T-76511
4/I/T-76512	4/I/T-76513	4/I/T-76516
4/I/T-76519	4/I/T-76529	4/I/T-76536
4/I/T-76604	4/I/T-76645	4/I/T-76700
4/I/T-76705	4/I/T-76770	4/I/T-76775
4/I/T-76776	4/I/T-76800	4/I/T-76801
4/I/T-76802	4/I/T-76805	4/I/T-76810
4/I/T-76811	4/I/T-76812	4/I/T-76813
4/I/T-76814	4/I/T-76815	4/I/T-76816
4/I/T-76817	4/I/T-76818	4/I/T-76819
4/I/T-76820	4/I/T-76821	4/I/T-76825
4/I/T-76826	4/I/T-76827	4/I/T-76828
4/I/T-76830	4/I/T-76831	4/I/T-76856
4/I/T-76857	4/I/T-76870	4/I/T-76872
4/I/T-76873	4/I/T-76880	4/I/T-76940
4/I/T-76950	4/I/T-76965	4/I/T-76970
4/I/T-76975	4/I/T-76977	4/T-76991
4/I/T-76999	4/I/T-77011	4/I/T-77012
4/I/T-77021	4/I/T-77022	4/I/T-77072
4/I/T-77073	4/I/T-77074	4/I/T-77075
4/I/T-77076	4/I/T-77077	4/I/T-77084
4/I/T-78070	4/I/T-78199	4/I/T-78299
4/I/T-78350	4/I/T-78473	4/I/T-78478
4/I/T-78480	4/I/T-78483	4/I/T-78499
4/I/T-78599	4/I/T-78999	5/I-91065
1/I/T-92135	1-92285	1/I/T-92542
1/I/T-92543	1/I/T-92544	1/I/T-92545
1/I/T-92546	5/I-92553	5/I-92555
5/I-92556	5/I-92557	5/I-92561
I-92562	5/I-92563	I-92564
5/I-92565	5/I-92568	5/I-92569
5/I-92571	5/I-92572	5/I-92575
5/I-92577	5/I-92584	5-92586
T-93005	5-93012	5-93015
T-93017	I-93018	5-93040
T-93041	5-93224	T-93225
T-93226	5-93230	T-93231
T-93232	5-93235	T-93236
5-93268	5-93270	5-93271
5/I/T-93278	4/I/T-93307	4/I/T-93308
4/I/T-93312	4-93313	4/I/T-93314
4/I/T-93315	4-93316	4/I/T-93317

Procedure Codes		
4/I/T-93318	4/I/T-93320	4/I/T-93321
4/I/T-93325	4/I/T-93350	5-93720
T-93721	5/I/T-93724	5/I/T-93731
5/I/T-93732	5/I/T-93733	5/I/T-93734
5/I/T-93735	5/I/T-93736	5/I/T-93799
4/I/T-93875	4/I/T-93880	4/I/T-93882
4/I/T-93886	4/I/T-93888	4/I/T-93890
4/I/T-93892	4/I/T-93893	4/I/T-93922
4/I/T-93923	4/I/T-93924	4/I/T-93925
4/I/T-93926	4/I/T-93930	4/I/T-93931
4/I/T-93965	4/I/T-93970	4/I/T-93971
4/I/T-93975	4/I/T-93976	4/I/T-93978
4/I/T-93979	4/I/T-93980	4/I/T-93981
5/I/T-94010	5-94014	5-94015
5-94016	5/I/T-94060	5/I/T-94070
5/I/T-94150	5/I/T-94200	5/I/T-94240
5/I/T-94250	5/I/T-94260	5/I/T-94350
5/I/T-94360	5/I/T-94370	5/I/T-94375
5/I/T-94400	5/I/T-94450	5/I/T-94620
5/I/T-94621	5/I/T-94680	5/I/T-94681
5/I/T-94690	5/I/T-94720	5/I/T-94725
5/I/T-94750	5/I/T-94772	5/I/T-94799
5/I/T-95805	5/I/T-95808	5/I/T-95810
5/I/T-95811	5/I/T-95812	5/I/T-95813
5/I/T-95816	5/I/T-95819	5/I/T-95822
5/I/T-95824	5/I/T-95827	5/I/T-95860
5/I/T-95861	5/I/T-95863	5/I/T-95864
5/I/T-95865	5/I/T-95866	5/I/T-95867
5/I/T-95868	5/I/T-95870	5/I/T-95872
5/I/T-95900	5/I/T-95903	5/I/T-95904
5/I/T-95925	5/I/T-95926	5/I/T-95927
5/I/T-95933	5/I/T-95934	5/I/T-95936
5/I/T-95937	5/I/T-95950	5/I/T-95951
5/I/T-95953	5/I/T-95956	5/I/T-95958

39.3.1 Computed Tomography (CT) and Magnetic Resonance Imaging (MRI)

CT imaging, computed tomography angiography (CTA), MRI, and magnetic resonance angiography (MRA) services are benefits of the Texas Medicaid Program.

CT combines the use of a digital computer and a rotating X-ray device to create detailed cross-sectional images or "slices" of organs and body parts, such as the lungs, liver, kidneys, pancreas, pelvis, extremities, brain, spine, and blood vessels. CT provides a detailed image of bony structures. CTA is used to visualize blood flow in arterial and venous vessels.

Note: *Providers and facilities are required to use the lowest possible radiation dose consistent with acceptable image quality for CT examinations of children. It is recommended that providers and facilities utilize national standards for CT imaging, such as the American College of Radiology's, "Practice Guidelines for Performing and Interpreting Diagnostic CT Examinations."*

MRI uses magnetic energy and radio waves to create cross-sectional images or "slices" of the human body. MRI is an effective diagnostic tool for detecting defects, diseases, and trauma. It is used to image many types of soft-tissue, including, but not limited to, the central nervous system, internal organs, and the musculoskeletal system. MRA is an MRI study of the arterial and venous blood vessels. MRA utilizes MRI technology and is used as an effective diagnostic tool to detect, diagnose, and aid the treatment of heart disorders, stroke, and blood vessel diseases.

Note: *Additional or alternate studies identified and ordered by the radiologist at the time of a prior authorized study meet the definition of an urgent condition.*

Authorization is not required for emergency department or inpatient hospital radiology services. Prior authorization is required for outpatient non-emergent CT, CTA, MRI, and MRA studies (i.e., those that are preplanned or scheduled) before rendering the service.

The following procedure codes require authorization:

Procedure Codes		
B-350	B-351	B-352
B-359	B-610	B-611
B-612	B-619	4/I/T-70336
4/I/T-70450	4/I/T-70460	4/I/T-70470
4/I/T-70480	4/I/T-70481	4/I/T-70482
4/I/T-70486	4/I/T-70487	4/I/T-70488
4/I/T-70490	4/I/T-70491	4/I/T-70492
4/I/T-70496	4/I/T-70498	4/I/T-70540
4/I/T-70542	4/I/T-70543	4/I/T-70544
4/I/T-70545	4/I/T-70546	4/I/T-70547
4/I/T-70548	4/I/T-70549	4/I/T-70551
4/I/T-70552	4/I/T-70553	4/I/T-70554
4/I/T-70555	4/I/T-71250	4/I/T-71260
4/I/T-71270	4/I/T-71275	4/I/T-71550
4/I/T-71551	4/I/T-71552	4/I/T-71555
4/I/T-72125	4/I/T-72126	4/I/T-72127
4/I/T-72128	4/I/T-72129	4/I/T-72130
4/I/T-72131	4/I/T-72132	4/I/T-72133
4/I/T-72141	4/I/T-72142	4/I/T-72146
4/I/T-72147	4/I/T-72148	4/I/T-72149
4/I/T-72156	4/I/T-72157	4/I/T-72158

Procedure Codes		
4/I/T-72159	4/I/T-72191	4/I/T-72192
4/I/T-72193	4/I/T-72194	4/I/T-72195
4/I/T-72196	4/I/T-72197	4/I/T-72198
4/I/T-73200	4/I/T-73201	4/I/T-73202
4/I/T-73206	4/I/T-73218	4/I/T-73219
4/I/T-73220	4/I/T-73221	4/I/T-73222
4/I/T-73223	4/I/T-73225	4/I/T-73700
4/I/T-73701	4/I/T-73702	4/I/T-73706
4/I/T-73718	4/I/T-73719	4/I/T-73720
4/I/T-73721	4/I/T-73722	4/I/T-73723
4/I/T-73725	4/I/T-74150	4/I/T-74160
4/I/T-74170	4/I/T-74175	4/I/T-74181
4/I/T-74182	4/I/T-74183	4/I/T-74185
4/I/T-75552	4/I/T-75553	4/I/T-75554
4/I/T-75555	4/I/T-75556	4/I/T-75635
4/I/T-76376	4/I/T-76377	4/I/T-76380
4/I/T-76390	4/I/T-76813	4/I/T-76814
4/I/T-77011	4/I/T-77058	4/I/T-77059
4/I/T-77084		

A request for retrospective authorization must be submitted no later than seven calendar days beginning the day after the study is completed. Retrospective authorization is required for outpatient emergent studies if the physician determines a medical emergency that imminently threatens life or limb exists, and the medical emergency requires advanced diagnostic imaging (CT, CTA, MRI, or MRA).

Retrospective authorization is required for outpatient urgent studies if the radiologist determines, during the provision of prior authorized services, that additional or alternate procedures are medically indicated, and that the urgent condition requires additional or alternate advanced diagnostic imaging (CT, CTA, MRI, or MRA).

The addition of post-three-dimensional reconstruction (procedure codes 4/I/T-76376 and 4/I/T-76377) CT, CTA, MRI, and MRA studies requires authorization if the authorization request is for outpatient, elective, diagnostic CT, CTA, MRI, and MRA imaging studies. Three-dimensional obstetric ultrasounds are not a benefit of the Texas Medicaid Program.

Prior authorization of nonemergent and retrospective authorization of urgent or emergent CT, CTA, MRI, and MRA studies will be considered on an individual basis that adheres to standard clinical evidence-based guidelines. Documentation must support the medical necessity of the study and must be maintained in the client's record by the ordering physician and the radiologist.

Note: *The authorization processes for emergent and nonemergent studies use nationally accepted guidelines and radiology protocols that are based on medical literature. Nationally accepted guidelines and protocols include those produced by the American College of Radiology (specifically, their Appropriateness Criteria), American Academy of Neurology, American Academy of Orthopedic Surgeons, American College of Cardiology, the American Heart Association, and the National Comprehensive Cancer Care Network.*

Providers may request prior or retrospective authorization by calling the TMHP Radiology Services Prior Authorization Line at 1-800-572-2116, by fax to 1-888-693-3210, or by mail to:

Texas Medicaid & Healthcare Partnership
730 Cool Springs Blvd, Suite 800
Franklin, TN 37067

Providers that make requests for authorization by phone must provide the following information:

- Diagnosis.
- Treatment history.
- Treatment plan.
- Medications.
- Previous imaging results.
- Additional requested documentation.

Providers that make requests by fax or mail must complete and maintain the Radiology Authorization Form. The form must document the medical necessity of the test, including diagnosis, treatment history, treatment plan, medications, and previous imaging results. Providers may be asked to provide additional documentation.

Section 1 of the Radiology Authorization Form must be completed, signed, and dated by the ordering physician before requesting prior authorization for a CT, CTA, MRI or MRA.

Section 2 of the Radiology Authorization Form must be completed, signed, and dated by the radiologist before requesting retrospective authorization for urgent or emergent studies.

Residents, physician assistants, and nurse practitioners may order radiological procedures; however, the ordering/referring clinician must sign the authorization form and use the group or supervising provider's provider identifier.

The completed form with original signature must be maintained in the client's medical record by the physician who ordered the tests.

Note: *The physician's signature must be current, unaltered, original, and handwritten. A computerized or stamped signature will not be accepted.*

Reimbursement for outpatient emergent and nonemergent CT, CTA, MRI, and MRA studies requires the authorization number on the claim at the time of claim submission.

When billed with the CMS-1500 claim form, claims for emergency CT, CTA, MRI, and MRA studies that were provided in an emergency department must be submitted with modifier U6 and the corresponding emergency services code to be considered for reimbursement.

When billed with the CMS-1450 claim form, claims submitted for emergency CT, CTA, MRI, and MRA studies that were provided in an emergency department must be submitted with the appropriate corresponding emergency services revenue code to be considered for reimbursement.

If two radiology CTs, CTAs, MRAs, or MRIs are performed in the emergency room and/or an outpatient setting on the same day without an authorization on file, the second procedure is denied. Providers may submit additional medical necessity documentation for payment reconsideration.

Intraoperative MRIs of the brain (procedure codes 4/I/T-70557, 4/I/T-70558, and 4/I/T-70559) are not benefits of the Texas Medicaid Program.

The authorization requirements for both nonemergent and emergent studies must be met to be considered for reimbursement.

If there is no authorization, both the technical and professional interpretation components are denied.

Refer to: "Hospital (Medical/Surgical Acute Care Facility)" on page 25-1.

"Physician" on page 36-1 for more information on MRI and contrast material.

39.3.2 Positron-Emission Tomography (PET) Scans

A PET scan is a noninvasive nuclear medicine procedure that images the chemical activity of body organs and tissues. The PET scan uses electronic detection of short-lived positron-emitting radiopharmaceuticals to measure metabolic, biochemical, and functional activity in tissue. A scanner then measures radioactivity as it is dispersed throughout the body, creating three-dimensional pictures of tissue function.

The following procedure codes are a benefit of the Texas Medicaid Program. Prior authorization is required with documentation of medical necessity.

Procedure Codes		
4/I/T-78608	4/I/T-78609	4/I/T-78811
4/I/T-78812	4/I/T-78813	4/I/T-78814
4/I/T-78815	4/I/T-78816	

39.3.2.1 Brain Imaging

Brain imaging PET scans are a benefit when either of the following is true:

- "When used as part of a pre-surgical evaluation to localize a focus of refractory seizure activity with documentation of a history of seizures that are not controlled through medications."
- "When differentiating recurrent brain tumors from scar tissue with documentation of a history of a primary brain tumor and a plan of treatment."

39.3.2.2 Tumor Imaging

Tumor-imaging PET scans are a benefit and are limited to staging and restaging of recurrent tumors in which the PET scan may assist in determining the optimal clinical management of the client.

Procedure codes 4/I/T-78459, 4/I/T-78491, and 4/I/T-78492 are *not* a benefit of the Texas Medicaid Program.

When requesting prior authorization for tumor-imaging PET scans, the provider must submit supporting documentation which indicates that standard imaging was not conclusive and that the provider's rationale for this procedure supports medical necessity.

39.3.3 Computed Tomography (CT) Scan

The Texas Medicaid Program pays for CT scans for specific diagnoses.

When a CT scan and an MRI of the *same* body area are performed on the same day, the CT scan will be paid and the MRI will be denied as part of an overlapping diagnostic procedure. Additional MRIs and/or CT scans of entirely different body areas performed on the same day will be paid with documentation of medical necessity.

Freestanding facilities may submit only the technical component of the CT scan. The radiologist or neurologist who then reads the scan will submit only the interpretation.

39.3.4 Cardiac Blood Pool Imaging

Cardiac blood pool imaging (procedure codes 4/I/T-78472, 4/I/T-78473, 4/I/T-78481, 4/I/T-78483, 4/I/T-78494, and 4/I/T-78496) is a covered benefit for the following diagnosis codes:

Diagnosis Codes				
3526	3940	3941	3942	3949
3950	3951	3952	3959	3960
3961	3962	3963	3968	3969
3970	3971	3979	41000	41001
41002	41010	41011	41012	41020
41021	41022	41030	41031	41032
41040	41041	41042	41050	41051
41052	41060	41061	41062	41070
41071	41072	41080	41081	41082
41090	41091	41092	4110	4111
41181	41189	412	4130	4131
4139	41400	41401	41402	41403
41404	41405	41406	41407	41410
41411	41412	41419	4142	4148
4149	4150	41511	41519	4160
4161	4168	4169	4170	4171
4178	4179	4200	42090	42091

Diagnosis Codes				
42099	4210	4211	4219	4220
42290	42291	42292	42293	42299
4230	4231	4232	4238	4239
4240	4241	4242	4243	42490
42491	42499	4250	4251	4252
4253	4254	4255	4257	4258
4259	4260	42610	42611	42612
42613	4262	4263	4264	42650
42651	42652	42653	42654	4266
4267	42681	42682	42689	4269
4270	4271	4272	42731	42732
42741	42742	4275	42760	42761
42769	42781	42789	4279	4280
4281	42820	42821	42822	42823
42830	42831	42832	42833	42840
42841	42842	42843	4289	4290
4291	4292	4293	4294	4295
4296	42971	42979	42981	42982
42989	4299	78099	7813	78650
78651	78652	78659	7991	V4321
V4581				

39.3.5 Myocardial Perfusion Imaging

Myocardial perfusion imaging, which uses radionuclides, is a noninvasive stress test that measures coronary blood flow (perfusion), especially to the left ventricle.

Myocardial perfusion imaging is a covered benefit of the Texas Medicaid Program when it is medically indicated.

Myocardial perfusion imaging studies will be limited to one study per day, including, but not limited to, the following procedure codes: 4/I/T-78460, 4/I/T-78461, 4/I/T-78464, and 4/I/T-78465.

When multiple procedure codes are billed, the most inclusive code will be paid and all other codes will be denied.

Myocardial perfusion imaging may be performed at rest and/or during stress using physical exercise or pharmacologicals. The following procedure codes may be used to bill for cardiovascular stress testing: 5-93015, T-93017, and I-93018.

39.3.6 Ambulatory Electroencephalogram (A/EEG)

Epilepsy is a clinical diagnosis which, in the overwhelming majority of cases, can be characterized with a standard electroencephalogram (EEG), a detailed history, a detailed physical examination that includes a comprehensive neurological examination, and an accurate description of the patient's epileptic phenomenon (because a positive interictal pattern of the EEG does not confirm the diagnosis beyond doubt).

There are some studies that show an advantage for intensive A/EEG monitoring in some cases where it has not been possible to confirm or support a diagnosis of epilepsy or to confirm or support the differential diagnosis of epilepsy from pseudoconvulsive episodes associated with transient cerebral ischemia from variable causes other than epilepsy.

A/EEG testing is a benefit of the Texas Medicaid Program. A 24-hour A/EEG may be covered for clients in whom:

- A seizure diathesis is suspected but is not defined by history, physical examinations, or resting EEG.
- Syncope or transient ischemic attacks have not been explained by conventional studies.

The time unit for monitoring is 24 hours. Benefits are limited to three 24-hour units for each physician for the same patient in a six-month period if it is medically necessary.

A/EEG should be billed using procedure codes 5/I/T-95950, 5/I/T-95951, 5/I/T-95953, or 5/I/T-95956.

Procedure codes 5/I/T-95950, 5/I/T-95951, 5/I/T-95953, and 5/I/T-95956 are related codes. If multiple procedure codes are billed on the same day, the most inclusive code will be paid, and all other codes will be denied.

Procedure codes 5/T-95950, 5/T-95951, 5/T-95953, and 5/T-95956 are automatically payable when billed with the following *International Classification of Diseases*, Ninth Revision, Clinical Modification (ICD-9-CM) codes or their equivalent narrative description listed below.

Request for payment of codes 5/T-95950, 5/T-95951, 5/T-95953, and 5/T-95956 in any place of service without the enumerated ICD-9-CM codes or their equivalent narrative description will be denied as an inappropriate service for the diagnosis. Upon appeal to the associate medical director, codes 5/T-95950, 5/T-95951, 5/T-95953, and 5/T-95956 may be paid with other related procedure codes when the submitted documentation establishes the medical necessity of the service.

Diagnosis Codes				
2390	2948	33111	33119	3315
33182	3332	34500	34501	34510
34511	3452	3453	34540	34541
34550	34551	34560	34561	34570
34571	34580	34581	34590	34591
64940	64941	64942	64943	64944
78097	7790	7797	78039	85011
85012				

39.3.7 Diagnosis Requirements for Other Services

A diagnosis is not required with a provider's request for payment except when providing the following services: A/EEGs, arteriograms, cardiac blood pool imaging, chest X-rays, CT scans, echography, electrocardiograms (ECGs), MRAs, MRIs, mammographies, noninvasive diagnostic studies, polysomnographies, and venographies.

Claims for all services provided to clients eligible for "Emergency Care Only" *must* have a diagnosis to be considered for reimbursement. As with all procedures billed to the Texas Medicaid Program, most baseline screening or comparison studies are not a benefit.

Refer to: "Physician" on page 36-1 for more information about these services.

39.3.8 Radiation Therapy

Radiation treatment management will be considered for reimbursement as defined in the paragraphs of the CPT Manual under the heading of "Radiation Treatment Management." Radiation treatment management is reported in units of five fractions or treatment sessions, regardless of the actual time period in which the services are furnished. The services need not be furnished on consecutive days. Multiple fractions representing two or more treatment sessions furnished on the same day may be counted separately as long as there has been a distinct break in therapy sessions, and the fractions are of the character usually furnished on different days. Procedure code 6-77427 is also reported if there are three or four fractions beyond a multiple of five at the end of a course of treatment; one or two fractions beyond a multiple of five at the end of a course of treatment are not reported separately. The professional services furnished during treatment management typically consists of:

- Review of port films.
- Review of dosimetry, dose delivery, and treatment parameters.
- Review of patient treatment set-up.
- Examination of patient for medical evaluation and management (e.g., assessment of the patient's response to treatment, coordination of care and treatment, review of imaging and/or lab test results).

39.3.8.1 Radiation Treatment Planning and Management

The following treatment planning procedure codes are benefits of the Texas Medicaid Program:

Procedure Codes		
6/I-77261	6/I-77262	6/I-77263
6/T-77280	6/T-77285	6/T-77290
6/T-77295	6/T-77299	6/I/T-77301

Treatment management procedure codes 6-77427, 6-77431, 6-77435, and 6-77499 are payable as the total component (type of service [TOS] 6) for services performed in place of service (POS) 1 (office or a facility recognized by Medicaid as a radiation treatment center), POS 3 (inpatient hospital), and POS 5 (outpatient hospital or a radiation treatment center).

39.3.8.2 Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services, and Proton Beam Treatment Delivery

The following procedure codes are a benefit of the Texas Medicaid Program:

Procedure Codes		
6/T-77300	6/T-77305	6/T-77310
6/T-77315	6/T-77326	6/T-77327
6/T-77328	6/T-77332	6/T-77333
6/I-77334	T-77371	T-77372
T-77373	6/T-77399	6-77520
6-77522	6-77523	6-77525

39.3.8.3 Clinical Brachytherapy

Brachytherapy (short distance or close treatment) is used to describe the use of radioactive isotopes in the treatment of cancer and benign diseases. Brachytherapy involves placement of radioactive sources, such as "seeds" or wires either in tumors (interstitial implants) or near tumors (intracavitary therapy and mold therapy).

The following procedure codes are a benefit of the Texas Medicaid Program:

Procedure Codes		
2/F-55875	2/F-55876	2/F-57155
2/F-58346	6/I-77750	6/I-77761
6/I-77762	6/I-77763	6/I-77776
6/I-77777	6/I-77778	6/T-77781
6/T-77782	6/T-77783	6/T-77784
6/T-77789	6/T-77799	

39.3.9 Technical Services (Radiation Treatment Delivery/Port Films)

Only the technical component (TOS T) is payable to physicians for the following services when they are rendered in a facility recognized by Medicaid as a radiation treatment center (POS 1) or in the physician's office (POS 1).

Procedure Codes		
T-77401	T-77402	T-77403
T-77404	T-77406	T-77407
T-77408	T-77409	T-77411
T-77412	T-77413	T-77414

Procedure Codes		
T-77416	T-77417	T-77418
T-77421	T-77422	T-77423

The County Indigent Health Care Program (CIHCP), physicians, physician groups, radiation treatment centers, hospitals, and hospital-based and freestanding/independent rural health clinics (RHCs) may submit procedure code T-77418 for consideration of reimbursement if it is performed in the office or outpatient hospital settings.

39.3.10 Radiation Treatment Centers/Outpatient Facilities

Radiation treatment centers and outpatient hospitals will be reimbursed only for the technical component for services rendered in POS 5 for the following services:

Procedure Codes		
Radiation Treatment Planning		
T-77280	T-77285	T-77290
T-77295	T-77299	
Medical Radiation Physics, Dosimetry, Treatment Devices, and Special Services		
T-77300	T-77305	T-77310
T-77315	T-77326	T-77327
T-77328	T-77332	T-77333
T-77334	T-77371	T-77372
T-77373	T-77399	
Radiation Treatment Delivery/Port Films		
T-77401	T-77402	T-77403
T-77404	T-77406	T-77407
T-77408	T-77409	T-77411
T-77412	T-77413	T-77414
T-77416	T-77417	T-77418
T-77421	T-77422	T-77423
Clinical Brachytherapy		
2/F-57155	2/F-58346	T-77781
T-77782	T-77783	T-77784
T-77789	T-77799	

The following clinical brachytherapy services procedure codes include admission to the hospital and daily care. Initial and subsequent hospital care will be denied on the same day that clinical brachytherapy services are billed.

Procedure Codes		
6/I-77750	6/I-77761	6/I-77762
6/I-77763	6/I-77776	6/I-77777
6/I-77778	6/I/T-77781	6/I/T-77782
6/I/T-77783	6/I/T-77784	6/I/T-77789
6/I/T-77799		

The following services will be allowed once per day, unless an appeal is submitted with documentation that supports the need for the service to be provided more than once:

- Therapeutic radiation treatment planning.
- Therapeutic radiology simulation-aided field setting.
- Teletherapy.
- Brachytherapy isodose calculation.
- Treatment devices.
- Proton beam delivery/treatment.
- Intracavity radiation source application.
- Interstitial radiation source application.
- Remote afterloading high intensity brachytherapy.
- Radiation treatment delivery.
- Localization.
- Radioisotope therapy.

A consultation on the same day as clinical treatment planning and clinical brachytherapy is included in the therapeutic radiology procedure.

Laboratory and diagnostic radiologic services provided in an office (POS 1) will be reimbursed to physicians as a total component. Radiation treatment centers will also be reimbursed for the total component for these services in POS 5. Injectable medications given during the course of therapy in any setting will be reimbursed separately.

Normal follow-up care by the same physician on the day of any therapeutic radiology service will be denied. Medical services within program limitations may be paid on appeal when documentation supports the medical necessity of the visit due to services unrelated to the radiation treatment or radiation treatment complication.

Procedure code 2-19298 is a benefit of the Texas Medicaid Program.

No separate payment will be made for any of the following procedure codes provided on the same day as radiation therapy by the same provider:

Procedure Codes		
2-16000	2-16020	2-16025
2/F-16030	2-36425	1-99050
1-99183	1-99211	1-99212
1-99213	1-99214	1-99215
3-99241	3-99242	3-99243
3-99244	3-99245	1-99281
1-99282	1-99283	1-99284
1-99285		

No separate payment will be made for established office or outpatient visits within 90 days after radiation treatment by the same provider.

Procedure Codes		
1-99211	1-99212	1-99213
1-99214	1-99215	1-99281

Procedure Codes		
1-99282	1-99283	1-99284
1-99285		

High energy neutron beam radiation therapy (procedure codes T-77422 and T-77423) are only payable for diagnosis codes 1420, 1421, 1422, 1428, and 1429.

39.3.11 Contrast Materials/Radiopharmaceuticals

Reimbursement for radiological procedures with descriptions that specify "with contrast," such as MRI and CT, includes payment for high osmolar, low osmolar contrast material (LOCM), and paramagnetic contrast materials. These contrast materials will not be reimbursed separately.

Radiopharmaceuticals may be considered for separate reimbursement if they are used for therapeutic treatment.

Procedure Codes		
6/I/T-79403	9-A9517	9-A9543
9-A9699		

39.4 Claims Information

Claims for radiological and physiological laboratory services and portable X-ray supplier services must include the referring/ordering provider.

Radiological and physiological laboratory services and portable X-ray supplier services must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"CMS-1500 Claim Filing Instructions" on page 5-22. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

39.4.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-22
TMHP Electronic Claims Submission	5-13
Communication Guide	A-1
Radiological/Physiological Laboratory and Portable X-Ray Supplier Claim Example	D-29
Acronym Dictionary	F-1

Section

40

Renal Dialysis Facility

40.1 Enrollment

To enroll in the Texas Medicaid Program, a renal dialysis facility must be Medicare-certified in the state where it is located. Facilities must also adhere to the appropriate rules, licensing, and regulations of the state where they operate.

All providers of laboratory services must comply with the rules and regulations of the *Clinical Laboratory Improvement Amendments* (CLIA) of 1988. Providers who do not comply with CLIA will not be reimbursed for laboratory services.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information.

"Clinical Laboratory Improvement Amendments (CLIA)" on page 26-2.

40.1.1 Medicaid Managed Care Enrollment

Renal dialysis facilities may be eligible to enroll in the Medicaid Managed Care health plans as primary care providers. To be reimbursed for services provided to Medicaid Managed Care clients, renal dialysis facilities must enroll with each Medicaid Managed Care health plan in which their clients are enrolled.

Refer to: "Managed Care" on page 7-1

40.2 Reimbursement

The Medicaid rates for renal dialysis facilities are composite rates based on calculations specified by the Centers for Medicare & Medicaid Services (CMS). The applicable Medicaid rates are listed in the current physician fee schedule, which is available on the TMHP website at www.tmhp.com/file library/file library /fee schedules.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

40.3 Benefits and Limitations

Renal dialysis services are available for Medicaid clients with one of the following diagnoses:

- *Acute renal disease.* A renal disease with a relatively short course, usually correctable.
- *Chronic renal disease (CRD) (end-stage renal disease [ESRD]).* A stage of renal disease that requires continuing dialysis or kidney transplantation to maintain life or health.

40.3.1 Renal Dialysis

Medicaid coverage of renal dialysis clients who may have Medicare coverage begins with the original onset date of dialysis treatments and may continue for a period of three months. During this period, Medicare eligibility is investigated through HHSC. If HHSC establishes that the client is Medicare-eligible, Medicaid coverage begins with the original onset date and continues until Medicare coverage begins. If HHSC determines that the client is not eligible for Medicare, Medicaid coverage of eligible clients begins with the original onset date and continues as long as the dialysis treatments are medically necessary, and the client is eligible for Medicaid.

In the case of a client who participates in self-dialysis training before the beginning of the third month, the Medicare waiting period is waived. The waiver is for Medicaid clients who can reasonably be expected to complete the training Program and, upon completion, enter a self-dialysis setting.

40.3.2 Kidney Transplants

Medicare coverage of a client who requires a kidney transplant can begin as early as the month in which a client is hospitalized for transplantation, provided the surgery takes place in that month or in the following two months. Medicare coverage of a client who receives a successful kidney transplant ends with the thirty-sixth month after the transplant. *At that time, Medicaid resumes full coverage of the client's claims for services covered under the Texas Medicaid Program, if the client remains eligible for Texas Medicaid.*

If HHSC verifies that a Medicaid client is not eligible for Medicare coverage of a transplant, the Texas Medicaid Program pays for the transplantation services. Medicaid does not pay for donor expenses. Facility expenses for kidney procurement, tissue matching, or the cost of maintaining a kidney before transplantation are included in the diagnosis-related group (DRG) reimbursement.

Medicare benefits for qualified clients include all covered Part A and B items and services. Coverage is not limited to items and services associated with renal disease. *Medicaid coverage of Medicare clients extends to the*

Medicare deductible and coinsurance. Medicaid may pay the Medicare deductible and coinsurance for clients who are eligible.

Refer to: "Organ/Tissue Transplants" on page 36-98 and "Organ/Tissue Transplant Services" on page 25-10 for information on organ transplant and facility services.

40.3.3 Facility Services

The facility bills an amount that represents the charge for the facility's service to the dialysis client. The facility's charge must not include the charge for the physician's routine supervision.

40.3.3.1 Facility Revenue Codes

Service	Revenue Code	Description
Maintenance	B-821	Hemodialysis (outpatient/home)–composite
	B-831	Peritoneal Dialysis (outpatient/home)–composite
	B-841	Continuous ambulatory peritoneal dialysis (CAPD) (outpatient/home)–composite
	B-851	continuous cycling peritoneal dialysis (CCPD) (outpatient/home)–composite
Training	B-829	Hemodialysis (outpatient/home)–other
	B-839	Peritoneal Dialysis (outpatient/home)–other
	B-849	CAPD (outpatient/home)–other
	B-859	CCPD (outpatient/home)–other
Support	B-845	CAPD (outpatient/home)–support services
	B-855	CCPD (outpatient/home)–support services

40.3.3.2 Maintenance Hemodialysis

The facility payment applies when a CRD client receives hemodialysis in an approved renal dialysis facility. Payment is based on the facility's per-treatment composite rate, as calculated by Medicare. Services included in the facility's charge are routine laboratory tests, personnel services, equipment, supplies, and other services associated with the treatment.

For hospitals to be reimbursed for maintenance hemodialysis, they must be enrolled as an approved dialysis facility with the appropriate provider identifier.

40.3.3.3 Maintenance Intermittent Peritoneal Dialysis (IPD)

Maintenance IPD is usually performed in sessions of 10 to 12 hours duration, 3 times per week. However, it is sometimes performed in fewer sessions of longer duration. If more than three sessions occur in one week, the provider must supply documentation of medical necessity with the claim.

40.3.3.4 Continuous Ambulatory Peritoneal Dialysis (CAPD) and Continuous Cycling Peritoneal Dialysis (CCPD) Support

Support services furnished to maintenance home CAPD/CCPD clients are payable to dialysis facilities. Home dialysis support services must be furnished by the facility in either the home or the facility. Use revenue codes B-845 or B-855 (CAPD and CCPD) when billing such services.

CAPD/CCPD support services include, but are not limited to, the following:

- Changing the connecting tube ("administration set").
- Watching the client perform CAPD/CCPD, and ensuring that it is done correctly. The observation includes reviewing any aspects of the technique they may have forgotten or informing the client of modifications in apparatus or technique.
- Documenting whether the client has or had peritonitis that requires physician intervention or client hospitalization.
- Inspecting the catheter site.

Routine laboratory services are not included in the support services and are reimbursed separately.

Equipment and supplies are not payable separately.

A client with Medicaid coverage may receive CAPD/CCPD support services furnished by the facility once per month. Charges for support services in excess of once per month must include documentation of medical necessity.

40.3.3.5 Hemodialysis, IPD, CCPD, and CAPD Training

Most self-dialysis training is given in an outpatient setting. While CAPD training itself usually does not justify inpatient status, CAPD training is covered when provided to an inpatient. It is reimbursed at the same rate as the facility's outpatient CAPD training rate. Payment for B-829, B-839, or B-859 consists of the facility's composite rate plus $20 per training session.

A client who is eligible for Medicaid may receive up to 18 days of training. Additional days of CAPD training (B-849) may be paid only when medical necessity is documented. Payment consists of the facility's composite rate plus $12 per training session.

CAPD training services and supplies provided by the dialysis facility include personnel services, parenteral items routinely used in dialysis, training manuals and materials, and routine CAPD laboratory tests.

No frequency limitation is applied to routine laboratory tests during the training period because these tests commonly are given during each day of training. Nonroutine laboratory tests performed during the training period require documentation of medical necessity.

It may be necessary to supplement the client's dialysis during CAPD training with IPD or hemodialysis because the client has not mastered the CAPD technique.

Three supplemental dialysis sessions are covered routinely. If more than three sessions are billed during the training, the claims must document the medical necessity.

40.3.4 Laboratory and Radiology Services

40.3.4.1 In-Facility Dialysis–Routine Laboratory

Laboratory services may be performed in the CRD facility or by an outside laboratory. Charges for routine laboratory tests performed according to the established frequencies in the following tables are included in the facility's dialysis charge billed to Medicaid regardless of where tests were performed. Routine laboratory services performed by an outside laboratory are billed to the facility.

Per Dialysis

Procedure Codes	
5-85014	5/I-85345
5/I-85347	

Per Week

Procedure Codes	
5/I-82565	5/I-84520
5/I-85610	

Per Month

Procedure Codes	
5/I-82040	5/I-82310
5/I-82374	5/I-82435
5/I-83615	5/I-84075
5/I-84100	5/I-84132
5/I-84155	5/I-84450
5/I-85025	5-85027

The routine tests listed in the tables above are frequently performed as an automated battery of tests such as the SMAC-12. These tests are considered routine and are included in the charge for dialysis, unless there is an additional diagnosis to document medical necessity for performing the tests in excess of the recommended frequencies.

If it is medically necessary to perform a routine laboratory test beyond the established frequency, payment may be made if the test is indicated on the claim form along with documentation of medical necessity.

Refer to: "Laboratory Paneling" on page 26-5 for more information about laboratory paneling procedures.

40.3.4.2 In-Facility Dialysis—Nonroutine Laboratory

The following are considered necessary, nonroutine tests. They must be billed separately from the dialysis charge when performed in the CRD facility or by an outside laboratory that bills the facility for laboratory services. All nonroutine laboratory and radiology tests beyond the recommended frequencies require medical justification.

Procedure code 1-99001 for nonroutine laboratory services may be billed to the Texas Medicaid Program *only* if the specimen is obtained by venipuncture or catheterization and sent to an outside lab. The claim form must document that the handling fee is for nonroutine laboratory services.

Once a Month

Procedure Code
5-87340

Every Three Months

Procedure Code
5/T-93005

Every Six Months

Procedure Codes	
4/I/T-71010	4/I/T-71020
5/I/T-95900	

Annually

Procedure Codes	
4/I/T-78300	4/I/T-78305
4/I/T-78306	

40.3.4.3 Continuous Ambulatory Peritoneal Dialysis

The following laboratory tests are routine for home maintenance CAPD clients when performed according to the indicated frequency. When the client is dialyzing in the home and is not undergoing IPD or hemodialysis in the facility, payment may be made. The provider must indicate the client's diagnosis and the type of dialysis on the claim form. Tests in excess of this frequency or tests not listed in the tables, require documentation of medical necessity for payment to be made.

Every Month

Procedure Codes		
5/I-82040	5/I-82310	5/I-82374
5/I-82565	5/I-83615	5/I-83735

Procedure Codes		
5/I-84075	5/I-84100	5/I-84132
5/I-84155	5-84156	5-84157
5/I-84160	5/I-84295	5/I-84450
5/I-84520	5-85018	

Every Three Months

Procedure Codes		
5-85004	5-85007	5-85008
5-85014	5-85027	5-85041

Every Six Months

Procedure Codes		
4/I/T-71010	4/I/T-71015	4/I/T-71020
4/I/T-78300	4/I/T-78305	4/I/T-78306
5-80069	5-81020	5/I/T-95900
5/T-93005		

40.3.4.4 Hematopoietic Agents, Erythropoietin Alfa (EPO), and Darbepoetin Alfa

Medicaid reimbursement is allowed for hematopoietic, EPO, and darbepoetin injections administered to chronic renal disease clients, chronic end-stage renal disease predialysis clients who have an anemia with a Hematocrit of 36 percent or less, and for clients with HIV infection who are being treated with Retrovir (AZT). Payment is limited to the end-stage renal dialysis facility and the physician in the office. EPO given for a hematocrit of 37 percent or above is not a benefit of the Texas Medicaid Program.

Refer to: "Hematopoietic Agents" on page 36-59 for more information about hematopoietic agents, erythropoietin alfa (EPO), and darbepoetin alfa.

40.3.4.5 Blood Transfusions

Payment of whole blood for transfusions billed by dialysis facilities is a covered service when medically indicated for a client eligible for Medicaid. The administration of blood transfusion is not payable to dialysis facilities and must be billed by the medical professional. Blood administration is considered a professional service and is not payable to dialysis facilities.

Use the following procedure codes when billing for blood:

Procedure Code	
0-P9010	0-P9011
9-P9021	

40.4 Claims Information

RENAL dialysis facility services must be submitted to TMHP in an approved electronic claims format or on a UB-04 CMS-1450 claim form. Providers may purchase UB-04 CMS-1450 claim forms from the vendor of their choice. TMHP does not supply them.

When completing a UB-04 CMS-1450 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

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

Section 5, "Claims Filing" for general information about claims filing.

"UB-04 CMS-1450 Claim Filing Instructions" on page 5-30 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Reminder: *The original onset date must be included on the claim form to prevent claim denial. The original onset date must be the same date entered on Form CMS-2728 sent to the Social Security office.*

40.4.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
UB-04 CMS-1450 Claim Filing Instructions	5-30
TMHP Electronic Claims Submission	5-13
Communication Guide	A-1
Renal Dialysis Facility CAPD Training	D-30
Renal Dialysis Facility CAPD/CCPD	D-30
Acronym Dictionary	F-1

Section

41

Rural Health Clinics (RHCs)

41.1 Enrollment

To enroll in the Texas Medicaid Program and qualify for participation as a Title XIX RHC, RHCs must be enrolled in Medicare.

A nine-digit provider identifier is issued to the RHC after a certification letter from Medicare is received, stating that the clinic qualifies for Medicaid participation.

All providers of laboratory services must comply with the rules and regulations of the *Clinical Laboratory Improvement Amendments* (CLIA). Providers who do not comply with CLIA are not reimbursed for laboratory services.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information.

"Clinical Laboratory Improvement Amendments (CLIA)" on page 26-2.

41.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with Medicaid Managed Care to be reimbursed for services provided to Medicaid managed care clients. Contact the individual Medicaid Managed Care health plan for enrollment information.

Refer to: "Managed Care" on page 7-1

41.2 Record Retention

Freestanding RHCs must retain their records for a minimum of six years. Hospital-based RHCs must retain their records for a minimum of ten years.

41.3 Reimbursement

Freestanding and hospital-based RHCs are reimbursed provider-specific per visit rates calculated in accordance with 1 TAC §355.8101.

41.4 Benefits and Limitations

41.4.1 Telemedicine Services

Remote site providers are limited to physicians (doctors of medicine [MDs] and doctors of osteopathy [DOs]), physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives (CNMs), federally qualified health centers (FQHCs), and RHCs.

RHC telemedicine providers must submit their claims using the appropriate encounter code and modifiers. Modifier U7, AM, or SA is to be used in the first modifier field on the claim form together with the modifier GT in the second modifier field on the claim form.

Refer to: "Physician" on page 36-1 for more information.

41.4.2 Freestanding and Hospital-Based RHC Services

An RHC must be located in an area designated by the federal government as a health-care shortage area.

The following services are benefits of RHCs under the Texas Medicaid Program:

- Physician services.
- Services and supplies furnished as incidental to physician services.
- Services provided by an NP, a CNS, a CNM, a clinical social worker, or PA services.
- Services and supplies furnished as incidental to the NP's or PA's services.
- Visiting nurse services on a part time or intermittent basis to homebound clients in areas determined to have a shortage of home health agencies. A homebound client is someone who is permanently or temporarily confined to his place of residence, not including a hospital or a skilled nursing facility, because of a medical condition.

  When an RHC bills for visiting nurse services, the written plan of treatment to be used for the visiting nurse must be developed by the RHC supervising physician. It must be approved and ordered by the client's treating physician if different from the supervising physician. The plan of treatment must be reviewed and approved at least every 60 days by the supervising physician of the clinic.

A *visit* is a face-to-face encounter between an RHC client and a physician, PA, NP, CNS, CNM, visiting nurse, or clinical NP. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except where one or the other of the following conditions exists:

- After the first encounter, the client suffers illness or injury requiring additional diagnosis or treatment.

- The RHC client has a medical visit and an *other* health visit.

An *other* health visit includes, but is not limited to, a face-to-face encounter between an RHC client and a clinical social worker.

For freestanding RHCs, all laboratory services provided in the RHC's laboratory are included in the encounter. This includes the basic laboratory tests as well as any other laboratory tests provided in the RHC laboratory. Consequently, there is no separate billing for laboratory services. However, if the RHC laboratory becomes a certified Medicare laboratory with its own supplier number, and enrolls in Medicaid as an independent laboratory, all laboratory tests (except the basic laboratory tests) performed for RHC and non-RHC clients can be billed to Medicaid. The claim should be filed under their independent laboratory Medicaid provider identifier and using the appropriate Healthcare Common Procedure Coding System (HCPCS) codes.

41.4.2.1 Freestanding Rural Health Clinic Services

The services listed below cannot be reimbursed to freestanding RHCs using the RHC nine-digit provider identifier. Use of the RHC provider identifier for billing these services causes claims to deny. Services in any of these four categories must be billed using the appropriate practitioner's group/individual, Texas Health Steps (THSteps), or family planning agency Medicaid nine-digit provider identifier:

- THSteps medical check ups.
- THSteps dental services.
- Family planning services (including implantable contraceptive capsules provision, insertion, or removal).
- Immunizations, unless they are billed outside of a THSteps medical check up.

These services (except for THSteps dental) must be billed with an AJ, AM, SA, or U7 modifier if performed in an RHC setting. Claims are paid under the Prospective Payment System (PPS) reimbursement methodology. When billing on the CMS-1500 claim form, use the appropriate national place of service code (POS) (72) for an RHC setting.

Payment to physicians for supplies is not a benefit of the Texas Medicaid Program. Costs of supplies are included in the reimbursement for office visits.

Outpatient hospital services (including emergency room services) and inpatient hospital services provided outside the RHC setting are to be billed using the individual or group physician Medicaid nine-digit provider identifier.

Exception: *If later in the same day the client suffers an additional illness or injury requiring diagnosis or treatment, the clinic may bill for a second visit.*

Freestanding RHCs bill an all-inclusive encounter for services provided.

All services provided that are incidental to the encounter must be included in the total charge for the encounter. They are not billable as a separate encounter.

Exception: *When billing for immunizations outside of a THSteps medical check up, procedure codes given in the THSteps section of this manual should be used. This is the only circumstance in which a freestanding RHC can bill for a procedure other than 1-T1015.*

All services provided during a freestanding RHC encounter must be billed using procedure code 1-T1015. The total billed amount should be the combined charges for all services provided during that encounter.

One of the following modifiers must be reported with procedure code 1-T1015 to designate the health-care professional providing the services: AJ, AM, or SA with POS 2, TH, or U7.

Reminder: *The primary* initial contact *is defined as "the health-care professional who spends the greatest amount of time with the client during that encounter."*

If more than one health-care professional is seen during the encounter, the modifier (if appropriate) must indicate the primary contact. For example, if an NP, CNS, or PA performs an antepartum exam, modifiers SA or U7, and TH, must be entered. A maximum of two modifiers may be reported with each encounter.

If the encounter is for antepartum or postpartum care, use modifier TH. FQHCs and RHCs must continue to use a TD or TE modifier if billing for visiting nurse services in a client's home or if billing THSteps for a service performed by a nurse.

41.4.2.2 Hospital-Based Rural Health Clinic Services

Hospital-based RHCs must use the encounter code 1-T1015. A hospital-based RHC is paid based on an all-inclusive encounter rate.

One of the following modifiers must be billed for general medical services: AJ, AM, or SA with POS 2, or U7.

The services listed below cannot be reimbursed to hospital-based RHCs using the RHC nine-digit provider identifier. Use of the RHC nine-digit provider identifier for billing these services causes claims to deny. Services in any of these four categories must be billed using the appropriate practitioner's group/individual, THSteps, or family planning agency provider identifier:

- THSteps medical check ups.
- THSteps dental.
- Family planning services (including implantable contraceptive capsules provision, insertion, or removal).
- Immunizations provided in hospital-based RHCs.

These services must be billed with an AM, U7, or SA modifier if performed in an RHC setting. Claims are paid under the PPS reimbursement methodology. When billing on the CMS-1500 claim form, use the appropriate national POS (72) for an RHC setting.

Outpatient hospital services (including emergency room services) and inpatient hospital services provided outside the RHC setting are to be billed using the individual or group physician provider identifier.

Hospital-based RHCs should bill pneumococcal and influenza vaccines as non-RHC services, under their hospital provider identifier.

41.4.2.3 FQHC/RHC After-Hours

After-hours care for FQHCs and RHCs is defined as care provided on weekends, on federal holidays, or before 8 a.m. and after 5 p.m. Monday through Friday.

PCCM clients (see "PCCM" on page 7-23) can access health-care services at FQHCs and RHCs when services are provided outside the normal business hours, including weekends or holidays, without a referral from the client'sprimary care provider.

After-hours care provided by FQHCs and RHCs do not require a referral from the client's primary care provider. FQHCs and RHCs that provide after-hours services to PCCM clients must submit claims with modifier TU.

41.4.2.4 Copayments for FQHCs and RHCs

The following copay procedure codes may be considered for reimbursement by the Texas Medicaid Program for FQHCs, RHCs, and associated providers:

Procedure Codes		
1-CP001	1-CP002	1-CP003
1-CP004	1-CP005	1-CP006
1-CP007	1-CP008	

41.5 Cost Report Submission

All RHCs are required to submit a copy of their Medicare audited cost report within 15 days of receipt from Medicare for fiscal years ending on or after January 1, 2001, to the following address:

Texas Medicaid & Healthcare Partnership
Medicaid Audit
PO Box 200345
Austin, TX 78720-0345

41.6 Claims Information

Freestanding and hospital-based RHC services must be submitted to TMHP in an approved electronic format or on a UB-04 CMS-1450 claim form. Providers may purchase UB-04 CMS-1450 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a UB-04 CMS-1450 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"UB-04 CMS-1450 Claim Filing Instructions" on page 5-30. Blocks that are not referenced are not required for processing by TMHP and may be left blank

41.6.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
UB-04 CMS-1450 Claim Filing Instructions	5-30
TMHP Electronic Claims Submission	5-13
Communication Guide	A-1
Rural Health Clinic Freestanding Claim Example	D-31
Rural Health Clinic Hospital-Based Claim Example	D-32
Acronym Dictionary	F-1

Section

42

School Health and Related Services (SHARS)

42.1 Overview

Medicaid services provided by school districts in Texas to Medicaid-eligible students are known as SHARS. The oversight of SHARS is a cooperative effort between the Texas Education Agency (TEA) and HHSC. SHARS allow local school districts, including public charter schools, to obtain Medicaid reimbursement for certain health-related services documented in a student's Individualized Education Program (IEP). SHARS are provided to students who meet all of the following requirements:

- Are under 21 years of age and Medicaid-eligible.
- Meet eligibility requirements for special education described in the *Individuals with Disabilities Education Act* (IDEA).
- Have IEPs that prescribe the needed services.

Covered SHARS include:

- Audiology services.
- Counseling.
- Nursing services.
- Physician services.
- Occupational therapy (OT).
- Physical therapy (PT).
- Psychological services, including assessments (1-96101).
- Speech therapy services.
- Personal care services.
- Transportation in a school setting.

These services must be provided by qualified personnel who are under contract with or employed by the school district. Furthermore, the school district must be enrolled as a SHARS Medicaid provider in order to bill the Texas Medicaid Program for these services.

The Centers for Medicare & Medicaid Services (CMS) requires SHARS providers to participate in the Random Moment Time Study (RMTS) to be eligible to bill for SHARS direct services. SHARS providers can call the RMTS contracted vendor at 1-888-321-1225.

42.2 School Enrollment

To enroll in the Texas Medicaid Program as a SHARS provider, school districts, including public charter schools, must employ or contract with individuals or entities that meet certification and licensing requirements in accordance with the Texas Medicaid State Plan for SHARS to provide program services. Since public school districts are government entities, they should select "public entity" on the enrollment application.

SHARS providers are required to notify parents/guardians of their rights to a "freedom of choice of providers" (42 *Code of Federal Regulations* [CFR] §431.51) under the Texas Medicaid Program. Most SHARS providers currently provide this notification during the initial Admission, Review, and Dismissal (ARD) process. If a parent requests that someone other than the employees or currently contracted staff of the SHARS provider (school district) provide a required service listed in the student's IEP, the SHARS provider must make a good faith effort to comply with the parent's request. The SHARS provider can negotiate with the requested provider to provide the services under contract. The requested provider must meet, comply with, and provide all of the employment criteria and documentation that the SHARS provider normally requires of its employees and currently contracted staff. The SHARS provider can negotiate the contracted fee with the requested provider and is not required to pay the same fee that the requested provider might receive from Medicaid for similar services. If the SHARS provider and the requested provider do not agree on a contract, the parties can determine whether a nonschool SHARS relationship in accordance with 42 CFR §431.51 is possible. If the parties do not agree to a nonschool SHARS relationship, the SHARS provider is responsible for providing the required services and must notify the parent that no contracted or nonschool SHARS relationship could be established with the requested provider.

Refer to: "Reimbursement" on page 2-2.

42.2.1 Nonschool SHARS Provider Enrollment

A nonschool SHARS provider must have either a current provider identifier as a Texas Medicaid provider of the IEP service or meet all of the eligibility requirements to obtain a provider identifier as a Texas Medicaid provider of the IEP service. For example, a nonschool SHARS provider of speech therapy must meet all provider criteria to provide Medicaid fee-for-service speech therapy and cannot hold only a state education certificate as a speech therapist.

To be enrolled in the Texas Medicaid Program as a nonschool SHARS provider, the enrollment packet must contain an affiliation letter that:

- Is written on school district letterhead.
- Is signed by the school district superintendent or designee.
- Contains assurances that the school district will reimburse the state share to HHSC for any Texas Medicaid payments made to the nonschool SHARS provider for the listed student and service.
- Lists the Medicaid number and Social Security number of the student to be served and notes the type of IEP SHARS service to be provided.
- Acknowledges that the nonschool SHARS provider has agreed in writing to:
  - Provide the listed SHARS service shown in the student's IEP.
  - Provide the listed SHARS service in the least restrictive environment as set forth in the IEP.
  - Maintain and submit all records and reports required by the school district to ensure compliance with the

IEP and compliance with IEP and documentation/billing requirements.

- States the effective period for this nonschool SHARS provider arrangement.

A separate affiliation letter is required for each Texas Medicaid client to be served by the nonschool SHARS provider. A nonschool SHARS provider is required to have a separate two-digit suffix for each school district with which it is affiliated. For example, if a nonschool SHARS provider has written agreements with Anywhere Independent School District (ISD) for two students and with Somewhere ISD for one student, then the nonschool SHARS provider would submit its claims for the two students from Anywhere ISD under provider identifier 1234567-01 and its claims for the one student from Somewhere ISD under provider identifier 1234567-02. The nonschool SHARS provider would submit two affiliation letters from Anywhere ISD to TMHP Provider Enrollment (one for each student served) and one affiliation letter from Somewhere ISD.

Since nonschool SHARS providers are private, nonpublic entities, they should select "private entity" on the enrollment application.

Nonschool SHARS services include audiology services, counseling services, nursing services, OT, PT, speech therapy services, and psychological services delivered in an individual setting. Nonschool SHARS services do not include evaluation/assessment, physician services, personal care services, or transportation.

42.2.2 Private School Enrollment

A private school may not participate in the SHARS program as a SHARS provider or as a nonschool SHARS provider.

42.2.3 Medicaid Managed Care Enrollment

SHARS providers do not enroll with the Medicaid Managed Care health plans. SHARS providers deliver services to all eligible Medicaid SHARS clients, including clients of the Medicaid Managed Care health plans. SHARS services are not covered by the Medicaid Managed Care health plans. SHARS services that are rendered to clients of Medicaid Managed Care are covered and reimbursed by TMHP. Students who are under 21 years of age and on a Medicaid 1915(c) waiver program are covered and reimbursed by TMHP.

SHARS providers should use program code 200 to bill for Primary Care Case Management (PCCM). SHARS providers should use program code 100 to bill for fee-for-service.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment and Responsibilities" on page 1-1 for more information about enrollment procedures.

42.3 Reimbursement and Certification of Funds

42.3.1 Reimbursement

Effective for dates of service on or after September 1, 2006, SHARS providers are reimbursed on an interim basis for covered services at either the lesser of the provider's billed charges or the provider's district-specific interim rate. SHARS providers receive Medicaid payments equal to the federal share and fund the state matching share through certification of public expenditures. The federal share is the applicable federal Medicaid assistance percentage (FMAP) in accordance with guidelines from CMS.

CMS requires the implementation of annual cost reporting, cost reconciliation, and cost settlement processes for all such Medicaid services delivered by school districts. Recent changes from CMS require that school districts, as public entities, not be paid in excess of their Medicaid-allowable costs and that any overpayments be recouped through the cost reconciliation and cost settlement processes. In an effort to minimize any potential recoupments, HHSC has assigned district-specific interim rates that are as close as possible to each district's estimated Medicaid-allowable costs for providing each service. School districts can access their district-specific interim rates on the HHSC website at www.hhsc.state.tx.us/medicaid/programs/rad/AcuteCare/Shars/Shars.html and click on the link titled *Click Here To Access The Interim Rates Table*.

Payments for services delivered by a nonschool SHARS provider are limited to either the lower of the nonschool SHARS provider's billed charges or the district-specific interim rate for the school district in which the student is enrolled and for the specific covered service provided. The school district with whom the nonschool SHARS provider is affiliated is required to pay HHSC the state portion of Medicaid payments made to the nonschool SHARS provider. Invoices for the state portion of Medicaid payments to nonschool SHARS providers are sent to the affiliated SHARS school districts on a quarterly basis.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement and "Federal Financial Participation (FFP) Rate" on page 2-7.

42.3.1.1 Certification of Funds

SHARS providers are required to certify on a quarterly basis the amount reimbursed during the previous federal fiscal quarter. TMHP Provider Enrollment mails the quarterly Certification of Funds letter to SHARS providers at the end of each quarter of the federal fiscal year (October 1 through September 30). The purpose of the letter is to verify that the school district incurred allowable costs/expenditures on the dates of service that were funded from state/local funds in an amount equal to or greater than the combined total of its interim rates times the paid units of service. While the payments were received the previous federal fiscal quarter, the actual dates of service could have been many months prior. Therefore, the certification of public expenditures is for the date of service and not the date of payment.

In order to balance amounts in the Certification of Funds, providers will receive or have access to the Certification of Funds Claims Information Report which shows that quarter's combined total payments for Medicaid fee-for-service claims and Medicaid PCCM claims. For help balancing the amounts in the letter, providers can contact their Provider Relations representative or the TMHP Contact Center at 1-800-925-9126.

Refer to: "TMHP Provider Relations" on page xiii for more information about provider relations representatives.

The Certification of Funds letter *must* be:

- Signed by the business officer or other financial representative who is responsible for signing other documents that are subject to audit.
- Notarized.
- Returned to TMHP within 25 calendar days of the date printed on the letter.

Failure to do so may result in recoupment of funds or the placement of a vendor hold on the provider's payments until the signed Certification of Funds letter is received by TMHP. Providers must contact the TMHP Contact Center at 1-800-925-9126, if they do not receive their Certification of Funds letter.

On an annual basis, SHARS providers are required to certify through their cost reports their total, actual, incurred allowable costs/expenditures, including the federal share and the nonfederal share.

42.3.1.2 Cost Reporting

Each SHARS provider is required to complete an annual cost report for all SHARS that were delivered during the previous state fiscal year (September 1 through August 31). The cost report is due on or before March 1 of the year following the reporting period. The first SHARS cost report will cover September 1, 2006, through August 31, 2007, and is due on or before March 1, 2008.

The primary purpose of the cost report is to document the provider's costs for delivering SHARS, including direct costs and indirect costs, and to reconcile the provider's interim payments for SHARS with its actual, total, Medicaid-allowable costs. The annual SHARS cost report includes a certification of funds statement which must be completed to certify the provider's actual, incurred costs/expenditures. All annual SHARS cost reports that are filed are subject to desk review by HHSC or its designee.

42.3.1.3 Cost Reconciliation and Cost Settlement

The cost reconciliation process must be completed within 24 months of the end of the reporting period covered by the annual SHARS cost report. The total Medicaid-allowable costs are compared to the provider's interim payments for SHARS delivered during the reporting period, which results in a cost reconciliation. The SHARS cost report is due on or before March 1, 2008, with the cost reconciliation and settlement processes completed no later than August 31, 2009.

If a provider's interim payments exceed the actual, certified, Medicaid-allowable costs of the provider for SHARS to Medicaid clients, HHSC will recoup the federal share of the overpayment by one of the following methods:

- Offset all future claims payments to the provider until the amount of the federal share of the overpayment is recovered.
- Recoup an agreed upon percentage from future claims payments to the provider to ensure recovery of the overpayments within one year.
- Recoup an agreed upon dollar amount from future claims payments to ensure recovery of the overpayment within one year.

If the actual, certified, Medicaid-allowable costs of a provider for SHARS exceed the provider's interim payments, HHSC will pay the federal share of the difference to the provider in accordance with the final, actual certification agreement and submit claims to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

HHSC shall issue a notice of settlement that denotes the amount due to or from the provider.

42.4 Record Retention

Student-specific records that are required for SHARS become part of the student's educational records and must be maintained for seven years rather than the five years required by Medicaid. All records that are pertinent to SHARS billings must be maintained by the school district until all audit questions, appeal hearings, investigations, or court cases are resolved. Records should be stored in a readily accessible location and format and must be available for state and/or federal audit.

The following is a checklist of the minimum documents to collect and maintain:

- IEP.
- Current provider qualifications (licenses, etc.).
- Attendance records.

- Prescriptions/referrals.
- Medical necessity documentation (e.g., diagnoses and history of chronic conditions or disability).
- Session notes or service logs, including provider signatures.
- Supervision logs.
- Special transportation logs.
- Claims submittal and payment histories.
- If applicable, nonschool SHARS provider's affiliation letter and signed agreement with the district.

42.5 Eligibility Verification

The following are means to verify Medicaid eligibility of students:

- Verify electronically through TMHP electronic data interchange (EDI) with TexMedConnect or the TDHconnect software.
  - School districts may inquire about the eligibility of a student by submitting the student's Medicaid number or two of the following: name, date of birth, or Social Security number.
  - A search can be narrowed further by entering the county code or sex of the student. Verifications may be submitted in batches without limitations on the number of students.
- Contact the Automated Inquiry System (AIS) at 1-800-925-9126.
- Contact the TMHP Contact Center at 1-800-925-9126.

42.6 Benefits and Limitations

All of the SHARS procedures listed in the following sections require a valid International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis code. SHARS include audiology services, counseling, physician services, nursing services, OT, PT, psychological services, speech therapy services, personal care services, and transportation.

Reminder: *SHARS are the services determined by the ARD committee to be medically necessary and reasonable to ensure that children with disabilities who are eligible for Medicaid and under 21 years of age receive the benefits accorded to them by federal and state law in order to participate in the educational program.*

42.6.1 Audiology

Audiology evaluation services include:

- Identification of children with hearing loss.
- Determination of the range, nature, and degree of hearing loss, including the referral for medical or other professional attention for the habilitation of hearing.
- Determination of the child's need for group and individual amplification.

Audiology therapy services include the provision of habilitation activities, such as language habilitation, auditory training, audiological maintenance, speech reading (lip reading), and speech conversation.

Audiology services must be provided by a professional who holds a valid state license as an audiologist or by an audiology assistant who is licensed by the state when the assistant is acting under the supervision of a qualified audiologist. State licensure requirements are equal to American Speech-Language-Hearing Association (ASHA) certification requirements.

Audiology evaluation is billable on an individual (1-92506, with modifier U9) basis only. Audiology therapy is billable on an individual (1-92507) and group (1-92508) basis. Only the time spent with the student present is billable; time spent without the student present is not billable. Session notes for evaluations are not required; however, documentation must include the billable start time, billable stop time, and total billable minutes with a notation of the activity performed (e.g., audiology evaluation). Session notes are required for therapy. Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

42.6.1.1 Audiology Billing Table

POS*	Procedure Code	Individual or Group	Therapist or Assistant
1, 2, or 9	1-92506 with modifier U9	Individual	Licensed audiologist
1, 2, or 9	1-92507 with modifier U9	Individual	Licensed audiologist
1, 2, or 9	1-92507 with modifier U1	Individual	Licensed/certified assistant
1, 2, or 9	1-92508 with modifier U9	Group	Licensed audiologist
1, 2, or 9	1-92508 with modifier GN-U1	Group	Licensed/certified assistant

***Place of Service: 1=office/school; 2=home; 9=other locations**

Providers must use a 15-minute unit of service for billing.

Refer to: "Billing Units Based on 15 Minutes" on page 42-13.

The recommended maximum billable time for audiology evaluation is three hours, which may be billed over several days. The recommended maximum billable time for direct audiology therapy (group and/or individual) is one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

42.6.2 Counseling Services

Counseling services are provided to help a child with a disability benefit from special education and must be listed in the IEP. Counseling services include, but are not limited to:

- Assisting the child and/or parents in understanding the nature of the child's disability.
- Assisting the child and/or parents in understanding the special needs of the child.
- Assisting the child and/or parents in understanding the child's development.
- Health and behavior interventions to identify the psychological, behavioral, emotional, cognitive, and social factors that are important to the prevention, treatment, or management of physical health problems.
- Assessing the need for specific counseling services.

Counseling services must be provided by a professional who has one of the following certifications or licensures: a licensed professional counselor (LPC), a licensed clinical social worker (LCSW, formerly LMSW-ACP), a licensed marriage and family therapist (LMFT), or a licensed psychologist.

Counseling services are billable on an individual (1-96152) or group (1-96153) basis. Session notes are required and documentation must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

School districts may receive reimbursement for emergency counseling services as long as the student's IEP includes a behavior improvement plan that documents the need for emergency services.

42.6.2.1 Counseling Services Billing Table

POS*	Procedure Code	Individual or Group
1, 2, or 9	1-96152 with modifier UB	Individual
1, 2, or 9	1-96153 with modifier UB	Group

***Place of Service: 1 = Office/School; 2 = Home; 9 = Other Locations**

Providers must use a 15-minute unit of service for billing.

Refer to: "Billing Units Based on 15 Minutes" on page 42-13.

The recommended maximum billable time is one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

42.6.3 Physician Services

Diagnostic and evaluation services are reimbursable under SHARS physician services. Physician services must be provided by a licensed physician (doctor of medicine [MD] or doctor of osteopathy [DO]). A physician prescription is required before PT or OT services can be reimbursed under SHARS. Speech therapy services require either a physician prescription or a referral from a licensed speech language pathologist (SLP) before the speech therapy services can be reimbursed under the SHARS program. The school district must maintain the prescription/referral. The prescription/referral must relate directly to specific services listed in the IEP. If a change is made to a service on the IEP that requires a prescription/referral, the prescription/referral must be revised accordingly.

The expiration date for the physician prescription is the earlier of either the physician's designated expiration date on the prescription or three years, in accordance with the IDEA three-year re-evaluation requirement.

SHARS physician services are billable only when they are provided on an individual basis. The determination as to whether or not the provider needs to see the student while reviewing the student's records is left up to the professional judgment of the provider. Therefore, billable time includes:

- The diagnosis/evaluation time spent with the student present.
- The time spent without the student present reviewing the student's records for the purpose of writing a prescription/referral for specific SHARS services.
- The diagnosis/evaluation time spent with the student present, and/or the time spent without the student present reviewing the student's records for the evaluation of the sufficiency of an ongoing SHARS service to see whether any changes are needed in the current prescription/referral for that service.

Session notes are not required for procedure code 1-99499; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the medical activity that was performed.

42.6.3.1 Medical Services Billing Table

POS*	Procedure Code
1, 2, or 9	1-99499

***Place of Service: 1 = Office/School; 2 = Home; 9 = Other Locations**

Providers must use a 15-minute unit of service for billing.

Refer to: "Billing Units Based on 15 Minutes" on page 42-13.

The recommended maximum billable time is one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

42.6.4 Nursing Services

Nursing services are skilled nursing tasks, as defined by the Texas Board of Nursing (BON), that are included in the student's IEP. Nursing services may be direct nursing care or medication administration. Examples of reimbursable nursing services include, but are not limited to:

- Inhalation therapy.
- Ventilator monitoring.
- Nonroutine medication administration.
- Tracheostomy care.
- Gastrostomy care.
- Ileostomy care.
- Catheterization.
- Tube feeding.
- Suctioning.
- Client training.
- Assessment of a student's nursing and personal care services needs.

Direct nursing care services are billed in 15-minute increments and medication administration is reimbursed on a per-visit increment. The registered nurse (RN) or advanced practice nurse (APN) determines whether these services must be billed as direct nursing care or medication administration.

Nursing services must be provided by an RN, an APN (including nurse practitioners [NPs] and clinical nurse specialists [CNSs]), licensed vocational nurse/licensed practical nurse (LVN/LPN), or a school health aide or other trained, unlicensed assistive person delegated by an RN or APN.

Nursing services are billable on an individual or group basis. Only the time spent with the student present is billable. Time spent without the student present is not billable. Session notes are not required for nursing services; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the type of nursing service that was performed.

42.6.4.1 Nursing Services Billing Table

POS*	Procedure Code	Individual or Group	Unit of Service
1, 2, or 9	1-T1002 with modifier TD	Individual	15 minutes
1, 2, or 9	1-T1002 with modifier TD-UD	Group	15 minutes
1, 2, or 9	1-T1502 with modifier TD		Medication administration, per visit
1, 2, or 9	1-T1002 with modifier U7	Delegation, individual	15 minutes
1, 2, or 9	1-T1002 with modifier U7-UD	Delegation, group	15 minutes
1, 2, or 9	1-T1502 with modifier U7		Delegation, medication administration, per visit
1, 2, or 9	1-T1003 with modifier TE	Individual	15 minutes
1, 2, or 9	1-T1003 with modifier TE-UD	Group	15 minutes
1, 2, or 9	1-T1502 with modifier TE		Medication, administration per visit

***Place of Service: 1=office/school; 2=home; 9=other locations**
Modifier TD = nursing services provided by an RN or APN
Modifier U7 = nursing services delivered through delegation.
Modifier TE = nursing services delivered by an LVN/LPN

While the procedure code descriptions specifically state "up to 15 minutes," the Medicaid-allowable fee is determined based on 15-minute increments. Therefore, providers must use a 15-minute unit of service for billing.

All of the nursing services minutes that are delivered to a student during a calendar day must be added together before they are converted to units of service. Do not convert minutes of nursing services separately for each nursing task that was performed.

Minutes of nursing services cannot be accumulated over multiple days. Minutes of nursing services can only be billed per calendar day. If the total number of minutes of nursing services is less than eight minutes for a calendar day, then no unit of service can be billed for that day, and that day's minutes cannot be added to minutes of nursing services from any previous or subsequent days for billing purposes.

Refer to: "Billing Units Based on 15 Minutes" on page 42-13.

The recommended maximum billable time for direct nursing services is four hours per day. The recommended maximum billable units for procedure code 1-T1502 with modifier TD, 1-T1502 with modifier U7, or 1-T1502 with modifier TE is a cumulative of four medication administration visits per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

42.6.5 Occupational Therapy

In order for a student to receive OT through SHARS, the name and complete address or the provider identifier of the licensed physician who prescribed the OT must be provided.

OT evaluation services include determining what services, assistive technology, and environmental modifications a student requires for participation in the special education program.

OT includes:

- Improving, developing, maintaining, or restoring functions impaired or lost through illness, injury, or deprivation.
- Improving the ability to perform tasks for independent functioning when functions are impaired or lost.
- Preventing, through early intervention, initial or further impairment or loss of function.

OT must be provided by a professional who is licensed by the Texas Board of Occupational Therapy Examiners or a certified occupational therapist assistant (COTA) acting under the supervision of a qualified occupational therapist.

OT evaluation is billable on an individual (1-97003) basis only. OT is billable on an individual (1-97530) or group (1-97150) basis. The occupational therapist or COTA can only bill for time spent with the student present, including time spent assisting the student with learning to use adaptive equipment and assistive technology. Time spent without the student present, such as training teachers or aides to work with the student (unless the student is present during the training time), report writing, and time spent manipulating or modifying the adaptive equipment, is not billable. Session notes are not required for procedure code 1-97003; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the activity that was performed (e.g., OT evaluation). Session notes are required for procedure codes 1-97530 and 1-97150. Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

42.6.5.1 Occupational Therapy Billing Table

POS*	Procedure Code	Individual or Group	Therapist or Licensed/Certified Assistant
1, 2, or 9	1-97003	Individual	Licensed therapist
1, 2, or 9	1-97530 with modifier GO	Individual	Licensed therapist
1, 2, or 9	1-97530 with modifier GO-U1	Individual	Licensed/certified assistant
1, 2, or 9	1-97150 with modifier GO	Group	Licensed therapist
1, 2, or 9	1-97150 with modifier GO-U1	Group	Licensed/certified assistant

***Place of Service: 1=office/school; 2=home; 9=other locations**

Providers must use a 15-minute unit of service for billing.

Refer to: "Billing Units Based on 15 Minutes" on page 42-13.

The recommended maximum billable time for OT evaluation is one hour, which may be billed over several days. The recommended maximum billable time for direct therapy (group and/or individual) is a cumulative of one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

42.6.6 Physical Therapy

In order for a student to receive PT through SHARS, the name and complete address or the provider identifier of the licensed physician who prescribes the PT must be provided.

PT evaluation includes evaluating the student's ability to move throughout the school and to participate in classroom activities and the identification of movement dysfunction and related functional problems.

PT is provided for the purpose of preventing or alleviating movement dysfunction and related functional problems.

PT must be provided by a professional who is licensed by the Texas Board of Physical Therapy Examiners or a licensed physical therapist assistant (LPTA) acting under the supervision of a qualified physical therapist.

PT evaluation is billable on an individual (1-97001) basis only. PT is billable on an individual (1-97110) or group (1-97150) basis. The physical therapist can only bill time spent with the student present, including time spent helping the student to use adaptive equipment and assistive technology. Time spent without the student present, such as training teachers or aides to work with the student (unless the student is present during the training time) and report writing, is not billable. Session notes are not required for procedure code 1-97001; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the activity that was performed (e.g., PT evaluation). Session notes are required for procedure codes 1-97110

and 1-97150. Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

42.6.6.1 Physical Therapy Billing Table

POS*	Procedure Code	Individual or Group	Therapist or Licensed/Certified Assistant
1, 2, or 9	1-97001	Individual	Licensed therapist
1, 2, or 9	1-97110 with modifier GP	Individual	Licensed therapist
1, 2, or 9	1-97110 with modifier GP-U1	Individual	Licensed/certified assistant
1, 2, or 9	1-97150 with modifier GP	Group	Licensed therapist
1, 2, or 9	1-97150 with modifier GP-U1	Group	Licensed/certified assistant
***Place of Service: 1=office/school; 2=home; 9=other locations**			

Providers must use a 15-minute unit of service for billing.

Refer to: "Billing Units Based on 15 Minutes" on page 42-13.

The recommended maximum billable time for PT evaluation is one hour, which may be billed over several days. The recommended maximum billable time for direct therapy (group and/or individual) is a cumulative of one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

42.6.7 Speech Therapy

42.6.7.1 Referral

The name and complete address or the provider identifier or license number of the referring licensed physician or licensed SLP is required before speech therapy services can be billed under SHARS. A licensed SLP's evaluation and recommendation for the frequency, location, and duration of speech therapy serves as the speech referral.

42.6.7.2 Description of Services

Speech evaluation services include the identification of children with speech and/or language disorders and the diagnosis and appraisal of specific speech and language disorders. Speech therapy services include the provision of speech and language services for the habilitation or prevention of communicative disorders.

Speech evaluation is billable on an individual (1-92506 with modifier GN) basis only. Speech therapy is billable on an individual (1-92507) or group (1-92508) basis. Providers can only bill time spent with the student present, including assisting the student with learning to use adaptive equipment and assistive technology. Time spent without the student present, such as report writing and training teachers or aides to work with the student (unless the student is present during training), is not billable. Session notes are not required for procedure code 1-92506; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the activity that was performed (e.g., speech evaluation). Session notes are required for procedure codes 1-92507 and 1-92508. Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

42.6.7.3 Provider and Supervision Requirements

Speech therapy services are eligible for reimbursement when they are provided by an ASHA-certified SLP who holds a Texas license or an ASHA-equivalent SLP (has a master's degree in the field of speech language pathology and a Texas license). Speech therapy services are also eligible for reimbursement when provided by an SLP with a state education agency certification, a licensed SLP intern, and a grandfathered SLP who is acting under the supervision or direction of an SLP.

The supervision must meet the following provisions:

- The supervising SLP must provide supervision that is sufficient to ensure the appropriate completion of the responsibilities that were assigned.
- The direct involvement of the supervising SLP in overseeing the services that were provided must be documented.
- The SLP who provides the direction must ensure that the personnel who carry out the directives meet the minimum qualifications set forth in the rules of the State Board of Examiners for Speech-Language Pathology and Audiology which relate to Licensed Interns or Assistants in Speech-Language Pathology.

CMS interprets "under the direction of a speech-language pathologist," as an SLP who:

- Is directly involved with the individual under his direction.
- Accepts professional responsibility for the actions of the personnel he agrees to direct.
- Sees each student at least once.
- Has input about the type of care provided.
- Reviews the student's speech records after the therapy begins.
- Assumes professional responsibility for the services provided.

42.6.7.4 Speech Therapy Billing Table

POS*	Procedure Code	Individual or Group	Therapist or Licensed/Certified Assistant
1, 2, or 9	1-92506 with modifier GN	Individual	Licensed therapist
1, 2, or 9	1-92507 with modifier GN-U8	Individual	Licensed therapist
1, 2, or 9	1-92507 with modifier GN-U1	Individual	Licensed/certified assistant acting under the supervision or direction of a SLP
1, 2, or 9	1-92508 with modifier GN-U8	Group	Licensed therapist
1, 2, or 9	1-92508 with modifier GN-U1	Group	Licensed/certified assistant acting under the supervision or direction of a SLP

***Place of Service: 1=office/school; 2=home; 9=other locations**

Providers must use a 15-minute unit of service for billing.

Refer to: "Billing Units Based on 15 Minutes" on page 42-13.

The recommended maximum billable time for evaluation is three hours, which may be billed over several days. The recommended maximum billable time for direct therapy (group and/or individual) is a cumulative of one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

42.6.8 Evaluation/Assessment and Psychological Services

42.6.8.1 Evaluation/Assessment

Evaluations/assessments include activities related to the evaluation of the functioning of a student for the purpose of determining eligibility, the needs for specific SHARS services, and the development or revision of IEP goals and objectives. An evaluation/assessment is billable if it leads to the creation of an IEP for a student with disabilities who is eligible for Medicaid and who is under 21 years of age, whether or not the IEP includes SHARS.

Evaluations/assessments (1-96101) must be provided by a professional who is a licensed specialist in school psychology (LSSP), a licensed psychologist, or a licensed psychiatrist in accordance with 19 TAC §89.1040(b)(1) and 34 CFR §300.136(a)(1).

Evaluation/assessment billable time includes:

- Psychological, educational, or intellectual testing time spent with the student present.
- Necessary observation of the student associated with testing.
- A parent/teacher consultation with the student present that is required during the assessment because a student is unable to communicate or perform certain activities.
- Time spent without the student present for the interpretation of testing results.

Time spent gathering information without the student present or observing a student is not billable evaluation/assessment time.

Occupational therapists, physical therapists, audiologists, and SLPs who perform an evaluation should bill for their time under their individual procedure codes (1-97003, 1-97001, and 1-92506, with modifier U9, or 1-92506, with modifier GN).

Assessments for visual impairment that are performed by a licensed physician can only be billed under the medical services procedure code 1-99499. State-mandated vision and hearing screenings are not billable under SHARS.

Session notes are not required; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note which assessment activity was performed (e.g., testing, interpretation, or report writing).

Evaluation/Assessment Billing Table

POS*	Procedure Code	Individual/Group	Unit of Service
1, 2, or 9	1-96101	Individual	1 hour

***Place of Service: 1=office/school; 2=home; 9=other locations**

Providers may bill in partial hours, expressed as 1/10th of an hour (six-minute segments). For example, express 30 minutes as a billed quantity of 0.5.

Refer to: "Billing Units Based on an Hour" on page 42-13.

The recommended maximum billable time is eight hours over several days. Time spent for the interpretation of testing results without the student present is billable time. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

42.6.8.2 Psychological Services

Psychological services are counseling services provided to help a child with a disability benefit from special education and must be listed in the IEP.

Psychological services must be provided by a licensed psychiatrist, a licensed psychologist, or an LSSP. Nothing in this rule prohibits public schools from contracting with licensed psychologists and licensed psychological associates who are not LSSPs to provide psychological services, other than school psychology, in their areas of

competency. School districts may contract for specific types of psychological services, such as clinical psychology, counseling psychology, neuropsychology, and family therapy, that are not readily available from the LSSP who is employed by the school district. Such contracting must be on a short-term or part-time basis and cannot involve the broad range of school psychological services listed in 22 TAC §465.38(1)(B).

All psychological services are billable on an individual (1-96152) or group (1-96153) basis. Session notes are required. Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

School districts may receive reimbursement for emergency psychological services as long as the student's IEP includes a behavior improvement plan that documents the need for the emergency services.

Psychological Services Billing Table

POS*	Procedure Code	Individual/Group
1, 2, or 9	1-96152 with modifier AH	Individual
1, 2, or 9	1-96153 with modifier AH	Group
***Place of Service: 1=office/school; 2=home; 9=other locations**		

Providers must use a 15-minute unit of service for billing.

Refer to: "Billing Units Based on 15 Minutes" on page 42-13.

Important: *The recommended maximum billable time for direct psychological therapy (group and/or individual) is a cumulative of one hour per day for nonemergency situations. Providers must maintain documentation of the reasons for the additional time, if more than the recommended maximum time is billed.*

42.6.9 Personal Care Services

Personal care services are provided to help a child with a disability or chronic condition benefit from special education. Personal care services include a range of human assistance provided to persons with disabilities or chronic conditions which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. An individual may be physically capable of performing activities of daily living (ADLs) and instrumental ADLs (IADLs) but may have limitations in performing these activities because of a functional, cognitive, or behavioral impairment. For personal care services to be billable, they must be listed in the student's IEP. Personal care services are billable on an individual (1-T1019 with modifier U5 or U6) or group (1-T1019 with modifier U5-UD or U6-UD) basis. Session notes are not required for procedure codes 1-T1019 with modifier U5 or 1-T1019 with modifier U5-UD; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the type of personal care service that was performed. Procedure codes 1-T1019 with modifier U6 and 1-T1019 with modifier U6-UD are billed using a one-way trip unit of service.

42.6.9.1 Personal Care Services Billing Table

POS*	Procedure Code	Individual or Group	Unit of Service
1, 2, or 9	T1019 with modifier U5	Individual, school	15 minutes
1, 2, or 9	T1019 with modifier U5-UD	Group, school	15 minutes
1, 2, or 9	T1019 with modifier U6	Individual, bus	Per one-way trip
1, 2, or 9	T1019 with modifier U6-UD	Group, bus	Per one-way trip
***Place of Service: 1=office/school; 2=home; 9=other locations**			

Refer to: "Billing Units Based on 15 Minutes" on page 42-13.

The recommended maximum billable units for 1-T1019 with modifier U6 or 1-T1019 with modifier U6-UD is a cumulative of four one-way trips per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended units of service are billed.

42.6.10 Transportation Services in a School Setting

Transportation services in a school setting are reimbursed when they are provided on a specially-adapted vehicle and if the following criteria are met:

- Provided to and/or from a Medicaid-covered service on the day for which the claim is made.
- A child requires transportation in a specially-adapted vehicle to serve the needs of the disabled.
- A child resides in an area that does not have school bus transportation, such as those in close proximity to a school.
- The Medicaid-covered SHARS is included in the student's IEP.
- The special transportation service is included in the student's IEP.

A specially-adapted vehicle is one that has been physically modified (e.g., addition of a wheelchair lift, addition of seatbelts or harnesses, addition of child protective seating, or addition of air conditioning). A bus monitor or other personnel accompanying children on the bus is not considered an allowable special adaptive enhancement for Medicaid reimbursement under SHARS specialized transportation. Specialized transportation services reimbursable under SHARS requires the Medicaid-eligible special education student has the following documented in his or her IEP:

- The student requires a specific physical adaptation or adaptations of a vehicle in order to be transported.
- The reason why the student needs the specialized transportation.

Children with special education needs who ride the regular school bus to school with other nondisabled children are not required to have the transportation services in a school setting listed in their IEP. Also, the cost of the regular school bus ride cannot be billed to SHARS. Therefore, the fact that a child may receive a service through SHARS does not necessarily mean that the transportation services in a school setting would be reimbursed for them.

Reimbursement for covered transportation services is on a student one-way trip basis. The following one-way trips may be billed if the student receives a billable SHARS service (including personal care services on the bus) and is transported on the school's specially adapted vehicle from:

- The student's residence to school.
- The school to the student's residence.
- The student's residence to a provider's office that is contracted with the district.
- A provider's office that is contracted with the district to the student's residence.
- The school to a provider's office that is contracted with the district.
- A provider's office that is contracted with the district to the student's school.
- The school to another campus to receive a billable SHARS service.
- The campus where the student received a billable SHARS service back to the student's school.

Covered transportation services from a child's residence to school and return are not reimbursable if, on the day the child is transported, the child does not receive a Medicaid-covered SHARS service (other than transportation). Documentation of each one-way trip provided must be maintained by the school district (e.g., trip log). This service must not be billed by default simply because the student is transported on a specially-adapted bus.

42.6.10.1 Transportation Services in a School Setting Billing Table

POS*	Procedure Code	Unit of Service
1, 2, or 9	1-T2003	Per one-way trip
***Place of Service: 1=office/school; 2=home; 9=other locations**		

42.7 Claims Information

42.7.1 Other Insurance

Medicaid guidelines state that other insurance carriers must be billed before billing the Texas Medicaid Program. If the SHARS student has other insurance, the SHARS provider can call the other insurance company to inquire whether the service is covered under the student's insurance plan. If the service is not covered under the student's insurance plan, the SHARS provider can obtain from the other insurance company a verbal denial without ever billing the other insurance carrier.

To appeal a Medicaid claim that was denied for other insurance using a verbal denial from the other insurance company, the SHARS provider should submit the following information:

- The date of the telephone call with the other insurance company.
- The name and telephone number of the insurance carrier.
- The name of the insurance representative.
- Policy and group holder information.
- The specific reason for denial.

Include the client's type of coverage to enhance the accuracy of future claims processing.

If the SHARS provider learns that the other insurance policy does cover the service, the SHARS provider must obtain parental permission to bill the other insurance carrier. If parental permission is not received or the SHARS provider does not wish to pursue payment through the other insurance carrier, the SHARS provider cannot bill the Texas Medicaid Program by submitting claims for the services to TMHP.

42.7.2 Claims Information

Claims for SHARS must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"CMS-1500 Claim Filing Instructions" on page 5-22. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

42.7.3 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-22

Resource	Page Number
TMHP Electronic Claims Submission	5-13
Communication Guide	A-1
School Health and Related Services (SHARS) Claim Example	D-33
Acronym Dictionary	F-1

42.7.4 Billing Units Based on 15 Minutes

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

Reminder: *Enter the number of billing units in Block 24G of the CMS-1500 paper claim form. Claims without this information will be reimbursed as a unit of 1.*

To calculate billing units, count the total number of billable minutes for the calendar day for the SHARS student, and divide by 15 to convert to billable units of service. If the total billable minutes are not divisible by 15, the minutes are converted to one unit of service if they are greater than seven and converted to 0 units of service if they are seven or less minutes.

For example, 68 total billable minutes/15 = 4 units + 8 minutes. Since the 8 minutes are more than 7 minutes, those 8 minutes are converted to one unit. Therefore, 68 total billable minutes = 5 units of service.

Examples:

- 0 min–7 mins = 0 units.
- 8 mins–22 mins = 1 unit.
- 23 mins–37 mins = 2 units.
- 38 mins–52 mins = 3 units.
- 53 mins–67 mins = 4 units.
- 68 mins–82 mins = 5 units.

42.7.5 Billing Units Based on an Hour

All claims for reimbursement are based on the actual amount of billable time associated with the SHARS service. For those services for which the unit of service is an hour (1 unit = 60 minutes = one hour), partial units should be billed in tenths of an hour and rounded up or down to the nearest six-minute increment.

Reminder: *Enter the number of billing units in Block 24G of the CMS-1500 paper claim form. Claims without this information will be reimbursed as a unit of 1.*

To calculate billing units, count the total number of billable minutes for the calendar day for the SHARS student and divide by 60 to convert to billable units of service. If the total billable minutes are not divisible by 60, the minutes are converted to partial units of service as follows:

- 0 mins–3 mins = 0 units.
- 4 mins–9 mins = 0.1 unit.
- 10 mins–15 mins = 0.2 unit.
- 16 mins–21 mins = 0.3 unit.
- 22 mins–27 mins = 0.4 unit.
- 28 mins–33 mins = 0.5 unit.
- 34 mins–39 mins = 0.6 unit.
- 40 mins–45 mins = 0.7 unit.
- 46 mins–51 mins = 0.8 unit.
- 52 mins–57 mins = 0.9 unit.

Other examples:

- 58 mins–63 mins = 1 unit.
- 64 mins–69 mins = 1.1 units.
- 70 mins–75 mins = 1.2 units.
- 76 mins–81 mins = 1.3 units.
- 82 mins–87 mins = 1.4 units.
- 88 mins–93 mins = 1.5 units.

Section

43

Texas Health Steps (THSteps)

43.1 THSteps Medical and Dental Administrative Information

This section describes the administrative requirements for the THSteps Program, including provider requirements, client eligibility requirements, and billing and claims processing information. "Clinical Information" on page 43-15 contains information for medical and dental services provided under THSteps. Providers needing additional information, may call 1-800-757-5691 or refer to the "THSteps Quick Reference Guide" on page M-1 for a more specific list of resources and telephone numbers. Providers may also contact the DSHS THSteps Provider Relations staff in the DSHS regional office by calling the appropriate regional office as listed in "DSHS Health Service Region Contacts" on page A-8.

43.1.1 Overview

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service is Medicaid's comprehensive preventive child health service for individuals birth through 20 years of age. In Texas, EPSDT is known as the THSteps program. EPSDT was defined by federal law as part of the *Omnibus Budget Reconciliation Act* (OBRA) of 1989 legislation and includes periodic screening, vision, hearing, and dental preventive and treatment services. In addition, Section 1905(r)(5) of the *Social Security Act (SSA)* requires that any medically necessary health-care service listed in the Act be provided to THSteps (EPSDT) clients even if the service is not available under the state's Medicaid plan to the rest of the Medicaid population. A service is medically necessary when it corrects or ameliorates the client's disability, physical, or mental illness, or chronic condition. These additional services are available through the Comprehensive Care Program (CCP). THSteps-CCP services are the diagnosis and treatment components of THSteps. For questions about coverage, providers can call THSteps-CCP at 1-800-846-7470.

43.1.2 Statutory Requirements

Several specific legislative requirements affect the THSteps program and the providers participating in the program. These include, but are not limited to, the following:

- Newborn Screening, *Health and Safety Code*, Chapter 37.
- Newborn Blood Screening, *Health and Safety Code*, Chapter 33.
- Parental Accompaniment, as outlined in Appendix K, THSteps Statutory Requirements, "Parental Accompaniment" on page K-2.
- Requirements for Reporting Abuse or Neglect, as outlined in "Compliance with Texas Family Code" on page 1-5.
- Simplified Enrollment, *Texas Human Resources Code*, §32.025.
- Early Childhood Intervention (ECI), 34 *Code of Federal Regulations* (CFR) Part 303; Chapter 73, *Texas Human Resources Code,* and Title 40 *Texas Administrative Code* (TAC), Chapter 108.
- Newborn Hearing Screening, *Health and Safety Code*, Chapter 37.
- Teen Confidentiality Issues. There are many state statutes that may affect consent to medical care for a minor, depending on the facts of the situation. Among the relevant statutes are Chapters 32, 33, 153, and 266 of the *Texas Family Code*. Providers may want to consult an attorney, their licensing board, or professional organization if guidance is needed or questions arise on matters of medical consent.

Refer to: "Texas Health Steps Statutory State Requirements" on page K-1 for more information.

43.1.3 Medical Transportation Program (MTP)

On request by the client, the Texas Department of Transportation MTP can assist the client with scheduling transportation for THSteps medical and dental check ups. Clients or their advocates may call the statewide MTP toll-free number (1-877-633-8747).

Refer to: "Medical Transportation" on page I-1 for more information.

43.1.4 Provider Enrollment

Providers cannot be enrolled if their professional license is due to expire within 30 days of application. Facility providers must submit a current copy of the supervising practitioner's license. To provide Medicaid services, each nurse practitioner (NP) must be licensed as a registered nurse (RN) and recognized as an advanced practice nurse (APN) by the Texas Board of Nursing (BON).

To enroll in the THSteps program, providers must be enrolled in the Texas Medicaid Program, and meet one of the following requirements:

- Physicians (doctor of medicine [MD] and doctor of osteopathy [DO]) currently licensed in the state where the service is provided.
- Health-care providers or facilities (public or private) capable of performing the required medical check up procedures under a physician's direction, such as regional and local health departments, family planning clinics, migrant health clinics, community-based hospitals and clinics, maternity clinics, rural health clinics (RHCs), federally qualified health centers (FQHCs), home health agencies, and school districts. In the case of a clinic, a physician is not required to be present in the clinic at all times during the hours of operation; however, a physician must assume responsibility for the clinic's operation.
- Family and pediatric nurse practitioners enrolled independently.

- Certified nurse-midwives (CNMs) enrolled as providers of THSteps medical check ups for newborns younger than 2 months of age and adolescent females.
- Women's health-care nurse practitioners enrolled as providers of THSteps medical check ups for adolescent females.
- Adult nurse practitioners enrolled as providers of THSteps check ups for adolescents.
- Physician assistants (PAs) may enroll independently as THSteps medical providers. It is recommended that PAs have expertise or additional education in the areas of comprehensive pediatric assessment.

Residents may provide medical check ups in a teaching facility under the personal guidance of the attending staff as long as the facility's medical staff by-laws and requirements of the Graduate Medical Education (GME) Program are met, and the attending physician has determined the intern or resident to be competent in performing these functions. THSteps does not require the supervising physician to examine the client as long as these conditions are met.

An RN may not enroll independently, but may perform THSteps medical check ups only under the supervision of a physician. The physician ensures that the RN has appropriate training and adequate skills for performing the procedures for which they are responsible.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for information about enrollment procedures.

43.1.4.1 Additional Education Requirements for Registered Nurses (RNs)

The educational requirements have changed for RNs who complete the physical assessment portion of the THSteps medical check up.

THSteps has developed online education modules that contain new courses approved for continuing education units (CEU) for RNs. A module that is specific to physical assessment is being developed, and its release is expected in early 2008. THSteps online education modules may be accessed at www.txhealthsteps.com.

Before a physician delegates a THSteps check up to an RN, the physician must establish the RN's competency to perform the service as required by the physician's scope of practice. The delegating physician is responsible for supervising the RN who performs the services. The delegating physician remains responsible for any service provided to a client.

The RN or the employer must maintain documentation that the available required courses were completed.

- Newborn screening.
- Introduction to the medical home.
- Overview.
- Dental health for primary care providers.
- Mental health screening.
- Developmental screening.
- Vision and hearing screening.
- Newborn hearing screening.
- Nutrition.
- Immunization.
- Cultural competence.
- Adolescent health screening.
- Weight management.
- Case management.
- Physical assessment. (It is anticipated that this course will be available in early 2008.)

RNs who have completed the previously required courses are encouraged, but not required, to take the online courses.

Refer to: "Provider Enrollment" on page 43-5 for more information about enrollment procedures.

43.1.4.2 Medicaid Managed Care Enrollment

The Medicaid Managed Care Program consists of two types of health-care delivery systems, Primary Care Case Management (PCCM) and health maintenance organization (HMO). THSteps medical providers do not have to enroll with PCCM to be reimbursed for medical check up services provided to PCCM clients. Bills are submitted directly to TMHP, and PCCM clients are free to choose the provider who will perform their THSteps medical check ups.

Under HMOs this same freedom of choice exists; however, providers bill the HMO rather than TMHP. Clients should check with their HMO to see whether they must select a provider in the network.

While preventive services are available in managed care, those provided to clients from birth through 20 years of age must be completed as THSteps medical check ups,

including completion of all components as noted in this section, and be submitted with appropriate THSteps procedure codes and THSteps provider identifiers.

Note: *Diagnosis and treatment of problems must be provided either by the client's primary care provider or by a provider referred by the client's primary care provider. If a THSteps medical check up is performed by a provider who is not the client's primary care provider, the results of the medical check up should be forwarded to the client's primary care provider so that the client's medical record can be updated, in keeping with the medical home concept.*

If an enrolled medical check up provider wants to discontinue participation, the provider must send written notification to the managed care health plan. The provider must also send written notification to TMHP at the following address:

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

Refer to: "Provider Enrollment" on page 43-5 for more information about enrollment.

"Managed Care" on page 7-1.

43.1.5 Eligibility for a Medical Check Up

Through outreach, THSteps staff (the Department of State Health Services [DSHS], HHSC, or contractors) encourage clients to use THSteps preventive medical check up services when they first become eligible for Medicaid and each time thereafter when they are periodically due or overdue for their next medical check up.

Providers are encouraged to perform check ups on any client they identify as eligible for medical check ups. They also are encouraged to notify clients when they are due for the next check up according to the THSteps periodicity schedule.

The client is periodically eligible for medical check up services based on the THSteps Periodicity Schedule. A THSteps statement under the client's name on the regular client Medicaid Identification (Form H3087) and the State of Texas Access Reform (STAR) Identification (Form H3087 STAR) indicates the THSteps services for which the client is currently eligible. A check mark on the identification form indicates eligibility for the particular service, such as eye exam, eye glasses, hearing aid, dental, prescriptions, and medical services. A blank space denotes that the client is not eligible for the particular service based on available data.

Check ups provided when a THSteps statement does not indicate a medical check up is due must be billed as an exception to the periodicity schedule.

Refer to: "Exceptions to Periodicity" on page 43-9 for further details about billing for a check up performed as an exception to periodicity.

Although the Medicaid Eligibility Verification Letter (Form H1027) identifies eligible clients when the client Form H3087 is lost or has not yet been issued, Form H1027 does not indicate periodic eligibility for medical check up services. Providers can call the TMHP Contact Center at 1-800-925-9126 or check the TMHP website at www.tmhp.com to verify a client's eligibility for medical check up services.

43.1.5.1 Newborn Eligibility

A newborn child may be eligible for Medicaid for up to one year if the child's mother is:

- Receiving Medicaid at the time of the child's birth.
- Eligible for Medicaid or would be eligible if pregnant.
- Living with the child.

If the newborn has Medicaid coverage, providers may not require a deposit for newborn care from the guardian. The child's eligibility ends if the child's mother relinquishes her parental rights or if it is determined that the child is no longer part of the mother's household. The hospital or birthing center must report the birth to HHSC Eligibility Services at the time of the child's birth.

If the hospital or birthing center notifies HHSC Eligibility Services that a newborn child was born to a Medicaid-eligible mother, then the hospital caseworker, mother, and attending physician (if identified) should receive a Medicaid Eligibility Verification Letter (Form H1027) from HHSC a few weeks after the child's birth. The H1027 includes the child's Medicaid number and effective date of coverage. After the child has been added to the HHSC eligibility file, a Form H3087 is issued.

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

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

Refer to: "Medicaid Identification Form H3087" on page 4-19.

43.1.6 Reimbursement

THSteps-enrolled providers are reimbursed for THSteps medical check ups and administration of immunizations in accordance with 1 TAC §355.8441.

THSteps medical check ups provided in an FQHC are reimbursed in accordance with 1 TAC §355.8261.

RHCs are reimbursed using visit rates calculated in accordance with 1 TAC §355.8101.

Refer to: "Texas Medicaid Reimbursement" on page 2-1 for more information about reimbursement.

43.1.7 Benefits and Limitations

43.1.7.1 Medical Check Up Visits

Medical check up services are covered for clients birth through 20 years of age when delivered in accordance with the THSteps Medical Check Ups Periodicity Schedule. The schedule specifies the screening procedures recommended at each stage of the client's life and identifies the time period based on the client's age when medical check up services are reimbursable.

Note: *Only services provided are considered for reimbursement. In accordance with federal policy, the Texas Medicaid Program and Medicaid clients cannot be charged when a client does not keep an appointment. All components of the check up must be completed if submitting a claim for a medical document.*

Providers should treat each THSteps check up as the only opportunity for a client's comprehensive assessment.

In acknowledgment of the practical situations that occur in the office or clinic settings, the periodicity schedule published in this manual has stressed the philosophy that the components of the THSteps medical check up should be completed according to the individual client's appropriate needs. If a component cannot be completed because of a medical contraindication of a client's condition, then a follow-up visit is necessary. The provider should document the reason the component(s) was not completed and schedule a follow-up visit.

If components of the THSteps check up have been provided one month preceding the client's birthday month and the medical check up occurs in the following month, providers should clearly refer to that previous documentation, including the date(s) of service in the current clinical notation, and add appropriate new documentation for the check up currently being billed.

All components of the THSteps medical check up are included in the reimbursement of the visit. The visit is a comprehensive medical check up and must include all assessments, screenings, immunizations, and laboratory tests as indicated on the periodicity schedule. When there is an available Current Procedural Terminology (CPT) code for a component, it is not reimbursed separately on the same day as a medical check up.

Reminder: *A complete check up is an assessment provided in accordance with mandated procedures and the narrative standards outlined for each procedure. Incomplete medical check ups are not reimbursed.*

Sports physical/examinations are not a benefit of the Texas Medicaid Program. If the client is due for a THSteps medical check up and a comprehensive medical check up is completed, a THSteps medical check up may be reimbursed.

Refer to: "THSteps Medical Check Ups Periodicity Schedule for Infants, Children, and Adolescents (Birth Through 20 Years of Age)" on page 43-17 for information about the components required at specific ages.

In the first two years of the client's life, providers may bill up to nine visits, regardless of the date of the last medical check up.

All of the check ups listed on the periodicity schedule have been developed based on recommendations of the American Academy of Pediatrics (AAP). In Texas, the THSteps program has modified the AAP periodicity schedule based on the scheduling of a test in federal EPSDT regulations or other programs or to meet the population's needs.

When the THSteps provider who performs the check up determines that a referral for diagnosis and treatment is necessary for a condition found during the check up, the referral should be made to a provider who is qualified to perform diagnostic or treatment services.

If the provider performing the medical check up can provide treatment for the identified condition, a separate claim for an *established* client office visit may be submitted on the same day as the check up with an appropriate established client CPT code for the diagnosis and treatment of the identified problem. Often minor illnesses or conditions (e.g., follow-up of a mild upper respiratory infection) during the THSteps medical check up do not warrant additional billing.

Exception: *Medicaid Managed Care (including PCCM) clients must be referred to their designated primary care provider for further treatment or referral.*

In addition, federal and state law requires providers to refer children within two business days of identification of a suspected developmental delay or disability to the local ECI program for children birth to 3 years. The provider may call the local ECI Program or the DARS Inquiries Line at 1-800-628-5115 to make referrals. Children 3 years and older with a suspected developmental delay or disability should be referred to the local school district.

For acute care claims, providers must bill the CPT codes for evaluation and management (E/M) of *established* clients with an appropriate diagnosis documented.

43.1.7.2 Follow-up Medical Check Up Visit

A follow-up check up visit, procedure code S-99211, is reimbursed at a maximum fee of $14.96 except for services performed in an RHC or FQHC setting. Follow-up check ups may be needed when required to complete necessary procedures related to the THSteps check up (e.g., to read a TB skin test, transportation and outreach work required by the provider to read a TB skin test, administering immunizations in cases where the child's immunizations were not up-to-date or medically contraindicated on the initial visit, and repeating laboratory work). A return visit to follow up on treatment initiated during the screen or to make a referral must not be filed as a follow-up visit.

Follow-up visits may not be billed on the same day as a THSteps visit.

A medical check up follow-up visit must be billed with a THSteps provider identifier to be considered for reimbursement for a THSteps visit. FQHCs must submit the same procedure code, but with modifier EP.

43.1.7.3 Newborn Examination

Inpatient newborn examinations billed with procedure codes 1-99431 and 1-99432 are counted as THSteps medical check ups and must include all the necessary components.

The required components of the initial THSteps newborn check up must meet THSteps requirements and must include the following documentation:

- History and physical examination.
- Length, height, weight, and head circumference.
- Sensory screening (vision and hearing appropriate to age).
- Hepatitis B immunization.
- Mandated initial newborn screen at 24–48 hours of age.
- Health education and anticipatory guidance with the parents or a responsible adult who is familiar with the client's medical history. Health education by the nursing staff, individually or in a class, is acceptable.

Note: *In Texas the newborn hearing screening is included in the in-hospital newborn exam.*

Providers must include and document the required components when billing procedure codes 1-99431 or 1-99432 to the Texas Medicaid Program.

If the provider chooses to do a brief examination (not including all the above components), the provider may bill procedure code 1-99431 or 1-99432 with modifier 52, which does not count as a THSteps check up.

Providers billing these newborn codes are not required to be THSteps providers, but they must be enrolled as Medicaid providers. TMHP encourages THSteps enrollment for all providers that offer a medical home for clients and provide them with well-child care and immunizations. Physicians and hospital staff are encouraged to inform parents eligible for Medicaid that the next THSteps check up on the periodicity schedule should be scheduled at 1 to 2 weeks of age and that regular check ups should be scheduled during the first year.

43.1.7.4 Medical Check Up, First 6 Days of Life

To encourage early check ups for high-risk but healthy newborns, providers may bill a THSteps medical check up in the first six days of life as an exception to periodicity. A physical examination is important if the client has been discharged early from the hospital or if the infant was born outside of a hospital. A home visit may be especially helpful for first-time mothers. The first regular check up on the periodicity schedule should still be scheduled at 1 to 2 weeks of age, is also reimbursable, and should include the second newborn screen.

The exception-to-periodicity check up performed in the first six days of life may be performed in a clinic, provider's office, or the family's home. If the check up is performed in the home, the provider must be designated by the discharging physician or the medical home physician before discharge and must provide a timely report of findings and recommendations to the infant's medical home.

Refer to: "Medical Home Concept" on page 43-12.

A THSteps medical check up in the first six days of life, billed as an exception to periodicity, must include the following documentation:

- Neonatal and family history.
- Review of systems.
- Height, weight, and head circumference.
- Physical and nutritional assessment.
- Vision and hearing screening.
- Age-appropriate immunization.
- Assessment of the mental health status of the infant and mother.
- Anticipatory guidance.

The metabolic screening should only be obtained if not obtained before discharge from the hospital. The repeat metabolic screening should be completed at the one- or two-week visit. If a potential or confirmed medical problem requires monitoring, it is recommended that the infant be seen in a clinic or medical provider's office, and the Texas Medicaid Program should be billed using codes for an acute care visit.

43.1.7.5 Exceptions to Periodicity

Payment is made for medical check ups that are exceptions to the periodicity schedule to allow for services in the categories below; however, if the client is due for a medical check up then the visit should be billed as regular check up, not an exception to periodicity.

- Medically necessary (such as developmental delay or suspected abuse).
- Environmental high-risk (such as sibling of a child with elevated blood lead).
- Required to meet state or federal exam requirements for Head Start, daycare, foster care, pre-adoption, or to provide a check up prior to the next periodically due check up, if the client will not be available when due. This includes clients whose parents are migrant/seasonal workers.
- Required for dental services provided under general anesthesia.
- Medically necessary check up in the first six days of life.

Refer to: "CMS-1500 Claim Filing Instructions" on page 5-22 for billing instructions.

THSteps medical exception to periodicity services must be billed with the same procedure codes, provider type, modifier, and condition indicators as a medical check up. Additionally, providers must use modifiers 23, 32, and SC to indicate the exception.

- Modifier 23 refers to a client who receives a medical check up prior to general anesthesia related to dental procedures.
- Modifier 32 refers to a client who receives a medical check up as mandated by state or federal programs, such as Head Start, entry into foster care, or adoption.
- Modifier SC refers to a check up that a client is receiving as a medically necessary service.

43.1.8 Verification of Medical Check Ups

The first source of verification that a THSteps medical check up has occurred is a paid claim or encounter. THSteps encourages providers to file a claim either electronically or on a CMS-1500 claim form as soon as possible after the date of service (DOS), as the paid claim updates client information, including the Medicaid Identification (Form H0387).

The second source of acceptable verification is a physician's written statement that the check up occurred. If the provider chooses to give the client written verification, it must include the client's name, Medicaid ID number, date of the medical check up, and a notation that a complete THSteps medical check up was performed. Verification of medical check ups should not be sent to THSteps but should be maintained by the client to be provided as needed by HHSC eligiblity caseworker.

If neither the first nor the second source of verification is available, a THSteps outreach worker may contact the provider's office for verification.

43.1.9 Claims Information

43.1.9.1 Procedure Coding for THSteps Medical Check Ups

The following are procedure codes and reimbursement fees for medical check ups:

Procedure Code	Reimbursement Fee
S-99381	$84.51
S-99382	$92.47
S-99383	$92.09
S-99384	$100.43
S-99385	$100.43
S-99211	$14.96
S-99391	$77.75
S-99392	$85.07
S-99393	$84.72
S-99394	$92.40
S-99395	$92.40

Claims for THSteps medical check ups must be submitted with the appropriate procedure codes (S-99381, S-99382, S-99383, S-99384, S-99385, S-99391, S-99392, S-99393, S-99394, and S-99395) and diagnosis code V202. Procedure codes S-99385 and S-99395 are restricted to clients 18 through 20 years of age for a THSteps medical check up.

THSteps medical check ups performed in an FQHC or RHC setting are paid an all-inclusive rate per visit. For services performed in an RHC, providers must use the national place of service code (POS) 72. An FQHC provider must use modifier EP when submitting claims for all THSteps visits in addition to the modifiers used to identify who performed the medical check up.

Condition indicators must be used to describe the results of the check up. A condition indicator must be entered on the claim with the periodic medical check up visit procedure code. Indicators are required whether a referral was made or not.

If a referral was made, providers must use the Y referral indicator. If no referral is made, providers must use the N referral indicator.

Procedure Codes	Referral Indicator	Condition Indicator
S-99381, S-99382, S-99383, S-99384, and S-99385 (New client preventive visit) or S-99391, S-99392, S-99393, S-99394, and S-99395 (Established client preventive visit)	N (No referral given)	NU (Not used)
S-99381, S-99382, S-99383, S-99384, and S-99385 (New client preventive visit) or S-99391, S-99392, S-99393, S-99394, and S-99395 (Established client preventive visit)	Y (Yes THSteps or EPSDT referral was given to the client)	S2 (Under treatment) or ST* (New services requested)

***The ST condition indicator should only be used when a referral is made to another provider or the client must be rescheduled for another appointment with the same provider. It does not include treatment initiated at the time of the check up.**

Modifiers AM, SA, TD, and U7 must be used to indicate the practitioner who performed the unclothed physical examination during the medical check up.

43.1.9.2 Immunizations

The specific diagnosis necessitating the vaccine/toxoid is required when billing with administration procedure codes 1/S-90465, 1/S-90466, 1/S-90467, 1/S-90468,

1/S-90471, 1/S-90472, 1/S-90473, and 1/S-90474 in combination with the appropriate vaccine administration code in the following table. For clients birth through 20 years of age, diagnosis code V202 may be used unless a more specific diagnosis code is appropriate

For all immunizations, if only one immunization is administered during a check up or visit, providers should bill administration procedure code 1/S-90465, 1/S-90467, 1/S-90471, and 1/S-90473 with a quantity of 1 in addition to the appropriate national code that describes the immunization administered.

If two or more immunizations are administered, providers should bill administration procedure codes 1/S-90465, 1/S-90467, 1/S-90471, or 1/S-90473 with a quantity of 1, procedure codes 1/S-90466, 1/S-90468, 1/S-90472, or 1/S-90474 with a quantity of 1 or more (depending on the number of vaccines administered), and the procedure codes that describe each immunization administered. The procedure codes that identify each vaccine are considered informational but are required on the claim.

Immunization administration fees are reimbursed based on the number of state-defined components (as identified on the table below) administered per injection: one state-defined component, $8 (no modifier); two state-defined components, $12 (modifier U2); three state-defined components, $16.00 (modifier U3). Combined antigen vaccines (e.g., DTaP or MMR) are reimbursed as one dose.

Vaccine Procedure Code	No. of Components
1/S-90632*	1
1/S-90633*	1
1-90636	2
1/S-90645	1
1/S-90646	1
1/S-90647	1
1/S-90648*	1
1/S-90649*	1
1/S-90655*	1
1/S-90656*	1
1/S-90657*	1
1/S-90658*	1
1/S-90660*	1
1/S-90669*	1
1/S-90680*	1
1/S-90700*	1
1/S-90702*	1
1-90703	1
1/S-90707*	1
1/S-90710*	2
1/S-90713*	1
1/S-90714*	1
1/S-90715*	2
1/S-90716*	1
1/S-90718	1
1/S-90723*	3
1-90732*	1
1/S-90733	1
1/S-90734*	1
1-90740	1
1/S-90744*	1
1/S-90746*	1
1-90747	1
1/S-90748*	2
1/S-90749	1

*** Texas Vaccines For Children (TVFC) distributed vaccine/toxoid.**

Providers may use the state defined modifier U1, as described below, in addition to the associated administered vaccine procedure code.

Modifiers	Description
U1	State-defined modifier: Vaccine is unavailable from TVFC. * U1 modifier only applies to the following vaccines: influenza, HPV and rotavirus, MMRV, and Tdap
U2	State-defined modifier: Administration of vaccine/toxoid with two state defined components
U3	State-defined modifier: Administration of vaccine/toxoid with three state defined components

*** "Unavailable" is defined as: A new vaccine approved by the Advisory Committee on Immunization Practices (ACIP) that has not been negotiated or added to a TVFC contract, funding for new vaccine that has not been established by TVFC, or national supply and/or distribution issues. Modifier U1 may not be used for failure to enroll in TVFC or to maintain sufficient TVFC vaccine/toxoid inventory.**

Exception: *Medical contraindications and exclusions from immunizations for reasons of conscience (including a religious belief and parental/client refusal) are the only acceptable reasons for not administering immunizations.*

Refer to: "Immunizations Overview" on page H-2 for exclusions from immunizations.

43.1.9.3 Billing

THSteps providers do not have to bill private insurance for a medical check up; they can bill TMHP directly even if the provider knows that the client has private insurance. For

THSteps medical check ups, TMHP is responsible for determining if a third party resource (TPR) exists and for seeking payment from the TPR.

Providers should bill their usual and customary fee. Providers are reimbursed the lesser of the billed amount or the maximum allowable fee.

THSteps medical check ups may be billed electronically or on a CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

Providers may request information about electronic billing or the claim form by contacting the TMHP THSteps Contact Center at 1-800-757-5691.

All procedures, including the informational-only procedures, must have a billed amount associated with each procedure listed on the claim. Informational-only procedure codes must be billed in the amount of at least $.01.

Providers must record the following on the CMS-1500 claim form to receive reimbursement for a medical check up:

- Appropriate THSteps medical check up procedure code (all ages).
- TB skin test procedure code, if administered (1 to 20 years of age).
- Immunization administration and vaccine procedure code(s) if administered (all ages).
- Condition indicator codes are placed in 24C. (ST, S2, or NU only).
- Provider type modifiers.
- EP modifier, if appropriate.

Submit claims to the following address:

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

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"CMS-1500 Claim Filing Instructions" on page 5-22 for billing instructions.

43.1.9.4 Claim Filing Resources

Refer to the following sections and/or forms for claims filing information:

Resource	Page Number
CMS-1500 Claim Filing Instructions	5-22
TMHP Electronic Claims Submission	5-13
Communication Guide	A-1
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
Diagnosis and Treatment (Referral from THSteps Check Up) Claim Form Example	D-11
THSteps Complete Medical Check Up (CMS-1500) Claim Form Examples	D-34
Acronym Dictionary	F-1

43.1.10 THSteps Medical Check Up Facilities

All THSteps medical check up policies apply to check ups completed in a physician's office, a health department, clinic setting, or in a mobile/satellite unit. Enrollment of a mobile/satellite unit must be under a physician or clinic name. Mobile units can be a van or any area away from the primary office and are considered extensions of that office and are not separate entities.

The physical setting must be appropriate so that all elements of the check up can be completed. For specific information, review the periodicity schedules and narrative explaining the schedules.

43.1.10.1 Medical Home Concept

HHSC and DSHS encourage providers participating in the Texas Medicaid Program to practice the "medical home concept" for clients with Medicaid. To realize the maximum benefit of health care, each family and individual needs to be a participating member of a readily identifiable, community-based medical home.

The medical home provides primary medical care and preventive health services and is the individual's and family's initial contact point when accessing health care. It is a partnership among the individual and family, health-care providers within the medical home, and extended network of consultative and specialty providers with whom the medical home has an ongoing and collaborative relationship.

The providers in the medical home are knowledgeable about the individual's and family's specialty care and health-related social and educational needs and are connected with necessary resources in the community that will assist the family in meeting those needs.

When referring for consultation, specialty/hospital services, and health and health-related services, the medical home maintains the primary relationship with the individual and family, keeps abreast of the current status of the individual and family through a planned feedback mechanism, and provides continuing primary medical care and preventive health services.

43.1.10.2 Continuity of Care and the Medical Home

The individual providing the medical check up (if not the medical home provider) must ask the parents whether the client has a physician or primary care medical home provider where the client usually receives medical care.

If the client's medical home is providing THSteps check ups, it is in the client's and family's best interest for providers to encourage the continuation of that relationship. If the family has a medical home but prefers to have their check up done by another provider, then the rendering provider should send a copy of the THSteps medical check up records to the primary care medical home provider.

If the medical check up provider is unable to offer a medical home to the client, the medical check up provider must enter into written agreements with providers who are willing to offer medical homes.

43.1.10.3 Mobile Units and the Medical Home

If a medical check up provider has mobile units functioning in different communities, the agreements with providers who are willing to offer the medical home must be signed in each community so that clients are referred to local providers for medical homes.

Medical check up providers with mobile units must advise families that they have freedom of choice concerning who completes the medical check ups.

43.1.11 THSteps Dental Services

Access to THSteps dental services is mandated by the Texas Medicaid Program and provides reimbursement for the early detection and treatment of dental health problems for Medicaid clients from birth through 20 years of age. THSteps dental service standards were designed to meet federal regulations and to incorporate the recommendations of representatives of national and state dental professional groups.

OBRA of 1989 mandated the expansion of the federal EPSDT program to include any service that is medically necessary and for which federal financial participation (FFP) is available, regardless of the limitations of the Texas Medicaid Program. This expansion is referred to as THSteps-CCP.

Refer to: "THSteps-CCP Overview" on page 43-33 for more information.

43.1.12 How the THSteps Dental Program Works

THSteps-designated staff (HHSC, DSHS, or its designee), through outreach and informing, encourage the parents or caregivers of eligible clients to use THSteps dental check ups and prophylactic care when clients first become eligible for Medicaid and each time clients are periodically due for their next dental check up.

Upon request, THSteps-designated staff (HHSC, DSHS, or its designee) assist the parents or caregivers of eligible clients with scheduling of appointments and transportation. Medicaid clients have freedom of choice of providers and are given names of enrolled providers. Call the DSHS THSteps Hotline at 1-877-847-8377 for a list of THSteps dental providers in a specific area.

When a client is eligible for a THSteps dental check up, a message is present on the Medicaid Identification Form (H3087 or H3087 STAR) under the client's name. If the client or caregiver believes the client is due for a dental check up and a message is not present, the provider may contact TMHP through the TMHP website at www.tmhp.com or AIS at 1-800-925-9126 to verify that the client is due for a dental check up.

Clients may receive an initial THSteps dental check up at 12 months of age and at 6-month intervals thereafter, through 20 years of age. Clients younger than 12 months of age are not eligible for *routine* dental examinations; however, they may be referred when a medical check up identifies the medical necessity for dental services. All THSteps clients birth through 20 years of age can be seen by the dentist at any time for emergency dental services for trauma, early childhood caries (ECCs), or any other appropriate dental or therapeutic procedure.

Clients birth through 20 years of age may self-refer for dental services.

Note: *Clients enrolled in Medicaid Managed Care are required to choose a medical provider in their health plan's network. The health plan does not reimburse for services rendered by nonparticipating providers. Please contact the specific health plan for enrollment information.*

43.1.13 Vision Services

Appropriate vision screening is a mandatory part of each medical check up visit.

Additionally, vision exams and services include eye examinations with refraction and eyeglasses. Eye examinations are available once per state fiscal year (SFY) (September 1 through August 31). This limit does not apply if the examination is for aphakia, disease, injury of the eye, or if medically necessary (for eyeglasses, defined as a 0.5 diopter change in one eye). Eyeglasses are available once every 24 months. Replacement of lost or destroyed eyewear is a benefit for THSteps clients.

Refer to: "Vision Screening" on page 43-22 for information about vision screening for clients.

"Vision Care (Optometrists, Opticians)" on page 45-1 for more information.

43.1.14 Hearing Services

Appropriate hearing screening is a mandatory part of each medical check up.

Additionally, hearing exams and services, including hearing aids, are available when medically necessary. Payment for services to eligible clients received through approved Program for Amplification for Children of Texas (PACT) providers is made through PACT at DSHS.

Refer to: "Inpatient Hearing Screening" on page 43-22 for information about hearing screening for clients.

43.1.15 Referrals for Medicaid-Covered Services

When a provider performing a check up determines that a referral for diagnosis or treatment is necessary for a condition found during the medical check up, that information must be discussed with the parents/guardians. A referral should be made to a provider who is qualified to perform the necessary diagnosis or treatment services. Medicaid Managed Care clients must be referred to their designated primary care provider for further treatment or referral.

A provider needing assistance to find a specialist that accepts clients with Medicaid coverage can call the THSteps Hotline at 1-877-847-8377.

Effort should be made to maintain continuity of care including follow-up to determine that the appointment was kept and that the provider receiving the referral has provided diagnosis and recommendations for further care to the referring provider.

If the provider performing the medical check up can provide treatment for the condition identified, a separate claim (CMS-1500 or UB-04 CMS-1450) may be submitted for the same DOS as the check up with an appropriate *established* patient office visit for the diagnosis and treatment of the identified problem.

For the acute care claim, an appropriate level CPT code for E/M of *established* clients should be selected with the diagnosis supporting this additional billing documented. Not all minor illnesses or conditions, such as follow-up of a mild upper respiratory infection, identified during the THSteps medical check up warrant additional billing. The billing of an additional office visit is only appropriate if the additional evaluation and treatment is required and performed for the identified condition(s). This additional service, since it is billed as an acute care claim to the Texas Medicaid Program, is independent of the THSteps medical check up and is viewed as a stand-alone service. Consequently, the medical record must contain documentation that supports the medical necessity and the level of service of the E/M code submitted for reimbursement.

In addition to referrals for conditions discovered during a check up or for specialized care, the following referrals may be used:

- Case Management for Children and Pregnant Women (CPW). CPW provides health-related case management services to eligible children and pregnant women. CPW services include assessing the needs of eligible clients, formulating a service plan, making referrals, problem-solving, advocacy, and follow-up regarding family and client needs. For more information about eligibility, see “Eligibility” on page 12-2. To make a referral, providers can call the THSteps Hotline at 1-877-847-8377 or a CPW case management provider in their area. A list of CPW providers can be found on the DSHS Case Management website at www.dshs.state.tx.us/caseman.
- *Hearing Services/PACT referrals*. For all age groups, providers must refer clients identified during the THSteps medical check up as needing a diagnostic hearing evaluation for permanent hearing loss or other hearing services, including hearing aids, to a PACT provider. PACT provides services and hearing aids for clients birth through 20 years of age that have permanent hearing loss and are Medicaid clients. Hearing exams and services, including hearing aids (prior authorization needed), are available when medically necessary. Payment for services to eligible clients received through approved PACT providers is made through PACT at DSHS. An appropriate hearing screening is a mandatory part of each medical check up.
- *Routine Dental Referrals.* Routine dental referrals are required for all clients at 1 year of age and every six months thereafter through 20 years of age (see “THSteps Dental Services” on page 43-13). *Clients younger than 12 months of age are not eligible for routine dental examinations.*
- *Referrals for Dental Care*. If a THSteps medical provider identifies the medical necessity for dental services, the provider must assist the client in planning follow-up care or in making a referral to a THSteps dental provider. Clients younger than 12 months of age also can be seen for emergency dental services by the dentist at any time for trauma, baby bottle tooth decay, or other oral health problems, such as ECCs. *Clients birth through 20 years of age may self-refer for dental care.*
- *Emergency Dental Referrals.* If a medical check up provider identifies an emergency need for dental services, such as bleeding, infection, or excessive pain, the client may be referred directly to a participating dental provider. Emergency dental services are covered at any time for all Medicaid clients birth through 20 years of age.

Note: *Assistance in coordinating dental referrals can be obtained from the THSteps Hotline at 1-877-847-8377 or the DSHS Regional THSteps Coordinator for the respective region (lists are provided in the “DSHS Health Service Region Contacts” on page A-8). In cases of both emergency and nonemergency dental services, clients have freedom of choice in selecting a dental provider who is participating in the THSteps Dental Program.*

- *Family Planning and Genetic Services Referrals*. For people eligible for Medicaid needing genetic services or family planning services, a referral should be made. Information about Medicaid-covered genetic services is available in “Genetic Services” on page 22-1 and information about family planning services is available in “Family Planning Services” on page 20-1. If the THSteps medical provider also provides family planning, the provider may inform the client of the availability of these services.
- *THSteps-CCP Services Referrals.* THSteps-CCP benefits are medically necessary services for which FFP is available and may not currently be benefits of the Texas Medicaid Program (e.g., orthotics, private duty nursing (PDN), and others), as well as expanded coverage of current services that have limitations.

- *Women, Infants, and Children (WIC) Referrals.* Clients under 5 years of age are eligible for WIC and should be referred to WIC.

Refer to: "Hearing Referrals" on page 43-23 for referrals following a hearing screening.

"Medicaid Managed Care" on page 7-4 for more information on referrals for providers in areas of the state covered by Medicaid Managed Care.

"THSteps-CCP Overview" on page 43-33 for more information.

43.1.16 Texas Vaccines for Children Program (TVFC)

For Medicaid clients birth through 18 years of age, the TVFC program provides free vaccines that are recommended according to the *Recommended Childhood and Adolescent Immunization Schedule* (ACIP, AAP, and the American Academy of Family Physicians [AAFP]). To obtain free vaccines for clients birth through 18 years of age, THSteps providers must enroll in TVFC at DSHS. Providers may not charge the Texas Medicaid Program for the cost of the vaccines obtained from TVFC; however the administration fee is considered for reimbursement.

When single antigen vaccine(s)/toxoid(s) or comparable antigen vaccine(s)/toxoid(s) are available for distribution through TVFC, but the provider chooses to use a different ACIP recommended product, the vaccine/toxoid will not be covered; however, the administration fee will be considered.

Note: *Administered vaccines/toxoids must be reported to DSHS. DSHS submits all vaccines/toxoids reported with parental consent to a centralized repository of immunization histories for clients younger than 18 years of age. This repository is known in Texas as ImmTrac.*

Refer to: Appendix H, "Immunizations" on page H-1 and "TVFC Provider Enrollment (3 Pages)" on page C-81 for more information about enrolling as a TVFC provider.

43.1.17 Vaccine Adverse Event Reporting System (VAERS)

The National Childhood Vaccine Injury Act (NCVIA) requires health-care providers to report:

- Any reaction listed by the vaccine manufacturer as a contraindication to subsequent doses of the vaccine.
- Any reaction listed in the Reportable Events Table that occurs within the specified time period after vaccination.

A copy of the Reportable Events Table can be obtained by calling VAERS at 1-800-822-7967 or by downloading it from vaers.hhs.gov/pubs.htm.

Clinically significant adverse events should be reported even if it is unclear whether a vaccine caused the event.

43.1.18 Information and Assistance

Providers should call TMHP THSteps Medical Inquiries at 1-800-757-5691 with questions about THSteps medical check ups. The line is available from 7 a.m. to 7 p.m., Central Time, Monday through Friday.

Clients that are eligible for Medicaid and have questions about the THSteps program should call the THSteps Hotline at 1-877-847-8377. Clients with questions about their Medicaid eligibility for the THSteps program should be directed to their caseworker at the local HHSC office or site.

43.1.18.1 Assistance with Program Concerns

Providers that have questions, concerns, or problems with program rules, policy, or procedure should contact DSHS regional program staff. THSteps staff contact numbers can be found in Appendix A, Section A.7 "DSHS Health Service Region Contacts" on page A-8, or on the THSteps website, www.dshs.state.tx.us/thsteps/default.shtm, or by calling THSteps at 1-512-458-7745.

THSteps regional staff make routine contact with providers to educate and assist providers with THSteps program policies and procedures.

43.1.18.2 Assistance with Claims Concerns

Providers with questions, concerns, or problems about claims should contact the TMHP Contact Center at 1-800-925-9126. For regional contact information, providers can refer to the TMHP website at www.tmhp.com/Providers/default.aspx then click on the *Regional Support* link.

43.2 Clinical Information

This section contains specific information about medical and dental services. For more specific administrative information, see "THSteps Medical and Dental Administrative Information" on page 43-5.

43.2.1 Documentation of Completed Check Ups

To assure completion of comprehensive medical check ups and the quality of care provided, providers must document all components of the THSteps medical check ups as they are completed. Clinical charts are subject to quality review activities including random chart review and focused studies of well-child care.

In acknowledgment of the practical situations that occur in the office or clinic settings, the AAP has stressed the philosophy that the components of all medical check ups should be performed when appropriate to the needs of the individual client. Consequently, completion of all recommended components of a THSteps medical check up may require follow-up check ups.

The Centers for Medicare & Medicaid Services (CMS) has clarified, in its *Medicaid Guide To State Entities*, the following expectations for the content of comprehensive preventive health visits:

- Comprehensive health history, including developmental and nutritional assessment.
- Comprehensive unclothed physical examination, including graphic recording of head circumference.
- Appropriate immunizations as indicated in the *Recommended Childhood and Adolescent Immunization Schedule*.
- Age-appropriate laboratory tests for anemia, lead poisoning, and newborn screening.
- Health education, including anticipatory guidance, is required.
- Age-appropriate vision and hearing screening.
- Direct referral to dental check ups beginning at 12 months of age.

43.2.2 THSteps Medical Check Ups Periodicity Schedule

The client is periodically eligible for medical check up services based on the THSteps medical check ups periodicity schedule. All the check ups listed on the periodicity schedule have been developed based on recommendations of the AAP. The AAP continues to emphasize the importance of separate counseling and anticipatory guidance for the client and the accompanying parent/guardian during the adolescent years. In Texas the THSteps program has modified the AAP periodicity schedule based on the scheduling of a laboratory or other test in federal EPSDT regulations, state statutes or other programs, or to meet the population's needs.

43.2.2.1 THSteps Medical Check Ups Periodicity Schedule for Infants, Children, and Adolescents (Birth Through 20 Years of Age)

The columns across the top of the schedule indicate the age a client is periodically eligible for a medical check up. The first column on the left of the chart identifies each procedure that must be performed at each appropriate age. (See Key at bottom of page and Footnotes on the following page.)

	Weeks		Months							Years																
Age[1]	**Inpatient**	**2**	**2**	**4**	**6**	**9**	**12**	**15**	**18**	**2**	**3**	**4**	**5**	**6**	**8**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**
History																										
Family	●	●	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Neonatal	●	●	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔													
Physical, Mental Health, and Developmental	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Behavioral Risk[2]																●	●	●	●	●	●	●	●	●	●	●
Physical Examination[3]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Measurements																										
Height, Weight	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Body Mass Index (BMI)										●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Fronto-Occipital Circumference	●	●	●	●	●	●	●	●	●	●																
Blood Pressure											●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Nutrition	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Developmental[4]		●	●	●	●	●	●	●	●	●	●	●	●	●												
Mental Health		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Sensory Screening[5]																										
Vision Screening[5a]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hearing Screening[5b]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tuberculosis Screening[6]							●	✔	✔	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Laboratory[7]																										
Newborn Hereditary/Metabolic Testing[8]	●	●	✔	✔	✔	✔	✔																			
Hgb or Hct[9]					●	✔	●	✔	✔	●	✔	✔	✔	●	✔	✔	✔	●	✔	✔	✔	●	✔	✔	✔	✔
Lead Screening[10]					✚	✚	●	✚	✚	●	✚	✚	✚	✚												
Hemoglobin Type[11]	●	●	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
STD Screening[14]																	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚
HIV Screening[15]																	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚
Pap Smear[16]																	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚
Hyperlipidemia[12]										✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚
Glucose[13]																✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚
Immunizations[17]	●	✔	●	●	●	✔	●		✔	✔	✔	●	✔	✔	✔	✔	✔	✔	●	●	✔	✔	✔	✔	✔	✔
Dental Referral[18]							●	✔	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anticipatory Guidance[19]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

Key

● Required, unless medically contraindicated or because of parent's reasons of conscience including a religious belief.

✔ Required as above, unless already provided on a previous check up at the required age and documented on the health record with the date of service.

✚ If answers on risk assessment questionnaires or other screening show a risk factor, further screening is required. Refer to Footnotes for more information about marked items.

43.2.2.2 THSteps Medical Check Ups Periodicity Schedule for Infants and Children (Birth Through 20 Years of Age) (continued)

Footnotes

1. If a child comes under care for the first time at any point on the schedule or if any procedures are not accomplished at the appropriate age, the client must be brought up-to-date with required procedures as soon as possible.
2. Screening for adolescent lifestyle risk factors is to include eating disorders, sexual activity, alcohol (and other drug use), tobacco use, school performance, depression, and risk of suicide.
3. An age-appropriate complete unclothed physical exam is required at each check up. Older children are to be appropriately draped. For adolescents who are sexually active, a pelvic exam should be part of the examination.
4. Developmental screening:
   a. Medical check ups completed by physicians, PAs, and APNs (pediatric nurse practitioners and family nurse practitioners) conducting THSteps check ups for children birth up to and including the six-year medical check up must include:
      - A standardized developmental screen (the provider's choice of observational or parent questionnaire) for a child between 9 through 12 months of age, 18 through 24 months of age, and every other year thereafter.
      - Standardized screening should also be conducted if a parent expresses concern about the child's developmental progress.
      - Developmental screening at all other visits to include a review of milestones (gross and fine motor skills; communication skills, speech-language development; self help/care skills; social, emotional, and cognitive development) and mental health.
   b. RNs conducting THSteps medical check ups for children birth up to and including the six-year medical check up are required to conduct:
      - A standardized observational screen for children in the following age groups: 9 through 12 months of age; 18 through 24 months of age; and if the child does not have a record of a standardized observational developmental screen, again between 24 months up to and including the six-year medical check up.
      - A standardized parent questionnaire at all other periodic visits birth through the six-year medical check up or when a parent expresses concern about the child's developmental progress.
5. Sensory screening:
   a. Vision:
      - Birth through 2 years of age—Screening includes history of high-risk conditions, observation, and physical examination.
      - Ages 3 through 10, 12, 15, and 18 years of age—Screening includes administration of an age-appropriate vision chart. Documentation of test results from a school vision screening program may be used if conducted within 12 months of the check up.
   b. Hearing:
      - Birth through 3 years of age—Screening includes history, observation, and screening by use of the Parent Hearing Questionnaire.
      - Ages 4 through 10, 12, 15, and 18 years of age—A puretone audiometer should be used to screen hearing at check ups. Subjective screening may be completed at all other check ups. Documentation of results from a school audiometric screening program may be used if conducted within 12 months of the check up.
6. In areas of low prevalence, administer the Tuberculosis (TB) Questionnaire annually beginning at 1 year of age. In areas of high prevalence, administer the TB skin test at 1 year of age, once between 4 through 6 years of age, and once between 11 through 17 years of age. Administer the TB Questionnaire annually beginning at 2 years of age and thereafter at other check ups. All clients should return for the provider to read the skin test. The TB Questionnaire is available in the *Texas Medicaid Provider Procedures Manual* (TMPPM).
7. All blood specimens are to be submitted to the DSHS Laboratory for analysis.
8. Newborn screening (hereditary/metabolic testing for disorders recommended by the American College of Medical Genetics [ACMG]) is required by Texas law before hospital discharge and again between 1 and 2 weeks of age. Date and results of the second newborn screening are to be documented.
9. Hemoglobin (Hgb) and hematocrit (Hct) testing conducted at a Women, Infants, and Children (WIC) clinic or in a provider's office are acceptable within one month if date and value are documented.
10. Mandatory blood lead screening at 12 and 24 months of age. The Lead Exposure Questionnaire (available in the TMPPM) is acceptable at other visits.
11. If Hgb type has been performed previously and results are documented in the client's chart, it does not need to be repeated. Hgb type also is part of the newborn screening.
12. Hyperlipidemia screening should be completed for those at risk of increased levels of cholesterol (THSteps does not provide a formal questionnaire).
13. Children should be screened for risk of Type II diabetes. Fasting glucose screening should be obtained for those at risk of Type II diabetes.
14. For sexually active or high-risk adolescents, screening is to include evaluation for genital warts, cultures for gonorrhea and chlamydia, and blood test for syphilis.
15. While all adolescents should be screened for the risk of human immunodeficiency virus (HIV) infection, actual testing is voluntary.
16. The first Pap smear should be obtained at 21 years of age, 3 years from the onset of sexual activity, or at another age based on provider discretion.
17. Clients are not to be referred to the local health department for immunizations. Vaccines must be obtained from the Texas Vaccines for Children Program at DSHS and administered at the time of the check up, unless medically contraindicated or because of parent's reasons of conscience including a religious belief.
18. Dental referrals are required for all patients beginning at 1 year of age. Patients are eligible for preventive dental check ups every six months thereafter, as well as emergency dental treatment at any time.
19. Counseling/anticipatory guidance is a required integral part of each check up and must be face-to-face with the child's parent/caretaker and face-to-face with adolescents.

Note: Additional information is available in the TMPPM. To quickly reference the subjects listed above, refer to the manual's Index or use the Search tool available in the electronic edition.

43.2.3 Medical Check Ups for Infants, Children, and Adolescents (Birth Through 20 Years of Age)

The following information gives descriptions and requirements for each pediatric assessment and test that must be performed during a THSteps medical check up in accordance with the periodicity schedule. The check up includes face-to-face contact with the client's parent or guardian.

Refer to: "THSteps Medical Check Ups Periodicity Schedule for Infants, Children, and Adolescents (Birth Through 20 Years of Age)" on page 43-17.

43.2.3.1 History

The client's initial history must include the following:

- Family medical history.
- Neonatal history.
- Physical and mental health history.
- Developmental history.
- Immunization history.
- History of feeding or nutrition problems.
- A complete review of body systems.

Subsequent histories may be specific for the client's age and health history.

The history must be obtained from an adult caregiver familiar with the client and the client's health history. Preferably, the adolescent and the parent should be interviewed separately.

Refer to: "Additional Adolescent Screening" on page 43-26 for more history/screening information for adolescents.

43.2.3.2 Physical

A complete physical examination is required at each visit, with infants totally unclothed and older clients undressed and suitably draped. The physical examination must include assessment of the following systems:

- Skin.
- Head, eyes, ears, nose, and throat (HEENT).
- Dental.
- Heart.
- Chest/lungs (includes breast exam for females past menarche).
- Abdomen (including hernia).
- Skeletal.
- Neurological (includes evaluation of cerebral, cranial nerve, and cerebellar functions; motor and sensory systems; and reflexes).
- Genitalia (includes observation for appropriate sexual development and testicular exam for adolescent males).

The unclothed physical examination must be completed by one of the following:

- A physician.
- An NP as described in "Provider Enrollment" on page 43-5.
- A PA.
- An RN as stated in "Additional Education Requirements for Registered Nurses (RNs)" on page 43-6.

43.2.3.3 Measurements

The physical examination must include the following measurements:

- Length, for clients approximately birth through 2 years of age.
- Height, for clients approximately 3 through 20 years of age.
- Weight, for clients birth through 20 years of age
- Body mass index (BMI) for clients 2 through 20 years of age.
- Fronto-occipital circumference, for clients younger than 2 years of age.
- Blood pressure (for clients 3 years of age and older, using the appropriate cuff size).

The requirements for measurements other than blood pressure are to be compared to the National Center for Health Statistics growth charts to identify significant deviations from norms. These charts are available on the CDC website at www.cdc.gov/nchs/about/major/nhanes/growthcharts/clinical_charts.htm or by calling THSteps at 1-512-458-7745.

Refer to: The WIC website as a resource for information about measuring heights and weights at www.dshs.state.tx.us/wichd/secure%2Dpol/nutrassess.pdf.

The requirements for measurements of blood pressure should be compared to Appendix I in *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* (2nd edition, revised), located at www.brightfutures.org or *Guidelines for Health Supervision III* from the AAP Publication Department, located at www.aap.org.

Refer to: "Documentation of Completed Check Ups" on page 43-15.

43.2.3.4 Nutritional Screening

The nutritional screening is to be accomplished during the basic examination using the following methods:

- Ask questions about dietary practices to identify unusual eating habits (such as pica or extended use of bottle feedings) or diets that are deficient or excessive in one or more food groups.

- Determine quality and quantity of individual diets (e.g., dietary intake, food acceptance, meal patterns, methods of food preparation and preservation, and utilization of food assistance programs like WIC and Texas Food Stamps).
- Conduct a complete physical examination, including an oral screening, paying special attention to general features, such as pallor, apathy, and irritability.
- Obtain accurate height and weight measurements and calculation of BMI as important indices of nutritional status.
- Perform laboratory screenings for anemia (hemoglobin and hematocrit), as indicated.

Risk Factors/Screening for Eating Disorders and Obesity

The risk factors/screening for eating disorders and obesity assessment is to be accomplished in the basic examination, using the following methods:

- Adolescents should be asked about body image and dieting patterns.
- Adolescents should be assessed for organic disease, anorexia nervosa, or bulimia if any of the following are found:
  - Weight loss greater than ten percent of previous weight.
  - Recurrent dieting when not overweight.
  - Use of self-induced emesis, laxatives, starvation, or diuretics to lose weight.
  - Distorted body image.
  - BMI below the fifth percentile.
- Adolescents should have an in-depth dietary and health assessment to determine psychosocial morbidity and risk for future chronic disease if they have a BMI equal to or greater than the 95th percentile for age and gender.
- Adolescents with a BMI between the 85th and 94th percentile are at risk for becoming overweight. A dietary and health assessment to determine psychosocial morbidity and risk for future chronic disease should be performed on these youth if the following are true:
  - Their BMI has increased by two or more units during the previous 12 months.
  - There is a family history of premature heart disease, obesity, hypertension, or diabetes mellitus.
  - They express concern about their weight.
  - They have elevated serum cholesterol levels or blood pressure.

If this assessment is negative, these adolescents should be provided general dietary and exercise counseling and should continue to be monitored annually.

43.2.3.5 Developmental Screening

Requirements for Developmental Screening by Physicians, PAs, and NPs

Medical check ups completed by physicians, PAs, and NPs for clients birth through 6 years of age must include:

- A standardized developmental screen (the provider's choice of observational or parent questionnaire) for a client between 9 through 12 months of age, 18 through 24 months of age, and every other year thereafter, or when a parent expresses concern about the client's developmental progress.
- A developmental screen at all other visits, including a review of milestones (gross and fine motor skills, communication skills and speech-language development, self help and care skills, social, emotional, and cognitive development) and mental health.

Requirements for Developmental Screening by RNs

RNs conducting THSteps medical check ups for a client birth through 6 years of age are required to conduct a standardized observational screen for a client 9 through 12 months of age and 18 through 24 months of age. If the client does not have a record of a standardized observational screen, the client should receive one between 24 months through 6 years of age. A standardized parent questionnaire is required at all other periodic visits through the 6th year of age or when a parent expresses concern about the client's developmental progress.

The combined use of a questionnaire and an observational screen reflects the client's developmental status more accurately than a single observational screen. If parents are unable to read or understand the questionnaire, the provider should use the parent questionnaire in an interview format. If the client fails the parent questionnaire, the provider should follow the instructions of the standardized screening tool concerning either observation testing or referral.

Clients 7 years of age and older should be screened by observation, history of school progress, and neurological assessment.

Choice and Use of Tools

A standardized screening tool is one that has been extensively evaluated through screening thousands of children and comparing the screen outcome of each individual client with the outcome of an in-depth developmental evaluation on that client.

If the screening tool used specifies that training is required to use the tool, the screener must complete this training.

Referrals for Developmental Assessment

Referral for an in-depth developmental evaluation is determined by the criteria of the specific tool. The screener should understand them. Referral for in-depth evaluation of development should be provided when parents express concern about their client's development, regardless of scoring on a standardized development screening tool.

An ECI program serves clients birth to 3 years of age with disabilities or developmental delays. Federal and state laws require a referral be made to an ECI within two business days of identifying a possible developmental concern. If the client is 4 years of age or older, referral should be made to the local school district, special education program.

Referrals may be based on professional judgment or a family's concern. A medical diagnosis or a confirmed developmental delay is not required for referrals.

Refer to: "Texas Health Steps Statutory State Requirements" on page K-1 for more information.

43.2.3.6 Mental Health

Guidelines for Mental Health Screening

The mental health screen is part of every comprehensive medical check up. The age-specific interview tools and parent questionnaires are provided as an option for performing this screen. They are intended for use as part of a comprehensive pediatric assessment. If these interview tools are used outside the context of a comprehensive examination, the interviewer must remember to collect information usually gathered in a pediatric history: household members, prenatal/newborn history, client's health history, and family illnesses.

The purpose of the mental health screen is to identify problems in any of six domains: feelings, behavior, social interactions, thinking, physical problems, and other problems that may include substance abuse. The provider choosing alternative screening tools or techniques should be certain to screen in these domains. Screening may reveal several minor problems or one or more significant problems that warrant referral for, or provision of, evaluation and, if indicated, treatment. In determining whether behaviors are serious enough to warrant referral, the screener must weigh the extent and intensity of the problems and explore the client's resiliency and psychological and social resources. If the client has been or is under treatment for any mental health conditions, record that treatment in the client's medical record.

Referral options may include parenting education programs, ECI programs (birth to 3 years of age), mental health evaluation and counseling, substance abuse assessment and programs, acute psychiatric hospitalization, or child protective services. The screener's responsibility is to identify and establish a referral relationship with these resources in the community.

Screeners with special training and credentials allowing evaluation and treatment of childhood behavior problems, mental illness, or substance abuse may choose to provide these services rather than referring. Other screeners should refer to mental health specialists.

Confidentiality

The screener introduces the screen by explaining that the information provided will be held in strictest confidence unless the screener recognizes a situation that places the client or others in danger.

Clients older than 4 years of age should not be present when the screener questions the parent about possible abuse or neglect.

Beginning when the client is about 10 years of age, questions about peer and family social interaction and substance abuse are explored with the client and parent separately. All parts of the screen are administered to the adolescent and their parent/caregiver separately, when possible, recognizing that some families may object to confidential discussions with young people and cultural competency should be exercised.

If observations of the client, the parent, or parent-client interaction lead the screener to suspect possible abuse or neglect, the screener must make a report to Child Protective Services. The report is required even though the screener may refer a family for evaluation or treatment of abuse/neglect.

Behavior of Particular Concern

Behavior generally expressive of mental health problems include those listed below. If the screener finds any of the following significant behaviors, further screening is unnecessary because referral is indicated:

- Setting fires.
- Suicidal behavior or ideation.
- Self-destructive activities.
- Torturing animals.
- Hurting other people.
- Destroying property.
- Loss of touch with reality.
- Inappropriate sexual behavior.
- Substance abuse.
- Parental concern about their ability to maintain the client in the home.

Important: *At the conclusion of a screening that is judged by the provider to be within regular limits, the screener should refer the client for a comprehensive mental health evaluation if the parent or the client (particularly an older client) is concerned that the client has mental health or behavior problems.*

Interview Tools/Referral Forms

The interview tools found on pages C-20 through C-27 contain age-specific questions to guide the provider in conducting a mental health screen. Items of concern should be circled. Extensive notes may have to be made on a separate sheet. A copy of this form may be used as a referral form.

The parent questionnaire is similar to the interview tool. It is advisable in the first visit to explain and administer the interview face-to-face. At subsequent visits, the age-appropriate form may be given to a literate parent or adolescent with the instruction, "Circle any of these items that you feel are a problem or concern for your child/you and that you would like to discuss with your provider."

43.2.3.7 Sensory Screening

Vision Screening

Newborns

During the initial test at birth, the provider should do the following:

- Check for red reflex.
- Note history for high-risk conditions, such as congenital infections (rubella, herpes, and others) or a family history of vision or eye problems.

Birth Through 2 Years of Age

The provider should do the following:

- Collect observations and a history from a caregiver.
- Check for red reflex.
- Determine whether pupils equally react to light.
- Screen for heterophoria with the corneal light reflex and cover test for clients older than 6 months of age.
- Note history for high-risk conditions, such as congenital infections (rubella, herpes, and others) or a family history of vision or eye problems.

At 3 Through 4 Years of Age

The provider should do the following:

- Administer Tumbling E or HOTV test or equivalent at both the 3- and 4-year visit.
- Screen through the 20/20 line.
- Determine whether the client reads more than half of the 20/40 line or four out of six HOTV symbols; refer if unable to read the majority of 20/40 line (one more than half of the symbols) or four out of six HOTV symbols.
- Screen for heterophoria with the corneal light reflex and cover test or Random Dot E.
- Refer clients with a two-line difference between the two eyes.
- Document and complete the test as described for birth to 2 years of age if a 3-year-old is unable to cooperate.

For Clients 5 Years of Age and Older

The provider should do the following:

- Evaluate with a letter chart or Tumbling E chart at ages 5 through 10, 12, 15, and 18 years of age.
- Refer if unable to read the majority of 20/30 line (one more than half of the symbols) or four out of six HOTV symbols.
- Administer a cover test or Random Dot E.

Note: *Documentation of the results of a school vision screening program may be used in place of testing in the office if within 12 months of the check up.*

Vision Screening Supplies

Vision screening supplies can be ordered from the following vendors:

School Health 865 Muirfield Drive Hanover Park, IL 60133 1-800-323-1305
Good-Lite 1155 Jansen Farm Drive Elgin, IL 60123 1-630-529-9720 1-800-362-3860
Prevent Blindness Texas 2202 Waugh Drive Houston, TX 77006 1-713-526-2559
Wilson Ophthalmic PO Box 496 Mustang, OK 73064 1-800-222-2020
Universal Ophthalmic Instruments, Inc. 8902 FM 2920 Spring, TX 77379 1-800-346-6214

Refer to: "Vision Care (Optometrists, Opticians)" on page 45-1 for more information.

Inpatient Hearing Screening

Newborn Hearing Screening

Health Safety Code, Chapter 47, *Vernon's Texas Codes Annotated* mandates that a hearing screening must be offered at the birthing facility before hospital discharge. The hospital is responsible for the purchase of equipment, training of personnel, screening of the newborns, certification of the program in accordance with DSHS standards, and notification to the provider, parents, and DSHS of screening results. There is no additional Medicaid reimbursement for the hearing screening, as the procedure is part of the newborn diagnosis-related group (DRG). Hospitals should use the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) procedure code 09547 to report this newborn hearing screen on the UB-04 CMS-1450.

This facility-based screening also meets the physician's required component for hearing screening in the inpatient newborn THSteps check up. The physician must assure that the hearing screening is offered or completed before discharging the newborn unless the birthing facility is exempt under the law from performing hearing screenings, in which case, the physician must assure there is an appropriate referral for a hearing screening to a birthing facility participating in the Newborn Hearing Screening Program.

The physician should discuss the screening results with the parents, especially if the hearing screening results are abnormal, and should order an appropriate referral for further diagnostic testing. If the results are abnormal, parent/legal guardian consent must be obtained to send information to DSHS for tracking and follow-up purposes.

A physician with any concerns about this process should contact the hospital administrator or the DSHS Audiology Services Program at 1-800-252-8023.

Initial Test at Birth

The provider should do the following:

- Verify that the parents received the results of the hearing screen at the birthing facility.
- Check for obvious physical abnormalities.
- Supply a Hearing Checklist for Parents and instruct in its use. This checklist should be discussed at the first in-office THSteps medical check up.
- Provide a referral for further diagnostic audiological testing for an infant with abnormal screening results or who is at high risk for hearing impairment.

Outpatient Hearing Screening and Diagnostic Testing for Clients

As part of the THSteps medical check up, physicians are required to complete the hearing screening component. Separate procedure codes should not be billed when hearing screenings are part of medical check ups or daycare/school requirements. Medicaid does not reimburse separately.

For clients that are seen in the office setting, the THSteps program requires a puretone audiometric test at visits where objective screening is required. In other childcare settings (e.g., daycare, preschool, Head Start, and elementary, middle, and high school), the DSHS Vision and Hearing Screening Program requires that a puretone audiometer be used for hearing screening.

Birth Through 3 Years of Age

The provider should do the following:

- Observe and record history from a responsible adult familiar with the client, using the Hearing Checklist for Parents located on page C-18, English and Spanish.
- Refer high-risk clients for further audiological diagnostic testing.

At 4 Years of Age and Older

The provider should do the following:

- Assess clients with a puretone audiometric hearing screen (1000, 2000, 4000 Hz) at 4 through 10 years of age.
- Perform a subjective hearing evaluation, which includes client history and observation of the client for the ability to answer questions and follow directions, at all other medical check ups where an audiometric screen is not required.
- Refer the client if any one of the three frequencies are recorded as greater than 25 dB in either ear.

At 11 Years of Age and Older

- The client must be assessed with a puretone audiometric hearing screen (1000, 2000, and 4000 Hz) at 12, 15, and 18 years of age.
- The client should have a subjective hearing evaluation at 11, 13, 14, 16, 17, 19, and 20 years of age that includes clientclient history and observation for the ability to answer questions and follow directions.
- Adolescents who do not respond to a 25 dB tone at any frequency should be referred for a diagnostic hearing evaluation.

Note: *Documentation of the results of a school screening audiometric testing program may be used in place of testing in the office if within 12 months of the check up.*

The CPT audiometric screening procedure codes 5/I-92551 and 5/I-92552 may not be billed on the same day by the same provider with THSteps medical check up procedure codes shown in the following table:

THSteps Medical Check Up Procedure Codes			
S-99381	S-99382	S-99383	S-99384
S-99385	S-99391	S-99392	S-99393
S-99394	S-99395		

It is recommended that pneumatic otoscopy be the primary method to visualize and assess the mobility of the tympanic membrane when distinguishing between otitis media with effusion and acute otitis media.

Tympanometry (impedance testing) may be considered for reimbursement as an objective diagnostic test of middle ear disease. Tympanometry (procedure code 5-92567) should never be used as the sole clinical means to establish the presence or absence of acute or chronic middle ear effusion or infection. Direct otoscopic examination by a suitably qualified provider, with or without pneumatic otoscopy, is the key element of the standard method used to establish a diagnosis of middle ear disease. Tympanometry must be limited to selected individual cases where its use demonstrably adds to the provider's ability to establish a diagnosis and provide appropriate treatment.

Tympanometry is limited to four services per year by the same provider and is based on medical necessity. Medical necessity must be documented in the client's medical record. Tympanometry does not meet the requirements for a sensory screening component of the THSteps medical check up. Acoustic reflex testing does not meet the requirement for hearing screening and is diagnosis restricted.

Hearing Referrals

For information on referrals to the PACT program, see "Referrals for Medicaid-Covered Services" on page 43-14 and "Benefits" on page 23-2.

Separate procedure codes may be billed for clients who require diagnostic hearing testing. The diagnostic audiometric testing codes 5/I-92567, 5/I-92585, 5-92586, 5/I/T-92587, and 5/I/T-92588 may be billed, as appropriate.

43.2.3.8 Tuberculosis Screening

The periodicity schedule for tuberculin tests is in accordance with federal Centers for Disease Control and Prevention (CDC) guidelines. THSteps requires a form of TB screening annually, as noted on the periodicity schedule, that is to be performed in the provider's office or clinic. This screening must be either the TB Questionnaire or a TB Mantoux skin test as described below. The TB Questionnaire was developed by the DSHS Infectious Disease Control Unit TB Program to determine if the client-client is at high risk for contracting TB and needs Mantoux skin testing. Providers may photocopy the questionnaires from Appendix C of this manual or download the form at www.dshs.state.tx.us/idcu/disease/tb/forms/#clinic. Select EF12-11494 (English) or EF12-11494A (Spanish).

If any question on the questionnaire is answered with a "yes" or "I don't know," a TB Mantoux skin test is to be performed at the visit, unless medically contraindicated (e.g., has a history of a previous positive purified protein derivative [PPD] test). If all questions are answered with a "no," the client does not need to have skin testing unless the provider believes it is needed for other medical reasons. Any newly-identified positive reactions should be evaluated by a screening provider or referred for evaluation. Report any suspected cases or diagnosed cases of TB to the client's local or regional health department.

Providers should contact their local or regional health department to determine whether their service area is a low- or high-prevalence area for TB. A listing of counties with a high prevalence for TB is available at www.dshs.state.tx.us/idcu/disease/tb/statistics/hiprev/default.asp. Providers can also call the TB program at 1-512-458-7447 for more information.

In areas determined to be low-prevalence for TB, the TB Questionnaire should be administered annually beginning at 1 year of age. A TB skin test should be performed if the TB Questionnaire indicates a risk factor or if the provider determines that a TB skin test is appropriate.

In areas of high TB prevalence, the provider shall administer the TB skin test at 1 year of age and once between 4 through 6 years of age then again between 11 through 17 years of age. In those age ranges where a skin test is recommended, the provider should administer the skin test at one of these ages and the questionnaire at the other annual check ups. However, the questionnaire should be administered if the client refuses the skin test or the client is uncooperative.

The TB skin test also should be administered at any time a risk factor is indicated or the provider determines a skin test is appropriate. TB skin tests should be performed on clients who have been in contact with a case of active TB, have lived in a homeless shelter, have been incarcerated or live with someone who has been incarcerated, have lived or visit regularly in an area endemic for TB, currently work in a health-care setting, recently immigrated from a country with a high prevalence of TB, or have associated with someone with human immunodeficiency virus (HIV) infection.

Important: *"Live virus vaccines can interfere with response to a tuberculin test (TB). TB testing, if otherwise indicated, can be performed either on the same day that the live virus vaccines are administered or no sooner than 4 to 6 weeks later." Morbidity and Mortality Weekly Report (MMWR), Vol. 43 #RR 1, p. 15.*

The materials (PPD-Mantoux antigen and syringe) are available free of charge to the provider at the provider's local or regional health departments. Tine® testing materials should not be used. The cost of administering the test is included in the medical check up fee. A follow-up medical check up visit is required to read all TB skin tests. The provider may bill the follow-up medical check up fee of $14.96 for visit procedure code S-99211 with a THSteps provider identifier. Providers must indicate on the claim procedure code 5-86580 when a skin test is performed. It is not necessary to track the completion of the TB Questionnaire on the claim.

If further evaluation is required to diagnose either latent TB infection or active TB disease, the provider may bill the appropriate office visit code. Diagnosis and treatment are provided as a medical office visit.

THSteps providers may obtain PPD-Mantoux antigen and syringes from their local or regional DSHS office. They will be requested to sign a DSHS Infectious Disease Control Unit PPD Agreement.

Refer to: "Guidelines: Tuberculosis Skin Testing (2 Pages)" on page C-72 for guidance on the evaluation of a positive skin test.

"TB Questionnaire" on page C-75.

"Cuestionario Para la Detección de Tuberculosis" on page C-76.

"PPD Agreement for Texas Health Steps Providers" on page C-78.

43.2.3.9 Immunizations

All providers must assess the immunization status of the client at every encounter and administer any medically indicated immunizations according to the ACIP schedule, unless medically contraindicated or because of a parent's or guardian's reason of conscience, including a religious belief. The reason the indicated vaccination/toxoid was not administered must be documented in the client's medical record. The check up provider is responsible for the administration of immunizations and must not refer clients to local health departments or other entities.

The TVFC Program provides free vaccines to clients enrolled in Medicaid who are birth through 18 years of age. TVFC provides vaccines that are recommended according to the Recommended Childhood Immunization Schedule (ACIP, AAP, and the AAFP).

Refer to: "Immunizations" on page H-1 and "TVFC Provider Enrollment (3 Pages)" on page C-81 for more information on enrolling as a TVFC provider.

"Recommended Childhood and Adolescent Immunization Schedule, 2007" on page H-3.

Vaccine Information Statement (VIS)

A VIS is required by federal mandate to inform parents and vaccine recipients of the risks and benefits of the vaccine they are about to receive. Not only is it important to explain the risks and benefits before a vaccine is administered, but it is also important that providers use the most current forms available. For more information about immunizations, vaccine preventable diseases, or literature and forms, call the DSHS Immunization Branch at 1-800-252-9152 or review information at www.dshs.state.tx.us/immunize/default.shtm.

43.2.3.10 Dental Screening

Dental Screening Guidelines for THSteps Medical Providers

The following information provides guidelines for THSteps medical providers in performing the initial dental screening as required within a comprehensive THSteps medical check up.

The applicable periodicity schedule for THSteps dental assessment follows the standards as adopted by the American Academy of Pediatric Dentistry. The oral screening by the medical provider, as required within the comprehensive THSteps medical check up, must occur at *all* THSteps medical check ups. The medical check up provider must initiate the referral for a comprehensive THSteps dental check up by a THSteps participating dentist, starting at 1 year of age and at six-month intervals thereafter (unless unusual circumstances dictate more frequent referrals).

Early Childhood Caries (ECC)

To reduce the risk of ECC, the parent/guardian should always be counseled in proper feeding practices, including the following:

- Never put a child to bed with a bottle containing any liquid other than water.
- Recommendations for decreasing the frequency and duration of bottle feeding.
- Bottle contents (water is recommended in the bottle other than at regular feeding times). Feedings should be followed by gentle cleansing of the oral structures with a clean, damp cloth or soft brush.
- Establish a goal to have the child to begin drinking from a cup at 6 months of age.

Early signs of ECC often present as chalky white spots, particularly on the lingual surfaces of maxillary incisors. These signs, or any indication of more advanced caries, should prompt an immediate referral to appropriate dental care providers for evaluation.

Primary Teeth

The 20 primary teeth are also called deciduous teeth or baby teeth. Besides functioning in mastication, they also serve roles in speech development, jaw development, and eventually, in the position of the permanent dentition. Premature loss of the primary teeth can lead to permanent space loss within the dental arch and significant problems with alignment and function of the permanent teeth. If a primary tooth is lost prematurely, it is important that the client be evaluated within the next few weeks by a dentist, and that a determination is made for space supervision. Delayed exfoliation of the primary teeth may also have a harmful effect on the permanent dentition and calls for a dental evaluation.

Permanent Teeth

The first permanent tooth is the 6-year molar, which is the sixth tooth from the mid-line between the central incisors. There are four of them, that erupt when a child is between 5 and 6 years of age. The first permanent molar is often mistaken for a primary tooth because no tooth is lost. These teeth are termed the keystones of the dental arches because they help guide the subsequent teeth into proper alignment.

Caries (Cavities)

Clients with developing primary or mixed (primary-permanent) dentition should be evaluated for caries (cavities).

Oral Soft Tissues

Oral soft tissues should be examined for any abnormalities. Consultation with a dental provider, where a differential diagnosis may apply, is highly recommended.

Sealants

Many studies have shown that dental sealants can protect teeth from decay when properly applied.

Client Dental Education

This education should include the following:

- The need for thorough daily oral hygiene practices.
- Education in potential gingival manifestations for clients with diabetes and clients under long-term medications therapy.
- Utilization of the THSteps eligibility for dental services.

Smokeless Tobacco

The use of smokeless tobacco is expanding in many population groups and is strongly correlated with an increase in the prevalence of oral cancer. Early intervention and education can play a significant role in reducing risks. The following steps should be taken:

- Assess patterns of use.
- Offer assistance in cessation, if appropriate.
- Evaluate oral hard and soft tissues particularly the mucobuccal folds, cheeks, and sublingual areas.

- Refer all suspected lesions to appropriate providers for evaluation and follow-up.

Dental Disease Prevention

Perhaps the two most important interventions are:

- Early and periodic dental check ups.
- Parent education that stresses to parents the important role they can play in preventing dental disease in their children.

Regularly-positioned teeth with normal occlusion add symmetry and harmony to the facial appearance and are an important aspect of the expression of emotion and personality.

Refer to: "THSteps Medical and Dental Administrative Information" on page 43-5 for more information.

43.2.3.11 Medical Check Up Laboratory Component

All components of the THSteps medical check up are included in the reimbursement for the visit, including all laboratory tests as indicated on the periodicity schedule. All required medical check up laboratory work must be performed by the DSHS laboratory. DSHS makes these services available free of charge to all enrolled THSteps medical check up providers for THSteps clients. THSteps laboratory services obtained as part of a medical check up and provided in a private laboratory are not reimbursed.

Exception: *THSteps laboratory specimens for blood test screening for hyperlipidemia or Type 2 diabetes may be sent to the provider's laboratory of choice.*

Refer to: "Check Up Laboratory Procedures" on page 43-28.

43.2.3.12 Health Education/Anticipatory Guidance

Health education is a federally mandated component of the THSteps medical check up and includes anticipatory guidance. *Face-to-face* health education and counseling with parents or guardians and clients *are required* to assist parents in understanding what to expect in terms of the client's development and to provide information about the benefits of healthy lifestyles and practices, and accident and disease prevention. Written material also may be given but will not replace face-to-face counseling.

Developmentally and age-appropriate health education, anticipatory guidance, and counseling include the following:

- Developmental expectations.
- Dental health.
- Sleep.
- Feeding and nutrition.
- Lead poisoning risks.
- Healthy lifestyle/practices.
- Accident and disease prevention.

Adolescent Development

Providers must give adolescents the following health guidance:

- Promote a better understanding of their physical growth and their psychosocial and psychosexual development.
- Promote the importance of becoming involved in decisions about their health care.

Healthy Lifestyles and Safety Practices

Providers must give adolescents health guidance on the following injury-prevention techniques:

- Promote the avoidance of the use of alcohol or other substances altogether and especially while using motor or recreational vehicles or where impaired judgment may lead to injury.
- Promote the use of safety devices, including seat belts, motorcycle and bicycle helmets, and appropriate athletic protective devices.
- Promote water safety and encourage the adolescent to learn to swim.
- Promote the resolution of interpersonal conflicts without violence.
- Promote the avoidance of the use of weapons and promote weapon safety.
- Promote obtaining appropriate physical conditioning before exercise.
- Promote avoidance of tobacco, alcohol, high noise exposure, other abusable substances, and anabolic steroids.

Diet and Fitness

Providers must give adolescents health guidance on the following diet and fitness topics:

- Benefits of a healthy diet.
- Ways to achieve a healthy diet.
- Maintenance of healthy weight.
- Benefits of safe exercise on a regular basis.
- Benefits of adequate rest.

Refer to: *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* (3rd edition revised), at www.brightfutures.org.

Guidelines for Health Supervision III from the AAP Publication Department, PO Box 927, 141 Northwest Point Blvd., Elkgrove Village IL 60009-0927.

43.2.3.13 Additional Adolescent Screening

Tobacco, Alcohol, and Drug Use Use

Providers must ask about use of cigarettes and smokeless tobacco. Adolescents who use tobacco products should be assessed further to determine their patterns of use. A cessation plan should be provided for adolescents who use tobacco products. A dental referral should be made for all adolescents with a history of tobacco use.

Providers must ask about the use of alcohol and other substances (marijuana, cocaine, paint/glue sniffing and others), and over-the-counter or prescription drugs (for nonmedical purposes), including anabolic steroids.

Adolescents that report any use of alcohol or other drugs or inappropriate use of medicines during the past year should be assessed further about family history, circumstances surrounding use, amount and frequency of use, attitudes and motivation about use, use of other drugs, and the adequacy of physical, psychosocial, and school functioning.

Adolescents whose substance use endangers their health should receive counseling and mental health treatment, as appropriate.

Adolescents that use anabolic steroids should be counseled to stop using steroids and informed about the danger of sharing needles.

The routine urine toxicology screening of adolescents is *not* recommended.

Adolescents that use alcohol or other drugs should also be asked about their sexual behavior and use of tobacco products.

Depression/Suicide Risk

Providers must ask about behavior or emotions that indicate depression or suicide risk.

Providers must perform screening for depression or suicide risk on adolescents that exhibit cumulative risk as determined by declining school grades, dysthymia, depressed or irritable mood, family dysfunction, homelessness, anxiety about sexual orientation, physical or sexual abuse, alcohol or other drug use, previous suicide attempt, and suicidal inclination or plans.

If suicide risk is suspected, adolescents should be evaluated immediately and referred to a psychiatrist or other mental health professional, or they should be hospitalized for immediate evaluation.

Nonsuicidal adolescents with symptoms of severe or recurrent depression should be evaluated and referred to a psychiatrist or other mental health professional for treatment.

Learning Problems

Providers must ask about learning or school problems and noise exposure (music, motorcycles, cars, etc.).

Providers must assess adolescents for a history of truancy, repeated absences, or poor or declining performance that could interfere with school success. Conditions to assess include learning disabilities, attention deficit hyperactivity disorder, medical problems, abuse, family dysfunction, mental disorder, and alcoholic or other drug abuse.

This assessment and the subsequent management plan should be coordinated with school personnel and the adolescent's parents or caregivers.

Physical, Sexual, or Emotional Abuse

Providers must ask about history of emotional, physical, and sexual abuse.

If abuse is suspected, adolescents should be assessed to determine the circumstances surrounding the abuse and the presence of physical, emotional, and psychosocial consequences, including involvement in health risk behaviors.

All health-care professionals are required to report all instances of suspected or confirmed abuse and neglect of adolescents and children. Regardless of whether the provider staff suspects that a report may have been previously made, a report must be made to one of the following:

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

Adolescents who report emotional or psychosocial sequelae should be referred to a psychiatrist or other mental health professional for evaluation and treatment.

Reporting Suspected Sexual Abuse

Reporting Abuse or Neglect, Rider 33 of Article II of the *General Appropriations Act*, House Bill (H.B.) 1, 78th Legislative Regular Session, 2003, requires DSHS to ensure all Medicaid providers comply with the provisions of state law as set forth in Chapter 261 of the *Texas Family Code* relating to investigations of child abuse and neglect reports, including suspected sexual abuse and HHSC reporting requirements.

Refer to: "Child Abuse Reporting Guidelines (2 Pages)" on page B-11 for more information. Providers must use the "Child Abuse Reporting Guidelines, Checklist for HHSC Monitoring" on page B-13 to document referral of suspected abuse.

Sexual Behavior/Sexually Transmitted Diseases (STDs)

Providers must ask about involvement in sexual behaviors during a general screening.

- Adolescents that are sexually active should be asked about their use and motivation to use condoms or barrier methods and contraceptive methods, their sexual orientation, the number of sexual partners they have had, whether they have exchanged sex for money or drugs, and their history of prior pregnancy or STDs.
- Adolescents at risk for pregnancy, STDs (including HIV), or sexual exploitation should be counseled on how to reduce this risk.
- Adolescents that are sexually active should also be asked about their use of tobacco products, alcohol, and other drugs.

STD Screening Procedures for Sexually Active Adolescents

Sexually active adolescents should be tested for gonorrhea, chlamydia, syphilis, and HIV. Providers can refer to the following CDC website for further information on HIV testing: www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm.

Consent for STD testing, including HIV, should be covered in the general consent.

STD risk status includes the following:

- Having used injectable drugs.
- Having had STD infections.
- Having had unprotected vaginal, anal, or oral sex.
- Having exchanged sex for drugs or money.
- Having had a sexual partner who is at risk for HIV infection (e.g., injectable drug use or past or present STD infection)

Providers can call 2-1-1 Texas for referrals to HIV/acquired immunodeficiency syndrome (AIDS) testing sites; prevention, case management, and treatment providers; STD clinics; and other related service organizations. The Texas HIV/STD Community Resource Directory is available at www.dshs.state.tx.us/hivstd/services/default.shtm. Testing sites may also be found online at www.hivtest.org.

Although HIV prevention counseling is not required, it is strongly recommended *for high-risk adolescents* and should include health guidance about responsible sexual behaviors, including abstinence. HIV prevention counseling should include the following:

- Counseling that abstinence from vaginal, oral, and anal intercourse is the most effective way to prevent pregnancy, STDs, and HIV infection.
- Counseling on how HIV infection is transmitted, the dangers of the disease, and the fact that using latex condoms reduces the risk of transmission of HIV and some STDs.
- Reinforcement of responsible sexual behavior for adolescents who are not sexually active currently and for those who use birth control and condoms appropriately.
- Counseling on the need to protect themselves and their partners from pregnancy, STDs, HIV infection, and sexual exploitation.

43.3 Check Up Laboratory Procedures

These services and supplies are limited to THSteps medical check up laboratory services provided in the course of a medical check up to THSteps clients. Unauthorized use of services and supplies is a violation of federal regulations. The reimbursement for the complete medical check up includes specimen collection supplies, mailing and shipping supplies, and receiving test results from the DSHS laboratory.

43.3.1 Reimbursement

Laboratory Services are reimbursed in accordance with 1 TAC §355.8610. Fee schedule for these services are available on the TMHP website at www.tmhp.com/file library/file library/fee schedules.

43.3.2 Laboratory Services

Laboratory services are available from the DSHS laboratory and may *not* be billed separately with an office visit or consultation on the same day as a THSteps medical check up.

Claims for THSteps check ups and for laboratory services are subject to retrospective review to assure compliance with the policy.

A THSteps laboratory test included in the periodicity schedule for a specific visit (or needed if not obtained at a previous visit) is a required component of the visit. These laboratory specimens, except Pap smears, screening for hyperlipidemia, and type 2 diabetes, *must* be submitted to the DSHS laboratory. Pap smears must be sent to the Women's Health Laboratory in San Antonio. Screening for hyperlipidemia and Type 2 diabetes may be sent to a laboratory of the provider's choice including DSHS laboratory.

Refer to: "Texas Health Steps (THSteps) Outpatient Laboratory Services" on page 26-3 for the addresses of the laboratories.

Providers can refer to the table at the end of this section for a list of the tests available from the DSHS laboratory that are included in the periodicity schedule. It is permissible to complete hematocrit and hemoglobin testing on site; however, there is no separate reimbursement for these tests and results must be clearly documented in the medical record. Results from these two tests are also acceptable from a WIC clinic or other provider, if actual results are available and have been obtained within one month of the visit date.

The THSteps program requires that all laboratory tests noted on the periodicity schedule be obtained as part of the medical check up, so all providers must use the date of the medical check up as the date of laboratory service.

If the medical check up findings result in an E/M visit for an acute problem, the provider should complete the test necessary to make a diagnosis. Tests obtained as part of the E/M visit may be processed at the provider's laboratory of choice and may be billed *unless* the test is a required component of the THSteps visit on the same day of a THSteps medical check up.

Note: *Providers should make a request on the laboratory form if an extreme health problem exists and telephone results are needed quickly. With the exception of weekends and holidays, routine specimens are analyzed and reported within three business days after receipt by the DSHS laboratory. Critical abnormal tests results (e.g., hemoglobin equal to or below 7g/dL or blood lead level greater than or equal to 40 mcg/dL) are identified in the*

laboratory within 36 hours after receipt of specimens and are reported to the submitter by telephone within one hour of confirmation.

THSteps laboratory specimens submitted to DSHS must include the client's name and Medicaid number as they appear on the Medicaid Identification (Form H3087) on a DSHS laboratory Request Form (Newborn Screening NBS-3, G-1B, G-2A, G-2B). Providers must write "pending" in the Medicaid number space, which is located in the payor source section of the laboratory requisition form, if a number is not currently available but is pending (i.e., a newborn or a newly-certified client verified by a Medicaid Eligibility Verification (Form H1027) as eligible for Medicaid).

Laboratory specimens received at DSHS that do not have a Medicaid number or the word *pending* written in the nine-character space for the Medicaid number will be analyzed, and the provider will be billed. Laboratory tests must also meet specific acceptance criteria for specimens submitted. For further information on specimen submission, providers can refer to the DSHS laboratory web page at www.dshs.state.tx.us/lab /MRS_specimens.shtm.

The reimbursement for the complete medical check up includes specimen collection, shipping, testing, and receiving test results from the DSHS laboratory.

The following services may not be billed separately with an office visit or consultation on the same day as a THSteps medical check up either by a provider or laboratory. Claims for procedure codes listed below submitted by a provider or a commercial laboratory for the same DOS as a THSteps medical check up are denied and are subject to retrospective review:

Laboratory Test Procedure Codes			
5-83020	5-83655	5-84203	5-85014
5-85018	5-86403	5-86592	5-86689
5-86701	5-87490	5-87590	I-88141
5-88142	5-88143	5-88147	5-88148
5-88150	5-88152	5-88153	5-88154
5-88164	5-88165	5-88166	5-88167
5-88174	5-88175		

The following are laboratory specimens related to blood testing screening for hyperlipidemia or Type 2 diabetes that may be sent to a laboratory of the provider's choice.

Laboratory Test Procedure Codes			
5-80061	5-82465	5-82947	5-82952
5-83718	5-84478		

Laboratories billing for these procedure codes on the same date of service as a medical check up visit may be reimbursed separately.

Providers who obtain and process these specimens in-house are not reimbursed separately.

43.3.3 Laboratory Supplies

THSteps medical providers receive a startup package of specimen collection supplies and mailing and shipping containers, including air bills for the shipping of glucose, cholesterol, and lipid profile specimens, after the laboratory receives a listing of verified THSteps providers. Before startup packages are sent to providers, the DSHS laboratory verifies enrollment of THSteps medical providers. The DSHS laboratory calls the provider to verify the shipping address. The DSHS laboratory provides THSteps medical providers with the items listed below associated with whole blood/serum specimen collection. If a newly-enrolled provider is not contacted, the provider should call the laboratory. Requests for specimen requisition forms are routed to the laboratory reporting staff and mailed separately to the providers.

The startup package includes:

- 2 mL vacuum tube (with anticoagulant) for venipuncture.
- Safety needle holders.
- 250 - 500 uL finger stick blood collector (with anticoagulant).
- 6 mL vacuum tube (without anticoagulant) for venipuncture (required for rapid plasma reagin [RPR], cholesterol, and lipid panel testing).
- 4 mL vacuum tube (with antiglycolytic agent) for venipuncture (required for glucose testing and available upon request).
- Snap-Apart filter paper collection card.
- 22 gauge x 1 inch vacuum needle.
- Safety lancets.
- Laboratory Forms G-1B, G-2A, and G-2B.
- Lead information pamphlets.
- Mailing container (single- or multiple-tube) with business reply (postage paid) label.

Requests for whole blood/serum specimen collection supplies should be made using DSHS Form G-399, which can be faxed or mailed to the following address:

Laboratory Services Section, MC 1947
Department of State Health Services
PO Box 149347
Austin, TX 78714-9347
1-512-458-7661 or 1-888-963-7111, ext. 7661
Fax: 1-512-458-7672

Providers should not order more than a three-month supply as most supplies have expiration dates and must be rotated frequently for efficient usage. To reduce waste in ordering, DSHS monitors supply requests according to the number of specimens submitted by the provider. Keep unused tubes with anticoagulant in the original airtight self-closing plastic bag to prevent moisture and dust from reaching the anticoagulant.

To order requisition forms (G-1B, G-2A, G-2B) from the DSHS laboratory, requests can be made by telephone AT 1-512-458-7578 or 1-888-963-7111, ext. 7578 or facsimile at 1-512-458-7533.

43.3.3.1 Newborn Screening Supplies

Providers that perform newborn screening can order supplies by submitting a Newborn Screening Supplies Order Form 14-03252.

Newborn screening supplies include:

- Newborn Screening Specimen Collection Form, Form NBS 3 (order by individual quantities).
- Mailing envelopes.
- Provider address labels.

To obtain a Newborn Screening Supplies Order Form from DSHS for written requests, providers should call (512) 458-7661 or 1-888-963-7111, ext. 7661.

Providers can obtain THSteps and Newborn Screening Supplies Order Form from the following website: www.dshs.state.tx.us/lab/MRS_forms.shtm.

43.3.3.2 Send Comments

Providers with complaints or comments about THSteps specimen collection supplies should contact the DSHS laboratory. Supplies are evaluated continually, and feedback from supply users are solicited. Documented comments may support or change an item in a state contract. Send a brief letter or fax to the following address:

Quality Assurance Unit
Laboratory Services Section, MC 1947
Department of State Health Services
PO Box 149347
Austin, TX 78714-9347
Fax: 1-512-458-7672

43.3.4 Required Tests

The following laboratory screening procedures are a required component of the THSteps medical check up and are to be performed in accordance with the age and frequency specified on the THSteps medical check up periodicity schedule.

43.3.4.1 Glucose

Clients should be screened for risk of type 2 diabetes. Fasting glucose screening should be obtained for those at risk of type 2 diabetes.

43.3.4.2 Hemoglobin or Hematocrit

Hemoglobin or hematocrit levels are required to indicate anemia resulting from poor diet or diseases. The required minimum frequency for hemoglobin or hematocrit testing is at 6 months, 12 months, 24 months, 6 years, 12 years, and 16 years of age. At 12 and 24 months of age, hemoglobin should be quantitated in conjunction with the lead screen. The laboratory request form must be marked for both hemoglobin and lead. Hemoglobin and hematocrit laboratory procedures performed at a WIC clinic or in a provider's office are acceptable if performed within one month and the date and value are documented.

The provider should note that the DSHS laboratory uses the sulfolyser (SLS-Hb) method to measure hemoglobin.

43.3.4.3 Hemoglobin Type

If the hemoglobin type has been done as a part of newborn screening and results are documented on the chart, the test does not need to be repeated. It also may be performed at the provider's discretion, as appropriate for age and population groups. For instance, certain clients need this procedure to screen for sickle cell disease or trait, if not done previously.

The DSHS laboratory uses isoelectric focusing electrophoresis for hemoglobin type screening.

The laboratory reports the types of hemoglobin detected. Providers should compare reported test results to the expected ranges, which are noted on the patient report, to determine whether further testing, such as confirmation, is needed. If a hemoglobin variant is reported as "Other," a specimen can be submitted to a reference laboratory for further testing and confirmation.

43.3.4.4 Hyperlipidemia

Hyperlipidemia is based on risk assessment. THSteps does not provide a formal risk assessment tool. Providers may refer to the AAP policy statement on cholesterol screening for more information.

The cholesterol screen consists of a blood cholesterol level. Clients do not need to fast before the screen. Specimens for lipid profiles should be from clients that have fasted at least 12 hours and are at-risk. A lipid profile includes the measurement of total blood cholesterol, triglycerides, and high-density lipoproteins (HDL), as well as a calculated value for low-density lipoproteins (LDL).

43.3.4.5 Lead Screening and Testing

In accordance with current federal regulations, THSteps requires that clients be screened for lead poisoning through either blood tests and/or parent questionnaires at 6, 12, 15, 18, and 24 months of age and annually until 6 years of age.

Blood lead analyses are mandatory at 12 and 24 months of age for THSteps clients. At other THSteps medical check ups (6 months, 15 months, 18 months, 3, 4, 5, and 6 years of age), the Form Pb-110: Risk Assessment for Lead Exposure questionnaire may be administered to the parent or guardian. If (at any age) the parent answers "yes" or "I don't know" to any of the questions, a blood lead analysis is to be performed. Providers may download the Pb-110: Risk Assessment for Lead Exposure questionnaire questions provided in both English and Spanish at www.dshs.state.tx.us/lead/pdf_files/pb_110_parent_questionnaire.pdf.

Providers may obtain more information about the medical and environmental management of lead-poisoned children from the DSHS Childhood Lead Poisoning Prevention Program by calling 1-800-588-1248 or visit the web page at www.dshs.state.tx.us/lead/default.shtm.

Specimen Collection and Handling

Specimens collected for total hemoglobin and lead testing must be submitted in DSHS specified whole blood collection tubes (purple top) that contain K2EDTA. Specimens submitted for hemoglobin types testing must be collected on the DSHS Snap-Apart filter paper collection card provided by the DSHS laboratory. Specimen collected on filter paper should be dry before mailing. Mail specimens daily. Specimens can be mailed at ambient temperature.

A separate tube (red top tube) must be submitted for syphilis (RPR) and/or hyperlipidemia testing, and a gray top tube (sodium fluoride/potassium oxalate) must be submitted for glucose testing regardless of any additional THSteps laboratory screening procedures being performed at the same time.

Due to changes in specimen collection, handling, and submission criteria recommended by the *Clinical Laboratory Improvement Amendments* (CLIA) (Regulatory Agency), contact the DSHS laboratory for the most current specimen requirements at 1-888-963-7111, Ext. 7430.

Refer to: "Lead Screening" on page J-1 for more information on lead screening procedures and follow-up.

43.3.4.6 Newborn Screening

The second mandated newborn screen at 1 to 2 weeks of age is a required component of the THSteps medical check up but is not required as an informational detail of the claim. Providers should document the date and the results of the second newborn screening in the client's medical record. Clients should not be referred to the local health department or other providers for this service.

Health and Safety Code, Chapter 33, Vernon's Texas Codes Annotated, requires testing for the disorders recommended by the American College of Medical Genetics (ACMG) on all newborns. This testing is the responsibility of any provider attending the newborn. All newborns must be tested a second time at 1 to 2 weeks of age. If there is any doubt that a client younger than 12 months of age was properly tested, the provider should submit the blood sample on the appropriate DSHS Form NBS-3 to the DSHS Newborn Screening Laboratory.

The provider should note the following:

- Results are mailed to the provider's address indicated on Form NBS-3.
- Laboratory recommendations for necessary follow-up procedures are included with the report.
- The DSHS NBS Case Management staff contacts the provider in cases of significant abnormality.

43.3.4.7 Urinalysis

Urinalysis (i.e., dipstick) is performed at the discretion of the provider. Providers must purchase their own supplies. The cost for performing this service is included in the fee for the medical check up.

Refer to: "Check Up Laboratory Procedures" on page 43-28 for more information on laboratory collection techniques.

43.3.5 Additional Required Laboratory Tests Related to Medical Check Ups for Adolescents

The DSHS Clinical Chemistry Laboratory must perform laboratory screening tests for THSteps clients for cholesterol, HIV, gonorrhea/chlamydia, and syphilis. The DSHS Women's Health Laboratories, Cytopathology Department performs Pap smear screening for THSteps clients.

Laboratory specimen collection testing materials and necessary forms and supplies are available at no additional cost to all enrolled THSteps medical providers. The following information describes laboratory test procedures, interpretation of laboratory test results, guidelines, and criteria for follow-up, as well as helpful information on specimen collection and handling.

43.3.5.1 Communicable Disease Reporting

Diagnoses of STDs, including HIV, are reportable conditions under 25 TAC, Chapter 97. Providers must report confirmed diagnoses of STDs as required by 25 TAC §97.132.

43.3.5.2 Cervical Cancer Screening

The first Pap smear should be obtained at 21 years of age, 3 years from the onset of sexual activity, or at any other age based on provider discretion. A Pap smear test is a microscopic examination of cells exfoliated or scraped from a mucosal surface. This test is most widely used in detecting malignant, premalignant, and infectious disease of the uterine cervix.

Laboratory Procedure

Specimens for the Pap smear must be sent to the DSHS Women's Health Laboratory in San Antonio. Pap smears arrive by mail or courier service and are processed in the Cytopathology Laboratory. The slides are stained with the Pap stain technique and coverslipped. Staff cytotechnologists examine all Pap smears for cellular disease and render a diagnosis on those determined to be negative or abnormal.

A quality control cytotechnologist rescreens at least 10 percent of the cases considered negative by the staff cytotechnologists. All abnormal cases are referred to a pathologist for final interpretation and follow-up recommendation. A computer-generated result report is mailed or faxed to the submitting THSteps medical check up provider. A statistical report is mailed monthly to providers documenting their totals by diagnosis and adequacy.

Request Form

Follow these steps to submit a request form:

1) Submit a test request form (Form M-47).
2) Make sure the slide and request form (or liquid-based Pap vial) are labeled with the client's last name. Wrap the completed M-47 form around the cardboard mailer for conventional Pap smears and fasten with a rubber band. For liquid-based Pap smears, place the vial in a zip-lock biohazard transport bag, and place the M-47 in the corresponding pocket.
3) The completed M-47 form must include the following information:
   - Name as it appears on the Medicaid Identification (Form H3087).
   - Address.
   - Date of birth.
   - Social Security number (SSN).
   - DOS.
   - Examiner.
   - ICD-9-CM diagnostic code for the visit or a descriptive narrative.
   - Test(s) ordered.
   - Specimen site (cervix, endocervix, and vaginal).
   - Submitting clinic code or name and address of clinic.
4) The completed test request form must include the Medicaid number or "Medicaid pending" must be written on the form for billing purposes.

Mailing Specimens and Ordering Supplies

THSteps providers can call for information, mail specimens to, or order supplies for obtaining Pap smears for THSteps adolescent screening from the following laboratory:

Women's Health Laboratories
2303 SE Military Drive, Suite 1
San Antonio, TX 78223
Customer Service: 1-888-440-5002 or 1-210-531-4596
Fax: 1-210-531-4506

To order supplies, providers should do the following:

- Providers must use order Form AG-30, 1643, or letterhead stationery.
- Fax the supply order form or include in the specimen packaging.
- Request supplies by telephone or email.
- Include their THSteps provider identifier.

The following supplies are available for order:

Conventional Pap Smears	Surepath Liquid-Based Pap Smears
Frosted slides	Cervex brush
Cytocervial brush	Cytorich preservative vial
Cyto fixative	M-47 form

Conventional Pap Smears	Surepath Liquid-Based Pap Smears
Cardboard slide mailers	Zip-lock biohazard transport bag
M-47 forms	
Cervical scrapers	Cardboard boxes
Cardboard boxes	Labels
Labels	AG-30 supply order form
AG-30 supply order form	

Providers that are already on the automated system through the DSHS Pharmacy are encouraged to continue using this system. Larger numbers of supplies are sent through the DSHS Pharmacy. Providers with consistent monthly workload volumes can request to be set up with a *standard monthly order* that is shipped at the same time each month.

43.3.5.3 STD Testing

Syphilis Testing

Syphilis testing should be performed on adolescents that are at high risk for infection. These high-risk adolescents include sexually active individuals living in an area with a high prevalence of STD, endemic for syphilis, or individuals at risk (e.g., past family history or prior history of other STDs or for adolescents who have had vaginal, anal, or oral sex, or have had a sexual partner who is at risk for infection). RPR card test is no longer a required test but should be obtained based on risk assessment.

Laboratory Procedure

Specimens for syphilis screening must be sent to the DSHS Austin laboratory. A RPR card test is the screening procedure. Due to changes in specimen collection, handling, and submission criteria, recommended by CLIA (Regulatory Agency), contact the DSHS laboratory for the most current specimen requirements at 1-888-963-7111, Ext. 7430. The provider should note the following:

- The RPR card test is a macroscopic nontreponemal testing procedure similar in sensitivity and reliability to the Venereal Disease Research Laboratory (VDRL).
- False-positive reactions occur with variable frequency as a result of reagin produced in diseases other than syphilis or provoked by immunization antigens.
- Specimens found reactive by RPR card test are confirmed for syphilis by TP-PA or FTA-ABS tests.
- The RPR Card Test cannot be performed if hemolysis of the specimen has occurred, the specimen volume is less than 0.5 mL, or the specimen is grossly contaminated with bacteria, lipemic, or otherwise extremely turbid.

Gonorrhea and Chlamydia Infection Testing

Gonorrhea and chlamydia infections are the most common reportable STDs in the United States today. For this reason, sexually active adolescents are tested for both these diseases simultaneously. Untreated infections may result in severe complications, including sterility and pelvic inflammatory disease.

HIV Testing

It is critical to maintain confidentiality when caring for clients, as well as their specimens. Providers must not leave specimens identified for HIV testing in open view of unauthorized medical personnel. Discussions with clients about their risk factors should be confidential. *Testing should be performed only after informed consent is obtained from the adolescent. Providers must not mail the client consent to the laboratory; the consent must be retained with the client's records.*

HIV testing may be performed for adolescents without requirement of parental consent. Adolescents at risk for HIV infection should be offered confidential HIV screening. If the client refuses the HIV test, the provider may not perform the test and must explain the option of anonymous testing and refer the client to a testing facility that offers anonymous testing. A notation must be made in the medical record that notification of the HIV test and the right to refuse was given. Providers may call the HIV/STD InfoLine for referrals to HIV/AIDS testing sites; prevention, case management, and treatment providers; STD clinics; and other related service organizations. The HIV/STD InfoLine is 1-800-299-2437. This toll-free HIV/AIDS and STD information and referral service is available for English- and Spanish-speaking callers and for those who are hearing-impaired.

Laboratory Procedure

Specimens for HIV screening must be sent to the DSHS Austin laboratory. The presence of HIV-1 antibodies in client serum is a long-term marker of infection. Specimens are tested on an enzyme immunoassay (EIA) that identifies antibodies that are specific for the HIV-1 virus. Specimens that are initially reactive on the EIA screen are retested in duplicate on the EIA. If either of the duplicate retests are reactive, the EIA is considered repeatedly reactive and a confirmatory test, the Western blot, is performed.

The Western blot involves the separation of the virus proteins by size on a special strip of filter paper. This strip is soaked in a dilution of client serum. If antibodies specific for the different proteins are present, they will bind to that portion of the strip. The antibodies are then detected with enzyme-labeled antibodies that cause a darkening on the strip where client antibodies have bound. Western blot bands are named by a letter indicating the type of molecule (p=protein, gp=glycoprotein), and a number that indicates their relative size in kilodaltons (e.g., p17=a protein 17 kilodaltons in size).

43.4 THSteps-Comprehensive Care Program (CCP)

43.4.1 THSteps-CCP Overview

THSteps-CCP is an expansion of the EPSDT service as mandated by the OBRA of 1989, which requires all states to provide all medically necessary treatment for correction of physical or mental problems to THSteps-eligible clients when FFP is available even if the services are not covered under the state's Medicaid plan. This expansion of services is provided only for those clients birth through age 20 years who are eligible to receive THSteps services. If the client's Medicaid identification (Form H3087) states "Emergency Care," "PE," or "QMB," the client is not eligible for THSteps-CCP benefits.

In May 1991, the CMS issued a clarification of this legislation that expanded THSteps-CCP services to include treatment for problems identified by any health-care professional, regardless of whether a formal EPSDT check up has been performed.

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

- "Comprehensive Outpatient Rehabilitation Facilities (CORFs)/Outpatient Rehabilitation Facilities (ORFs)" on page 43-43.
- "Durable Medical Equipment Supplier (THSteps-CCP Only)" on page 43-45.
- "Early Childhood Intervention (ECI) (THSteps-CCP Only)" on page 43-58.
- "Licensed Dietitians (THSteps-CCP Only)" on page 43-59.
- "Occupational Therapists (THSteps-CCP Only)" on page 43-60.
- "Orthotic and Prosthetic Suppliers (THSteps-CCP Only)" on page 43-62.
- "Personal Care Services (THSteps-CCP Only)" on page 43-65.
- "Pharmacies (THSteps-CCP Only)" on page 43-70.
- "Private Duty Nursing (PDN) THSteps-CCP Only" on page 43-73.
- "Psychiatric Hospital/Facility (Freestanding) (THSteps-CCP Only)" on page 43-83.
- "Speech-Language Pathologists (THSteps-CCP Only)" on page 43-90.

Refer to: "THSteps Medical and Dental Administrative Information" on page 43-5 for more information.

43.4.1.1 Enrollment

THSteps-CCP providers must meet Medicaid/HHSC participation standards to enroll in the program. All THSteps-CCP providers must be enrolled in the Texas Medicaid Program to be reimbursed for services. Provider enrollment inquiries and application requests must be sent to the TMHP Provider Enrollment department at:

Provider Enrollment
Texas Medicaid & Healthcare Partnership
PO Box 200555
Austin, TX 78720-0555.

Home and community support services agencies (HCSSAs) that want to provide THSteps-CCP PDN, physical therapy (PT), speech therapy (ST), or occupational therapy

(OT) services under the licensed-only home health (LHH) category must first enroll with TMHP. To enroll with TMHP in the LHH category, an HCSSA must:

- Complete a provider enrollment form, which can found on the TMHP website at www.tmhp.com, provide its license information, and check the "Only CCP services" box on the form.
- Obtain a Texas Provider Identifier (TPI) for CCP services.
- Provide THSteps-CCP PDN, PT, OT, or ST services only to THSteps-eligible CCP clients and use the TPI number it was assigned for CCP services. Traditional Medicaid services must be delivered under the licensed and certified home health (LCHH) category.

43.4.1.2 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with a Medicaid Managed Care health plan to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plans for enrollment information. Refer to "Managed Care" on page 7-1 for more information on Medicaid Managed Care programs.

Refer to: "Provider Enrollment" on page 43-5 for more information about enrollment procedures.

43.4.1.3 Communication with THSteps-CCP

Providers can use the TMHP website and the following telephone or fax numbers for prior authorization or information on THSteps-CCP services:

Website, Telephone, and Fax Numbers for Prior Authorization or Information on THSteps-CCP Services	
In-Home Care (Home Health Services)/THSteps-CCP	1-800-846-7470
THSteps-CCP Fax	1-512-514-4212
Comprehensive Care Inpatient Psychiatric (CCIP)	1-800-213-8877
CCIP Fax	1-512-514-4211
TMHP website	www.tmhp.com

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

Providers can submit the following prior authorization requests for the following on the TMHP website:

Comprehensive Care Inpatient Psychiatric (CCIP):

- Psychiatric Inpatient Initial Admission Request Form.
- Psychiatric Inpatient Extended Stay Request Form.

CCP:

- THSteps-CCP ECI Request for Initial/Renewal Outpatient Therapy.
- Request for Initial Outpatient Therapy (Form TP-1).
- Request for Extension of Outpatient Therapy (Form TP-2).
- Donor Human Milk Request Form.
- Pulse Oximeter Form.
- Wheelchair/Scooter/Stroller Seating Assessment Form (THSteps-CCP/Home Health Services).
- Texas Medicaid Palivizumab (*Synagis*) Prior Authorization Request Form.
- THSteps-CCP Prior Authorization Request Form.
  - Apnea Monitor.
  - Bed/Crib.
  - Formula.
  - Total Parenteral Nutrition (TPN)/Hyperalimentation
  - PDN.
  - Miscellaneous.

Refer to: "Prior Authorization Requests Through the TMHP Website" on page 5-4 for additional information including mandatory documentation requirements and retention.

Send requests for prior authorization and appeals of prior authorization requests to the following address:

Texas Medicaid & Healthcare Partnership
Comprehensive Care Program
PO Box 200735
Austin, TX 78720-0735

Address first-time claims and appeals of incomplete claims for THSteps-CCP only to the following address:

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

Direct all other correspondence to a department (e.g., Provider Enrollment). Send all other claims, appeals, and resubmissions to the following address:

Texas Medicaid & Healthcare Partnership
PO Box 200285
Austin, TX 78720-0285

Clients should direct written communication to HHSC at the following address:

HHSC
Customer Service
1100 West 49th Street
Austin, TX 78756-3168

Medicaid clients and families may contact HHSC at 1-800-252-8263.

Documentation requirements for specific services and supplies are found in the provider-specific sections of this section.

43.4.1.4 Client Eligibility

The client must be birth through 20 years of age and eligible for THSteps at the time of the service request and service delivery. If the client's Medicaid Identification (Form H3087) states "Emergency Care," "PE," or "QMB," the client is not eligible for THSteps-CCP benefits.

Clients are ineligible for THSteps-CCP services beginning the day of their 21st birthday.

43.4.1.5 Benefits

Payment is considered for any health-care service that is medically necessary and for which FFP is available. THSteps-CCP benefits are allowable services not currently covered under the Texas Medicaid Program (e.g., speech-language pathology [SLP] services for nonacute conditions, PDN, prosthetics, orthotics, apnea monitors and some durable medical equipment [DME], some specific medical nutritional products, medical nutrition services, inpatient rehabilitation, travel strollers, and special needs car seats). THSteps-CCP benefits also include expanded coverage of current Texas Medicaid Program services where services are subject to limitations (e.g., diagnosis restrictions for TPN or diagnosis restrictions for attendant care services). Requests for services that require a prior authorization (prior authorization is a condition for reimbursement, not a guarantee of payment) must be submitted to the TMHP Medical Director. For information about dental, TPN, respiratory therapy, personal care services (PCS), and vision care benefits, refer to provider-specific sections of this manual.

Medicaid Benefits for Children

The following are Medicaid benefits for clients living with a family (including foster care):

- Medical services (physician, hospital, hearing aids [PACT], and eyeglasses).
- THSteps medical check ups (including immunizations) and dental exams and services.
- Medications through the Texas Medicaid Vendor Drug Program (VDP) (unlimited prescriptions, some over-the-counter with prescription).
- THSteps-CCP (prosthetics, orthotics, PCS, and SLP services for nonacute conditions).
- Texas Medicaid (Title XIX) Home Health Services that may be considered medically necessary (e.g., nursing visits, supplies, DME, and PT and OT for acute conditions provided in the home).

Medicaid benefits for clients living in residential treatment centers include the following:

- Medical services (physician, hospital, hearing aids [PACT], and eyeglasses).
- THSteps medical check ups (including immunizations) and dental exams and services.
- Medications through VDP (unlimited prescriptions, some over-the-counter with prescription).
- THSteps-CCP, excluding outpatient mental health services.

Medicaid benefits for clients living in nursing facilities include the following:

- Medical services (physician, hospital, hearing aids [PACT], and eyeglasses).
- THSteps medical check ups (including immunizations) and dental exams and services.
- Medications through VDP (unlimited prescriptions).
- THSteps-CCP is limited to the following:
  - Adaptive strollers.
  - Augmentative communication devices.
  - Orthotics.
  - Prosthetics.
  - Texas Medicaid (Title XIX) Home Health Services custom DME.

Medicaid benefits for clients in intermediate care facilities for the mentally retarded (ICF-MR) facilities (*not* state schools) include the following:

- Medical services (physician, hospital, hearing aids [PACT], and eyeglasses).
- THSteps medical check ups (including immunizations) and dental exams and services.
- Medications through VDP (unlimited prescriptions).
- THSteps-CCP (limited to orthotics and prosthetics).
- DME (covered in the daily rate).

Medicaid Procedure Codes

The following table identifies THSteps-CCP-related Medicaid procedure codes. This list is not all-inclusive but represents the most commonly billed THSteps-CCP procedures that are not listed in specific sections. These codes are not payable for all provider types. Other codes are listed in specific THSteps-CCP sections of this manual, and additional codes can be found in "Texas Medicaid (Title XIX) Home Health Services" on page 24-1. Prices are subject to change.

Procedure Codes				
9-E1340	J-E1639	L-E1639	J-E1800	J-E1805
J-E1810	J-E1815	9-L1500	9-L1940	9-L2270
9-L3150	9-L6628			

Limitations

Payment cannot be made for any service, supply, or equipment for which FFP is not available. The following are some examples:

- Vehicle modification, mechanical, and/or structural (such as wheelchair lifts).
- Structural changes to homes, domiciles, or other living arrangements.
- Environmental equipment, supplies, or services, such as room dehumidifiers, air conditioners, filters, space heaters, fans, water purification systems, vacuum cleaners, and treatments for dust mites, rodents, and insects.
- Ancillary power sources and other types of standby equipment (except for technology-dependent clients such as those who are ventilator-dependent for more than six hours per day).
- Educational programs, supplies, or equipment (such as a personal computer or software).
- Equine or hippotherapy.
- Exercise equipment, home spas or gyms, toys, or therapeutic balls.

- Tennis shoes.
- Respite care (relief to caregivers).
- Aids for daily living (toothbrushes, spoons, and foot stools).
- Take-home drugs from hospitals. Eligible hospitals may enroll in and bill VDP. Pharmacies that want to enroll should call 1-512-338-6978.
- Therapy involving any breed of animal.

43.4.1.6 Prior Authorization and Documentation Requirements

Prior authorization is a condition for reimbursement; it is not a guarantee of payment. A prior authorization number (PAN) is a TMHP-assigned number establishing that a service or supply has been determined to be medically necessary and for which FFP is available. It is *each provider's responsibility* to check the client's Medicaid Identification (Form H3087) at the time *each service is provided* to verify eligibility. Any service provided while the client is not eligible cannot be reimbursed by TMHP. The responsibility for payment of services is determined by private arrangements made between the provider and client.

Prior authorization of THSteps-CCP services may be requested in writing by completing the appropriate request form, attaching any necessary supportive documentation, and mailing or faxing it to the TMHP-CCP department. Prior authorization may also be requested through the TMHP website. (Providers can refer to "Prior Authorization Requests Through the TMHP Website" on page 5-4 for additional information to include, mandatory documentation, and retention requirements). All requested information on the form must be completed, or the request is returned to the provider. Incomplete forms are *not* accepted. If prior authorization is granted, the potential provider of service (such as the DME supplier, pharmacy, RN, or physical therapist [PT]) receives a letter that includes the PAN, the procedures authorized, and the length of the authorization. Providers are notified in writing whether additional information is needed to process the request for services.

Written requests for prior authorization are *mandatory* for the following services:

- Apnea monitors for clients older than 4 months of age or after an initial two months of rental.
- Customized DME not authorized under Texas Medicaid (Title XIX) Home Health Services (such as power wheelchairs).
- Diapers, wipes, and underpads for clients younger than 4 years of age.
- DME not authorized under Texas Medicaid (Title XIX) Home Health Services.
- Formula for a client birth through 20 years of age if the client does not have a gastrostomy tube (G-tube) or has a metabolic disorder.
- Freestanding psychiatric services.
- Freestanding rehabilitation services.
- Gastrostomy buttons (G-buttons) not authorized under Texas Medicaid (Title XIX) Home Health Services.
- Pediatric pneumograms, except for the first two pediatric pneumograms for infants younger than 12 months of age (refer to criteria in "Physician" on page 36-1).
- PDN.
- PT, OT, SLP services.
- TPN.

Submit a THSteps-CCP Prior Authorization Request Form and documentation to support medical necessity to the THSteps-CCP department *before* providing services.

Important: *Documentation to support medical necessity of the service, equipment, or supply (such as prescription, letter, and therapy notes) must be current, signed, and dated by a physician (MD or DO) before services are performed. Providers must keep the information on file.*

Refer to: THSteps-CCP provider-specific sections for prior authorization requirements of specific services.

Diagnosis Coding

All providers should obtain the client's medical diagnosis from the physician. This information must be reflected on each claim submitted to TMHP using ICD-9-CM coding.

Purchase Versus Equipment Rental

When providing equipment not authorized under Texas Medicaid (Title XIX) Home Health Services for THSteps-CCP clients with long-term or chronic conditions, it is more cost-effective, in many cases, to purchase the equipment rather than rent it. The client's condition and length of time the equipment will be used should be carefully assessed before authorization for rental or purchase is requested.

THSteps-CCP does not pay for the purchase of certain types of equipment (e.g., apnea monitors); consequently, long-term rental may be considered. Most other equipment is rented for only four months initially. During this time, the provider should assess whether the equipment should be purchased *before* the rental lapses. Rentals must be prior authorized.

After prior authorization is obtained for purchase, the new equipment must be provided and rental discontinued. THSteps-CCP does not purchase used equipment.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

Providers of customized or nonbasic medical equipment also must be enrolled as Medicare DME providers.

Drug Approval, Medical Device

Manufacturers may request drug or medical device products be added to THSteps-CCP by sending the information in writing to the following address:

HHSC
1100 West 49th Street
Austin, TX 78756-3179

HHSC reviews the information. Requests for consideration should *not* be sent to TMHP.

Refer to: "THSteps-CCP ECI Request for Initial/Renewal Outpatient Therapy" on page B-107.

43.4.1.7 Physician Signature

The signature of the physician (MD or DO) on a prescription or THSteps-CCP Authorization Request Form must be current to the service date(s) of the request, i.e., the signature must always be before the service start date and no older than three months before the current date(s) of service requested. Physician signatures dated after the service start date on initial requests cannot be accepted as documentation supporting medical necessity. A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply. If services begin as a result of a verbal order before the physician's signature date, submit proof of the verbal order with the request.

Stamped signatures and dates are not accepted on THSteps-CCP Authorization Request Forms or prescriptions for THSteps-CCP prior authorized services, supplies, or equipment. Verbal orders must be cosigned and dated by a physician (MD or DO) within two weeks or per provider policy if less. Signatures of NPs, clinical nurse specialist (CNSs), PAs, or doctors of philosophy (PhDs) are *not* accepted.

Physician prescriptions must be specific to the type of service requested. For example, if the provider is requesting PT, the prescription must request physical therapy, not just therapy.

43.4.2 Respiratory Syncytial Virus (RSV) Prophylaxis

The Texas Medicaid Program considers the AAP criteria as the most useful single reference describing the evidence basis for RSV prophylaxis medical necessity. RSV immune globulin, intramuscular palivizumab (*Synagis*) is a benefit of THSteps-CCP when medically necessary.

Based upon RSV surveillance data and the expert opinion of Texas-based specialists, the RSV season in Texas is expected to start on October 1 of each calendar year. This date may change each calendar year, based upon feedback from experts. Prophylaxis may begin in the two weeks preceding the start of the season.

Beginning at 6 months of age, all high-risk infants, including those who qualify for RSV prophylaxis, and their contacts should be immunized against influenza, unless influenza immunization is medically contraindicated in the case of a specific individual.

During the RSV season, hospitalized infants determined to be at risk of severe RSV disease should receive their first dose of RSV prophylaxis 48–72 hours before being discharged.

Discharge planning should arrange outpatient follow-up for continued administration of palivizumab if medically indicated. *Subsequent doses of palivizumab should be given approximately every 30 days.*

43.4.2.1 Reimbursement

Refer to: "Drugs/Biologicals" on page 2-5.

43.4.2.2 Prior Authorization

All palivizumab requires prior authorization through THSteps-CCP.

All requests for palivizumab must be submitted to THSteps-CCP on a completed Texas Medicaid Palivizumab (*Synagis*) Prior Authorization Request Form.

The form must be signed and dated by the ordering physician. The physician's original, handwritten signature and date is required on the form and must be maintained in client's medical record.

Based upon RSV surveillance data and the expert opinion of Texas-based specialists, the RSV season in Texas is expected to start on October 1. This date may change each calendar year, based upon feedback from experts.

Providers may start submitting for prior authorization beginning September 1, with an administration date starting on or after October 1.

Clients starting on or after November 1 should continue approximately every 30 days until a stop date of March 31.

Subsequent doses of palivizumab should be given approximately every 30 days. Clients continue with four more doses, with the last dose given by February 28 for those starting in October. Clients starting late in the season should continue until a stop date of March 31.

Hospitalized infants determined to be at risk of severe RSV disease in September may receive the first injection before October 1 before discharge from the hospital. Clients continue with five more doses, with the last dose given by February 28.

Palivizumab may be prior authorized for Medicaid clients birth through 23 months of age who have hemodynamically significant heart disease when the documentation submitted demonstrates at least one of the following:

- The presence of moderate to severe pulmonary hypertension.
- Active treatment for and diagnosis of hemodynamically significant heart disease, including *both* of the following documentation requirements:
  - Active treatment for hemodynamically significant heart disease within the six months preceding the start of the RSV season (i.e., treatment dates between April 1 and September 30) consisting of digitalis, diuretics, or supplemental oxygen.
  - A diagnosis code consistent with hemodynamically significant congenital heart disease (i.e., congenital anatomical cardiac defects or cardiomyopathies of any etiology).

The following table lists the most common cardiac diagnosis codes:

Diagnosis Codes				
3960	3961	3962	3963	3968
3969	4170	4171	4178	4179
4240	4241	4242	4243	4250
4251	4253	4254	4257	4259
4280	4281	4289	4599	7450
74510	74511	74512	74519	7452
7453	7454	7455	74560	74561
74569	7457	7458	7459	74600
74601	74602	74609	7461	7462
7463	7464	7465	7466	7467
74681	74682	74683	74684	74687
7470	74710	74711	74720	74721
74722	74729	7473	74740	74749

Palivizumab may be prior authorized for Medicaid clients birth through 23 months of age who have underlying lung disease when the documentation submitted demonstrates the following:

- Active treatment for lung disease within the six months preceding the start of the RSV season (i.e., treatment dates between April 1 and September 30) consisting of one of the following:
  - Corticosteroids (systemic or inhaled), diuretics, or supplemental oxygen therapy.
  - Mechanical ventilation.
- One of the following diagnoses of significant lung disease:
  - Chronic respiratory failure.
  - Chronic respiratory disease arising in the perinatal period.
  - Cystic fibrosis.
  - Congenital bronchiectasis.
  - Diaphragmatic defects.
  - Congenital cystic lung disease.
  - Congenital agenesis, hypoplasia and dysplasia of lung.
  - Other respiratory diagnoses with supportive documentation of medical necessity.

The following table identifies common chronic lung disease (CLD) diagnosis codes:

Diagnosis Codes			
27700	27701	27702	27703
27709	51883	7484	7485
74861	7506	7566	7707

Note: *CLD, also known as chronic respiratory disease arising in the perinatal period, was formerly called bronchopulmonary dysplasia. It can develop in pre-term neonates treated with oxygen and positive pressure ventilation. Many cases are seen in infants who previously had respiratory distress syndrome (RDS). CLD is characterized by disordered lung growth and a reduction in the number of structures available for gas exchange. CLD is not asthma, croup, recurrent upper respiratory infections, chronic bronchitis, chronic bronchiolitis, or a history of a previous RSV infection.*

Palivizumab may be prior authorized for Medicaid clients birth through 11 months of age when documentation includes a diagnosis code indicating the client was born at 28 weeks estimated gestational age or earlier (76521, 76522, 76523, or 76524).

Palivizumab may be prior authorized for Medicaid clients birth through 5 months of age when the documentation includes:

- A diagnosis code indicating the infant was born at 29–32 weeks estimated gestational age (76525 or 76526).
- A diagnosis code indicating the infant was born between 32 and 35 weeks gestational age (76526, 76527, or 76528) and documentation of severe neuromuscular disease (including chronic respiratory failure [51883]).
- Significant congenital anomalies of the airway, including diagnosis code 7480, 7482, and 7503, which is expected to compromise respiratory reserve, or documentation of two of the following:
  - Direct exposure to tobacco smoke or documented environmental air pollutants.
  - Regular childcare attendance.
  - Direct exposure to siblings who attend childcare or school outside of the home.

Palivizumab may be prior authorized for Medicaid clients than have stem cell transplants or solid organ transplant and are birth through 23 months of age. The following table lists diagnosis codes related to transplants:

Diagnosis Codes				
V420	V421	V422	V424	V426
V427	V4281	V4283	V4284	

Providers may request prior authorization for RSV prophylaxis through THSteps-CCP for clients with medical conditions not otherwise noted. All such requests must provide documentation to support the determination of medical necessity for this service.

43.4.2.3 Benefits and Limitations

Palivizumab is not reimbursed for dates of service outside the RSV season.

Exception: *Palivizumab may be reimbursed for two weeks preceding the start of the RSV season for hospitalized infants determined to be at risk of severe RSV disease in September.*

Palivizumab injections given during an inpatient hospital stay are considered included in the hospital DRG and are not separately reimbursed.

Palivizumab is not reimbursed for Medicaid clients 24 months of age or older at the start of the RSV season in Texas.

THSteps-CCP may consider reimbursement for the intramuscular version of the RSV prophylaxis when billed with procedure code 1-90378. Palivizumab is provided in single use vials and must be billed per mg. Providers are required to maintain accurate records of the total number of units given and the total number of units purchased, administered and wasted for each client. If billing waste, the total number of units billed must include the number of units wasted. The Texas Medicaid Program reimburses providers for waste only if a partial vial is actually wasted and not if the partial vial is used for another patient.

Example: *If 180 mg is administered to a client and 20 mg is wasted, 200 services/units must be billed, not four services/units.*

Reimbursement is provided no more than once approximately every 30 days. RSV prophylaxis medications are covered in the home, office, or outpatient settings.

Providers may not bill the Texas Medicaid Program if the RSV prophylaxis was obtained through the VDP.

43.4.2.4 Obtaining Palivizumab

Providers have two options for obtaining palivizumab for Medicaid clients in fee-for-service and PCCM: Providers may purchase and bill for palivizumab; or they may obtain the drug through the VDP.

Note: *For Medicaid Managed Care clients, providers must contact the client's HMO.*

Option 1–Traditional reimbursement for palivizumab:

1) The treating provider identifies a Medicaid-enrolled client with indications for RSV prophylaxis with palivizumab.
2) The provider purchases palivizumab for administration to the client in office.
3) The provider adheres to the Texas Medicaid Program benefits policy, as outlined in "Respiratory Syncytial Virus (RSV) Prophylaxis" on page 43-37. Prior authorization is required.
4) The injection provider bills for the drug, an injection administration fee, and any medically necessary office-based E/M service provided at time of injection.
5) The provider is reimbursed through the Texas Medicaid Program claims payment system.

Option 2–Obtaining palivizumab through the VDP

1) The treating provider identifies a Medicaid-enrolled client with indications for RSV prophylaxis with palivizumab.
2) The provider obtains palivizumab through the VDP.
3) The provider adheres to the Texas Medicaid Program benefits policy, as outlined in "Respiratory Syncytial Virus (RSV) Prophylaxis" on page 43-37, except that prior authorization is required for all clients as noted below.

The provider or provider's agent sends a prescription for palivizumab with supporting clinical information on the Texas Medicaid Vendor Drug Program Palivizumab (*Synagis*) Prescription Form to a Texas Medicaid-enrolled pharmacy that is a member of the Synagis Distribution Network. The administering provider does not purchase the drug.

Refer to: HHSC's Vendor Drug Program Active Pharmacy Search page (www.hhsc.state.tx.us/hcf/vdp/dw/PharmacySearch.html) to search for participating pharmacies.

4) The pharmacy contacts VDP's Prior Authorization Call Center. Prior authorization is required for all clients.
5) If the information submitted does not demonstrate medical necessity the request is denied. Both the pharmacy and provider are notified of the denial.
6) If the information submitted demonstrates medical necessity, the request is approved and both pharmacy and provider are notified.
7) The selected pharmacy fills the prescription and overnight ships an individual dose of the medication, in the name of the Medicaid client, directly to the provider. An initiation packet also is mailed to the client's family, informing them of RSV and palivizumab's benefits and side effects.
8) The treating provider administers the palivizumab injection to the Medicaid client in the office setting.
9) The injection provider bills for an injection administration fee and any medically necessary office-based E/M service provided at time of injection. The provider does not bill the Texas Medicaid Program for the drug.
10) The pharmacy contacts the provider each month after initial injection to obtain updated client information to ensure the proper amount for the next dose.

    The following client demographic information is required:

    - The client's date of birth.
    - The client's age in months, as of October 1, 2006.
    - The client's estimated gestational age (in weeks) at birth.
    - The client's body weight (in pounds or kilograms).
    - The monthly dose required.

43.4.3 Clinician-Directed Care Coordination Services (THSteps-CCP Only)

43.4.3.1 Reimbursement

Clinician-directed care coordination services are reimbursed in accordance with 1 TAC §355.8441. The fee schedules for the services in this section are available on the TMHP website at www.tmhp.com/file library /file library/fee schedules.

43.4.3.2 Benefits and Limitations

Clinician-directed (physician, APN, and PA) care coordination services is a benefit of THSteps-CCP for eligible clients who are birth through 20 years of age and have special health needs. These services are payable only to the clinician (primary care or sub-specialist) who provides the medical home for the client.

To provide a medical home for the client, the primary care clinician directs care coordination together with the client and/or family. Care coordination consists of managing services and resources for clients with special health needs and their families to maximize the clients' potential and provide them with optimal health care.

Clinician-directed care coordination services (face-to-face and non-face-to-face) must include the following components:

- A written care plan (either a formal document or documentation contained in the client's progress notes) developed and revised by the clinician, in partnership with the client, family, and other agreed-upon contributors. This plan is shared with other providers, agencies, and organizations involved with the care of the client, including educational and other community organizations with permission of the client and/or family. The care plan must be maintained by the clinician and reviewed every six months or more frequently as necessary for the client's needs.
- Care among multiple providers that are coordinated through the clinician.
- A central record or database maintained by the clinician containing all pertinent medical information, including hospitalizations and specialty care.
- Assistance for the client and/or family in communicating clinical issues when a client is referred for a consultation or additional care, such as evaluation, interpretation, implementation, and management of the consultant recommendations for the client and/or family in partnership and collaboration with other providers, the client, and/or family.

Clinician-directed care coordination services should also include the supervision of the development and revision of the client's emergency medical plan in partnership with the client, the family, and other providers for use by emergency medical services (EMS) personnel, utility service companies, schools, other community agencies, and caregivers.

Face-to-face care coordination services are encompassed within the various levels of E/M encounters and prolonged services.

Non-face-to-face clinician-directed care coordination services include:

- Prolonged services (procedure codes 1-99358 and 1-99359).
- Medical team conference (procedure codes 1-99361 and 1-99362).
- Care plan oversight/supervision (procedure codes 1-99390, 1-99340, 1-99374, 1-99375, 1-99377, 1-99378, 1-99379, and 1-99380).

Non-face-to-face clinician-directed care coordination services are not considered case management by the Texas Medicaid Program.

Specifically, non-face-to-face clinician oversight/supervision of the development and/or revision of a client's care plan (care plan oversight services procedure codes 1-99374 and 1-99375) may include the following activities, which do not have to be contiguous:

- Review of charts, reports, treatment plans, or lab or study results, except for the initial interpretation or review of lab or study results ordered during, or associated with, a face-to-face encounter.
- Telephone calls with other Medicaid-enrolled health-care professionals (*not* employed in the same practice) involved in the care of the client.
- Telephone or face-to-face discussions with a pharmacist about pharmacological therapies (*not* just ordering a prescription).
- Medical decision-making.
- Activities to coordinate services, if the coordination activities require the skill of a clinician.
- Documenting the services provided, which includes writing a note in the client's chart describing the services provided, decision-making performed, and amount of time spent performing the countable services, including the start and stop times and time spent by the physician working on the care plan after the nurse has conveyed pertinent information from agencies/facilities to the physician.

The following activities are *not* covered as non-face-to-face clinician supervision of the development and/or revision of the client's care plan (care plan oversight services):

- Time that the staff spends getting or filing charts, calling home health agencies or clients, and similar administrative actions.
- Clinician telephone calls to client or family, except when necessary to discuss changes in client's care plan.
- Clinician time spent telephoning prescriptions to a pharmacist (does not require clinician work and does not require a clinician to perform).

- Clinician time getting and/or filing the chart, dialing the telephone, or time on hold (does not require clinician work and does not meaningfully contribute to the treatment of the illness or injury).
- Travel time.
- Time spent preparing claims and for claims processing.
- Initial interpretation or review of lab or study results that were ordered during or associated with a face-to-face encounter.
- Services included as part of other E/M services.
- Consults with health professionals not involved in the client's case.
- Work included in hospital discharge day management (procedure codes 1-99238 and 1-99239) and discharge from observation (procedure code 1-99217).

43.4.3.3 Prior Authorization Requirements

Non-face-to-face clinician directed care coordination services require prior authorization. Prior authorization is a condition for reimbursement; it is not a guarantee of payment. Providers must submit a request for prior authorization within seven business days of the date of service. Prior authorization is limited to a maximum of six months. Prior authorization is required to recertify the client for additional six-month periods and requires submission of a new request with documentation supporting medical necessity for ongoing services.

Prior authorization for an initial non-face-to-face clinician-directed care coordination requires documentation of at least one covered face-to-face inpatient or outpatient E/M visit by the clinician directing the care coordination during the six months preceding the provision of the first non-face-to-face care coordination service.

Prior authorization for subsequent non-face-to-face clinician directed care coordination services requires at least one covered face-to-face inpatient or outpatient E/M visit by the clinician directing the care coordination during the previous 12 months or more frequently as indicated by the client's condition.

Prior authorization of THSteps-CCP services may be requested in writing by completing a THSteps-CCP Prior Authorization Request Form, attaching the necessary supportive documentation as detailed below, and mailing or faxing it to the TMHP-CCP department:

Texas Medicaid & Healthcare Partnership
Comprehensive Care Program
PO Box 200735
Austin, TX 78720-0735
Fax: 1-512-514-4212

For prior authorization to be considered, clients must require complex and multidisciplinary care modalities involving regular clinician development and/or revision of care plans, review of subsequent reports of client status, and review of related laboratory and other studies.

- *Medically complex:* The health care needed by a Medicaid client achieves the designation of *medically complex* when the approved plan of care (POC) necessitates a clinical professional practicing within the scope of his or her license and in the context of a medical home to coordinate ongoing treatment to ensure its safe and effective delivery. The diagnosis must be covered under the Texas Medicaid Program and be characterized by one of the following:
  - Significant and interrelated disease processes that involve more than one organ system (including behavioral health diagnoses) and require the services of two or more licensed clinical professionals, specialists, or subspecialists.
  - Significant physical or functional limitations that require the services of two or more therapeutic or ancillary disciplines, including, but not limited to, nursing, nutrition, OT, PT, ST, orthotics, and prosthetics.
  - Significant physical, developmental, or behavioral impairment that requires the integration of two or more medical and/or community-based providers, including, but not limited to, educational, social, and developmental professionals, that impact the care of the client.
- *Multidisciplinary Care:* Care is multidisciplinary when the medically necessary covered services of an approved POC include the need to coordinate the assessment, treatment, and/or services of a Medicaid-enrolled clinical provider with two or more additional medical, educational, social, developmental, or other professionals impacting the health care of the client.

Documentation of the following components must be submitted with the authorization form to obtain an initial authorization or renewal:

- A current medical summary, encompassing all disciplines and all aspects of the client's care, and containing key information about the client's health, e.g., conditions, complexity, medications, allergies, past surgical procedures, etc.
- A current list of the main concerns/issues/problems as well as key strengths/assets and the related current clinical information including a list of all diagnoses with ICD-9-CM diagnosis codes.
- Planned action steps/interventions to address the concerns and to sustain/build strengths, with the expected outcomes.
- Disciplines involved with the client's care and how the multiple disciplines will work/are working together to meet the client's need. Providers should explain how the multidisciplinary approach will/do benefit the client's needs.
- Short-term and long-term goals with timeframes.

The supporting documentation can be any of the following:

- A formal written care plan.
- Progress note detailing the care coordination planning.
- A letter of medical necessity detailing the care plan oversight and care coordination.

Prior authorization is effective for care coordination services provided over a period of six months. Clinicians must submit a revised care plan for subsequent periods of prior authorization.

43.4.3.4 Non-Face-to-Face Services

Non-Face-to-Face Medical Conferences

Procedure codes 1-99361 or 1-99362 must be used when billing for medical team conferences.

Non-Face-to-Face Clinician Supervision of a Home Health Client

Procedure codes 1-99374 or 1-99375 must be used when billing for services requiring interaction with the home health agency.

Non-Face-to-Face Clinician Supervision of a Hospice Client

Procedure codes 1-99377 or 1-99378 must be used when billing for services requiring interaction with a hospice.

Other Non-Face-to-Face Supervision

Procedure codes 1-99339 or 1-99340 must be used when billing for services requiring interaction with an independently-enrolled nurse or other provider (e.g., not an home health agency, nursing facility, or hospice provider).

Non-Face-to-Face Prolonged Services

Procedure codes 1-99358 or 1-99359 must be used when billing for prolonged services without face-to-face contact. This service is to be reported in addition to other clinician services, including E/M services at any level, or healthcare professionals outside of an home health agency, hospice, or nursing facility.

Non-face-to-face prolonged services are limited to a maximum of 90 minutes once per client per provider or if one of the following significant changes in the client's clinical condition occurs:

- The client will soon be, or has recently been, discharged from a prolonged and complicated hospitalization that required coordination of complex care with multiple providers in order for the client to be adequately cared for in the home.
- Documentation of recent trauma resulting in new medical complications that require complex interdisciplinary care.
- The client has a new diagnosis of a medically complex condition requiring additional interdisciplinary care with additional specialists.

Procedure code 1-99359 must be billed for the same date of service as procedure code 1-99358.

General Requirements for Non-Face-to-Face Clinician-Directed Care Coordination Services

These services may be reimbursed for the clinician time involved in this coordination. The clinician billing the services must personally perform the services. Care coordination services delegated to or performed by others do not count towards care coordination reimbursement.

Documentation

Clinician-directed care coordination services must be documented in the client's medical record. Documentation must support the services being billed and must include a record of the clinician's time spent performing specific care coordination activities, including start and stop times. The documentation should also include a formal care plan and emergency services plan. The supporting documentation maintained in the client's medical records must be dated and include the following components and requirements:

- Problem list.
- Interventions.
- Short-term and long-term goals.
- Responsible parties.

Client medical records are subject to retrospective review.

Payment is made for care coordination to a clinician providing post-surgical care during the postoperative period only if the care coordination is documented to be unrelated to the surgery.

Non-Face-to-Face Care Plan Oversight

The clinician who bills for the care plan oversight must be the same clinician who signed the POC in the home or domiciliary (procedure codes 1-99339 and 1-99340), home health agency (procedure codes 1-99374 and 1-99375), hospice (procedure codes 1-99377 and 1-99378), or nursing facility (procedure codes 1-99379 and 1-99380).

Procedure code 1-99339 is denied if billed on the same date of service by the same provider as procedure code 1-99340.

Procedure code 1-99374 is denied if billed on the same date of service by the same provider as procedure code 1-99375.

Procedure code 1-99377 is denied if billed on the same date of service by the same provider as procedure code 1-99378.

Procedure code 1-99379 is denied if billed on the same date of service by the same provider as procedure code 1-99380.

Care plan oversight services may be reimbursed for the clinician time involved in this coordination. The clinician billing the services must personally perform the services. Care coordination services delegated to or performed by others do not count towards care coordination reimbursement.

Only two clinician-directed care plan oversight services (procedure codes 1-99339 or 1-99340, 1-99374 or 1-99375, 1-99377 or 1-99378, and 1-99379 or 1-99380) are reimbursed every six months.

Payment is made only to one clinician per client per calendar month for procedure code 1-99374 or 1-99375.

Other

The clinician may not have a significant financial or contractual relationship with the home health agency as defined in 42 CFR §424.

The clinician may not be the medical director or employee of the hospice and may not furnish services under arrangements with the hospice, including volunteering.

Medical Team Conference

One medical team conference (procedure code 1-99361 or 1-99362) may be reimbursed every six months when the coordinating clinician attests that they are providing the medical home for the client. The coordinating clinician may be the client's primary care provider or a specialist.

Additional medical team conferences may be considered with documentation of a change in the client's medical home.

The medical team conference time must be documented in the client's record.

43.4.3.5 Face-to-Face Services

General Requirements for Face-to-Face Clinician-Directed Care Coordination Services

Providers must use the most appropriate face-to-face E/M procedure codes to bill for care coordination services.

- When counseling or care coordination requires more than 50 percent of the client and/or family encounter (face-to-face time in the office or other outpatient setting, or floor/unit time in the hospital), then time may be considered the key or controlling factor to qualifying for a particular level of E/M service.
- Counseling is discussion with the client and/or family concerning diagnostic studies or results, prognosis, risks and benefits, management options, importance of adhering to the treatment regimen, and client and family education.

Modifiers must be used as appropriate for billing.

Any face-to-face inpatient or outpatient E/M procedure code that is a benefit of the Texas Medicaid Program, except hospital discharge-day management (procedure codes 1-99238 and 1-99239) and discharge from observation (procedure code 1-99217), may be billed on the same day as the following non-face-to-face clinician-directed care coordination procedure codes when the procedure requires significant, separately-identifiable E/M services by the same physician on the same day.

Procedure Codes		
1-99339	1-99340	1-99358
1-99359	1-99361	1-99362
1-99374	1-99375	1-99377
1-99378	1-99379	1-99380

43.4.4 Comprehensive Outpatient Rehabilitation Facilities (CORFs)/Outpatient Rehabilitation Facilities (ORFs)

43.4.4.1 Enrollment

CORFs and outpatient PT/speech pathology (OPT/SP) providers must be certified by Medicare, have a valid provider agreement with HHSC, and have documentation that the TMHP enrollment process has been completed.

For questions about enrollment or billing, call the TMHP Contact Center at 1-800-925-9126.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

43.4.4.2 Reimbursement

CORFs and ORFs are reimbursed in accordance with 1 TAC 355.8441.

The fee schedules for the services in this section are available on the TMHP website at www.tmhp.com /file library/file library/fee schedules.

Refer to: "Texas Medicaid Reimbursement" on page 2-1 for more information about reimbursement.

43.4.4.3 Benefits and Limitations

CORFs and ORFs can bill only outpatient rehabilitation services to the Texas Medicaid Program for THSteps clients.

Medicaid clients birth through 20 years of age are entitled to all medically necessary services under the following conditions:

- The requested services correct or ameliorate the client's disability, physical or mental illness, or condition.
- No TPR is financially responsible for the services.
- The documentation supporting medical necessity must clearly and consistently describe the client's current diagnosis, functional status, and condition.

Proiders must consistently describe the treatment throughout the documentation and provide a sufficient explanation as to how the requested services correct or ameliorate the client's disability or physical or mental illness or condition.

The client must be eligible for THSteps-CCP and under a physician's treatment for consideration of reimbursement.

Clients receiving therapy services reimbursed by THSteps-CCP must have conditions that require ongoing medical supervision. To establish medical necessity, a physician's prescription and a revised therapy treatment plan are required at least once every six months. Therapy services for acute conditions are reimbursed by the Texas Medicaid Program.

PT, OT, and ST services require prior authorization. Providers must use the modifiers GP (PT) or GO (OT) to identify the type of therapy being requested and must file claims with these modifiers to identify the type of therapy performed. Claims received without the appropriate modifiers are denied with the explanation of benefit (EOB), "This procedure requires a modifier. Please appeal claim with the appropriate modifier."

A request for authorization must include documentation from the provider that supports the medical necessity of the service, equipment, or supply.

The initial therapy request must include the following:

- A Request for Initial Outpatient Therapy (Form TP-1) signed and dated by the therapist and physician.
- A copy of the current evaluation signed and dated by the therapist.
- Documentation indicating the treatment goals.
- Documentation indicating anticipated measurable progress toward goals.
- Documentation explaining client gross or fine motor delays or expressive or receptive delays in years or months compared to chronological age.

The extension of the therapy request must include the following:

- A Request for Extension of Outpatient Therapy (Form TP-2) signed and dated by the therapist and physician.
- A summary statement of measurable progress made during the treatment period.
- Documentation indicating new treatment goals.
- Documentation indicating anticipated measurable progress for the next treatment period.

All physician and provider signatures on the TP-1 and TP-2 forms, physician orders, and other documentation must be current, unaltered, original, handwritten, and dated. Computerized or stamped signatures and dates are not accepted.

Refer to: "Request for Initial Outpatient Therapy (Form TP-1)" on page B-80, and "Request for Extension of Outpatient Therapy (2 Pages) (Form TP-2)" on page B-81.

If a provider discontinues therapy with a client and a new provider begins therapy during an existing authorization period, a new evaluation must be submitted. Prior authorization is mandatory and is not a guarantee of payment. Providers must adhere to filing guidelines for payment consideration.

PT, OT, and ST evaluations should be billed using appropriate procedure codes. These codes should be billed with a quantity of one for each type of therapy performed (PT, OT, or ST), regardless of the time spent with the client.

OT, PT, and ST encounters should be billed in increments of 15 minutes (i.e., a quantity of 1 equals 15 minutes; a quantity of 2 equals 30 minutes, etc.).

Providers can bill only time spent with the client present, including assisting the student with learning to use adaptive equipment and assistive technology. The evaluation and reevaluation procedure codes are inclusive payments that include the written report and other administrative tasks. Time spent without the client present, such as report writing and training aides to work with the client (unless the client is present during training), is not billable.

Evaluations and reevaluations are reimbursed as a per-evaluation/reevaluation encounter with a quantity of 1. An evaluation and therapy of the same discipline/type are not reimbursable when they are performed on the same date of service, e.g., PT evaluation and PT encounters are not payable for the same date of service. OT, PT, and ST evaluations can be reimbursed once per six months to any provider at the same facility. OT, PT, and ST reevaluations can be reimbursed once per month to any provider at the same facility. An evaluation or reevaluation performed on a more frequent basis would be outside the current benefit limitations and would only be considered for reimbursement with prior authorization or written documentation of medical necessity. CORFs and ORFs are subject to a maximum of 8 units (2 hours) each of PT, OT, or ST services per date of service per modifier per client.

The documentation retained in the client's file must note the billable start time, billable stop time, total billable minutes, and activity that was performed.

The procedures below may be payable to CORFs/ORFs based on a PPS fee schedule.

Procedure Code	Type	Modifier	Billing Increment
1-S9152	ST		Per re-evaluation
1-92506	ST		Per evaluation
1-92507	ST		Per 15 min.
1-92508	ST		Per 15 min.
1-92610	ST		Per evaluation
1-92526	ST		Per 15 min.
1-97001	PT		Per evaluation
1-97002	PT		Per re-evaluation
1-97003	OT		Per evaluation
1-97004	OT		Per re-evaluation

Procedure Code	Type	Modifier	Billing Increment
1-97012	PT, OT	GO, GP	Per 15 min.
1-97014	PT, OT	GO, GP	Per 15 min.
1-97016	PT, OT	GO, GP	Per 15 min.
1-97018	PT, OT	GO, GP	Per 15 min.
1-97022	PT, OT	GO, GP	Per 15 min.
1-97024	PT, OT	GO, GP	Per 15 min.
1-97026	PT, OT	GO, GP	Per 15 min.
1-97028	PT, OT	GO, GP	Per 15 min.
1-97032	PT, OT	GO, GP	Per 15 min.
1-97033	PT, OT	GO, GP	Per 15 min.
1-97034	PT, OT	GO, GP	Per 15 min.
1-97035	PT, OT	GO, GP	Per 15 min.
1-97036	PT, OT	GO, GP	Per 15 min.
1-97039	PT		Per 15 min.
1-97110	PT, OT	GO, GP	Per 15 min.
1-97112	PT, OT	GO, GP	Per 15 min.
1-97113	PT, OT	GO, GP	Per 15 min.
1-97116	PT, OT	GO, GP	Per 15 min.
1-97124	PT, OT	GO, GP	Per 15 min.
1-97139	PT, OT	GO, GP	Per 15 min.
1-97140	PT, OT	GO, GP	Per 15 min.
1-97150	PT, OT	GO, GP	Per 15 min.
1-97530	PT, OT	GO, GP	Per 15 min.
1-97535	PT, OT	GO, GP	Per 15 min.
1-97537	PT, OT	GO, GP	Per 15 min.
1-97542	PT, OT	GO, GP	Per 15 min.
1-97750	PT, OT	GO, GP	Per 15 min.
1-97799	PT, OT	GO, GP	Per 15 min.

43.4.4.4 Claims Information

CORFs must file their claims on the UB-04 CMS-1450 claim form. Providers may purchase these claim forms from the vendor of their choice. TMHP does not supply the forms. Submit electronic claims with a PAN. Failure to provide a PAN on an electronic claim results in claim denial.

Refer to: "Prior Authorization and Documentation Requirements" on page 43-36 for more information about PANs.

"TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

The procedure codes CORFs use are UB-04 CMS-1450 revenue or CPT codes. The acceptable POS is outpatient facility (POS 5).

The PAN must be identified in Block 63 of the UB-04 CMS-1450 claim form or the appropriate field of the electronic software. PT, OT, and SLP *evaluations* should be billed with procedure code B-424, B-434, or B-444. This code should be billed with a quantity of 1 for each type of therapy performed (PT, OT, and SLP), regardless of time spent with the client. The codes used for billing therapy are the CPT codes. The codes are in the 1-90000 series. The *Texas Medicaid Bulletin* provides updates to the CPT codes.

Refer to: "Occupational Therapists (THSteps-CCP Only)" on page 43-60.

"Physical Therapists (THSteps-CCP Only)" on page 43-71.

"Speech-Language Pathologists (THSteps-CCP Only)" on page 43-90.

"Comprehensive Outpatient Rehabilitation Facility (CORF) (THSteps-CCP Only)" on page D-10 for a claim form example.

"UB-04 CMS-1450 Claim Filing Instructions" on page 5-30 for paper claims completion instructions.

43.4.5 Durable Medical Equipment Supplier (THSteps-CCP Only)

Medicaid clients birth through 20 years of age are entitled to all medically necessary DME. DME is medically necessary when it is required to correct or ameliorate disabilities or physical or mental illnesses or conditions. Any numerical limit on the amount of a particular item of DME can be exceeded for Medicaid clients birth through 20 years of age if medically necessary. Likewise, time periods for replacement of DME do not apply to Medicaid clients birth through 20 years of age if the replacement is medically necessary. When prior authorization is required, the information submitted with the request must be sufficient to document the reasons why the requested DME item or quantity is medically necessary.

43.4.5.1 Enrollment

To be eligible to participate in THSteps-CCP, providers of DME must be enrolled in VDP (for payment of prescription drugs) or be enrolled in Medicare. Providers of customized or nonbasic medical equipment must also be enrolled as a Medicare DME provider. Orthotic and prosthetic providers are also enrolled as Medicare DME providers.

Home health agencies that provide DME should refer to "Texas Medicaid (Title XIX) Home Health Services" on page 24-1 to enroll as a DME–Home Health Services (DMEH) provider.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community*

standards and standards that govern occupations, as explained in 1 TAC §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

Refer to: "Provider Enrollment" on page 43-5 for more information about enrollment procedures.

43.4.5.2 Reimbursement

DME and expendable supplies are reimbursed in accordance with 1 TAC §355.8441. The fee schedules for the services in this section are available on the TMHP website at www.tmhp.com/file library/file library/fee schedules.

Refer to: "Texas Medicaid Reimbursement" on page 2-1 for more information about reimbursement.

43.4.5.3 Benefits and Limitations

THSteps-CCP benefits are for Medicaid THSteps-eligible clients birth through 20 years of age. THSteps-CCP eligibility ends on the day of the client's 21st birthday. If the client's Medicaid ID states "Emergency Care," "PE," or "QMB," the client is not eligible for THSteps or THSteps-CCP benefits.

DME is defined as medical equipment or an appliance that is manufactured to withstand repeated use, ordered by a physician for use in the home, and is required to correct or ameliorate the client's disability, condition, or illness.

Because there is no single authority (such as a federal agency) that confers the official status of "durable medial equipment" on any device or product, HHSC retains the right to make such determinations with regard to DME covered by Texas Medicaid. DME covered by Texas Medicaid must either have a well-established history of efficacy or, in the case of novel or unique equipment, valid peer-reviewed evidence that the equipment corrects or ameliorates a covered medical condition or functional disability.

Requested DME may be a benefit of the Texas Medicaid Program when it meets the Medicaid definition of DME.

The majority of DME and expendable supplies are covered through Texas Medicaid (Title XIX) Home Health Services.

If a service cannot be provided through Texas Medicaid (Title XIX) Home Health Services, these services may be covered through THSteps-CCP if they are determined to be medically necessary for the child and for which FFP is available.

If a DME provider is unable to deliver an unauthorized piece of equipment, the provider should allow the client the option of obtaining the equipment or supplies from another provider.

Periodic rental payments are made only for the lesser of either the period of time the equipment is medically necessary, or when the total monthly rental payments equal the reasonable purchase cost for the equipment.

DME will be purchased when a purchase is determined to be medically necessary and more cost effective than leasing the device with supplies. Only new, unused equipment will be purchased. When a provider is replacing a piece of rental equipment with purchased equipment, the provider must supply a new piece of equipment to the client.

Purchase is justified when the estimated duration of need multiplied by the rental payments would exceed the reasonable purchase cost of the equipment or it is otherwise more practical to purchase the equipment.

DME repair will be considered based on the age of the item and cost to repair it.

A request for repair of DME must include a statement or medical information from the attending physician substantiating that the medical appliance or equipment continues to serve a specific medical purpose and an itemized estimated cost list from the vendor or DME provider of the repairs. Rental equipment may be provided to replace purchased medical equipment for the period of time it will take to make necessary repairs to purchased medical equipment.

DME that has been delivered to the client's home and then found to be inappropriate for the client's condition will not be eligible for an upgrade within the first six months following purchase unless there had been a significant change in the client's condition, as documented by the physician familiar with the client. All adjustments and modifications within the first six months after delivery are considered part of the purchase price.

Rental reimbursement to the same provider cannot exceed the purchase price, except as addressed in specific policies.

All DME purchased for a client becomes the Medicaid client's property upon receipt of the item. This property includes equipment delivered which will not be prior authorized or reimbursed in the following instances:

- Equipment delivered to the client before the physician signature date on the THSteps-CCP Prior Authorization Form or prescription.
- Equipment delivered more than three business days before obtaining prior authorization from TMHP that meets the criteria for purchase.

As long as the client is eligible for THSteps-CCP services on the date the custom equipment is ordered from the manufacturer, the provider should use the order date as the date of service since custom equipment is client specific and cannot be used for another client.

Providers must use the following TOS codes when providing THSteps-CCP services:

TOS	Description
J	Purchase (new)
L	Rental (monthly)
1	Medical services (including some injectable drugs)
9	Medical supplies
9	Purchase of orthotic or prosthetic devices

To establish medical necessity of the equipment for the client, the provider must have on file in the client's records current documentation that is signed by a physician (e.g., signed and dated prescription) showing the following:

- A diagnosis relative to each item requested.
- The specific type of supply needed.
- The length of time needed.

A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

Prior Authorization and Documentation Requirements

Prior authorization is required. Prior authorization is a condition for reimbursement; it is not a guarantee of payment.

Providers requesting written authorization should complete the "THSteps-CCP Prior Authorization Request Form" on page B-105 and attach documentation to support the request. The documentation must include a current prescription signed and dated by a physician (MD or DO) and then be mailed or faxed to TMHP. For specific policy information not contained in this manual related to the purchase of DME, providers can call TMHP-CCP Customer Service at 1-800-846-7470.

43.4.5.4 Physician Signature

The physician's signature and date, required on a prescription and the THSteps-CCP Prior Authorization Request Form, must be current to the service date of the request.

Refer to: "Physician Signature" on page 43-37 for complete information about this requirement.

Physician prescriptions must be specific to the TOS requested. For example, if the provider is requesting a customized wheelchair, the prescription must request a customized wheelchair, not just a wheelchair.

Documentation of Services for Supplies

Providers must retain delivery slips or invoices, documenting the date of delivery for all supplies provided to a client, which they must disclose to HHSC or its designee on request. These records and claims must be retained for a minimum of five years from the date of service (DOS) or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.

Documentation of delivery must include *one* of the following:

- Delivery slip or invoice signed and dated by the client/caregiver.
- A dated carrier tracking document attached to the delivery slip or invoice.

The DOS is the date supplies are delivered and/or shipped to the client as evidenced by the dated tracking document.

DME Certification and Receipt Form

Providers must complete and retain the "DME Certification and Receipt Form" on page B-35 for all Medicaid clients before submitting a claim for payment. This form is for equipment only, not supplies. The DME provider must retain this form and not submit it with the claim.

Specific THSteps-CCP Policies

Most DME and supplies are available under Texas Medicaid (Title XIX) Home Health Services. If the service is not available under Texas Medicaid (Title XIX) Home Health Services, THSteps-CCP may cover the requested service, if the client is THSteps-CCP-eligible and the service is medically necessary, requested by a physician, and for which FFP is available.

Refer to: "DME Certification and Receipt Form" on page B-35.

"Texas Medicaid (Title XIX) Home Health Services" on page 24-1 for specific policies.

43.4.5.5 Mobility Aids

Mobility aids and related supplies, including, but not limited to, strollers, special needs car seats, travel safety restraints, and thoracic-hip-knee-ankle orthoses (THKAO)/parapodiums are a benefit to assist clients to move about in their environment. Mobility aids equipment includes, but is not limited to, the items detailed below.

Mobility aids and related supplies may be considered for reimbursement through the THSteps-CCP for clients birth through 20 years of age that are THSteps-CCP eligible when the following criteria are met:

- The equipment requested must be medically necessary.
- FFP must be available.
- The client's mobility status would be compromised without the requested equipment.
- The requested equipment or supplies must be safe for use in the home.

Mobility aids may be considered through THSteps-CCP if the requested equipment is not available through Texas Medicaid (Title XIX) Home Health Services or the client does not meet criteria through Texas Medicaid (Title XIX) Home Health Services.

Mobility aid lifts for vehicles, and vehicle modifications are not reimbursed through the Texas Medicaid Program in accordance with federal regulations.

Note: *Permanent ramps, vehicle ramps and home modifications are not a benefit of the Texas Medicaid Program.*

Authorization

Prior authorization is required for all mobility aids and related services except travel safety restraints for clients with a medical condition requiring them to be transported in either a prone or supine position.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

A completed THSteps-CCP Prior Authorization Request Form prescribing the DME and/or medical supplies must be signed and dated by the prescribing physician familiar with the client before requesting prior authorization. All signatures must be current, unaltered, original, and handwritten. Computerized or stamped signatures and dates are not accepted. The completed THSteps-CCP Prior Authorization Request Form must be maintained by the requesting provider and the prescribing physician. The original signature copy must be kept in the physician's medical record for the client.

To avoid unnecessary denials, the physician must provide correct and complete information, including accurate documentation of the medical necessity for the equipment/services requested. The physician must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for the mobility aid. A determination is made by the THSteps-CCP nurses as to whether the equipment will be rented, purchased, repaired, or modified based on the client's needs, duration of use, and age of equipment.

A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

Mobility aid equipment that has been purchased is anticipated to last a minimum of five years and may be considered for replacement when five years have passed and/or the equipment is no longer repairable. The DME may then be considered for prior authorization. Replacement of equipment may also be considered when loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent reoccurrence must be submitted.

When prior authorization of a mobility aid replacement is requested before five years have passed, the following information must be submitted with the request:

- A statement from the prescribing physician or licensed occupational therapist (OT) or PT.
- Documentation supporting why the equipment no longer meets the client's needs.

HHSC or its designee determines whether the equipment is rented, purchased, repaired, or modified based on the client's needs, duration of use, and age of equipment.

DME Certification and Receipt Form

The DME Certification and Receipt Form is required and must be completed before reimbursement can be made for any DME delivered to a client. The certification form must include the name of the item, the date the client received the DME, and the signatures of the provider and the client or primary caregiver. This form must be maintained by the DME provider in the client's record.

Rental of equipment includes all necessary accessories, supplies, adjustments, repairs, and replacement parts.

Strollers (a multi-positional client transfer system with integrated seat, operated by care giver)

A stroller for medical needs may be considered under any of the following conditions:

- The client does not own another seating system, including, but not limited to, a wheelchair.
- The client's condition does not require another type of seating system, including, but not limited to, a wheelchair.

If the client does not meet criteria for a stroller, a wheelchair may be considered through Texas Medicaid (Title XIX) Home Health Services.

A medical stroller does not have the capacity to accommodate the client's growth. Strollers for medical use may be considered for prior authorization when the following criteria are met:

- The client weighs 30 pounds or more.
- The client does not already own another seating system, including but not limited to, a standard or custom wheelchair.
- The stroller must have a firm back and seat, or insert.
- The client is expected to be ambulatory within one year of request date or is not expected to need a travel chair or wheelchair within two years of request date.

The following supporting documentation must be submitted:

- A completed Wheelchair/Stroller Seating Assessment Form (B83) that includes documentation supporting medical necessity. This documentation should address why the client is unable to ambulate a minimum of 10 feet due to his/her condition (including, but not limited to, AIDS, sickle cell anemia, fractures, a chronic diagnosis, or chemotherapy), or if able to ambulate further, why a stroller is required to meet the client's needs.
- If the client is over two years of age, documentation must support that the client's condition, stature, weight, and positioning needs to allow adequate support from a stroller.

Note: *A stroller may be considered on a case-by-case basis with documentation of medical necessity for a client who does not meet the criteria listed above.*

A seating assessment must be completed by a physician or licensed OT or PT, who is not employed by the equipment supplier, before requesting prior authorization. If the seating assessment is completed by a physician,

reimbursement is considered part of the physician's office visit and is not prior authorized. Other providers must use procedure codes 1-97001 and 1-97003 when billing for a seating evaluation.

The seating assessment must:

- Explain how the family will be trained in the use of the equipment.
- Anticipate changes in the client's needs and include anticipated modifications or accessory needs, as well as the anticipated width of the medical stroller to allow client growth with use of lateral/thigh supports.
- Include significant medical information pertinent to the client's mobility and how the requested equipment will accommodate these needs, including intellectual, postural, physical, sensory (visual and auditory), and physical status.
- Address trunk and head control, balance, arm and hand function, existence and severity of orthopedic deformities, any recent changes in the client's physical and/or functional status, and any expected or potential surgeries that will improve or further limit mobility.
- Include information on the client's current mobility/seating equipment, how long the client has been in the current equipment, and why it no longer meets the client's needs.
- Include the client's height, weight, and a description of where the equipment is to be used. Seating measurements are required.
- Include the accessibility of client's residence.
- Include manufacturer's information, including the description of the specific base, any attached seating system components, and any attached accessories.

To request prior authorization for procedure code J-E1035, the criteria must be met for the level of stroller requested:

- *Level One: Basic Stroller.* The client meets the criteria for a stroller. Providers must use procedure code J-E1035.
- *Level Two: Stroller with Tray for Oxygen and/or Ventilator.* The client meets the criteria for a level-one stroller and is oxygen- or ventilator-dependent. Providers must use procedure code J-E1035 with modifier TF.
- *Level Three: Stroller with Positioning Inserts.* The client meets the criteria for a level-one or level-two stroller and requires additional positioning support. Providers must use procedure code J-E1035 with modifier TG.

Stroller Ramps—Portable and Threshold

A portable ramp is defined as a ramp that is a unit able to be carried as needed to access a home and weighing no more than 90 pounds and/or measuring no more than ten feet in length. A threshold ramp is defined as a ramp that provides access over elevated thresholds.

Portable ramps exceeding the above criteria may be considered on a case-by-case basis with documentation of medical necessity and a statement that the requested equipment is safe for use.

Providers must use procedure code J-E1399 for portable and threshold stroller ramps.

One portable and one threshold ramp for stroller access may be considered for prior authorization when documentation supports medical necessity and includes the following:

- The date of purchase and serial number of the client's medical stroller or documentation of a medical stroller request being reviewed for purchase.
- Diagnosis with duration of expected need.
- Ramps may be considered for rental for short-term disabilities.
- Ramps may be considered for purchase for long-term disabilities.
- A diagram of the house showing the access point(s) with the ground-to-floor elevation and any obstacles.

A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply. Prior authorization is a condition for reimbursement, not a guarantee of payment.

Mobility aid lifts for vehicles, and vehicle modifications are not reimbursed through the Texas Medicaid Program according to federal regulations.

Note: *Permanent ramps, vehicle ramps, and home modifications are not a benefit of the Texas Medicaid Program.*

43.4.5.6 Thoracic-Hip-Knee-Ankle Orthoses (THKAO) (Vertical or Dynamic Standers, Standing Frames/Braces, and Parapodiums)

THKAO (vertical or dynamic standers, standing frames or braces, and parapodiums), including all accessories, require prior authorization. A THKAO may be considered if the client requires assistance to stand and remain standing. A THKAO is not considered for prior authorization if the client already owns a stander (other than a vertical stander or standing frame or brace) or gait trainer.

Prior authorization may be considered for the THKAOs with the following documentation:

- Diagnoses relevant to the requested equipment, including functioning level and ambulatory status.
- Anticipated benefits of the equipment.
- Frequency and amount of time of a standing program.
- Anticipated length of time the client will require this equipment.
- Clients height/weight/age.
- Anticipated changes in the client's needs, anticipated modifications, or accessory needs, as well as the growth potential of the stander.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

Vertical or Dynamic Stander

A vertical stander or dynamic stander is used to initiate standing for clients who cannot maintain a good standing posture or may never be able to stand independently. A

vertical stander is used to develop weight bearing through the legs in order to decrease demineralization and to promote better body awareness. Documentation for these standers must address medical necessity for the standers to be mobile.

Providers must use procedure code 9-L1510 for a vertical stander. Providers must use procedure code J-E0642 for a dynamic stander.

Standing Frame or Brace

A standing frame or brace is used to help very young clients, 12 months of age or older, who have good head control in the upright position and who have a neuromuscular disease/condition resulting in a lack of sufficient muscle power in the trunk and lower extremities to stand with their hands free.

Providers must use procedure code 9-L1510 for a standing frame or brace.

Parapodium

A parapodium is used to help clients with neuromuscular diseases/conditions resulting in a lack of sufficient muscle power in the trunk and lower extremities to stand with their hands free. It helps develop a sense of balance and aids in learning functional movements such as standing with the hands free. A parapodium acts as an exoskeleton, providing side struts and chest, hip, knee, and foot bracing.

A parapodium may be considered for reimbursement for one of the following levels:

- *Level One: Small Parapodium.* The client has a maximum axillary height of 35 inches and a maximum weight of 55 pounds (normal age range is 1 through 10 years of age). Providers must use procedure code 9-L1500 or 9-L1520.
- *Level Two: Medium parapodium.* The client has a maximum axillary height of 41 inches and a maximum weight of 77 pounds (normal age range is 5 through 12 years of age). Providers must use procedure code 9-L1500-TF or 9-L1520-TF.
- *Level Three: Large parapodium.* The client has a maximum axillary height of 45 inches and a maximum weight of 115 pounds (normal age range is 10 through 16 years of age). Providers must use procedure code 9-L1500-TG or 9-L1520-TG. Labor for parapodium assembly may be prior authorized.

Feeder Seats, Floor Sitters, Corner Chairs, and Travel Chairs

Feeder seats, floor sitters, corner chairs, and travel chairs are not considered medically necessary and are not a benefit of THSteps-CCP. If a client requires seating support and meets the criteria for a seating system, a stroller may be considered for reimbursement with prior authorization through THSteps-CCP, or a wheelchair may be considered through Texas Medicaid (Title XIX) Home Health Services.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

Scooters

Scooters may be considered for reimbursement through Texas Medicaid (Title XIX) Home Health Services.

Equipment Accessories

THSteps-CCP may consider prior authorization of equipment accessories, such as ventilator and oxygen trays and positioning inserts, when supporting documentation takes into account all the client's needs, capabilities, and physical/mental status.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

Equipment Modifications

A modification is the replacement of a component due to changes in the client's condition, not the replacement of a component that is no longer functioning.

All modifications within the first six months after delivery are considered part of the purchase price.

THSteps-CCP may consider prior authorization of modifications to custom equipment if a change occurs in the client's needs, capabilities, or physical/mental status that cannot be anticipated. Documentation must include:

- All projected changes in the client's needs.
- The age of the current equipment, and the cost of purchasing new equipment versus modifying current equipment.

Equipment Adjustments

Adjustments do not require supplies.

Adjustments within the first six months after delivery are not prior authorized, because these are considered part of the purchase price.

Up to one hour of labor for adjustments may be considered for reimbursement with prior authorization through THSteps-CCP as needed after the first six months. Providers must use procedure code 9-E1340 for adjustments.

Equipment Repairs

Repairs require replacement of components that are no longer functional. Repairs to client-owned equipment may be considered for reimbursement with prior authorization through THSteps-CCP.

Technician fees are considered part of the cost of the repair. Providers must use procedure code 9-E1340.

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

A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

Rentals may be considered for reimbursement during the repair period of the client's owned equipment.

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

Mobility Aids – THSteps-CCP HCPCS Procedure Codes and Limitations

Procedure Code	Maximum Limitation
1-97001	As needed
1-97003	As needed
J-E0700*	One per five years
J-E1035*	One per five years
J-E1035-TF*	One per five years
J-E1035-TG*	One per five years
J-E1037	Not a benefit
L-E1037	Not a benefit
9-E1340*	As needed
J-E1399*	One per five years
9-L1500*	One per five years
9-L1500-TF*	One per five years
9-L1500-TG*	One per five years
9-L1510*	One per five years
9-L1520*	One per five years
9-L1520-TF*	One per five years
9-L1520-TG*	One per five years
*** Procedure codes that require prior authorization**	

Providers must use modifiers TF and TG for equipment repairs.

43.4.5.7 Apnea Monitor

Apnea monitors to monitor chest movement and measure heart rate are a benefit of THSteps-CCP for infants.

Apnea monitors used in the home are paid for two months without prior authorization for infants with one of the following diagnoses:

Diagnosis Codes				
53010	53011	53012	53019	53020
53021	53081	53085	7707	77081
77082	77083	77084	77089	78603
V198				

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

Procedure code L-E0619 is used when billing for apnea monitors.

All apnea monitors provided to THSteps-CCP clients must be capable of recording apneic episodes.

The POS for apnea monitors is in the client's home.

Prior authorization is required for rental of an apnea monitor if the client is more than 4 months of age *or* the initial two-month rental period has expired.

Prior authorization must be obtained in writing and must include:

- A completed THSteps-CCP Prior Authorization Request Form, signed and dated by the physician.
- Documentation to support medical necessity and appropriateness of the apnea monitor.
- A physician interpretation, signed and dated by the physician, of the most recent two-month's apnea monitor downloads.

Apnea monitors are not authorized if the documentation does not support medical necessity.

Procedure code 1-94774 may be used by the physician to bill for the interpretation of the apnea monitor recordings.

Electrodes and lead wires for the apnea monitor are a benefit only if the apnea monitor is owned by the client. If the apnea monitor is rented, the electrodes and lead wires are considered part of the rental fee. The electrodes and lead wires may be considered for purchase with procedure codes 9-A4556 and 9-A4557 and only with documentation of medical necessity and a statement from the physician that the client owns the monitor. The apnea monitor/pulse oximeter combination device is not a benefit of the Texas Medicaid Program.

43.4.5.8 Croup Tent/Pulse Oximeter

Croup Tent

The croup tent consists of a plastic tent and humidification system placed over a crib or bed to provide a high humidity environment.

A croup tent requires prior authorization.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

Reimbursement for the croup tent is per month, regardless of whether the therapy is for only one day or one week.

Rental of the croup tent includes purchase of the croup tent canopy, rental of a compressor, set-up charge, and supplies.

Separate payment is not made for individual components.

Procedure code L-E1399 must be used for rental of the croup tent.

Pulse Oximeter

A pulse oximeter is used to monitor the client's body oxygen saturation level for those clients at risk for hypoxia.

A pulse oximeter is a benefit of the Texas Medicaid Program through THSteps-CCP. A higher level pulse oximeter may be reimbursed based on documentation of medical necessity.

A pulse oximeter requires prior authorization.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

A pulse oximeter may be reimbursed for rental only once a month and is limited to a maximum of six months, at which time purchase may be considered for those clients requiring long-term monitoring.

The provider is responsible for retaining a current prescription.

A pulse oximeter rental, including the probes, may be authorized for clients who are one of the following:

- Birth through 20 years of age and ventilator and/or oxygen dependent.
- Weaning from oxygen and/or a ventilator and have other documented medically necessary conditions requiring a pulse oximeter in the home.

A pulse oximeter may be considered for reimbursement for clients birth through 20 years of age with one of the following levels:

- *Level One.* Basic level monitoring and/or spot checks. Applicable if the client meets at least one the of the following criteria:
  - Client is oxygen- and/or ventilator-dependent at least part of the day (Less than eight hours per day).
  - Client is clinically stable and able to wean from oxygen and/or ventilator.
  - Client has another medically necessary condition requiring monitoring of oxygen saturation.
  - There is a caregiver identified and present who has been trained in use of the oximeter and how to respond to readings in a medically safe way.
- *Level Two.* Providers must use modifier TF when the oximeter device is for intermediate level of care and continuous monitoring. Applicable if the client meets all the following criteria:
  - Client is oxygen- and/or ventilator-dependent a significant portion of the day (e.g., 8 to 16 hours per day).
  - Client needs continuous monitoring of oxygen saturation during sleep and/or to maintain optimal levels.
  - There is a caregiver identified and present who has been trained in use of the oximeter and how to respond to readings in a medically safe way.
- *Level Three.* Providers must use modifier TG if the oximeter device is for a serious condition and there is critical need for continuous monitoring. Applicable if the client meets all the following criteria:
  - Client has frequent need for changes in oxygen and ventilator settings.
  - Client is oxygen- and/or ventilator-dependent (e.g., 16 to 24 hours per day).
  - Client is in the weaning process from oxygen and/or ventilator and experiencing respiratory complications.
  - Client requires equipment that is motion-sensitive, has more complex readouts, or monitoring capabilities.
  - There is a caregiver identified and present who has been trained in use of the oximeter and how to respond to readings in a medically safe way.

A pulse oximeter rental is limited to once per month for a maximum of six months. For those clients not requiring long-term monitoring, a rental extension may be considered for up to six months for level two and three oximeters (TF and TG devices). Purchase may be considered for those clients requiring long term monitoring. Before purchase, the provider must supply a new oximeter to the client.

For all requests providers must:

- Submit the completed Pulse Oximeter Form in addition to the required THSteps-CCP Prior Authorization Request Form. (see "Pulse Oximeter Form" on page B-78 and the "THSteps-CCP Prior Authorization Request Form" on page B-105.)
- Clearly indicate medical necessity using the TF and TG modifiers on the Pulse Oximeter Form.
- Continue to use the current code for lease (L-E0445 with modifier RR) and purchase (J-E0445 with modifier NU).

When requesting prior authorization, providers must use the following procedure codes with the appropriate modifier:

Procedure Code	Limitation
L-E0445 *with* modifier RR	One per month
J-E0445 *with* modifier NU	One every three years
L-E0445 *with* modifiers RR *and* TF	One per month
J-E0445 *with* modifiers NU *and* TF	One every three years
L-E0445 *with* modifiers RR *and* TG	One per month
J-E0445 *with* modifiers NU *and* TG	One every five years

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

Replacement sensor probes (reusable or disposable) for client-owned oximeters require prior authorization through THSteps-CCP.

Sensor probes are limited to four per month using procedure code 9-A4606. Clients birth through 20 years of age may obtain additional probes with documentation of medical necessity.

Respiratory Care Equipment – THSteps-CCP Procedure Codes and Limitations

Procedure Code	Maximum Limitation
9-A4556	15 per month/client-owned monitor
9-A4557	Two pair per year/client-owned monitor
L-E0445	One per month
J-E0445	One per five years
L-E0619	One per month
L-E1399	One per month

43.4.5.9 Electronic Blood Pressure Monitoring Device

An electronic blood pressure monitoring device is not a benefit of Texas Medicaid (Title XIX) Home Health Services. It is a benefit of THSteps-CCP only in the home setting when:

- The client is younger than 12 months of age (coverage for clients 12 months of age or older may be considered upon review by HHSC or its designee with supporting documentation of medical necessity).
- The client is THSteps-CCP-eligible.
- The equipment is prescribed by a physician.
- Documentation is provided supporting medical necessity of the requested equipment.

Prior authorization is required for an electronic blood pressure monitoring device. A THSteps-CCP Prior Authorization Request Form, signed and dated by the physician, must be submitted with the documentation supporting medical necessity for the device. Supporting documentation of medical necessity must include the diagnosis.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

An electronic blood pressure monitoring device is restricted to the following diagnosis codes. Other diagnoses can be considered upon review by HHSC or its designee.

Diagnosis Codes				
4010	4011	4019	40200	40201
40210	40211	40290	40300	40301
40310	40311	40390	40391	40400
40401	40402	40403	40410	40411
40412	40413	40490	40491	40492
40493	40501	40509	40511	40519
4150	41511	41512	41519	4160
4161	4168	4169	4240	4241
4242	4243	4251	4252	4253
4254	4260	42610	42611	42612
42613	4262	4263	4264	42650
42651	42653	42654	4266	4267
42681	42682	42689	4269	4270
4271	4272	42731	42732	42781
4280	4281	42820	42821	42822
42823	42830	42831	42832	42833
42840	42841	42842	42843	4289
5830	5831	5832	5834	5836
5837	58381	58389	5839	5845
5846	5847	5848	5849	5880
58889	591	59371	59372	59373
7450	74510	74511	74512	74519
7452	7453	7454	7455	74560
74561	74569	7457		

Procedure code L-E1399 is used to bill for the monthly rental of an electronic blood pressure monitoring device.

43.4.5.10 Incontinence Supplies for Clients Younger Than 4 Years of Age

Incontinence supplies, such as diapers/briefs/liners, wipes, and underpads, may be considered for reimbursement through THSteps-CCP for those clients younger than 4 years of age with a medical condition resulting in an increased urine and/or stool output beyond the typical output for this age group, such as celiac disease, short bowel syndrome, Crohn's disease, thymic hypoplasia, AIDS, congenital adrenal hyperplasia, diabetes insipidus, Hirschsprung's disease, or radiation enteritis.

Lack of bladder and/or bowel control is considered normal development up to 4 years of age.

Prior authorization is required for incontinence supplies through THSteps-CCP. A completed THSteps-CCP Prior Authorization Request Form prescribing the supplies must be signed and dated by the prescribing physician familiar with the client before requesting prior authorization. All signatures and dates must be current, unaltered, original, and handwritten. Computerized or stamped signatures and dates will not be accepted. The completed THSteps-CCP Prior Authorization Request Form must be maintained by the DME provider and the prescribing physician in the client's medical record.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

To facilitate a determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including accurate documentation of the medical necessity of the supplies requested.

To request prior authorization for incontinence supplies, the following documentation must be provided for the item(s) requested:

- Accurate diagnostic information pertaining to the underlying diagnosis/condition as well as any other medical diagnoses/conditions, to include the client's overall health status.
- Diagnosis/condition causing increased urination/stooling.
- Client height, weight, and waist size.
- Number of times per day the physician has ordered the supply be used.
- Quantity of disposable supplies requested per month

A determination is made by HHSC or its designee as to the number of incontinence supplies prior authorized based on the client's medical needs.

A combination of diapers, briefs, and liners may be considered for authorization for clients younger than 4 years of age and are limited to 300 per month.

Note: *Procedure codes identified with (*) in the table below indicate those considered in the combination of 300 per month. Requests for services exceeding the amounts listed must be submitted with documentation of medical necessity.*

Providers must use the following procedure codes when billing for incontinence supplies for clients younger than 4 years of age:

Procedure Code	Maximum Limitation
9-A4335	2 per month
9-A4554	150 per month
9-A6250	2 per month*
9-T4521	300 per month*
9-T4522	300 per month*
9-T4523	300 per month*
9-T4524	300 per month*
9-T4525	300 per month*
9-T4526	300 per month*
9-T4527	300 per month*
9-T4528	300 per month*
9-T4529	300 per month*
9-T4530	300 per month*
9-T4531	300 per month*
9-T4532	300 per month*
9-T4533	300 per month*
9-T4534	300 per month*
9-T4535	300 per month*
9-T4543	300 per month

43.4.5.11 Pediatric Hospital Cribs/Enclosed Beds/Reflux Wedges and Slings

Pediatric hospital cribs, enclosed beds, reflux wedges, and slings may be considered under the THSteps-CCP Program with prior authorization.

The safety enclosure frame/canopy/bubble top (J-E0316) may be a benefit when the protective crib top/bubble top is for safety use. It is not considered for prior authorization when it is to be used as a restraint or for the convenience of family or caregivers.

Enclosed bed systems that are not approved by the Food and Drug Administration (FDA) are not a covered benefit.

Non-pediatric hospital cribs/enclosed beds can be considered through Texas Medicaid (Title XIX) Home Health Services.

The client's diagnosis, medical needs, developmental level, and functional skills must be documented. A diagnosis alone without documentation of medical necessity and functional skills is insufficient information to approve a pediatric hospital crib or enclosed bed.

Reflux slings or wedges may be considered for clients who birth through 11 months of age. Reflux slings or wedges may be used as positioning devices for infants who require elevation after feedings when prescribed by a physician as medically necessary and appropriate.

Prior Authorization

Prior authorization is required for the DME provided through THSteps-CCP. In order to facilitate a determination of medical necessity and avoid unnecessary denials, providers must include all necessary information at the time a request is made.

A completed THSteps-CCP Prior Authorization Form prescribing the DME and/or medical supplies must be signed and dated by the prescribing physician familiar with the client prior to requesting authorization. The completed THSteps-CCP Prior Authorization Form must include the procedure codes for the services requested. All signatures and dates must be current, unaltered, original, and handwritten. Computerized or stamped signatures and dates are not accepted. The completed THSteps-CCP Prior Authorization Form must be maintained by the requesting provider and the prescribing physician The original signature copy must be kept in the physician's medical record for the client. To complete the prior authorization process the provider must fax or mail the completed THSteps-CCP Prior Authorization Form to the THSteps-CCP prior authorization unit.

Documentation supporting medical necessity must include all of the following:

- The diagnosis, medical needs, treatments, developmental level, and functional skills of the client. A diagnosis alone is insufficient information to consider prior authorization of the requested equipment.
- The age, length, and weight of the client.
- A description of any other devices that have been used, the length of time used, and why they were ineffective.
- How the requested equipment will correct or ameliorate the client's condition beyond that of a standard child's crib, regular bed, or standard hospital bed.
- The name of the manufacturer and the manufacturer's suggested retail price (MSRP).

A determination will be made by HHSC or its designee whether the equipment will be rented, purchased, repaired, or modified based on the client's needs, duration of use, and age of equipment.

DME Certification and Receipt Form

The DME Certification and Receipt Form is required and must be completed before reimbursement can be made for any DME delivered to a client. The certification form must include the name of the item, the date the client received the DME, and the signatures of the provider and the client or primary caregiver. This form must be maintained by the DME provider in the client's medical record.

The following procedure codes may be considered for pediatric hospital cribs, enclosed beds, and/or a reflux wedge or sling: J/L-E0300, J/L-E0316, 9-E1340, and J/L-E1399

Procedure code J/L-E1399 may be used for pediatric hospital cribs which are not enclosed, reflux wedges, or reflux slings.

In situations where the equipment has been abused or neglected by the client, the client's family, or the caregiver a referral to the DSHS THSteps Case Management unit will be made by the THSteps-CCP prior authorization unit for clients birth through 20 years of age. Providers will be notified that the State will be monitoring this client's services to evaluate the safety of the environment for both the client and equipment.

Replacement

Pediatric hospital cribs, enclosed beds, and safety enclosure frame/canopies that have been purchased are anticipated to last a minimum of five years and may be considered for replacement when five years have passed and/or the equipment is no longer functional and no longer repairable. The DME may then be considered for prior authorization. Replacement of equipment may also be considered when loss or irreparable damage has occurred. A copy of the police or fire report when appropriate, and the measures to be taken to prevent reoccurrence must be submitted.

Repairs

Repairs to client-owned equipment may be considered with documentation of medical necessity.

Technician fees are considered part of the labor cost for the repair.

Providers are responsible for maintaining documentation in the client's medical record specifying repairs.

Rentals may be considered during the period of repair.

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

43.4.5.12 Medical Nutritional Products

Medical nutritional products for clients birth through 20 years of age are available only through THSteps-CCP.

Medical nutritional products may be approved for clients who are THSteps-CCP-eligible, birth through 20 years of age, and have specialized nutritional requirements. Medical nutritional products must be prescribed by a physician and be medically necessary. FFP for the medical nutritional product must also be available.

Documentation that supports medical necessity must include one of the following:

- Identification of a metabolic disorder requiring a medically necessary nutritional product.
- Indication that part or all nutritional intake is through a tube (e.g., nasogastric or gastrostomy/jejunostomy).
- Identification/explanation of the medical condition resulting in the requirement for a medical nutritional product.

Prior authorization is not required for the following:

- Nutritional products developed for use in metabolic disorders for those clients with a documented metabolic disorder. (Claims must include the diagnosis indicating the metabolic disorder, and the nutritional product must be for use in metabolic disorders, or the claim is denied.).
- Nutritional products used for clients receiving part or all of their nutritional intake through a tube. Claims submitted for nutritional products not covered by THSteps-CCP are denied. Claims submitted must indicate the client has a feeding tube, or the claim is denied.

Mandatory prior authorization is required for any request that does *not* meet the above criteria. To request prior authorization, submit the THSteps-CCP Prior Authorization Request Form and documentation to support medical necessity. Documentation may include the following:

- Height and weight.
- Growth history.
- Why the client cannot be maintained on an age-appropriate diet.
- Other formulas tried and why they did not meet the client's needs.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

Authorization may be given for up to 12 months.

THSteps-CCP will *not* cover the following:

- Nutritional products for clients that could be sustained on an age-appropriate diet.
- Products traditionally used for infant feeding.
- Pudding products (except for clients with documented oropharyngeal motor dysfunction who receive greater than 50 percent of their daily caloric intake from this product).
- Nutritional products for the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth. Documentation should describe the medical condition that led to these conditions.

- Nutritional products for infants younger than 12 months of age unless medical necessity is documented and other criteria are met. A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

Generic medical nutritional products that have been approved by the U.S. Department of Agriculture (USDA) for use in the Special Supplemental Nutrition Program for WIC may be approved for use by THSteps-CCP clients. Reimbursement is determined using the *Red Book*, less 10.5 percent. Reimbursement for products not listed in the Red Book is based on the same methodology using the AWP supplied by the manufacturer of the product. The provider is responsible for obtaining and submitting necessary product information with the request for products.

Enteral Nutritional Products

All enteral nutritional products paid under the Texas Medicaid Program are paid based on units of 100 calories (as documented by the manufacturer) with the appropriate "B" code (as documented by the Statistical Analysis Durable Medical Equipment Regional Carrier [SADMERC] Product Classification List for Enteral Nutrition in effect at the time) and with the appropriate modifier based on the product's AWP less 10.5 percent (as documented by the *Red Book*).

It is the provider's responsibility to know the correct "B" code, the correct units of 100 calories, and the modifier for requesting prior authorization and payment. Supporting documentation for these components must be maintained in the provider's records and be made available upon request by HHSC or its designee. The documentation must include number of cans delivered, number of ounces in each can, and number of calories in each can or how many ounces equal 100 calories, so substantiation of the units billed may be ascertained.

Payment is based on the lower of billed charges or the Medicaid allowed fee, with the Medicaid allowed fee based on the appropriate "B" code, modifier, and units of 100 calories.

It is the provider's responsibility to know when products are discontinued by the manufacturer, when container sizes change, and when names change. Submit requests for prior authorization and payment accordingly.

A written request must be submitted when using procedure code 9-B9998 to request generic medical nutritional products that require prior authorization.

Note: *The Palmetto GBA SADMERC Product Classification List is located on the website www.palmettogba.com.*

The following procedure codes and/or modifiers should be used if indicated as necessary on the Palmetto GBA SADMERC Product Classification list for that medical nutritional product.

Procedure Code	Modifier
9-B4100	None
9-B4150	U2, U3, U4, U5
9-B4152	U2, U3, U6
9-B4153	U5, U6, U7, U8, U9
9-B4154	U1, U2, U3, U4, U5, U6, U7, U8, U9, UA, UB, UC, UD
9-B4155	U2, U3, U4, U5, U8, UC
9-B4157	None
9-B4158	None
9-B4159	None
9-B4160	None
9-B4161	None
9-B4162	None

Modifier	Fee per Unit
U1	$0.30
U2	$0.50
U3	$0.70
U4	$0.85
U5	$1.05
U6	$1.70
U7	$2.00
U8	$2.50
U9	$3.00
UA	$4.00
UB	$5.00
UC	$6.00
UD	Manually priced

43.4.5.13 Donor Human Milk

Donor human milk is a benefit of THSteps-CCP for eligible THSteps clients birth through 11 months of age meeting *all* of the following criteria:

- The requesting physician has documented medical necessity.
- The parent or guardian has signed and dated an informed consent form indicating that the risks and benefits of using banked donor human milk have been discussed with them.
- The donor human milk bank adheres to quality guidelines consistent with the Human Milk Bank Association of North America or such other standards as may be adopted by HHSC.

A Donor Human Milk Request Form must be completed every 180 days, and copies must be maintained in the client's records of both the ordering physician and the providing milk bank. The physician ordering the donor human milk must complete all fields in Part A of the original form, including the documentation of medical necessity. This information *must* be substantiated by written documentation in the clinical record. The physician

must specify the quantity and time frame in the Quantity Requested field (e.g., cubic centimeters per day or ounces per month).

A copy of the Donor Human Milk Request Form must also be maintained in the client's records at the providing milk bank. The donor milk bank providing the donor human milk must complete all fields in Part B of the original form.

The milk bank must specify the quantity and time frame in the Quantity Provided field.

Refer to: "Donor Human Milk Request Form" on page B-36.

The physician's substantiating documentation of medical necessity and the signed and dated written informed consent form must be maintained in the client's clinical records. The clinical records are subject to retrospective review by HHSC or its designee.

A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

The documentation must address all of the following criteria:

- Why the particular infant cannot survive and gain weight on any other formula (e.g., elemental, special, or routine formulas or food) or any enteral nutritional product other than donor human milk.
- Why donor human milk must be used.
- That a clinical feeding trial of an appropriate nutritional product has occurred every 180 days. If the infant is too fragile for a feeding trial, documentation *must* support the illness that makes the infant too fragile to test.
- That the informed consent details for the parent or guardian the risks and benefits of using banked donor human milk.

The physician *must* address the benefits and risks of using donor human milk, such as HIV, freshness, effects of pasteurization, nutrients, and growth factors to the parent. The physician also must address donor screening, pasteurization, milk storage, and transport of the donor milk. The physician may obtain this information from the donor milk bank.

Donor human milk is reimbursed only to a Texas Medicaid-enrolled donor milk bank and only for clients in the home setting. Donor human milk may be reimbursed for a maximum of six months per request.

Providers must use procedure code 9-B9998 to bill for donor human milk, per ounce. Donor human milk is reimbursed at $2.50 per ounce. Reimbursement for donor human milk provided in the inpatient setting is included in the DRG.

43.4.5.14 Special Needs Car Seats and Travel Restraints

Special Needs Car Seats

A special needs car seat may be considered for reimbursement with prior authorization for a client who has outgrown an infant car seat and is unable to travel safely in a booster seat or seat belt. Consideration should be given to the manufacturer's weight and height limitations and must reflect allowances for at least 12 months of growth.

A special needs car seat must have a top tether installed. The top tether is essential for proper use of the car seat. The installer is reimbursed for the installation by the manufacturer.

The provider must maintain a statement that has been signed and dated by the client's parent or legal guardian in the client's medical record that states the following:

- A top tether has been installed in the vehicle in which the client will be transported, by a manufacturer-trained vendor.
- Training in the correct use of the car seat has been provided by a manufacturer-trained vendor.
- The client's parent or legal guardian has received instruction and has demonstrated the correct use of the car seat to a manufacturer-trained vendor.

Providers must use procedure code J-E1399 for a special needs car seat.

Car seat accessories available from the manufacturer may be considered for reimbursement with prior authorization when medically necessary for correct positioning.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

To request prior authorization for a special needs car seat or accessories, the following criteria must be met:

- The client's weight must be at least 40 pounds, *or* the client's height must be at least 40 inches.
- Supporting documentation must include the following and must be submitted for prior authorization:
  - Accurate diagnostic information pertaining to the underlying diagnosis/condition as well as any other medical diagnoses/conditions, to include the client's overall health status.
  - A description of the client's postural condition specifically including head and trunk control (or lack of control) and why a booster chair or seatbelt will not meet the client's needs (the car seat must be able to support the head if head control is poor).
  - The expected long-term need for the special needs car seat.
  - A copy of the manufacturer's certification for the installer's training to insert the specified car seat.

A request for a client who does not meet the criteria may be considered on a case-by-case basis on review by HHSC or its designee.

A stroller base for a special needs car seat is not a benefit of the Texas Medicaid Program.

Travel Safety Restraints

A travel safety restraint and ankle or wrist belts may be considered for reimbursement through THSteps-CCP without prior authorization for clients with a medical condition requiring them to be transported in either a

prone or supine position. The DME provider and the prescribing physician familiar with the client must maintain documentation in the client's medical record supporting the medical necessity of the travel safety restraint.

A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply. Authorization is a condition for reimbursement, not a guarantee of payment.

Providers must use procedure code J-E0700 for travel safety restraints, ankle, and wrist belts.

43.4.6 Early Childhood Intervention (ECI) (THSteps-CCP Only)

43.4.6.1 Enrollment

To be a qualified provider, the provider must contact the Texas ECI Program at 1-512-424-6759. After meeting the criteria of the Texas ECI Program, providers should request a Medicaid application from TMHP Provider Enrollment. ECI providers are eligible to enroll as Texas Medicaid THSteps-CCP providers rendering service to clients younger than 3 years of age with a disability and/ or developmental delay as defined by ECI criteria.

To participate in the Texas Medicaid Program, an ECI provider must comply with all applicable federal, state, and local laws and regulations about the services provided.

Reimbursement is available for PT, OT, speech-language therapy, nutrition, audiology, and psychological services for clients enrolled in ECI through THSteps-CCP. Regular THSteps-CCP guidelines apply, including the requirement for evaluations.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "THSteps-Comprehensive Care Program (CCP)" on page 43-33 for more information.

"Provider Enrollment" on page 43-5 for more information about enrollment procedures.

43.4.6.2 Reimbursement

ECI services are reimbursed in accordance with 1 TAC §355.113.

Refer to: "Reimbursement" on page 43-7 for more information about reimbursement.

43.4.6.3 ECI-THSteps-CCP Services

ECI THSteps-CCP services end on the client's third birthday.

Because the ECI program requires local ECI providers to follow quality assurance procedures and develop individualized family service plans for each client, THSteps-CCP does not require copies of therapy evaluations or periodic progress notes to be submitted with therapy claims. ECI providers must complete the entire "THSteps-CCP ECI Request for Initial/Renewal Outpatient Therapy" on page B-107. The form must include a physician signature current for all dates of service and the appropriate therapist signature for the requested service (e.g., a request for OT must be signed by an occupational therapist and not a physical therapist).

Prior authorization through THSteps-CCP is necessary to expedite claims processing.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

Physician Signature

The physician's signature, required on a prescription and the THSteps-CCP ECI Request for Initial Renewal Outpatient Therapy form, must be current to the service date of the request.

ST services provided to clients enrolled in ECI are eligible for reimbursement through THSteps-CCP when provided by or under the direction (supervision) of a Texas-licensed speech-language pathologist (SLP) with a master's degree or certified by the American Speech-Language-Hearing Association (ASHA). SLPs, with a Certificate of Clinical Competence in Speech-Language Pathology from ASHA or licensed by the Texas State Board of Examiners for Speech-Language Pathology and Audiology with a master's degree (ASHA equivalent qualified SLP), may provide supervision of ECI speech-language therapy services provided by individuals practicing with a Texas SLP intern license or individuals licensed as SLP assistants.

The supervision must meet the following provisions:

- The supervising speech-language pathologist provides sufficient supervision as set forth by the State Board of Examiners for Speech-Language Pathology and Audiology to ensure appropriate completion of the responsibilities assigned.
- Documentation exists of direct involvement of the supervising SLP in overseeing the services provided.
- The SLP providing the direction must ensure that the personnel carrying out the directives meet the minimum qualifications set forth in the rules of the State Board

of Examiners for Speech-Language Pathology and Audiology relating to Licensed Assistant in Speech-Language Pathology.

SLP is a regulated profession in Texas. ST providers with ASHA certification must also be licensed by the State Board of Examiners for Speech-Language Pathology and Audiology.

ECI providers must complete the THSteps-CCP ECI Request for Initial/Renewal Outpatient Therapy Form for authorization for reimbursement of speech-language services. The form must include a physician signature current for all dates of service and a signature of an ASHA-certified or equivalent qualified SLP enrolled in the Texas Medicaid Program.

Claims for services provided by licensed SLP interns or individuals licensed as SLP assistants must reflect the ASHA-certified or -equivalent supervising SLP's provider identifier.

Refer to: "THSteps-CCP ECI Request for Initial/Renewal Outpatient Therapy" on page B-107.

"Physician Signature" on page 43-37 for complete information about this requirement.

43.4.6.4 Claims Information

Providers must submit services by an ECI provider to TMHP in an approved electronic format or on a CMS-1500 claim form. Providers must purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

Claims for services that have been prior authorized must reflect the PAN in Block 23 of the CMS-1500 claim form or its equivalent.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"CMS-1500 Claim Filing Instructions" on page 5-22 for claims completion instructions.

"Early Childhood Intervention (THSteps-CCP Only)" on page D-12.

"Targeted Case Management for Early Childhood Intervention (ECI)" on page 13-1 for more information.

43.4.7 Licensed Dietitians (THSteps-CCP Only)

43.4.7.1 Enrollment

Independently practicing licensed dietitians may enroll in the Texas Medicaid Program to provide services to THSteps-CCP clients. Providers of nutrition assessments and counseling must be currently licensed by the Texas State Board of Examiners of Dietitians in accordance with the *Licensed Dietitians Act*, Chapter 701, Texas Occupations Code.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 43-5 for more information about enrollment procedures.

43.4.7.2 Reimbursement

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

Refer to: "Texas Medicaid Reimbursement" on page 2-1 for more information about reimbursement.

43.4.7.3 Benefits and Limitations

Only providers enrolled as licensed dietitians are eligible for reimbursement for dietitian services.

THSteps-CCP is for Medicaid THSteps-eligible clients birth through 20 years of age. THSteps-CCP eligibility ends on the client's 21st birthday. If the client's Medicaid ID states "Emergency Care," "PE," or "QMB," the client is not eligible for THSteps or THSteps-CCP benefits. THSteps-CCP may cover nutrition assessment and/or counseling to prevent, treat, or minimize the effects of illness, injury, or other impairments.

Nutrition services may be a benefit when:

- The client is THSteps-CCP eligible.
- Prescribed by a physician.
- Medically necessary.
- Completed by a Medicaid-enrolled dietitian licensed by the Texas State Board of Examiners of Dietitians.
- Completed in the home or office.

Prior authorization is *not* required for two nutrition assessments per year or for four nutrition counseling visits per year. Providers are responsible for maintaining documentation to support medical necessity in the client's clinical record. A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

Prior authorization *is* required for more than two assessments or more than four nutrition counseling visits per year. Submit these requests with written documentation to support medical necessity. A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

To request prior authorization or submit claims, providers must use the procedure code 1-S9470 with a maximum fee of $30.45 and procedure code 1-97802 or 1-97803 with a maximum fee of $10.15 per 15 minutes.

If 1-S9470 and either 1-97802 or 1-97803 are billed for the same date of service, 1-97802 or 1-97803 is paid and 1-S9470 is denied.

Physician Signature

The physician's signature, required on a prescription and the THSteps-CCP Prior Authorization Request Form, must be current to the service date of the request.

Refer to: "Physician Signature" on page 43-37 for complete information about this requirement.

43.4.7.4 Claims Information

Providers must submit services provided by licensed dietitians in an approved electronic claims format or on a CMS-1500 claim form from the vendor of their choice. TMHP does not supply the forms.

Claims for services that have been prior authorized must reflect the PAN in Block 23 of the CMS-1500 Claim Form or its equivalent.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"Licensed Dietitians (THSteps-CCP Only)" on page D-20 for a claim form example.

"CMS-1500 Claim Filing Instructions" on page 5-22 for claims completion instructions.

43.4.8 Occupational Therapists (THSteps-CCP Only)

43.4.8.1 Enrollment

HHSC allows Medicaid enrollment of independently practicing, currently licensed OTs in THSteps-CCP. Some OT services are also available under Texas Medicaid (Title XIX) Home Health Services.

The Texas Medicaid Program enrolls and reimburses OTs only for THSteps-CCP services and Medicare crossovers. The information in this section is applicable to THSteps-CCP services only. This section does not apply to CORFs.

CORF information is provided in "Comprehensive Outpatient Rehabilitation Facilities (CORFs)/Outpatient Rehabilitation Facilities (ORFs)" on page 43-43.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 43-5 for more information about enrollment procedures.

"Occupational Therapy (OT) Services" on page 24-16.

43.4.8.2 Reimbursement

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

The fee schedules for the services in this section are available on the TMHP website at www.tmhp.com /file library/file library/fee schedules.

Refer to: "Texas Medicaid Reimbursement" on page 2-1 for more information about reimbursement.

43.4.8.3 Benefits and Limitations

Procedural modifiers are required for home health agencies billing for OT visits. Providers must use procedural modifier GO for OT.

THSteps-CCP is available for Medicaid THSteps-eligible clients birth through 20 years of age. THSteps-CCP eligibility ends on the day of the client's 21st birthday. If the client's Medicaid ID states "Emergency Care," "PE," or "QMB," the client is not eligible for THSteps or THSteps-CCP benefits.

The following CPT codes should be used for billing OT services under THSteps-CCP. Not all codes are payable to all provider types.

Procedure Codes			
1-97003	1-97004	1-97012	1-97014
1-97016	1-97018	1-97022	1-97024
1-97026	1-97028	1-97032	1-97033
1-97034	1-97035	1-97036	1-97039
1-97110	1-97112	1-97113	1-97116
1-97124	1-97139	1-97140	1-97150

Procedure Codes			
1-97530	1-97535	1-97537	1-97542
1-97750	1-97760	1-97761	1-97762
1-97799			

OT may be billed as POS 1 or 2 and may be authorized to be provided in the following locations: home of the client, home of the caregiver/guardian, client's daycare facility, or the client's school. Services provided to a client on school premises are only permitted when delivered before or after school hours. The only THSteps-CCP therapy that can be delivered in the client's school during regular school hours are those delivered by school districts as School Health and Related Services (SHARS) in POS 9.

OT services are benefits under THSteps-CCP when provided to clients who have disabilities or an ongoing health condition, such as a musculoskeletal or neuromusculoskeletal condition or other conditions requiring medically necessary OT. OT services are a benefit of Texas Medicaid (Title XIX) Home Health Services when provided in the home for acute conditions. If the client is ineligible for these services through Texas Medicaid (Title XIX) Home Health Services, these services may be provided under THSteps-CCP.

Procedure codes 1-97012, 1-97014, 1-97016, 1-97018, 1-97022, 1-97024, 1-97026, 1-97028, and 1-97150 are limited to one service per day. The procedure codes in the following table may be paid in multiple 15-minute quantities.

Procedure Codes			
1-97032	1-97033	1-97034	1-97035
1-97036	1-97039	1-97110	1-97112
1-97113	1-97116	1-97124	1-97139
1-97140	1-97530	1-97535	1-97537
1-97760	1-97761		

Procedure code 1-97760 is only payable for clients birth through 20 years of age. Procedure code 1-97010 is not a benefit.

Procedure codes that may be billed in multiple quantities (i.e., 15 minutes each) are limited to a total of two hours per day of individual, group, or a combination of individual and group therapy.

Procedure codes 1-97750 and 1-97762 are comprehensive codes and include an office visit. When an office visit is also billed on the same day by the same provider, 1-97750 and 1-97762 pays and the office visit is denied as part of these procedure codes. Procedure code 1-97762 is only payable for clients birth through 20 years of age.

Procedure code 1-97003 is payable once per six months for any provider at the same facility. Procedure code 1-97004 is payable once per month for any provider at the same facility. These codes are not payable on the same day as the procedure codes in the following table:

Procedure Codes			
1-97012	1-97014	1-97016	1-97018
1-97022	1-97024	1-97026	1-97028
1-97032	1-97033	1-97034	1-97035
1-97036	1-97039	1-97110	1-97112
1-97113	1-97116	1-97124	1-97139
1-97140	1-97150	1-97530	1-97750
1-97760	1-97761	1-97762	

Important: *OT prescribed primarily as an adjunct to psychotherapy is not a benefit.*

Providers must use the procedure codes 1-97003 with a maximum fee of $140.00, 1-97004 with a maximum fee of $140.00, or 1-97535 with a maximum fee of $35.00 for services provided by an independently practicing OT for developmental treatment. Procedure code 1-97003 may be billed without prior authorization. Procedure code 1-97535 may be billed only once per month per provider.

For procedure code 1-97003, a quantity of one is allowed for payment per six months per provider without prior authorization or written documentation of medical necessity. An evaluation is not paid on the same day as a treatment.

A request for OT services may be prior authorized for no longer than six months duration. A new request must be submitted if therapy is required for a longer duration.

Typical sessions do not exceed one hour in length. Documentation supporting the need for longer sessions is required. No limits exist on the number of sessions that may be provided per week. The number of sessions per week must be supported by documentation showing that such sessions are medically necessary.

Refer to: "Occupational and Physical Therapy Services" on page 25-40 for acute conditions.

Prior Authorization, Documentation Requirements

Providers must use "Request for Initial Outpatient Therapy (Form TP-1)" on page B-80 for initial requests and "Request for Extension of Outpatient Therapy (2 Pages) (Form TP-2)" on page B-81 for extension requests. Home health agencies must include the GO modifier on the TP1 or TP2 form when requesting OT.

Prior authorization is a condition for reimbursement; it is not a guarantee of payment. Prior authorization for OT services is required except for evaluation and re-evaluation. Submit appropriate documentation with the request for prior authorization or with each claim for consideration of reimbursement.

Clients receiving therapy services reimbursed by THSteps-CCP must have chronic conditions that require ongoing medical supervision. To establish medical necessity, a physician prescription and revised therapy treatment plan are needed at least every six months.

A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

The initial therapy request must include a TP-1 form and an initial therapy treatment plan. The initial therapy treatment plan must include the following:

- A signed and dated physician's prescription.
- A copy of the current evaluation, signed and dated by the therapist.
- The documented age of the client at the time of the evaluation.
- Documentation indicating the treatment goals, anticipated measurable progress toward goals, the prognosis, and the client's fine motor skills in years/months. Goals may include improving function, maintaining function, or slowing the deterioration of function.

To request an extension of service, the following documentation must be submitted:

- A TP-2 form, including a *current* physician signature and date.
- All documentation required in initial authorizations (except the TP-1 form).
- Documentation of all progress made from the beginning of the previous treatment period to the current service request date, including progress towards previous goals.
- Information that supports the client's capability of continued measurable progress.
- A proposed treatment plan for the requested extension dates with specific goals related to client's individual needs. Therapy goals may include improving function, maintaining function, or slowing of deterioration of function.

Therapy may be extended *beyond two years*, but the following required documentation must be forwarded for authorization to be considered:

- A TP-2 form.
- All documentation required in initial authorizations (except the TP-1 form).
- A comprehensive team evaluation summarizing all prior treatment as well as all progress that was made during that time.
- A report from the case managing physician indicating all progress that the client made toward all goals during all previous therapy sessions.

If a provider discontinues therapy with a client and a new provider *begins* therapy during an existing authorization period, submission of a new treatment plan and obtaining a new authorization are required, as well as documentation of the last therapy visit with the previous provider. A letter from the guardian stating the date therapy ended with the previous provider is sufficient.

Physician Signature

The physician's signature and date, required on a prescription and the appropriate authorization request form, must be current to the service date(s) of the request.

Refer to: "Physician Signature" on page 43-37 for complete information about this requirement.

ECI Program Provisions

Because the state ECI Program requires local ECI providers to follow quality assurance procedures and develop individualized family service plans for each client, THSteps-CCP does not require copies of therapy evaluations or periodic progress notes to be submitted with therapy claims. ECI providers should complete the ECI Request for Initial/Renewal Outpatient Therapy form, which must include a physician signature current for all dates of service. Prior authorization through THSteps-CCP is encouraged to expedite claims processing, or the form may be submitted with the claim.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

43.4.8.4 Claims Information

Providers must submit claims for services provided by an independently practicing OT in an approved electronic claims format or on a CMS-1500 claim form from the vendor of their choice. TMHP does not supply the forms.

Important: *Attach the invoice to the claim for any specialized equipment.*

Therapy is only reimbursed when provided in POS 1 (office) or 2 (home). Procedure code 1-97003 may only be billed with a quantity of 1. Claims for services that have been prior authorized must reflect the PAN in Block 23 of the CMS-1500 Claim Form or its electronic equivalent.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"Occupational Therapists (THSteps-CCP Only)" on page D-24.

"CMS-1500 Claim Filing Instructions" on page 5-22 for claims completion instructions. Attach the invoice to the claim for any specialized equipment.

43.4.9 Orthotic and Prosthetic Suppliers (THSteps-CCP Only)

Medicaid clients birth through 20 years of age are entitled to all medically necessary DME. DME is medically necessary when it is required to correct or ameliorate disabilities or physical or mental illnesses or conditions. Any numerical limit on the amount of a particular item of DME can be exceeded for Medicaid clients birth through 20 years of age if medically necessary. Likewise, time periods for replacement of DME do not apply to Medicaid

clients birth through 20 years of age if the replacement is medically necessary. When prior authorization is required, the information submitted with the request must be sufficient to document the reasons why the requested DME item or quantity is medically necessary.

43.4.9.1 Enrollment

To be eligible to participate in THSteps-CCP, providers of orthotics and prosthetics services must be enrolled in Medicare.

The Texas Medicaid Program enrolls and reimburses orthotic and prosthetic suppliers only for THSteps-CCP services and Medicare crossovers. The information in this section is applicable to THSteps-CCP services only.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 43-5 for more information about enrollment procedures.

43.4.9.2 Reimbursement

Orthotic and prosthetic services are reimbursed in accordance with 1 TAC §355.8441. Outpatient hospitals are reimbursed for THSteps DME and expendable supplies in accordance with 1 TAC §355.8061.

Refer to: "Texas Medicaid Reimbursement" on page 2-1 for more information about reimbursement.

43.4.9.3 Benefits and Limitations

Orthotics and prosthetics are a covered benefit of THSteps-CCP for clients requiring orthotics or prosthetics that are medically necessary and prescribed by a physician (MD or DO). Orthotic devices, provided to ICF-MR clients and clients who reside in a nursing facility, are a benefit of THSteps-CCP. Payment is made directly to the vendor. The equipment belongs to the client or family. Non-orthotic devices, such as a knee immobilizer, are not a benefit for nursing facility residents and ICF-MR clients.

Orthoses and prostheses must be dispensed, fabricated, and modified by an approved orthotist or orthotist/prosthetist.

Prior Authorization, Documentation Requirements

All requests for prior authorization or claim reimbursement must:

- Be for orthotic or prosthetic devices prescribed by a physician (MD or DO) or a podiatrist. A podiatrist prescription is valid for conditions of the ankle and foot. The prescription is placed on file for a time period not to exceed 12 months. At the end of the prescription period, an authorization is required for any repairs, replacement parts, devices, or supplies.
- Contain a prescription dated before the date of service. The date of service must be within three months of the prescription date. The service is considered "provided" on the date the supplier has placed an order for the equipment and has incurred liability for the equipment.
- Include accurate diagnostic information pertaining to the orthotic/prosthetic device requested.
- Explain the medical necessity of the orthotic or prosthetic requested. A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.
- Be for orthotic devices provided by a currently licensed orthotist or prosthetist enrolled with Medicare and THSteps-CCP. *Exception*: upper extremity splints made with low temperature materials and inhibitive casting may be provided by OTs or PTs.
- Be for prosthetic devices provided by a currently licensed prosthetist or orthotist/prosthetist.

Requests for prior authorization must be filed using a THSteps-CCP Prior Authorization Request Form completed by the treating physician.

Telephone authorization is allowed for most orthotic devices. When authorization has not been requested, the documentation supporting medical necessity must be maintained in the client's medical record.

Requests for authorization and reimbursement of single items exceeding the $1,500.00 allowable dollar amount must be supported by written documentation demonstrating medical necessity. All other items may be authorized during a telephone request.

The DOS for a custom-made or fitted orthosis is the date the supplier places an order for the equipment and incurs liability for the equipment. For a recipient who has lost eligibility, custom-made orthotic devices may be reimbursed when the DOS occurred during a month the client was eligible for Medicaid.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

43.4.9.4 Cranial Orthotic Devices

Cranial orthotic devices are molding helmets or bands that are used for the purpose of shaping the skull or to protect the skull and have been proven to be most effective in children between the ages of 3 and 18 months of age.

Cranial orthosis (cranial molding devices) when used as a treatment of plagiocephaly without synostosis is considered cosmetic, not medically necessary, and not a benefit of the Texas Medicaid Program.

Cranial orthosis for nonsynostotic plagiocephaly may be considered for authorization with documentation supporting associated functional impairment and use of the cranial orthosis will modify or prevent the development of functional impairment including orofacial musculoskeletal or neurocognitive disorders.

Cranial orthotic devices may be authorized for clients between the ages of 3 and 18 months of age.

Cranial orthotic devices must be prior authorized for reimbursement through THSteps-CCP with documentation supporting medical necessity. Written documentation must include:

- Client's diagnosis and age.
- The recommendations of the craniofacial team (the team must include a pediatric neurosurgeon or craniofacial surgeon) or pediatric neurosurgeon.
- The determining factors used in recommendation of treatment.
- Any alternative treatment courses that have been tried.
- Plan of treatment and/or follow up schedule.

Cranial orthotic devices may be reimbursed using procedure codes 9-A8002. 9-A8003, 9-A8004, and 9-S1040.

Craniostenosis Helmets

Procedure codes 9-A8002, 9-A8003, and 9-A8004 require prior authorization and may be considered for reimbursement for neoplasm of the brain, subarachnoid hemorrhage, epilepsy, or cerebral palsy.

All requests for diagnoses other than those listed above or for clients younger than 4 months of age or older than 18 months of age require submission of documentation of medical necessity. A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

43.4.9.5 Corrective Shoe, Wedge, and Lift

THSteps-CCP may authorize and reimburse prescription shoes (corrective/orthopedic), wedges, and lifts. The authorization request and reimbursement must meet the following requirements:

Corrective Shoes

For consideration of coverage, corrective shoes must be prescribed by a licensed physician (MD or DO) or a podiatrist *and* meet one of the following requirements:

- Permanently attached to a brace.
- Custom modified by an orthotist or orthotist/prosthetist at the direction of the prescribing physician.
- Necessary to hold a surgical correction, postoperative casting, or serial/clubfoot casting. The corrective shoe may be authorized up to one year post procedure.

Note: *Corrective shoes that are not attached to a brace require authorization.*

Requests for corrective shoes that do not meet the criteria listed above may be submitted with the appropriate documentation to medical review for consideration.

A corrective shoe does *not* include tennis shoes (even if prescribed by a physician and worn with a removable brace).

A corrective shoe does *not* include a shoe insert when it is not part of a modified shoe or when the shoe in which it is inserted is not attached to a brace (other than procedure code 9-L3000).

Only one pair of corrective shoes can be authorized every three months. Two pairs of shoes may be purchased at the same time; however, in such situations additional requests for shoes are not considered for another six months.

Requests for corrective shoes that do not meet the criteria listed above may be submitted with the appropriate documentation to medical review for consideration.

Authorization requests for corrective shoes *must* be submitted in writing.

Wedge and Lift

A wedge or lift must be for unequal leg length greater than one-half inch. Reimbursement may include the cost of the prescription shoe.

Dynamic Splint

Requests for dynamic splints may be submitted for medical review with the following documentation supporting medical necessity:

- Client's condition.
- Client's current course of therapy.
- Rationale for the use of the dynamic splint.
- Likelihood that the family and client will comply with the prescribed use of the dynamic splint.

Removable Shoe Insert, UCB (University of California at Berkeley) Type

Shoe inserts are not a benefit when they are not part of a modified shoe or when the shoe in which they are inserted is not attached to a brace, with the exception of the UCB removable shoe insert.

A UCB removable shoe insert may be prior authorized and reimbursed when the service meets one of the following:

- Client has a valgus deformity and significant congenital pes planus (75461) with pain.
- Client has a structural problem which results in significant pes planus, such as Down syndrome.
- Client has acute plantar fasciitis.

Procedure code 9-L3000 may be payable when billing for a removable foot insert.

Reciprocating Gait Orthoses (RGO)

RGO may be covered for clients with spina bifida or similar functional disabilities. Prior authorization is required. The prior authorization request must include a statement from the prescribing physician indicating the medical necessity, PT plan, and information that the family is expected to comply with the treatment plan.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

Repairs, Modifications, and Fittings of Orthosis/Prostheses

Repairs due to regular wear and modifications due to growth or change in medical status are a benefit when proven more cost-effective than replacing the device. Additional information from the provider may be requested to determine cost-effectiveness.

Authorization is required for repairs, modifications, and fittings. Documentation supporting medical necessity must be provided when requesting authorization.

Reimbursement of fittings is considered included in the regular reimbursement fee except in situations such as parapodiums, where time spent at fitting may be extensive. Fitting for parapodiums must be prior authorized.

For repairs, modifications, and fittings to an orthosis, providers must bill using procedure codes 9-E1340, 9-L4205, and 9-L4210.

Replacement of Orthoses/Prostheses

Replacement of an orthotic/prosthetic device is considered when loss or irreparable damage has occurred. A copy of the police or fire report is required when appropriate, along with the measures to be taken to prevent recurrence of similar loss. Supporting medical documentation is required for the replacement of an orthotic or prosthetic device if less than six months from the actual date the client received the device. If less than one year since initial purchase, request for replacement is referred to the medical director for review.

In situations where the equipment has been abused or neglected by the client, the client's family or the caregiver, a referral to the DSHS THSteps Case Management unit is made by the Home Health Services unit for clients birth to 20 years of age. Providers are notified that the State is monitoring this client's services to evaluate the safety of the environment for both the client and equipment.

Training in Using the Orthotic or Prosthetic Device

Training in the use of an orthotic or prosthetic device for a client who has not worn one previously, has not worn one for a prolonged period, or is receiving a different type may be reimbursed when the training is provided by a PT or OT.

If prior authorization is not requested, submit documentation to support medical necessity with each claim and include a prescription signed by a physician (MD or DO).

A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

Prior authorization is a condition for reimbursement, not a guarantee of payment.

Physician Signature

The physician's signature and date is required on a prescription and the THSteps-CCP Prior Authorization Request Form must be current to the service date of the request.

Refer to: "Physician Signature" on page 43-37 for complete information about this requirement.

43.4.9.6 Claims Information

Submit services provided by orthotic and prosthetic suppliers in an approved electronic format or on a CMS-1500 claim form. Providers must purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"CMS-1500 Instruction Table" on page 5-25 for claims completion instructions and information on electronic billing.

Important: *Attach the invoice to the claim for any specialized equipment.*

Include the name of the referring physician in Block 17 of CMS-1500 claim form or its electronic equivalent. Orthotics or prosthetics may be billed in POS 1 (office), 2 (home), or 5 (outpatient). Claims for services that have been prior authorized must reflect the PAN in Block 23 of the CMS-1500 claim form or its electronic equivalent.

Refer to: "Orthotic and Prosthetic Suppliers (THSteps-CCP Only)" on page D-25 for a claim form example.

43.4.10 Personal Care Services (THSteps-CCP Only)

PCS is a benefit of THSteps-CCP for Texas Medicaid clients birth through 20 years of age, who are not inpatients or residents of a hospital, in a nursing facility or ICF-MR, or in an institution for mental disease. PCS are support services provided to clients who meet the definition of medical necessity and require assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health related functions because of a physical, cognitive, or behavioral limitation related to a client's disability or chronic health condition. PCS are provided by someone other than the minor client's legal or foster parent or legal guardian or the client's spouse.

43.4.10.1 Enrollment

Providers that want to participate in the delivery of PCS to Medicaid clients must be enrolled with the Texas Medicaid Program through TMHP and have the appropriate Texas Department of Aging and Disability Services (DADS) licensure and/or certification.

All PCS providers must have a TPI and a National Provider Identifier (NPI).

LCHH agencies that are currently enrolled as Texas Medicaid providers through TMHP must bill for PCS using their existing home health TPI.

Refer to: Providers that are *currently* contracted with DADS to administer consumer directed services (CDS) or provide PCS through the service responsibility option (SRO), including providers currently enrolled in the Texas Medicaid Program, are required to enroll/reenroll separately as a CDS or SRO provider. The Texas Medicaid Program enrolls only new providers that are *currently* contracted with DADS to provide PCS through CDS and SRO.

Providers (other than those discussed above) that want to render PCS to Medicaid clients must enroll with the Texas Medicaid Program through TMHP. The Texas Medicaid Program enrollment rules for PCS participation require providers to have one of the following categories of DADS licensure prior to enrollment:

- Personal Assistance Services (PAS).
- LHHS.
- LCHHS.

Additionally, providers must:

- Have an NPI.
- Have a TPI with the Texas Medicaid Program in one of the following enrollment categories: LHHS agency, LCHHS agency, or PCS provider.

Providers that are enrolled with the Texas Medicaid Program as any entity other than a LHHS agency or LCHHS agency are required to meet the provider enrollment rules in order to participate in the delivery of PCS through the Texas Medicaid Program.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 43-5 for more information about enrollment procedures.

43.4.10.2 Reimbursement

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

43.4.10.3 PCS Provider Responsibilities

PCS providers must comply with all applicable federal, state, and local laws and regulations.

All PCS providers must maintain written policies and procedures for obtaining consent for medical treatment in the absence of the parent/guardian. The procedure and policy must meet the standards of the *Texas Family Code*.

Providers must accept clients only when there is a reasonable expectation the client's needs can be adequately met in the POS. The POS must be able to support the client's health and safety needs and adequately support the use, maintenance, and cleaning of all required medical devices, equipment, and supplies. Necessary primary and backup utility, communication, and fire safety systems must be available in the POS.

The PCS provider is responsible for the supervision of the PCS attendant as required by the PCS provider's licensure requirements.

Documentation of Services Provided/Retrospective Review

Documentation elements that are routinely assessed for compliance in retrospective review of client records include the following:

- All entries are legible to people other than the author, dated (month, day, year, time), and signed by the author.
- Each page of the record documents the client's name and Medicaid identification number.
- Client assessment time is documented at the beginning of each shift.
- All attendants' arrival/departure times are documented with signature and time in the narrative section of the attendants' notes.
- Entries are dated and timed every one to two hours.
- The type of assistance, time given, route or method used, client response, and other pertinent information must be provided.
- Documentation of services should correlate with and reflect medical necessity for the services provided on any given day.
- Client's arrival or departure from the home setting must be documented with the time of arrival, departure, mode of transportation, and who accompanied the client.

43.4.10.4 Benefits and Limitations

PCS are those services that assist eligible clients in performing ADLs, IADLs, and other health-related functions. The scope of ADLs, IADLs, and health-related functions includes a range of activities that healthy, non-disabled adults can perform for themselves. Typically, developing children gradually and sequentially acquire the ability to perform these ADLs, IADLs, and health-related functions for themselves. If a typically developing child of the same chronological age could not safely and independently perform an ADL, IADL, or health-related function without adult supervision, then the client's parent/guardian is responsible for insuring the client's needs for the ADLs, IADLs, and health-related functions are met.

PCS include direct intervention (assisting the client in performing a task) or indirect intervention (cueing the client to perform a task). ADLs, IADLs, and health-related functions include but are not limited to the following:

ADLs	IADLs	Health-Related Functions
Bathing	Accessing and utilizing health services	Exercise
Dressing	Application/ maintenance of prosthetics and orthotics	Medication administration and management
Eating	Communication	Range of motion
Grooming	Grocery/household shopping	Reporting as to the client's condition, including changes to the client's condition or needs and completing appropriate records
Maintaining continence	Light housework	Skin care - maintenance of the hygienic state of the client's skin under optimal conditions of cleanliness and comfort
Mobility	Laundry	Use of DME
Positioning	Meal preparation	
Transferring	Money management	
Toileting	Participation in age appropriate activities	
	Personal hygiene	
	Transportation*	

ADLs	IADLs	Health-Related Functions
* Transportation includes coordination for transportation to medical and other appointments and/or accompaniment to appointments. PCS does not include the payment for transportation or transportation vehicles since these services are available through the MTP.		

PCS do not include the following:

- ADLs, IADLs, or health-related functions that a typically developing child of the same chronological age could not safely and independently perform without adult supervision.
- Services that provide direct intervention when the client has the physical, behavioral, and cognitive abilities to perform an ADL, IADL, or health-related function without adult supervision.
- Services provided to an inpatient or a resident of a hospital, nursing facility, ICF-MR, or an institution for mental disease.
- Duplication of services provided by other programs.

Place of Services

PCS may be provided in the following settings if medically necessary:

- The client's home.
- The client's school.
- The client's daycare facility.
- Any community setting in which the client is located.

Note: *For claims filing purposes, the PCS provider must bill POS 2 (home) when submitting claims to TMHP.*

The Texas Medicaid Program does not reimburse for duplicate services.

The Texas Medicaid Program does not reimburse providers for PCS that duplicate services that are the legal responsibility of school districts. The school district, through the SHARS program, is required to meet the client's personal care needs while the client is at school. If those needs cannot be met by SHARS or the school district, the school district must submit documentation to the DSHS case manager indicating the school district is unable to provide all medically necessary services. When clients are receiving both PCS and PDN services from an individual person over the same span of time, the combined total number of hours for PCS and PDN are reimbursed according to the maximum allowable rate.

43.4.10.5 Client Eligibility

The PCS benefit is available to Texas Medicaid clients who:

- Are birth through 20 years of age.
- Are enrolled with the Texas Medicaid Program.
- Have physical, cognitive, or behavioral limitations related to a disability or chronic health condition that inhibits the client's ability to accomplish ADLs, IADLs, or health-related functions.

The following needs of a client's parent/guardian are considered when the client has met the above criteria:

- The parent/guardian's need to sleep, work, attend school, and meet his/her own medical needs.
- The parent/guardian's legal obligation to care for, support, and meet the medical, educational, and psychosocial needs of his/her other dependents.
- The parent/guardian's physical ability to perform the personal care services.

Clients enrolled in the following DADS Long Term Care (LTC) waiver programs are prohibited from accessing the PCS benefits that are administered by TMHP:

- Community Living Assistance and Support Services (CLASS).
- Deaf/Blind Multiple Disabilities (DBMD).
- Community-Based Alternatives (CBA).
- Consolidated Waiver Program (CWP).
- Home and Community Services (HCS).

Clients who are enrolled in STAR+PLUS receive the PCS benefit or personal attendant services through their STAR+PLUS health plan. Claims for these clients must be submitted to their STAR+PLUS health plans for payment consideration, not to TMHP. The STAR+PLUS health plans accept referrals and provide authorizations for eligible clients. The STAR+PLUS health plans process and reimburse personal attendant services claims for their clients who are 20 years of age or younger. DSHS does not assess or authorize PCS for STAR+PLUS-enrolled clients. TMHP does not process or authorize PCS for STAR+PLUS health plan clients.

TMHP processes and authorizes PCS for STAR waiver and PCCM clients. TMHP also processes and authorizes PCS for clients who are enrolled in the Medically Dependent Children Program (MDCP) waiver and the Texas Home Living program waiver (TxHmL) programs. If a STAR or PCCM client decides to participate in an LTC waiver program other than MDCP or TxHmL, the client is no longer eligible for the PCS benefit administered by TMHP.

Accessing the PCS Benefit

Clients must be referred to DSHS before receiving the PCS benefit. A referral can be made by any person who recognizes a client may have a need for PCS, including, but not limited to, the following:

- The client.
- A primary practitioner or primary care provider.
- A licensed health professional who has a therapeutic relationship with the client and ongoing clinical knowledge of the client.
- A family member.

Referrals to DSHS can be made to the appropriate DSHS Health Service Region, based on the client's place of residence in the state. Clients, parents, or guardians may also call the TMHP PCS Client Line at 1-888-276-0702 for more information on PCS. PCS providers should provide the DSHS and/or TMHP PCS Client Contact Line information to the client, parent, or guardian.

Upon receiving a referral, DSHS assigns the client a case manager, who then conducts an assessment in the client's home with the input and assistance of the client, parent, or guardian. Based on the assessment, the case manager identifies whether the client has a need for PCS. If the case manager identifies a need for PCS, the client, parent, or guardian is asked to select a Medicaid-enrolled PCS provider in their area. Client choices for PCS providers may include licensed home health agencies, consumer directed services agencies (CDSAs), SRO providers, or PAS-only providers.

Once a provider is selected, the DSHS case manager prior authorizes a quantity of PCS based on the assessment and requests TMHP to issue a PAN to the selected PCS provider. The PCS provider uses the PAN to submit claims to TMHP for the services provided. DSHS also contacts the client's primary practitioner (a licensed physician, APN, or PA) or primary care provider to obtain a statement of need.

The Primary Practitioner's Role in the PCS Benefit

A client accessing the PCS benefit must have a primary practitioner (a licensed physician, APN, or PA) or a primary care provider who has a therapeutic relationship and ongoing clinical knowledge of the client. The primary practitioner or primary care provider must have established a diagnosis for the client and must provide continuing care and medical supervision of the client. When the DSHS case manager has determined the client has a need for the PCS benefit, the case manager contacts the client's primary practitioner or primary care provider to obtain a Practitioner Statement of Need. The Statement of Need certifies the client has a physical, cognitive, or behavioral limitation related to a disability or chronic health condition and is birth through 20 years of age. The Statement of Need must be signed and dated by the primary practitioner or primary care provider within 60 days of the initial start of care (SOC). The primary practitioner or primary care provider must mail or fax the completed Statement of Need to the appropriate DSHS Health Services Region. DSHS keeps the signed and dated Statement of Need in the client's case management record for the duration of the client's participation in the benefit.

PCS Provided in Group Settings

PCS may be provided in a provider/client ratio other than one-to-one. PCS may be provided by more than one attendant to an individual client, or PCS may be provided to more than one client by one attendant. Settings in which providers can provide PCS in a provider/client ratio other than one-to-one include homes with more than one client needing PCS, foster homes, and independent living arrangements.

A PCS provider may be prior authorized to provide PCS to more than one client over the span of the day as long as:

- Each client's care is based on an individualized service plan.

- Each client's needs and service plans do not overlap with another client's needs and service plan.

43.4.10.6 Prior Authorization

All PCS must be prior authorized by a DSHS case manager based upon client need, as determined by the client assessment. DSHS prior authorizes PCS for eligible clients, including clients enrolled in PCCM. The DSHS case manager notifies TMHP of the authorized quantity of PCS. TMHP sends a notification letter with the PAN to the client, parent, or guardian and the selected PCS provider if PCS is approved or modified. Only the client, parent, or guardian receives a notification letter with an explanation of denied services. PCS is prior authorized for six-month periods. PCS providers must provide services from the start of care date agreed to by the client, parent, or guardian and the case manager during the client assessment.

When a client experiences a change in condition, the client, parent, or guardian must notify the DSHS Health Service Office in the client's region. A DSHS case manager must perform a new assessment and prior authorize any modifications in the quantity of PCS, based on the new assessment. TMHP issues a new PAN to the client, parent, or guardian and the selected PCS provider. If the change is made during a current six-month prior authorization period, the new prior authorization for the revised services starts a new six-month prior authorization period.

For continuing and ongoing PCS needs beyond the initial six-month prior authorization period, a DSHS case manager must conduct a new assessment and submit a new authorization request to TMHP. TMHP sends a notification letter updating the prior authorization to the client, parent, or guardian and the selected PCS provider.

Providers can call a toll-free PCS Provider Inquiry Line at 1-888-648-1517 for assistance with inquiries regarding the status of a PCS prior authorization. Providers should direct inquiries about other Medicaid services to the TMHP Contact Center at 1-800-925-9126. PCS providers should not contact the DSHS case managers or health service regions on behalf of clients, but should encourage the client, parent, or guardian to contact the appropriate DSHS Health Service Region with inquiries or concerns about the PCS assessment.

43.4.10.7 Claims Information

TMHP processes PCS claims. PCS providers must submit claims for services in an approved electronic claims format or on the appropriate claim form based on their provider type. Providers, other than home health agencies, enrolled as a PAS-only provider, a CDSA, or an SRO provider should file PCS claims using claim form CMS-1500. Home health agencies, including those enrolled as a CDSA, or an SRO provider, should file PCS claims using the UB-04 CMS-1450 claim form. TMHP does not supply the forms.

PCS is considered for reimbursement when providers use procedure code 1-T1019 in conjunction with the appropriate modifier listed in the table below. PCS provided by a home health agency or PAS-only provider, including PCS being provided under the SRO defined in the 40 TAC Part 1, Chapter 41, must be billed in 15-minute increments. PCS provided by a CDSA under the CDS option defined in 40 TAC Part 1, Chapter 41, must submit the attendant fee in 15-minute increments. CDSAs must bill the administration fee once per calendar month per client for any month in which the client receives PCS under the CDS option and regardless of the number of PCS units of service the client receives under the CDS option during the month. PCS claims are considered for reimbursement only when TMHP has issued a valid PAN to a PCS provider.

PCS Procedure Codes	
All PCS Providers* (except CDSA)	
Procedure Code	T1019
Modifier	U6
Increments	15 minutes
CDSA Under CDS Option*	
Procedure Code	T1019
Modifier	U7 (Attendant fee each 15 minutes)
	U8 (Administration fee once a month)
*** 40 TAC, Part 1, Chapter 41**	

When PCS is provided in a provider/client ratio other than one-to-one, only the time spent on direct PCS for each client may be billed. Total PCS billed for all clients cannot exceed the individual provider's total number of hours spent at the POS.

Example: *If the prior authorized PCS hours for Client A is 4 hours, Client B is 6 hours, and the actual time spent with both clients is 8 hours, the provider must bill for the actual one-on-one time spent with each client, not to exceed the client's prior authorized hours or total hours worked. It would be acceptable to bill 4 hours for Client A and 4 hours for Client B, or 3 hours for Client A and 5 hours for Client B. It would not be acceptable to bill 5 hours for Client A and 3 hours for Client B. It would be acceptable to bill 10 hours if the individual person actually spent 10 hours onsite providing prior authorized PCS split as 4 hours for Client A and 6 hours for Client B. A total of 10 hours cannot be billed if the individual person worked only 8 hours.*

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"CMS-1500 Claim Filing Instructions" on page 5-22 for claims completion instructions. Attach the invoice to the claim for any specialized equipment.

"UB-04 CMS-1450 Instruction Table" on page 5-32 for claims completion instructions.

43.4.11 Pharmacies (THSteps-CCP Only)

43.4.11.1 Enrollment

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

Pharmacy providers currently enrolled with VDP are also enrolled in THSteps-CCP with TMHP. This enrollment allows pharmacy providers to bill for those medications and supplies payable by Medicaid for clients younger than 21 years of age but *not* covered by VDP (e.g., some over-the-counter drugs, diapers, and disposable or expendable medical supplies). Pharmacy providers must continue to bill HHSC for drugs covered under VDP.

Direct questions about VDP to 1-800-435-4165.

Pharmacies that wish to supply disposable or expendable medical supplies or DME must be enrolled as DMEH providers and should obtain these items through the Home Health Services Unit.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 43-5 for more information about enrollment procedures.

"Texas Medicaid (Title XIX) Home Health Services" on page 24-1 for details about coverage through Texas Medicaid (Title XIX) Home Health Services.

43.4.11.2 Reimbursement

Providers of DME and expendable supplies are reimbursed for THSteps services in accordance with 1 TAC §355.8441. Pharmacies are reimbursed in accordance with 1 TAC § 355.8551.

Refer to: "Texas Medicaid Reimbursement" on page 2-1 for more information about reimbursement.

43.4.11.3 Eligibility

Providers must issue one month's supply of the required items at a time because client eligibility is determined monthly.

43.4.11.4 Benefits and Limitations

Expendable medical supplies and basic medical equipment are available under Texas Medicaid (Title XIX) Home Health Services. Some services may be provided under THSteps-CCP. Clients must be birth through 20 years of age and eligible for THSteps-CCP; the services must be medically necessary and have FFP available for them. THSteps-CCP eligibility ends on the day of the client's 21st birthday. If the client's Medicaid ID states "Emergency Care," "PE," or "QMB," the client is not eligible for THSteps or THSteps-CCP benefits.

Physician Signature

The physician's signature and date, required on a prescription and the appropriate request form, must be current to the service date of the request.

Physician prescriptions must be specific to the type of service requested.

Example: *If requesting incontinent supplies, the prescription must request specific incontinent supplies, not just supplies.*

Examples of expendable supplies include incontinent supplies and medical nutritional products for clients birth through 20 years of age.

Refer to: "Physician Signature" on page 43-37 for complete information about this requirement.

Incontinence Supplies for Clients Birth Through 3 Years of Age

Incontinence supplies for clients birth through 3 years of age are only available through THSteps-CCP.

Written prior authorization is required for diapers and all other related incontinence supplies (such as diaper wipes and underpads) for clients younger than 4 years of age. Providers must use the appropriate national procedure codes when billing for incontinent supplies for clients birth through 3 years of age.

Supplies that any guardian or caretaker would usually provide during the routine care of the client are *not* covered under THSteps-CCP. Examples include:

- Nutritional products traditionally used for infant feeding.
- Incontinence supplies, such as diapers (Diapers are considered usual for clients younger than 4 years of age. An exception may be made by written request for prior authorization based on specific medical criteria.).
- Lotions, soaps, powder, or aids for daily living.

Claims may be reduced because the *customary* limits have been exceeded. Providers may submit a prior authorization request for amounts over the *customary* limits if there is documentation that supports the medical necessity of such a request. If prior authorization is not given, the provider may appeal the claim.

A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

Medications, Vitamins, and Minerals

VDP reimburses for a large number of prescription and over-the-counter medications. See "Vendor Drug Program" on page E-1 for more information about VDP. Some prescription medications that are not payable through VDP may be paid to enrolled pharmacy providers through THSteps-CCP if the medications are determined to be medically necessary.

Not all medications covered by THSteps-CCP require prior authorization. For those medications that require prior authorization, submit complete documentation with each prior authorization request, including:

- A prescription by the physician with the name of the medication, dosage, frequency, duration, and route of administration.
- Documentation and diagnosis that supports the medical necessity of the requested medications.

Providers must use the appropriate national procedure code when billing for medications and vitamins through THSteps-CCP.

43.4.11.5 Claims Information

Pharmacy providers are not required to provide a diagnosis on the claim form.

Pharmacy providers must submit claims for services in an approved electronic claims format or on a CMS-1500 claim form from the vendor of their choice. TMHP does not supply the forms.

Claims for services that have been prior authorized must reflect the PAN in Block 23 of the CMS-1500 claim form or its equivalent.

Pharmacies using their VDP provider identifier should obtain prior authorization for prescription medications not paid through VDP. If a claim is submitted without a diagnosis, then a provider must attach documentation establishing medical necessity and a signed prescription from a physician (MD or DO). Electronic claims must have diagnosis code V7285 for the claim to be accepted.

A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

Triplicate Prescription Form

The State Pharmacy Board requires the use of the triplicate prescription form for Schedule II controlled substances. The pharmacy filling the prescription sends a copy of the form to the Texas Department of Public Safety. Completion of the form is not substantially different from writing a prescription.

Incidental Services

Medicaid payments to providers for covered services include incidental services such as completion of required forms. Because completion of the triplicate prescription form as required by the State Pharmacy Board is a requirement of doing business, it is not acceptable to charge Medicaid clients a fee for completing the form. Providers that charge Medicaid clients this fee are violating provisions of Medicaid regulations and are subject to administrative sanctions or actions.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"Pharmacy (THSteps-CCP Only)" on page D-25 for a claim form example.

"CMS-1500 Instruction Table" on page 5-25 for claims completion instructions. Attach the invoice for any specialized equipment to the claim.

43.4.12 Physical Therapists (THSteps-CCP Only)

43.4.12.1 Enrollment

HHSC allows enrollment of independently-practicing licensed PTs under THSteps-CCP.

The information in this section applies to THSteps-CCP services only. This section does not apply to CORFs. CORF information may be found in "Comprehensive Outpatient Rehabilitation Facilities (CORFs)/Outpatient Rehabilitation Facilities (ORFs)" on page 43-43.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 43-5 for more information about enrollment procedures.

"Physical Therapists/Independent Practitioners" on page 35-1 for acute services.

43.4.12.2 Reimbursement

PT services are reimbursed in accordance with 1 TAC §355.8441. The fee schedules for the services in this section are available on the TMHP website at www.tmhp.com/file library/file library/fee schedules.

Refer to: "Texas Medicaid Reimbursement" on page 2-1 for more information about reimbursement.

43.4.12.3 Benefits and Limitations

The following CPT codes should be used for billing PT services under THSteps-CCP. Not all codes are payable to all provider types.

Procedural modifiers are required for home health agencies billing for PT visits. Providers must use procedural modifier GP for PT.

THSteps-CCP is for Medicaid/THSteps-eligible clients birth through 20 years of age. THSteps-CCP eligibility ends on the day of the client's 21st birthday. If the client's Medicaid ID states "Emergency Care," "PE," or "QMB," the client is not eligible for THSteps or THSteps-CCP benefits. If the client is ineligible for Texas Medicaid (Title XIX) Home Health Services, these services may be provided under THSteps-CCP.

CPT Procedure Codes			
1-97001	1-97002	1-97012	1-97014
1-97016	1-97018	1-97022	1-97024
1-97026	1-97028	1-97032	1-97033
1-97034	1-97035	1-97036	1-97039
1-97110	1-97112	1-97113	1-97116
1-97139	1-97150	1-97530	1-97535
1-97537	1-97542	1-97750	1-97760
1-97761	1-97762	1-97799	

PT may be billed as POS 1 (office) or 2 (home) and may be authorized to be provided in the following locations: home of the client, home of the caregiver/guardian, client's daycare facility, or the client's school. Services provided to a client on school premises are only permitted when delivered before or after school hours. The only THSteps-CCP therapy that can be delivered in the client's school during regular school hours are those delivered by school districts as SHARS as POS 9.

A request for PT services may be prior authorized for no longer than six months duration. A new request must be submitted if therapy is required for a longer duration.

Typical sessions do not exceed one hour in length. Documentation supporting the need for longer sessions is required. No limitations exist to the number of sessions that may be provided per week; however, documentation supporting the medical necessity for the requested services is required.

Providers must use the procedure codes 1-97001 with a maximum fee of $140.00, 1-97002 with a maximum fee of $140.00, and 1-97535 with a maximum fee of $35.00 for services provided by an independently practicing PT for developmental therapies. Procedure code 1-97001 may be billed without prior authorization. Only a quantity of one is allowed for payment per six months per provider without prior authorization or written documentation of medical necessity. An evaluation should not be billed on the same day as a treatment. Procedure code 1-97002 may only be billed once per month per provider.

Prior Authorization, Documentation Requirements

Providers must use the "Request for Initial Outpatient Therapy (Form TP-1)" on page B-80 for an initial request accompanied by a PT evaluation and the "Request for Extension of Outpatient Therapy (2 Pages) (Form TP-2)" on page B-81 for an extension request. Home health agencies must include the GP modifier on the TP1 or TP2 form when requesting PT.

Prior authorization is a condition for reimbursement; it is *not* a guarantee of payment.

Prior authorization for PT services is required except for evaluation and re-evaluation. Submit appropriate documentation with the request for prior authorization or with each claim for consideration of reimbursement.

Clients receiving therapy services reimbursed by THSteps-CCP have chronic conditions that require ongoing medical supervision. To establish medical necessity, a physician's prescription and revised therapy treatment plan are needed at least every six months.

A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

The initial therapy treatment plan must include a TP-1 and the following:

- A signed and dated physician's prescription.
- A copy of the current evaluation, signed and dated by the therapist.
- The documented age of the client at the time of the evaluation.
- Documentation indicating the treatment goals, anticipated measurable progress toward goals, the prognosis, and the client's gross motor skills in years/months. Goals may include improving function, maintaining function, or slowing the deterioration of function.
- Description of specific therapy being prescribed.

To request an *extension of services*, the following documentation must be submitted:

- A TP-2 form, including a *current* physician signature and date.
- All documentation required in initial authorizations (except the TP-1 form).
- Documentation of all progress made from the beginning of the previous treatment period to the current service request date, including progress towards previous goals.
- Information that supports the client's capability of continued measurable progress.
- A proposed treatment plan for the requested extension dates with specific goals related to the client's individual needs. Therapy goals may include improving function, maintaining function, or slowing the deterioration of function.

Therapy may be extended beyond two years, but the following required documentation must be forwarded for review for authorization to be considered:

- All documentation required in initial authorizations (except the TP-1 form).
- A comprehensive team evaluation summarizing all prior treatment as well as all progress that was made during that time.
- A report from the case-managing physician indicating all progress that the client made toward all goals during all previous therapy sessions.

If a provider discontinues therapy with a client and a new provider begins therapy during an existing authorization period, submission of a new treatment plan and obtaining a new authorization are required, as well as documentation of the last therapy visit with the previous provider. A letter stating when therapy ended with the previous provider is sufficient.

Physician Signature

The physician's signature and date, required on a prescription and the "THSteps-CCP Prior Authorization Request Form" on page B-105, must be current to the service date of the request.

Physician prescriptions must be specific to the TOS requested.

Example: *If requesting PT, the prescription must request physical therapy, not just therapy.*

ECI Program Provisions

Because the state ECI program requires local ECI providers to follow quality assurance procedures and develop individualized family service plans for each client, THSteps-CCP does not require copies of therapy evaluations or periodic progress notes to be submitted with therapy claims. ECI providers should complete the "THSteps-CCP ECI Request for Initial/Renewal Outpatient Therapy" on page B-107, which must include a physician signature current for all dates of service. Physician prescriptions requirements as stated on the form must be followed by ECI providers. (Refer to THSteps-CCP—PT, OT, and SLP sections.) Prior authorization through the THSteps-CCP is encouraged to expedite claims processing or the form may be submitted with the claim.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

All providers should obtain the client's medical diagnosis supporting the need for therapy from the physician. Reflect this information on each claim submitted to TMHP using ICD-9-CM coding.

Refer to: "Physician Signature" on page 43-37 for complete information about this requirement.

"Request for Initial Outpatient Therapy (Form TP-1)" on page B-80.

43.4.12.4 Claims Information

Providers must submit claims for services provided by independently practicing licensed PTs in an approved electronic claims format or on a CMS-1500 claim form from the vendor of their choice. TMHP does not supply the forms.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing."CMS-1500 Instruction Table" on page 5-25 for claims completion instructions.

Important: *Attach the invoice to the claim for any specialized equipment.*

PT is only payable when provided in POS 1 (office) or 2 (home). Procedure codes 1-97001, 1-97110, 1-97150, and 1-97535 may only be billed with a quantity of 1. Claims for services that have been authorized must reflect the PAN in Block 23 of the CMS-1500 Claim Form or its electronic equivalent.

Refer to: "Physical Therapists (THSteps-CCP Only)" on page D-26.

43.4.13 Private Duty Nursing (PDN) THSteps-CCP Only

Medicaid clients birth through 20 years of age are entitled to all medically necessary PDN services and/or home health skilled nursing services. Nursing services are medically necessary under the following conditions:

- The requested services are nursing services as defined by the *Texas Nursing Practice Act* and its implementing regulations.
- The requested services correct or ameliorate the client's disability or physical or mental illness or condition. Nursing services correct or ameliorate the client's disability or physical or mental illness or condition when the services improve, maintain, or slow the deterioration of the client's heath status.
- There is no TPR financially responsible for the services.

Requests for nursing services must be submitted on the required Medicaid forms and include supporting documentation. The supporting documentation must:

- Clearly and consistently describe the client's current diagnosis, functional status, and condition.
- Consistently describe the treatment throughout the documentation.
- Provide a sufficient explanation as to how the requested nursing services correct or ameliorate the client's disability or physical or mental illness or condition.

Medically necessary nursing services are authorized either as PDN services or as home health skilled nursing services, depending on whether the client's nursing needs can be met on a per-visit basis.

"Parent/guardian" means the person(s) lawfully charged with the duty of taking care of the client, and includes biological parents, adoptive parents, foster parents, guardians, and individuals court-appointed as managing conservators. A parent/guardian of a minor client or the client's spouse is not eligible for Medicaid reimbursement for providing PDN services to the client.

43.4.13.1 Enrollment

LCHH services agencies may enroll to provide PDN under THSteps-CCP.

RNs and licensed vocational nurses (LVNs) may also enroll independently to provide PDN under THSteps-CCP.

Home health agencies must do all of the following:

- Comply with provider participation requirements for home health agencies that participate in the Texas Medicaid Program.
- Comply with mandatory reporting of suspected abuse and neglect of children or adults.
- Maintain written policies and procedures for obtaining consent for medical treatment for clients in the absence of the parent/guardian.
- Comply with all requirements in this manual and the *Texas Medicaid Bulletin*.

Independently-enrolled RNs and LVNs must be enrolled as providers in THSteps-CCP and comply with all of the following:

- The terms of the Texas Medicaid Provider Agreement.
- All state and federal regulations and rules relating to the Texas Medicaid Program.
- The requirements of this manual, including all updates and revisions published in the *Texas Medicaid Bulletin*, all handbooks, standards, and guidelines published by HHSC.

Independently-enrolled RNs and LVNs must also:

- Provide at least 30 days written notice to clients of their intent voluntarily to terminate services except in situations of potential threat to the nurse's personal safety.
- Comply with mandatory reporting of suspected abuse and neglect of children.
- Maintain written policies and procedures for obtaining consent for medical treatment for clients in the absence of the parent/guardian.

Independently-enrolled RNs must:

- Hold a current license from the Texas BON to practice as an RN.
- Agree to provide services in compliance with all applicable federal, state, and local laws and regulations, including the *Texas Nursing Practice Act*.
- Comply with accepted professional standards and principles of nursing practice.

Independently-enrolled LVNs must:

- Hold a current license from the Texas BON to practice as an LVN.
- Agree to provide services in compliance with all applicable federal, state, and local laws and regulations, including the *Texas Nursing Practice Act*.
- Comply with accepted standards and principles of vocational nursing practice.
- Be supervised by an RN once per month. The supervision must occur when the LVN is present and be documented in the client's medical record.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 43-5 for more information about enrollment procedures.

43.4.13.2 Reimbursement

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

43.4.13.3 Benefits and Limitations

PDN is a benefit for clients birth through 20 years of age and eligible for THSteps-CCP. THSteps-CCP eligibility ends on the day of the client's 21st birthday. If the client's Medicaid ID states "Emergency Care," "PE," or "QMB," the client is not eligible for THSteps or THSteps-CCP benefits.

PDN is nursing services, as described by the *Texas Nursing Practice Act* and its implementing regulations, for clients who meet medical necessity criteria and who require individualized, continuous, skilled care beyond the level of skilled nursing visits normally prior authorized under Texas Medicaid (Title XIX) Home Health Services skilled nursing (SN).

PDN must be ordered or prescribed by a physician and provided by an RN, an LVN, a licensed practical nurse (LPN), or through RN delegation to a qualified aide (an unlicensed person such as a home health aide (HHA), a medication aide, or a nurse aide as set out by the TAC.

Professional nursing provided by an RN, as defined in the *Texas Nursing Practice Act*, means the performance of an act that requires substantial specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of professional nursing. The

term *does not* include acts of medical diagnosis or the prescription of therapeutic or corrective measures. Professional nursing involves:

- The observation, assessment, intervention, evaluation, rehabilitation, care and counsel, or health teachings of a person who is ill, injured, infirm, or experiencing a change in normal health processes.
- The maintenance of health or prevention of illness.
- The administration of a medication or treatment as ordered by a physician, podiatrist, or dentist.
- The supervision of delegated nursing tasks or teaching of nursing.
- The administration, supervision, and evaluation of nursing practices, policies, and procedures.
- The performance of an act delegated by a physician.
- Development of the nursing care plan.

Vocational nursing, as defined in the *Texas Nursing Practice Act*, means a directed scope of nursing practice, including the performance of an act that requires specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of vocational nursing. The term *does not* include acts of medical diagnosis or the prescription of therapeutic or corrective measures. Vocational nursing involves:

- Collecting data and performing focused nursing assessments of the health status of an individual.
- Participating in the planning of the nursing care needs of an individual.
- Participating in the development and modification of the nursing care plan.
- Participating in health teaching and counseling to promote, attain, and maintain the optimum health level of an individual.
- Assisting in the evaluation of an individual's response to a nursing intervention and the identification of an individual's needs.
- Engaging in other acts that require education and training, as prescribed by board rules and policies, commensurate with the nurse's experience, continuing education, and demonstrated competency.

Professional and vocational nursing care consists of those services that must, under state law, be performed by an RN or LVN as defined by the *Texas Nursing Practice Act* §301.002. These services include observation, assessment, intervention, evaluation, rehabilitation, care and counseling, and health teaching and are further defined as nursing services in 42 CFR §§409.32, 409.33, and 409.44.

- In determining whether a service requires the skill of a licensed nurse, consideration must be given to the inherent complexity of the service, the condition of the client, and the accepted standards of medical and nursing practice.
- The fact that the nursing care can be, or is, taught to the client or to the client's family or friends does not negate the skilled aspect of the service when the service is performed by a nurse.
- If the service could be performed by the average nonmedical person, the absence of a competent person to perform it does not cause it to be a nursing service.
- If the nature of a service is such that it can safely and effectively be performed by the average nonmedical person without direct supervision of a licensed nurse, the services cannot be regarded as nursing care.
- Some services are classified as nursing care on the basis of complexity alone (e.g., intravenous and intramuscular injections or insertion of catheters), and if reasonable and necessary to the treatment of the client's illness or injury, would be covered on that basis. In some cases, however, the client's condition may cause a service that would ordinarily not be considered nursing care to be considered nursing care. This would occur when the client's condition is such that the service can be safely and effectively provided only by a nurse.
- A service that, by its nature, requires the skills of a nurse in order for it to be provided safely and effectively, continues to be a skilled service even if it is taught to the client, the client's family, or other caregivers.

Qualified aides who are employed by a home health agency may perform simple procedures as an extension of therapy or nursing services under the supervision of licensed providers.

Qualified aide services include the following:

- Obtaining and recording the client's vital signs (temperature, pulse, respirations, and blood pressure).
- Observation, reporting, and documentation of the client's status and the care or service furnished.
- Completing appropriate documentation.
- Assisting with nutrition and fluid intake.
- Reporting changes in the client's condition and needs.
- Assistance with medications that are ordinarily self-administered.
- Exercise.
- Ambulation.
- Range of motion.
- Positioning.
- Safe transfer.

PDN should prevent prolonged and/or frequent hospitalizations or institutionalization and provide cost-effective and quality care in the most appropriate, least restrictive environment. PDN provides direct nursing care and caregiver training and education. The training and education is intended to optimize client health status and outcomes and to promote family-centered, community-based care as a component of an array of service options.

A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply. THSteps-CCP is obligated to authorize all medically necessary PDN to promote independence and support the client living at home.

PDN cannot be authorized for the primary purpose of providing respite care, childcare, activities of daily living for the client, housekeeping services, or comprehensive case management beyond the service coordination required by the *Texas Nursing Practice Act*.

Supervision and Delegation

All LVNs must be supervised as required by the *Texas Nursing Practice Act*:

- Supervision is the process of directing, guiding, and influencing the outcome of an individual's performance of an activity.
- LVNs must have a licensed resource person (RN, APN, PA, or physician) whom they can reach by telephone or other similar means, but onsite supervision is not required.

RNs can delegate specific tasks, activities, and functions to unlicensed personnel, but such delegation requires supervision and the following as set out by the Texas BON:

- The clients must meet the medical necessity and eligibility requirements for PDN.
- A qualified aide performing skilled services must meet the requirements to provide each skilled service (e.g., Home Health Aide Certification, Medication Technician Certification, Certified Nurse Aide, etc.).
- A qualified aide is expected to maintain and work within the scope of his/her training or licensure during the entire course of the treatment he/she is providing for the client.
- A qualified aide performing as a certified nurse aide/certified medication aide may do additional skilled tasks as delegated by the supervising nurse but must abide by all the rules outlined in the TAC.

In addition to federal, state, and local rules and regulations regarding nurse delegation, RNs delegating to qualified personnel must:

- Make a supervisory visit to the client's residence at least once every two weeks when the qualified aide is providing skilled nursing care to the client.
- Make a supervisory visit to the client's residence at least once every two weeks when skilled nursing care and PT, OT, and/or ST are being provided by the qualified aide.
- Prepare written instructions for the qualified aide regarding the delegated services.
- Maintain written documentation of all supervisory visits in the client's record.

Note: *A supervisory visit is not to exceed more than one hour per individual visit.*

43.4.13.4 Criteria

Client Eligibility Criteria

To be eligible for PDN services, a client must meet all the following criteria:

- Be birth through 20 years of age and eligible for Medicaid and THSteps.

Note: *THSteps-CCP is available for Medicaid THSteps-eligible clients birth through 20 years of age. THSteps-CCP eligibility ends on the day of the client's 21st birthday. If the client's Medicaid ID states "Emergency Care," "PE," or "QMB," the client is not eligible for THSteps or THSteps-CCP benefits.*

- Meet medical necessity criteria for PDN.
- Have a primary physician who:
  - Provides a prescription for PDN.
  - Establishes a POC.
  - Provides a statement that PDN services are medically necessary.
  - Provides continuing medical care and supervision of the client, including, but not limited to, examination or treatment within 30 days (initial requests of PDN services) or examination or treatment that complies with the THSteps periodicity schedule or is within six months of the PDN extension SOC date, whichever is more frequent (for extensions of PDN services). This requirement may be waived based on review of the client's specific circumstances.
  - Provides specific written, dated orders for the client.
- Require care beyond the level of services provided under Texas Medicaid (Title XIX) Home Health Services.

Clients birth through 17 years of age must reside with an identified responsible adult who is either trained to provide nursing care or is capable of initiating an identified contingency plan when the scheduled private duty nurse or qualified aide is unexpectedly unavailable.

Retroactive Client Eligibility

Retroactive eligibility occurs when an individual has been approved for Medicaid coverage but has not yet been assigned a Medicaid client number at the time of service delivery.

To be reimbursed for any current services after the client's eligibility is on TMHP's eligibility file, a provider must obtain prior authorization from THSteps-CCP within three business days of the date eligibility is added to the TMHP system. This date is called the "add date." The request must be received by THSteps-CCP no later than 5 p.m., Central Time, on the third day to be considered received within three business days.

The provider is responsible for verifying eligibility. The provider is strongly recommended to access AIS or TMHP EDI frequently while providing services to the client. If services are discontinued before the client is added to TMHP's eligibility file, the agency must still obtain prior authorization within three business days and submit all claims within 95 days from the add date.

Medical Necessity

PDN is considered medically necessary when a client has a disability, physical or mental illness, or chronic condition and requires continuous, skillful observations, judgments, and interventions to correct or ameliorate his or her health status.

Refer to: 1 TAC §363.309 and the SSA §1905(a) for more information about the definition of medically necessary EPSDT services.

The following elements should always be addressed in documentation submitted for a request for PDN:

- Is dependent on technology to sustain life.
- Requires ongoing and frequent skilled interventions to maintain or improve health status, and the delayed skilled intervention is expected to result in any of the following conditions:
  - Deterioration of a chronic condition.
  - Risk of death.
  - Loss of function.
  - Imminent risk to health status due to medical fragility.

Place of Service (POS)

PDN authorizations are based on the need for skilled care in the client's home; however, these services may follow the client and may be provided in any of the following settings:

- Client's home.
- Nurse provider's home.
- Client's school.
- Client's daycare facility.

The POS must be able to support the client's health and safety needs. It must be adequate to accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies required by the client. Necessary primary and backup utilities, communication, fire, and safety systems must be available at all times.

Amount and Duration of PDN

The amount and duration of PDN should always be commensurate with the client's medical needs. Requests for services should reflect changes in the client's condition that affect the amount and duration of PDN.

A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

43.4.13.5 Prior Authorization

Prior Authorization Requirements

When a provider receives a referral for PDN, the provider must have an RN perform a nursing assessment of the client within the client's home environment. This assessment must be performed before seeking prior authorization for PDN, with any request for PDN recertification, or any request to modify PDN hours. The assessment must demonstrate the following:

- Medical necessity for PDN.
- Safety of providing care in the proposed setting.
- If birth through 17 years of age, the client resides with an identified responsible adult who is either trained to provide nursing care or is capable of initiating an identified contingency plan when the scheduled private duty nurse or qualified aide is unexpectedly unavailable.
  - An identified responsible adult is an individual 18 years of age or older who has agreed to accept the responsibility for a client's provision of food, shelter, clothing, education, nurturing, and supervision. Responsible adults include: biological parents, adoptive parents, foster parents, guardians, individuals court-appointed as managing conservators, and other family members by birth or marriage.
  - An identified contingency plan is a structured process, designed by the responsible adult and the PDN provider, by which a client will receive care when a scheduled private duty nurse or qualified aide is unexpectedly unavailable, and the responsible adult is unavailable, or is not trained, to provide the nursing care. The identified responsible adult must be able to initiate the contingency plan.
- The existing level of care and any additional health-care services including the following: SHARS, MDCP, PT, OT, ST, primary home care (PHC), and case management services.

Note: *Services provided under these programs do not prevent a client from obtaining all medically necessary services. Certain school services are provided to meet education needs, not medical needs. Records related to a client's* Individuals with Disabilities Education Act *(IDEA) services are confidential records that clients do not have to release or provide access to.*

When an RN completes a client assessment and identifies a medical necessity for ADLs or health-related functions to be provided by a nurse or by a qualified aide under the supervision of an RN, the scope of PDN services may include these ADLs or health-related functions.

Note: *THSteps-CCP does not review or authorize PDN based on partial or incomplete documentation.*

PDN must be prior authorized, and requests for PDN must be based on the current medical needs of the client.

The following criteria are considered for PDN prior authorization:

- The documentation submitted with the request is complete.
- The requested services are nursing services as defined by the *Texas Nursing Practice Act* and its implementing regulations.
- The explanation of the client's medical needs is sufficient to support a determination that the requested services correct or ameliorate the client's disability, physical or mental illness, or chronic condition.

- The client's nursing needs cannot be met on an intermittent or part-time basis through Texas Medicaid (Title XIX) Home Health Services skilled nursing services.
- There is no TPR financially responsible for the services.

Only those services that THSteps-CCP determines to meet the medical necessity criteria for PDN are reimbursed. Before THSteps-CCP determines the requested nursing services do not meet the criteria, the TMHP medical director contacts the treating physician to determine whether additional information or clarification can be provided that would allow for the prior authorization of the requested PDN. If the TMHP medical director is not successful in contacting the treating physician or cannot obtain additional information or clarification, the TMHP medical director makes a decision based on the available information.

Providers must obtain prior authorization within three calendar days of the SOC for services that have not been prior authorized. During the prior authorization process, providers are required to deliver the requested services from the SOC date. The SOC date is the date agreed to by the physician, the PDN provider, and the client or parent/guardian and is indicated on the submitted POC as the SOC date.

Note: *THSteps-CCP does not prior authorize an SOC date earlier than seven calendar days before contact with TMHP.*

Prior authorization is a condition for reimbursement, not a guarantee of payment.

Prior authorizations for more than 16 hours per day are not issued to a single, independently enrolled nurse.

Requests for prior authorizations of PDN should always be commensurate with the client's medical needs. Requests for services should reflect changes in the client's condition that affect the amount and duration of PDN.

The length of the prior authorization is determined on an individual basis and is based on the goals and timelines identified by the physician, provider, and client or parent/guardian. PDN is not prior authorized for more than six months at a time.

PDN is not prior authorized under any of the following conditions:

- The client does not meet medical necessity criteria.
- The client does not have a primary physician.
- The client is 21 years of age or older.
- The client's needs are within the scope of services available through Texas Medicaid (Title XIX) Home Health Services SN and/or home health agency services because the needs can be met on a part-time or intermittent basis.

Start of Care (SOC)

The SOC is the date that care is to begin, as agreed on by the family, the client's physician, and the provider, and as listed on the POC and the THSteps-CCP Prior Authorization Request Form. Providers are responsible for determining whether they can accept the client for services.

Once the provider accepts a client for service and accepts responsibility for providing PDN, the provider is required to deliver those services beginning with the SOC date. Providers are responsible for a safe transition of services when the authorization decision is a denial or a reduction of services. Providers are required to notify the physician and the client's family on receipt of an authorization, a denial, or a change in PDN.

Providers must submit complete documentation no later than three business days from an SOC date to obtain initial coverage for the SOC date.

Note: *Texas Medicaid (Title XIX) Home Health Services does not authorize a SOC date earlier than three business days before contact with TMHP.*

For PDN extensions, THSteps-CCP must receive complete documentation no later than 3 business days before the SOC date. It is recommended that extension requests be submitted up to 30 days before the current authorization ends.

During the prior authorization process for initial and extension requests, providers are required to deliver the requested services from the SOC date.

Prior Authorization of Initial Requests

Completed initial requests must be received and dated by THSteps-CCP within three business days of the SOC. The request must be received by THSteps-CCP no later than 5 p.m., Central Time, on the third day to be considered received within three business days. If a request is received more than three business days after the SOC, or after 5 p.m., Central Time, on the third day, authorization is given for dates of service beginning three business days before receipt of the completed request.

Example: *A provider begins PDN services on Monday, June 1. The completed request is received by THSteps-CCP on Friday, June 5. The authorization will start on Tuesday, June 2 (three business days before June 5). If the complete request had been received on Thursday, June 4, the authorization would have started on June 1, as requested.*

Initial requests for PDN generally are considered for up to 60 days of services.

Authorization for Revision of Current Services

Completed requests for revision of PDN hours during the current authorization period must be received by THSteps-CCP within three business days of the revised SOC. The request must be received by THSteps-CCP no later than 5 p.m., Central Time, on the third day to be considered received within three business days. If a request is received more than three business days after the revised SOC or after 5 p.m., Central Time, on the third day, authorization is given for dates of service beginning three business days before receipt of the completed request.

Revisions to a current certification must fall within the certification period. If the revision extends beyond the current certification period, new authorization documentation must be submitted to THSteps-CCP.

Example: *A provider begins PDN services on Monday, June 1. The client becomes ill on Friday, June 5, and requires increased skilled nursing intervention of a short*

duration. The completed revision request is received by THSteps-CCP on Thursday, June 11. The authorization will start on Monday, June 8 (three business days before June 11). If the complete request had been received on Wednesday, June 10, the revision authorization would have started on June 5, as requested.

Revision requests for PDN generally are considered for up to 60 days of services.

Recertifications of Authorizations

Completed extension requests must be received and dated by THSteps-CCP at least 7 calendar days before, but no more than 30 days before, the current authorization expiration date. The request must be received by THSteps-CCP no later than 5 p.m., Central Time, on the seventh day, to be considered received within 7 calendar days. If a request is received less than 7 calendar days before the current authorization expiration date, or after 5 p.m., Central Time, on the seventh day, authorization is given for dates of service beginning no sooner than 7 calendar days after the receipt of the completed request by THSteps-CCP.

Example: *A provider has a current prior authorization that expires on June 10. The completed request is received by THSteps-CCP on June 2, eight calendar days before the current authorization period ends. The authorization for extension will begin on June 11, as requested. If the completed request had been received on June 15, the prior authorization could not begin until June 12, instead of June 11, as requested.*

Recertification requests for PDN are considered for up to 60 days of services.

Extended Authorizations

THSteps-CCP accepts requests for extended authorizations for PDN. Extensions may be authorized for four or six months. The following criteria are required for extended authorization:

- The client has received PDN services for at least a year.
- The client's condition has been medically stable for at least six months.
- PDN requests and authorizations for the previous six months have been at the same level.
- No significant changes in the client's condition are anticipated.
- The client's parent/guardian, physician, and provider agree that an extended authorization is appropriate.

The extended authorization process involves the following:

- All required documentation for PDN services (including the Physician POC, the Nursing Care Addendum to POC, and the THSteps-CCP Prior Authorization Request Form) is submitted.
- Dates of service on the THSteps-CCP Prior Authorization Request Form covers four or six months as appropriate.
- A THSteps-CCP Prior Authorization Private Duty Nursing 4 or 6 Month Authorization is attached. This form must include all required information and signatures.
- The nursing care provider is responsible for ensuring that a new Physician POC is obtained every 60 days and maintained in the client's record. Providers should not submit interim POCs to THSteps-CCP unless requesting a revision.
- The nursing care provider should notify THSteps-CCP at any time during the authorization period if the client's condition and need for skilled nursing care significantly changes.
- The nursing care provider may request a revision from TMHP at any time during the authorization period if the client's condition requires it.
- All authorization timelines apply to extended authorizations also.

Refer to: "Nursing Addendum to Plan of Care (THSteps-CCP) (7 Pages)" on page B-57

"THSteps-CCP Prior Authorization Private Duty Nursing 4 or 6 Month Authorization" on page B-106.

Termination of Authorization

An authorization may be terminated when the:

- Client is no longer eligible for THSteps-CCP or Medicaid.
- Client no longer meets the medical necessity criteria for PDN.
- POS can no longer accommodate the client's health and safety.
- Client or parent/guardian refuses to comply with the service plan and compliance is necessary to assure the client's health and safety.

Client/Provider Notification

When PDN is approved as requested, the provider receives written notification. The provider is responsible for notifying the client/family and the physician of the authorized services.

THSteps-CCP notifies the client and provider in writing when the following instances occur:

- PDN is denied.
- PDN hours authorized are less than the hours requested on the POC.
- PDN hours are modified (e.g., hours are requested by the week but are authorized by the day).
- THSteps-CCP receives incomplete information from the provider.
- Dates of service authorized are different from those requested.
- The provider is responsible for notification and coordination with the physician and family.

Authorization Appeals

Providers may appeal denials or modifications of requested PDN with documentation to support the medical necessity of the requested PDN. A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply. Appeals must be submitted to

THSteps-CCP with complete documentation and any additional information within two weeks of the date on the decision letter. If changes are made to the authorization based on this documentation, THSteps-CCP goes back no more than three business days for initial or revision requests and no more than seven calendar days for extension requests when additional documentation is submitted.

The client or parent/guardian are notified of any denial or modification of requested services and are given information about how to appeal THSteps-CCP's decision.

43.4.13.6 Documentation

Documentation Details

Documentation forms have been designed to improve communication between providers and THSteps-CCP. The forms are available in English and Spanish.

All documentation must be submitted together, and requests are not reviewed until all documentation is received. If complete documentation is received at THSteps-CCP by 3 p.m., Central Time, a response is returned to the provider within one business day. Complete documentation for initial, revision, recertification, and extension requests for PDN authorizations include all of the following:

- "THSteps-CCP Prior Authorization Request Form" on page B-105.
- The physician's POC.
- "Nursing Addendum to Plan of Care (THSteps-CCP) (7 Pages)" on page B-57.

THSteps-CCP Prior Authorization Request Form

The THSteps-CCP Prior Authorization Request Form must be completed, signed, and dated by the physician. The physician must mark the Private Duty Nursing box documenting the stability of the client for PDN. All requested dates of service must be included.

Plan of Care (POC)

The POC must be recommended, signed, and dated by the client's primary physician. A POC must meet the standards outlined in the 42 CFR §484.18 related to the written POC. The primary physician must review and revise the POC, in consultation with the provider and the parent/guardian, for each prior authorization, or more frequently as the physician deems necessary or the client's situation changes.

Pursuant to 42 CFR §484.18, the POC must include the following elements:

- All pertinent diagnoses.
- Client's mental status.
- Types of services requested including amount, duration, and frequency.
- Medical equipment needed.
- Prognosis.
- Rehabilitation potential.
- Functional limitations.
- Activities permitted.
- Nutritional requirements.
- Medications, including dose, route, and frequency.
- Treatments, including amount, duration, and frequency.
- Safety measures needed.
- Instructions for a timely discharge from service, if appropriate.
- Date the client was last seen by the physician.
- Other medical orders.
- Start- and end-of-care dates.
- Identified responsible adult and/or identified contingency plan.

Note: *Coverage periods do not coincide necessarily with calendar weeks or months but, instead, cover a number of services to be scheduled between a start and end date that is assigned during the prior authorization period. A week covers from the day of the week on which the prior authorization period begins and continues for seven days. For example, if the prior authorization starts on a Thursday, the prior authorization week runs Thursday through Wednesday. The number of nursing hours authorized for a week must be contained in that prior authorization week. Hours billed in excess of those authorized for the PAN week are subject to recoupment.*

Nursing Addendum to Plan of Care (THSteps-CCP) Form

The Nursing Addendum to Plan of Care (THSteps-CCP) Form addresses PDN eligibility criteria, nursing care plan summary, health history summary, 24-hour schedule, and the rationale for the hours of PDN requested.

The following is a description of the nursing care plan summary:

- The nursing care summary is not a complete nursing care plan.
- Information must be client-focused and detailed.
- The *Problem List* must reflect the reasons that nursing services are needed. The problem list is not the nursing care plan. Providers should identify two-to-four current priority problems from their nursing care plan. The problem does not need to be stated as a nursing diagnosis. The problems listed should focus on the primary reasons that a licensed nurse is required to care for the client. Other attached documents *are not* accepted in lieu of this section.
- The *Goals* should relate directly to the problems listed and be client-specific and measurable. Goals may be short- or long-term; however, for many clients who receive PDN, the goals generally are long-term.
- The *Outcomes* are the effects of the provider's nursing interventions and must be measurable. Generally, these are more short-term than goals. For initial requests, list expected outcomes. Extension requests should note the results of nursing interventions.
- The *Progress* should be viewed as a "yardstick" or continuum on which progress toward goals is marked. Initial requests should state expected progress for the

authorization period. Extension requests should list the progress noted during the previous authorization period. It is recognized that all progress may not be positive.

- The addendum must summarize the client's health problems relating to the medical necessity for PDN.
- The addendum must clearly communicate a picture of the client's overall condition and nursing care needs.
- The summary of recent health history is imperative in determining whether the client's condition is stable or if new nursing care needs have been identified. This section gives the PDN provider an opportunity to describe the client's recent health problems, including acute episodes of illness, hospitalizations, injuries, etc. The summary should create a complete picture of the client's condition and nursing care needs. The summary may cover the previous 90 days, even though the authorization period is 60 days; however, the objective of the summary is to capture the client's recent health problems and current health priorities. This section should not be merely a list of events. This section is the place to indicate the frequency of nursing interventions if they are different from the physician's order on the POC, such as, the order may be for a procedure to be PRN (Pro Re Nata—"As Needed"), but it is actually being performed every two hours.
- The addendum must include the rationale for increasing, decreasing, or maintaining the level of PDN and must relate to the client's health problems and goals.
- The addendum must include the provider's plan to decrease hours or discharge from service (if appropriate).

The Client's 24-Hour Daily Schedule

All direct care services must be identified. It is understood that the schedule may change, as the client's needs change. THSteps-CCP does not have to be notified of changes in the schedule except as they occur when a PDN extension is requested.

Responsible Adult or Identified Contingency Plan Requirement

For clients birth through 17 years of age, the client must reside with an identified responsible adult who is either trained to provide nursing care or is capable of initiating an identified contingency plan when the scheduled private duty nurse or qualified aide is unexpectedly unavailable.

- An identified responsible adult is an individual 18 years of age or older who has agreed to accept the responsibility for a client's provision of food, shelter, clothing, education, nurturing, and supervision. Responsible adults include: biological parents, adoptive parents, foster parents, guardians, individuals court-appointed as managing conservators, and other family members by birth or marriage.
- An identified contingency plan is a structured process, designed by the responsible adult and the PDN provider, by which a client will receive care when a scheduled private duty nurse or qualified aide is unexpectedly unavailable, and the responsible adult is unavailable, or is not trained, to provide the nursing care. The identified responsible adult must be able to initiate the contingency plan.

The parent/guardian's signature must be on the form acknowledging:

- Information about THSteps-CCP PDN has been discussed and received.
- PDN may change or end based on a client's need for nursing care.
- PDN is not authorized for the primary purpose of providing respite, childcare, ADLs, or housekeeping.
- All requirements have been met before seeking prior authorization for PDN.
- The parent/guardian has participated in the development of the POC and the nursing care plan for the client.
- Emergency plans have been made and are part of the client's care plan.
- The client or parent/guardian agrees to follow the physician's POC.

Retrospective Review and Documentation of Services Provided

Documentation elements that are routinely assessed for compliance in retrospective review of client records include, but are not limited to, the required documentation noted above, as well as the following:

- All entries are legible to people other than the author, dated (month, day, year, time), and signed by the author.
- Each page of the record documents the client's name and Medicaid identification number.
- Client assessment time is documented at the beginning of each shift.
- All nurses' arrival/departure times are documented with signature and time in the narrative section of the nurses' notes.
- Entries are dated and timed every one-to-two hours.
- The name of the medication, dose, route, time given, client response, and other pertinent information must be provided when medication is administered.
- The name of treatment, time given, route or method used, client response, and other pertinent information must be provided when treatments are administered.
- The amount, type, times given, route or method used, client response, and other pertinent information must be provided when feedings are administered.
- The POC and documentation of services should correlate with and reflect medical necessity for the services provided on any given day.
- A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

- Client's arrival or departure from the home setting must be documented with the time of arrival, departure, mode of transportation, and who accompanied the client.
- Documentation of teaching the client or the client's parent/guardian should include the length of time, the subject of the teaching, the understanding of the subject matter by the person receiving the teaching, and other pertinent information.
- Supervisory visits must include specifics of the visit.
- If a client is receiving skilled nursing services through another program or service in addition to THSteps-CCP, such as MDCP, each provider's shift notes must designate specifically which type of service they are providing during that shift.

43.4.13.7 Claims Information

PCS providers must submit claims for services in an approved electronic claims format or on the appropriate claim form based on their provider type. Home health agencies must submit claims on the UB-04 CMS-1450 claim form. Independently enrolled nurses must submit claims on the CMS-1500 claim form. TMHP does not supply the forms.

Claims for PDN services should be submitted to TMHP as follows:

Procedure Code	Maximum Fee
Independently Enrolled RNs/LVNs	
1-T1000 with modifier TE	$5.94 per 15 minutes
1-T1000 with modifier TD	$8.68 per 15 minutes
1-T1004	$2.87 per 15 minutes
Home Health Agencies	
C-T1002	$11.28 per 15 minutes
C-T1003	$8.25 per 15 minutes
C-T1004	$2.87 per 15 minutes

Note: *Independently enrolled LVNs should use TE modifier, and independently enrolled RNs should use the TD modifier.*

Because of the nature of the service being provided, some billing situations are unique to PDN. These billing requirements are as follows:

- All hours worked on one day should be billed together, on one detail, even if they involve two shifts. For example, if Nurse A works 7 a.m. to 11 a.m. and then returns and works 7 p.m. to 11 p.m., services should be billed for eight hours (32 15-minute units) on one detail for that date of service.
- An individually-enrolled nurse will not be reimbursed for more than 16 hours of PDN services in one day.

PDN may be delivered in a provider/client ratio other than one-to-one. An RN/LVN/qualified aide may be prior authorized to provide PDN services to more than one client over the span of the day as long as each client's care is based on an individualized POC, and each client's needs and POC do not overlap with another client's needs and POC. Only the time spent on direct PDN for each client is reimbursed. Total PDN billed for all clients cannot exceed an individual provider's total number of hours at the POS.

A single nurse may be reimbursed for services to more than one client in a single setting when the following conditions are met:

- Hours for PDN for each client have been authorized through THSteps-CCP.
- Only the actual "hands-on" time spent with each client is billed for that client.
- The hours billed for each client does not exceed the total hours approved for that client and does not exceed the actual number of hours for which services were provided.

Example: *If the prior authorized PDN hours for Client A is 4 hours, Client B is 6 hours, and the actual time spent with both clients is 8 hours, the provider must bill for the actual one-on-one time spent with each client, not to exceed the client's prior authorized hours or total hours worked. It would be acceptable to bill 4 hours for Client A and 4 hours for Client B, or 3 hours for Client A and 5 hours for Client B. It would not be acceptable to bill 5 hours for Client A and 3 hours for Client B. It would be acceptable to bill 10 hours if the nurse actually spent 10 hours onsite providing prior authorized PDN services split as 4 hours for Client A and 6 hours for Client B. A total of 10 hours cannot be billed if the nurse worked only 8 hours.*

Settings in which a PDN provider may provide services in a provider-client ratio other than one-to-one include homes with more than one client receiving PDN, foster homes, and/or independent living arrangements.

For reimbursement purposes, PDN should always be submitted with POS 2 (home) regardless of the setting in which services are actually provided. PDN may be provided in any of the following settings:

- Client's home.
- Nurse provider's home.
- Client's school.
- Client's daycare facility.

Note: *PDN that duplicate services that are the legal responsibility of the school districts are not reimbursed. The school district, through the SHARS program, is required to meet the client's skilled nursing needs while the client is at school; however, if those needs cannot be met by SHARS or the school district, documentation supporting medical necessity may be submitted to the THSteps-CCP.*

A parent/guardian of a minor client or a client's spouse may not be reimbursed for PDN even if the parent/guardian is an enrolled provider or employed by an enrolled provider.

PDN is subject to retrospective review and possible recoupment when the medical record does not document that the provision of PDN is medically necessary based on the client's situation and needs. The PDN provider's record must explain all discrepancies between the service

hours approved and the service hours provided. For example, the parents released the provider from all responsibility for the service hours or the agency was not able to staff the service hours. The release of provider responsibility does not indicate the client does not have a medical need for the services during those time periods.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"CMS-1500 Claim Filing Instructions" on page 5-22 for claims completion instructions. Attach the invoice to the claim for any specialized equipment.

"UB-04 CMS-1450 Instruction Table" on page 5-32 for claims completion instructions.

"Reimbursement" on page 43-7 for more information about reimbursement.

43.4.14 Psychiatric Hospital/Facility (Freestanding) (THSteps-CCP Only)

43.4.14.1 Enrollment

To be eligible to participate in THSteps-CCP, a psychiatric hospital/facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), have a valid provider agreement with HHSC, and have completed the TMHP enrollment process. Facilities certified by Medicare must also meet the JCAHO accreditation requirements.

Freestanding psychiatric hospitals enrolled in Medicare may also receive payment for Medicare deductible and coinsurance amounts with the exception of clients 21 through 64 years of age. The information in this section is applicable to THSteps-CCP services only.

All providers of laboratory services must comply with the rules and regualtions of CLIA. Providers not complying with CLIA are not reimbursed for laboratory services.

Continuity of Hospital Eligibility Through Change of Ownership

Under procedures set forth by the CMS, Department of Health and Human Services, a change in ownership of a hospital does not terminate Medicare eligibility. Medicaid participation may be continued subject to the following requirements:

- Recertification as a Title XVIII (Medicare) hospital is obtained if applicable.
- A new Title XIX (Medicaid) agreement between the hospital and HHSC under new ownership is obtained.

Providers can obtain the Medicaid hospital participation agreement by contacting TMHP Provider Enrollment.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 43-5 for more information about enrollment procedures.

"Clinical Laboratory Improvement Amendments (CLIA)" on page 26-2 for information about CLIA requirements.

43.4.14.2 Reimbursement

Reimbursement for acute care inpatient psychiatric care provided by mental health facilities is made according to the *Tax Equity and Fiscal Responsibility Act* of 1982 (TEFRA) interim reimbursement principles (reasonable cost basis). A new provider is reimbursed initially at an 80-percent interim rate. At the time of a tentative or final cost settlement, the interim rate is adjusted to reflect the hospital's cost-to-charge ratio.

For more information on cost reports for their facility, providers should call Medicaid Audit at 1-512-506-6117.

Refer to: "Reimbursement" on page 43-7 for more information.

43.4.14.3 LoneSTAR Select 015 – Managed Care

LoneSTAR Select affects how hospitals are reimbursed for inpatient services provided to Medicaid clients not enrolled in one of the programs operated by HHSC.

Acute care hospitals providing inpatient services to Medicaid clients enrolled in a Medicaid Managed Care organization such as an HMO, a prepaid health plan, or PCCM model operated by HHSC, are reimbursed according to the agreement each hospital has with each Medicaid Managed Care health plan.

Inpatient services provided to Medicaid clients before their enrollment in a Medicaid Managed Care health plan are reimbursed according to one of the following:

- Agreement each contracted hospital has with LoneSTAR Select.
- Standard reimbursement methodologies usually in effect for the hospital, for noncontracted and exempt hospitals.

Inpatient services provided to Medicaid clients after the effective date of their enrollment in one of the Medicaid Managed Care health plans are reimbursed according to the agreement each hospital has with the Medicaid Managed Care health plan.

If a Medicaid client disenrolls from one of the Medicaid Managed Care health plans, the inpatient services provided after the disenrollment date are again reimbursed according to the agreement that the hospital has in effect with LoneSTAR Select or according to standard reimbursement methodologies in effect for noncontracted and exempt hospitals.

Outpatient Services

Day treatment or outpatient services are not a benefit for freestanding psychiatric hospitals under traditional Medicaid.

Provider Cost Reporting, Review

The method of determining reasonable cost is similar to that used by Title XVIII (Medicare). Hospitals must include inpatient costs in the cost reports submitted annually. One copy of the applicable CMS cost report form is to be prepared by the provider.

If a change of ownership or provider termination occurs, the cost report is due within 45 days after the date of the termination or change in ownership. Any request for an extension should be made on or before the cost report due date and sent to Medicaid Audit at the following address:

Texas Medicaid & Healthcare Partnership
Medicaid Audit
PO Box 200345
Austin, TX 78720-0345

Providers must file annual cost reports as follows:

- Provider submits one copy of the cost report to Medicaid Audit within five months of the end of the hospital's fiscal year (FY) along with any amount due to the Texas Medicaid Program.
- Medicaid Audit performs a desk review of the cost report and makes a tentative settlement with the hospital. A tentative settlement letter requests payment for any balance due to the Texas Medicaid Program or instructs TMHP to pay the amount due to the provider. Interim payment rates are changed at this time based on the cost report.
- Medicaid final settlement is made after a copy of all the following information is received from the provider or the Medicare intermediary:
  - Audited or settled without audit Medicare Cost Report.
  - Medicare Notice of Amount of Program Reimbursement.
  - Medicare Audit Adjustment Report, if applicable.
- Field audits are conducted when necessary.

Call Medicaid Audit at 1-512-514-3686 for more information.

Medicaid hospitals may request copies of their claim summaries for their cost reporting FY. The summaries for tentative settlements include three additional months of claim payments for the FY. The summaries for final settlements include ten additional months of claim payments for the FY. This is the same data used by Medicaid Audit to determine the tentative and final settlements and interim rates.

The Medicaid claim summary data is only generated once a month, and the logs are received by the 15th of the following month. Requests for tentative settlement logs should be submitted within 30 days after the fiscal year-end. Final settlement log requests should be submitted within nine months after the fiscal year-end.

Medicaid logs may be accessed through the provider's administrator account on the TMHP website at www.tmhp.com. Providers that do not have a provider administrator account can create an account on the TMHP website.

Providers may order paper copies of the Medicaid logs by calling 1-512-506-6117 or writing to the following address:

Texas Medicaid & Healthcare Partnership
Medicaid Audit
PO Box 200345
Austin, TX 78720-0345

Providers should allow 45 days for receipt of these logs.

43.4.14.4 Benefits and Limitations

Inpatient Services

Inpatient hospital services include medically necessary items and services ordinarily furnished by a Medicaid psychiatric hospital or by an approved out-of-state hospital under the direction of a psychiatrist for the care and treatment of inpatient clients.

The client must be Medicaid THSteps-eligible and birth through 20 years of age at the time of the service request and service delivery. If the client's Medicaid ID states "Emergency Care," "PE," or "QMB," the client is not eligible for THSteps or THSteps-CCP benefits.

The following conditions must apply:

- The client has a psychiatric condition that requires inpatient treatment.
- The inpatient treatment is directed by a psychiatrist.
- The inpatient treatment is provided in a nationally accredited freestanding psychiatric facility or state psychiatric hospital.
- The provider is enrolled in the Texas Medicaid Program.

Client services must be provided in the most appropriate setting and in a timely manner to meet the mental health needs of the client.

Supporting documentation (certification of need) must be documented in the individual client's record. This documentation must be maintained by each facility for a minimum of five years and be readily available for review whenever requested by HHSC or its designee.

When a client requires admission, or once the client becomes Medicaid-eligible while in the facility, a certification of need must be completed in the client's record within 14 days.

Prior authorization is required for inpatient psychiatric care.

A completed Psychiatric Inpatient Admission Form or Psychiatric Inpatient (Extended) Request Form prescribing the inpatient psychiatric services must be signed and dated by the admitting physician familiar with the client prior to requesting authorization. All signatures must be current, unaltered, original, and handwritten. Computerized or stamped signatures are not accepted. The completed Psychiatric Inpatient Admission Form or Psychiatric Inpatient Admission (Extended) Request Form must be maintained by the requesting provider and the prescribing physician. The original signature copy must be kept in the hospital's medical record for the client.

Documentation of medical necessity for inpatient psychiatric care must specifically address the following issues:

- Why the ambulatory care resources in the community cannot meet the treatment needs of the client.
- Why inpatient psychiatric treatment under the care of a psychiatrist is required to treat the acute episode of the client.
- How the services can reasonably be expected to improve the condition or prevent further regression of the client's condition in a proximate time period.

For initial inpatient admissions, the completed Psychiatric Inpatient Admission Form must be faxed no later than the date of the client's admission unless the admission is after 5 p.m. or on a holiday or a weekend. When the admission occurs after 5 p.m. or on a holiday or a weekend, the CCIP unit must receive the faxed request on the next business day following admission. If the admission occurs after 2 p.m., the provider should contact the CCIP unit by telephone and fax the Psychiatric Inpatient Admission Form to the CCIP unit on the following business day. To complete the prior authorization process, the provider must fax the completed Psychiatric Inpatient Admission Form to the CCIP prior authorization unit. To facilitate a determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including accurate documentation of medical necessity for the services requested.

For court-ordered admissions, a copy of the physician's certificate and all court-ordered commitment papers signed by the judge must be submitted with the psychiatric hospital inpatient form.

Initial admissions may be prior authorized for a maximum of five days based on Medicaid eligibility and documentation of medical necessity. All psychiatric admission requests for clients under 12 years of age are reviewed by a psychiatrist. Psychiatric admission requests for clients ages 12 through 20 are reviewed by a mental health professional. Any requests for psychiatric admissions that do not meet criteria for admission are referred to a psychiatrist for final determination.

Providers must submit a Psychiatric Inpatient (Extended) Request Form to the CCIP unit requesting prior authorization for a continuation of stay. Requests for a continuation of stay must be received on or before the last day authorized or denied. The provider is notified of the decision in writing via fax by the CCIP unit. If the date of the CCIP unit determination letter is on or after the last day authorized or denied, the request for continuation of stay is due by 5:00 p.m. of the next business day.

The Psychiatric Inpatient (Extended) Request Form must reflect the need for continued stay in relation to the original need for admission. Any change in the client's diagnosis must be noted on the request. Additional documentation or information supporting the need for continued stay may be attached to the form. Up to seven days may be authorized for an extension request.

Court-ordered services are not subject to the five-day admission limitation or the seven-day continued stay limitation. Court-ordered services include:

- Mental health commitments.
- Condition of probation (COP).

Medicaid Clinical Criteria for Inpatient Psychiatric Care For Clients

The client must have a valid Axis II, DSM-IV-TR diagnosis as the principle admitting diagnosis, and outpatient therapy or partial hospitalization must have been attempted and failed, or a psychiatrist must have documented reasons why an inpatient level of care is required. The client's Axis II diagnosis must also be included on the request for inpatient psychiatric treatment.

The client must meet at least one of the following criteria:

- The client is presently a danger to self, demonstrated by at least one of the following:
  - Recent suicide attempt or active suicidal threats with a deadly plan and an absence of appropriate supervision or structure to prevent suicide.
  - Recent self-mutilative behavior or active threats of same with likelihood of acting on the threat and an absence of appropriate supervision or structure to prevent self-mutilation (i.e., intentionally cutting/burning self).
  - Active hallucinations or delusions directing or likely to lead to serious self-harm or debilitating psychomotor agitation or retardation resulting in a significant inability to care for self.
  - Significant inability to comply with prescribed medical health regimens due to concurrent Axis I psychiatric illness and such failure to comply is potentially hazardous to the life of the client. A medical (Axis III) diagnosis must be treatable in a psychiatric setting.
- The client is a danger to others. This behavior should be attributable to the client's specific Axis I, DSM-IV-TR diagnosis and can be adequately treated only in a hospital setting. This danger is demonstrated by one of the following:
  - Recent life-threatening action or active homicidal threats of same with a deadly plan and availability of means to accomplish the plan with the likelihood of acting on the threat

  - Recent serious assaultive or sadistic behavior or active threats of same with the likelihood of acting on the threat and an absence of appropriate supervision or structure to prevent assaultive behavior
  - Active hallucinations or delusions directing or likely to lead to serious harm of others
- The client exhibits acute onset of psychosis or severe thought disorganization, or there is significant clinical deterioration in the condition of someone with a chronic psychosis rendering the client unmanageable and unable to cooperate in treatment, and the client is in need of assessment and treatment in a safe and therapeutic setting.
- The client has a severe eating or substance abuse disorder, which requires 24-hour-a-day medical observation, supervision, and intervention.
- The proposed treatment/therapy requires 24-hour-a-day medical observation, supervision, and intervention.
- The client exhibits severe disorientation to person, place, or time.
- The client's evaluation and treatment cannot be carried out safely or effectively in other settings due to severely disruptive behaviors, and other behaviors which may include physical, psychological, or sexual abuse.
- The client requires medication therapy or complex diagnostic evaluation where the client's level of functioning precludes cooperation with the treatment regimen.
- The client is involved in the legal system, manifests psychiatric symptoms, and is ordered by a court to undergo a comprehensive assessment in a hospital setting to clarify the diagnosis and treatment needs.

The proposed treatment/therapy plan must include all of the following:

- Active supervision by a psychiatrist with the appropriate credentials as determined by the Texas Medical Board and with documented specialized training, supervised experience, and demonstrated competence in the care and treatment of clients. Treatment/therapy plans should be guided by the standards of treatment specified by the Texas Society of Child and Adolescent Psychiatry.
- Implementation of individualized treatment plan.
- Provision of services that can reasonably be expected to improve the client's condition or prevent further regression so a lesser level of care can be implemented.
- Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a psychiatrist and is being provided in the least restrictive environment available. Ambulatory care resources available in the community do not meet the client's needs.

Continued Stays

Continued stays are considered when the client meets at least one of the criteria from above and a treatment/therapy regimen that includes all of the following:

- Active supervision by a psychiatrist.
- The treatment/therapy requires an inpatient level of care.
- Initial discharge plans have been formulated and actions have been taken toward implementation including documented contact with a local mental health provider.

Continued stays are considered for clients whose discharge plan does not include returning to their natural home if the party responsible for placement has provided the provider with three documented placement options for which the client meets admission criteria, but cannot accept the client. Up to five days may be authorized per request to allow alternative placement to be located. Up to three extensions may be authorized.

Authorization is a condition for reimbursement; it is not a guarantee of payment.

A toll-free telephone and fax line are available to complete the authorization process. Contact the TMHP CCIP Unit at 1-800-213-8877, or fax to 1-512-514-4211.

In Medicaid Managed Care Organizations, eligible clients must receive all medically necessary services. Authorization procedures and approved providers may differ for managed care clients. Contact the client's specific healthcare plan for details.

Prior Authorization and Denials

All prior authorization requests not submitted or received by the THSteps-CCIP in accordance with established policies are denied through the submission date, and claim payment is not made for the dates of service denied.

All denials may be appealed. THSteps-CCIP must receive these appeals within 15 days of the THSteps-CCIP denial notice. Appeals of a denial for an initial admission and/or a continued stay, must be accompanied by the documentation supporting medical necessity that the provider believes warrants reconsideration. Appeals of a denial for late submission of information, must be accompanied by documentation which the provider believes supports the compliance with HHSC claims submission guidelines. Appeals are reviewed first by an experienced psychiatric Licensed Clinical Social Worker (LCSW) or an RN to determine whether the required criteria is documented and then forwarded to a psychiatrist for final determination. The provider is notified of all denial determinations in writing via fax by THSteps-CCIP.

Utilization Review

All decisions on requests and/or appeals for admission or continuation of stay are responded to in writing and faxed to the provider by TMHP.

Utilization review activities of all Medicaid services provided by hospitals reimbursed under either the DRG prospective payment system or TEFRA are required by Title XIX of the SSA, Sections 1902 and 1903. The review activities are performed through a series of monitoring systems developed to ensure that services are appropriate to need and in the optimum quality and quantity. Clients and providers are subject to utilization review monitoring. The monitoring focuses on the appropriate screening activities, medical necessity of all services, and the quality of care reflected by the choice of services provided, type of provider involved, and settings in which care was delivered. This monitoring ensures cost-effective administration of the Texas Medicaid Program.

A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

Utilization review may also occur by an examination of particular claims or services not within the regular screening review when a specific utilization review is requested by HHSC or the Texas Attorney General's Office.

Retrospective Utilization Review

All admissions are subject to retrospective utilization review. The complete medical record is used to evaluate the medical necessity of admission, each day of continued inpatient care, and the quality of care provided.

Reminder: *Admissions and continued stays must be certified in accordance with 42 CFR §§441.150 through 441.182. Certification of need must be established and maintained as documentation for each Medicaid client. Each facility must maintain this documentation and make it readily available for review whenever requested by HHSC or its designee.*

For admissions of Medicaid-eligible clients or admission of clients who gain Medicaid eligibility while in the facility, the certification of need must be completed by the interdisciplinary team responsible for the POC within 14 days of admission.

Documentation of medical necessity for inpatient psychiatric care must specifically address the following issues:

- Why the ambulatory care resources in the community cannot meet the treatment needs of the client.
- Why inpatient psychiatric treatment under the care of a psychiatrist is required to treat the acute episode of the client.
- How the services can reasonably be expected to improve the condition or prevent further regression of the client's condition in a proximate time period.

A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

43.4.14.5 Claims Information

Submit inpatient psychiatric hospital services to TMHP in an approved electronic claims format or on a UB-04 CMS-1450 claim form. Providers must purchase the UB-04 CMS-1450 claim forms from the vendor of their choice. TMHP does not supply the forms.

The PAN must be identified in Block 63 of the UB-04 CMS-1450 or the appropriate field of the electronic form. Prior authorization is a condition for reimbursement; it is *not* a guarantee of payment.

Important: *Attach the invoice to the claim for any specialized equipment.*

Use of revenue code 124 is restricted to freestanding psychiatric and rehabilitation hospitals. Acute care hospital claims billing charges using revenue code 124 are manually changed to reflect the same charges using revenue code 120. TMHP must receive claims for payment consideration according to filing deadlines for inpatient claims.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"Psychiatric Hospital/Facility (THSteps-CCP Only)" on page D-27 for a claim form example.

"UB-04 CMS-1450 Instruction Table" on page 5-32 for claims completion instructions.

43.4.15 Rehabilitation Hospital (Freestanding) (THSteps-CCP Only)

Note: *Rehabilitation provided at an acute care facility is covered through traditional Medicaid.*

43.4.15.1 Enrollment

To be eligible to participate in THSteps-CCP, a freestanding rehabilitation hospital must be certified by Medicare, have a valid Provider Agreement with HHSC, and have completed the TMHP enrollment process. The Texas Medicaid Program enrolls and reimburses freestanding rehabilitation hospitals for THSteps-CCP services and Medicare deductible/coinsurance. The information in this section is applicable to THSteps-CCP services only.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas*

Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

Refer to: "Provider Enrollment" on page 43-5 for more information about enrollment procedures.

43.4.15.2 Continuity of Hospital Eligibility Through Change of Ownership

Under procedures set forth by the CMS and Department of Health and Human Services, a change in ownership of a hospital does not terminate Medicare eligibility; therefore, Medicaid participation may be continued subject to the following requirements:

- Recertification as a Title XVIII (Medicare) hospital is obtained.
- A new Title XIX (Medicaid) agreement between the hospital and HHSC under new ownership is obtained.

Providers can obtain the Medicaid hospital participation agreement by contacting TMHP Provider Enrollment.

43.4.15.3 Reimbursement

Inpatient

Reimbursement for care provided in the freestanding rehabilitation hospital is made under the Texas DRG Payment System.

A new provider is given a reimbursement interim rate of 50 percent until a cost audit has been performed. Payment is calculated by multiplying the standard dollar amount (SDA) for the hospital's payment division indicator times the relative weight associated with the DRG assigned by Grouper.

Important: *Outpatient services are not reimbursed.*

The DRG payment may be enhanced by an adjusted day or cost outlier payment, if applicable. For example, the limit per spell of illness under Texas Medicaid guidelines is waived for clients birth through 20 years of age. An outlier payment may be made to compensate for unusual resource utilization or lengthy stay.

The following criteria must be met to qualify for a day outlier payment. Inpatient days must exceed the DRG day threshold for the specific DRG. Additional payment is based on inpatient days that exceed the DRG day threshold multiplied by 70 percent of the per diem amount of a full DRG payment. The per diem amount is established by dividing the full DRG payment amount by the arithmetic mean length of stay for the DRG.

To establish a cost outlier, TMHP determines the outlier threshold by using the greater of the full DRG payment amount multiplied by 1.5 or an amount determined by selecting the lesser of the universe mean of the current base year data multiplied by 11.14 or the hospital's SDA multiplied by 11.14.

The calculation that yields the greater amount is used in calculating the actual cost outlier payment. The outlier threshold is subtracted from the amount of reimbursement for the admission established under the TEFRA principles and the remainder multiplied by 70 percent to determine the actual amount of the cost outlier payment.

If an admission qualifies for both a day and a cost outlier, the outlier resulting in the highest payment to the hospital is paid.

The Remittance and Status (R&S) report reflects the outlier reimbursement payment and defines the type of outlier paid, day or cost.

Providers should call the TMHP provider relations representative for their area with questions about the outlier payment.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

Client Transfers

When more than one hospital provides care for the same case, the hospital furnishing the most significant amount of care receives consideration for a full DRG payment.

The other hospital(s) is paid a per diem rate based on the lesser of the mean length of stay for the DRG or eligible days in the facility. The DRG modifier PT on the R&S report indicates per diem pricing related to a client transfer.

Client transfers within the same facility are considered one continuous stay and receive only one DRG payment. The facility must bill only one claim.

After all hospital claims have been submitted, TMHP performs a post-payment review to determine whether the hospital furnishing the most significant amount of care received the full DRG. If the review reveals that the hospital furnishing the most significant amount of care did not receive the full DRG, an adjustment is initiated.

Provider Cost Reporting, Review

The method of determining reasonable cost is similar to that used by Title XVIII (Medicare). Hospitals must include inpatient costs in the cost reports submitted annually. One copy of the applicable CMS cost report form is to be prepared by the provider.

If a change of ownership or provider termination occurs, the cost report is due within 45 days after the date of the termination or change in ownership. Any request for extension of time to file should be made on or before the cost report due date and sent to Medicaid Audit at the address indicated below.

Providers must file annual cost reports as follows:

- Provider submits one copy of the cost report to Medicaid Audit within three months of the end of the hospital's FY, along with any amount due to the Texas Medicaid Program.
- The Medicaid Audit Department performs a desk review of the cost report and makes tentative settlement with the hospital. A tentative settlement letter requests payment for any balance due to the Texas Medicaid

Program or instructs TMHP to pay the amount due to the provider. Interim payment rates are changed at this time, based on the cost report.

- Medicaid final settlement is made after a copy of all the following information is received from the provider or the Medicare intermediary: audited or settled without audit Medicare Cost Report, Medicare Notice of Amount of Program Reimbursement, and Medicare Audit Adjustment Report, if applicable.
- Field audits are conducted when necessary.

Providers can call Medicaid Audit at 1-512-514-3686 for more information.

Medicaid hospitals may request copies of their claim summaries for their cost reporting FY. The summaries for tentative settlements include two additional months of claim payments for the FY. The summaries for final settlements include ten additional months of claim payments for the FY. Medicaid Audit uses the same data to determine the tentative and final settlements and interim rates.

The Medicaid claim summary data is only generated once a month, and the logs are received by the 15th of the following month. Requests for tentative settlement logs should be submitted within 30 days after the fiscal year-end. Final settlement log requests should be submitted within one month after the fiscal year-end.

These Medicaid logs may be requested in paper copies by mailing a Medicaid Audit Request for Claims Summary to the following address:

Texas Medicaid & Healthcare Partnership
Medicaid Audit
PO Box 200345
Austin, TX 78720-0345

Providers should allow 45 days for receipt of these logs.

43.4.15.4 Benefits and Limitations

Inpatient Rehabilitation Hospital Services

Inpatient rehabilitation hospital services include medically necessary items and services ordinarily furnished by a Medicaid hospital or by an approved out-of-state hospital under the direction of a physician for the care and treatment of inpatient clients. Conditions requiring rehabilitation may be acute, have an exacerbation of a chronic condition, or have a chronic condition. A condition is considered to be acute or an exacerbation of a chronic condition only during the six months from the onset date of the acute condition or the exacerbation of the chronic condition. Requests for services beyond this time period may be considered on a case-by-case basis.

Prior authorization is mandatory. After receiving the documentation establishing the medical necessity and plan of medical care by the treating physician, prior authorization is considered by THSteps-CCP for both the initial service and an extension of service. A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

Requests for prior authorization of subsequent services are not to exceed 60 days. Requests for prior authorization of subsequent services must be received before the end-date of the preceding prior authorization.

The request for inpatient rehabilitation and the treatment plan must be signed and dated by the physician. All signatures must be original and handwritten. Computerized or stamped signatures are not accepted.

Providers should send THSteps-CCP prior authorization requests and any other THSteps-CCP correspondence to the following address:

Texas Medicaid & Healthcare Partnership
Comprehensive Care Program (CCP)
PO Box 200735
Austin, TX 78720-0735

All prior authorization documentation must be made a permanent part of the medical record.

Electronic billers also must submit the PAN on the claim. Electronic billers should consult their software vendor for the location of this field in their software.

Client

Prior authorization is considered for clients that meet the following criteria:

- Are birth through 20 years of age.
- Are THSteps-eligible at the time of service.
- Have an acute problem and/or acute deterioration of a chronic problem that would benefit from comprehensive treatment.
- Are expected to improve within a 60-day period and be restored to a more functional lifestyle for an acute condition or the previous level of function for an exacerbation of a chronic condition.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

Comprehensive Treatment

The intensity of necessary rehabilitative service cannot be provided in the outpatient setting.

Comprehensive treatment must be under the leadership of a physician.

Comprehensive treatment must be an active interdisciplinary team, defined as at least two types of therapies.

Comprehensive treatment must consist of at least two appropriate physical modalities designed to resolve or improve the client's condition (PT, OT, and speech language), and must be provided for a minimum of three hours per day for five days per week.

Goal

The goal is to return the client to a functional or more functional lifestyle in a reasonable period of time.

Length of Treatment

Initial authorization may be for up to two months. Additional increments may be given per recertification.

Termination of Treatment Authorization

The minimum requirements for termination of treatment authorization are as follows:

- Active progressive treatment plan is not aggressively pursued under the direction of a physician.
- Progress cannot be documented in a reasonable amount of time by the interdisciplinary team.
- A plateau is reached and additional progress cannot be documented or expected. Plateauing is defined as the point at which maximal improvement has been documented and continued improvement ceases.

Attending Physician Documentation

The minimum requirements provided by the medical request are as follows:

- The date of onset of the illness or injury requiring the rehabilitation admission.
- A brief synopsis of previous medical treatment, including outcomes of the treatment relative to the debilitating condition.
- The treatment plan to be followed in the inpatient rehabilitation hospital.
- The expected outcome to be achieved by the active treatment plan, and the time interval at which such an outcome should be obtained.
- Why outpatient PT, speech language, and/or OT does not meet client needs.
- That alternative treatment sites have been evaluated, and why they are inappropriate for the client needs.
- Whether the client has a reasonable expectation for meaningful improvement from the treatment plan that will restore the client to maximum expected function and/or achieve independent living capabilities in a reasonable period of time.

For an extension of prior authorization, discussion of why the initial two months of inpatient rehabilitation has not met the client's needs and why the client cannot be treated in an outpatient setting is required.

43.4.15.5 Claims Information

Providers must submit inpatient rehabilitation hospital services to TMHP in an approved electronic claims format or on a UB-04 CMS-1450 claim form. Providers must purchase the UB-04 CMS-1450 claim forms from the vendor of their choice. TMHP does not supply the forms.

Use of revenue code 124 is restricted to freestanding psychiatric and rehabilitation hospitals. Acute care hospital claims billing charges using revenue code 124 are manually changed to reflect the same charges using revenue code 120.

TMHP must receive claims for payment consideration according to filing deadlines for inpatient claims. Claims for services that have been authorized must reflect the PAN in Block 63 of the UB-04 CMS-1450 claim form or its electronic equivalent.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"Rehabilitation Hospital (THSteps-CCP Only)" on page D-29 for a claim form example.

"UB-04 CMS-1450 Claim Filing Instructions" on page 5-30 for claims completion instructions.

43.4.16 Speech-Language Pathologists (THSteps-CCP Only)

43.4.16.1 Enrollment

HHSC allows enrollment of independently-practicing licensed SLPs under THSteps-CCP. The Texas Medicaid Program enrolls and reimburses SLPs for THSteps-CCP services only. This section does not apply to CORFs.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 43-5 for more information about enrollment procedures.

43.4.16.2 Reimbursement

Speech-language services are reimbursed in accordance with 1 TAC §355.8441. The fee schedules for the services in this section are available on the TMHP website at www.tmhp.com/file library/file library/fee schedules.

Refer to: "Texas Medicaid Reimbursement" on page 2-1 for more information about reimbursement.

43.4.16.3 Benefits and Limitations

THSteps-CCP is for Medicaid/THSteps-eligible clients birth through 20 years of age. THSteps-CCP eligibility ends on the client's 21st birthday. If the client's Medicaid ID states "Emergency Care," "PE," or "QMB," the client is not eligible for THSteps or THSteps-CCP benefits.

ST may be billed as POS 1 or 2 and may be authorized to be provided in the following locations: home of the client, home of the caregiver/guardian, client's daycare facility, or the client's school. Services provided to a client on school premises are only permitted when delivered before or after school hours. The only THSteps-CCP therapy that can be delivered in the client's school during regular school hours are those delivered by school districts as SHARS as POS 9.

A request for ST services may be prior authorized for no longer than six months duration. A new request must be submitted if therapy is required for a longer duration.

Typical sessions do not exceed one hour in length. Documentation supporting the need for longer sessions is required. No limitations exist to the number of sessions that may be provided per week; however, documentation supporting the medical necessity for the requested services is required.

Speech-language services are benefits under THSteps-CCP when provided to clients experiencing speech-language difficulty because of a disability, ongoing health condition, or communication disorder such as a disease or trauma, developmental delay, oral motor problem, or congenital anomaly or other conditions requiring medically necessary speech-language services.

Providers must use the following procedure codes for services provided by an independently-practicing SLP for developmental therapies.

Procedure Codes			
1-92506	1-92507	1-92508	1-97535
1-92610	1-92626	1-92627	1-92630
1-92633	1-S9152		

Providers may use procedure code 1-92507 or 1-92508 for each half-hour session. If the claim does not state the amount of time spent on the session, a quantity of one is paid. Speech-lanuage pathology sessions are limited to one hour per day.

Procedure codes 1-92506, 1-92610, 1-92626, and 1-92627 may be billed without prior authorization. Only one is allowed for payment per six months per provider without prior authorization or written documentation of medical necessity. An evaluation should not be billed on the same day as treatment.

Procedure code 1-S9152 may only be billed once per month per provider.

Reimbursement for ST includes VitalStim therapy for dysphagia. The Texas Medicaid Program does not separately reimburse for VitalStim therapy for clients with dysphagia.

Refer to: "Speech-Language Therapy" on page 36-130.

43.4.16.4 Prior Authorization, Documentation Requirements

Providers must use the "Request for Initial Outpatient Therapy (Form TP-1)" on page B-80 for initial requests accompanied by the ST evaluation and the "Request for Extension of Outpatient Therapy (2 Pages) (Form TP-2)" on page B-81 for extension requests.

Prior authorization is a condition for reimbursement; it is *not* a guarantee of payment.

Prior authorization is required for speech-language therapy services except for evaluation and re-evaluation. Submit documentation with the request for prior authorization or with each claim for consideration of reimbursement.

Clients receiving therapy services reimbursed by THSteps-CCP must have chronic conditions that require ongoing medical supervision. To establish medical necessity, a physician prescription and revised therapy treatment plan are required at least every six months. A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

The initial therapy treatment plan must include a TP-1 and an initial therapy treatment plan. The initial therapy treatment plan must include the following:

- A signed and dated physician's prescription.
- A copy of the current evaluation, signed and dated by the therapist.
- The documented age of the client at the time of the evaluation.
- Documentation indicating the treatment goals, anticipated measurable progress toward goals, the prognosis, and the client's gross motor skills in years/months. Goals may include improving, maintaining, or slowing the deterioration of function.

To request an extension of services, the following documentation must be submitted:

- A TP-2 form, including a current physician's signature and date.
- All documentation required in initial authorizations (except the TP-1 form).
- Documentation of all progress made from the beginning of the previous treatment period to the current service request date, including progress towards previous goals.
- Information that supports the client's capability of continued measurable progress.
- A proposed treatment plan for the requested extension dates with specific goals related to the client's individual needs. Therapy goals may include improving, maintaining, or slowing the deterioration of function.

Therapy may be extended beyond two years, but the following required documentation must be forwarded for review for authorization to be considered:

- A TP-2 form.

- All documentation required in initial authorizations (except the TP-1 form).
- A comprehensive team evaluation summarizing all prior treatment as well as progress that was made during that time.
- A report from the case-managing physician indicating all progress that the client made toward all goals during all previous therapy sessions.

If a provider discontinues therapy with a client and a new provider begins therapy during an existing authorization period, submission of a new treatment plan and a new authorization is required, along with documentation of the last therapy visit with the previous provider. A letter from the guardian stating the date therapy ended with the previous provider is sufficient.

Physician Signature

The physician's signature, required on a prescription and the appropriate authorization request form, must be current to the service date of the request.

Refer to: "Physician Signature" on page 43-37 for complete information about this requirement.

43.4.16.5 Claims Information

Providers must submit claims for services provided by SLPs in an approved electronic claims format or on a CMS-1500 claim form from the vendor of their choice. TMHP does not supply the forms.

Claims for services that have been authorized must reflect the PAN in Block 23 for the CMS-1500 claim form or its electronic equivalent.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"Speech-Language Pathologists (THSteps-CCP Only)" on page D-33 for an example.

"CMS-1500 Claim Filing Instructions" on page 5-22 for claims completion instructions.

43.4.16.6 THSteps-CCP Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-22
CMS-1450 Claim Filing Instructions	5-30
TMHP Electronic Claims Submission	5-13
Communication Guide	A-1
Donor Human Milk Form Example	B-36
Psychiatric Hospital Inpatient Admission Form	B-76
Psychiatric Inpatient (Extended) Request Form	B-77
THSteps-CCP ECI Request for Initial/Renewal Outpatient Therapy	B-107
THSteps-CCP Prior Authorization Request (2 pages)	B-105
Wheelchair/Seating Evaluation Form (THSteps-CCP) (6 pages)	B-117
CORF (THSteps-CCP Only) Claim Form Example	D-10
Durable Medical Equipment (THSteps-CCP Only) Claim Form Example	D-12
ECI (THSteps-CCP Only) Claim Form Example	D-12
Licensed Dietitian (THSteps-CCP Only) Claim Form Example	D-20
Occupational Therapists (THSteps-CCP Only) Claim Form Example	D-24
Orthotic and Prosthetic Suppliers (THSteps-CCP Only) Claim Form Example	D-25
Pharmacy (THSteps-CCP Only) Claim Form Example	D-25
Physical Therapist (THSteps-CCP Only) Claim Form Example	D-26
Private Duty Nurses (THSteps-CCP Only) Claim Form Example	D-27
Psychiatric Hospital/Facility (THSteps-CCP Only) Claim Form Example	D-27
Rehabilitation Hospital (THSteps-CCP Only) Claim Form Example	D-29
Speech-Language Pathologists (THSteps-CCP Only) Claim Form Example	D-33
Acronym Dictionary	F-1

Section

44

Tuberculosis (TB) Clinics

44.1 Enrollment

To enroll in the Texas Medicaid Program, a TB clinic must be:

- A public entity operating under a HHSC tax identification number (TIN) (TB regional clinic); *or*
- A public entity operating under a non-HHSC TIN (city/county/local clinic); *or*
- A nonhospital-based entity for private providers.

Providers of TB-related clinic services must apply to the Department of State Health Services (DSHS) Infectious Disease Control Unit Tuberculosis Program (IDCU/TB). The following enrollment process must be followed:

- Providers must complete a provider application from IDCU/TB. Providers must have the facilities and resources available to provide all services required under the Texas Medicaid Program. Upon written notice of approval by IDCU/TB, Medicaid enrollment applications from the TMHP Provider Enrollment are sent to HHSC-approved providers of TB-related clinic services.
- Providers must complete a provider agreement from TMHP for enrollment in the Texas Medicaid Program. TMHP is responsible for issuing a group or individual nine-digit provider identifier. Providers that list additional (satellite) clinics in the IDCU/TB provider application will receive nine-digit performing provider identifiers for each off-site clinic. TB off-site clinics operating under the jurisdiction of the applying provider must use the assigned group provider identifier and their nine-digit performing provider identifier. Enrollment as a Medicaid provider is not complete until the TMHP enrollment packet has been finalized and a nine-digit provider identifier number is issued to the provider.

The effective date for participation is the date an approved provider application with *IDCU/TB* is established.

To receive a provider application form or provider supplement, send a request to the following address:

Texas Department of State Health Services
Infectious Disease Control Unit Tuberculosis Program
Mail Code 1939
1100 West 49th Street
Austin, TX 78756-3199

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures related to the TMHP Medicaid enrollment applications.

44.1.1 Managed Care Program Enrollment

TB clinics do not need to enroll with the Medicaid Managed Care health plans. All services provided by TB clinics are submitted to TMHP for all Medicaid clients, including Medicaid Managed Care clients.

44.2 Provider Responsibilities

If approved to bill as a TB clinic under the Texas Medicaid Program, the provider must adhere to the following requirements:

- Be a facility that is not an administrative, organizational, or financial part of a hospital, but is organized and operated to provide medical care to outpatients.
- Comply with all applicable federal, state, and local laws and regulations.
- Employ or have a contract or formal arrangement with a licensed physician (doctor of medicine [MD] or doctor of osteopathy [DO]) who is responsible for providing medical direction and supervision over all services provided to the clinic's clients. To meet this requirement, a physician must see the client at least once, prescribe the type of care provided and, if the services are not limited by the prescription, periodically review the need for continued care.
- Adhere to the guidelines issued by HHSC, under the authority of the *Texas Health and Safety Code*, and ensure that services are consistent with the recommendations of the American Thoracic Society and the Centers for Disease Control and Prevention (CDC). For more information, visit the website at www.cdc.gov /tb/pubs/mmwr/maj_guide.htm.
- Ensure that services provided to each client are commensurate with the client's medical needs based on the client's assessment/evaluation, diagnostic studies, plan of care, and physician direction. These services must be documented in the client's medical records.
- Be enrolled and approved for participation in the Texas Medicaid Program.
- Sign a written provider agreement with HHSC or its designee. By signing the agreement, the provider of TB-related clinic services agrees to comply with the terms of the agreement and all requirements of the Texas Medicaid Program including regulations, rules, handbooks, standards, and guidelines published by HHSC or its designee.

- Bill for services covered by the Texas Medicaid Program in the manner and format prescribed by HHSC or its designee.
- Be organized and operated to provide TB-related services, which include, but are not limited to, the covered services as indicated in "Benefits and Limitations" on page 44-3.
- Not provide services within a skilled nursing facility (SNF), intermediate care facility (ICF), or intermediate care facility for the mentally retarded (ICF-MR).

Refer to: "Provider Enrollment" on page 1-2 for more information.

44.3 Reimbursement

The Medicaid rates for TB clinics are calculated in accordance with 1 TAC §355.8341.

Chest X-rays are payable in addition to the encounter rate for TB clinic services because of the large variations in client needs and frequency of X-rays. The Medicaid rate for X-rays are calculated in accordance with 1 TAC §§355.8341 and 355.8085 and are listed in the current physician fee schedule, which is available on the TMHP website at www.tmhp.com/file library/file library /fee schedules. To request a hard copy, call the TMHP Contact Center at 1-800-925-9126.

Private providers of TB-related clinic services will receive the maximum allowable fee. Public providers of TB-related clinic services will only receive the federal matching rate of the maximum allowable fee in effect at the time of service. The federal matching rate is adjusted on October 1 of each year, or as otherwise directed by the Centers for Medicare & Medicaid Services (CMS).

Public providers of TB-related clinic services receive only the federal share of Medicaid payments. The nonfederal share of the Medicaid payments to public provider TB clinics are funded through certification of public expenditures (CPE). DSHS will certify for those public provider TB clinics that have a contract with IDCU/TB.

Refer to: "Reimbursement" on page 2-2 for more information.

44.4 Certification of Funds

As public providers of TB-related clinic services receiving only the federal share of Medicaid payments, public provider TB clinics fund the state/local (e.g., nonfederal) share through CPE.

The Certification of Funds letter is mailed by TMHP Provider Enrollment to DSHS at the end of each quarter of the federal fiscal year (FFY), which is October 1 through September 30. The letter requires certification of 100 percent of the Medicaid-allowable costs for the dates of services covered by payments received within the previous federal fiscal quarter (including the federal share, the total state/local share, and the total computable expenditure).

To assist in certifying the funds documented in the letter, the Certification of Funds Claims Information Report will be available for review upon receipt of the letter. The report will contain Texas Medicaid fee-for-service (FFS) (Program 100) and Texas Medicaid Primary Care Case Management (PCCM) (Program 200) claims on the same page sorted by paid date.

Refer to: "TMHP Provider Relations" on page xiii for more information about provider relations representatives.

The Certification of Funds letter must be:

- Signed by a DSHS business officer or other financial representative who is responsible for signing other documents that are subject to audit.
- Notarized.
- Returned to TMHP within 25 calendar days of the date printed on the letter.

Failure to do so may result in recoupment of funds or the placement of a vendor hold on the provider's payments until the signed Certification of Funds letter is received by TMHP. If the Certification of Funds letter was not received, contact TMHP Contact Center at 1-800-925-9126.

44.5 Benefits and Limitations

The level of service provided varies depending on whether the services are delivered by a nonphysician or physician and if medications are prescribed.

44.5.1 TB-Related Clinic Services and Procedure Codes

Providers may be required to demonstrate the ability to provide the full scope of services and documentation of service delivery methodology. The following services are covered for reimbursement.

44.5.1.1 Chest X-Rays Procedure Codes

The following table lists chest X-ray procedure codes:

Procedure Codes		
4-71010	4-71020	4-71021
4-71022	4-71035	

44.5.1.2 Classification System for TB

The current clinical classification system for TB is based on the pathogenesis of the disease. TB disease should be ruled in or out, within the standard 90 day period. Therefore, a client should not be a class 5 for more than 90 days (three months). Health-care providers should comply with state and local laws and regulations requiring the reporting of TB. All persons with class 3 or class 5 TB should be reported within one business day to the regional or local health department.

The following table lists the TB classifications:

TB Class	Description
Class 0—No TB exposure: not infected	No history of exposure; negative reaction to tuberculin skin test
Class 1—TB exposure: no evidence of infection	History of exposure; negative reaction to tuberculin skin test
Class 2—Latent TB infection (LTBI): no disease	Positive reaction to tuberculin skin test; negative bacteriologic studies (if done); no clinical, bacteriological, or radiographic evidence of active TB
Class 3—TB clinically active	M. tuberculosis cultured (if done); clinical, bacteriological, or radiographic evidence of current disease
Class 4—TB not clinically active	History of episode(s) of TB *or* Abnormal but stable radiographic findings Positive reaction to the tuberculin skin test Negative bacteriologic studies (if done) *and* No clinical or radiographic evidence of current disease
Class 5—TB suspected	Diagnosis is pending

44.5.1.3 Initial Examination and Procedure Codes

An initial examination should be performed by providers when any class of client is evaluated for the first time. A client can receive another initial examination six months (180 rolling days) from the previous one if there has been an interruption in therapy (such as reinitiation of treatment for clients lost to follow-up). Services may include, but are not limited to:

- Record initiation.
- Clinical assessment/diagnostic procedures.
- Counseling and education/preventive services.
- Physician consultation and evaluation.
- Prescribed medications/instruction.

The following table describes the procedure codes and modifiers to be billed for initial examinations:

Service	Client Class	Procedure Code/Modifier	Maximum Fee
Initial Exam Level 01: Nonphysician services only	1 or 2	D-99204 *with* modifier TF	$26.53
	3 or 5	D-99204 *with* modifier TG	$43.27
Initial Exam Level 06: Nonphysician and Physician services	1 or 2	D-99204 *with* modifiers TF *and* AM	$52.90
	3 or 5	D-99204 *with* modifiers TG *and* AM	$73.51
Initial Exam Level 07: Nonphysician and Physician services Prescribed Medications (Initial Treatment)	3 or 5	D-99205 *with* modifier TG	$253.99

Service	Client Class	Procedure Code/Modifier	Maximum Fee
Initial Exam Level 08: Nonphysician and Physician services Prescribed Medications (Preventive Treatment)	1 or 2	D-99205 *with* modifier TF	$54.10

Physician examination procedure codes may be used only when any class of client was initially evaluated without the consultation and evaluation of a physician. This examination cannot be billed if the provider billed for Level 06, 07, or 08 for the initial examination. Services may include, but are not limited to, the following:

- Record maintenance.
- Nonphysician assistance with evaluation.
- Physician consultation and evaluation.
- Prescribed medications/instruction.

Service	Client Class	Procedure Code/Modifier	Maximum Fee
Physician Exam Level 06: Nonphysician and Physician services	1 or 2	D-99201 *with* modifier TF	$37.48
	3 or 5	D-99201 *with* modifier TG	$38.51
Physician Exam Level 07: Nonphysician and Physician services Prescribed Medications (Initial Treatment)	3 or 5	D-99202 *with* modifier TG	$218.99
Physician Exam Level 08: Nonphysician and Physician services Prescribed Medications (Preventive Treatment)	1 or 2	D-99202 *with* modifier TF	$38.68

44.5.1.4 Follow-Up Examination

Use the follow-up examination only when any class of client is being evaluated during the course of treatment. This examination cannot be billed on the same day as any other examination (except directly observed therapy [DOT] or directly observed preventive therapy [DOPT]). Services may include, but are not limited to, record maintenance, clinical assessment and diagnostic procedures, nonphysician assistance with evaluation, and physician consultation and evaluation.

The following procedure codes and modifiers may be billed for follow-up examinations:

Service	Client Class	Procedure Code/Modifier	Maximum Fee
Follow-Up Exam Level 01: Nonphysician services only	1 or 2	D-99214 *with* modifier TF	$22.12
	3 or 5	D-99214 *with* modifier TG	$27.12
Follow-Up Exam Level 06: Nonphysician and Physician services	1 or 2	D-99214 *with* modifiers TF *and* AM	$46.37
	3 or 5	D-99214 *with* modifiers TG *and* AM	$51.50

44.5.1.5 Monthly Examination

Use the monthly examination only when any class of client is being evaluated for a routine monthly diagnostic examination. This examination may be reimbursed every 25 rolling days. This examination always includes a 30-day supply of medications regardless of level. Services may include, but are not limited to, record maintenance, clinical assessment and diagnostic procedures, nonphysician assistance with evaluation, physician consultation and evaluation, and prescribed medications/instructions.

The following procedure codes and modifiers may be billed for monthly examinations:

Service	Client Class	Procedure Code/Modifier	Maximum Fee
Monthly Exam Level 02: Nonphysician services Prescribed Medications (Initial Treatment)	3 or 5	D-99212 *with* modifier TG	$202.38
Monthly Exam Level 03: Nonphysician services Prescribed Medications (Preventive Treatment)	1 or 2	D-99212 *with* modifier TF	$13.54
Monthly Exam Level 04: Nonphysician services Prescribed Medications (Maintenance Treatment)	3 or 5	D-99213 *with* modifier TG	$44.30
Monthly Exam Level 05: Nonphysician services Prescribed Medications (Advanced Treatment)	3 or 5	D-99215 *with* modifier TG	$809.94
Monthly Exam Level 07: Nonphysician and Physician services Prescribed Medications (Initial Treatment)	3 or 5	D-99212 *with* modifier TG *and* AM	$212.27
Monthly Exam Level 08: Nonphysician and Physician services Prescribed Medications (Preventive Treatment)	1 or 2	D-99212 *with* modifiers TF *and* AM	$47.57
Monthly Exam Level 09: Nonphysician and Physician services Prescribed Medications (Maintenance Treatment)	3 or 5	D-99213 *with* modifiers TG *and* AM	$55.19
Monthly Exam Level 10: Nonphysician and Physician services Prescribed Medications (Advanced Treatment)	3 or 5	D-99215 *with* modifiers TG *and* AM	$819.83

44.5.1.6 DOT/DOPT Examination

Use the DOT/DOPT examination only when any class of client is DOT or DOPT in the clinic and other settings. This examination is the only type of examination that can be billed more than once per day. Services may include, but are not limited to, the following:

- Monitoring and maintenance—Record documentation of each and every DOT/DOPT dose observed and swallowed.
- Monitoring the reporting of the completion of drug therapy.
- Toxicity assessment for each DOT/DOPT dose observed.

The following procedure codes and modifiers may be billed for DOT/DOPT examinations:

Service	Client Class	Procedure Code/Modifier	Maximum Fee
DOT/DOPT Exam Level 01: Nonphysician services only	1 or 2	D-99211 *with* modifier TF	$9.69
	3 or 5	D-99211 *with* modifier TG	$15.77

44.5.1.7 Medication Levels

The medication levels vary according to length of regimen and number of medications per regimen. The following medication levels apply to specific examination types:

Level	Description
Initial	4-drug treatment for first two months (Level 02 and 07 only)
Preventive	2-drug treatment for preventive therapy (Level 03 and 08 only)
Maintenance	2-drug treatment for the remaining 4 months (Level 04 and 09 only)
Advanced	Multiple drug treatment for drug resistance clients (Level 05 and 10 only)

44.5.1.8 Diagnosis Codes

Diagnoses are used in conjunction with the corresponding TB400B classifications. Client classification 1 or 2 and modifier code TF use *International Classification of Diseases*, Ninth Revision, Clinical Modification (ICD-9-CM) codes 7955 or V011.

The following table lists the available diagnosis codes for Client Classification 3 or 5, and modifier code TG:

ICD-9-CM Code										
01010	01011	01012	01013	01014	01015	01016	01080	01081	01082	01083
01084	01085	01086	01090	01091	01092	01093	01094	01095	01096	01100
01101	01102	01103	01104	01105	01106	01110	01111	01112	01113	01114
01115	01116	01120	01121	01122	01123	01124	01125	01126	01130	01131
01132	01133	01134	01135	01136	01140	01141	01142	01143	01144	01145
01146	01150	01151	01152	01153	01154	01155	01156	01160	01161	01162
01163	01164	01165	01166	01170	01171	01172	01173	01174	01175	01176
01180	01181	01182	01183	01184	01185	01186	01190	01191	01192	01193
01194	01195	01196	01200	01201	01202	01203	01204	01205	01206	01210
01211	01212	01213	01214	01215	01216	01220	01221	01222	01223	01224
01225	01226	01230	01231	01232	01233	01234	01235	01236	01280	01281
01282	01283	01284	01285	01286	01300	01301	01302	01303	01304	01305
01306	01310	01311	01312	01313	01314	01315	01316	01320	01321	01322
01323	01324	01325	01326	01330	01331	01332	01333	01334	01335	01336
01340	01341	01342	01343	01344	01345	01346	01350	01351	01352	01353
01354	01355	01356	01360	01361	01362	01363	01364	01365	01366	01380
01381	01382	01383	01384	01385	01386	01390	01391	01392	01393	01394
01395	01396	01400	01401	01402	01403	01404	01405	01406	01480	01481
01482	01483	01484	01485	01486	01500	01501	01502	01503	01504	01505
01506	01510	01511	01512	01513	01514	01515	01516	01520	01521	01522
01523	01524	01525	01526	01550	01551	01552	01553	01554	01555	01556
01560	01561	01562	01563	01564	01565	01566	01570	01571	01572	01573
01574	01575	01576	01580	01581	01582	01583	01584	01585	01586	01590

ICD-9-CM Code										
01591	01592	01593	01594	01595	01596	01600	01601	01602	01603	01604
01605	01606	01610	01611	01612	01613	01614	01615	01616	01620	01621
01622	01623	01624	01625	01626	01630	01631	01632	01633	01634	01635
01636	01640	01641	01642	01643	01644	01645	01646	01650	01651	01652
01653	01654	01655	01656	01660	01661	01662	01663	01664	01665	01666
01670	01671	01672	01673	01674	01675	01676	01690	01691	01692	01693
01694	01695	01696	01700	01701	01702	01703	01704	01705	01706	01710
01711	01712	01713	01714	01715	01716	01720	01721	01722	01723	01724
01725	01726	01730	01731	01732	01733	01734	01735	01736	01740	01741
01742	01743	01744	01745	01746	01750	01751	01752	01753	01754	01755
01756	01760	01761	01762	01763	01764	01765	01766	01770	01771	01772
01773	01774	01775	01776	01780	01781	01782	01783	01784	01785	01786
01790	01791	01792	01793	01794	01795	01796	01800	01801	01802	01803
01804	01805	01806	01880	01881	01882	01883	01884	01885	01886	01890
V712										

44.5.1.9 Place of Service (POS)

The POS identifies where services are performed. Providers of TB-related clinic services should only use POS 1 (office).

44.6 Claims Information

All TB-related clinic services must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 paper claim form from the vendor of their choice. TMHP does not supply them.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"CMS-1500 Claim Filing Instructions" on page 5-22. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

44.6.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-22
TMHP Electronic Claims Submission	5-13
Communication Guide	A-1
Tuberculosis (TB) Screening and Education Tool	C-74
Tuberculosis (TB) Claim Form Example	D-35
Acronym Dictionary	F-1

Section

45

Vision Care (Optometrists, Opticians)

45.1 Enrollment

To enroll in the Texas Medicaid Program, optometrists (doctors of optometry [ODs]) must be licensed by the licensing board of their profession to practice in the state where the service is performed, at the time the service is performed, and be enrolled as Medicare providers.

An optometrist cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Ophthalmology" on page 36-91.

"Provider Enrollment" on page 1-2 for more information about enrollment procedures.

45.1.1 Medicaid Managed Care Enrollment

Vision aid providers must enroll with Medicaid Managed Care to be reimbursed for services provided to Medicaid Managed Care clients.

45.2 Reimbursement

Professional services by an optometrist for contact lenses and prosthetic eyewear are reimbursed in accordance with 1 TAC, §§355.8001, 355.8081, and 355.8085.

Fee schedules for services in this chapter are available on the TMHP website at www.tmhp.com/file library /file library/fee schedules. Federally qualified health centers (FQHCs) are paid an all-inclusive rate per visit for payable services. Specific procedure codes that meet the definition of a payable visit are marked with a "†."

Suppliers of nonprosthetic lenses and frames are reimbursed the lesser of their billed amount or of the established maximum allowable fee.

Optometrist services provided in a skilled nursing facility (SNF) or intermediate care facility for the mentally retarded (ICF-MR) may be reimbursed by the Texas Medicaid Program if the client's attending physician has ordered the service and the order is included in the client's medical records at the facility.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

Vision Claim Form Example on page D-36

"Nonprosthetic Eyeglasses and Contacts" on page 45-10

45.3 Provider Responsibilities

Suppliers of eyewear must comply with all Medicaid provider responsibilities and adhere to the following guidelines:

- Do not delay the ordering of eyewear or the dispensing of eyeglasses to the client while payment is pending from TMHP.
- Deliver the eyewear in a reasonable amount of time (usually two or three weeks from the date the order is placed by the client).
- Obtain the required eligibility information from the client's Medicaid Identification Form (Form H3087).
- Refer to the Eyeglasses column of the Medicaid Identification Form (Form H3087) to determine whether eyeglasses have been dispensed at Medicaid's expense within the last 24 months. Providers are advised to ask clients if they have recently received vision care services that may not appear on the Medicaid Identification Form (Form H3087) because of the monthly lag in updating form information.
- Update the Eyeglasses column of the Medicaid Identification Form (Form H3087) to indicate that eyewear was dispensed. Initial, date, and mark the form to indicate that the service was performed. Temporary cataract lenses or glasses are payable during the four-month convalescent period even if the Medicaid Identification Form (Form H3087) does not have a check mark (✓) under the Eyeglasses column. However, the Medicaid Identification Form (Form H3087) must not have a check mark under the Eyeglasses column if nonprosthetic eyeglasses are to be obtained for use in conjunction with cataract contact lenses.
- Have the client sign and date the Vision Care Eyeglass Patient Certification Form and retain it in the providers' records if the client selects eyewear that is not covered or eyewear is lost or destroyed.
- Have the client, parents, or guardian sign and date the Vision Care Eyeglass Patient Certification Form and retain in their records.
- Do not charge a Medicaid client more than a patient not enrolled in Medicaid for noncovered services (e.g., tints, oversized lenses, or frames).
- Keep invoices on file for a minimum of five years.
- Submit claims using the date eyeglasses were ordered as the date of service (DOS) (the start of the 95-day filing period), not the date the eyewear was dispensed.

45.4 Benefits and Limitations

45.4.1 Eye Examinations

The Texas Medicaid Program reimburses optometrists for eye examinations with refractions for diagnoses of refractive error, aphakia, and disease or injury of the eye.

45.4.1.1 Refractive Errors

Procedure codes 1-S0620 and 1-S0621 are payable to optometrists when the diagnosis is refractive error.

Procedure code 1-S0620 or 1-S0621 is to be used by optometrists when billing for a Medicaid-only client and consists of preliminary diagnosis; analysis and complete diagnosis; and prescription and treatment.

Claims for eye examination services require a diagnosis. If eyeglasses are not prescribed, diagnosis code V720 may be used. V720 must not be used on claims for eyewear. If the diagnosis is not known by the supplier of the eyewear, diagnosis code 3689 is acceptable. Claims for eye examinations that lack a diagnosis are listed as an incomplete claim on the Remittance and Status (R&S) report and must be resubmitted for payment consideration. Electronic claims that lack a diagnosis will be rejected. A letter with the reason for rejection and instructions for resubmission will be mailed the following business day.

Procedure codes 1-S0620† and 1-S0621 are limited to the following diagnosis codes:

Diagnosis Codes				
36203	36204	36205	36206	36207
3670	3671	36720	36721	36722
36731	36732	3674	36751	36752
36753	36781	36789	3679	37182
V720				

45.4.2 Eye Examinations for the Purpose of Prescribing Eyewear

Refer to the Eye Exam column of the client's current Medicaid Identification Form (Form H3087) to determine if the client is eligible for an eye examination. Clients are eligible for new eyewear whenever there is a diopter change of 0.5 or more (old and new prescription must appear on the claim).

Clients 20 years of age and younger are eligible for one examination with refraction for the purpose of obtaining eyewear during each state fiscal year (SFY) (September 1 to August 31, vision care annual periodicity schedule).

The eye exam limitation can be exceeded for clients younger than 21 years of age, but only in the following situations:

- A school nurse, teacher, or parent requests the eye examination (identify this information in Block 9 of the CMS-1500 claim form) if medically necessary.
- Medically necessary (identify this information in Block 19 of the CMS-1500 claim form).

Clients 21 years of age and older are eligible for one examination with refraction for the purpose of obtaining eyewear every 24 months.

A new patient eye examination will be limited to one every 24 months, per client, per provider. A new patient eye examination in any place of service (POS) will be denied if the history shows that the same provider has furnished a medical service (type of service [TOS] 1), a surgical service (TOS 2), or a consult (TOS 3) within two years. Services billed as new patient eye exams, procedure codes 1-92002 or 1-92004, in excess of this limitation will be denied.

Eye examinations for aphakia and disease or injury to the eye are not subject to any of the limitations listed above and are payable even if the Medicaid Identification Form (Form H3087) does not have a check mark (✓) under the Eye Exam column.

Vision care services performed in SNF or ICF-MR must be ordered by the attending physician. Providers must document the physician's name and address or provider identifier in Block 17 of the CMS-1500 claim form. Claims submitted without this information are listed on the R&S as incomplete and must be corrected and resubmitted for consideration of payment. Electronic claims of this nature will be rejected. Attending physician information for electronic claims must be noted in the appropriate field of an approved electronic claims format.

If an office evaluation and management service or consultation is billed in addition to the eye exam, the evaluation and management service or consultation will be denied as part of the eye exam.

The following services are considered part of the office visit/eye examination reimbursement when performed on the same day:

Procedure Codes			
1-92015†	1-92020†	1-92060†	1-92100†

† = Services payable to an FQHC based on an all-inclusive rate per visit.

Note: *Procedure code 1-92015 may be considered separately for reimbursement if it is used to bill the Texas Medicaid Program for the refractive portion of an examination of clients who are eligible for both Medicare and Medicaid.*

The following services may be billed in addition to an office visit/eye examination:

Procedure Codes			
1-92018	1-92019	1-92025	1-92081†
1-92082†	1-92083*†	1-92120†	1-92135
1-92140†			

*** Procedure codes that are considered bilateral.**

† = Services payable to an FQHC based on an all-inclusive rate per visit.

Orthoptic and/or pleoptics training is considered part of the office visit, and is not separately payable.

Office visits/eye examinations will be denied if billed with any of the following ophthalmology services on the same day:

Procedure Codes		
1-92225†	1-92226†	1-92230†
1-92235†	1-92240†	1-92250*†
1-92260*†	1-92265*†	1-92270*†
1-92275*†	1-92285*†	1-92286*†
1-92287*†	5/I/T-95930†	

*** Procedure codes that are considered bilateral.**
† = Services payable to an FQHC based on an all-inclusive rate per visit.

In accordance with the *Omnibus Budget Reconciliation Act (OBRA) of 1986,* Section 9336, an optometrist is considered a physician, with respect to the provision of any item or service the optometrist is authorized to perform by state law or regulation. Services by an optometrist are not limited to procedure codes 1-S0620 and 1-S0621.

The following procedure codes are payable to optometrists when accompanied by an appropriate diagnosis:

Procedure Codes			
2-65205	2-65210	2-65220	2-65222
2-65286	2-65430	2-67820	2-67938
2-68530	2-68761	2-68801	2-68810
2-68840	E-92002	E-92004	E-92012
E-92014	1-92015	1-92020	1-92025
1-92060	1-92065	1-92081	1-92082
1-92083	1-92100	1-92120	1-92135
1-92140	1-92225	1-92226	1-92230
1-92235	1-92240	1-92250	1-92260
1-92265	1-92270	1-92275	1-92285
1-92286	1-92287	9-92326	1-95060†
5/I-95933†	1-99000	1-99050	1-99056
1-S0620	1-S0621		

† = Services payable to an FQHC based on an all-inclusive rate per visit.

Evaluation and management services and consultation codes (Table A) are payable to optometrists, when indicated, for the diagnoses in Table B.

Table A: Evaluation and Management Services and Consultation Procedure Codes.

Procedure Codes			
1-99201	1-99202	1-99203	1-99204
1-99205	1-99211	1-99212	1-99213
1-99214	1-99215	1-99221	1-99222
1-99223	1-99231	1-99232	1-99233
1-99234	1-99235	1-99236	1-99238
1-99239	3-99241	3-99242	3-99243
3-99244	3-99245	3-99251	3-99252
3-99253	3-99254	3-99255	1-99281
1-99282	1-99283	1-99284	1-99285
1-99304	1-99305	1-99306	1-99307
1-99308	1-99309	1-99310	1-99315
1-99316	1-99318	1-99324	1-99325
1-99326	1-99327	1-99328	1-99334
1-99335	1-99336	1-99337	1-99341
1-99342	1-99343	1-99344	1-99345
1-99347	1-99348	1-99349	1-99350

Table B: Diagnosis Limitations

Diagnosis Codes				
05320	05321	05322	05329	05440
05441	05442	05443	05444	05449
0760	0761	0769	0770	0771
0772	0773	0774	0778	0903
0905	0906	0907	0909	09150
09151	09152	09840	09841	09842
09843	09849	11502	11512	11592
1301	1302	1900	1901	1902
1903	1904	1905	1906	1907
1908	1909	2240	2241	2242
2243	2244	2245	2246	2247
2248	2249	2340	36000	36001
36002	36003	36004	36011	36012
36013	36014	36019	36020	36021
36023	36024	36029	36030	36031
36032	36033	36034	36040	36041
36042	36043	36044	36050	36051
36052	36053	36054	36055	36059
36060	36061	36062	36063	36064
36065	36069	36081	36089	3609
36100	36101	36102	36103	36104
36105	36106	36107	36110	36111
36112	36113	36114	36119	3612
36130	36131	36132	36133	36181
36189	3619	36201	36202	36203
36204	36205	36206	36207	36210
36211	36212	36213	36214	36215
36216	36217	36218	36221	36229
36230	36231	36232	36233	36234

Diagnosis Codes				
36235	36236	36237	36240	36242
36243	36250	36251	36252	36253
36254	36255	36256	36257	36260
36261	36262	36263	36264	36265
36266	36752	36753	36789	36800
36801	36802	36803	36810	36811
36812	36813	36814	36815	36816
3682	36830	36831	36832	36833
36834	36840	36841	36842	36843
36844	36845	36846	36847	36851
36852	36853	36854	36855	36859
36860	36861	36862	36863	36869
3688	3689	36900	36901	36902
36903	36904	36905	36906	36907
36908	36910	36911	36912	36913
36914	36915	36916	36917	36918
36920	36921	36922	36923	36924
36925	3693	3694	36960	36961
36962	36963	36964	36965	36966
36967	36968	36969	36970	36971
36972	36973	36974	36975	36976
3698	3699	37000	37001	37002
37003	37004	37005	37006	37007
37020	37021	37022	37023	37024
37031	37032	37033	37034	37035
37040	37044	37049	37050	37052
37054	37055	37059	37060	37061
37062	37063	37064	3708	3709
37100	37101	37102	37103	37104
37105	37110	37111	37112	37113
37114	37115	37116	37120	37121
37122	37123	37124	37130	37131
37132	37133	37140	37141	37142
37143	37144	37145	37146	37148
37149	37150	37151	37152	37153
37154	37155	37156	37157	37158
37160	37161	37162	37170	37171
37172	37173	37181	37182	37189
3719	37200	37201	37202	37203
37204	37205	37210	37211	37212
37213	37214	37215	37220	37221
37222	37230	37231	37233	37239
37240	37241	37242	37243	37244
37245	37250	37251	37252	37253

Diagnosis Codes				
37254	37255	37256	37261	37262
37263	37264	37271	37272	37273
37274	37275	37281	37289	3729
37300	37301	37302	37311	37312
37313	3732	37331	37332	37333
37334	3734	3735	3736	3738
3739	37400	37401	37402	37403
37404	37405	37410	37411	37412
37413	37414	37420	37421	37422
37423	37430	37431	37432	37433
37434	37441	37443	37444	37445
37446	37450	37451	37452	37453
37454	37455	37456	37481	37482
37483	37484	37485	37486	37487
37489	3749	37500	37501	37502
37503	37511	37512	37513	37514
37515	37516	37520	37521	37522
37530	37531	37532	37533	37541
37542	37543	37551	37552	37553
37554	37555	37556	37557	37561
37569	37581	37589	37600	37601
37602	37603	37604	37610	37611
37612	37613	37621	37622	37630
37631	37632	37633	37634	37635
37636	37640	37641	37642	37643
37644	37645	37646	37647	37650
37651	37652	3766	37681	37682
37689	3769	37700	37701	37702
37703	37704	37710	37711	37712
37713	37714	37715	37716	37721
37722	37723	37724	37730	37731
37732	37733	37734	37739	37741
37742	37743	37749	37751	37752
37753	37754	37761	37762	37763
37771	37772	37773	37775	3779
74300	74303	74306	74310	74311
74312	74320	74321	74322	74330
74331	74332	74333	74334	74335
74336	74337	74339	74341	74342
74343	74344	74345	74346	74347
74348	74349	74351	74352	74353
74354	74355	74356	74357	74358
74359	74361	74362	74363	74364
74365	74366	74369	7438	7439

Diagnosis Codes				
8700	8701	8702	8703	8704
8708	8709	8710	8711	8712
8713	8714	8715	8716	8717
8719	9180	9181	9182	9189
9210	9211	9212	9213	9219
9300	9301	9302	9308	9309
9400	9401	9402	9403	9404
9405	9409			

Procedure code 1-S0620 or 1-S0621 is payable with a diagnosis of refractive error only. Procedure code 1-92015 is not payable with a diagnosis of refractive error.

The following sonography procedures are payable to an optometrist when accompanied by an appropriate diagnosis:

Procedure Codes		
4/I/T-76511	4/I/T-76512	4/I/T-76513
4/I/T-76516	4/I/T-76519	4/I/T-76529

If an office evaluation and management service is billed in addition to the eye examination, the evaluation and management service will be denied as part of the eye exam.

If a consultation is billed in addition to the eye exam, it will be denied as part of the eye exam.

Procedure code 1-99173 will deny as part of another procedure/service billed on the same day (e.g., Texas Health Steps [THSteps] visit or evaluation and management service).

45.4.2.1 Disease or Injury to the Eye

The following codes are payable to optometrists for the diagnosis of aphakia, disease of the eye, or injury of the eye:

Procedure Codes	
E-92002†	E-92004†
E-92012†	E-92014†
† = Services payable to an FQHC based on an all-inclusive rate per visit.	

Providers may not withhold from a client a prescription for eyeglasses pending Medicaid payment for the eye examination. Prescriptions for eyeglasses must be given to the client on request.

45.4.2.2 Echography

Procedure codes 4-76511, 4-76512, 4-76513, and 4-76999 are payable for the following diagnoses or conditions:

Diagnosis Codes				
1900	1901	1984	2240	2241
2340	2388	2398	25050	25051
25052	25053	36100	36101	36102
36103	36104	36105	36106	36107
36110	36111	36112	36113	36114
36119	3612	36130	36131	36132
36133	36181	36189	3619	36201
36202	36210	36211	36212	36213
36214	36215	36216	36217	36218
36221	36229	36230	36231	36232
36233	36234	36235	36236	36237
36240	36241	36242	36243	36250
36251	36252	36253	36254	36255
36256	36257	36260	36261	36262
36263	36264	36265	36266	36270
36271	36272	36273	36274	36275
36276	36277	36281	36282	36283
36284	36285	36289	36340	36341
36342	36343	36361	36362	36363
36370	36371	36372	36441	36641
37921	37922	37923	37924	37925
37926	37929	37992		

Procedure codes 4-76511, 4-76512, 4-76516, 4-76519 are payable for the following diagnoses:

Diagnosis Codes				
36600	36601	36602	36603	36604
36609	36610	36611	36612	36613
36614	36615	36616	36617	36618
36619	36620	36621	36622	36623
36630	36631	36632	36633	36634
36641	36642	36643	36644	36645
36646	36650	36651	36652	36653
3668	3669	37100	37101	37102
37103	37104	37105	37110	37111
37112	37113	37114	37115	37116
37120	37121	37122	37123	37124
37130	37131	37132	37133	37140
37141	37142	37143	37144	37145
37146	37148	37149	37150	37151
37152	37153	37154	37155	37156
37157	37158	37160	37161	37162
37170	37171	37172	37173	37181
37182	37189	3719	37931	37932
37933	37934	37939	74330	74331
74332	74333	74334	74335	74336
74337	74339			

Procedure code 4-76529 is payable for the following diagnoses:

Diagnosis Codes				
36050	36051	36052	36053	36054
36055	36059	36060	36061	36062
36063	36064	36065	36069	3766
8704	8715	8716	9300	9301
9302	9308	9309		

Procedure code 4-76511, 4-76516, or 4-76519 will not be reimbursed if procedure code 4-76512 is billed on the same day, by any provider.

45.4.2.3 Corneal Topography

Corneal topography (1-92025), is a benefit of the Texas Medicaid Program.

An initial or established visit/consultation is payable on the same day as the topography. These visits remain subject to the global surgery fee guidelines.

Corneal topography is subject to global surgery fee guidelines.

If topography is performed within the global surgical pre- and post-care days of the following ophthalmic procedures, the topography is denied as *part of*.

Procedure Codes		
2/F-65270	2/F-65272	2-65273
2/F-65275	2/F-65280	2/F-65285
2/F-65286	2/F-65400	2/F-65420
2/F-65426	2-65430	2-65435
2-65436	2-65450	2-65600
2/8/F-65710	2/8/F-65730	2/8/F-65750
2/8/F-65755	2/F-65880	2/F-66600
2/F-66605	2/F-66625	2/F-66630
2/F-66635	2/F-66820	2/F-66821
2/F-66830	2/F-66840	2/F-66850
2/F-66852	2/F-66920	2/F-66930
2/F-66940	2/F-66983	2/8/F-66984
2/F-66985	2/F-66986	

Corneal topography is considered for reimbursement without prior authorization when submitted with any of the following diagnoses:

Diagnosis Codes				
37000	37001	37002	37003	37004
37005	37006	37007	37100	37101
37102	37103	37104	37120	37121
37122	37123	37140	37142	37146
37148	37149	37160	37161	37162
37170	37171	37172	37173	37240
37241	37242	37243	37244	37245

Diagnosis Codes				
37281	37289	8710	8711	9402
9403	9404	99651	V425	V4561
V4569				

Services are payable to an FQHC based on an all-inclusive rate per visit.

Procedure code 1-92025 must be prior authorized when used for the fitting of contact lenses (diagnosis codes 36720, 36722 and 74341). Prior authorization criteria must be met for both topography and for contact lenses. Procedure code 1-92025 may only be billed once per eye, per day, by any provider.

Refer to: "Contact Lenses" on page 45-9 for contact lens information.

45.4.2.4 Therapeutic Optometrists

The following procedure codes are payable to therapeutic optometrists:

Procedure Codes		
2-65205	2-65210	2-65220
2-65222	2-65286	2-65430
2-67820	2-67938	2-68530
2-68761	2-68801	2-68810
2-68840		

45.4.3 Medicare/Medicaid

Eye examinations for the purpose of prescribing, fitting, or changing eyeglasses/contact lenses because of refractive errors are not a benefit of Medicare. These services must be filed directly to Medicaid when performed for a Medicare/Medicaid client. Medicare coverage is limited to eye examinations for treatment of eye disease or injury and for a diagnosis of aphakia. When performing an eye examination with refraction for a Medicare/Medicaid client diagnosed with aphakia or disease or injury to the eye, the following procedures must be followed:

- Procedure code 1-92015 must be used to bill Medicaid for the refractive portion of the examination and is payable with a diagnosis of aphakia or ocular disease only.
- The medical portion of the eye examination (1-92002, 1-92004, 1-92012, 1-92014) is covered by Medicare and must be billed to Medicare first. Medicare forwards this portion of the examination automatically to TMHP for payment of coinsurance and/or deductible.

Important: *Providers performing eye exams for refractive errors on STAR+PLUS Medicaid Eligibility Verification (Medicaid Qualified Medicare Beneficiary [MQMB])* must *bill TMHP, not the STAR+PLUS health plan.*
Do not send the refraction (1-92015) to Medicare first.

Medicaid will not waive the 95-day filing deadline if the claim is billed to Medicare in error, nor will Medicare transfer the refraction to Medicaid for payment.

Medicare allows payment of one pair of conventional eyewear (contact lens or glasses) for clients who have had cataract surgery with insertion of an intraocular lens (IOL) (Medicare considers the IOL the prosthetic device). Medicaid providers must bill Medicare for the conventional (nonprosthetic) eyewear provided following an IOL insertion and bill Medicaid for any replacements of the conventional (nonprosthetic) eyewear using the *Y* codes in the "Nonprosthetic Eyeglasses and Contacts" tables beginning on page 45-10.

45.4.4 Nonprosthetic Eyewear

Eligible clients may receive nonprosthetic frames and/or lenses once every 24 months. This benefit period begins with the month the glasses are first dispensed. Refer to the Eyeglasses column of the client's Medicaid Identification Form (Form H3087) for determination of eligibility for this service. When there is a change in visual acuity (equal to or greater than 0.5 diopter in one eye), clients are eligible for new nonprosthetic eyeglasses, regardless of when they received their last pair of nonprosthetic eyeglasses or if their Medicaid Identification Form (Form H3087) does not have a check mark (✓) in the Eyeglasses column.

The Texas Medicaid Program provides for serviceable eyeglasses, contact lenses that are medically necessary and prior authorized, necessary major repairs to eyeglasses for clients younger than 21 years of age, and replacement of lost/destroyed eyeglasses and contact lenses for clients younger than 21 years of age.

Exception: *Diagnosis of aphakia does not require prior authorization.*

For clients younger than 21 years of age, there are no limitations on replacements for lost or destroyed eyewear. Eyewear will be reimbursed even if the client's Medicaid Identification Form (Form H3087) does not have a check mark (✓) in the services already rendered.

Clients in Medicaid Managed Care health plans may be eligible for additional eyeglass benefits under their plan. Check with the client's health plan for details.

Eyewear must be medically necessary and:

- Prescribed by a physician (doctor of medicine [MD], a doctor of osteopathy [DO]), or an optometrist (OD).
- Prescribed to significantly improve vision or correct a medical condition.
- Must meet the following eyeglass program specifications for frames and lenses:

Frames

- Frames composed of all zynolite components. The frame is the entire piece of eyewear without the lenses.
- Frames composed of a combination of zynolite and metal components are reimbursed to the maximum allowable amount for a zynolite frame. The client may be billed the difference between the reimbursed amount and the billed amount, as the metal portion is not a benefit of the program.
- All metal frames are *not* a benefit of the Texas Medicaid Program. Clients may be billed for frames that are beyond Medicaid benefits, as specified in "Noncovered Services/Supplies" on page 45-9.
- American-made unless foreign-made frames are comparable in quality and are less expensive.
- Serviceable and able to meet statutory quality standards.
- Composed of new materials.

Eyeglass Lenses

- Clear glass or plastic.
- Heat or chemically-treated dress eyewear able to meet standards of the American Standard Prescription Requirements for first quality glass and plastic lenses.
- Composed of new materials.
- A minimum kryptoc or 22 mm flat top lens or equivalent if bifocal.
- A minimum flat top 7/25 lens or equivalent if trifocal.

45.4.4.1 Dispensing Requirements

Providers must be able to dispense standard size frames at no cost to the eligible client. Providers must also show each eligible client a minimum of three styles of zylonite frames for male or female, child or adult, in a choice of three colors. The provider may also show combination frames of zylonite and metal. The Texas Medicaid Program can reimburse the zylonite maximum allowable amount for a combination frame. If the cost of frames exceeds the Medicaid maximum allowable fee, the client may be billed the difference of the billed amount. If there is no Medicaid coverage for the eyewear, the client is responsible for the entire amount.

Clients must acknowledge their choice of eyewear beyond program limitations by signing the "Vision Care Eyeglass Patient (Medicaid Client) Certification Form" on page B-115.

45.4.4.2 Replacements

Clients younger than 21 years of age may obtain replacements of nonprosthetic eyewear because of loss or destruction. Clients 21 years of age and older are not eligible for replacements because of loss or destruction of nonprosthetic eyewear. There is no limitation on the number of replacements a client younger than 21 years of age may receive. If eyewear is lost or destroyed, the provider must have the client sign the "Vision Care Eyeglass Patient (Medicaid Client) Certification Form" on page B-115. Replacement codes must be used to ensure accurate processing.

45.4.4.3 Repairs

Clients younger than 21 years of age may obtain repairs of nonprosthetic eyewear when the actual cost of materials exceeds $2. An invoice for the repair materials is not required to be submitted with the claim. Providers are required to maintain this information in the client's medical file and make it available for review by TMHP, HHSC, or the Attorney General's office when requested. The cost of repair supplies cannot exceed the amount that would have been payable, if the damaged eyewear had been a new purchase. All repair materials billed to the Texas Medicaid Program must be new and at least equivalent to the original item.

Repairs costing $2 or less are considered minor repairs. The eyeglass supplier is required to perform minor repairs on request (without charge) on eyewear that they have dispensed. Therefore, the Texas Medicaid Program or the client may not be billed for any minor repairs.

No benefits are allowed for repair of eyeglasses that do not meet the minimum program specifications or for clients who are eligible for Medicaid and are 21 years of age and older.

45.4.4.4 Contact Lenses

The Texas Medicaid Program allows reimbursement for contact lenses when no other option is available to correct a visual defect. Prior authorization is mandatory and must be received before dispensing the lens(es), unless the diagnosis is aphakia. Additionally, the client must be eligible for Medicaid at the time the lens(es) are dispensed. Providers must include the following information in each prior authorization request for contact lens(es):

- The client's name and Medicaid number, as they appear on the Medicaid card.
- The diagnosis causing the refractive error (for example, keratoconus).
- The current prescription (also include the previous prescription, if the request is because of a significant change in vision).
- The indication of the eye to be treated (right, left, or bilateral).
- The specific procedure code for contact lens(es) requested.
- A brief statement addressing the medical need for contact lens(es) (specify why eyeglasses are inappropriate or contraindicated for this client).
- The provider identifer.
- The signature of the physician or optometrist requesting prior authorization.

Requests lacking this information will be denied. Mail or fax the request to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

Soft bandage plano lenses may be dispensed and billed to the Texas Medicaid Program in an emergency situation without prior authorization. The claim must document the medical emergency.

Replacement contact lenses are a benefit for lost or destroyed contact lenses for clients younger than 21 years of age when prior authorized by TMHP. Clients eligible for Medicaid may receive new nonprosthetic contact lenses when there is a significant change in visual acuity (equal to or greater than 0.5 diopter in one eye) and when prior authorized by TMHP.

When billing for bilateral lenses, providers are to use the appropriate code for unilateral lens and specify a quantity of 2 in Block 24E of the claim form.

Refer to: "Nonprosthetic Eyeglasses and Contacts" on page 45-10.

The Vision Claim Form Example on page D-36

"Prosthetic Eyeglasses and Contacts" on page 45-12.

45.4.4.5 Noncovered Services/Supplies

The following services and supplies are not benefits of the Texas Medicaid Program:

- All metal frames (for example, frames with all metal structural components; plastic nose pieces or sheathing over ear pieces do *not* constitute a combination frame).
- Repairs and replacements of lost or destroyed eyewear for clients 21 years of age and older.
- Artificial eyes.
- Plano sunglasses.
- Eyeglasses that do not significantly improve visual acuity or impede progression of visual problems.
- Eyewear prescribed or dispensed to clients at a hospital or nursing facility without documented orders of the attending physician in the client's medical records.
- Eyeglasses for residents of institutions where the reimbursement formula and vendor payment include this service.
- Optional eyeglass features requested by the client that do not increase visual acuity (e.g., lens tint, industrial hardening, decorative accessories, or lettering).
- Prisms that are ground into the lenses.

Clients may be billed for noncovered frames and other items beyond Medicaid benefits.

Providers must have the client sign and date the Vision Care Eyeglass Patient Certification Form and retain it in the provider's records.

The client payment amount is *not* considered other insurance and must not be entered as a credit amount in the electronic field.

Example: *The client wants oversized frames and tinted lenses for a total of $140 ($100 for frames, $30 for lenses, $10 for tinting). Medicaid pays $33.15 for the eyeglasses ($14.45 for the frames and $9.35 per lens, or $18.70 for both lenses). With the Medicaid payment of $33.15, the client may be billed for the balance, which includes the difference between the Medicaid payment for the frames and lenses, plus the $10 charge for the tinted lenses.*

The provider may withhold the noncovered eyewear, contacts, or eyeglasses until the client pays for those items. If the client fails to pay for the noncovered items or has not returned for finished eyewear within a reasonable length of time (two to three months), the provider may return any reusable items to stock. Any payment made by TMHP for frames must be refunded to the Texas Medicaid Program. If a client requests eyewear that is beyond program benefits (for example, combination zylonite and metal frames or high-powered lenses), Medicaid allows reimbursement up to the maximum fee. The provider may charge the client the difference between the Medicaid payment and the customary charge for the eyewear requested, when the client has been shown the complete selection of Medicaid-covered eyewear and when the following conditions are met:

- The client rejects the Medicaid-covered eyewear and wants eyewear that complies with Texas Medicaid Program specifications, but is not included in the selection of Medicaid-covered eyewear.
- The client indicates a willingness to pay the difference between the Medicaid payment and the actual charge. The provider must have the client sign the Vision Care Eyeglass Patient Certification Form and retain it in the provider's records.

Providers who advertise "two-for-one" eyeglass special promotions without restrictions may not refuse the offer to clients with Medicaid coverage.

For the purpose of the Texas Medicaid Program, high-powered lenses are defined as those with a sphere greater than 7.00d or a cylinder greater than 4.00d. High-powered lenses are a benefit for clients younger than 21 years of age through THSteps-Comprehensive Care Program (CCP).

Procedure Codes for High-Powered Lenses

Procedure Codes		
E-V2102	E-V2105	E-V2106
E-V2109	E-V2110	E-V2111
E-V2112	E-V2113	E-V2114
E-V2202	E-V2205	E-V2206
E-V2209	E-V2210	E-V2211
E-V2212	E-V2213	E-V2214
E-V2302	E-V2305	E-V2306
E-V2309	E-V2310	E-V2311
E-V2312	E-V2313	E-V2314

Prior authorization is not required for high-powered lenses. The invoice is required and must be maintained in the provider's files. When billing on paper for these services, the invoice must be submitted with the claim and providers are to include a copy of the prescription and manufacturer's suggested retail price. Providers are to use the invoice cost as the billed amount and list the prescription on the claim form, indicating the power is greater than plus or minus 7 diopters or the cylinder is greater than plus or minus 4 diopters. The billed amount should not exceed the invoice amount.

A client who experiences difficulty with daily living activities or employment related to vision may be referred to the Texas Department of Assistive and Rehabilitative Services (DARS). DARS can evaluate the client and may provide resources for assistance, as appropriate.

Modifier RP must be used when billing for replacement lenses. When billing for an adult with diagnosis code 37931, modifier VP must also be billed.

Refer to: The list of offices for the "Department of Assistive and Rehabilitative Services (DARS), Blind Services" on page A-17.

The claim form example, "Vision" on page D-36.

Nonprosthetic Eyeglasses and Contacts

45.4.5 Nonprosthetic Eyeglasses and Contacts

45.4.5.1 Frames

Procedure Code	Special Instructions
E-V2020	Single vision eyeglasses (not high powered), procedure code V2020, should be billed with the lens codes on this table.
E-V2025	Single vision eyeglasses (not high powered), with deluxe frames, procedure code V2025, should be billed with the lens codes on the following tables. V2025 must be used for nonprosthetic eyewear that is beyond program benefits.

45.4.5.2 Lenses

Providers must use the following codes when dispensing new lenses only (e.g., a client has 0.5 or greater diopter change requiring new lenses only). Providers are to bill a quantity of 2 for a pair of lenses.

Procedure Codes				
E-V2100	E-V2101	E-V2103	E-V2104	E-V2107
E-V2108	E-V2121	E-V2200	E-V2201	E-V2203

Procedure Codes				
E-V2204	E-V2207	E-V2208	E-V2221	E-V2300
E-V2301	E-V2303	E-V2304	E-V2307	E-V2308
E-V2321				

The maximum fee for procedure code E-V2121 is $70.46.

45.4.5.3 Replacements

Providers must use the procedure codes in the table below when billing for lost or destroyed eyewear (only available for clients younger than 21 years of age). Use modifier RP to indicate replacement. Bill the appropriate quantity of lenses.

Procedure Code				
E-V2020	E-V2025	E-V2100	E-V2101	E-V2103
E-V2104	E-V2107	E-V2108	E-V2121	E-V2200
E-V2201	E-V2203	E-V2204	E-V2207	E-V2208
E-V2221	E-V2300	E-V2301	E-V2303	E-V2304
E-V2307	E-V2308	E-V2321		

Refer to: "Contact Lenses" on page 45-9 for prior authorization information.

45.4.5.4 Contact Lenses (Must be Prior Authorized)

Procedure Code			
1-92070	9-92326	9-V2500*	9-V2501*
9-V2502*	9-V2510*	9-V2511*	9-V2512*
9-V2513*	9-V2520*	9-V2521*	9-V2522*
9-V2523*	9-V2530*	9-V2531*	9-V2599*
***Use modifier VP for aphakic patients. Does not require prior authorization with a diagnosis of aphakia.**			

45.4.5.5 Contact Lens Services Not Covered

Procedure codes 9-V2503 and 1-92310 are not covered.

45.4.5.6 Major Eyeglass Repairs

Providers billing for major eyeglass repairs should use procedure code 9-V2799. This procedure will be manually priced.

45.4.6 Prosthetic Eyewear

Postsurgical prosthetic lenses are those lenses that replace the function of the eye's organic lens. Replacement may be necessary because of a congenital defect or trauma. However, the most frequent cause is surgical cataract extraction. The lenses can be contact lenses, eyeglasses, or both. The date of cataract surgery is not required on claims for permanent postsurgical prosthetic eyewear. The date of surgery is required to determine the convalescence period for temporary prosthetic eyewear. Contact lenses required as a postsurgical prosthetic may be supplied *without* prior authorization. Claims for temporary lenses are not payable, if dispensed after the four-month convalescence period. Claims for temporary eyewear that do not include the date of surgery are listed on the R&S as a claim in process and must be resubmitted for consideration of payment. Electronic claims of this type will be rejected. A letter with the rejection reason and instructions for resubmission will be mailed to the provider the following business day. Surgery dates on electronic claims must be identified in the appropriate fields of an approved electronic claims format.

The name of the surgeon who performed the cataract surgery is not required on claims for postsurgical prosthetic eyewear.

The Texas Medicaid Program provides as many temporary prosthetic lenses (contacts or eyeglasses) as necessary during the postsurgical convalescence period (up to four months after surgery) and one pair of permanent prosthetic contact lenses, eyeglasses, or both, in a lifetime (exceptions include replacements and new prosthetic eyewear when there is a significant change in visual acuity).

Contact lenses required as a postsurgical prosthetic may be supplied without prior authorization. Procedure codes for temporary postsurgical prosthetic lenses must be used only during the four-month convalescence period. After the convalescence period, procedure codes for permanent prosthetic eyewear must be used.

45.4.6.1 Medicare Coverage

Postsurgical prosthetic cataract lenses are also a benefit of Medicare. If the client is eligible for Medicare coverage, the provider must bill Medicare first. Medicaid pays any deductible and/or coinsurance due. The provider must not require the client to pay the deductible and/or coinsurance.

45.4.6.2 Replacements

Regardless of age, coverage is provided for the replacement of lost or destroyed prosthetic eyewear. Providers must use procedure code 9-92326 when billing for contact lenses replacement. For replacement of cataract eyewear frames or lenses, providers must use the permanent cataract eyewear codes.

The client must sign and date the Vision Care Eyeglass Patient Certification Form, and the provider must retain it in the provider's records.

Medicare allows payment of one pair of conventional eyewear (contact lens or glasses) for clients who have had cataract surgery with insertion of an IOL. Medicare considers the IOL the prosthetic device. Medicaid providers must bill Medicare for the conventional (nonprosthetic) eyewear provided following an IOL insertion and bill Medicaid for any replacements of the conventional (nonprosthetic) eyewear using the *Y* codes from the "Nonprosthetic Eyeglasses and Contacts" tables beginning on page 45-10.

45.4.6.3 Significant Diopter Change

Clients are eligible for new prosthetic eyewear when there is a significant change in visual acuity (equal to or greater than 0.5 diopter in one eye). The new prescription must be indicated in Block 24D, line 5, and the old prescription directly below it in Block 24D, line 6 of the CMS-1500 claim form. Prescription information for electronic claims must be in the electronic claims format. Providers must consult their vendor for the location of this field in the providers' electronic format. The procedure codes listed for new eyewear must be used. Reimbursement is $61.37 per lens. Prior authorization is not required.

45.4.7 Prosthetic Eyeglasses and Contacts

Services for prosthetic eyewear must be billed with a diagnosis of aphakia (37931 or 74335) to be considered for reimbursement. Contact lenses require prior authorization unless billed with a diagnosis of aphakia.

45.4.7.1 Contact Lenses

Providers must use the following codes when billing for cataract contact lenses:

Procedure Code			
1-92070	9-92326	9-V2500*	9-V2501*
9-V2502*	9-V2510*	9-V2511*	9-V2512*
9-V2513*	9-V2520*	9-V2521*	9-V2522
9-V2523			

***Does not require prior authorization with a diagnosis of aphakia.**

45.4.7.2 Eyeglasses

Providers must use the following procedure codes when billing for cataract eyeglass frames and lenses (whether the lenses are glass or plastic):

Procedure Codes				
E-V2020	E-V2025	E-V2100	E-V2101	E-V2102
E-V2103	E-V2104	E-V2105	E-V2106	E-V2107
E-V2108	E-V2109	E-V2110	E-V2111	E-V2112
E-V2113	E-V2114	E-V2200	E-V2201	E-V2202
E-V2203	E-V2204	E-V2205	E-V2206	E-V2207
E-V2208	E-V2209	E-V2210	E-V2211	E-V2212
E-V2213	E-V2214	E-V2300	E-V2301	E-V2302
E-V2303	E-V2304	E-V2305	E-V2306	E-V2307
E-V2308	E-V2309	E-V2310	E-V2311	E-V2312
E-V2313	E-V2314	9-V2410	9-V2430	E-V2700
E-V2755				

When prescribing bilateral lenses, providers are to use the appropriate code for a unilateral lens and specify a quantity of 2 in Block 24E of the claim form.

45.5 Claims Information

Vision care services must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"CMS-1500 Claim Filing Instructions" on page 5-22. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

45.5.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Filing Instructions	5-22
TMHP Electronic Claims Submission	5-13
Communication Guide	A-1
Vision Care Eyeglass Patient (Medicaid Client) Certification Form	B-115
Vision Care Eyeglass Patient (Medicaid Client) Certification Form (Spanish) claim form example	B-116
Vision claim form example	D-36
Acronym Dictionary	F-1

Part

III

Appendices

State and Federal Offices Communication Guide

A.1 Texas Health and Human Services Commission (HHSC) Central Office Addresses

Use the following address for general inquiries or for any group that is not listed in the table below:

Texas Health and Human Services Commission
4900 N. Lamar Blvd.
Austin, TX 78751-2316

Note: *Remember to use the four-digit addition to the ZIP code.*

Use the following address for the HHSC Inspector General:

Texas Health and Human Services Commission
Office of Inspector General
PO Box 85200
Austin, TX 78708-5200

Note: *Remember to use the four-digit addition to the ZIP code.*

For the following groups, use the corresponding address and include the group name on the second line of the address.

Address	Group Name
DSHS (Group Name) (Mail Code) P. O. Box 149347 Austin, TX 78717-9347	Children with Special Health Care Needs (CSHCN) Services Program Family Planning (Mail Code 1920) Genetic Services Indigent Health Care (Mail Code 2831) Texas Health Steps (THSteps) (Mail Code 1938)
HHSC Medicaid CHIP–H200 PO Box 85200 Austin, TX 78708	
HHSC Quality Review/Limited Program—1323 PO Box 85200 Austin, TX 78708	
HHSC Third Party Resources (TPR) PO Box 85200 Mail Code 1354 Austin, TX 78708-5200	
HHSC Medical and UR Appeals H-230 PO Box 85200 Austin, TX 78708	
HHSC Vendor Drug H-630 PO Box 85200 Austin, TX 78708	

A.2 HHSC Regional Offices of Eligibility Services (OES) Officers and Regional Directors

Officers OES Fax 1-512-206-5273	Regional Directors		Administrative Assistants
Adriana Ramirez-Byrnes 1-512-206-4602	01 Lubbock – Mary Doan 5806 34th Street Lubbock, TX 79407	Phone: 1-806-791-7529 Fax: 1-806-791-7590 Mail Code 217-1 Toll-Free: 1-888-440-5688	Shenaz Haney 1-806-791-7530
Charles Gordon 1-512-206-4836	02/09 Abilene – Jerry Flores 4601 South First Street, Abilene 79604 PO Box 521 Abilene, TX 79604	Phone :1-325-795-5526 Fax: 1-325-795-5523 Mail Code 001-1 Toll-Free: 1-866-480-2553	Gayle Armstrong 1-325-795-5522
Charles Gordon 1-512-206-4836	03 Grand Prairie – Amy Cuellar PO Box 532089, Grand Prairie 75053-2089 801 W. Freeway Grand Prairie, TX 75051	Phone: 1-972-337-6171 Fax: 1-972-337-6298 Mail Code 012-5 Toll-Free: 1-877-236-6500	Kemia Andrew 1-972-337-6198
Adriana Ramirez-Byrnes 1-512-206-4602	04 Tyler – Fay Booker 302 E. Rieck Road Tyler, TX 75703	Phone: 1-903-509-5142 Fax: 1-903-509-5133 Mail Code 313-5 Toll-Free: 1-866-480-2554	Charolette Wade 1-903-509-5125
Adriana Ramirez-Byrnes 1-512-206-4602	05 Beaumont - Stephanie Semien 285 Liberty, 11th Floor Beaumont, TX 77701	Phone: 1-409-951-3425 Fax: 1-409-951-3449 Mail Code 028-1 Toll-Free: 1-866-480-2555	Janet Benson 1-409-951-3413
Adriana Ramirez-Byrnes 1-512-206-4602	06 Houston - Carolyn A. Maxie 5425 Polk Street, Ste. 230, Houston 77023 PO Box 16017 Houston, TX 77222-6017	Phone: 1-713-767-2448 Fax: 1-713-767-2440 Mail Code 178-7 Toll-Free: 1-800-500-4266	Rebecca Flores (Interim) 1-713-767-2446
Charles Gordon 1-512-206-4836	07 Austin – Mari Forcade 4616-1 West Howard Lane, Ste. 120 Austin, TX 78728	Phone: 1-512-832-7617 Fax: 1-512-832-7665 Mail Code 016-1 Toll-Free: 1-866-480-2556	Melissa Boyd 1-210-832-7692
Charles Gordon 1-512-206-4836	08 San Antonio – Grace Moser 11307 Roszell, San Antonio 78217 PO Box 23990 San Antonio, TX 78223	Phone: 1-210-619-8226 Fax: 1-210-619-8293 Mail Code 279-4 Toll-Free: 1-877-322-3233	Hedy Streiff (Interim) 1-210-619-8019
Charles Gordon 1-512-206-4836	10 El Paso - Margaret Adame 401 E. Franklin, El Paso 79901 PO Box 981017 El Paso, TX 79998-1017	Phone: 1-915-834-7580 Fax: 1-915-834-7582 Mail Code 111-1 Toll-Free: 1-866-480-2557	Thelma Rey (Interim) 1-915-834-7591
Adriana Ramirez-Byrnes 1-512-206-4602	11 Edinburg - Joe Alvarez 2520 South "I" Road, Edinburg 78539 PO Box 960 Edinburg, TX 78540-0960	Phone: 1-956-316-8272 Fax: 1-956-316-8175 Mail Code 108-1 Toll-Free: 1-866-480-2558	Baudelia Vasquez 1-956-316-8273
Adriana Ramirez-Byrnes 1-512-206-4602	Assistance Response Team Sandra Dillett, Director 4616-1 West Howard Lane, #120 Austin, TX 78728	Phone: 1-512-832-7645 Fax: 1-512-832-7665 Mail Code 016-1	Tomea McDowell 1-512-832-7661
Charles Gordon 1-512-206-4836	Customer Care Center Ana Bonilla, Director 4000 S. IH 35 West Austin, TX 78704	Phone: 1-512-533-3675 Fax: 1-512-437-3554 Mail Code 1207	Geneva Riojas Jimenez 1-512-533-3781

Officers OES Fax 1-512-206-5273	Regional Directors		Administrative Assistants
Adriana Ramirez-Byrnes 1-512-206-4602	Medicaid Eligibility Janis Ambs 801 W. Freeway, Suite 410 Grand Prairie, TX 75051	Phone: 1-972-337-6193 Fax: 1-972-264-9488 Mail Code 012-5	Marty Stalewski 1-972-337-6166

For additonal office information,visit the HHSC website at www.hhsc.state.tx.us.

Refer to: "DSHS Health Service Regions Map" on page A-7 to identify the regional boundaries.

A.2.1 Telephone Communication with HHSC and the Department of State Health Services (DSHS)

Contact	Telephone Number
Assessment Utilization Services (limited program) (Option 4)	1-800-436-6184
DSHS Program for Amplification for Children of Texas (PACT) (hearing aid, evaluations)	1-800-252-8023
DSHS Emergency Medical Services Division	1-512-834-6700
DSHS IMMTRAC Help Desk	1-800-348-9158
DSHS Immunization Branch	1-800-252-9152
DSHS Medical Transportation Program (MTP) Hotline	1-877-633-8747
DSHS THSteps/EPSDT Hotline	1-877-847-8377
Vendor Drug Program Provider Hotline	1-800-435-4165

A.3 Client Telephone Communication with HHSC

Clients should call the client toll-free number at 1-800-252-8263.

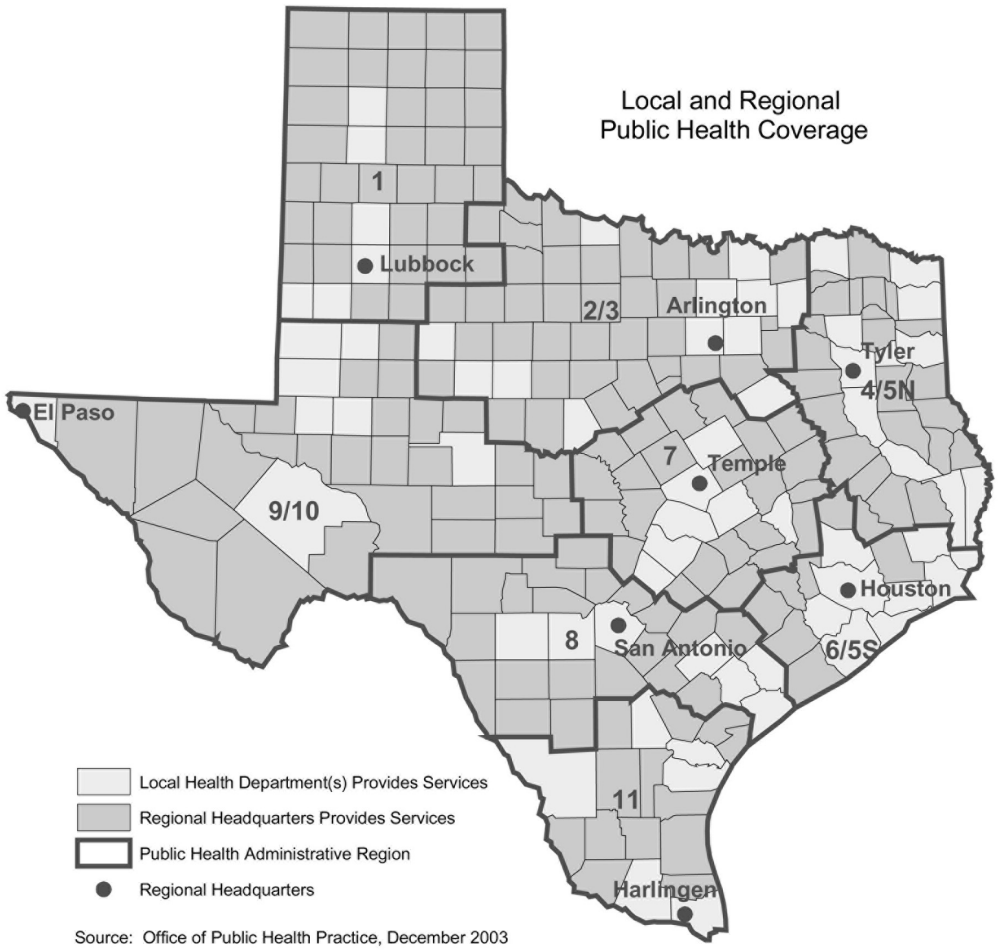
A.4 Federal and State Telephone Numbers

Telephone Number	Department/Program
1-800-342-AIDS	AIDS Hotline (Nationwide, distributed by Centers for Disease Control and Prevention [CDC], Atlanta, Georgia)
1-800-299-2437	HIV/STD InfoLine
1-800-255-1090	Texas HIV Medication Program
1-800-252-5400	Child/Elder Abuse Intake (Department of Family and Protective Services [DFPS])
1-512-458-7420	Vision and Hearing Screening Program (DSHS)
1-512-834-6650, Ext. 2601	CLIA Certification Line
1-800-458-9858	Client Abuse Hotline for Long Term Care Services and Support—Nursing Facilities (HHSC)
1-800-252-8263	Client Inquiry Hotline (HHSC) (Medicaid questions from clients with Medicaid only)
1-512-458-7745	THSteps Program (DSHS)
1-512-458-7661 Fax: 1-512-458-7672	Laboratory Supply Orders (DSHS)
1-512-458-7598 1-512-458-7578	Interpretation of Lab Results (DSHS) Report of Lab Results (DSHS)
1-210-534-8857 Ext. 2357	Adolescent Preventive Visit Pap Smear Supplies/Forms Texas Center for Infectious Disease (Women's Health Laboratories)
1-512-458-7796	Family Planning Program
1-800-436-6184	Fraud or Abuse of Provider Services (HHSC Office of Inspector General)
1-800-436-6184	Fraud or Abuse/Long Term Care Services and Support—Nursing Facilities/HHSC
1-800-436-6184	Fraud or Abuse/Client/HHSC
1-800-792-1109	Goal-Directed Therapy
1-512-438-3169 or 1-800-252-8010	Hospice Program (HHSC Policy Development division)
1-800-252-9152	Immunization Branch (DSHS)
1-800-252-8263	Managed Care (LoneSTAR Health Initiative or STAR Program)—HHSC
1-800-925-9126	Medically Needy Spend Down Unit
1-800-MEDICARE or 1-800-633-4227	Medicare/Social Security Administration
1-800-252-8023	Newborn Screening (DSHS)
1-800-252-8023	Program for Amplification of Children of Texas (PACT) (DSHS)
1-800-436-6184	Recipient Utilization Control Unit (HHSC) (For Limited status review and for referrals from providers for potential client overutilization, etc.)
1-713-526-2559	Snellen Letter (Tumbling E Wall Chart)
1-800-435-4165 or 1-512-338-6962	Vendor Drug Program (HHSC) (Specifically for pharmacy use)

A.5 HHSC Contract Manager Staff for Medicaid Eligibility Outstation Workers

Region	Contact	Telephone Number
1	Mary Doan	1-806-791-7529 or 1-888-440-5688
2/9	Jerry Flores	1-325-795-5526 or 1-866-480-2553
3	Amy Cuellar	1-972-337-6171 or 1-877-236-6500
4	Fay Booker	1-903-509-5142 or 1-866-480-2554
5	Stephanie Semien	1-409-951-3425 or 1-866-480-2555
6	Carolyn A. Maxie	1-713-767-2448 or 1-800-500-4266
7	Mari Forcade	1-512-832-7617 or 1-866-480-2556
8	Grace Moser	1-210-619-8226 or 1-877-322-3233
10	Margaret Adame	1-915-834-7580 or 1-866-480-2557
11	Joe T. Alvarez	1-956-316-8272

A.6 DSHS Health Service Regions Map



A.7 DSHS Health Service Region Contacts

Health Service Region 1 Regional Office (Lubbock)	Health Service Regions 2 & 3 Regional Office (Arlington)
DSHS/PHR 1 1109 Kemper Lubbock, TX 79403 1-806-744-3577 Fax: 1-806-741-1366	DSHS/PHR 2 & 3 1301 S. Bowen, Suite 200 Arlington, TX 76013 1-817-264-4500 Fax: 1-817-264-4506
Public Health Director Peter W. Pendergrass, MD, MPH	Public Health Director James A. Zoretic, MD
Deputy Regional Director Barry Wilson	Deputy Regional Director (acting) Earlene Quinn
Director of Social Work Services Pat Greenwood, MSSW, LCSW	Director of Social Work Services Crystal Womack, LCSW
Communicable Disease Manager Ray Borges	Director of Clinic Operations Dorothy Kuhlmann, RN
Immunization Program Manager Keila Johnson	Immunization Program Manager Sonna Sander
Tuberculosis Team Leader Vacant	Communicable Disease Program Manager Gary Willett
THSteps Operations Lead Tricia Vowels 1109 Kemper, Mail Code 1899 Lubbock, TX 79403 1-806-767-0414 Fax: 1-806-767-0403	Tuberculosis Team Leader Jeff Ralston
	Emergency Preparedness Bryan Flow, DVM
DSHS Regional Family Planning Specialist Patricia Rennie 1101 Camino La Costa Austin, TX 78752 1-512-467-9875 Fax: 1-512-451-1468	THSteps Operations Lead Karen Riley 1301 S. Bowen Road #200, Mail Code 1905 Arlington, TX 76013
DSHS Regional Contract Coordinator (Titles V, X, and XX Family Planning) Cindy Don 1301 S. Bowen Road, Suite 200 Arlington, TX 76013 1-817-264-4743 Fax: 1-817-264-4912	HIV/STD Program Manager Gary Willett
	DSHS Regional Contract Coordinator (Titles V, X, and XX Family Planning) Cindy Don 1301 S. Bowen Road, Suite 200 Arlington, TX 76013 1-817-264-4743 Fax: 1-817-264-4912

Health Service Regions 4 & 5 (North) Regional Office (Tyler)	Health Service Regions 6 & 5 (South) Regional Office (Houston)
DSHS/PHR 4 & 5 North 1517 West Front Street Tyler, TX 75702 1-903-595-3585 Fax: 1-903-593-4187	DSHS 6 & 5 South 5425 Polk Avenue, Suite J Houston, TX 77023 1-713-767-3000 Fax: 1-713-767-3049
Public Health Director Dr. Paul K. McGaha, DO, MPH	Public Health Director (acting Regional Medical Director) Aashish Shah, MD., F.A.C.O.G.
Deputy Regional Director William C. Oliver, M.P.A.	Deputy Regional Director Greta Etnyre, MS, RD
Director of Social Work Services Peggy Wooten, LCSW	Director of Social Work Services Raymond Turner, LCSW, MA
Director of Nursing Barbara Lay, RN, MSN	Director of Nursing Carol Patwari, MSRN
Immunization Program Manager Toni Wright	Immunization Program Manager Alkarim Kanji, BS, RN, RRA
HIV/STD Program Manager Charles O'Brien	HIV/STD Program Manager Vacant
Tuberculosis Program Manager Teresa Santiago, RN	Tuberculosis Program Manager Lewis Gonzalez, MD
THSteps Operations Lead Sharon Gibson 1517 W. Front, , Mail Code 1358 Tyler, TX 75702 1-903-533-5245	THSteps Operations Lead Sharon Hill 5425 Polk Avenue, Suite J, Mail Code 1906 Houston, TX 77023-1497 1-713-767-3105
DSHS Regional Contract Coordinator (Titles V, X, and XX Family Planning) Sharon Flournoy 1750 N. Eastman Road, Room 118 Longview, TX 75601 1-903-232-3292 Fax: 1-903-232-3278	DSHS Regional Contract Coordinator (Titles V, X, and XX Family Planning) Sharon Flournoy 1750 N. Eastman Road, Room 118 Longview, TX 75601 1-903-232-3292 Fax: 1-903-232-3278

Health Service Region 7 Regional Office (Temple)	Health Service Region 8 Regional Office (San Antonio)
DSHS/PHR 7 2408 S 37th Street Temple, TX 76504-7168 1-254-778-6744 Fax: 1-254-778-4066	DSHS/PHR 8 7430 Louis Pasteur Drive San Antonio, TX 78229 1-210-949-2000 Fax: 1-210-949-2010
Public Health Director James Morgan, MD, MPH	Public Health Director Sandra Guerra-Cantu, MD, MPH
Deputy Regional Director John Burlinson	Deputy Regional Director Vacant
Director of Social Work Services Eileen Walker, MS, LBSW	Director of Social Work Services Vicky Contreras, LCSW
Director of Nursing Pat Collins, RN	Director of Nursing Sandra Jones, RN
Immunization Program Manager Mike Czepiel	Immunization Program Manager Laurie Henefey
HIV/STD Program Manager Al Gonzales	Communicable Disease Program Manager Cherise Rohr-Allegrini, PhD
Tuberculosis Program Manager/Nurse Consultant Dana Schoepf, RN	HIV/STD Program Manager Deborah Mayhew
THSteps Operations Lead Kimberly Langley 2408 S. 36th Street, Mail Code 1902 Temple, TX 76504 1-254-778-6744	THSteps Operations Lead Velma Stille 7430 Louis Pasteur Drive, Mail Code 5716 San Antonio, TX 78229 1-210-949-2159
DSHS Regional Contract Coordinator (Titles V, X, and XX Family Planning) Carolyn Wachel 2408 South 37th Street Temple, TX 76504 1-254-778-6744 Ext. 2851 Fax: 1-254-773-2722	DSHS Regional Contract Coordinator (Titles V, X, and XX Family Planning) Marlene McLeod, RN 1331 E. Court, Suite 101 Seguin, TX 78155 1-830-372-0841 Fax: 1-830-372-1784

Health Service Regions 9 & 10 Regional Office (El Paso)	Health Service Region 11 Regional Office (Harlingen)
DSHS/PHR 9 & 10 401 E. Franklin, Suite 210 El Paso, TX 79901 1-915-834-7675 Fax: 1-915-834-7799	DSHS/PHR 11 601 W. Sesame Drive Harlingen, TX 78550 1-956-423-0130 Fax: 1-956-412-3915
Public Health Director Luis Escobedo, MD, MPH	Public Health Director Brian Smith, MD, MPH
Deputy Regional Director Blanca Serrano, MPH, RS	Deputy Regional Director Sylvia Garces-Hobbs
Director of Social Work Services Donna Cordoni	Director of Social Work Services R. Scott Horney, LCSW
Director of Nursing Sharon Lindsey, RN	Director of Nursing Darlene Farias, RN
Immunization Program Manager Jose Padilla	Immunization Program Manager Ivette Nunez
HIV/STD Program Manager Oscar Hernandez	HIV/STD Program Manager Richard Anguiano
Communicable Disease Manager Gale Morrow, MPH, CHES	Tuberculosis Program Manager Maria San Pedro, MSPHN, RN
THSteps Operations Lead Donna Cordoni 401 E. Franklin, Suite 200, Mail Code 1903 El Paso, TX 79901 1-915-834-7733	THSteps Operations Lead Ray Garza 601 W. Sesame Drive, Mail Code 1869 Harlingen, TX 78550 1-956-444-3257
DSHS Regional Contract Coordinator (Titles V, X, and XX Family Planning) Carolyn Wachel 2408 South 37th Street Temple, TX 76504 1-254-778-6744 Ext. 2852 Fax: 1-254-773-2722	DSHS Regional Contract Coordinator (Titles V, X, and XX Family Planning) Berta Cavazos 601 W. Sesame Drive Harlingen, TX 78550 1-956-423-0130 Fax: 1-956-444-3299

A.8 State Participating Local Health Departments and Public Health Districts

State Participating Local Health Departments and Public Health Districts	
Abilene Public Health Department Region 2/3 Larry Johnson, Administrator PO Box 6489 (79608-6489) 2241 South 19th Street Abilene, TX 79605 1-325-692-5600 Fax: 1-915-690-6707	Hidalgo County Health Department Region 11 Eduardo Olivarez, Administrator Omar Garza, MD, Director 1304 South 25th Street Edinburg, TX 78539-7205 1-956-383-6221 Fax: 1-956-383-8864
Amarillo Bi-City-County Health District Department of Health J. Rush Pierce, Jr., MD, Health Authority, Matt Richardson, Director for the City of Amarillo Department of Health 1411 Amarillo Blvd. Amarillo, TX 79105 1-806-351-7220 Fax: 1-806-351-7275	Houston Health & Human Services Department Region 6/5 S Stephen L. Williams, MD, MPH, Director 8000 North Stadium Drive Houston, TX 77054 1-713-794-9311 Fax: 1-713-798-0862
Andrews City-County Health Department Region 9/10 Robert Garcia, MD, Director 211 North West 1st Street Andrews, TX 79714 1-915-524-1434 Fax: 1-915-524-1461	Jackson County Health Department Region 8 Bain C. Cate, MD, Director 411 North Wells, Room 102 Edna, TX 77957 1-512-782-5221 Fax: 1-512-782-7312
Angelina County & Cities Health District Region 4/5N Sharon Shaw, Administrator John Rudis, MD, Director Lufkin, TX 75901 1-936-632-1372 Fax: 1-936-632-2640	Jasper-Newton County Public Health District Region 4/5 N Lanie J. Benson, MD, MPH, Director 139 West Lamar Street Jasper, TX 75951 1-409-384-6829 Fax: 1-409-384-7861
Atascosa County Health Department Region 8 Gerald B. Phillips, MD, Director 1102 Campbell Avenue Jourdanton, TX 78026 1-830-769-3451 Fax: 1-210-769-2349	Jefferson County Health Authority Cecil A. Walkes, MD 1295 Pearl Street Beaumont, TX 77701 1-409-835-8530 Fax: 1-409-839-2353
Austin Department of Health & Human Services Region 7 Health District David Lurie, Director 2100 E. St. Elmo, Building E Austin, TX 78744 1-512-707-3220 Fax: 1-512-707-5404	Liberty County Health Authority Steven C. Ellerbe, DO 720 Travis Liberty, TX 77575 1-936-336-6439 Fax: 1-936-336-6517
Beaumont City Health Department Region 5/6 S Ingrid West-Holmes, Director PO Box 3827 950 Washington Blvd Beaumont, TX 77704 1-409-832-4000 Fax: 1-409-832-4270	Live Oak County Health Department Region 11 Guaracy F. Carvalho, MD, Director Drawer 670 (78022) Live Oak County Courthouse George West, TX 78022 1-361-449-2733 Fax: 1-361-449-3035

State Participating Local Health Departments and Public Health Districts	
Bell County Public Health District Region 7 Wayne Farrell, Director PO Box 3745 (76505) South 9th Street Temple, TX 76501 1-254-778-4766 Fax: 1-254-778-8251	Lubbock City Health Department Region 1 Tommy Camden, Director PO Box 2548 (79408) 1902 Texas Avenue Lubbock, TX 79405 1-806-775-2899 Fax: 1-806-775-3209
Brazoria County Health Department Region 6/5 S Leo D. O'Gorman, MD, MPH, Director 432 East Mulberry Angleton, TX 77515 1-979-864-1484 Fax: 1-979-756-1456	Maverick County Health Department Region 8 Arturo Batres, MD, Director 490 S. Bibb Eagle Pass, TX 78852 1-830-773-9438 Fax: 1-830-773-6450
Brazos County Health Department Region 7 Ken Bost, Executive Director 201 North Texas Avenue Bryan, TX 77803-5317 1-979-361-4440 Fax: 1-409-823-6993	Marshall-Harrison County Health District Region 4/5 N Ginger Garrett, Director PO Box 1627 (75670) 98 East Houston Street Marshall, TX 75670 1-903-938-8338 Fax: 1-903-938-8330
Brownwood-Brown County Health Department Region 2/3 Russ Skinner, MD, Director PO Box 1389 Brownwood, TX 76804 1-325-646-0554 Fax: 1-325-643-8157	Medina County Health Department Region 8 John W. Meyer, MD, Director 3103 Avenue G Hondo, TX 78861 1-830-741-6191 Fax: 1-830-426-4202
Calhoun County Health Department Region 8 Laine Benson, MD, Director 117 West Ash Port Lavaca, TX 77979 1-361-552-9721 Fax: 1-361552-9722	Midland County Health Department Region 9/10 Celestino Garcia, RS, Administrator James M. Humphreys, Jr., MD, Director Mailing address: PO Box 4905 Midland,TX 79704 Physical address: 3303 West Illinois St., Space 22 Midland, TX 79703 1-432-681-7613 Fax: 1-432-681-7634
Cameron County Health Department Region 11 Yvette Salinas, Administrator 1122 Morgan Blvd. Harlingen, TX 78550 1-956-427-8037 Fax: 1-956-427-8107	Milam County Health Department Region 7 Rod Holcombe, Director E. Douglas Perrin, MD, Director PO Box 469 (76520) 209 South Houston Street Cameron, TX 76520 1-254-697-7039 Fax: 1-254-697-4809

State Participating Local Health Departments and Public Health Districts	
Cass County Health Department Region 4/5 N R. Bruce LeGrow, MD, Director PO Box 310 (75563) South Kaufman and Rush Linden, TX 75563 1-903-756-7051 Fax: 1-214-796-3976	Montgomery County Health Department Region 6/5 S Debbie McCarthy, CNM, MSN, Director 508 Medical Center Blvd Conroe, TX 77304-2808 1-936-525-2800 Fax: 1-936-539-4668
Chambers County Health Department Region 6/5 S Leonidas S. Andres, MD, Director PO Box 670 (77514) 1222 Main Street Anahuac, TX 77514 1-409-267-8356 Fax: 1-409-267-4276 landres@ih2000.net	Orange County Health Department Region 6/5 Howard C. Williams, MD Sheila Cole, Director 2014 North 10th Street Orange, TX 77630 1-409-883-6119 Fax: 1-409-883-3147 Williams@pnx.com
Cherokee County Health Department Region 4/5 N Judy Beck, MD, Director 1209 N. Main Street Rusk, TX 75785 1-903-683-4688 Fax: 1-903-683-2393	Paris-Lamar County Health Department Region 4/5 N Anthony Bethel, Director PO Box 938 (75460) 740 South West 6th Street Paris, TX 75460 1-903-785-4561 Fax: 1-903-737-9924
City of Dallas Department of Environmental & Health Services/Region 2/3 Karen D. Rayzer, Director 1500 Marilla Street, Suite 7AN Dallas, TX 75201 1-214-670-5711 Fax: 1-214-670-3863	Plainview-Hale County Health District Region 1 John Castro, Director 111 East 10th Plainview, TX 79072 1-806-293-1359 Fax: 1-806-296-1125
City of Laredo Health Department Region 11 Hector Gonzalez, Director PO Box 2337 (78044) 2600 Cedar Street Laredo, TX 78040 1-956-723-2051 Fax: 1-956-726-2632	Port Arthur City Health Department Region 6/5 S Ernestine Wade, RN, Director 449 Austin Avenue Port Arthur, TX 77640 1-409-983-8800 Fax: 1-409-983-8870
Collin County Health Care Services Region 2/3 Candy Blair, Director 825 North McDonald Street, Suite 130 McKinney, TX 75069 1-972-548-5500 Fax: 1-972-548-7221	San Angelo-Tom Green County Health Department Region 9/10 Mike Loving, Director Mailing address: PO Box 1751 (76902) Physicla address: 2 City Hall Plaza San Angelo, TX 76903 1-915-657-4214 Fax: 1-915-655-4874
Colorado County Health Authority Raymond R. Thomas, MD 610 S. Austin Road Eagle Lake, TX 77434 1-979-234-2551 Fax: 1-979-234-5994	San Antonio Metropolitan Health District Region 8 Fernando Guerra, MD, MPH, Director 332 West Commerce, Suite 307 San Antonio, TX 78205-2489 1-210-207-8730 Fax: 1-210-207-8999

State Participating Local Health Departments and Public Health Districts	
Corpus Christi-Nueces County Public Health District/Region W Annette Rodriguez, Interim Director PO Box 9727 (78469) 1702 Horne Road Corpus Christi, TX 78416 1-512-851-7200 Fax: 1-512-851-7295	San Patricio County Health Department Region 11 Katherine Sessions,Director James Mobley, MD, Director 313 North Rachal Sinton, TX 78387 1-361-364-6208 Fax: 1-361-364-6117
Corsicana-Navarro County Public Health District Region 2/3 Kent Rogers, MD, Director 618 North Main Corsicana, TX 75110 1-903-874-6731 Fax: 1-903-872-7215	Scurry County Health Department Region 2/3 Robert B. Pierce, MD, Director 911 26th Street Snyder, TX 79549 1-325-573-3508 Fax: 1-325-573-0380
Cuero-DeWitt County Health Department Region 8 Bain C. Cate, MD, Director 106 North Gonzales Street Cuero, TX 77954 1-361-275-3461	Smith County Public Health District Region 4/5 N George T. Roberts, Jr., F.A.C.H.E., Director 815 North Broadway Tyler, TX 75702-4507 1-903-535-0036 Fax: 1-903-535-0052
Dallas County Health Department Region 2/3 Zachary S.Thompson, Director 2377 Stemmons Freeway Dallas, TX 75207-2710 1-214-819-6070 Fax: 1-214-819-6022	South Plains Public Health District Region 1 Morris S. Knox, MD, Director 919 East Main Street Brownfield, TX 79316 1-806-637-2164 Fax: 1-806-637-4295
Del Rio-Val Verde County Health Department Manuel A. Martinez, BS, MD, Director 400 Pecan Street (3rd Floor) Del Rio, TX 78840 1-830-774-7570 Fax:1-830-774-7642 manuel_martinez@valverdecounty.org	Sweetwater-Nolan County Health Department Region 2/3 Don Ware, RS, Director PO Box 458 (79556) 301 East 12th Street Sweetwater, TX 7z9556 1-915-235-5463 Fax: 1-915-236-6856
Denton County Health Department Region 2/3 Bing Burton, Administrator 306 N. Loop 288, Suite 183 Denton, TX 76209 1-940-349-2900 Fax: 1-940-349-2905	Texarkana-Bowie County Family Health Center Region 4/5 N Kathy Moore, Administrator 902 West 12th Texarkana, TX 75501 1-903-793-3255 Fax: 1-903-792-2289
Ector County Health Department Region 9/10 Gino Solla, Director Nathan Galloway, MD, Director 221 North Texas Odessa, TX 79761 1-432-498-4141 Fax: 1-432-498-4143	Uvalde City-County Health Department Region 8 Honorable William Mitchell Sterling H. Fly, Jr., MD, Director 119 East South Street Uvalde, TX 78801 1-830-278-2922 Fax: 1-830-278-7682

State Participating Local Health Departments and Public Health Districts	
El Paso City-County Health and Environmental District/Region 9/10 Jorge Magaña, MD, Director 1148 Airway Blvd El Paso, TX 79925-3692 1-915-771-5701 Fax: 1-915-543-3541	Victoria County Health Department Region 8 Lanie Benson, MD, Director PO Box 2350 (77902) 107 West River Victoria, TX 77902 1-512-578-6281 Fax: 1-512-578-7046
Fort Bend County Health Department Region 6/5 S J. Johnson-Minter, MD, Interim Director PO Box 668 (77471) 3409 Avenue F Rosenberg, TX 77471 1-281-342-6414 Fax: 1-281-342-7371	Waco-McLennan County Public Health District Region 7 Janet Emerson, Director 225 West Waco Drive Waco, TX 76707 1-254-750-5450 Fax: 1-254-750-5663
Forth Worth-Tarrant County Department of Public Health Region 2/3 Bob Galvan, Director Nick Curry, MD, Director 1800 University Drive Fort Worth, TX 76107 1-817-871-7237 Fax: 1-817-871-7335	Walker County Health Authority Region 6/5 S M. Gebre-Selassie, MD 2804 Lake Road, #4 Huntsville, TX 77340 1-936-291-9600 Fax: 1-936-291-1625
Galveston County Health District Region 6/5 S Ralph D. Morris, MD, MPH, Director PO Box 939 (77568) 1207 Oak Street La Marque, TX 77568 1-409-938-2401 Fax: 1-409-938-2243 rmorris@gchd.org	Wichita Falls-Wichita County Public Health District Region 2/3 Barbara Clements, RNC, Director Tom Edmonson, Administrator 1700 Third Street Wichita Falls, TX 76301 1-940-761-7800 Fax: 1-940-767-5242
Grayson County Health Department Region 2/3 Carolyn Fruthaler, MD 515 North Walnut Sherman, TX 75090 1-903-893-0131 Fax: 1-903-892-3776	Williamson County and Cities Public Health District Region 7 Karen Wilson, RN, MN, MPH, Director PO Box 570 (78627) 303 Main Street Georgetown, TX 78626 1-512-930-4387 Fax: 1-512-930-3110
Greenville-Hunt County Health Department Region 2/3 Robert F. Deuell, MD, Director Henry Underwood, DO, Director 2500 Lee Street, Rm. 402 Greenville, TX 75401 1-903-455-1761 Fax: 1-903-454-1316	Wilson County Health Department Region 8 Harry L. Chavez, MD, Director PO Box 276 (78114) Wilson County Courthouse Floresville, TX 78114 1-830-393-7350
Hardin County Health Department Region 6/5 S H.A. Hooks, MD, Director PO Box 820 (77625) Highway 326 West Kountze, TX 77625 1-409-246-5188 Fax: 1-409-246-4373	Wood County Health Department Region 4/5 N David C. Murley, MD, Director Wood County Courthouse PO Box 596 (75783 Quitman, TX 75783 1-903-763-5406 Fax: 1-903-763-2902

State Participating Local Health Departments and Public Health Districts	
Harris County Health Department Region 6/5 S 2223 W. Loop South Houston, TX 77027 1-713-439-6016 Fax: 1-713-439-6080 thyslop@hc.co.harris.tx.us	Zavala County Health Department Region 8 Antonio Rivera, MD, Director 600 North John F. Kennedy Drive Crystal City, TX 78839 1-210-374-3010 Fax: 1-210-374-3007
Hays County Health Department Region N Larry Birdwell, DO, Director 401-A Broadway Drive San Marcos, TX 78666 1-512-353-4353 Fax: 1-512-396-4656	

A.9 Program for Amplification for Children of Texas (PACT) Participants

A current list of PACT providers can be found on the DSHS Audiology website at www.dshs.state.tx.us/audio/pactpro.shtm.

A.10 Department of Assistive and Rehabilitative Services (DARS), Blind Services

DARS, Blind Services	
Central Office Administrative Building 4800 North Lamar Administrative Building #100 Austin, TX 78756 1-512-377-0500 1-800-252-5204 (voice or TDD) Fax: 1-512-377-0461	Laredo 313 West Village Blvd., Suite 112 Laredo, TX 78041 1-956-723-2954 1-800-687-7030 Fax: 1-956-791-8142
Abilene 4601 S. 1st Street, Suite M Abilene,TX 79604-0521 1-325-795-5840 1-800-687-7009 Fax: 1-325-795-5850	Lubbock Corporate Center 5121 69th Street, Suite A-5 Lubbock, TX 79424 1-806-798-8181 1-800-687-7032 Fax: 1-806-798-8689
Amarillo 7120 I-40 West, Suite 100 Amarillo, TX 79106-2500 1-806-353-9568 1-800-687-7010 Fax: 1-806-354-0982	Lufkin 3201 South Medford, #5 Lufkin, TX 75901 1-936-634-8700 1-800-687-7033 Fax: 1-936-634-7731
Austin 7517 Cameron Road #120 Austin, TX 78752 1-512-459-8575 1-800-687-7008 Fax: 1-512-453-0200	McAllen 801 Nolana, Suite 115 McAllen, TX 78504 1-956-971-9419 1-800-687-7037 Fax: 1-956-971-9423

DARS, Blind Services	
Beaumont 6432 Concord Road Beaumont, TX 77708 1-409-898-4188 1-800-687-7013 Fax: 1-409-898-4225	Odessa 3016 Kermit Hwy. Odessa, TX 79764 1-432-332-3181 1-800-687-7034 Fax: 1-432-332-3183
Bryan-College Station 1115-A Welsh College Station, TX 77840 1-409-696-9610 1-800-687-7014 Fax: 1-409-693-4291	San Angelo State of Texas Services Center 622 South Oakes, Suite D San Angelo, TX 76903-7013 1-915-659-7920 1-800-687-7038 Fax: 1-915-659-7929
Corpus Christi 410 S. Padre Island Drive, #103 Corpus Christi, TX 78405 1-361-289-1128 1-800-687-7015 Fax: 1-361-289-0754	San Antonio Trinity Building 4204 Woodcock Drive, #274 San Antonio, TX 78228 1-210-325-9751 1-800-687-7039 Fax: 1-210-325-7508
Dallas 6500 Greenville Ave., Suite 250 Dallas,TX 75206 214-378-2600 1-800-687-7017 Fax: 1-214-378-2634	Southeast 10060 Fuqua Houston, TX 77089 1-713-944-9924 1-800-687-7036 Fax: 1-713-944-0851
El Paso 401.E. Franklin, Suite #240 El Paso,TX 79901 1-915-834-7004 1-800-687-7020 Fax: 1-915-834-7072	Texarkana 410 Baylor, Suite C Texarkana, TX 75501 1-903-255-3200 1-800-687-7040 Fax: 1-903-255-3209
Fort Worth 4200 South Freeway, #307 Fort Worth, TX 76115-1404 1-817-759-3500 1-800-687-7023 Fax: 1-817-759-3532	Tyler Woodgate Office Park, Building 1 1121 ESE Loop 323, #106 Tyler, TX 75701 1-903-581-9945 1-800-687-7042 Fax: 1-903-581-9944
Harlingen 1812 West Jefferson Harlingen, TX 78550 1-956-423-9411 1-800-687-7025 Fax: 1-956-423-7145	Victoria Town Plaza Mall 1502 East Airline, #13 Victoria, TX 77901 1-361-575-2352 1-800-687-7043 Fax: 1-361-576-5712
Houston 427 West 20th, #407 Heights Medical Tower Houston, TX 77008 1-713-802-3100 1-800-687-7028 Fax: 1-713-802-3132	Waco 801 Austin Street, Suite 710 Waco, TX 76701 1-254-753-1552 1-800-687-7044 Fax: 1-254-753-1343

DARS, Blind Services	
	Wichita Falls 3709 Gregory Street, Suite 102 Wichita Falls, TX 76308-1624 1-940-691-8675 1-800-687-7045 Fax: 1-940-691-5610

Forms

B.1 Abortion Certification Statements Form

The signature of the physician must be original script (not stamped or typed). A copy of the signed certification statement must be submitted with each claim for reimbursement. Faxes are not acceptable at this time.

"I, (physician's name), certify that on the basis of my professional judgment, an abortion procedure is necessary because (client's full name, Medicaid number, and complete address) suffers from a physical disorder, injury, or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place her in danger of death unless an abortion is performed."

Signature _____

"I, (physician's name), certify that on the basis of my professional judgment, an abortion procedure for (client's full name, Medicaid number, and complete address) is necessary to terminate a pregnancy that was the result of rape. I have counseled the client concerning the availability of health and social support services and the importance of reporting the rape to the appropriate law enforcement authorities."

Signature _____

"I, (physician's name), certify that on the basis of my professional judgment, an abortion procedure for (client's full name, Medicaid number, and complete address) is necessary to terminate a pregnancy that was the result of incest. I have counseled the client concerning the availability of health and social support services and the importance of reporting the incest to the appropriate law enforcement authorities."

Signature _____

B.2 Affidavit

THE STATE OF TEXAS

COUNTY OF _____

AFFIDAVIT

Before me, the undersigned authority, personally appeared, who being by me duly sworn, deposed as follows:

My name is _____

I am of sound mind, capable of making the affidavit, and personally acquainted with the facts herein stated:

I am the custodian of the records of _____
(Facility Name and Address)

_____

Attached here are _____ pages from the medical record of:
(# of Pages)

_____
(Patient Name)

Hospital Stay period: _____
(Admission and Discharge Date)

These pages of records are kept by said Hospital in the regular course of business and it was in the regular course of hospital business for an employee or representative of said Hospital, with knowledge of the act, event, condition, opinion or diagnosis recorded, to make the record or to transmit information thereof to be included in such record and the record was made at or near the time or reasonably soon thereafter.

The record attached hereto is the **original or an exact duplicate of the original** and **no other** documents exist on the files for the above named person, which pertain to the admission and discharge, noted above.

_____
(Signature)

SWORN TO AND SUBSCRIBED before me on this _____ day of _____. 200_____

_____
(Notary Public in and for the STATE OF TEXAS)

SEAL

_____
(Printed Name)

My commission expires: _____

B.3 Ambulance Fax Cover Sheet

Texas Medicaid & Healthcare Partnership
12357-B RIATA TRACE PKWY, STE 150
Austin, TX 78727

DATE: _____ TIME: _____(AM) (PM)

FROM: _____ TO: AMBULANCE UNIT

PHONE: _____ PHONE: 1-800-540-0694

FAX: _____ FAX: 1-512-514-4205

*For clients who meet the definition of severely disabled: The client's physical condition limits his/her mobility, which requires the client to be bed-confined at all times or life support systems to be monitored.

If Hospital to Hospital or Hospital Discharge, supply:

ORIGIN: _____ DESTINATION: _____

All providers supply the following information:

*The requestor's name and title _____

*The client's full name _____

*The client's Medicaid number _____

*The initial transport date _____

*Full name of the transporting Ambulance Company _____

*Texas Provider Identifier (TPI) of the transporting Ambulance Company _____

*National Provider Identifier (NPI) of the transporting Ambulance Company _____

*Taxonomy Code of the transporting Ambulance Company _____

*The type of Prior Authorization being requested: _____Short Term (1–60 days)

Please supply one or more of the following documentation:

*Admit and discharge records for dates of service

*A history and physical that has been done within 6 months

*The Care Plan with Daily Activity Sheet from the Nursing Home within 6 months

*Home Health Care Plan within 6 months

NUMBER OF PAGES INCLUDING COVER SHEET:_____

Effective Date_07302007/Revised Date_11142007

B.4 Authorization to Release Confidential Information (2 Pages)

PATIENT'S NAME _____

I authorize _____ and/or _____, and/or
(Name of HMO) (Name of BHO)

the following person/agency/group:

_____

Provider/Agency/Group Address City State ZIP

To disclose information and records regarding my treatment, medical and/or behavioral health condition to the following professional person/agency, physician and/or facility;

_____

Provider/Agency/Group Address City State ZIP

Information to be released or exchanged include (check all that apply):

_____ History and physical

_____ Discharge and Summary

_____ Behavioral Health Treatment Records

_____ Laboratory Reports

_____ Physical Health Treatment Records

_____ Medication Records

_____ Information on HIV or communicable disease treatment

_____ Other (specify) _____

The authorized purpose(s) for this release are:

_____ Diagnosis and Treatment

_____ Coordination of Care

_____ Insurance Payment Purposes

_____ Other (specify) _____

I understand that my health and behavioral health records are protected from disclosure under Federal and/or state law. I may revoke this authorization. This authorization is valid until I revoke it or sixty (60) days after I have completed treatment, whichever is sooner. Once I revoke this authorization, no information can be released except as authorized or allowed by law. File copy is considered equivalent to the original.

This authorization was explained to me as I signed it of my own free will on:

The _____day of _____, 20____.

_____ _____

Signature of Client Signature of Witness

_____

Signature of Parent, Guardian, or Authorized Representative, if required

NOTICE OF CLIENT'S REFUSAL TO RELEASE INFORMATION:

I have reviewed the above release of information form and refuse to authorize release of health and behavioral health information to mental health and/or alcohol and/or drug abuse treatment providers and/or physical health providers.

Executed this _____day of _____, 20____.

_____ _____

Signature of Client Signature of Witness

_____

Signature of Parent, Guardian, or Authorized Representative, if required

The person signing this authorization is entitled to a copy.

TO PERSON RECEIVING THE CONFIDENTIAL INFORMATION: PROHIBITION OF REDISCLOSURE

Federal and state law protects the confidentiality of the information disclosed to you related to the individual's alcohol and drug abuse treatment. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by such regulations. Disclosure is limited to the purpose and persons included on the authorization form. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. State laws may also protect the confidentiality of the client's records.

TO THE INDIVIDUAL FILLING THIS OUT:
You have the right to ask us about this form. You also have the right to review the information you give us on the form. (There are a few exceptions). If the information is wrong, you can ask us to correct it. The Health and Human Services Commission has a method of asking for corrections. You can find it in Title 1 of the Texas Administrative Code, section 351.17 through 351.23. To talk to someone about this form or ask for corrections, please contact NorthSTAR. You can write to NorthSTAR at 1199 S. Beltline Rd., Coppell, Texas 75019. You can also call the NorthSTAR Helpline at 1-972-906-2500.

B.5 Authorization to Release Confidential Information (2 Pages) (Spanish)

NOMBRE DEL PACIENTE _____

Autorizo a _____, a _____ y a la siguiente persona, agencia o grupo:
(Nombre de la HMO) (Nombre de la BHO)

_____

Proveedor/Agencia/Grupo Dirección Ciudad Estado ZIP

para que divulgue información y expedientes relacionados con mi tratamiento y estado de salud física, mental o de abuso de sustancias a las siguientes personas, agencias, doctores y centros profesionales:

_____

Proveedor/Agencia/Grupo Dirección Ciudad Estado ZIP

La información que se divulgará o intercambiará es, entre otra (marque toda la que sea pertinente):

_____ Historia clínica y física

_____ Documentos de alta y resumen

_____ Documentos del tratamiento de la salud mental y abuso de sustancias

_____ Informes de laboratorio

_____ Documentos del tratamiento de la salud física

_____ Documentos de medicamentos

_____ Información del tratamiento del VIH o de las enfermedades transmisibles

_____ Otra (especifique) _____

Esta divulgación se ha autorizado con el siguiente propósito (marque todos los que sean pertinentes):

_____ Diagnóstico y tratamiento

_____ Coordinación de la atención médica

_____ Pagos del seguro

_____ Otro (especifique) _____

Entiendo que mis expedientes de salud mental y abuso de sustancias están protegidos contra la divulgación bajo la ley federal o estatal. Puedo revocar esta autorización. Esta autorización tiene vigencia hasta que yo la revoque o sesenta (60) días después de que yo haya terminado el tratamiento, lo que suceda primero. Una vez que revoque esta autorización, no se podrá divulgar ninguna información, excepto como lo autorice o lo permita la ley. La copia de archivo se considera equivalente al original.

Se me explicó esta autorización y la firmé por mi propia voluntad:

El día _____ del mes de _____ de 20____.

_____ _____

Firma del cliente **Firma del testigo**

_____

Firma del padre, tutor o representante autorizado, si es necesario

AVISO SOBRE LA DECISIÓN DEL CLIENTE DE NO AUTORIZAR LA DIVULGACIÓN DE INFORMACIÓN:

He revisado el formulario anterior para la divulgación de información y me he negado a autorizar la divulgación de información de salud mental y abuso de sustancias a los proveedores de salud física o de tratamiento de salud mental o contra el abuso de alcohol o drogas.

Firmado este día _____ del mes de _____ de 20____.

_____ _____

Firma del cliente **Firma del testigo**

_____

Firma del padre, tutor o representante autorizado, si es necesario

La persona que firma esta autorización tiene derecho a una copia.

PARA LA PERSONA QUE RECIBE LA INFORMACIÓN CONFIDENCIAL: PROHIBICIÓN SOBRE LA DIVULGACIÓN

Las leyes federales y estatales protegen la confidencialidad de la información que usted recibió sobre el tratamiento del abuso de alcohol y drogas de la persona. Las normas federales (42 CFR Parte 2) le prohiben a usted dar esta información a otra persona a menos que se haya permitido expresamente en un consentimiento escrito de la persona de quien se trata, o de otra manera permitida por dichas normas. La divulgación se limita al propósito y a la persona anotados en el formulario de autorización. Las reglas federales limitan el uso de la información a investigar o enjuiciar penalmente a algún paciente que tiene problemas de abuso de alcohol o drogas. Es posible que las leyes estatales también protejan la confidencialidad de los expedientes del paciente.

PARA LA PERSONA QUE LLENA ESTE FORMULARIO:

Tiene el derecho de hacernos preguntas sobre este formulario. También tiene el derecho de revisar la información que nos da en el formulario. (Hay algunas excepciones). Si la información está incorrecta, puede pedir que la corrijamos. La Comisión de Salud y Servicios Humanos tiene un método para pedir correcciones. Puede encontrarlo en el Título 1 del Código Administrativo de Texas, Secciones 351.17 a 351.23. Para hablar con alguien acerca de esta forma, o para pedir correcciones, haga el favor de comunicarse con NorthSTAR. Puede comunicarse con NorthSTAR escribiendo a 1199 S. Beltline Rd., Coppell, Texas 75019 ó llamando a la Línea de Ayuda de NorthSTAR al 1-972-906-2500.

B.6 Birthing Center Report (Newborn Child or Children) Form 7484

MAIL FORM TO:

Texas Health and Human Services Commission
Data Integrity 952-X
PO BOX 149030
Austin, TX 78714-9030

Date Rec'd in Data Integrity

PURPOSE: This form is to be used by BIRTHING CENTERS ONLY to report the birth of a child of a mother currently eligible under the Medicaid program of the Texas Health and Human Services Commission (HHSC). All data items below must be completed to avoid delay in future medicaid claims payments. If the child's FIRST name is unknown at the time this form is completed, the last name will suffice and must be shown.

ACTION: To avoid delay in your receiving notice of the Medicaid client number of the newborn child, please complete this document and submit it to HHSC within 5 days after the birth of the child. The 5 days is a guideline and is not mandatory. Notice of the assigned client number will be promptly mailed to you for use in submitting the child's Medicaid claim.

To avoid delay in processing the child's Medicaid claims, please retain all Medicaid claims of the newborn child until you receive a client number for the child. All newborn claims should then be submitted to TMHP using the newly assigned client number.

Mother's Name (Last, First, MI)		Admission Date (mm/dd/yy)	Mother's Medicaid client No.
Mother's Mailing Address–Street		Mother's D.O.B. (mm/dd/yy)	Mother's Medical Record No.
City, State, ZIP			
Child's Name (Last, First, MI)	Sex ❑ M ❑ F	Child's DOB (mm/dd/yy)	Child's Medical Record No.
Child's Name (Last, First, MI)	Sex ❑ M ❑ F	Child's DOB (mm/dd/yy)	Child's Medical Record No.
Child's Name (Last, First, MI)	Sex ❑ M ❑ F	Child's DOB (mm/dd/yy)	Child's Medical Record No.

Has the mother relinquished her rights to the newborn child? . . . . . ❑Yes ❑No

If "Yes," give date of relinquishment . . . . . _____

Certified Midwife
Birthing Center Name
Birthing Center Address – Street
City, State, ZIP

Certification No C N M 0 0	TPI
Completed By (please type or print)	
Birthing Center Telephone No. ( )	Date Form Mailed

B.7 Child Abuse Reporting Guidelines (2 Pages)

HHSC Child Abuse Screening, Documenting, and Reporting Policy for Medicaid Providers

Each contractor/provider shall comply with the provisions of state law as set forth in Chapter 261 of the Texas Family Code relating to investigations of report of child abuse and neglect and the provisions of this HHSC policy. HHSC shall distribute funds only to a contractor/provider who has demonstrated a good faith effort to comply with child abuse reporting guidelines and requirements in Chapter 261 and this HHSC policy. Contractor/provider staff shall respond to disclosures or suspicions of abuse/neglect of minors [by reporting] to appropriate agencies as required by law.

PROCEDURES

I Each contractor/provider shall adopt this policy as its own.

II Each contractor/provider shall report suspected sexual abuse of a child as described in this policy and as required by law.

III. Each contractor/provider shall develop an internal policy and procedures that describe how it will determine, document, and report instances of abuse, sexual or nonsexual, in accordance with the Texas Family Code, Chapter 261.

REPORTING GENERALLY

I Professionals as defined in the law are required to report not later than the 48th hour after the professional first has cause to believe the child has been or may be abused or is the victim of the offense of indecency with a child.

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

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

IV Reports of abuse or indecency with a child shall be made to:

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

V The law requires that the following be reported:

- A Name and address of the minor, if known;
- B Name and address of the minor's parent or the person responsible for the care, custody, or welfare of the child if not the parent, if known; and
- C Any other pertinent information concerning the alleged or suspected abuse, if known.

VI Reports can be made anonymously.

VII A contractor/provider may not reveal whether or not the child has been tested or diagnosed with HIV or AIDS.

VIII If the identity of the minor is unknown (e.g., the minor is at the provider's office to anonymously receive testing for HIV or an STD), no report is required.

REPORTING SUSPECTED SEXUAL ABUSE

I Each contractor/provider shall ensure that its employees, volunteers, or other staff report a victim of abuse who is an unmarried minor under 14 years of age and is pregnant or has a confirmed sexually transmitted disease acquired in a manner other than through perinatal transmission.

II The Texas Family Code, Chapter 261, requires other reporting of other instances of sexual abuse. Other types of reportable abuse may include, but are not limited to, the actions described in:

- A Penal Code, §21.11(a) relating to indecency with a child;
- B Penal Code, §21.01(2) defining "sexual contact";
- C Penal Code, §43.01(1) or (3)-(5) defining various sexual activities; or
- D Penal Code, §22.011(a)(2) relating to sexual assault of a child;
- E Penal Code, §22.021(a)(2) relating to aggravated sexual assault of a child.

III Each contractor/provider may utilize the attached Checklist for HHSC Monitoring for all clients under 14 years of age. The checklist, if used, shall be retained by each contractor/provider and made available during any monitoring conducted by HHSC.

TRAINING

I Each contractor/provider shall develop training for all staff on the policies and procedures in regard to reporting child abuse. New staff shall receive this training as part of their initial training/orientation. Training shall be documented.

II As part of the training, staff shall be informed that the staff person who conducts the screening and has cause to suspect abuse has occurred is legally responsible for reporting. A joint report may be made with the supervisor.

B.8 Child Abuse Reporting Guidelines, Checklist for HHSC Monitoring

Date: _____

Client's name: _____

Client's age (use this checklist only if the client is under 14): _____

Staff person conducting screening: _____

Each contractor/provider shall ensure that its employees, volunteers, or other staff report a victim of child abuse who is a minor under 14 years of age who has engaged in sexual activity with any individual to whom the minor is not married. Sexual activity would be indicated if the minor is pregnant or has confirmed diagnosis of a sexually transmitted disease acquired in a manner other than through perinatal transmission.

Using the criteria above, did you determine that a report of child abuse is required? _____ Yes _____ No

If "yes," please report and complete the information below.

Report was made: _____ Yes _____ No

Staff person who submitted the report (optional): _____

Date reported: _____

Name of agency to which report was made: _____

DFPS call ID# or law enforcement assigned # (optional): _____

Name of person who received report (optional): _____

Phone number of contact (when applicable): _____

B

Use of the checklist for HHSC monitoring of reporting of abuse of children younger than 14 years of age who are pregnant or have STDs does not relieve contractors or subcontractors of the requirements in Chapter 261, Texas Family Code, to report any other instance of suspected child abuse.

B.9 Claim Status Inquiry (CSI) Authorization Form

This form is for ACUTE CARE providers only.

If you are a Long Term Care provider, contact TMHP's EDI Help Desk at 888-863-3638 to request the correct form.

The following information MUST be completed before you can be granted Claim Status Inquiry (CSI) access.

1. Enter your Production User ID: _____

2. Enter your Production User ID Password: _____

*The TMHP **Production User ID** (Submitter ID) is the electronic mailbox ID used for downloading your Claim Status Inquiry reports. For assistance with identifying and using your Production User ID and password, contact your software vendor or clearinghouse.*

3. Select Action:

A ☐ Add Claim Status Inquiry Privileges

B ☐ Revoke Claim Status Inquiry Privileges

4. Enter organization information:

*List the billing Texas Provider Identifier (TPI) and National Provider Identifier (NPI) number(s) you choose to access using the Production User ID given above. **Submit additional copies of this form if you need to add more TPI and NPI numbers.***

Provider Name *Must be the name associated with the TPI Base number listed at right.*	**7–Digit BILLING TPI Base Number** *The first 7 digits of the 9 digit TPI number.**	**10-digit BILLING NPI/API***

***Note:** *Performing TPI and NPI/API numbers do not have Claim Status Inquiry access. Enter only **BILLING** TPI and NPI/API numbers.*

5. Enter Requestor Information:

Name: _____

Title: _____

Signature: _____

Telephone Number: _____ ext. _____

Fax Number: _____ ext. _____

6. Return this form to:

Texas Medicaid & Healthcare Partnership
Attention: EDI Help Desk, MC–B14
PO Box 204270
Austin, TX 78720-4270

Or Fax to
512-514-4228 or 512-514-4230

DO NOT WRITE IN THIS AREA — For Office Use

Input By: _____ Input Date: _____ Mailbox ID: _____

Effective Date_07302007/Revised Date_06012007

B.10 Client Medicaid Identification (Form H3087) (19 Pages)

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/24/2008	610098	40	30	02	123456789	AUGUST 31, 2008

952-X 123456789 40 30 02 030711
JOHN DOE
743 GOLF IRONS
DEL VALLE TX 78617

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

Under 21 years old? Please call your doctor, nurse or dentist to schedule a checkup if you see a reminder under your name. If there is no reminder, you can still use Medicaid to get health care that you need.

A ✓ on the line to the right of your name means that you can get that service too.

READ THE BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

¿Tiene menos de 21 años? Por favor, llame a su doctor, enfermera o dentista para hacer una cita si hay una nota debajo de su nombre. Aunque no haya ninguna nota, puede usar Medicaid para recibir la atención médica que necesite.

Las marcas ✓ a la derecha en el mismo renglón donde está su nombre significan que usted puede recibir esos servicios también.

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	DENTAL SERVICES	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JOHN DOE	08-27-1997	M	07-09-2008			✓	✓	✓		✓	✓

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-G1/April 2007

B

FOR THE CLIENT: About your Medicaid ID Form

This is your Medicaid Identification form. A new Medicaid Identification form will be mailed to you each month. Take your most recent Medicaid Identification form with you when you visit your doctor or receive services from any of your health care providers. This form helps health care providers know which services you can receive and to bill Medicaid.

If you receive a letter from HHSC stating that the Medicaid program will not pay for certain health services your provider thinks you need, the letter will inform you of your right to ask for a fair hearing to appeal the denial of services. The letter will tell you whom to call or where you can write to request a hearing.

NOTE: According to state law a recipient of Medicaid automatically gives HHSC his or her right to financial recovery from personal health insurance, other recovery sources and money received as a result of personal injuries, to the extent HHSC has paid for medical services. This allows HHSC to recover the costs of medical services paid by the Medicaid program. Any applicant or recipient who knowingly withholds information regarding any sources of payment for medical services violates state law.

Get Answers to Your Questions		
Question	**Contact**	**Phone**
Whom can I call to find out which services are paid by Medicaid?	**Medicaid Hotline**	**1-800-252-8263**
Whom can I call if I get a bill from a Medicaid provider?	**Texas Medicaid Healthcare Partnership Client Hotline**	**1-800-335-8957**
Whom should I call if I need help finding or contacting a doctor, dentist, case manager, or other Medicaid provider for someone 21 years old or younger?	**Texas Health Steps**	**1-877-847-8377**
Who can drive me to my Medicaid provider?	**Medical Transportation**	**1-877-633-8747**
Who can help me if I have questions or problems with my health plan, or my Primary Care Case Management (PCCM) doctor?	**STARLINK**	**1-866-566-8989**
If I am receiving help paying my high medical bills and I need information about my case, whom do I call?	**Texas Medicaid Healthcare Partnership Client Hotline**	**1-800-335-8957**
Whom can I call to find out about nursing home care, adult day care or other long-term care services?	**Department of Aging and Disability Services Consumer Rights Hotline**	**1-800-458-9858**
Who can tell me about how my other insurance might affect my Medicaid benefits?	**Texas Medicaid Healthcare Partnership Third Party Resources Hotline**	**1-800-846-7307**
To whom do I report Medicaid fraud, waste or abuse?	**Office of Inspector General**	**1-800-436-6184**
Whom do I talk to about helping me pay my private insurance premiums?	**Health Insurance Premium Program Hotline**	**1-800-440-0493**
Whom do I talk to if I receive supplemental security income and I need to change my address?	**Social Security Administration**	**1-800-772-1213**
Whom do I call if I have questions about my Medicare Rx Prescription Program?	**Medicare**	**1-800-MEDICARE (1-800-633-4227)**

PARA EL CLIENTE: información sobre la forma de identificación de Medicaid

Esta es su forma de Identificación de Medicaid. Se le enviará por correo una nueva forma de Identificación de Medicaid cada mes. Lleve con usted la forma más reciente cuando vaya al doctor o reciba servicios de uno de sus proveedores de atención médica. Esta forma ayuda a los proveedores de atención médica a saber cuáles servicios puede recibir usted y a facturar a Medicaid.

Si recibe una carta de la Comisión de Salud y Servicios Humanos (HHSC) indicando que el programa Medicaid no pagará ciertos servicios de salud que su proveedor cree que usted necesita, la carta le informará de su derecho de pedir una audiencia imparcial para apelar la negación de servicios. La carta le indicará a quién debe llamar o a dónde puede escribir para solicitar una audiencia.

NOTA: según las leyes estatales una persona que recibe Medicaid le otorga automáticamente a la HHSC su derecho a recuperación económica de un seguro de salud personal, otras fuentes de recuperación y dinero que reciba por lesiones personales, hasta en la medida en la que la HHSC haya pagado por servicios médicos. Esto le permite a la HHSC recuperar los costos de servicios médicos pagados por el programa Medicaid. Cualquier solicitante o cliente que a sabiendas retenga información sobre las fuentes de pago por servicios médicos viola la ley estatal.

Reciba respuestas a sus preguntas		
Pregunta	Contacto	Teléfono
¿A quién puedo llamar para información sobre que servicios paga el Medicaid?	Línea directa de Medicaid	1-800-252-8263
¿A quién puedo llamar si recibo una cuenta de un proveedor de Medicaid?	Línea Directa del Cliente de Texas Medicaid Healthcare Partnership	1-800-335-8957
¿A quién debo llamar si necesito ayuda para encontrar o comunicarme con un doctor, dentista, administrador de casos u otro proveedor de Medicaid para alguien que tiene 21 años o menos?	Pasos Sanos de Texas	1-877-847-8377
¿Quién me puede llevar a mi proveedor de Medicaid?	Transporte médico	1-877-633-8747
¿Quién me puede ayudar si tengo preguntas o problemas con mi plan de salud o con mi doctor de Primary Care Case Management (PCCM)?	STARLINK	1-866-566-8989
Si estoy recibiendo ayuda para pagar mis cuentas médicas elevadas y necesito información sobre mi caso, ¿a quién llamo?	Línea Directa del Cliente de Texas Medicaid Healthcare Partnership	1-800-335-8957
¿A quién puedo llamar para información sobre la atención en una casa para convalecientes, cuidado de adultos durante el día, u otros servicios de atención a largo plazo?	Línea Directa del Derecho al Consumidor del Departamento de Servicios a Adultos Mayores y Personas Discapacitadas	1-800-458-9858
¿Quién me puede decir como puede afectar mi otro seguro médico mis beneficios de Medicaid?	Línea Directa de Recursos de Terceros de Texas Medicaid Healthcare Partnership	1-800-846-7307
¿A quién le denuncio el fraude, malgasto o abuso de Medicaid?	Oficina de la Fiscalía General	1-800-436-6184
¿Con quién hablo sobre ayuda para pagar mis primas de seguro privado?	Línea Directa del Programa de Primas de Seguro de Salud	1-800-440-0493
¿Con quién hablo si recibo Seguridad de Ingreso Suplementario y necesito cambiar mi dirección?	Administración de Seguro Social	1-800-772-1213
¿A quién llamo si tengo preguntas sobre mi Programa de Medicare Rx para Medicamentos con Receta?	Medicare	1-800-MEDICARE (1-800-633-4227)

Form H3087/Page 2/03-2007

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

1 ATFF 01-00001

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/05/2008	610098		40	02	123456789	JULY 31, 2008

952-X 123456789 40 02 030731
JANE DOE
743 GOLF IRONS
HUNTINGTON TX 75949

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

Under 21 years old? Please call your doctor, nurse or dentist to schedule a checkup if you see a reminder under your name. If there is no reminder, you can still use Medicaid to get health care that you need.

A ✓ on the line to the right of your name means that you can get that service too.

READ THE BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

¿Tiene menos de 21 años? Por favor, llame a su doctor, enfermera o dentista para hacer una cita si hay una nota debajo de su nombre. Aunque no haya ninguna nota, puede usar Medicaid para recibir la atención médica que necesite.

Las marcas ✓ a la derecha en el mismo renglón donde está su nombre significan que usted puede recibir esos servicios también.

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	DENTAL SERVICES	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	12-09-1999	F	06-01-2008			✓	✓	✓		✓	✓

THSTEPS MEDICAL AND DENTAL CHECK-UP DUE / NECESITA SU EXAMEN MEDICO Y DENTAL DE THSTEPS

B

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-G2/April 2007

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

41 ATFF 01-00041

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/15/2008	610098		37	02	123456789	JULY 31, 2008

LIMITED

952-X 123456789 37 02 030731
JANE DOE
743 GOLF IRONS
CROCKETT TX 75835

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

Under 21 years old? Please call your doctor, nurse or dentist to schedule a checkup if you see a reminder under your name. If there is no reminder, you can still use Medicaid to get health care that you need.

A ✓ on the line to the right of your name means that you can get that service too.

READ THE BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

¿Tiene menos de 21 años? Por favor, llame a su doctor, enfermera o dentista para hacer una cita si hay una nota debajo de su nombre. Aunque no haya ninguna nota, puede usar Medicaid para recibir la atención médica que necesite.

Las marcas ✓ a la derecha en el mismo renglón donde está su nombre significan que usted puede recibir esos servicios también.

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	DENTAL SERVICES	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	01-05-1997	F	06-01-2008				✔	✔		✔	✔

LIMITED

TO DOCTOR: **
JAMES B SMITH MD **
WEST MEDICAL BLDG. **
111 EAST 18TH AVE. **
AUSTIN TX 78759 **

TO PHARMACY:
HAPPY PHARMACY
11223 WEST 27th

AUSTIN TX 78759

FOR ADDITIONAL INFORMATION REGARDING LIMITATION TO ONE PRIMARY CARE PROVIDER AND/OR PHARMACY
Call the Limited Program at 1-800-436-6184

PARA MÁS INFORMACIÓN SOBRE EL USO DE UN SOLO PROFESIONAL MÉDICO O UNA SOLA FARMACIA
Llame al Programa Limitado a 1-800-436-6184

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-GL/April 2007

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

15 ATFF 01-00015

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/24/2008	610098	13	13	04	123456789	JULY 31, 2008

MQMB

952-X 123456789 13 13 04 030731
JANE DOE
743 GOLF IRONS
GRANGER TX 76530

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

Under 21 years old? Please call your doctor, nurse or dentist to schedule a checkup if you see a reminder under your name. If there is no reminder, you can still use Medicaid to get health care that you need.

A ✓ on the line to the right of your name means that you can get that service too.

READ THE BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

¿Tiene menos de 21 años? Por favor, llame a su doctor, enfermera o dentista para hacer una cita si hay una nota debajo de su nombre. Aunque no haya ninguna nota, puede usar Medicaid para recibir la atención médica que necesite.

Las marcas ✓ a la derecha en el mismo renglón donde está su nombre significan que usted puede recibir esos servicios también.

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	DENTAL SERVICES	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	01-14-1946	F	09-01-2008		123456789HIC	✔				✔	✔

NOTICE TO PROVIDER

This recipient is eligible for regular Medicaid benefits.

This recipient is also eligible for coverage of Medicare deductible and coinsurance liabilities on valid Medicare claims. Coverage is subject to Medicaid reimbursement limitations.

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-GM/April 2007

B

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030
RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

8 ATFF 01-00008
Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN PARA MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/24/2008	610098	13	14	04	123456789	JULY 14, 2008

Q M B

952-X 123456789 13 14 04 030714
JOHN DOE
743 GOLF IRONS
LAREDO TX 78046

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.
765432198	JOHN DOE	11-30-1962	M	07-01-2008	M	123456789HIC

Q M B

QUALIFIED MEDICARE BENEFICIARIES

NO MEDICARE PRESCRIPTION DRUGS AUTHORIZED. YOU ARE ELIGIBLE FOR MEDICARE RX.

NO SE AUTORIZÓ NINGUNA RECETA MÉDICA DE MEDICARE. USTED LLENA LOS REQUISITOS PARA RECIBIR MEDICARE RX.

Notice to Providers :

THIS CLIENT IS ELIGIBLE FOR QMB BENEFITS ONLY.

This client is eligible only for coverage of Medicare deductible and coinsurance liabilities on valid Medicare claims. Coverage is subject to Medicaid reimbursement limitations.

Form H3087-C1/January 2006

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

41 ATFF 01-00041

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/15/2008	610098		37	02	123456789	July 31, 2008

EMERGENCY

952-X 123456789 37 02 030731
JANE DOE
743 GOLF IRONS
CROCKETT TX 75835

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	DENTAL SERVICES	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	01-05-1999	F	06-01-2008				✔	✔		✔	✔

B

TO DOCTOR:	**	TO PHARMACY:
JAMES B SMITH MD	**	HAPPY PHARMACY
WEST MEDICAL BLDG.	**	11223 WEST 27th
111 EAST 18TH AVE.	**	
AUSTIN TX 78759	**	AUSTIN TX 78759

Form H3087-EM/April 2007

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

1 ATFG 01-00001

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	**GOOD THROUGH:** VÁLIDA HASTA:
07/24/2008	610098	13	13	04	123456789	AUGUST 31, 2008

HOSPICE

952-X 123456789 13 13 04 030831
JANE DOE
743 GOLF IRONS
CARROLTON TX 75006

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

Under 21 years old? Please call your doctor, nurse or dentist to schedule a checkup if you see a reminder under your name. If there is no reminder, you can still use Medicaid to get health care that you need.

A ✓ on the line to the right of your name means that you can get that service too.

READ THE BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

¿Tiene menos de 21 años? Por favor, llame a su doctor, enfermera o dentista para hacer una cita si hay una nota debajo de su nombre. Aunque no haya ninguna nota, puede usar Medicaid para recibir la atención médica que necesite.

Las marcas ✓ a la derecha en el mismo renglón donde está su nombre significan que usted puede recibir esos servicios también.

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	DENTAL SERVICES	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	10-28-1944	F	07-01-1999			✔	✔	✔		✔	✔

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-GH/April 2007

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

191 ATFF 01-00191

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/15/2008	610098	13	13	04	123456789	JULY 31, 2008

LIMITED PHARMACY

STAR+PLUS PROGRAM
Your Health Plan ■ Your Choice

952-X 123456789 13 13 04 030731
JANE DOE
743 GOLF IRONS
HOUSTON TX 77228

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

You are enrolled in STAR+PLUS, the state's plan for Medicaid in your county. You have a Primary Care Provider (PCP). Your health plan and PCP are listed under your name. If you have Medicare you will not have a PCP listed.

If you have any concerns or questions about STAR+PLUS, please call 1-800-964-2777 for help.

READ BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

Usted está inscrito en STAR+PLUS, el plan del estado para Medicaid en su condado. Tiene un Proveedor de Cuidado Primario (PCP). Bajo su nombre aparecen el nombre de su plan de salud y de su PCP. Si usted recibe Medicare, el nombre del PCP no aparecerá.

Si tiene alguna inquietud o pregunta con respecto a **STAR+PLUS**, por favor, llame al **1-800-964-2777** para conseguir ayuda.

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	DENTAL SERVICES	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	01-05-1985	F	10-01-1997			✔	✔	✔		✔	✔
	/	/WELBY	MARCUS	L MD								

B

LIMITED PHARMACY

** TO PHARMACY:
** HAPPY PHARMACY
** 11223 WEST 27th
** AUSTIN TX 78759

FOR ADDITIONAL INFORMATION REGARDING LIMITATION TO ONE PHARMACY

Call the Limited Program at 1-800-436-6184

PARA MÁS INFORMACIÓN SOBRE EL USO DE UNA SOLA FARMACIA

Llame al Programa Limitado a 1-800-436-6184

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-P1/April 2007

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

31 ATFF 01-00031

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/24/2008	610098		42	02	123456789	JULY 31, 2008

P E

952-X 123456789 42 02 030731
JANE DOE
743 GOLF IRONS
RIO BRAVO TX 78046

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	DENTAL SERVICES	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	11-08-1995	F	07-14-2008			✔	✔	✔		✔	✔

PRESUMPTIVE ELIGIBILITY

Notice to Providers: This client has been approved for Presumptive Medicaid Eligibility for Pregnant Women until the regular Medicaid determination is made.

Medicaid covered services during the presumptive eligibility period are limited to medically necessary outpatient services and family planning services. Labor, delivery, inpatient services and THSteps medical and dental services are not covered.

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-PE/April 2007

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030
RETURN SERVICE REQUESTED

190 ATFF 01-00190
Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/15/2008	610098	13	13	04	123456789	JULY 31, 2008

LIMITED PHARMACY

STAR+PLUS PROGRAM
Your Health Plan ■ Your Choice

952-X 123456789 13 13 04 030731
JANE DOE
743 GOLF IRONS
HOUSTON TX 77220

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

You are enrolled in STAR+PLUS, the state's plan for Medicaid in your county. You have a Primary Care Provider (PCP). Your health plan and PCP are listed under your name. If you have Medicare you will not have a PCP listed.

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

Usted está inscrito en STAR+PLUS, el plan del estado para Medicaid en su condado. Tiene un Proveedor de Cuidado Primario (PCP). Bajo su nombre aparecen el nombre de su plan de salud y de su PCP. Si usted recibe Medicare, el nombre del PCP no aparecerá.

If you have any concerns or questions about STAR+PLUS, please call 1-800-964-2777 for help. READ BACK OF THIS FORM!

Si tiene alguna inquietud o pregunta con respecto a **STAR+PLUS,** por favor, llame al **1-800-964-2777** para conseguir ayuda.
¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.
765432198	JANE DOE	07-25-1984	F	03-01-1996		

BEST HEALTH PLAN /1-800-123-4567 / CALL HEALTH PLAN FOR PCP NAME OR OTHER INFORMATION

LIMITED PHARMACY

** TO PHARMACY:
** HAPPY PHARMACY
** 11223 WEST 27th
** AUSTIN TX 78759

FOR ADDITIONAL INFORMATION REGARDING LIMITATION TO ONE PRIMARY CARE PHARMACY Call the Limited Program at 1-800-436-6184

PARA MÁS INFORMACIÓN SOBRE EL USO DE UNA SOLA FARMACIA
Llame al Programa Limitado a 1-800-436-6184

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-PL/February 2007

B

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

1 ATFF 01-00001

Texas Health and Human Services Commission

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/15/2008	610098	13	13	04	123456789	JULY 31, 2008

TEXAS STAR PROGRAM
Your Health Plan ■ Your Choice

952-X 123456789 13 13 04 030731
JANE DOE
743 GOLF IRONS
LUCAS TX 75002

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

You are enrolled in the STAR Program. Your health plan's name and telephone number are listed under your name. You have a Primary Care Provider (PCP). Call your health plan for your PCP's name.

If you see a reminder under your name, please call your PCP or dentist to schedule a checkup. If you do not see a reminder and are 21 or older, you can get a medical checkup from your PCP once a year. You can also use the STAR Program to get the health care that you need.

Questions about the STAR Program?

Please call 1-800-964-2777 for help. READ BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

Usted está inscrito en el Programa STAR. El nombre y el teléfono de su plan de salud aparecen debajo de su nombre. Usted tiene un Proveedor de Cuidado Primario (PCP). Llame al plan de salud para averiguar el nombre de su PCP.

Si bajo su nombre hay una notificación, llame a su PCP o dentista para hacer una cita para un chequeo. Si no hay una notificación y usted tiene 21 años or más, puede hacerse un chequeo médico con su PCP una vez por año. También puede usar el Programa STAR para recibir los servicios médicos que necesita.

¿Tiene preguntas sobre el **Programa STAR**?

Por favor, llame al **1-800-964-2777** para conseguir ayuda. ¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	DENTAL SERVICES	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE /	04-02-1964 /WELBY	F	11-01-2006 MARCUS	L MD		✔	✔	✔		✔	✔

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-S1/April 2007

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

184 ATFF 01-00184

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/15/2008	610098		01	02	123456789	JULY 31, 2008

LIMITED PHARMACY

952-X 123456789 01 02 030731
JANE DOE
743 GOLF IRONS
HOUSTON TX 77093

TEXAS STAR PROGRAM
Your Health Plan ■ Your Choice

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

You are enrolled in the STAR Program. Your health plan's name and telephone number are listed under your name. You have a Primary Care Provider (PCP). Call your health plan for your PCP's name.

If you see a reminder under your name, please call your PCP or dentist to schedule a checkup. If you do not see a reminder and are 21 or older, you can get a medical checkup from your PCP once a year. You can also use the STAR Program to get the health care that you need.

Questions about the STAR Program?

Please call 1-800-964-2777 for help.
READ BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

Usted está inscrito en el Programa STAR. El nombre y el teléfono de su plan de salud aparecen debajo de su nombre. Usted tiene un Proveedor de Cuidado Primario (PCP). Llame al plan de salud para averiguar el nombre de su PCP.

Si bajo su nombre hay una notificación, llame a su PCP o dentista para hacer una cita para un chequeo. Si no hay una notificación y usted tiene 21 años or más, puede hacerse un chequeo médico con su PCP una vez por año. También puede usar el Programa STAR para recibir los servicios médicos que necesita.

¿Tiene preguntas sobre el **Programa STAR**?

Por favor, llame al **1-800-964-2777** para conseguir ayuda. ¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	DENTAL SERVICES	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	01-04-1984	F	06-01-2007			✔	✔	✔		✔	✔
	/	/WELBY		MARCUS		L MD						

B

LIMITED PHARMACY

** TO PHARMACY:
** HAPPY PHARMACY
** 11223 WEST 27th
** AUSTIN TX 78759

FOR ADDITIONAL INFORMATION REGARDING LIMITATION TO ONE PHARMACY
Call the Limited Program at
1-800-436-6184

PARA MÁS INFORMACIÓN SOBRE EL USO DE UNA SOLA FARMACIA
Llame al Programa Limitado a
1-800-436-6184

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-S2/April 2007

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

187 ATFF 01-00187

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/15/2008	610098		01	02	123456789	JULY 31, 2008

STAR+PLUS PROGRAM
Your Health Plan ■ Your Choice

952-X 123456789 01 02 030731
JANE DOE
743 GOLF IRONS
HOUSTON TX 77056

NOTE: Prescription benefits for Medicare clients age 21 and over may be limited to three (3) per month.

NOTA: Puede que los beneficios de recetas para los clientes de Medicare mayores de 21 años se limiten a tres (3) por mes.

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

You are enrolled in STAR+PLUS, the state's plan for Medicaid in your county. Your health plan's name and telephone number are listed under your name. Call your health plan for your Primary Care Provider (PCP) name or refer to your health plan identification card. If you have Medicare you will not have a STAR+PLUS PCP.

If you have any concerns or questions about STAR+PLUS, please call 1-800-964-2777 for help.

READ BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO
PUEDE RECIBIR SERVICIOS DE MEDICAID

Usted está inscrito en STAR+PLUS, el plan del estado para Medicaid en su condado. Bajo su nombre aparecen el nombre y el teléfono de su plan de salud. Llame al plan de salud para saber el nombre de su Proveedor de Cuidado Primario (PCP) o vea la tarjeta de identificación del plan. Si usted recibe Medicare, no tendrá un PCP de STAR+PLUS.

Si tiene alguna inquietud o pregunta con respecto a **STAR+PLUS**, por favor, llame al **1-800-964-2777** para conseguir ayuda.

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	DENTAL SERVICES	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	01-04-1984	F	06-01-2007			✔	✔	✔		✔	✔
	/	/WELBY	MARCUS	L MD								

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-S3/April 2007

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

198 ATFF 01-00198

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/15/2008	610098		01	02	123456789	JULY 31, 2008

Primary Care Case Management (PCCM)

952-X 123456789 01 02 030731
JANE DOE
743 GOLF IRONS
HOUSTON TX 77143

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

You now receive your Medicaid medical care through Primary Care Case Management (PCCM). Your primary care provider (PCP) is listed below. If you want to pick a different PCP, call toll-free 1-888-302-6688.

Your PCP is your first stop for getting medical care. When you are sick or injured, your PCP will help you. Your PCP can also assist with THSteps checkups for children and teenagers, prenatal and well woman care. For more information, read your handbook, Primary Care Provider and Hospital List, or call PCCM toll-free at 1-888-302-6688.

READ BACK OF THIS FORM!

TODA PERSONA NOMBRADA A CONTINUACIÓN PUEDE RECIBIR SERVICIOS DE MEDICAID

Usted ahora recibe la atención médica de Medicaid por medio de Primary Care Case Management (PCCM). El nombre de su Proveedor de Cuidado Primario (PCP) aparece a continuación. Si quiere escoger a otro PCP, llame gratis al 1-888-302-6688.

Su PCP es el primer lugar al que debe ir para recibir atención médica. Cuando esté enfermo o lesionado, su PCP le ayudará. También le puede ayudar con los chequeos de Pasos Sanos de Texas para niños y jóvenes, con la atención prenatal y los chequeos preventivos para la mujer. Para más información, lea el manual titulado Lista de Proveedores de Cuidado Primario y Hospitales, o llame gratis a PCCM al 1-888-302-6688.

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	DENTAL SERVICES	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	02-04-1985	F	07-01-2008			✔	✔	✔		✔	✔
PCCM /1-800-123-4567 / DR. JEREMY IRONS												

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-S4/April 2007

B

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030
RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

185 ATFF 01-00185
Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/15/2008	610098		01	02	123456789	JULY 31, 2008

LIMITED PHARMACY

952-X 123456789 01 02 030731
JANE DOE
743 GOLF IRONS
HOUSTON TX 77093

TEXAS STAR PROGRAM
Your Health Plan ■ Your Choice

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

You are enrolled in the STAR Program. Your health plan's name and telephone number are listed under your name. You have a Primary Care Provider (PCP). Call your health plan for your PCP's name.

If you see a reminder under your name, please call your PCP or dentist to schedule a checkup. If you do not see a reminder and are 21 or older, you can get a medical checkup from your PCP once a year. You can also use the STAR Program to get the health care that you need.

Questions about the STAR Program?
Please call 1-800-964-2777 for help.
READ BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO
PUEDE RECIBIR SERVICIOS DE MEDICAID

Usted está inscrito en el Programa STAR. El nombre y el teléfono de su plan de salud aparecen debajo de su nombre. Usted tiene un Proveedor de Cuidado Primario (PCP). Llame al plan de salud para averiguar el nombre de su PCP.

Si bajo su nombre hay una notificación, llame a su PCP o dentista para hacer una cita para un chequeo. Si no hay una notificación y usted tiene 21 años or más, puede hacerse un chequeo médico con su PCP una vez por año. También puede usar el Programa STAR para recibir los servicios médicos que necesita.

¿Tiene preguntas sobre el **Programa STAR**?
Por favor, llame al **1-800-964-2777** para conseguir ayuda.
¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.
765432198	JANE DOE	07-25-1984	F	04-01-2008		

BEST HEALTH PLAN /1-800-123-4567 / CALL HEALTH PLAN FOR PCP NAME OR OTHER INFORMATION

LIMITED PHARMACY

** TO PHARMACY:
** HAPPY PHARMACY
** 11223 WEST 27th
** AUSTIN TX 78759

FOR ADDITIONAL INFORMATION REGARDING LIMITATION TO ONE PRIMARY CARE PHARMACY
Call the Limited Program at 1-800-436-6184

PARA MÁS INFORMACIÓN SOBRE EL USO DE UNA SOLA FARMACIA
Llame al Programa Limitado a 1-800-436-6184

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-SL/January 2006

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

192 ATFF 01-00192

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/15/2008	610098	13	13	04	123456789	JULY 31, 2008

STAR+PLUS PROGRAM
Your Health Plan ■ Your Choice

952-X 123456789 13 13 04 030731
JANE DOE
743 GOLF IRONS
HOUSTON TX 77231

NOTE: Prescription benefits for Medicare clients age 21 and over may be limited to three (3) per month.
NOTA: Puede que los beneficios de recetas para los clientes de Medicare mayores de 21 años se limiten a tres (3) por mes.

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

You are enrolled in STAR+PLUS, the state's plan for Medicaid in your county. Your health plan's name and telephone number are listed under your name. Call your health plan for your Primary Care Provider (PCP) name or refer to your health plan identification card. If you have Medicare you will not have a STAR+PLUS PCP.

If you have any concerns or questions about STAR+PLUS, please call 1-800-964-2777 for help.

READ BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

Usted está inscrito en STAR+PLUS, el plan del estado para Medicaid en su condado. Bajo su nombre aparecen el nombre y el teléfono de su plan de salud. Llame al plan de salud para saber el nombre de su Proveedor de Cuidado Primario (PCP) o vea la tarjeta de identificación del plan. Si usted recibe Medicare, no tendrá un PCP de STAR+PLUS.

Si tiene alguna inquietud o pregunta con respecto a **STAR+PLUS,** por favor, llame al **1-800-964-2777** para conseguir ayuda.

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.
765432198	JANE DOE	07-25-1951	F	06-01-2004		
BEST HEALTH PLAN		**/1-800-123-4567 / CALL HEALTH PLAN FOR PCP NAME OR OTHER INFORMATION**				

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-SP/February 2007

B

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

186 ATFF 01-00186

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/15/2008	610098		01	02	123456789	JULY 31, 2008

TEXAS STAR PROGRAM
Your Health Plan ■ Your Choice

952-X 123456789 01 02 030731
JANE DOE
743 GOLF IRONS
HOUSTON TX 77096

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

You are enrolled in the STAR Program. Your health plan's name and telephone number are listed under your name. You have a Primary Care Provider (PCP). Call your health plan for your PCP's name.

If you see a reminder under your name, please call your PCP or dentist to schedule a checkup. If you do not see a reminder and are 21 or older, you can get a medical checkup from your PCP once a year. You can also use the STAR Program to get the health care that you need.

Questions about the STAR Program?

Please call 1-800-964-2777 for help. READ BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO
PUEDE RECIBIR SERVICIOS DE MEDICAID

Usted está inscrito en el Programa STAR. El nombre y el teléfono de su plan de salud aparecen debajo de su nombre. Usted tiene un Proveedor de Cuidado Primario (PCP). Llame al plan de salud para averiguar el nombre de su PCP.

Si bajo su nombre hay una notificación, llame a su PCP o dentista para hacer una cita para un chequeo. Si no hay una notificación y usted tiene 21 años or más, puede hacerse un chequeo médico con su PCP una vez por año. También puede usar el Programa STAR para recibir los servicios médicos que necesita.

¿Tiene preguntas sobre el **Programa STAR**?

Por favor, llame al **1-800-964-2777** para conseguir ayuda.
¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.
765432198	JANE DOE	07-25-1982	F	01-01-2008		
BEST HEALTH PLAN		**/1-800-123-4567 / CALL HEALTH PLAN FOR PCP NAME OR OTHER INFORMATION**				

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-ST/January 2006

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030
RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

2 ADEQ 01-00002
Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: VÁLIDA HASTA:
04/09/2008	012338	41	02		111111111	⇨ AUGUST 31, 2008

Women's Health Program

952-X 111111111 41 02 070430
SUSIE Q CITIZEN
11111 MAIN STREET
AUSTIN TX 77777

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR
222222222	SUSIE Q CITIZEN	01-21-1980	F	02-01-2008	

B

You must take this Medicaid Identification form with you when you visit your doctor or receive Medicaid services from any of your health care providers. This form helps health care providers know which services you can receive and how to bill Medicaid. You will receive a new Medicaid Identification form each month while you are eligible for Medicaid services.

You are enrolled in Women's Health Program. If you would like to apply for other Medicaid services, call us toll free at **2-1-1**, Monday through Friday, 8 a.m. to 8 p.m. Central Time.

Notice to Providers

Women's Health Program services covered by Medicaid during the period of eligibility are limited to:

An annual visit and exam.

Contraception, except emergency contraception.

Debe llevar con usted esta forma de identificación de Medicaid cuando vaya al doctor o reciba servicios de Medicaid de uno de sus proveedores de atención médica. Esta forma ayuda a los proveedores de atención médica a saber que servicios puede recibir y cómo cobrarle a Medicaid. Recibirá una nueva forma de identificación de Medicaid cada mes que llene los requisitos para recibir servicios de Medicaid.

Usted está inscrita en el programa Programa de Salud de la Mujer. Si quiere solicitar otros servicios de Medicaid, llámenos gratis al **2-1-1**, de lunes a viernes, de 8 a.m. a 8 p.m. hora central.

Aviso a los proveedores

Los servicios del programa Programa de Salud de la Mujer que cubre Medicaid durante el periodo de elegibilidad están limitados a :

Una visita y un examen anuales.

Anticonceptivos, salvo los anticonceptivos de emergencia.

Form H3087-WH/January 2007

B.11 Credit Balance Refund Worksheet

Provider Name: _____

TPI: _____ NPI: _____

ICN/PCN	Patient Name	Company Name/Address	Policy Number	Group Number	Insurance Paid Amount	Refund Amount

Mail refund checks, made payable to TMHP, along with the "Credit Balance Refund Worksheet" to the following address:

Texas Medicaid & Healthcare Partnership
CBA Worksheets & Refunds
PO Box 202948
Austin TX 78720-9981

B.12 DME Certification and Receipt Form

This certification is required by section 32.024 of the *Human Resources Code* and must be completed before the DME provider can be paid for durable medical equipment provided to a Medicaid client. This is to certify that on (month, day, year).....:

- The client received the .....(equipment) as prescribed by the physician.
- The equipment has been properly fitted to the client and/or meets the client's needs.
- The client, the parent or guardian of the client, and/or the primary caregiver of the client, has received training and instruction regarding the equipment's proper use and maintenance.

.....

Signature of DME Supplier

Signature of Client/Parent/Guardian/
Primary Caregiver

Certificación y recibo de equipo médico duradero (DME)

Esta certificación es necesaria bajo la Sección 32.024 del Código de Recursos Humanos y se debe llenar antes de poder reembolsar al proveedor del equipo médico duradero por cualquier equipo médico proporcionado al cliente de Medicaid. Esto certifica que el: (mes, día, año).....

- El cliente recibió [el] [la] [los] [las] .....(equipo) que el doctor recetó.
- El equipo ha sido adaptado correctamente para el cliente o satisface las necesidades del cliente.
- El cliente, su padre o tutor, o el cuidador principal del cliente, ha recibido entrenamiento e instrucción con respecto al uso y mantenimiento apropiado del equipo.

.....

Firma del Proveedor del Equipo Médico Duradero

Firma del Cliente, Padre, Tutor o Cuidador principal

B.13 Donor Human Milk Request Form

Donor Human Milk Request Form (Must be Reordered Every 180 Days)			
Client Name:		Client Medicaid Number:	
Date of birth:		Client's weight:	
Parts A and B must be completed and copies retained in both the physician's and the milk bank's records. These forms and clinical records are subject to retrospective review.			
Part A			
The physician must keep up-to-date documentation of medical necessity and the signed written consent form in the child's clinical record to be considered for Medicaid reimbursement.			
☐ The medical necessity for breast milk* is: Child's diagnosis:			
Date of last feeding trial: / /			
Reason donor milk is the only appropriate source of human milk for this client:			
*This information must be substantiated by written documentation in the clinical record of why the particular infant cannot survive and gain weight on any appropriate formula, such as an elemental formula or enteral nutritional product, other than donor human breast milk, and that a clinical feeding trial has occurred every 180 days.)			
☐ The parent/guardian has signed and dated an informed consent that the risks and benefits of using banked donor human milk has been discussed with them.			
Dates of service requested	From:	To:	Quantity Requested:
Physician's Signature:		Date: / /	
Physician Name:		Physician's Fax Number:	
License Number:	TPI:	NPI:	
Part B			
The particular donor human milk bank adheres to quality guidelines consistent with the Human Milk Banking Association of North America, or other standards established by HHSC. Yes ☐ No ☐			
Milk Bank Name:		Milk Bank Fax Number:	
Milk Bank Address:			
Milk Bank Representative Signature		Date: / /	
Milk Bank Representative's Name:		TPI:	
NPI:	Taxonomy:	Benefit Code:	

Effective Date_07302007/Revised Date_6012007

B.14 Electronic Funds Transfer (EFT) Information

Electronic Funds Transfer (EFT) is a payment method to deposit funds for claims approved for payment directly into a provider's bank account. These funds can be credited to either checking or savings accounts, provided the bank selected accepts Automated Clearinghouse (ACH) transactions. EFT also avoids the risks associated with mailing and handling paper checks, ***ensuring funds are directly deposited into a specified account.***

The following items are specific to EFT:

- Pre–notification to your bank takes place on the cycle following the application processing.
- Future deposits are received electronically after pre–notification.
- The Remittance and Status (R&S) report furnishes the details of individual credits made to the provider's account during the weekly cycle.
- Specific deposits and associated R&S reports are cross–referenced by both the provider identifiers (i.e., NPI, TPI, and API) and R&S number.
- EFT funds are released by TMHP to depository financial institutions each Friday.
- The availability of R&S reports is unaffected by EFT and they continue to arrive in the same manner and time frame as currently received.

TMHP must provide the following notification according to ACH guidelines:

> *Most receiving depository financial institutions receive credit entries on the day before the effective date, and these funds are routinely made available to their depositors as of the opening of business on the effective date. Please contact your financial institution regarding posting time if funds are not available on the release date.*
>
> *However, due to geographic factors, some receiving depository financial institutions do not receive their credit entries until the morning of the effective day and the internal records of these financial institutions will not be updated. As a result, tellers, bookkeepers, or automated teller machines (ATMs) may not be aware of the deposit and the customer's withdrawal request may be refused. When this occurs, the customer or company should discuss the situation with the ACH coordinator of their institution who, in turn should work out the best way to serve their customer's needs.*
>
> *In all cases, credits received should be posted to the customer's account on the effective date and thus be made available to cover checks or debits that are presented for payment on the effective date.*

To enroll in the EFT program, complete the attached Electronic Funds Transfer Authorization Agreement. ***You must return the agreement and either a voided check or a statement from your bank written on the bank's letterhead to the TMHP address indicated on the form.***

Call the TMHP Contact Center at 1–800–925–9126 for assistance.

B.15 Electronic Funds Transfer (EFT) Authorization Agreement

*Enter **ONE** Texas Provider Identifier (TPI) per Form*

NOTE: *Complete all sections below and **attach a voided check or a statement from your bank written on the bank's letterhead**.*

Type of Authorization: ☐ **NEW** ☐ **CHANGE**

Provider Name	**Nine–Character Billing TPI**
National Provider Identifier (NPI)/Atypical Provider Identifier (API):	**Primary Taxonomy Code:** **Benefit Code:**
Provider Accounting Address	**Provider Phone Number** **( ) Ext.**
Bank Name	**ABA/Transit Number**
Bank Phone Number	**Account Number**
Bank Address	**Type Account (check one)** ☐ Checking ☐ Savings

I (we) hereby authorize Texas Medicaid & Healthcare Partnership (TMHP) to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I (we) am responsible for the validity of the information on this form. If the company erroneously deposits funds into my (our) account, I (we) authorize the company to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay period.

I (we) agree to comply with all certification requirements of the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by the Texas Health and Human Services Commission (HHSC) or its health insuring contractor. I (we) understand that payment of claims will be from federal and state funds, and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

I (we) will continue to maintain the confidentiality of records and other information relating to clients in accordance with applicable state and federal laws, rules, and regulations.

Authorized Signature _____ **Date** _____

Title _____ **Email Address (if applicable)** _____

Contact Name _____ **Phone** _____

Return this form to:
Texas Medicaid & Healthcare Partnership
ATTN: Provider Enrollment
PO Box 200795
Austin TX 78720–0795

DO NOT WRITE IN THIS AREA — For Office Use

Input By: **Input Date:**

B.16 External Insulin Pump

Client Name:	Date of birth: / /	Medicaid number:
Physician Information		
Name :	Physician specialty:	
Telephone:	Fax number:	License number:
TPI:	NPI:	

The following information is the minimum documentation required for consideration of medical necessity and must be submitted with a completed and signed Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

1. Lab values: current and past blood glucose levels, and glycosylated hemoglobin (Hb/A1C) levels—note date of lab draws

2. Client history of severe glycemic excursions, brittle diabetes, hypoglycemic/hyperglycemic reactions, nocturnal hypoglycemia, any extreme insulin sensitivity, and/or very low insulin requirements

3. Client history of any wide fluctuations in blood glucose level before mealtimes

4. Client history of any dawn phenomenon where fasting blood glucose level often exceeds 200 mg/dL

5. Day-to-day variations in client's work/school schedule, mealtimes and/or activity level, which require multiple insulin injections

6. For purchase after the initial trial period a statement of client's compliance and effectiveness of the pump is required

Physician signature:	Date: / /

Effective Date_07302007/Revised Date_06012007

B.17 Federally Qualified Health Center Report (Newborn Child or Children) Form 7484

Texas Health and Human Services Commission
Data Integrity 952-X
PO Box 149030
Austin, TX 78714-9030

Date Rec'd in Data Integrity

PURPOSE: This form is to be used by FEDERALLY QUALIFIED HEALTH CENTERS ONLY to report the birth of a child of a mother currently eligible under the Medicaid program of the Texas Health and Human Services Commission (HHSC). All data items below must be completed to avoid delay in future medicaid claims payments. If the child's FIRST name is unknown at the time this form is completed, the last name will suffice and must be shown.

ACTION: To avoid delay in your receiving notice of the Medicaid client number of the newborn child, please complete this document and submit it to the HHSC within 5 days after the birth of the child. The 5 days is a guideline and is not mandatory. Notice of the assigned client number will be promptly mailed to you for use in submitting the child's Medicaid claim.

To avoid delay in processing the child's Medicaid claims, please retain all Medicaid claims of the newborn child until you receive a client number for the child. All newborn claims should then be submitted to TMHP using the newly assigned client number.

Mother's Name (Last, First, MI)		Admission Date (mm/dd/yy)	Mother's Medicaid Recipient No.
Mother's Mailing Address–Street		Mother's D.O.B. (mm/dd/yy)	Mother's Medical Record No.
City, State, ZIP			
Child's Name (Last, First, MI)	Sex ❑ M ❑ F	Child's DOB (mm/dd/yy)	Child's Medical Record No.
Child's Name (Last, First, MI)	Sex ❑ M ❑ F	Child's DOB (mm/dd/yy)	Child's Medical Record No.
Child's Name (Last, First, MI)	Sex ❑ M ❑ F	Child's DOB (mm/dd/yy)	Child's Medical Record No.

Has the mother relinquished her rights to the newborn child? . . . . . ❑Yes ❑No

If "Yes," give date of relinquishment . . . . . _____

Child's Attending Physician
Certified Midwife
Health Center Name
Health Center Address – Street
City, State, ZIP

Physician's Medical Lic. No. TXB	TPI
Certification No CNM00	TPI

Completed By (please type or print)	
FQHC Telephone No. ( )	Date Form Mailed

B.18 Hearing Evaluation, Fitting, and Dispensing Report (Form 3503)

Name (Last, First, Middle Initial)	Client No.	Age	Birth Date
Address (Street, City, State, ZIP Code)			
Date of Examination	Place of Examination	Puretone Audiometry: ANSI 1969 ❑ Yes ❑ No	
Date of Calibration	Ambient Noise** _____dBa_____dBc	**Ambient noise level measurements MUST be made at the time of EACH evaluation not conducted in a commercially sound treated facility	

Indicate with an asterisk (*) by Recorded Threshold when masking is used

AIR CONDUCTION SOUND FIELD TEST RESULT IN DECIBELS
(Completed by physicians and audiologist only)

	500 Hz	1000 Hz	2000 Hz	4000 Hz
LE				
RE				
Masking Level LE				
Masking Level RE				

BONE CONDUCTION

	500 Hz	1000 Hz	2000 Hz	4000 Hz
LE				
RE				
Masking Level LE				
Masking Level RE				

SPEECH AUDIOMETRY

	SRT	PB Quiet	PB Level	Thres. Disc.
LE				
RE				
Masking Level LE				
Masking Level RE				

FITTING AND DISPENSING RESULTS

	UNAIDED	AIDED AID 1 LE ❑	AIDED AID 1 RE ❑	AIDED AID 2 LE ❑	AIDED AID 2 RE ❑	OPTIONAL LE ❑	OPTIONAL RE ❑
Make							
Model							
Gain/Volume							
SAT							
SRT							
PB Quiet							
PB Level							
PB Noise**							
PB Level							
Noise Level							
MCL							
Discomfort							
Dynamic Range							

**Specify type of noise used _____

Ear Fitted p R p L Acquisition Cost_____

Manufacturer_____

Model_____

Comments:

Is report of Physician's Examination attached? ❑ Yes ❑ No

FITTER AND DISPENSER: The fitter and dispenser must sign below.

_____
Name of Fitter and Dispenser (please type or print)

_____
Signature – Fitter and Dispenser Date

This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

I, _____ do hereby certify that I am _____ and that
(Signature of Physician or Audiologist) (Title of Person Certifying)

I am duly authorized to make this certification for and on behalf of _____
(Name of Payee Company Claimant)

I further certify that the attached invoice is correct and that it corresponds in every particular with the supplies and/or services contracted for. I further certify that the account is true, correct and unpaid.

_____
(Signature of Physician or Audiologist) Date

_____

B.19 Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions (2 Pages)

Page 1 of 2

General Instructions

This form must be completed and signed as outlined in the instructions below before DME/medical supplies providers contact TMHP Home Health Services for prior authorization.

Either the DME supplier/Medicaid provider or the prescribing physician may initiate the form. This completed form must be retained in the records of both the DME supplier/medical provider and the prescribing physician, and is subject to retrospective review. This form becomes a prescription when the physician has signed section B.

Note: *This form cannot be accepted beyond 90 days from the date of the prescribing physician's signature.*

The supplier or prescribing physician can complete Section A. Include the most appropriate procedure code description using the Healthcare Common Procedure Coding System (HCPCS). In addition, include the appropriate quantity and the manufacturer's suggested retail price (MSRP) if the item requires manual pricing. A price is not required for those items with a maximum fee listed in the Texas Medicaid Fee Schedule. The appropriate box must be completed to indicate whether this section was completed by the physician or the supplier. If the item requested is beyond the quantity limit or a custom item, additional documentation must be provided to support determination of medical necessity.

All fields must be filled out completely. The prescribing physician's TPI (if a Texas Medicaid provider), NPI, and license number must be indicated.

Section A: Requested Durable Medical Equipment and Supplies

The supplier or prescribing physician can complete Section A. Include the most appropriate procedure code description using the Healthcare Common Procedure Coding System (HCPCS). In addition, include the appropriate quantity and the manufacturer's suggested retail price (MSRP) if the item requires manual pricing. A price is not required for those items with a maximum fee listed in the Texas Medicaid Fee Schedule. The appropriate box must be completed to indicate whether this section was completed by the physician or the supplier. If the item requested is beyond the quantity limit or a custom item, additional documentation must be provided to support determination of medical necessity.

Requested Durable Medical Equipment and Supplies

Item number	HCPCS Code	Quantity	Price
1	J-E1399	1	$50.00
2	J-E1220	1	$2500.00
3			
4			
5			

Examples of Supplies

Item number	HCPCS Code	Quantity	Price
1	9-A4253	2 boxes	N/A
2	9-A4259	1 box	N/A
3	9-A4245	1 box	N/A
4			
5			

Physicians must indicate their professional license number. If the prescribing physician is out of state, the physician must provide the license number and state of professional licensure. Texas Medicaid TPI and UPIN numbers are not acceptable as licensure. The *Addendum to the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form* must be used when prescribing more than 5 items. The *Addendum to the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form* must accompany *the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form*.

Note: *Addendums received without this form will not be accepted.*

Reminder: *Home health services are not a benefit for clients residing in a nursing facility, hospital, or intermediate care facility.*

Note for DME: *The DME company must also complete the DME Certification and Receipt Form. All equipment is to be assembled, installed, and used pursuant to the manufacturer's instructions and warning.*

Effective Date_07302007/Revised Date_06252007

Page 2 of 2

Section B: Diagnosis and Medical Information

Section B is a prescription for DME/supplies and must be filled out by the prescribing physician.

The prescribing physician must indicate the ICD-9 code with a brief description, corresponding to the item number requested from Section A and complete justification for determination of medical necessity for the requested item(s). If applicable, include height/weight, wound stage/dimensions and functional/mobility.

Note: *The date last seen must be within the past 12 months.*

The prescribing physician must indicate the duration of need for the prescribed supplies/DME. The estimated duration of need should specify the amount of time the supplies/DME will be needed, such as six weeks, three months, lifetime, etc. The prescribing physician's TPI (if a Texas Medicaid provider), NPI, and license number must be indicated.

Note: *Signatures from nurse practioners, physician assistants, and chiropractors will not be accepted. Signature stamps and date stamps are not acceptable.*

Diagnosis and Medical Need Information

ICD-9	Requested Section A No.[2]	Complete justification for determination of medical necessity for requested item(s). Refer to Section A: Requested Durable Medical Equipment and Supplies.[1,2]
438	1,2	Unable to get in and out of the tub or shower
27801	2	Need swing-away arms and legs for transfer secondary to hemiparesis and need oversize chair for clients weighing 400 lbs.

1. Refer to Footnote 1 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

2. Refer to Footnote 2 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

Examples of Supplies

ICD-9	Requested Section A No.[2]	Complete justification for determination of medical necessity for requested item(s). Refer to Section A: Requested Durable Medical Equipment and Supplies.[1,2]
25001	3,4,5	

1. Refer to Footnote 1 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

2. Refer to Footnote 2 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

Effective Date_07302007/Revised Date_06252007

B.20 Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form

See instructions for completing Title XIX Home Health Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. This order form cannot be accepted beyond 90 days from the date of the physician's signature. Fax completed form to 1-512-514-4209.

Section A: Requested Durable Medical Equipment and Supplies

This section was completed by (check one): ☐ Requesting Physician ☐ Supplier

Client name:	Client date of birth: / /
Client Medicaid number:	Is client under 21 years of age? YES ☐ NO ☐
Supplier name:	Supplier address:

Supplier telephone:	Supplier Fax:	Supplier TPI:
Supplier NPI:	Supplier Taxonomy:	Supplier Benefit Code:
Physician name:	Physician telephone:	Physician Fax:

I certify that the services being supplied under this order are consistent with the physician's determination of medical necessity and prescription. The prescribed items are appropriate and can safely be used in the client's home when used as prescribed.

DME/medical supplies provider representative signature:	Date: / /

DME/medical supplies provider representative name (Typed or Printed):

Item Number	HCPCS Code	Description of DME/medical supplies	Quantity	Price	Prior authorization required?	Beyond quantity limit?[1]	Custom item?[1]
1					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
2					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
3					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
4					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
5					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

1. If "Yes," additional documentation must be provided to support determination of medical necessity.

☐ Check if additional documentation is attached as outlined in the TMPPM.

Is the DME Provider Medicare certified? YES ☐ NO ☐	If yes, indicate Medicare number:

Section B: Diagnosis and Medical Need Information

This is a prescription for DME/supplies and must be filled out by the prescribing physician.

ICD-9	Brief Diagnosis Descriptor	Requested Item Number from Section A[2]	Complete justification for determination of medical necessity for requested item(s)[2] (Refer to Section A, footnote 1)
__ __ __ . __ __			
__ __ __ . __ __			
__ __ __ . __ __			
__ __ __ . __ __			

2. Each item requested in Section A must have a correlating diagnosis and medical necessity justification.
Enter all Item numbers from the table in Section A that pertain to each diagnosis.

If applicable, include height/weight, wound stage/dimensions and functional/mobility status in table below.

Height	Weight	Wound stage/dimensions	Functionality/mobility status

***Note**: The "Date last seen" and "Duration of need" items below **must** be filled in.*

Date last seen by physician: / /

Duration of need for DME: _____ month (s)	Duration of need for supplies: _____ month (s)

By signing this form, I hereby attest that the information completed in Section "A" is consistent with the determination of the client's current medical necessity and prescription. By prescribing the identified DME and/or medical supplies, I certify the prescribed items are appropriate and can safely be used in the client's home when used as prescribed.

Signature and attestation of prescribing physician:	Date: / /

Signature stamps and date stamps are not acceptable

Prescribing physician's license number:

Prescribing physician's TPI:	Prescribing physician's NPI:

☐ Check if all of the information in Section A was complete at the time of the prescribing provider signature

Effective Date_07302007/Revised Date_06012007

B.21 Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form

Section A: Requested Durable Medical Equipment and Supplies

This section was completed by (check one): ☐ Requesting Physician ☐ Supplier

Client name:	Client date of birth: / /
Client Medicaid number:	Is client under 21 years of age? Yes ☐ No ☐

Supplier Information

Name:	Telephone:	Fax number:
Address:		
TPI:	NPI:	
Taxonomy:	Benefit Code:	

Prescribing Physician Information

Name:	Telephone:	Fax number:

I certify that the services being supplied under this order are consistent with the physician's determination of medical necessity and prescription. The prescribed items are appropriate and can safely be used in the client's home when used as prescribed.

DME/medical supplies provider representative signature:	Date: / /

DME/medical supplies provider representative name (Typed or Printed):

Item Number	HCPCS Code	Description of DME/medical supplies	Quantity	Price	Prior authorization required?	Beyond quantity limit?[1]	Custom item?[1]
6					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
7					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
8					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
9					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
10					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
11					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
12					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
13					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
14					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
15					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
16					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
17					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
18					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
19					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
20					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
21					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
22					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
23					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
24					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
25					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
26					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

1. If "Yes," additional documentation must be provided to support determination of medical necessity.

☐ Check if additional documentation is attached as outlined in the TMPPM.

Is the DME Provider Medicare certified? YES ☐ NO ☐	If yes, indicate Medicare number:

Section B: Diagnosis and Medical Need Information

This is a prescription for DME/supplies and must be filled out by the prescribing physician.

By signing this form, I hereby attest that the information completed in Section "A" is consistent with the determination of the client's current medical necessity and prescription. By prescribing the identified DME and/or medical supplies, I certify the prescribed items are appropriate and can safely be used in the client's home when used as prescribed.

Signature and attestation of prescribing physician:	Date: / /

Signature stamps and date stamps are not acceptable

Prescribing physician's license number:	
Prescribing physician's TPI:	Prescribing physician's NPI:

☐ Check if all of the information in Section A was complete at the time of the prescribing provider signature

Effective Date_07302007/Revised Date_06012007

B

B.22 Home Health Services Plan of Care (POC) Instructions

Use the guidelines below in filling out the Home Health Plan of Care (POC) form.	
Client Information	
Client's name	Last name, first name, middle initial
Date of birth	Date of birth given by month, day and year
Date last seen by doctor	Client must be seen by a physician within 30 days of the initial start of care and at least once every 6 months thereafter unless a diagnosis has been established by the physician and the client is currently undergoing physician care and treatment
Medicaid number:	Nine-digit number from client's current Medicaid identification card.
Home Health Agency Information	
Name	Name of Home Health agency
License number	Medical license number issued by the state of Texas
Address	Agency address given by street, city, state and ZIP code
Telephone	Area code and telephone number of agency
TPI	Texas Provider Identifier number (10-digit) of agency
NPI	National Provider Identifier number (10-digit) of agency
Taxonomy	Ten-character Taxonomy code showing service type, classification, and specialization of the medical service provided by the agency
DME TPI	Texas Provider Identifier number (10-digit) of agency DME
Benefit Code	Code identifying state program for the service provided
Physician Information	
Name	Name of Physician
License number	Physician's medical license number issued by the state of Texas
Telephone	Area code and telephone number of physician
TPI	Texas Provider Identifier number (10-digit) of physician
NPI	National Provider Identifier number (10-digit) of physician
Plan of Care Information	
Status	Indicate with a check mark if POC is for a new client, extension (services need to be extended for an additional 60 day period) or a revised request
Original SOC date	First date of service in this 365 day benefit period
Revised request effective date	Date revised services, supplies or DME became effective
Services client receives from other agencies	List other community or state agency services client receives in the home. Examples: primary home care (PHC), community based alternative (CBA), etc.
Diagnoses	Diagnosis related to ordered home health services. For reimbursement, diagnoses must match those listed on the claim and be appropriate for the services ordered (Include ICD-9 code if PT/OT is ordered)
Functional Limitations/ Permitted Activities	Include on revised request only if pertinent
Prescribed medications	List medications, dosages, routes, and frequency of dosages (Include on revised request if applicable)
Diet Ordered	Examples: Regular, 1200 cal. ADA, pureed, NG tube feedings, etc. (Include on revised request if applicable)
Mental Status	Examples: alert and oriented, confused, slow to learn, etc. (include on revised request if applicable)
Prognosis	Examples: good, fair, poor, etc. (include on revised request if applicable)
Rehabilitation potential	Potential for progress, examples: good, fair, poor, etc. (include on revised request if applicable)
Safety precautions	Examples: oxygen safety, seizure precautions, etc. (include on revised request if applicable)
Medical necessity, clinical condition, treatment plan	Describe medical reason for all services ordered, nursing observations pertinent to the plan of care, and the proposed plan of treatment. For PT, list specific modalities and treatments to be used.
SNV, HHA, PT, OT visits requested:	State the number of visits requested for each type of service authorized
Supplies	List all supplies authorized
DME	List each piece of DME authorized, check whether DME is owned, if DME is to be repaired, purchased, or rented, and for what length of time the equipment will be needed
RN signature	The signature and date this form was filled out and completed by the RN
From and To dates	Dates (up to 60 days) of authorization period for ordered home health services
Conflict of Interest Statement	Relevant to the physician signing this form; physician should check box if exception applies.
Physician signature, Date signed, Printed physician name	The physician's signature and the date the form was signed by the physician ordering home health services, and the physician's printed name

Effective Date_07302007/Revised Date_06292007

B.23 Home Health Services Plan of Care (POC)

Write legibly or type. Claims will be denied if POC is illegible or incomplete.

Client's name:			Date of birth: / /	
Date last seen by doctor: / /			Medicaid number:	
Home Health Agency Information				
Name:	Fax number:		Telephone:	
Address:				
TPI:	NPI:		Taxonomy:	
DME TPI:		Benefit Code:		
Physician Information				
Name:			Telephone:	
TPI:	NPI:		License number:	
Status (check one):	New client ☐	Extension ☐	Revised Request ☐	
Original SOC date: / /		Revised request effective date: / /		
Services client receives from other agencies:				
Diagnoses (include ICD-9 codes if PT/OT is ordered):				
Function Limitations/Permitted Activities/Homebound Status:				
Prescribed medications:				
Diet ordered:		Mental status:		
Prognosis:		Rehabilitation potential:		
Safety Precautions:				
Medical Necessity, clinical condition, treatment plan (Brief narrative of the medical indication for the requested services and instructions for discharge, etc., include musculoskeletal/neuromuscular condition if PT/OT requested):				
SNV visits requested:				
HHA visits requested:				
PT visits requested:				
OT visits requested:				
Supplies:				
DME Item No. 1	Own ☐	Repair ☐	Buy ☐	Rent ☐ How long is this DME item needed?
DME Item No. 2	Own ☐	Repair ☐	Buy ☐	Rent ☐ How long is this DME item needed?
DME Item No. 3	Own ☐	Repair ☐	Buy ☐	Rent ☐ How long is this DME item needed?
DME Item No. 4	Own ☐	Repair ☐	Buy ☐	Rent ☐ How long is this DME item needed?
RN signature:			Date signed: / /	
I anticipate home care will be required:	From: / /		To: / /	

Conflict of Interest Statement

By signing this form, I certify that I do not have a significant ownership interest in, or a significant financial or contractual relationship with, the billing Home Health Services agency if Home Health Services for the above client are to be covered by the Texas Medicaid Program.
Check if this exception applies.

☐ Exception for governmental entities (Home Health Services agency operated by a federal, state or local governmental authority) or exception for sole community Home Health Services agency as defined by 42CFR 424.22.

Physician signature:	Date signed: / /

Effective Date_07302007/Revised Date_06292007

B.24 Home Health Services Prior Authorization Checklist

Contact Medicaid Home Health Services at 1-800-925-8957

To facilitate the authorization process, the home health agency nurse should have completed the following tasks before contacting TMHP for prior authorization of home health services:

- Completion of this optional form
- Evaluation of the client in the home (preferably by the same nurse requesting services)

PLEASE DO NOT SUBMIT THIS FORM TO TMHP.

Date:_____ Agency Nurse Name:_____
Client Medicaid Number:_____ Client Name: _____
Client Medicare Number:_____ Date Last Seen by Physician: _____
Start of Care Date:_____ Date of Last Hospitalization:_____
Date of Home Evaluation: _____
Diagnoses:_____
_____
(If PT is requested, please provide ICD-9-CM diagnosis codes)
Skilled Nursing functions to be provided: _____
_____
_____
_____
Pertinent Nursing Observations (prior teaching, size and descriptions of wounds, functional limitations, etc.): _____
_____
_____
Observations of home setting that may effect care (i.e., cleanliness, availability of running water, electricity and refrigeration, etc.): _____
_____
_____
Availability and capability of caregiver(s): _____
_____
Services client receives from other sources (i.e., Primary Home Care): _____
_____
Services Requested: ___ Skilled Nursing Frequency _____
___ Home Health Services Aide Frequency _____
___ Physical Therapy Frequency _____
___ DME_____ Repair _____Rent _____ Purchase
_____Bid #1
_____Bid #2
___ Supplies: _____
TMHP Nurse: _____ PAN: _____

B.25 Hospital Report (Newborn Child or Children) HHSC Form 7484

Texas Health and Human Services Commission
Data Integrity 952-X
PO BOX 149030
Austin TX 78714-9030

Date Rec'd in Integrity Control

PURPOSE: This form is to be used by HOSPITALS ONLY to report the birth of a child of a mother currently eligible under the Texas Medicaid Program of the Texas Health and Human Services Commission (HHSC). All data items below must be completed to avoid delay in future Medicaid claims payments. If the child's FIRST name is unknown at the time this form is completed, the last name will suffice and must be shown.

ACTION: To avoid delay in your receiving notice of the Medicaid Recipient number of the newborn child, please complete this document and submit it to HHSC within 5 days after the birth of the child. The 5 days is a guideline and is not mandatory. Notice of the assigned client number will be promptly mailed to you for use in submitting the child's Medicaid claim.

To avoid delay in processing the child's Medicaid claims, please retain all Medicaid claims of the newborn child until you receive a client number for the child. All newborn claims should then be submitted to TMHP using the newly assigned client number.

Mother's Name (Last, First, MI)		Admission Date (mm/dd/yy)	Mother's Medicaid Recipient No.
		| | | | | |	| | | | | | | | | |
Mother's Mailing Address – Street		Mother's D.O.B. (mm/dd/yy)	Mother's Medical Record No.
		| | | | | |	| | | | | | | | | |
City, State, ZIP			
Child's Name (Last, First, MI)	Sex ❑ M ❑ F	Child's DOB (mm/dd/yy) | | | | | |	Child's Medical Record No. | | | | | | | | | |
Child's Name (Last, First, MI)	Sex ❑ M ❑ F	Child's DOB (mm/dd/yy) | | | | | |	Child's Medical Record No. | | | | | | | | | |
Child's Name (Last, First, MI)	Sex ❑ M ❑ F	Child's DOB (mm/dd/yy) | | | | | |	Child's Medical Record No. | | | | | | | | | |

Has the mother relinquished her rights to the newborn child? . . . . . ❑ Yes ❑ No

If "Yes," give date of relinquishment . . . . . _____

Child's Attending Physician
Hospital Name
Hospital Address—Street
City, State, ZIP

Physician's Medical License No.	TPI
T| X| B| | | | | | |	| | | | | | | | |
Completed By (please type or print)	
Hospital Telephone No. ( )	Date Form Mailed | | | | | |

B.26 Hysterectomy Acknowledgment Form

MEDICAID CLIENT IDENTIFICATION NUMBER _/_/_/_/_/_/_/_/_/_

Hysterectomy Acknowledgment

I hereby acknowledge that I was, prior to surgery _____ (month, day, year), informed both orally and in writing that a hysterectomy (surgical removal of the uterus) will render the individual on whom that procedure is performed permanently incapable of bearing children.

_____ _____

Signature of Client or Designated Representative Date

Reconocimiento

Yo afirmo haber sido informada verbalmente y por escrito, antes de la cirugía _____ (mes, día, año) que una histerectomía (extracción quirúrgica del útero) dejará a la persona a la cual se haya operado permanentemente, incapaz de tener hijos.

_____ _____

Firma del Cliente o Representante Designado Fecha

Interpreter's Statement

To be used if an interpreter is provided to assist the individual having the hysterectomy.
I have translated to the individual having a hysterectomy the information and advice presented orally by the individual obtaining consent. I have also read the consent form to _____ in _____ language and explained its contents to her. To the best of my knowledge and belief she understood this explanation.

_____ _____

Signature of Interpreter Date

Revised 8/22/95

B.27 Informational Inquiry Form

Client Information	
Today's date: / /	Medicaid number:
Date of birth: / /	Social Security Number:
Last name:	First name:

Accident Information	
Date of loss: / /	Type of accident:
Case comments:	

Attorney Information		
Name:	Contact name:	
Street Address:		
City:	State:	Zip Code:
Telephone:	Fax number:	

Insurance Information		
Company name:	Contact name:	
Street Address:		
City:	State:	Zip Code:
Telephone:	Fax number:	
Insurance claim number:		

Provider Information		
Name:	Telephone:	
Street Address:		
City:	State:	Zip Code:
TPI:	NPI:	
Taxonomy:	Benefit Code:	

Mail completed copy to:
HHSC/OIG/TPR Unit
INFOC
PO Box 85200
Mail Code 1354
Austin, TX 78708-5200

Effective Date_01152008/Revised Date_06122007

B.28 Medicaid Certificate of Medical Necessity for Chest Physiotherapy Device Form—Initial Request

Section A: **To be completed by the physician or physician staff**		
Client Information		
Name:	Medicaid number:	
Primary diagnosis:		
Client respiratory diagnosis:		
Physician Information		
Name:	Telephone:	Fax number:
Address:		
License number:	TPI:	NPI:

Section B: **To be completed by the physician**	
Device requested	☐ High frequency chest wall compression system (HFCWCS)
	☐ Intrapulmonary percussive ventilation Device (IPV)
	☐ Cough stimulating device (cofflator)

☐	Client had respiratory illness or complication in the past 6 months (provide additional information in narrative section, i.e., nebs for respiratory secretions, I.V. antibiotics, hospitalizations).	Yes ☐ No ☐
☐	Client or family unable to do chest physiotherapy (provide medical reasons in narrative section).	Yes ☐ No ☐
☐	Client has tried other modes of chest physiotherapy, including the use of electrical percussor therapy or flutter valve for a minimum of four months prior to the request and that the therapy has been ineffective (provide information on other therapies and why they are ineffective in narrative section).	Yes ☐ No ☐
☐	Device use has not resulted in, nor exacerbated any gastrointestinal, manifestations, aspiration, pulmonary manifestation, nor seizure activity.	Yes ☐ No ☐
☐	Client had pulmonary function studies in last 6 months, if applicable (provide results in narrative section).	Yes ☐ No ☐
☐	Client has frequently missed work, school or extracurricular activities in the last 6 months due to respiratory illnesses and ineffective chest physiotherapy (provide medical reasons in narrative section).	Yes ☐ No ☐

Clients can have only one chest physiotherapy device at a time. The HFCWCS is available for purchase after the initial rental period with additional documentation. Use of these devices may affect the number of private duty nursing hours for chest physiotherapy the client is receiving through the Comprehensive Care Program (CCP). Refer to the complete policy in the Texas Medicaid (Title XIX) Home Health Services section of the Texas Medicaid Provider Procedures Manual.

Section C: **The physician prescribing a chest physiotherapy device must complete the narrative information regarding the medical necessity as requested above, or attach a letter with this information.**	
Narrative note for medical necessity (write legibly):	
Physician signature:	Date: / /
Submit with completed Title XIX Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form	

Effective Date_07302007/Revised Date_06012007

B.29 Medicaid Certificate of Medical Necessity for Chest Physiotherapy Device Form—Extended Request

Section A: To be completed by the physician or physician staff		
Client Information		
Name:	Medicaid number:	
Primary diagnosis:		
Respiratory diagnosis:		
Physician Information		
Name:	Telephone:	Fax number:
License number:	TPI:	NPI:

Section B: To be completed by the physician	
Device requested	☐ High frequency chest wall compression system (HFCWCS)
	☐ Intrapulmonary percussive ventilation Device (IPV)
	☐ Cough stimulating device (cofflator)

☐	Client had respiratory illness or complications **since** initial authorization (include additional information in narrative section, i.e., nebs for respiratory secretions, I.V., antibiotics, and hospitalizations).	Yes ☐ No ☐
☐	Physicians description/assessment of the effectiveness indicates decreased medication use, shorter hospital length of stay (LOS), decreased hospitalizations, and fewer school, work, or extracurricular activity absences due to diagnosis related complications.	Yes ☐ No ☐
☐	System has not exacerbated any gastrointestinal manifestations, nor caused aspiration and exacerbation of pulmonary manifestation, nor an exacerbation of seizure activity.	Yes ☐ No ☐
☐	Client has been **compliant** in use of device (document minutes logged per treatment, times per day of treatments, and number of days used for entire trial period).	Yes ☐ No ☐
☐	Client has achieved the desired health outcome with device.	Yes ☐ No ☐

Clients can have only one chest physiotherapy device at a time. The HFCWCS is available for purchase after the initial rental period with additional documentation. Use of these devices may affect the number of private duty nursing hours for chest physiotherapy the client is receiving through the Comprehensive Care Program (CCP). Refer to the complete policy in the Texas Medicaid (Title XIX) Home Health Services section of the Texas Medicaid Provider Procedures Manual.

Section C: The physician prescribing a chest physiotherapy device must complete the narrative information regarding the medical necessity as requested above, or attach a letter with this information.	
Narrative note for medical necessity (write legibly):	
Physician signature:	Date: / /
Submit with completed Title XIX Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form	

Effective Date_07302007/Revised Date_06012007

B.30 Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy

Section A - (To Be Completed By Physician or Physician's Staff)			
Client Name:		Client Medicaid Number:	
Physician Information			
Name:		Telephone:	
Address:			
License Number:	TPI:		NPI:
Supplier Information			
Name:		Contact Person:	
Address:			
Telephone:		Fax number:	
TPI:		NPI:	
Taxonomy:		Benefit Code:	
SECTION B- (To Be Completed By Physician)			
CPAP/BIPAP S Request			
Diagnosis:			
Date of Polysomnogram: (Polysomnogram required for all CPAP requests) / /			
If request is for BIPAP, explanation of the inability to tolerate CPAP:			
AHI/RDI:	Sleep Time (hours):	Total Apneas:	
Obstructive apneas:		Lowest Oxygen Saturation (percent):	
BIPAP ST Request			
Diagnosis:			
If request is for BIPAP ST, explanation of the inability to tolerate BIPAP S:			
Date of Polysomnogram (If Applicable): / /			
Lowest Oxygen Saturation (percent): or Arterial PO2 (mm Hg):			
If prescribed for central sleep apnea	Central apneas/hr:	Longest central apnea: sec.	
Oxygen Therapy Request			
Diagnosis:			
Lowest Oxygen Saturation at rest or with exercise (percent): or Arterial PO2 (mm Hg):			
Lowest Oxygen Saturation during sleep (percent): or Arterial PO2 (mm Hg):			
Flow rate (l/min.):	Hours of treatment per day (estimated):		
Is oxygen therapy required for mobility within the home?		☐ Yes	☐ No
Is oxygen therapy required for mobility when leaving the home?		☐ Yes	☐ No
Prescribing Physician Signature:		Date: / /	
Submit with completed Title XIX Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form			

Effective Date_07302007/Revised Date_08062007

B.31 Medicaid Certificate of Medical Necessity for Reduction Mammaplasty

Section A: **To be completed by the physician or physician staff**			
Client Information			
Name:		Medicaid number:	
Height:	Weight:	Date of birth: / /	
Breast size (must include photograph):			
Physician Information			
Name:	Telephone:	Fax number:	
Address:			
Medical license number:	TPI:	NPI:	
Taxonomy:	Benefit Code:		

Section B: **To be completed by the physician**			
☐	Client has evidence of a restrictive pulmonary defect (provide results of pulmonary function studies in narrative section).		Yes ☐ No ☐
☐	Client has evidence of severe neck and back pain (provide results of therapies tried in narrative section).		Yes ☐ No ☐
☐	Client has evidence of ulnar paresthesia from thoracic nerve root compression (provide results of therapies tried in narrative section).		Yes ☐ No ☐
☐	Client has evidence of ischemic heart disease (provide results of abnormal EKG and/or coronary angiography).		Yes ☐ No ☐
☐	This client, if age 40 or over, has had a mammogram within the past year that was negative for cancer.		Yes ☐ No ☐
☐	Estimated the grams of breast tissue to be removed from each breast.	Right:	Left:
☐	The client is in a weight reduction program and has lost _____lbs.		Yes ☐ No ☐

Section C: **Physician prescribing Reduction Mammaplasty must complete narrative information regarding the medical necessity as requested above.**	
Narrative note for medical necessity (write legibly):	
Physician signature:	Date: / /
Refer to the Reduction Mammaplasty policy in the Physician section of the *Texas Medicaid Provider Procedures Manual*.	

Effective Date_07302007/Revised Date_06012007

B

B.32 Medical Necessity for In-Home Total Parenteral Hyperalimentation (TPN)

Section A: To be completed by the provider

Client Information

Name:	Medicaid number:	
Date of birth: / /	Height: feet inches	Weight: lbs.

Physician Information

Name:	Fax number:	Telephone:
Address:	License number:	

Provider Information

Name:	Address:
Telephone:	Fax number:
TPI:	NPI:
Taxonomy:	Benefit Code:

Home Health Agency Information

Name:	Telephone:	Fax number:
Address:	RN contact name:	

Section B: *Must* be completed by the physician prescribing TPN

Date TPN Started : / /	Estimated length of need (1–99 months, 99 months infers lifetime need):	
Diagnosis codes (expand on this in Section C narrative notes):		
Frequency of labs:	Hours per day of infusion:	Number of days per week of infusion:
Frequency of registered nurse (RN) home visits:		
Usual lab ordered (attach latest lab results, include CA++, K+, LFT, albumin):		
TPN prescription:	Percent of daily nutritional needs from TPN:	
Client is able to take any oral nutrition/supplements: Yes ☐ No ☐	Client receives enteral tube feedings: Yes ☐ No ☐ (attach TPN formula prescription)	

Section C: The physician prescribing TPN must complete narrative information on medical necessity. If pertinent, include documentation on trials with oral/enteral feedings.

Narrative notes for medical necessity:

Physician signature:	Date / /

Effective Date_01152008/Revised Date_11162007

B.33 Nursing Addendum to Plan of Care (THSteps-CCP) (7 Pages)

Client name:	Medicaid number:	Date: / /

Documentation Requirements

All of the following documents must be complete and received by Texas Medicaid Healthcare Partnership (TMHP) before review or authorization of PDN services can occur:

1. All components of the Nursing Addendum to Plan of Care (THSteps-CCP) completed and submitted with
2. The Home Health Plan of Care (POC) form, and
3. THSteps-CCP Prior Authorization Request Form (*additional information may be attached*).

☐ If the client is under 18 years of age, he/she must reside with an identified responsible adult/parent/guardian who is either trained to provide nursing care, or is capable of initiating an identified contingency plan when the scheduled PDN or qualified aide is unexpectedly unavailable.

Name:	Relationship:	Telephone:

☐ The client has an identified contingency plan.

☐ The client has a primary physician who provides ongoing health care and medical supervision.

☐ The place(s) where PDN services will be delivered supports the health and safety of the client.

☐ If applicable, there are necessary backup utilities, communication, fire, and safety systems available and functional.

1. Nursing Care Plan Summary

PDN services are based on a nursing assessment and nursing care plan established by the nurse provider in collaboration with the physician, client, and family. The nursing care plan provides a systematic way to document care given, client responses to interventions, and progress toward the goals of care.

Problem list:

Goals of care:

Specific measurable outcomes:

Progress toward goals:

Additional comments:

Effective Date_09012007/Revised Date_08142007

Client name:	Medicaid number:	Date: / /

2. Summary of Recent Health History—For initial authorization or 90-day summary for extension of PDN services

Include recent hospitalizations, emergency room visits, surgery (may submit a discharge summary), illnesses, changes in condition, changes in medication or treatment, parent/guardian update, other pertinent observations.

3. Rationale for PDN Hours—To either increase, decrease, or stay the same. Also address plans to decrease PDN hours.

Client name:	Medicaid number:	Date: / /	Client/parent/guardian initials:
List other in-home resources:			

4. Schedule of Services 24-hour Daily Flow Sheet, 00:00—05:45, Military Time

Must include PDN and family (if family has volunteered) coverage, and coverage from other resources.
Codes: N=PDN hours, P=family (if family has volunteered), S=school/daycare, A=qualified aide, O=other in-home resource(s), specify name above

Military Time	Sunday	Provider	Monday	Provider	Tuesday	Provider	Wednesday	Provider	Thursday	Provider	Friday	Provider	Saturday	Provider
00:00														
00:15														
00:30														
00:45														
01:00														
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04:45														
05:00														
05:15														
05:30														
05:45														

Client name:	Medicaid number:	Date: / /	Client/parent/guardian initials:
List other in-home resources:			

4. Schedule of Services 24-hour Daily Flow Sheet, 06:00—011:45, Military Time

Must include PDN and family (if family has volunteered) coverage, and coverage from other resources.

Codes: N=PDN hours, P=family (if family has volunteered), S=school/daycare, A=qualified aide, O=other in-home resource(s), specify name above

Military Time	Sunday	Provider	Monday	Provider	Tuesday	Provider	Wednesday	Provider	Thursday	Provider	Friday	Provider	Saturday	Provider
06:00														
06:15														
06:30														
06:45														
07:00														
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11:30														
11:45														

Client name:	Medicaid number:	Date: / /	Client/parent/guardian initials:
List other in-home resources:			

4. Schedule of Services 24-hour Daily Flow Sheet, 12:00—017:45, Military Time

Must include PDN and family (if family has volunteered) coverage, and coverage from other resources.
Codes: N=PDN hours, P=family (if family has volunteered), S=school/daycare, A=qualified aide, O=other in-home resource(s), specify name above

Military Time	Sunday	Provider	Monday	Provider	Tuesday	Provider	Wednesday	Provider	Thursday	Provider	Friday	Provider	Saturday	Provider
12:00														
12:15														
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Client name:	Medicaid number:	Date: / /	Client/parent/guardian initials:
List other in-home resources:			

4. Schedule of Services 24-hour Daily Flow Sheet, 18:00—023:45, Military Time

Must include PDN and family (if family has volunteered) coverage, and coverage from other resources.

Codes: N=PDN hours, P=family (if family has volunteered), S=school/daycare, A=qualified aide, O=other in-home resource(s), specify name above

Military Time	Sunday	Provider	Monday	Provider	Tuesday	Provider	Wednesday	Provider	Thursday	Provider	Friday	Provider	Saturday	Provider
18:00														
18:15														
18:30														
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23:00														
23:15														
23:30														
23:45														

Client name:	Medicaid number:	Date: / /

5. Acknowledgement

Must be signed by the client/parent/guardian and the nurse provider.

By signing this form, the client/parent/guardian and the nurse provider acknowledge:

- Discussion and receipt of information about the THSteps-CCP Private Duty Nursing service,
- PDN services may increase, decrease, stay the same, or be terminated based on a client's need for skilled care,
- PDN is not authorized for respite, child care, activities of daily living, or housekeeping,
- All required criteria from the first page of this addendum are met, and completed documentation is submitted to TMHP,
- Participation in the development of the Nursing Care Plan for this client, and
- Emergency plans are part of the client's care plan and include telephone numbers for the client's physician, ambulance, hospital, and equipment supplier and information on how to handle emergency situations.

The client/parent/guardian agrees to follow through with the plan of care as prescribed by the client's physician.

Number of PDN hours requested	Hours per day:	**or**	Hours per week:
Dates of service from:	/ /	**to**	/ /

		/ /
Signature of client/parent/guardian	Printed name	Date
		/ /
Signature of PDN nurse provider	Printed name	Date
		/ /
Signature of prescribing physician	Printed name	Date

B

B.34 Other Insurance Form

Client Name: _____

Client Medicaid Number: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone #: _____

Policy Holder Name: _____

Policy Holder SSN: _____

Employer Name: _____

Group Number: _____

Ins. Eff. Date: _____ Ins. Term. Date: _____

List any family members and their SSN or Medicaid ID numbers that are covered under this policy: _____

_____

_____

COMMENTS: _____

_____

_____

CONTACT: TMHP Third Party Resources (TPR) 1-800-846-7307
TMHP Third Party Resources (TPR) fax 1-512-514-4225

MAIL CORRESPONDENCE: Texas Medicaid & Healthcare Partnership
TPR Correspondence
Third Party Resources Unit
PO Box 202948
Austin, TX 78720-9981

B.35 Primary Care Case Management (PCCM) Behavioral Health Consent Form

DIRECTIONS: This is an authorization for the release of information to your primary care provider.

PLEASE FILL OUT THE INFORMATION BELOW:

I, _____
Name Address

( )
City, State Phone

authorize: _____
Provider Name

to disclose to: _____
Provider Name Address

( )
City, State Phone

from (date) _____ to (date) _____ the following information:

Please indicate what, if any, information you would like to release.

- ☐ Total Medical Records to be released to primary care provider
- ☐ Medication Information **Only** to be released to primary care provider
- ☐ Medical Records to health plan

I understand that my records are protected under Federal (42 CFR Part 2) and/or State Confidentiality Regulations. This authorization may be withdrawn at any time in writing except to the extent that the program or person which is to make this disclosure has acted in reliance on it. Upon revocation of authorization, further release of information shall cease immediately. File copy is considered equivalent to the original. This release of information expires in thirty (30) days or sixty (60) days following completion or termination of treatment, whichever is later.

I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

EXECUTED THIS _____ DAY OF _____

_____ _____
(Witness) (Patient)

_____
(Parent, Guardian, or Authorized Representative, if required)

The person signing this authorization is entitled to a copy.

TO THE INDIVIDUAL FILLING THIS OUT:
You have the right to ask us about this form. You also have the right to review the information you give us on the form. (There are a few exceptions). If the information is wrong, you can ask us to correct it. The Health and Human Services Commission has a method for asking for corrections. You can find it in Title 1 of the Texas Administrative Code, section 351.17 through 351.23. To talk to someone about this form or ask for corrections, please contact the Texas Medicaid & Healthcare Partnership (TMHP). You can write to the Texas Medicaid & Healthcare Partnership (TMHP), Attention: State Action Request Support Manager, MC-C04, PO Box 204270, Austin, TX 78720-4270. You can also call the Texas Medicaid & Healthcare Partnership PCCM Client Helpline at 1-888-302-6688.

TO THE RECIPIENT OF CONFIDENTIAL INFORMATION, PROHIBITION ON DISCLOSURE:
If the information disclosed to you is related to substance abuse treatment, these records' confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient to release substance abuse records. The Federal Rules restrict any use of the information to criminally investigate or prosecute any substance abuse patient. State laws may also protect the confidentiality of patient's records.

Revised June 12, 2005

B.36 Primary Care Case Management (PCCM) Behavioral Health Consent Form (Spanish)

INSTRUCCIONES. Esta es una autorización para la divulgación de información para su Proveedor de Cuidado Primario.

POR FAVOR, DÉ LA SIGUIENTE INFORMACIÓN:

Yo, _____
Nombre Dirección

( )
_____
Ciudad, Estado Teléfono

autorizo a: _____
Nombre del proveedor

para que le dé a: _____
Nombre del proveedor Dirección

( )
_____
Ciudad, Estado Teléfono

la siguiente información de (fecha) _____ a (fecha) _____ :

Por favor, indique qué información quiere divulgar, si es que quiere divulgar alguna.

☐ Todos los expedientes médicos se pueden divulgar al Proveedor de Cuidado Primario
☐ **Sólo** la información sobre medicamentos se puede divulgar al Proveedor de Cuidado Primario
☐ Los expedientes médicos se pueden divulgar al plan de salud

Entiendo que mis expedientes están protegidos bajo Normas de Confidencialidad Estatales y Federales (42 CFR Parte 2). Esta autorización puede revocarse por escrito en cualquier momento, excepto en el caso en que el programa o la persona que hará la divulgación haya dependido de ella para tomar una acción. Al revocar la autorización, la divulgación adicional de información se detendrá inmediatamente. Las copias de archivo se consideran equivalentes al original. Esta autorización para divulgar información se vence en treinta (30) o sesenta (60) días después de que se termine o se suspenda el tratamiento, el que se llegue después.

También reconozco que se me explicó detalladamente la información que se divulgará y que doy este consentimiento por mi propia voluntad.

FIRMADO ESTE DÍA _____ DE _____

_____ _____
(Testigo) (Paciente)

_____
(Padre, Tutor o Representante Autorizado, si se exige)

La persona que firma esta autorización tiene derecho a una copia.

PARA LA PERSONA QUE LLENA ESTE FORMULARIO:
Tiene el derecho de hacernos preguntas sobre este formulario. También tiene el derecho de revisar la información que nos da en el formulario. (Hay algunas excepciones). Si la información está incorrecta, puede pedir que la corrijamos. La Comisión de Salud y Servicios Humanos tiene un método para pedir correcciones. Puede encontrarlo en el Título 1 del Código Administrativo de Texas, Secciones 351.17 a 351.23. Para hablar con alguien acerca de esta forma, o para pedir correcciones, haga el favor de comunicarse con Texas Medicaid & Healthcare Partnership (TMHP). Puede comunicarse con el personal de Texas Medicaid & Healthcare Partnership (TMHP), Attention: State Action Request Support Manager, MC-C04, PO Box 204270, Austin, TX 78720-4270. También puede llamar a la Línea de Ayuda al Cliente de PCCM, 1-888-302-6688.

PARA LA PERSONA QUE RECIBE LA INFORMACIÓN CONFIDENCIAL: PROHIBICIÓN SOBRE LA DIVULGACIÓN
Si la información que usted ha recibido tiene que ver con el tratamiento para el abuso de sustancias, la ley federal protege la confidencialidad de estos expedientes. Las normas federales (42 CFR Parte 2) le prohiben a usted hacer cualquier otra divulgación de estos expedientes sin el consentimiento escrito específico de la persona de quien se tratan, o de otra manera permitida por dichas normas. Una autorización general para la divulgación de información médica o de otro tipo no es suficiente para divulgar expedientes relacionados con el abuso de sustancias. Las reglas federales limitan el uso de la información a investigar o enjuiciar penalmente a algún paciente de abuso de sustancias. Es posible que las leyes estatales también protejan la confidencialidad de los expedientes del paciente.

B.37 Primary Care Case Management (PCCM) Community Health Services Referral Request Form

Provider Information		
Name:	Contact name:	Telephone:
Address:		
NPI:	TPI:	

Client Information		Client Information	
Name:		Name:	
Medicaid number:		Medicaid number:	
Telephone:		Telephone:	
Reason for Referral		Reason for Referral	
☐ Appointment no show	☐ Abuse of emergency room	☐ Appointment no show	☐ Abuse of emergency room
☐ Treatment plan adherence	☐ Abuse of doctor/staff	☐ Treatment plan adherence	☐ Abuse of doctor/staff
☐ Other:		☐ Other:	
Case Management/Health Education Needs		Case Management/Health Education Needs	
☐ Asthma	☐ Childhood illness	☐ Asthma	☐ Childhood illness
☐ Community resources	☐ Cardiac	☐ Community resources	☐ Cardiac
☐ Nutrition	☐ Transportation	☐ Nutrition	☐ Transportation
☐ Dental	☐ Parenting	☐ Dental	☐ Parenting
☐ Behavioral psych disorder	☐ Diabetes	☐ Behavioral psych disorder	☐ Diabetes
☐ Prenatal	☐ Exercise	☐ Prenatal	☐ Exercise
☐ Tobacco use		☐ Tobacco use	
☐ Child/Adult with Special Health Care Needs		☐ Child/Adult with Special Health Care Needs	
☐ Other:		☐ Other:	
Comments:		Comments:	

Client Information		Client Information	
Name:		Name:	
Medicaid number:		Medicaid number:	
Telephone:		Telephone:	
Reason for Referral		Reason for Referral	
☐ Appointment no show	☐ Abuse of emergency room	☐ Appointment no show	☐ Abuse of emergency room
☐ Treatment plan adherence	☐ Abuse of doctor/staff	☐ Treatment plan adherence	☐ Abuse of doctor/staff
☐ Other:		☐ Other:	
Case Management/Health Education Needs		Case Management/Health Education Needs	
☐ Asthma	☐ Childhood illness	☐ Asthma	☐ Childhood illness
☐ Community resources	☐ Cardiac	☐ Community resources	☐ Cardiac
☐ Nutrition	☐ Transportation	☐ Nutrition	☐ Transportation
☐ Dental	☐ Parenting	☐ Dental	☐ Parenting
☐ Behavioral psych disorder	☐ Diabetes	☐ Behavioral psych disorder	☐ Diabetes
☐ Prenatal	☐ Exercise	☐ Prenatal	☐ Exercise
☐ Tobacco use		☐ Tobacco use	
☐ Child/Adult with Special Health Care Needs		☐ Child/Adult with Special Health Care Needs	
☐ Other:		☐ Other:	
Comments:		Comments:	

For Primary Care Case Management Clients Only
Fax to Community Health Services at (512) 302-0318
Referrals are also received by telephone at 1-888-276-0702 (M-F, 8 a.m. to 5 p.m., CST)

Effective Date_01152008/Revised Date_08032007

B.38 Primary Care Case Management (PCCM) Inpatient/Outpatient Authorization Form

This form is used to obtain prior authorization (PA) for elective inpatient admission/procedures and outpatient services, update an existing inpatient or outpatient authorization, and provide notification of emergency admissions.

Telephone number: 1-888-302-6167 (option 1 inpatient, option 2 outpatient)	Fax number: 1-512-302-5039

Please check the appropriate action you are requesting

Inpatient Services	Outpatient (OP) Services
☐ Notification (complete fields in Section 1 excluding clinical documentation)	☐ Prior authorization for outpatient services (complete Section 1)
☐ DRG or clinical update (complete Section 2)	☐ Update/change codes from original OP PA request (complete Section 2)
☐ Non Routine OB/NB (complete Section 1)	
☐ Prior Authorization of scheduled admission/procedure (complete Section 1)	

Client Information

PCN Number:	Name:	Date of Birth: / /

Facility Information

Name:			
Address:			
Telephone:		Fax number:	
TPI:	NPI:	Taxonomy:	Benefit Code:

Admitting/Performing Physician Information

Name:		Telephone:	
Address:		Fax number:	
TPI:	NPI:	Taxonomy:	Benefit Code:

Form completed by:	Date form completed: / /

Section 1

Service Type	☐ Outpatient Service(s)	☐ Emergent/Urgent Admit	☐ Scheduled Admission/ Procedure	☐ Admit Following Observation

Date of service: / /	Procedure code(s):
Primary diagnosis code:	
Secondary diagnosis codes:	

*DRG code:	Reference number:	Discharge date: / /

Clinical documentation supporting medical necessity for a scheduled admission/procedure, outpatient services or non-routine OB/NB:

Section 2 (Update information when necessary)

Primary diagnosis code:		
Secondary diagnosis codes:		
Date of service: / /	Procedure code(s):	*DRG code:

Clinical documentation to support medical necessity of DRG or procedure code change:

Only required for DRG admission

Effective Date_07302007/Revised Date_07302007

B.39 Primary Care Case Management (PCCM) Referral Form

Primary Care Provider Information	
Name:	
Contact name:	Telephone:
NPI:	TPI:

Client Information	
Name:	Date of birth: / /
Medicaid number:	Telephone:
Provider signature:	Referral date: / /

Referring Provider Information (If different from the primary care provider)	
Name:	
Contact name:	Telephone:
NPI:	TPI:

Consulting Provider/Facility	
Provider/Facility name:	Telephone:
Address:	
Appointment time and date: ___:___ / /	Medicaid number (if known):
Reason for referral:	

To the Consultant

This notice authorizes the following care: ☐ Evaluation only ☐ Evaluation and treatment

☐ Evaluation and single treatment ☐ As needed Number of treatments _____

Other (specify):

Initial consultations are for one visit only for evaluation and development of a treatment plan unless otherwise specified. All consultations require a written report (preferably typed and attached to this form) to the primary care provider and phone conferences as necessary to assure continuity of care. Referrals are valid for 30 days from the time of issue and it is the consulting provider's responsibility to verify eligibility prior to delivering services. Consulting providers may not authorize secondary referrals. All requests for additional services or visits to other providers must come through the primary care provider. All claims are subject to retrospective review for purposes of determining eligibility, benefit coverage, appropriateness, and medical necessity. Claims payment may be affected by review findings.

Consultant comments:	
Consultant signature:	Date / /

Please return findings and report to the primary care provider listed above.

Effective Date_01152008/Revised Date_08032007

B

B.40 Primary Care Case Management (PCCM) Pre-Contractual/Recredentialing Site and Medical Record Evaluation

Provider Information			
Name:	TPI:		NPI:
Address:	City:		Zip:
Telephone:	Date: / /		

Site Evaluation					
Site Criteria	**Meets Criteria**		**Condition of participation**		**Comments (include provider's comments regarding any criteria not met)**
	Yes	**No**	**N/A**	**COP**	
Office Appearance					
1. Appears clean	☐	☐		**COP**	
2. Clearly visible	☐	☐			
3. In good repair	☐	☐		**COP**	
4. Not odorous	☐	☐			
5. Adequate seating	☐	☐		**COP**	
6. Good visibility from reception area	☐	☐			
Office Space					
7. Rest rooms available	☐	☐		**COP**	
8. Rest rooms adequate	☐	☐		**COP**	
9. Rest room(s) wheelchair accessible	☐	☐	☐	**COP**	
10. Number of examination rooms adequate	☐	☐		**COP**	
11. Examination rooms well-equipped	☐	☐		**COP**	
Emergency Preparedness					
12. Emergency equipment available	☐	☐			
13. What types of equipment	☐	☐			
14. Staff knowledgeable of equipment	☐	☐	☐	**COP**	
15. Staff trained in CPR	☐	☐			
16. Emergency numbers posted	☐	☐			
Safety					
17. Smoke alarms	☐	☐		**COP**	
18. Fire extinguisher	☐	☐		**COP**	
19. Exit signs	☐	☐		**COP**	
20. Passageways clear	☐	☐		**COP**	
21. Proper disposal of biological and chemical waste	☐	☐		**COP**	
Handicapped Access					
22. Wheelchair ramp	☐	☐		**COP**	
23. Wide doors	☐	☐		**COP**	
24. Elevators (not applicable if single story)	☐	☐	☐	**COP**	
Staff					
25. Courteous	☐	☐		**COP**	
26. Answer phones promptly	☐	☐		**COP**	
27. Appear knowledgeable	☐	☐			
28. Neat/well groomed	☐	☐			
Medical Records					
29. Individual charts for each client	☐	☐		**COP**	
30. Stored in dedicated space	☐	☐		**COP**	
31. Personal/biographical data present	☐	☐		**COP**	
32. Provider identification and date	☐	☐		**COP**	
33. Handwriting legible	☐	☐		**COP**	
34. Allergies noted prominently	☐	☐		**COP**	
35. Health education/preventive services noted	☐	☐		**COP**	
36. Advance directives offered (adults)	☐	☐	☐		
37. Confidentiality maintained	☐	☐		**COP**	
Determination	☐	☐			**Reviewer:**
Addendum Limited English Proficiency Question: Are translation services available to clients with limited English language skills?	☐	☐			Offer telephone numbers for translation services if needed.

Effective Date_01152008/Revised Date_08022007

B.41 Physician's Examination Report

Client Name (Last, First, M)	Client No.	Date of Birth
Address (Street, City, State, ZIP Code)		

1. Date Of Examination*

2. Ear Examination:

a. Within Normal Limits ❑ Yes ❑ No

b. Cerumen Removed ❑ Yes ❑ No

c. Describe Ear Abnormalities:

3. Is more otolaryngological examination/treatment required to provide medical clearance for the fitting of a hearing aid? ❑ Yes ❑ No

If yes, refer this patient for consultation and completion of this form.

4. Are there any medical contradictions to hearing aid usage in either ear? ❑ Yes ❑ No

If yes, a hearing aid is medically prohibited in ❑ Right Ear ❑ Left Ear

5. Is the above-named individual a candidate for a hearing aid evaluation? ❑ Yes ❑ No

Signature* - Physician	Physician's Name (please type or print)	Medical Specialty
Address		Telephone No.

***NOTE PLEASE FURNISH THE PATIENT WITH THE SIGNED AND DATED ORIGINAL AND ONE COPY OF THIS FORM**

This form and supporting documentation must be maintained in the client's file.

A new Physician's Examination Report must be completed any time there is a change in the client's hearing or a new hearing aid is needed.

B.42 Physician's Medical Necessity Certification for Nonemergency Ambulance Transports (Texas Medicaid Program)

Request Date: _____/_____/ _____	Transport Date: _____/_____/ _____
Patient's Name:	Medicaid Number:
Transported From:	Transported To:
Physician's Printed Name:	Physician License #:

In order for ambulance services to be covered, they must be medically necessary and reasonable. Medical necessity is established when the patient's condition is clinically considered severely disabled and as such that transportation by any other means (including services provided through the Medicaid Medical Transportation Program or through that which is included in the rate for Long Term Care - Nursing Facilities) is contraindicated. A round-trip transport from the client's home to a scheduled medical appointment (e.g., an outpatient or freestanding dialysis or radiation facility) is covered when the client meets the definition of severely disabled.

The HHSC Medicaid Program has defined "severely disabled" as that client's physical condition limits mobility and requires the client to be bed-confined at all times, unable to sit unassisted at all times, or requires continuous life-support systems (including oxygen or IV infusion).

Please complete the questions below in order for the authorization to be evaluated under Medicaid coverage criteria.

1.)Is the patient severely disabled as defined by the above definition? ❑Yes ❑No
2.)If no, this client does not qualify for nonemergency ambulance transport.
3.)If yes, please check the appropriate medical condition listed below.

This patient:

- ❑ Requires continuous oxygen and monitoring by trained staff
- ❑ Requires airway monitoring or suction
- ❑ Requires restraints or sedation **(MUST BE EXPLAINED IN OTHER)**
- ❑ Comatose and requires trained monitoring
- ❑ Is actively seizure-prone and requires trained monitoring
- ❑ Had to remain immobile because of a fracture/possibility of a fracture that had not been set
- ❑ Patient is ventilator-dependent
- ❑ Contractures **(MUST BE EXPLAINED IN OTHER)**
- ❑ Has advanced decubitus ulcers and requires wound precautions **(MUST BE EXPLAINED IN OTHER)**
- ❑ Requires isolation precautions (VRE, MRSA, etc.) **(MUST BE EXPLAINED IN OTHER)**
- ❑ Patient requires continuous IV therapy
- ❑ Requires cardiac monitoring
- ❑ Is exhibiting signs of a decreased level of consciousness **(MUST BE EXPLAINED IN OTHER)**
- ❑ Total hip replacement requires hip precautions and cannot sit safely **(MUST BE EXPLAINED IN OTHER)**
- ❑ **Other** (explain)

I CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS, TO THE BEST OF MY KNOWLEDGE, COMPLETE AND ACCURATE AND SUPPORTED IN THE MEDICAL RECORD OF THE PATIENT. THE INFORMATION BEING UTILIZED ON THIS FORM IS BEING GATHERED TO ASSIST IN SEEKING REIMBURSEMENT FOR A NONEMERGENCY AMBULANCE TRANSPORT FROM THE MEDICAID PROGRAM. I UNDERSTAND THAT ANY INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION, WHICH LEADS TO INAPPROPRIATE PAYMENTS, ARE SUBJECT TO INVESTIGATIONS UNDER APPLICABLE FEDERAL AND STATE LAWS. * **THIS AUTHORIZATION WILL BE VALID FOR 180 DAYS FROM THE DATE OF ISSUANCE AND WILL CERTIFY THAT THE PATIENT REMAINS SEVERELY DISABLED FOR THAT PERIOD OF TIME.**

Signature of Attending or Patient's Personal Physician _____/_____/_____ Date Signed

Requesting Provider Information	
Name:	Telephone:
Address:	
Fax number:	TPI:
NPI:	Taxonomy:

Effective Date_07302007/Revised Date_06012007

B.43 Private Pay Agreement

Private Pay Agreement

I understand _____ is accepting me as a private pay patient for the period of
(Provider Name)
_____, and I will be responsible for paying for any services I receive. The provider will not file a claim to Medicaid for services provided to me.

Signed: _____

Date: _____

B.44 Provider Information Change Form Instructions

Signatures

- The provider's signature is required on the Provider Information Change Form for any and all changes requested for individual provider numbers.
- A signature by the authorized representative of a group or facility is acceptable for requested changes to group or facility provider numbers.

Address

- Performing providers (physicians performing services within a group) may *not* change accounting information.
- For Traditional Medicaid and the CSHCN Services Program, changes to the accounting or mailing address require a copy of the W-9 form.
- For Traditional Medicaid, a change in ZIP Code requires copy of the Medicare letter for Ambulatory Surgical Centers.

Tax Identification Number (TIN)

- TIN changes for individual practitioner provider numbers can only be made by the individual to whom the number is assigned.
- Performing providers *cannot* change the TIN.

Provider Demographic Information

An online provider lookup (OPL) is available, which allows users such as Medicaid clients and providers to view information about Medicaid-enrolled providers. To maintain the accuracy of your demographic information, please visit the OPL at www.tmhp.com. Please review the existing information and add or modify any specific practice limitations accordingly. This will allow clients more detailed information about your practice.

General:

- TMHP must have either the nine-digit Texas Provider Identifier (TPI), or the National Provider Identifier (NPI)/Atypical Provider Identifier (API), primary taxonomy code, physical address, and benefit code (if applicable) in order to process the change. Forms will be returned if this information is not indicated on the Provider Information Change Form.
- The W-9 form is required for *all* name and TIN changes.
- Mail or fax the completed form to:

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

Effective Date_12042007/Revised Date_120420(

B.45 Provider Information Change Form

Traditional Medicaid, Children with Special Health Care Needs (CSHCN) Services Program, and Primary Care Case Management (PCCM) providers can complete and submit this form to update their provider enrollment file. Print or type all of the information on this form. Mail or fax the completed form and any additional documentation to the address at the bottom of the page.

Check the box to indicate a PCCM Provider ☐	Date : / /
Nine-Digit Texas Provider Identifier (TPI):	Provider Name:
National Provider Identifier (NPI):	Primary Taxonomy Code:
Atypical Provider Identifier (API):	Benefit Code:

List any additional TPIs that use the same provider information:

TPI:	TPI:	TPI:
TPI:	TPI:	TPI:
TPI:	TPI:	TPI:

Physical Address—The physical address cannot be a PO Box. Ambulatory Surgical Centers enrolled with Traditional Medicaid who change their ZIP Code must submit a copy of the Medicare letter along with this form.

Street address City County State Zip Code

Telephone: ( )	Fax Number: ( )	Email:

Accounting/Mailing Address—All providers who make changes to the Accounting/Mailing address must submit a copy of the W-9 Form along with this form.

Street Address City State Zip Code

Telephone: ( )	Fax Number: ( )	Email:

Secondary Address

Street Address City State Zip Code

Telephone: ( )	Fax Number: ( )	Email:

Type of Change (check the appropriate box)

☐	Change of physical address, telephone, and/or fax number
☐	Change of billing/mailing address, telephone, and/or fax number
☐	Change/add secondary address, telephone, and/or fax number
☐	Change of provider status (e.g., termination from plan, moved out of area, specialist) *Explain in the Comments field*
☐	Other (e.g., panel closing, capacity changes, and age acceptance)

Comments:

Tax Information—Tax Identification (ID) Number and Name for the Internal Revenue Service (IRS)

Tax ID number:	Effective Date:

Exact name reported to the IRS for this Tax ID:

Provider Demographic Information—Note: This information can be updated on www.tmhp.com.

Languages spoken other than English:

Provider office hours by location:

Accepting new clients by program (check one): Accepting new clients ☐ Current clients only ☐ No ☐

Patient age range accepted by provider:	Additional services offered (check one): HIV ☐ High Risk OB ☐
Participation in the Woman's Health Program? Yes ☐ No ☐	Patient gender limitations: Female ☐ Male ☐ Both ☐

Signature and date are *required* or the form will *not* be processed.

Provider signature:	Date: / /

Mail or fax the completed form to: Texas Medicaid & Healthcare Partnership (TMHP)
Provider Enrollment
PO Box 200795
Austin, TX 78720-0795

Fax: 512-514-4214

Effective Date_12042007/Revised Date_12042007

B.46 Psychiatric Inpatient Initial Admission Request Form

12357-B Riata Trace Parkway, Suite 150
Austin, Texas 78727-6422

TMHP CCIP

Telephone: 1-800-213-8877
Fax: 1-512-514-4211

I. Identifying Information					
Medicaid Number:			Date: / /		
Client Name	Last:		First:		Middle Initial:
Date of birth: / /	Age:	Sex:	Date of admission: / /	Time:	
Facility Information					
Name:			Contact Person:		
Address:					
TPI:	NPI:		Taxonomy:		Benefit Code:
Commitment Type: *(If applicable)*	Effective Date: / /		County:	Judge:	
Referral source: ☐ Admitting MD ☐ MH Professional ☐ Other (list):					
Current living arrangements: ☐ With parent(s) ☐ Group/foster home ☐ Other (list):					

IIA. Primary symptom described in "specific observable behavior" that requires acute hospital care
(Include: precipitating events leading to admission)

IIB. Other relevant clinical information, including inability to benefit from less restrictive setting
(Attach additional pages or documents, as necessary)

IIC. Psychiatric medications (include total daily doses)	**IID. Present and past drug/alcohol usage:**	
	Name of chemical	Current use?

IIE. Past psychiatric treatment

1. Number of previous inpatient admissions: [ ] Dates of most recent inpatient stay: / / to / /
2. Previous ambulatory/outpatient treatment (provider or facility, frequency) – If none, why:

III. Current diagnosis (Axis I):

IV. Additional diagnosis (Axis I and Axis II):

V. Current functional assessment scores (DSM IV): GAF [ ]

VI. No. of hospital days requested: [ ] Dates: / / to / /

Projected discharge date (required): / /

VII. Aftercare plan:

Provider or Facility:

Frequency:

Signature (attending MD):	Date: / /
Print name:	Provider license number
Provider TPI:	Provider NPI:

Effective Date_07302007/Revised Date_07102007

B.47 Psychiatric Inpatient Extended Stay Request Form

12357-B Riata Trace Parkway, Suite 150
Austin, Texas 78727-6422

TMHP CCIP

Telephone: 1-800-213-8877
Fax: 1-512-514-4211

I. Identifying Information					
Medicaid Number:			Date: / /		
Client Name	Last:		First:		Middle Initial:
Date of birth: / /		Age:	Sex:	Date of admission: / /	
Facility Information					
Name:			Contact Person:		
Address:					
TPI:	NPI:		Taxonomy:		Benefit Code:
Commitment Type: *(If applicable)*	Effective Date: / /		County:	Judge:	
IIA. Current status of primary symptoms that require continued acute hospital care (Include: 1. Date of most recent occurrence; 2. Frequency; 3. Duration; 4. Severity)					
IIB. Other relevant clinical/diagnostic information about the patient from the past 72 hours (Attach additional pages or documents, as necessary)					
IIC. Current psychiatric medication (include total daily doses)			**IID. Discharge criteria**		
			1.		
			2.		
			3.		
IIE. Describe treatment, contacts, plans (including outcome) with family, school, etc.					
III. Current diagnosis (Axis I):					
IV. Additional diagnosis (Axis I and Axis II):					
V. Current functional assessment scores (DSM IV): GAF [ ]					
VI. No. of hospital days requested: [ ] Dates: / / to / /					
Projected discharge date (required): / /					
VII. Aftercare plan:					
Provider or Facility:					
Frequency:					
Signature (attending MD):				Date: / /	
Print name:			Provider license number		
Provider TPI:			Provider NPI:		

Effective Date_07302007/Revised Date_07102007

B

B.48 Pulse Oximeter Form

Client Name:	Medicaid number:	
DME Provider Information		
Name:	Telephone:	Fax number:
Address:		
TPI:	NPI:	
Taxonomy:	Benefit Code:	

Equipment Information

HCPCS Code	Product Name and Model Number	Retail Price

New device provided for purchase? ☐ Yes ☐ No

Equipment designated for clinical use only is not considered appropriate for use in the home

Note: *Oxygen dependent is defined as ongoing, regular need for use of supplemental oxygen for a significant portion of the day to maintain oxygen saturation. This does not include: PRN use; when only used when sick; when only used when suctioning; when desaturation occurs only when crying; when desaturation occurs only with seizure activity.*

The following information must be completed by the physician

Diagnosis and Basis for Medical Necessity of requested services:

Dates of Service requested for Prior Authorization | From: / / | To: / /

☐ Client is ventilator and/or oxygen dependent

Client is ventilator dependent ____ hours per day | Client is oxygen dependent ____ hours per day

☐ Client is weaning from oxygen and/or a ventilator

☐ Anticipated length of monitor need: ☐ Months: ☐ 1-3 years ☐ More than 3 years

☐ Who will respond to the monitor alarm?

☐ Can the patient's medical needs be met with intermittent "spot check" of oxygen saturations? ☐ Yes ☐ No

☐ What is the medical basis for need of continuous monitoring?

☐ Is the client receiving any nursing services such as PDN, Home Health Visits, MDCP, CBA, and Private Insurance?

Please indicate services:

Number of hours/visits:

Physician Information

Signature:		Date: / /
Name (printed):		Telephone:
Address:		
TPI:	NPI:	License number:

Must be submitted with a THSteps-CCP Prior Authorization Request Form

Effective Date_07302007/Revised Date_06012007

B.49 Radiology Prior Authorization Request Form

This form is used to obtain prior authorization (PA) for elective outpatient services or update an existing outpatient authorization.

Telephone number: 1-800-572-2116		Fax number: 1-800-572-2119		Date of Request: / /
Please check the appropriate action requested:				
☐ CT Scan	☐ CTA Scan	☐ MRI Scan	☐ MRA Scan	☐ Update/change codes from original PA request
Client Information				
Name:		Medicaid number:		Date of Birth: / /
Facility Information				
Name:				Reference number:
Address:				
TPI:			NPI:	
Taxonomy:			Benefit Code:	
Requesting/Referring Physician Information				
Name:				License number:
Address:				
Telephone:			Fax number:	
TPI:			NPI:	
Taxonomy:			Benefit Code:	
Section 1				
Service Types	Outpatient Service(s) ☐		Emergent/Urgent Procedure ☐	
Date of Service: / /			Procedures Requested:	
Diagnosis Codes	Primary:		Secondary:	
Clinical documentation supporting medical necessity for a radiology procedure includes treatment history, treatment plan, medications, and previous imaging results:				
Requesting/Referring Physician (Signature Required):				
Print Name:			Date: / /	
Section 2— Updated Information (when necessary)				
Date of Service: / /			Procedures Requested:	
Diagnosis Codes	Primary:		Secondary:	
Clinical documentation supporting medical necessity for a procedure code change includes treatment history, treatment plan, medications, and previous imaging results:				
Requesting/Referring Physician (signature required):				
Print Name:			Date: / /	
Physician must complete and sign this form prior to requesting authorization.			Requesting/Referring Physician License No.:	
Requesting/Referring Physician NPI:			Requesting/Referring Physician TPI:	

Effective Date_07302007/Revised Date_08062007

B

B.50 Request for Initial Outpatient Therapy (Form TP-1)

Request For Initial Outpatient Therapy (Form TP-1)

CCP - Texas Medicaid & Healthcare Partnership PO Box 200735 Austin TX 78720-0735 1-800-846-7470 CCP FAX: 1-512-514-4212	Texas Medicaid & Healthcare Partnership CSHCN PO Box 200855 Austin TX 78720-0855 1-800-568-2413 or 1-512-514-3000 FAX: 1-512-514-4222

Medicaid Number:		CSHCN Number:	
Client Name:	Date of birth: / /	Telephone:	
Client Address:			
Has the child received therapy in the last year from the public school system? ☐ Yes ☐ No			
Date of Initial Evaluation	PT	OT	SLP
A copy of the initial evaluation must be attached			
ICD-9 Code/Diagnosis:		Date of onset:	

Category of Therapy Being Requested

PT/OT for:	☐ Developmental anomalies	☐ Pre-surgery	☐ Post-surgery Date of surgery / /	
☐ Cast Removal Date Removed / /		☐ Serial Casting	☐ Acute Episode of Chronic Condition	
☐ New Condition	☐ Specialty Clinic	☐ Home Program	☐ ADL (activities of daily living)	
☐ Equipment Assessment		☐ Equipment Training		
Speech for:	☐ Craniofacial	☐ Developmental Anomalies	☐ New Condition	☐ Post Cochlear Implant

Check the service requested, indicate the date(s) of service and frequency per week or month:
Dates of service cannot exceed six months. If possible, end requested date of service on the last day of the month.

Service Type	Service Date(s)		Frequency per week	Frequency per month
	From:	To:		
☐ **PT**	/ /	/ /		
☐ **OT**	/ /	/ /		
☐ **SLP**	/ /	/ /		

Procedure code(s) for therapy services:

Specialist	Name	Signature	Date Signed
Physician			/ /
PT Therapist			/ /
OT Therapist			/ /
SLP Therapist			/ /

Provider Information

Name:	Telephone:	Fax:
Address:		

Medicaid Identifying Information

TPI:	NPI:	Taxonomy:	Benefit Code:

CSHCN Identifying Information

TPI:	NPI:	Taxonomy:	Benefit Code:

FOR OFFICE USE ONLY: Medicaid ☐ Yes ☐ No HMO ☐ Yes ☐ No Restrictions:

PAN# Valid To

FORM TP-1

Effective Date_07302007/Revised Date_06012007

B.51 Request for Extension of Outpatient Therapy (2 Pages) (Form TP-2)

Request for Extension of Outpatient Therapy (Form TP-2)

CCP - Texas Medicaid & Healthcare Partnership PO Box 200735 Austin TX 78720-0735 1-800-846-7470 CCP FAX: 1-512-514-4212	Texas Medicaid & Healthcare Partnership CSHCN PO Box 200855 Austin TX 78720-0855 1-800-568-2413 or 1-512-514-3000 FAX: 1-512-514-4222

Medicaid Number:		CSHCN Number:	
Client Name:		Date of birth: / /	Telephone:
Client Address:			
Has the child received therapy in the last year from the public school system? ☐ Yes ☐ No			
Date of Initial Evaluation	PT	OT	SLP
A copy of the initial evaluation must be attached			
ICD-9 Code/Diagnosis:		Date of onset:	

Category of Therapy Being Requested

PT/OT for:	☐ Developmental anomalies	☐ Pre-surgery	☐ Post-surgery Date of surgery / /	
☐ Cast Removal Date Removed / /		☐ Serial Casting	☐ Acute Episode of Chronic Condition	
☐ New Condition	☐ Specialty Clinic	☐ Home Program	☐ ADL (activities of daily living)	
☐ Equipment Assessment		☐ Equipment Training		
Speech for:	☐ Craniofacial	☐ Developmental Anomalies	☐ New Condition	☐ Post Cochlear Implant

Check the service requested, indicate the date(s) of service and frequency per week or month:
Dates of service cannot exceed six months. If possible, end requested date of service on the last day of the month.

Service Type	Service Date(s)		Frequency per week	Frequency per month
	From:	To:		
☐ **PT**	/ /	/ /		
☐ **OT**	/ /	/ /		
☐ **SLP**	/ /	/ /		

Procedure code(s) for therapy services:

Specialist	Name	Signature	Date Signed
Physician			/ /
PT Therapist			/ /
OT Therapist			/ /
SLP Therapist			/ /

Provider Information

Name:	Telephone:	Fax:
Address:		

Medicaid Identifying Information

TPI:	NPI:	Taxonomy:	Benefit Code:

CSHCN Identifying Information

TPI:	NPI:	Taxonomy:	Benefit Code:

FOR OFFICE USE ONLY: Medicaid ☐ Yes ☐ No HMO ☐ Yes ☐ No Restrictions:

FORM TP-2 Page 1 of 2

Effective Date_07302007/Revised Date_06012007

B

PAN# Valid To

Medicaid Number:	CSHCN Number:
Client Name:	Date of birth: / /

Current Functional Status:

New Treatment Goals:

Prior Dates of Service: from / / to / /

Prior Functional Status:

Prior Treatment Goals:

Prior Treatment Provided:

FORM TP-2 Page 2 of 2

Effective Date_07302007/Revised Date_06012007

B.52 Request for Extended Outpatient Psychotherapy/Counseling Form

1. Identifying Information					
Client Information					
Medicaid number:			Date: / /		
Client name	Last:		First:		Middle Initial:
Date of birth: / /	Age:	Sex:	Began current treatment: / /		
Current living arrangements:	☐ With parent(s)	☐ Group/foster home	☐ Other (list):		
Provider Information					
Performing provider:			Telephone:		
Address:					
TPI:			NPI:		
Taxonomy:			Benefit Code:		
2. Current DSM IV diagnosis (list all appropriate codes):					
Axis I diagnosis:					
Axis II diagnosis:			GAF:		
Current substance abuse?	☐ None	☐ Alcohol	☐ Drugs	☐ Alcohol and Drugs	
3. Recent primary symptoms that require additional therapy/counseling					
Include date of most recent occurrence, frequency, duration, and severity:					
4. History					
Psychiatric inpatient treatment	☐ Yes	☐ No	Age at first admission:		
Prior substance abuse?	☐ None	☐ Alcohol	☐ Drugs	☐ Alcohol and Drugs	
Significant medical disorders:					
5. Current psychiatric medications (include dose and frequency):					
6. Treatment plan for extension					
Measurable short term goals, specific therapeutic interventions utilized and measurable expected outcome(s) of therapy:					
7. Number of additional sessions requested (limit 10 per request)					
List the specific procedure codes requested:					
How many of each type?	IND		Group		Family
Dates	From (start of extension visits): / /		To (end of planned requested visits): / /		
List specific procedure codes requested:					
Provider signature:			Date: / /		
Provider printed name:					

Effective Date_07302007/Revised Date_06012007

B

B.53 Sample Letter - XUB Computer Billing Service Inc.

XUB Computer Billing Service, Inc.
4040 Main Street
Anytown, USA 11111

Dear Sir:

This letter authorizes the XUB Computer Billing Service, Inc. to use my signature and to attest on my behalf to the requirements authorized in the following paragraphs, when submitting Medicaid claims on my behalf.

This is also to certify that information appearing on billings submitted by me for the Texas Medical Assistance Program is and will be true, accurate, and complete. I understand that payment of any Texas Medical Assistance Program claim will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state laws. These certifications are made in accordance with requirements found at 42 Code Federal Regulations 455.18 and 455.19.

I also certify that the items billed to the Texas Medical Assistance Program are and will be for services that have been and will be personally provided by me or under my personal direction, and in cases of physician services, the services, supplies, or other items billed have been and will be medically necessary for the diagnosis or treatment of the condition of the patients, and are provided without regard to race, color, sex, national origin, age, or handicap.

Additionally, I agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the Texas Medical Assistance Program. I also agree to furnish them at no cost and provide access to information regarding any payments claimed for providing such services as the State Agency, Attorney General's Office, and Department of Health and Human Services (HHS) Office may request for five years from date of service (6 years for freestanding rural health clinic; 10 years for hospital-based rural health clinic), or until any dispute is settled, whichever occurs first.

I agree to accept the amounts paid by the Medicaid Program as full payment for the services rendered for which a Medicaid benefit is provided under the Texas Medical Assistance Program.

This letter, to be retained in your files, bears my true and original signature:

_____/_____/_____
Provider Signature Date

_____ _____
TPI NPI

B.54 Specimen Submission Form G-1C, Maternal Serum Prenatal Triple Screen, Instructions

Note: *Form G-1C, Maternal Serum Prenatal Triple Screen, is provided for the provider's convenience. Previously it was part of the G-1B form. It is not a THSteps form.*

For information on Triple Screens, call: 1-800-687-4363 or 1-888-963-7111 x7138 or Fax: (512) 458-7139.
For mailing and specimen packaging information, visit DSHS Laboratory Services Section's web page at http://www.dshs.state.tx.us/lab/.

The specimen submission form ***must*** accompany each specimen.
The patient's name listed on the specimen ***must*** match the patient's name listed on the form.
If the Date of Collection field is not completed, the specimen will be rejected.

Place Bar Code Label Here: Place the specimen bar code label that will be used to identify and track the specimen in the DSHS laboratory information management system. If you are performing remote entry, place specimen bar code label here.

Section 1. SUBMITTER INFORMATION

All submitter information is required.

Submitter/TPI number, Submitter name and Address: The submitter number is a unique number that the Texas Department of State Health Services (DSHS) Laboratory Services Section assigns to each of our submitters. For Texas Health Steps (THSteps) specimens, use the pre-assigned Texas Provider Identifier (TPI) number. To obtain a TPI number and THSteps enrollment, contact Texas Medicaid and Healthcare Partnership (TMHP) at 1-800-925-9126.

To request a DSHS Laboratory Services Section submitter number, a master form, or to change submitter information, please call (888) 963-7111 x7578 or (512) 458-7578, or fax (512) 458-7533.

NPI Number: Beginning May 23, 2007, all health care providers must use the National Provider Identifier (NPI) number and the TPI number or other submitter number will no longer be used. The NPI number is the new national standard identifier for health care providers adopted by the Centers for Medicare & Medicaid Services (CMS) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. To obtain an NPI number, contact the National Plan and Provider Enumeration System (NPPES) toll free at (800) 465-3203 or via their web site at https://nppes.cms.hhs.gov/NPPES/Welcome.do.

Indicate the submitter's name, address, city, state, and zip code. Please print clearly, use a pre-printed label, or use a photocopy of a master form provided by the Laboratory Services Section.

Contact Information: Indicate the telephone number and name of the person to contact at the submitting facility in case the laboratory needs additional information about the specimen. The fax number should indicate the number of the fax machine where the report should be sent.

Clinic Code: Please provide, if applicable. This is a code that the submitter furnishes to help them identify which satellite office submits a specimen and to help the submitter identify where the lab report belongs, if the submitter has a primary mailing address with satellite offices.

Section 2. PATIENT INFORMATION

Complete all patient information including last name, first name, middle initial, address, city, state, zip code, telephone number, country of origin, race/ethnicity, date of birth, age, sex, social security number (SSN), pregnant, medical record number, ICD diagnosis code, and previous DSHS lab specimen number.

NOTE: The patient's name listed on the specimen ***must*** match the patient's name listed on the form.

Information that is required to bill Medicare, Medicaid, or private insurance has been marked with double asterisks (**). You may use a pre-printed patient label.

ICD Diagnosis Code: Indicate the diagnosis code that would help in processing, identifying, and billing of this specimen.

Section 3. TRIPLE SCREEN REQUEST & PATIENT INFORMATION

In order to interpret this test, **all** patient information in this section of this form must be provided. Without the date of collection, accurate gestational age, maternal weight, maternal date of birth, maternal race, and information about maternal diabetic status, a complete assessment cannot be made. *The time and date the specimen is removed from freezer* ***must*** *be provided to determine specimen acceptability.*

Section 4. PHYSICIAN INFORMATION

Physician's name, UPIN, and NPI Number: Give the name of the physician and their unique physician ID number (UPIN) and NPI number, if applicable. Beginning May 23, 2007, the NPI number will replace the UPIN. This information is required to bill Medicare and insurance.

Section 5. PAYOR SOURCE

THE SUBMITTER WILL BE BILLED, if the required billing information is not provided or multiple boxes are checked**.**

Indicate the party that will receive the bill.

Medicaid or Medicare:
- Mark the appropriate box and write in the Medicaid or Medicare number.
- If the patient name on the form does not match the name on the card, the submitter will be billed.

Private Insurance:
- Mark the appropriate box, and
- Complete all fields on the form that have an asterisk (*).
- If the private insurance information is not provided on the specimen form, the submitter will be billed.

DSHS Program:
- Do NOT check a DSHS program as a Payor Source if the patient has Medicaid or Medicare.
- If you are contracting and/or enrolled with a DSHS program to provide services that require laboratory testing, please indicate which program. For program descriptions, see the Laboratory Services Section's Manual of Reference Services located on the web site at http://www.dshs.state.tx.us/lab/.
- If there is no other Payor Source for the patient and the patient meets the program's eligibility criteria, check the appropriate DSHS program.

HMO / Managed care / Insurance company: Print the name, address, city, state, and zip code of the insurance company to be billed. If all insurance information is not provided on the specimen form, the submitter will be billed.

Responsible party: Print the name of the responsible party, the insurance ID number, insurance company's phone number, group name, and group number.

Signature and Date: Have the responsible party sign and date to authorize the release of their information, if DSHS is to bill their insurance or HMO.

For specific test instructions and information about tube types, see the Laboratory Services Section Manual of Reference Services on our web site at http://www.dshs.state.tx.us/lab/.

B.55 Specimen Submission Form G-1C, Maternal Serum Prenatal Triple Screen

Note: *Form G-1C, Maternal Serum Prenatal Triple Screen, is provided for the provider's convenience. Previously it was part of the G-1B form. It is not a THSteps form.*

TEXAS Department of State Health Services

Prenatal Screening: (800) 687-4363

G-1C Specimen Submission Form (MAR 2006) Rev 2
CLIA #45D0660644
Laboratory Services Section
1100 W. 49th Street, MC-1947
Austin, Texas 78756-3194
(888) 963-7111 x7318 or (512) 458-7318
http://www.dshs.state.tx.us/lab

Place Bar Code Label Here

Section 1. SUBMITTER INFORMATION – (REQUIRED)**

Submitter/TPI Number ** | Submitter Name **
NPI Number ** | Address
City ** | State ** | Zip Code **
Phone ** | Contact
Fax | Clinic Code

Section 2. PATIENT INFORMATION -- (REQUIRED)**

NOTE: **Patient name** on specimen is **REQUIRED & MUST** match name on this form & Medicare/Medicaid card.

Last Name ** | First Name ** | MI
Address ** | Telephone Number
City ** | State ** | Zip Code ** | Country of Origin

Race: ☐ White / Caucasian ☐ Black or African American ☐ American Indian / Native Alaskan ☐ Asian ☐ Native Hawaiian / Pacific Islander ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Semitic ☐ Chinese ☐ Filipino ☐ Korean ☐ Oriental ☐ Multiple ☐ Not Specified ☐ Unknown

DOB (mm/dd/yyyy) ** | Age | Sex | SSN ** | Pregnant? ☐ Yes ☐ No ☐ Unknown
Medical Record Number | ICD Diagnosis Code ** | Previous DSHS Specimen Lab Number

Section 3. TRIPLE SCREEN REQUEST & PATIENT INFORMATION

NOTES: Please see the form's instructions for details on how to complete this form. Details of test and specimen requirements can be found in the Laboratory Services Section's Manual of Reference Services. Visit our web site at http://www.dshs.state.tx.us/lab/.

(All information is required for testing.)

O.B. History G_____ P_____ AB_____

	Yes	No	
Multiple fetuses?	☐	☐	Specify *number of fetuses:* _____
On insulin **prior to** pregnancy (IDDM)	☐	☐	
Maternal medication	☐	☐	Specify: _____
Repeat specimen?	☐	☐	If yes, indicate reason: _____

Gestational Age (Select one calculation method.)

☐ DATE of LMP _____ (mm/dd/yy)
☐ Ultrasound dating _____ weeks _____ days on _____ (mm/dd/yy)
☐ If sono by 1/10 of week _____.____ weeks on _____ (mm/dd/yy)
☐ Physical exam _____ weeks _____ days on _____ (mm/dd/yy)
☐ Estimated Delivery Date _____ (mm/dd/yy) by: US_____ LMP_____ Exam____

CURRENT WEIGHT	DATE OF COLLECTION	TIME OF COLLECTION	COLLECTED BY	Time and Date of Removal from Freezer prior to shipping (REQUIRED)

Section 4. PHYSICIAN INFORMATION -- (REQUIRED)**

Physician's Name **
Physician's UPIN ** | **Physician's NPI Number ****

Section 5. PAYOR SOURCE – (REQUIRED)

Indicate whether we should bill the submitter, Medicaid, Medicare, private insurance, or DSHS Program. If Medicaid or Medicare is indicated, the Medicaid/Medicare number is required. If private insurance or DSHS Program is indicated, the required billing information below is designated with an asterisk (*). If required information is not provided, **THE SUBMITTER WILL BE BILLED.**

☐ Submitter ☐ Private Insurance
☐ Medicaid ☐ Medicare

Medicaid/Medicare #: _____
(attach copy of card)

DSHS Programs:
☐ Title V – Family Planning ☐ Other: _____
☐ Title V – MCH
☐ Title X – Family Planning
☐ Title XX – Family Planning

HMO / Managed Care / Insurance Company Name *
Address *
City * | State * | Zip Code *
Insurance Phone Number * | Responsible Party's Insurance ID Number *
Group Name * | Group Number *

"I hereby authorize the release of information related to the services described here and hereby assign any benefits to which I am entitled to the Texas Department of State Health Services, Laboratory Services Section." Signature of patient or responsible party.

Signature * Date *

FOR DSHS LABORATORY USE ONLY

Specimen received
Specimen condition
Verify specimen
Edit
Completed
Mailed & faxed
Revised, mailed & faxed
Revised, mailed & faxed

B.56 Specimen Submission Form G-1C, Maternal Serum Prenatal Triple Screen, Spanish Instructions (2 Pages)

Marzo de 2006 Página 1 de 2

Instrucciones del formulario de remisión de muestras de pruebas triples prenatales de suero materno G-1C

Puede obtener información sobre las Pruebas triples llamando al: 1-800-687-4363 ó 1-888-963-7111, extensión 7138, o mandando un fax al: (512) 458-7139.
Para obtener información sobre envíos por correo y el embalaje de las muestras, visite la página web de la Sección de Servicios de Laboratorio del DSHS en http://www.dshs.state.tx.us/lab/.

Debe acompañar cada muestra con un formulario de remisión de muestras.
El nombre del paciente de la muestra ***debe*** ser el mismo que el nombre del paciente del formulario.
Si no rellena el campo Fecha de obtención, se rechazará la muestra.

Coloque la etiqueta de código de barra aquí: coloque la etiqueta de código de barra de la muestra a ser usada para identificar y ubicar la muestra en el sistema de administración de datos del laboratorio del DSHS. Si está ingresando remotamente, coloque la etiqueta de código de barra de la muestra aquí.

Sección 1. DATOS DEL REMITENTE

Se requieren todos los datos del remitente.

Número de remitente y de TPI, nombre y dirección del remitente: el número de remitente es un número único que la Sección de Servicios de Laboratorio del Departamento Estatal de Servicios de Salud de Texas (Texas Department of State Health Services [DSHS]) asigna a cada uno de nuestros remitentes. Para muestras de Pasos Sanos de Texas (Texas Health Steps [THSteps]), utilice el número Identificador de proveedor de Texas (Texas Provider Identifier [TPI]) preasignado. Para obtener un número de TPI e inscribirse en Pasos Sanos de Texas, llame a la Asociación de Medicaid y Salud de Texas (Texas and Healthcare Partnership [TMHP]) al 1-800-925-9126.

Para solicitar un número de remitente a la Sección de Servicios de Laboratorio del DSHS, el formulario original o para cambiar los datos del remitente, sírvase llamar al (888) 963-7111, extensión 7578, o al (512) 458-7578 o mandar un fax al (512) 458-7533.

Núm. de NPI: a partir del 23 de mayo de 2007, todos los proveedores de salud deben usar el número Identificador de proveedor nacional (National Provider Identifier [NPI]) y ya no se usará el número de TPI u otro número de remitente. El número NPI es el nuevo identificador nacional oficial para proveedores de salud adoptado por los Centros de Servicios de Medicaid y Medicare (Centers for Medicare & Medicaid Services [CMS]) de conformidad con la Ley de Transferibilidad y Responsabilidad de Seguros Médicos (Health Insurance Portability and Accountability Act [HIPAA]) de 1996. Para obtener un número de NPI, llame al Sistema Nacional de Enumeración de Planes y Proveedores (National Plan and Provider Enumeration System [NPPES]) gratis al (800) 465-3203 o visite su sitio web en https://nppes.cms.hhs.gov/NPPES/Welcome.do.

Indique el nombre, dirección, ciudad, estado y código postal del remitente. Escriba claramente en letra de molde, utilice una etiqueta preimpresa o utilice una fotocopia del formulario original proporcionado por la Sección de Servicios de Laboratorio.

Datos de contacto: indique el número telefónico y el nombre de la persona a contactar en el centro remitente en caso de que el laboratorio necesite información adicional sobre la muestra. El número de fax debe indicar el número de la máquina de fax adónde se debe enviar el informe.

Código de la clínica: sírvase proporcionarlo, de ser aplicable. Se trata de un código que el remitente provee para ayudar a identificar cuál oficina satélite remite una muestra y para ayudar al remitente a identificar adónde pertenece el informe de laboratorio, si el remitente tuviese una dirección de correo postal primaria con oficinas satélite.

Sección 2. DATOS DEL PACIENTE

Rellene todos los datos del paciente incluido el apellido, el nombre, la inicial del segundo nombre, la dirección, ciudad, estado, código postal, número telefónico, país de origen, raza/etnia, fecha de nacimiento, edad, sexo, número de Seguro Social, si es mujer si está embarazada, número de expediente médico, código diagnóstico de ICD y número previo del laboratorio de muestras del DSHS.

NOTA: el nombre del paciente de la muestra ***debe*** ser el mismo que el nombre del paciente del formulario.

La información requerida para facturar a Medicare, Medicaid o un seguro privado ha sido señalada con doble asterisco (**). Puede utilizar una etiqueta de paciente preimpresa.

Código diagnóstico de ICD: indique el código diagnóstico que ayudaría a procesar, identificar y facturar la muestra.

Sección 3. SOLICITUD DE PRUEBA TRIPLE Y DATOS DEL PACIENTE

A fin de interpretar la prueba, se deben proporcionar **todos** los datos del paciente en esta sección del formulario. Sin la fecha de obtención, la edad de gestación precisa, el peso materno, la fecha de parto, la raza materna y la información sobre el estado diabético materno, no se puede realizar una evaluación completa. *Se **debe** proporcionar la fecha y hora de remoción de la muestra del congelador para determinar la aceptabilidad de la muestra.*

Sección 4. DATOS DEL MÉDICO

Nombre y número de UPIN y NPI del médico: dé el nombre del médico y el número identificador único del médico (unique physician ID number [UPIN]) y el número NPI, de ser aplicable. A partir del 23 de mayo de 2007, el número NPI reemplazará al UPIN. Se requiere esa información para facturar a Medicare y al seguro.

Sección 5. PAGADOR

SE FACTURARÁ AL REMITENTE, si no se proporciona la información de facturación requerida o si se marcan múltiples casillas**.**

Indique la parte que recibirá la factura.

Medicaid o Medicare:
- Marque la casilla correspondiente y escriba el número de Medicaid o Medicare.
- Si el nombre del paciente del formulario no es el mismo que el nombre de la tarjeta, se facturará al remitente.

Seguro privado:
- Marque la casilla correspondiente y
- Rellene todos los campos del formulario que tengan asterisco (*).
- Si no proporciona los datos del seguro privado en el formulario de la muestra, se facturará al remitente.

Programa del DSHS:
- NO marque un programa del DSHS como Pagador si el paciente cuenta con Medicaid o Medicare.
- Si está contratado o inscrito en un programa del DSHS para proporcionar servicios que requieran pruebas de laboratorio, sírvase indicar qué programa es. Encontrará las descripciones de los programas en el Manual de servicios de referencia de la Sección de Servicios de Laboratorio en el sitio web http://www.dshs.state.tx.us/lab/.
- Si no existe otro Pagador del paciente y el paciente reúne los criterios de participación del programa , marque el programa del DSHS correspondiente.

HMO/Atención dirigida/aseguradora: ponga en letra de molde el nombre, dirección, ciudad, estado y código postal de la aseguradora a la que se facturará. Si no proporciona todos los datos del seguro en el formulario de la muestra, se facturará al remitente.

Parte responsable: ponga en letra de molde el nombre de la parte responsable, el número de identificación del seguro, el número telefónico de la aseguradora, el nombre del grupo y el número del grupo.

Firma y fecha: haga que la parte responsable firme y feche para autorizar la divulgación de los datos de la misma, si DSHS ha de facturar al seguro o HMO de ésta.

Puede encontrar instrucciones de pruebas e información específica sobre los tipos de probetas de ensayo en el Manual de servicios de referencia de la Sección de Servicios de Laboratorio en nuestro sitio web en http://www.dshs.state.tx.us/lab/.

B.57 Specimen Submission Form G-1C, Maternal Serum Prenatal Triple Screen (Spanish, 2 Pages)

TEXAS Department of State Health Services

Prueba prenatal: (800) 687-4363

G-1C Formulario de remisión de muestras (MZO. 2006) Rev. 2

CLIA núm. 45D0660644

Laboratory Services Section
1100 W. 49th Street, MC-1947
Austin, Texas 78756-3194
(888) 963-7111, ext. 7318, o (512) 458-7318
http://www.dshs.state.tx.us/lab

Coloque la etiqueta de código de barra aquí

Sección 1. DATOS DEL REMITENTE – (REQUERIDO)**

Núm. de remitente y de TPI **
Nombre del remitente **
Núm. de NPI **
Dirección
Ciudad **
Estado **
Código Postal **
Núm. de teléfono **
Contacto
Fax
Código de la clínica

Sección 2. DATOS DEL PACIENTE -- (REQUERIDO)**

NOTA: se **REQUIERE** el **nombre del paciente** en la muestra **y** éste **DEBE** ser el mismo que el nombre del formulario y la tarjeta de Medicare/Medicaid.

Apellido **
Primer nombre **
Inicial del 2.º nombre
Dirección **
Núm. de teléfono
Ciudad **
Estado **
Código Postal **
País de origen

Raza: ☐ Blanca/caucásica ☐ Negra o afroamericana ☐ Amerindia/nativa de Alaska ☐ Asiática ☐ Nativa de Hawai/isleña del Pacífico ☐ Otra

Etnia: ☐ Hispana ☐ No hispana ☐ Semítica ☐ China ☐ Filipina ☐ Coreana ☐ Oriental ☐ Múltiple ☐ No se especifica ☐ Se desconoce

Fecha de nacimiento (mm/dd/aaaa) **
Edad
Sexo
Núm. de Seguro Social **
Si es mujer, ¿está embarazada? ☐ Sí ☐ No ☐ Se desconoce

Núm. de expediente médico
Código diagnóstico de ICD **
Núm. previo de laboratorio de muestras del DSHS

Sección 3. SOLICITUD DE PRUEBA TRIPLE Y DATOS DEL PACIENTE

NOTAS: consulte las instrucciones del formulario para conocer los detalles de cómo rellenarlo. Puede encontrar los detalles de los requisitos de pruebas y muestras en el Manual de servicios de referencia de la Sección de Servicios de Laboratorio. Visite nuestro sitio web en http://www.dshs.state.tx.us/lab/.

(Se requiere toda la información para las pruebas).

Historial de obstetricia G_____ P_____ AB_____

	Sí	No	
¿Fetos múltiples?	☐	☐	Especifique *el número de fetos:* _____
Uso de insulina **previo al** embarazo (IDDM)	☐	☐	
Medicamento materno	☐	☐	Especifique: _____
¿Repetir muestra?	☐	☐	Si "sí", indique la razón: _____

Edad de gestación (elija un método de cálculo).

Sección 4. DATOS DEL MÉDICO -- (REQUERIDO)**

Nombre del médico **
UPIN del médico **
Núm. NPI del médico **

Sección 5. PAGADOR – (REQUERIDO)

Indique si debemos facturar al remitente, a Medicaid, a Medicare, al seguro privado o al programa del DSHS. Si indica Medicaid o Medicare, se requiere el número de Medicaid/Medicare. Si indica seguro privado o programa del DSHS, la siguiente información de facturación requerida se señala con un asterisco (*).
Si no provee la información requerida,
SE FACTURARÁ AL REMITENTE.

☐ Remitente ☐ Seguro privado
☐ Medicaid ☐ Medicare

Núm. de Medicaid/Medicare: _____
(anexe la copia de la tarjeta)

Programas del DSHS:

☐ Título V – Planificación familiar ☐ Otro: _____
☐ Título V – MCH
☐ Título X – Planificación familiar
☐ Título XX – Planificación familiar

Nombre de la HMO/Atención dirigida/aseguradora *
Dirección *
Ciudad *
Estado *
Código Postal *
Núm. tel. de aseguradora *
Núm. de id. de seguro de parte responsable *
Nombre del grupo *
Núm. del grupo *

"Por este conducto autorizo la divulgación de información relativa a los servicios aquí descritos y asimismo asigno toda prestación a la que tenga derecho a la Sección de Servicios de Laboratorio del Departamento Estatal de Servicios de Salud de Texas".
Firma del paciente o la parte responsable.

Firma * Fecha *

FOR DSHS LABORATORY USE ONLY

Specimen received
Specimen condition
Verify specimen
Edit

B

☐ FECHA de LMP _____ (mm/dd/aa) ☐ Datación de ultrasonido _____ semana s _____ días el _____ (mm/dd/aa) ☐ Si es ecografía a 1/10 de semana _____.____ semanas el _____ (mm/dd/aa) ☐ Examen físico _____ semana s _____ días el _____ (mm/dd/aa) ☐ Fecha de parto calculada _____ (mm/dd/aa) por: US_____LMP_____ Examen____	*Completed* *Mailed & faxed*

PESO ACTUAL	FECHA DE OBTENCIÓN	HORA DE OBTENCIÓN	OBTENIDA POR	Fecha y hora de remoción del Congelador antes del envío (REQUERIDO)	
					Revised, mailed & faxed
					Revised, mailed & faxed

B.58 Statement for Initial Wound Therapy System In-Home Use (2 Pages)

Statement for Initial Wound Therapy System In-Home Use (Page 1 of 2)

Patient Name:	Patient Medicaid Number:
Patient Diagnosis:	Date of birth: / /

Home Health Agency Information

Name:	Telephone:
Address:	
TPI:	NPI:
Taxonomy:	Benefit Code:

Indicators for Continuation of Treatment

Must be completed by the physician familiar with the client and prescribing the wound care system. Answer "Yes" or "No" for each question and any answers which apply.

1. Was the initial medical necessity justified by one of the following? **Yes** ☐ **No** ☐

- ☐ Stage III or Stage IV pressure ulcer
- ☐ Pre-operative myocutaneous flap or graft
- ☐ Recent (within 14 days) myocutaneous flap or graft
- ☐ Diabetic ulcer
- ☐ Chronic open wound
- ☐ Venous stasis ulcer

2. The patient's history reflects one or more of the following: **Yes** ☐ **No** ☐

- ☐ Previous failed wound care interventions, how long ago_____, how was it resolved_____
- ☐ Severe coexisting chronic illness
- ☐ Frequent reoccurrence of advanced pressure ulcers related to severely limited mobility
- ☐ Wound care therapy was initiated in the hospital or skilled nursing facility (SNF). If "Yes," provide the following:

Admission date: / /	Admitting diagnosis:	Discharge date: / /

3. The patient uses a pressure-reducing surface: **Yes** ☐ **No** ☐

- ☐ Non-powered mattress overlay
- ☐ Non-powered mattress replacement
- ☐ Powered mattress overlay
- ☐ Powered mattress replacements
- ☐ Powered bed system
- ☐ Air fluidized bed

NOTE: If "No," why not?

4. The patient has an albumin greater than 3 mg/dl. **Yes** ☐ **No** ☐

Date of last albumin (within the past 30 days): / / Result:

NOTE: If the patient has an albumin level less than 3 mg/dl, please list the albumin level and describe the type of nutritional treatment which the patient is receiving:

5. The patient has diabetes mellitus. **Yes** ☐ **No** ☐

Hemoglobin A1c level:	Date Hemoglobin A1c drawn (within the past 30 days): / /

6. The patient's wound is free of necrotic tissue. **Yes** ☐ **No** ☐

NOTE: If the wound has recently been debrided, identify the type and date of debridement:

- ☐ Surgical Date: / / ☐ Physical Date: / /
- ☐ Chemical Date: / / ☐ Autolytic Date: / /

7. The patient's wound is free of infection. **Yes** ☐ **No** ☐

NOTE: If the wound is infected, identify the wound treatment, include dosage, frequency, route and duration of any medications (including, but not limited to, antibiotics):

8. The patient's overall health status will allow wound healing. **Yes** ☐ **No** ☐

NOTE: Describe all medical conditions which might affect wound healing, address incontinence if pertinent, and what is being done to decrease contamination of the wound:

9. Name of family member/friend/caregiver who agrees to be available to assist patient:

Physician Information

Signature:		Date: / /
Name (print):	Telephone:	
License number:	TPI:	NPI:

Effective Date_07302007/Revised Date_06012007

B

Statement for Initial Wound Therapy System In-Home Use (Page 2 of 2)

Patient Name:	Patient Medicaid Number:
Patient Diagnosis:	Date of birth: / /

Contraindicators to Initial Wound Therapy

Must be completed by the physician familiar with the client and subscribing the wound care system or the registered nurse (RN). Check any that apply.

Does the patient have any of the following conditions: **Yes** ☐ **No** ☐

- ☐ Fistulas to the body
- ☐ Wound is ischemic
- ☐ Gangrene
- ☐ Osteomylelitis (unless being treated – describe below)
- ☐ Skin cancer in the margins
- ☐ Presence of necrotic tissue, including bone
- ☐ Less than six months to live

Initial Wound Profile

Must be completed by the physician familiar with the client and subscribing the wound care system or the RN.
NOTE: Use additional paper if more than two wounds are currently being treated.

Wound No. 1

Type of wound:
- ☐ Pressure ulcer
- ☐ Pre-operative myocutaneous flap or graft
- ☐ Recent (within 14 days) myocutaneous flap or graft
- ☐ Diabetic ulcer
- ☐ Chronic open wound
- ☐ Venous stasis ulcer

Location:	Stage:	Age of wound:
Date of surgery (if flap or graft): / /	Type of debridement and date: / /	

Wound color:	L x W x D:	Odor:	Drainage:
Tunneling (depth and position):		Undermining (depth and position):	

List all previous wound interventions: (use additional space if necessary):

Wound No. 2

Type of wound:
- ☐ Pressure ulcer
- ☐ Pre-operative myocutaneous flap or graft
- ☐ Recent (within 14 days) myocutaneous flap or graft
- ☐ Diabetic ulcer
- ☐ Chronic open wound
- ☐ Venous stasis ulcer

Location:	Stage:	Age of wound:
Date of surgery (if flap or graft): / /	Type of debridement and date: / /	

Wound color:	L x W x D:	Odor:	Drainage:
Tunneling (depth and position):		Undermining (depth and position):	

List all previous wound interventions: (use additional space if necessary):

Physician Signature:	Date: / /
REQUIRED RN Signature:	Date: / /
IF APPROPRIATE	

Effective Date_07302007/Revised Date_06012007

B.59 Statement for Recertification of Wound Therapy System In-Home Use

Patient Name:	Patient Medicaid Number:
Patient Diagnosis:	Date of birth: / /

Home Health Agency Information

Name:	Telephone:
Address:	
TPI:	NPI:
Taxonomy:	Benefit Code:

Indicators for Continuation of Treatment

Must be completed by the physician familiar with the client and prescribing the wound care system. Answer "Yes" or "No" for each question and any answers which apply.

1. Was the initial medical necessity justified by one of the following? **Yes** ☐ **No** ☐

- ☐ Stage III or Stage IV pressure ulcer
- ☐ Pre-operative myocutaneous flap or graft
- ☐ Recent (within 14 days) myocutaneous flap or graft
- ☐ Diabetic ulcer
- ☐ Chronic open wound
- ☐ Venous stasis ulcer

2. Is the wound showing progress? **Yes** ☐ **No** ☐

- ☐ 30 days or longer since myocutaneous flap or graft
- ☐ 30 days with no demonstrated improvement
- ☐ wound healed, no depth
- ☐ wound healing with improvement

Location:	Stage:	Age of wound:	
Wound color:	L x W x D:	Odor:	Drainage:
Tunneling (depth and position):		Undermining (depth and position):	

Wound description (i.e. formation of granulation and date and type of debridement done in last 30 days):

NOTE: Include above information for each wound if more than one.

3. The patient continues to use a pressure-reducing surface. **Yes** ☐ **No** ☐

NOTE: If "No," why not?

4. Name of family member/friend/caregiver who continues to agree to assist patient:

Contraindicators to Continuation of Treatment

(Check any that apply)

Does the patient have any of the following conditions? **Yes** ☐ **No** ☐

- ☐ Fistulas to the body
- ☐ Wound is ischemic
- ☐ Gangrene
- ☐ Osteomylelitis (unless being treated – describe below)
- ☐ Skin cancer in the margins
- ☐ No demonstrable improvement in wound over past 30 days
- ☐ Presence of necrotic tissue, including bone
- ☐ Less than six months to live

Physician Information

Signature:		Date: / /
Name (Print):		Telephone:
License number:	TPI:	NPI:

Effective Date_07302007/Revised Date_06102007

B.60 Sterilization Consent Form Instructions (2 Pages)

Per Title 42 *Code of Federal Regulation*s (CFR) 50, Subpart B, all sterilizations require a valid consent form regardless of the funding source. Ensure all required fields are completed for timely processing.

Fax or mail the Sterilization Consent Form five business days before submitting the associated claim(s) to expedite the processing of the Sterilization Consent Form and associated claim(s).

Fax fully completed Sterilization Consent Forms to Texas Medicaid & Healthcare Partnership (TMHP) at 1-512-514-4229. Claims and appeals are not accepted by fax. Only send family planning sterilization correspondence to this fax number.

Note: Hysterectomy Acknowledgment forms are not sterilization consents and should be faxed to 1-512-514-4218.

Clients must be *at least 21 years of age* when the consent form is signed. If the client was not 21 years of age when the consent form was signed, the consent will be denied. Changing signature dates is considered fraudulent and will be reported to the Office of the Inspector General (OIG).

There must be at least 30 days between the date the client signs the consent form and the date of surgery, with the following exceptions:

Exceptions: (1) Premature delivery - There must be at least 30 days between the date of consent and the client's expected date of delivery. (2) Emergency Abdominal Surgery -There must be at least 72 hours between the date of consent and the date of surgery. Operative reports detailing the need for emergency surgery are required.

Listed below are field descriptions for the Sterilization Consent Form. Completion of *all* sections is required to validate the consent form, with only two exceptions:

Exceptions: Race and Ethnicity Designation is requested but not required. The Interpreter's Statement is not required as long as the consent form is written in the client's language, or the person obtaining the consent speaks the client's language. If this section is partially completed, the consent will be denied for incomplete information.

This Sterilization Consent Form may be copied for provider use. Providers are encouraged to frequently recopy the original form to ensure legible copies and to expedite consent validation.

Required Fields

All of the fields must be legible in order for the consent form to be valid. Any illegible field will result in a denial of the submitted consent form. Resubmission of legible information must be indicated on the consent form itself. Resubmission with information indicated on a cover page or letter will not be accepted.

Consent to Sterilization

- Name of Doctor or Clinic
- Name of the Sterilization Operation
- Client's Date of Birth (month, day, year)
- Client's Name (first and last names are required)
- Name of Doctor or Clinic
- Name of the Sterilization Operation
- Client's Signature
- Date of Client Signature - *Client must be at least 21 years of age on this date. This date cannot be altered or added at a later date.*

Effective Date_07302007/Revised Date_06012007

Interpreter's Statement (If applicable)

- Name of Language Used by Interpreter
- Interpreter's Signature
- Date of Interpreter's Signature (month, day, year)

Statement of Person Obtaining Consent

- Client's Name (first and last names are required)
- Name of the Sterilization Operation
- Signature of Person Obtaining Consent -The statement of person obtaining consent must be completed by the person who explains the surgery and its implications and alternate methods of birth control. The signature of person obtaining consent must be completed at the time the consent is obtained. The signature must be an *original signature*, not a rubber stamp.
- Date of the Person Obtaining Consent's Signature (month, day, year) - Must be the same date as the client's signature date.
- Facility Name - Clinic/office where the client received the sterilization information
- Facility Address - Clinic/office where the client received the sterilization information

Physician's Statement

- Client's Name (first and last names are required)
- Date of Sterilization Procedure (month, day, year) - Must be at least 30 days and no more than 180 days from the date of the client's consent except in cases of premature delivery or emergency abdominal surgery.
- Name of the Sterilization Operation
- Expected Date of Delivery (EDD) - Required when there are less than 30 days between the date of the client consent and date of surgery. Client's signature date must be at least 30 days prior to EDD
- Circumstances of Emergency Surgery - Operative report(s) detailing the need for emergency abdominal surgery are required
- Physician's Signature - Stamped or computer-generated signatures are not acceptable
- Date of Physician's Signature (month, day, year) - This date must be *on or after* the date of surgery

Paperwork Reduction Act Statement

This is a required statement and must be included on every Sterilization Consent Form submitted.

Additional Required Fields

- The following provider identification numbers will be required to expedite the processing of the consent form:

  TPI
  NPI
  Taxonomy
  Benefit Code

- Provider/Clinic Phone Number
- Provider/Clinic Fax Number (If available)
- Family Planning Title for Client - Indicate by circling V, X, XIX (Medicaid), or XX

Effective Date_07302007/Revised Date_06012007

B.61 Sterilization Consent Form (English)

Sterilization Consent Form

(Fax Consent Form to 1-512-514-4229)

Client Medicaid or family planning number:	Date Client Signed / / (month/day/year)

Notice: *Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving federal funds.*

Consent to Sterilization

I have asked for and received information about sterilization from _____ (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible. **I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children or father children.** I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on ____ (month), ____(day), ____ (year). I, _____, hereby consent of my own free will to be sterilized by _____(doctor or clinic) by a method called _____.

My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed. I have received a copy of this form.

Client's Signature:	Date of Signature: / / (month/day/year)

Notice: *You are requested to supply the following information, but it is not required.*

Race and Ethnicity Designation

Ethnicity ☐ Not Hispanic or Latino ☐ Hispanic or Latino

Race (mark one or more) ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White

Interpreter's Statement

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice and presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in the _____ language and explained its contents to him/her. To the best of my knowledge and belief, he/she has understood this explanation.

Interpreter Signature:	Date of Signature: / / (month/day/year)

Statement of Person Obtaining Consent

Before _____ (client's full name), signed the consent form, I explained to him/her the nature of the sterilization operation known as a _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

Signature of person obtaining consent:	Date of Signature: / / (month/day/year)
Facility name:	Facility address:

Physician's Statement

Shortly before I performed a sterilization operation upon _____ (name of individual to be sterilized), on_____/_____/_____ at (date of sterilization), I explained to him/her the nature of the sterilization operation _____(specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraphs:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.) (1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed. (2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

Premature delivery - Individual's expected date of delivery:_____/_____ /_____ (month, day, year)

Emergency abdominal surgery (describe circumstances): _____

Physician's Signature:	Date of Signature: / / (month/day/year)

Paperwork Reduction Act Statement

A federal agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays the currently valid OMB control number. Public reporting burden for this collection of information will vary; however, we estimate an average of one hour per response, including for reviewing instructions, gathering and maintaining the necessary data, and disclosing the information. Send any comment regarding the burden estimate or any other aspect of this collection of information to the OS Reports Clearance Officer, ASBTF/Budget Room 503 HHH Building, 200 Independence Avenue, S.W., Washington, D.C. 20201.

Respondents should be informed that the collection of information requested on this form is authorized by 42 CAR part 50, subpart B, relating to the sterilization of persons in federally assisted public health programs. The purpose of requesting this information is to ensure that individuals requesting sterilization receive information regarding the risks, benefits and consequences, and to assure the voluntary and informed consent of all persons undergoing sterilization procedures in federally assisted public health programs. Although not required, respondents are requested to supply information on their race and ethnicity. Failure to provide the other information requested on this consent form, and to sign this consent form, may result in an inability to receive sterilization procedures funded through federally assisted public health programs.

All information as to personal facts and circumstances obtained through this form will be held confidential, and not disclosed without the individual's consent, pursuant to any applicable confidentiality regulations.

All Fields in This Box Required for Processing

TPI:	NPI:	Taxonomy:
Benefit Code:	Provider/clinic telephone:	Provider/Clinic fax number:

Titled Billed (check one): ☐ V ☐ X ☐ XIX ☐ (Medicaid) ☐ XX

Effective Date_01152008/Revised Date_09242007

B.62 Sterilization Consent Form (Spanish)

Sterilization Consent Form (Spanish)

(Fax Consent Form to 1-512-514-4229)

Client Medicaid or family planning number:	Date Client Signed / / (month/day/year)

Nota: *La decisión de no esterilizarse que usted puede tomar en cualquier momento, no causará el retiro o la retención de ningún beneficio que le sea proporcionado por programas o proyectos que reciben fondos federales.*

Consentimiento para Esterilización

Yo he solicitado y he recibido información de _____(médico o clínica) sobre la esterilización. Cuando inicialmente solicité esta información, me dijeron que la decisión de ser esterilizada/o es completamente mía. Me dijeron que yo podía decidir no ser esterilizada/o. Si decido no esterilizarme, mi decisión no afectará mi derecho a recibir tratamiento o cuidados médicos en el futuro. No perderé ninguna asistencia o beneficios de programas patrocinados con fondos federales, tales como A.F. D. C. o Medicaid, que recibo actualmente o para los cuales seré elegible. **Entiendo que la esterilización se considera una operación permanente e irreversible. Yo he decidido que no quiero quedar embarazada, no quiero tener hijos o no quiero procrear hijos.** Me informaron que me pueden proporcionar otros métodos de anticoncepción disponibles que son temporales y que permitirán que pueda tener o procrear hijos en el futuro. He rechazado estas opciones y he decidido ser esterilizada/o. Entiendo que seré esterilizada/o por medio de una operación conocida como _____. Me han explicado las molestias, los riesgos y los beneficios asociados con la operación. Han respondido satisfactoriamente a todas mis preguntas.

Entiendo que la operación no se realizará hasta que hayan pasado 30 días, como mínimo, a partir de la fecha en la que firme esta Forma. Entiendo que puedo cambiar de opinión en cualquier momento y que mi decisión en cualquier momento de no ser esterilizada/o no resultará en la retención de beneficios o servicios médicos proporcionados a través de programas que reciben fondos federales.
Tengo por lo menos 21 años y nací el ____ (mes), ____(día), ____ (año). Yo, _____, por medio de la presente doy mi consentimiento de mi libre voluntad para ser esterilizada/o por _____ (médico o clínica) por el método llamado _____.
Mi consentimiento vence 180 días a partir de la fecha en la que firme este documento.
También doy mi consentimiento para que se presente esta Forma y otros expediente médicos sobre la operación a: Representantes del Departamento de Salud y Servicios Sociales, o Empleados de programas o proyectos financiados por ese Departamento, pero sólo para que puedan determinar si se han cumplido las leyes federales. He recibido una copia de esta Forma.

Firma:	Fecha: / / (mes, día , año)

Nota: *Se ruega proporcione la siguiente información, aunque no es obligatorio hacerlo:*

Definición de Raza y Origen Étnico

Origen étnico	☐ No hispano o latino	***Raza (marque según aplique)***	☐ Natural de Hawaii u otras islas del Pacífico	☐ Negro o afroamericano	
	☐ Hispano o latino		☐ Indígena americano o indígena de Alaska	☐ Blanco	☐ Asiático

Declaración Del Intérprete

Si se han proporcionado los servicios de un intérprete para asistir a la persona que será esterilizada: He traducido la información y los consejos que verbalmente se le han presentado a la persona que será esterilizada/o por el individuo que ha obtenido este consentimiento. También le he leído a él/ella la Forma de Consentimiento en idioma _____ y le he explicado el contenido de esta forma. A mi mejor saber y entender, ella/él ha entendido esta explicación.

Firma:	Fecha: / / (mes, día , año)

Declaración De La Persona Que Obtiene Consentimiento

Antes de que _____(nombre de persona) firmara la Forma de Consentimiento para la Esterilización, le he explicado a ella/él los detalles de la operación _____, para la esterilización, el hecho de que el resultado de este procedimiento es final e irreversible, y las molestias, los riesgos y los beneficios asociados con este procedimiento. He aconsejado a la persona que será esterilizada que hay disponibles otros métodos de anticoncepción que son temporales. Le he explicado que la esterilización es diferente porque es permanente. Le he explicado a la persona que será esterilizada que puede retirar su consentimiento en cualquier momento y que ella/él no perderá ningún servicio de salud o beneficio proporcionado con el patrocinio de fondos federales. A mi mejor saber y entender, la persona que será esterilizada tiene por lo menos 21 años de edad y parece ser mentalmente competente. Ella/él ha solicitado con conocimiento de causa y por libre voluntad ser esterilizada/o y parece entender la naturaleza del procedimiento y sus consecuencias..

Firma de la persona que obtiene el consentimiento:	Fecha: /: /: (mes, día , año)
Lugar:	Dirección:

Declaración Del Médico

Previamente a realizar la operación para la esterilización a _____ (nombre de persona esterilizada/o), en _____/_____/_____ (fecha de esterilización: día, mes, año), le expliqué a él/ella los detalles de esta operación para la esterilización _____(especifique tipo de operación), del hecho de que es un procedimiento con un resultado final e irreversible, y las molestias, los riesgos y los beneficios asociados con esta operación. Le aconsejé a la persona que sería esterilizada que hay disponibles otros métodos de anticoncepción que son temporales. Le expliqué que la esterilización es diferente porque es permanente. Le informé a la persona que sería esterilizada que podía retirar su consentimiento en cualquier momento y que ella/él no perdería ningún servicio de salud o ningún beneficio proporcionado con el patrocinio de fondos federales. A mi mejor saber y entender, la persona que será esterilizada tiene a lo menos 21 años de edad y parece ser mentalmente competente. Ella/él ha solicitado con conocimiento de causa y libre voluntad ser esterilizada/o y parece entender el procedimiento y las consecuencias de este procedimiento. (Instrucciones para uso alternativo de párrafos finales: Utilice el párrafo 1 que se presenta a continuación, excepto para casos de parto prematuro y cirugía abdominal de emergencia cuando se ha realizado la esterilización a menos de 30 días después de la fecha en la que la persona firmó la Forma de Consentimiento para la Esterilización. Para esos casos, utilice el párrafo 2 que se presenta más adelante. Tache con una X el párrafo que no se aplique). (1) Han transcurrido por lo menos 30 días entre la fecha en la que la persona firmó esta Forma de Consentimiento y la fecha en la que se realizó la esterilización. (2) La operación para la esterilización se realizó a menos de 30 días, pero a más de 72 horas, después de la fecha en la que la persona firmó la Forma de Consentimiento debido a las siguientes circunstancias (marque la casilla apropiada y escriba la información requerida):
Parto prematuro - Fecha prevista de parto _____/_____ /_____(mes, día , año)
Cirugía abdominal de urgencia (Describa las circunstancias): _____

Firma del médico:	Fecha: / / (mes, día , año)

Declaración Sobre Ley De Reducción De Trámites

Una agencia federal no debe llevar a cabo o patrocinar la recolección de información, y el público no está obligado a responder a la misma o a facilitar la información, a no ser que dicha solicitud de información presente un número de control válido de la OMB. La carga horaria para el público que completa esta forma variará; sin embargo, se ha estimado un promedio de una hora por cada respuesta, cálculo que incluye el tiempo para revisar las instrucciones, buscar y presentar los datos exigidos y completar la forma. Para enviar sus comentarios sobre la carga horaria estimada o cualquier otro aspecto de la información requerida, escriba a OS Reports Clearance Officer, ASBTF/Budget Room 503 HHH Building, 200 Independence Avenue, S.W., Washington, D.C. 20201.Se debe informar al público que responde a esta forma que la recolección de información solicitada en la misma se autoriza en virtud de 42 CAR parte 50, subparte B, que tiene que ver con la esterilización de personas en programas de salud pública que son financiados por el gobierno federal. El propósito de la recolección de esta información es asegurar que las personas que solicitan la esterilización sean informadas sobre los riesgos, los beneficios y las consecuencias de esta operación, y para asegurar el consentimiento voluntario e informado de todas las personas que se someten al procedimiento de esterilización en programas de salud pública que reciben asistencia federal. Se pide a las personas que llenan la forma que incluyan datos sobre su raza y grupo étnico, aunque esta información no es requerida. Toda la demás información solicitada en esta forma de consentimiento es requerida. Si la persona que llena la forma no proporciona la información requerida o si no firma esta forma de consentimiento, podría resultar en que no recibiera el procedimiento de esterilización financiado por un programa de salud pública patrocinado con fondos federales.Toda la información de datos y circunstancias personales obtenidas por medio de esta Forma son confidenciales y no se divulgarán sin el consentimiento de la persona, en conformidad con todos los reglamentos aplicables de confidencialidad.

All Fields in This Box Required for Processing

TPI:	NPI:	Taxonomy:
Benefit Code:	Provider/clinic telephone:	Provider/Clinic fax number:
Titled Billed (check one): ☐ V ☐ X ☐ XIX ☐ (Medicaid) ☐ XX		

Effective Date_01152008/Revised Date_09242007

B

B.63 Texas Medicaid Palivizumab (Synagis) Prior Authorization Request Form

Patient's Name:			Client ID:
Date of birth: / /	Gender: ☐ M	☐ F	Telephone Number:
Address:		City:	State: Zip:
Parent/Legal Guardian (if applicable):			
Age in months at start of RSV season (as of October 1):			Estimated gestational age at birth: completed weeks
Requested dates of service—From:	To:		Quantity Requested:

☐ Clients less than 24 months chronological age at the start of the RSV season can qualify based on criteria to the right. Diagnoses and conditions must be clearly documented in the client's medical record. Date of birth on or after 09/30/2005. (See Medicaid Bulletin NO. 199 November/December 2006 for details related to congenital heart and chronic lung disease diagnoses.)	☐ Hemodynamically significant heart disease: (specify ICD-9-CM code): **Or** ☐ Chronic lung disease (CLD)*: (specify ICD-9-CM code): **And** Required any of the following therapies within the past 6 months: ☐ Supplemental oxygen ☐ Digitalis ☐ Steroids (systemic or inhaled) ☐ Diuretics ☐ Mechanical ventilation *CLD was formerly called bronchopulmonary dysplasia. It can develop in pre-term neonates who are treated with oxygen and positive pressure ventilation. Many cases are seen in infants who previously had respiratory distress syndrome (RSD). CLD is characterized by disordered lung growth and a reduction in the number of structures available for gas exchange. CLD is not asthma, croup, recurrent upper respiratory infections, chronic bronchitis, chronic bronchiolitis, or a history of a previous RSV infection.
☐ Clients less than 12 months chronological age at the start of the RSV season can qualify based on criteria to the right. Date of birth on or after 09/30/06.	☐ ≤ 28 completed weeks gestational age at birth (specify ICD-9-CM code):
☐ Clients less than 6 months of age at the start of RSV season can qualify based on criteria to the right. Diagnoses, conditions, and risk factors must be clearly documented in client's medical record. Date of birth on or after 03/31/2007.	☐ 29 to 32 completed weeks gestational age at birth (specify ICD-9-CM code): **Or** ☐ 32 to 35 completed weeks gestational age (specify ICD-9 code): **With** the following documented in the patient's medical record**:** ☐ Severe neuromuscular disease (including chronic respiratory failure, 51883) **Or** ☐ Significant congenital anomalies of the airway expected to compromise respiratory reserve **And** *two* of the following: Required any of the following therapies within the past 6 months: ☐ Direct exposure to tobacco smoke or other air pollution ☐ Attends child care ☐ Direct contact with siblings who attend school or child care

☐ Stem cell transplant (specify ICD-9CM Code):	☐ Solid organ transplant (specify ICD-9CM Code):

Additional clinical information about medical necessity that is not provided above:

Physician Name (printed):			Date: / /
Address:	City:	State:	Zip:
Telephone Number:	Fax Number:		
Physician Signature:		License number:	
TPI:	NPI:	Taxonomy:	Benefit Code:

Effective Date_07302007/Revised Date_09172007

B.64 Texas Medicaid Vendor Drug Program Palivizumab (Synagis) Prescription Form

Patient's Name _____ Texas Medicaid Recipient Number _ _ _ _ _ _ _ _ _ _

Date of Birth _____ Gender: ☐ Male ☐ Female

Address (Street) _____

City _____ State _____ ZIP _____ Phone _____ Phone _____

Parent/Legal Guardian Name **(if applicable)** _____

AGE IN MONTHS AT START OF RSV SEASON (AS OF NOVEMBER 1ST) _____	ESTIMATED GESTATIONAL AGE AT BIRTH: _____COMPLETED WEEKS
CHRONOLOGICAL AGE AT START OF RSV SEASON	**GESTATIONAL AGE AT BIRTH OR DISEASE STATE**
☐ IF < 24 MONTHS CHRONOLOGICAL AGE, CAN QUALIFY BASED ON CRITERIA TO THE RIGHT. DATE OF BIRTH ON OR AFTER 11/02/2003 (SEE MEDICAID BULLETIN #190 FOR DETAILS RELATED TO CONGENITAL HEART DISEASE DIAGNOSES.)	☐ HEMODYNAMICALLY SIGNIFICANT HEART DISEASE: (SPECIFY ICD-9 CODE(S)) _____ **OR** ☐ CHRONIC LUNG DISEASE: (SPECIFY ICD-9 CODE(S) _____ **AND** AT LEAST ONE OF THE FOLLOWING: ☐ REQUIRED ROUTINE SUPPLEMENTAL OXYGEN WITHIN PAST 6 MONTHS: ☐ REQUIRED ANY OF THE FOLLOWING THERAPIES WITHIN THE PAST 6 MONTHS: ☐ IPRATROPIUM ☐ INHALED BETA 2 AGONIST ☐ METHYLXANTHINES ☐ STEROIDS (systemic or inhaled) ☐ SYMPATHOMIMETICS (e.g., epinephrine, isoproterenol)
☐ IF ≤ 12 MONTHS CHRONOLOGICAL AGE, CAN QUALIFY BASED ON CRITERIA TO THE RIGHT DATE OF BIRTH ON OR AFTER 10/02/2004	☐ ≤ 28 COMPLETED WEEKS GESTATIONAL AGE AT BIRTH: (SPECIFY ICD-9 CODE): _____
☐ IF ≤ 6 MONTHS CHRONOLOGICAL AGE, CAN QUALIFY BASED ON CRITERIA TO THE RIGHT DATE OF BIRTH ON OR AFTER 04/02/2005	☐ BETWEEN 28 & 31 COMPLETED WEEKS GESTATIONAL AGE: (SPECIFY iCD-9 CODE): _____ ☐ BETWEEN 32 & 35 COMPLETED WEEKS GESTATIONAL AGE (SPECIFY ICD-9 CODE): _____ AND ONE OF THE FOLLOWING: ☐ SEVERE NEUROMUSCULAR DISEASE: (SPECIFY): _____ ☐ CONGENITAL AIRWAY ANOMALY: (SPECIFY) : _____ ☐ BETWEEN 32 & 35 COMPLETED WEEKS GESTATIONAL AGE (SPECIFY ICD-9 CODE): _____ AND TWO OF THE FOLLOWING: ☐ DIRECT EXPOSURE TO TOBACCO SMOKE OR OTHER AIR POLLUTION ☐ ATTENDS CHILD CARE ☐ DIRECT CONTACT WITH SIBLINGS WHO ATTEND SCHOOL OR CHILD CARE
ADDITIONAL CLINICAL INFORMATION PERTAINING TO MEDICAL NECESSITY NOT OTHERWISE PROVIDED ABOVE:	

Rx: ☐ **Synagis ® (palivizumab) 50mg and/or 100mg vials and Sterile Water for injection 10ml**
Sig: Reconstitute as directed and inject 15mg/kg one time per month. **Quantity:** QS for weight based dosing

☐ Syringes 1ml 25G 5/8" ☐ Syringes 3ml 20G 1"

☐ Epinephrine 1:1000 amp. Sig: Inject 0.01mg/kg as directed ☐ Known Allergies: _____

☐ Other: _____

Sig: _____ **Refills:** _____

Physician Name (printed) _____ Date _____

Address _____

City _____ State _____ ZIP _____ Phone_____

Physician Signature _____ Texas License No. _____

Effective Date_09172007/Revised Date_09172007

B.65 Electronic Remittance and Status (ER&S) Agreement (2 Pages)

Before your ER&S Agreement* can be processed, you MUST choose ONE of the following:

* *These changes affect ONLY the ELECTRONIC version of the Remittance & Status Report. To make changes to the PAPER version of the R&S report, contact TMHP Provider Enrollment.*

☐ **Set up INITIALLY** (first time). Use Production User ID*: _____ (9 digits)

☐ **CHANGE** Production User ID FROM: _____ (9 digits)

TO: _____ (9 digits)

☐ **REMOVE** Production ID Remove: _____ (9 digits)

** *The TMHP **Production User ID** (Submitter ID) is the electronic mailbox ID used for downloading your Electronic Remittance & Status (ER&S) reports. For assistance with identifying and using your Production User ID and password, contact your software vendor or clearinghouse.*

This information MUST be completed before your request can be processed.

Provider Name *(must match TPI/NPI number)*	Billing TPI Number	Provider Tax ID Number
Provider's Physical Address	Billing NPI Number	Provider Phone Number
Provider Contact Name *(if other than provider)*	Provider Contact Title	Contact Phone Number

Do not complete this block UNLESS the ER&S will be downloaded by anyone OTHER than the provider.

Name of Business Organization to Receive ER&S	Business Organization Phone Number
Business Organization Contact Name	Business Organization Contact Phone No.
Business Organization Address	Business Organization Tax ID

Check each box after reading and understanding the following statements.

If you are unsure about anything that is stated below, contact the TMHP EDI Help Desk at (888) 863-3638.
All three statements must be checked before we can process your Electronic Remittance & Status Agreement.

☐ I (we) request to receive Electronic Remittance and Status information and authorize the information to be deposited in the electronic mailbox as indicated above. I (we) accept financial responsibility for costs associated with receipt of Electronic R&S information.

☐ I (we) understand that paper formatted R&S information will continue to be sent to my (our) accounting address as maintained at TMHP until I (we) submit an Electronic R&S Certification Request form.

☐ I (we) will continue to maintain the confidentiality of records and other information relating to recipients in accordance with applicable state and federal laws, rules, and regulations.

Provider Signature	**Date**
Title	**Fax Number**

DO NOT WRITE IN THIS AREA — For Office Use

Input By: _____ Input Date: _____ Mailbox ID: _____

Effective Date_07302007/Revised Date_06012007

Before faxing or mailing this agreement, ensure that all required information is completely filled out, and that the agreement is signed.

Incomplete agreements cannot be processed.

Mail to:

Texas Medicaid & Healthcare Partnership
Attention: EDI Help Desk MC–B14
PO Box 204270
Austin, TX 78720-4270

Fax to:

(512) 514-4228
OR
(512) 514-4230

B

Effective Date_07302007/Revised Date_06012007

B.66 Texas Medicaid Prior Authorization Request Form: Intrathecal Baclofen or Morphine Pump Sections I and II (2 Pages)

Note: *Please complete all information in the manner requested to ensure timely processing.* ********Otherwise additional information will be requested. This form is to be used for request of* either *Intrathecal Baclofen or Morphine pump.*

Section I: The following items must be filled out by the treating physician.		
Client name (last, first, M.I.):		
Medicaid number:	Date of birth: / /	
CPT code(s) with description of procedure(s) requested:		
Dates of service being requested:	From: / /	To: / /
Diagnosis or ICD-9 code(s) as related to the prescription:		
Performing Provider Information		
Name:	Telephone (include area code)	
Address:		
Specialty (e.g., pediatric neurosurgeon):		
TPI:	NPI:	
Taxonomy:	Benefit Code:	
Facility Information		
Note*: Provide the facility information below only if it is different from the performing provider's information.*		
Name:	Telephone:	
Address:		
TPI:	NPI:	
Taxonomy:	Benefit Code:	
		/ /
Original Physician's Signature (Stamped signatures not accepted)	Printed name of physician	Date signed
** The completion of this form does not guarantee prior authorization. Once this information is reviewed and a determination has been made, you will receive a written response to the prior authorization request. If a prior authorization number is issued, it will be included in the response.		

Effective Date_07302007/Revised Date_06012007

Note: *Please complete all information in the manner requested to ensure timely processing.* ********Otherwise additional information will be requested. This form is to be used for request of* either *Intrathecal Baclofen or Morphine pump.*

Client name (last, first, M.I.):	
Medicaid number:	Date of birth: / /

Section II: Please attach the following information as it applies to this request. This information must be signed and dated by the physician (stamped signatures will not be accepted).

1. History and Physical—include the following information:

A. Age of onset of signs/symptoms, which are directly related to this request (if requesting baclofen, specify muscle groups affected, degree of spasticity, paralysis, etc.)

B. Prior hospitalizations/treatments for these symptoms or diagnoses

C. Other Diagnoses

D. Current level of functioning in activities of daily living (ADL)

E. Pertinent lab/X-Ray results

F. Client's weight (in kilograms)

G. Family and/or client's role, participation, and compliance with client's care

H. Medications (name, dosage, route, and frequency)

I. Response of client to prior treatments (medications)/surgery/ baclofen/morphine pump

2. Plan of Care

Include information pertinent to the treatment plan. You do not need to duplicate information already contained in the "history and physical" section. You may attach your medical chart "plan of care" for this section if it is succinct, complete, and responds to all of these questions.

A. Medical/surgical management of client (current treatment plan)

1. Medical plan of care (medications, therapy, consultations)

2. Surgical plan of care (e.g., consultations, scheduled surgeries)

3. Recommendation and plan of care with a baclofen/morphine pump (including expected schedule of treatment, anticipated drug dosage, and volume and response evaluation, and, if requesting baclofen, the muscle groups to be treated)

4. Follow-up plan and any long-term alternatives

B. Are there any other treatments, which you expect to be tried, if the baclofen/morphine is ineffective?

C. List the names, specialties, and telephone numbers of other physicians involved in the multidisciplinary care of this client

******The completion of this form does not guarantee prior authorization. Once this information is reviewed and a determination has been made, you will receive a written response to the prior authorization request. If a prior authorization number is issued, it will be included in the response.

Effective Date_07302007/Revised Date_06012007

B.67 Texas Medicaid Refund Information Form

Please attach this completed form to your refund check made payable to TMHP, include a copy of the Medicaid Remittance and Status (R&S) report, and mail to the following address:

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

Date: _____ Refunding provider's name: _____
Provider's TPI: _____ Provider contact name: _____
Provider's telephone number with extension: _____
Provider's e-mail address: _____
Provider's NPI: _____ Taxonomy: _____

Claim Information:

Medicaid claim number (from *R&S*) refund should be applied to: _____
Patient's name: _____
Patient's Medicaid number: _____
Date(s) of service: _____

Reason for the Refund:

_____ Other insurance paid $_____ on this claim. **Attach EOB.** If no EOB available, complete the following:

Insurance company name: _____

Address: _____

Telephone number: _____ Policy number: _____

_____ TMHP audit identified overpayment
_____ Duplicate Medicaid payment
_____ Claim paid on the wrong patient's Medicaid ID number
_____ Claim paid on the wrong provider's Medicaid TPI/NPI/API
_____ Above-named person is not our patient
_____ Billing error
_____ Service was not rendered as billed
_____ Late credit for blood or pharmacy
_____ Medicare adjusted payment
_____ Patient's Medicare eligibility
_____ Other (describe in detail): _____
_____

Effective_Date_07302007/Revised_Date_06012007

B.68 THSteps-CCP Prior Authorization Request Form

If any portion of this form is incomplete, it will be returned.

Request for:	☐ **DME**	☐ **Supplies**	☐ **Private Duty Nursing**	☐ **Inpatient Rehabilitation**	☐ **Other**

Client Information

Client Name (Last, First, MI):	
Medicaid Number (PCN):	Date of Birth: / /

Supplier/Vendor Information

Supplier Name:	Telephone:	Fax Number:
Supplier Address:		

TPI:	NPI:	Taxonomy:	Benefit Code:

Diagnosis and Medical Necessity of Requested Services

Dates of Service	From: / /	To: / /

HCPCS Code	Brief Description of requested Services	Retail Price

Note: *HCPCS codes and descriptions must be provided.*

Primary Practitioner's Certifications—To be completed by the primary practitioner

By prescribing the identified DME and/or medical supplies, I certify to the following:

☐ The client is under 21 years of age AND

☐ The prescribed items are appropriate and can safely be used by the client when used as prescribed

For Private Duty Nursing, I certify:

☐ The client's medical condition is sufficiently stable to permit safe delivery of private duty nursing as described in the plan of care.

Signature of prescribing physician:	Date:
Printed or typed name of physician:	

TPI:	NPI:	License Number:

Contact Information for Completed Forms		**For TMHP Use Only**
Fax Number:	**1-512-514-4212**	
Mailing Address:	**CCP** **PO Box 200735** **Austin, TX 78720-0735**	

Effective Date_07302007/Revised Date_06292007

B.69 THSteps-CCP Prior Authorization Private Duty Nursing 4 or 6 Month Authorization

Client name:	Client Medicaid number:	Date: / /

The following criteria must be met before seeking a 4- or 6-month authorization of private duty nursing (PDN) services. Remember that authorization is a condition for reimbursement; it is not a guarantee. Each nurse provider should verify the continued Medicaid coverage for each client for each month of service.

☐	Client has received PDN services for at least one year.
☐	Client has had no new significant diagnosis, treatment, illness/injury or hospitalization in at least 6 months that would be expected to affect the need for PDN services.
☐	There has been no change in the PDN requests in the previous 6 months.
☐	Client's physician and client/parent/guardian do not anticipate any significant changes in the client's condition for the requested authorization period.
☐	The nurse provider will ensure that a new physician plan of care is obtained every 60 days and will be maintained with the client's record.
☐	The nurse provider will advise TMHP-CCP of any significant changes in the client's condition, treatments or physician orders which occur during the authorization period if the number of PDN hours needs to change.
☐	The client's physician, client/parent/guardian, and nurse provider understand that the authorization may be changed during the authorization period if the client's condition or skilled needs change significantly.

All required acknowledgments must be signed and dated

I have read and understand the above information.

/ /

Signature of the client/parent/guardian	Date

Brief statement of why a 4- or 6-month extension is appropriate for this client:

I have discussed the above information with the client/parent/guardian.

/ /

Signature of nurse provider	Date

To be completed by the client's physician

The above services are medically necessary, the client's condition is stable and this request supports the client's health and safety needs.

/ /

Signature of the client's physician	Date

Printed name:

Telephone:	Fax number:

Mailing address	City, State, and ZIP code

Fax completed request to TMHP-CCP at 1-512-514-4212

Effective Date_09012007/Revised Date_08142007

B.70 THSteps-CCP ECI Request for Initial/Renewal Outpatient Therapy

Child's Name:		Medicaid number:	
Has the child received therapy in the last year from the public school system? ☐ Yes ☐ No			Date of birth: / /
Date of Initial Evaluation	PT: / /	OT: / /	SLP: / /
Diagnoses:			

Requested Treatment Plan: Indicate the date(s) of service and frequency per week or month:

Service Type	Service Date(s)		Frequency per week	Frequency per month
	From:	To:		
☐ **PT**	/ /	/ /		
☐ **OT**	/ /	/ /		
☐ **SLP**	/ /	/ /		

New Application: Have treatment goals been developed? ☐ Yes ☐ No

Is the child capable of making measurable progress? ☐ Yes ☐ No

Renewal Application: Has the child made measurable progress during this period? ☐ Yes ☐ No

Is the child capable of making continued measurable progress during this period? ☐ Yes ☐ No

Provider Information		
Name:		
Billing address:		
Physician Information		
Signature:		Date: / /
Name (printed):	TPI No.:	NPI No.:
PT Therapist Information		
Signature:		Date: / /
Name (printed):		Telephone:
Address:		
TPI:	NPI:	
Taxonomy:	Benefit Code:	
OT Therapist Information		
Signature:		Date: / /
Name (printed):		Telephone:
Address:		
TPI:	NPI:	
Taxonomy:	Benefit Code:	
SLP Therapist Information		
Signature:		Date: / /
Name (printed):		Telephone:
Address:		
TPI:	NPI:	
Taxonomy:	Benefit Code:	

Effective Date_07302007/Revised Date_06012007

B.71 THSteps Dental Mandatory Prior Authorization Request Form

Submit to:
THSteps Dental
Prior Authorization Unit
PO Box 202917
Austin, TX 78720-2917

Note: All information is required—print clearly or type				
Patient Information				
Name:			Date of Birth: / /	
Address:				
Medicaid Number:			Gender: ☐ **M** ☐ **F**	
Check the following diagnostic tools submitted for review with the authorization request:				
For restorative and intermediate care facility for the mentally retarded (ICF-MR):				
Panorex ☐	FM X-ray ☐	Periapicals ☐	Documentation ☐	
For orthodontic case, diagnostic tools mailed:				
Models ☐	HLD ☐	Panorex ☐	Documentation ☐	Cephlometric X-ray ☐
FM X-ray ☐	Photos ☐	Other ☐		

Date of service diagnostic tools were produced:			
Procedure Code	Tooth Number or Letter	Surface	Charge
			Total

Note: All information is required—print clearly or type	
Signature of dentist:	Date: / /
Printed or typed name of dentist:	Dentist telephone:
Dentist address:	
Dentist Identifying Numbers	
TPI:	NPI:
Taxonomy:	Benefit Code:

Effective Date_07302007/Revised Date_06012007

B.72 THSteps Dental Criteria for Dental Therapy Under General Anesthesia (2 Pages)

Total points needed to justify treatment under general anesthesia = 22.

Age of client at time of examination	Points
Less than four years of age	8
Four and five years of age	6
Six and seven years of age	4
Eight years of age and older	2

Treatment Requirements (Carious and/or Abscessed Teeth)	Points
1-2 teeth or one sextant	3
3-4 teeth or 2-3 sextants	6
5-8 teeth or 4 sextants	9
9 or more teeth or 5-6 sextants	12

Behavior of Client**	Points
Definitely negative–unable to complete exam, client unable to cooperate due to lack of physical or emotional maturity, and/or disability	10
Somewhat negative–defiant; reluctant to accept treatment; disobeys instruction; reaches to grab or deflect operator's hand, refusal to take radiographs	4
Other behaviors such as moderate levels of fear, nervousness, and cautious acceptance of treatment should be considered as normal reponses and are not indications for treatment under general anesthesia	0
** Requires that narrative fully describing circumstances be present in the client's chart	

Additional Factors**	Points
Presence of oral/perioral pathology (other than caries), anomaly, or trauma requiring surgical intervention**	15
Failed conscious sedation**	15
Medically compromising of handicapping condition**	15
** Requires that narrative fully describing circumstances be present in the client's chart	

I understand and agree with the dentist's assessment of my child's behavior.

PARENT/GUARDIAN SIGNATURE: _____DATE: _____

Clients in need of general anesthesia who do not meet the 22-point threshold, by report, will require prior authorization.

To proceed with the dental care and general anesthesia, this form, the appropriate narrative, and all supporting documentation, as detailed in Attachment 1, must be included in the client's chart. The client's chart must be available for review by representatives of TMHP and/or HHSC.

PERFORMING DENTIST'S SIGNATURE: _____

DATE: _____License No. _____

Effective Date_01152008/Revised Date_12032007

Medicaid Dental Policy Regarding Criteria for Dental Therapy Under General Anesthesia–Attachment 1

Purpose: To justify I.V. Sedation or General Anesthesia for Dental Therapy, the following documentation is required in the Child's Dental Record.

Elements: Note those required* and those as appropriate**:

1) * Client's Demographics including Date of Birth
2) * Relevant Dental and Medical Health History
   ** including Medical Evaluation Justifying Relevant Medical Condition(s)
3) * Dental Radiographs, Intraoral/Perioral Photography, and/or Diagram of Dental Pathology
4) * Proposed Dental Plan of Care
5) * Signed Consent by Parent/Guardian giving permission for the proposed dental treatment and acknowledging that the reason for the use of general anesthesia for dental care has been explained.
6) *The parent/guardian dated signature on the Criteria for Dental Therapy Under General Anesthesia form attesting that they understand and agree with the dentist's assessment of their child's behavior
7) ** Other Relevant Narrative Justifying Need for General Anesthesia
8) * Completed Criteria for Dental Therapy Under General Anesthesia form
9) * The dentist's attestation statement and signature may be put on the bottom of the Criteria for Dental Therapy Under General Anesthesia form or included in the chart as a stand-alone form:

"I attest that the client's condition and the proposed treatment plan warrant the use of general anesthesia. Appropriate documentation of medical necessity is contained in the client's record and is available in my office."

REQUESTING DENTIST'S SIGNATURE: _____DATE: _____

Effective Date_01152008/Revised Date_12032007

B.73 THSteps Referral Form Instructions

The referral form assists in relaying correct and pertinent information to the person or agency receiving the referral. It may be mailed or hand-carried by the client. When the form is returned, it should be placed in the client's record.

Receiving/Referring Agencies
The name and address of both agencies should be completed to allow communication if additional information is necessary and to return a completed referral. If the referral is to a physician and the client is not able to name the physician who will be seen, this space may be completed MD/DO.

Identifying Information
This section concerning patient information should be as complete as possible. This section will assist the receiving agency to locate the client.

Reason for Referral
This section should contain information which is relevant to the referral. It may contain an assessment with request for further evaluation, or a request for intervention by a physician, hospital, or other agency involved with the client. Other information pertinent to the referral, such as family history or involvement with other agencies, may also be included.

Release of Information
This section must be signed.

Findings/Services Rendered
This final section provided the receiving agency the vehicle with which to transmit information back to originator of referral. Form may be mailed or carried by the client.

B.74 THSteps Referral Form

Referral date:_____

TO: Name and address of receiving agency or person

FROM: Name and address of person or referring agency

Client's name:_____

Address:_____

Telephone:_____

Name of spouse/parent/guardian

_____

Social Security number:_____

Birth date: _____Sex: (M)____(F)____

DIRECTIONS TO HOME:_____

_____

Marital status: S M W D Sep. Unk.

REASON FOR REFERRAL:

_____

RETURN RESPONSE REQUESTED

Signature/Title

Signature signifies receipt/knowledge of this referral and authorizes the referring agency to release information necessary for its completion, and the referring agency is released from all legal responsibility that may arise from this act.

_____

Signature of Client/Parent/Guardian

FINDINGS AND SERVICES RENDERED:

_____

1) White - Receiving Agency

Signature/Title

2) Yellow - Receiving Agency Response

_____

3) Pink - Client Record

Date

Note: Instructions (L-29a) for use of Referral Form should accompany the document. (HHSC) L-29 Rev. (6/91)

B.75 Tort Response Form

Client Information					
Today's date: / /			Medicaid number:		
Date of birth: / /			Social Security Number:		
Last name:			First name:		
Information Provided By:					
Attorney ☐	Insurance ☐	Provider ☐	Recipient ☐	HHSC ☐	Other ☐
Name:			Telephone:		
Accident Information					
Date of loss: / /	Type of accident:				
Case comments:					
Attorney Information					
Name:			Contact name:		
Street Address:					
City:			State:		Zip Code:
Telephone:			Fax number:		
Insurance Information					
Company name:			Contact name:		
Street Address:					
City:			State:		Zip Code:
Adjuster's name:			Claim number:		
Policyholder:			Policy number:		
Telephone:			Fax number:		

Fax or Mail completed copy to:
Texas Medicaid & Healthcare Partnership
Tort Department
PO Box 202948
Austin, TX 78720-9981
Fax: 1-512-514-4225

Effective Date_01152008/Revised Date_06292007

B.76 Ventilator Service Agreement

Client Information		
Name:	Medicaid number:	
Provider Information		
Name:		
NPI:	TPI:	
Ventilator Information		
Date of Purchase: / /	Date of Request: / /	Serial number:
Manufacturer:	Model number:	

Service Agreement

The Manufacturer's recommended preventive maintenance schedule for the ventilator make and model must be submitted with the Ventilator Service Agreement request.

If this is a renewal Ventilator Service Agreement, in addition to the above, the following documentation must also be submitted:

1. Documentation of the monthly ventilator service procedures performed by a respiratory therapist and client assessments by a respiratory therapist.
2. Description of ventilator preventive maintenance performed during the last ventilator service agreement period:

Provider Responsibilities

Provider responsibilities for maintaining the ventilator service agreement Include:

1. Ensure routine service procedures outlined by the ventilator manufacturer are followed.
2. Provide all internal filters, all external filters and all ventilator circuits, (with the exhalation valve), as part of the ventilator service agreement payment.
3. Provide a respiratory therapist and a back-up ventilator on a 24-hour on call basis.
4. Provide monthly visits to the client's home by a respiratory therapist to perform routine service procedures, monitor functioning of the ventilator system and assess client's status. The provider must maintain documentation of monthly visits in accordance with Medicaid Records Retention Policy.
5. Provide a substitute ventilator while the manufacturers recommended preventative maintenance is being performed on the client owned ventilator.

The ventilator service agreement must be prior authorized every six (6) months.

Provider Representative Signature:	Date / /

Submit with completed Title XIX Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form

Effective Date_01152008/Revised Date_08072007

B.77 Vision Care Eyeglass Patient (Medicaid Client) Certification Form

I, _____ , certify that:

Printed name of Medicaid client

(Check all that apply:)

☐ I was offered a selection of serviceable glasses at no cost to me, but I desired a type or style of eyewear beyond Medicaid program benefits. *I will be responsible for any balance for eyewear beyond Medicaid program benefits.*

My selection(s) beyond Medicaid benefits were:

1. _____
2. _____
3. _____
4. _____

☐ The glasses that are being replaced were unintentionally lost or destroyed.

☐ I picked up/received the eyewear.

_____ _____

Medicaid client signature | Witness signature

_____ _____

Date | Date

_____

Client Medicaid number

_____

Provider TPI

_____

Provider NPI

Effective Date_01152008/Revised Date_08072007

B.78 Vision Care Eyeglass Patient (Medicaid Client) Certification Form (Spanish)

Yo, _____ , declaro que:
Nombre del cliente de Medicaid

(Marque todos los que apliquen)

☐ Yo necesito reemplazar los lentes que tengo. Me ofrecieron una selección de lentes gratis, pero deseo otro tipo que no está incluido en el programa de Medicaid. *Yo entiendo que tendré que pagar por la diferencia.*

La selección(es) de lentes que escogí fue:

1. _____
2. _____
3. _____
4. _____

☐ Los lentes que van a ser reemplazados no fueron perdidos o destruidos intencionadamente.

☐ Yo recibí los lentes.

_____ _____
Firma del Cliente Firma de Testigos

_____ _____
Fecha Fecha

_____
Número de identificación de Medicaid del Cliente

_____
Número de identificación del proveedor (TPI)

_____
Número de identificación del proveedor (NPI)

Effective Date_01152008/Revised Date_08082007

B.79 Wheelchair/Scooter/Stroller Seating Assessment Form (THSteps-CCP/Home Health Services) (Next 6 Pages)

Instructions
A current wheelchair seating assessment conducted by a physician, physical or occupational therapist must be completed for purchase of or modifications (including new seating systems) to a customized wheelchair. Please attach manufacturer information, descriptions, and an itemized list of retail prices of all additions that are not included in base model price. Complete Sections I-VI for manual wheelchairs. Complete Sections I-VII for power wheelchairs.

Client Information	
First name:	Last name:
Medicaid number:	Date of birth:
Diagnosis:	
Height:	Weight:

I. Neurological Factors
Indicate client's muscle tone: ☐ Hypertonic ☐ Absent ☐ Fluctuating ☐ Other
Describe client's muscle tone:
Describe active movements affected by muscle tone:
Describe passive movements affected by muscle tone:
Describe reflexes present:

II. Postural Control				
Head control:	☐ Good	☐ Fair	☐ Poor	☐ None
Trunk control:	☐ Good	☐ Fair	☐ Poor	☐ None
Upper extremities:	☐ Good	☐ Fair	☐ Poor	☐ None
Lower extremities:	☐ Good	☐ Fair	☐ Poor	☐ None

III. Medical/Surgical History And Plans:
Is there history of decubitis/skin breakdown? ☐ Yes ☐ No *If yes, please explain:*
Describe orthopedic conditions and/or range of motion limitations requiring special consideration (i.e., contractures, degree of spinal curvature, etc.):
Describe other physical limitations or concerns (i.e., respiratory):
Describe any recent or expected changes in medical/physical/functional status:
If surgery is anticipated, please indicate the procedure and expected date:

IV. Functional Assessment:		
Ambulatory status:	☐ Nonambulatory	☐ With assistance
	☐ Short distances only	☐ Community ambulatory
Indicate the client's ambulation potential:	☐ Expected within 1 year	
	☐ Not expected	
	☐ Expected in future within ___ years	

IV. Functional Assessment:		
Wheelchair Ambulation: Is client totally dependent upon wheelchair? ☐ Yes ☐ No *If no, please explain:*		
Indicate the client's transfer capabilities:	☐ Maximum assistance	☐ Moderate assistance
	☐ Minimum assistance	☐ Independent
Is the client tube fed? ☐ Yes ☐ No *If yes, please explain:*		
Feeding:	☐ Maximum assistance	☐ Moderate assistance
	☐ Minimum assistance	☐ Independent
Dressing:	☐ Maximum assistance	☐ Moderate assistance
	☐ Minimum assistance	☐ Independent
Describe other activities performed while in wheelchair:		

V. Environmental Assessment
Describe where client resides:
Is the home accessible to the wheelchair? ☐ Yes ☐ No
Are ramps available in the home setting? ☐ Yes ☐ No
Describe the client's educational/vocational setting:
Is the school accessible to the wheelchair? ☐ Yes ☐ No
Are there ramps available in the school setting? ☐ Yes ☐ No
If client is in school, has a school therapist been involved in the assessment? ☐ Yes ☐ No
Name of school therapist:
Name of school:
School therapist's telephone number:

V. Environmental Assessment
Describe how the wheelchair will be transported:
Describe where the wheelchair will be stored (home and/or school):
Describe other types of equipment which will interface with the wheelchair:

VI. Requested Equipment:	
Describe client's current seating system, including the mobility base and the age of the seating system:	
Describe why current seating system is not meeting client's needs:	
Describe the equipment requested:	
Describe the medical necessity for mobility base and seating system requested:	
Describe the growth potential of equipment requested in number of years:	
Describe any anticipated modifications/changes to the equipment within the next three years:	
Physician/Therapist's name:	Physician/Therapist's signature:
Physician/Therapist's title:	Date:
Physician/Therapist's telephone number: ( ) -	
Physician/Therapist's employer (name):	Physician/Therapist's address (work or employer address):

VII. POWER WHEELCHAIRS:
Complete if a power wheelchair is being requested

Describe the medical necessity for power vs. manual wheelchair:
(Justify any accessories such as power tilt or recline)

Is client unable to operate a manual chair even when adapted? ☐ Yes ☐ No

Is self propulsion possible but activity is extremely labored? ☐ Yes ☐ No
If yes, please explain:

Is self propulsion possible but contrary to treatment regimen? ☐ Yes ☐ No
If yes, please explain:

How will the power wheelchair be operated (hand, chin, etc.)?

Has the client been evaluated with the proposed drive controls?

Does the client have any condition that will necessitate possible change in access or drive controls within the next five years?

Is the client physically and mentally capable of operating a power wheelchair safely and with respect to others?
☐ Yes ☐ No

Is the caregiver capable of caring for a power wheelchair and understanding how it operates?
☐ Yes ☐ No

How will training for the power equipment be accomplished?

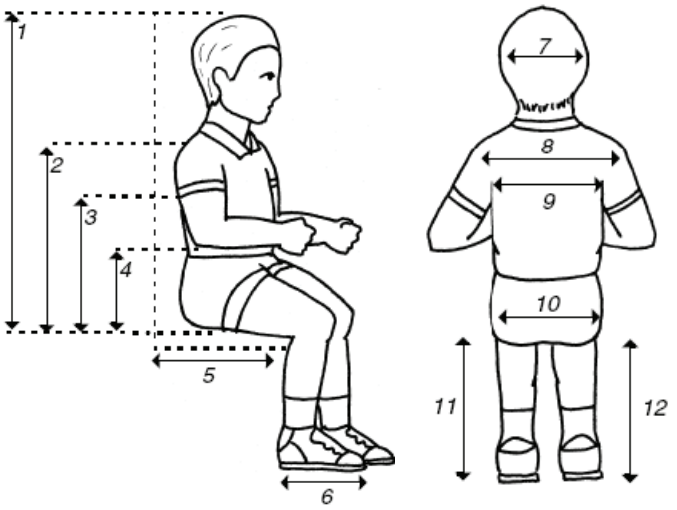
Physician/Therapist's name:	Physician/Therapist's signature:
Physician/Therapist's title:	Date:
Physician/Therapist's telephone number: ( ) -	
Physician/Therapist's employer (name):	Physician/Therapist's address (work or employer address):

B

Home Health/CCP Measuring Worksheet

General Information	
Client's name:	Date of birth:
Client's Medicaid number:	Height:
Date when measured:	Weight:
Measurer's name:	Measurer's telephone number: ( ) -

Measurements



1:	Top of head to bottom of buttocks
2:	Top of shoulder to bottom of buttocks
3:	Arm pit to bottom of buttocks
4:	Elbow to bottom of buttocks
5:	Back of buttocks to back of knee
6:	Foot length
7:	Head width
8:	Shoulder width
9:	Arm pit to arm pit
10:	Hip width
11:	Distance to bottom of left leg (popliteal to heel)
12:	Distance to bottom of right leg (popliteal to heel)

Additional Comments

THSteps Forms

C.1 Claim Forms

Providers must order CMS-1500 and ADA Dental Claims Forms from the vendor of their choice. Copies cannot be used. Claims filing instructions and examples of the claim forms are located in "Claims Filing" on page 5-1.

Refer to: "CMS-1500 Claim Filing Instructions" on page 5-22

"CMS-1500 Blank Claim Form" on page 5-24

"2006 ADA Dental Claim Filing Instructions" on page 5-43

C.2 Child Health Clinical Records

The use of forms ECH 1–7 is optional. These forms were developed to assist providers in documenting all components of the medical check up and can be downloaded from the THSteps website at secure.thstepsproducts.com/forms/ths_forms.htm. Lead poisoning screening questionnaires can be downloaded from the Childhood Lead Poisoning Prevention Program website at www.dshs.state.tx.us/lead/providers.shtm.

Tuberculosis screening questionnaires can be downloaded from the Tuberculosis Elimination Division website, www.dshs.state.tx.us/idcu/disease/tb/forms/default.asp#clinic. These forms are also available within this appendix.

Forms CH-9W through CH-12W are only available by calling THSteps at 1-512-458-7745.

Stock Number	Form
CH-9W	Growth Chart - Infant Girl
CH-10W	Growth Chart - Infant Boy
CH-11W	Growth Chart - Child Girl
CH-12W	Growth Chart - Child Boy
ECH-1	Child Health History
ECH-2	Preventive Health Visit - Birth to 1 Month
ECH-3	Preventive Health Visit - 2–6 Months
ECH-4	Preventive Health Visit - 7–12 Months
ECH-5	Preventive Health Visit - 13 Months to 2 Years
ECH-6	Preventive Health Visit - 3–5 Years
ECH-7	Preventive Health Visit - 6–10 Years
	Form Pb-110, Risk Assessment for Lead Exposure
	TB Questionnaire

For forms for documenting medical check ups for adolescents of all ages, please refer to sources such as *Bright Futures: Guide-lines for Health Supervision of Infants, Children, and Adolescents* (2nd edition, revised), located at www.brightfutures.org or the Guidelines for Adolescent Preventive Services (GAP) Implementation Materials located at: www.ama-assn.org/ama/pub/category/1981.html. For nutritional screening for all ages, refer to Bright Futures.

C.3 Child Health History (2 Pages)

Child Health History

Department of State Health Services
Child Health Record
Preventive Health Visit

Pregnancy and Birth

G ___ P ___ AB ____
Total number of living children _____Weight gain/loss_____
Mother's age at birth _____
Number of years between previous pregnancy and this child _____
Trimester Prenatal Care Began: 1 2 3
Prenatal Care Provider _____
Vitamins: ____Y __ N Iron: ____Y __N
If child over 5 years: uncomplicated pregnancy, labor, delivery and nursery course:___ Y____N*
**If yes, proceed with "Child's Medical History.*

Maternal Complications

____Vaginal bleeding
____Anemia
____Hypertension
____Rh negative
____Diabetes
____Premature labor
____Injury/hospitalization/surgery
____Flu-like illness or high temp.
____Kidney or bladder infection
____STDs
____Hepatitis (A, B, or C)
____Exposure to TB
____Exposure to lead/chemicals
____Dental disease

Maternal Substance Use

____OTC meds_____
____Prescription meds _____
____Tobacco _____
____Alcohol _____
____Street drugs _____
____Caffeine _____

Family Medical History

Abbreviations for relatives listed below.

M - Mother	MGM - Maternal Grandmother	PGM - Paternal Grandmother
F - Father	MGF - Maternal Grandfather	PGF - Paternal Grandfather
S - Sibling	MA - Maternal Aunt	PA - Paternal Aunt
	MU - Maternal Uncle	PU - Paternal Uncle

Y N HIV + individual in household (***do not identify***)

____ Anemia//blood disorder
____ Heart disease before age 50
____ Cholesterol req. treatment
____ Hypertension/stroke
____ Asthma/allergy
____ Cancer
____ Diabetes
____ Epilepsy/seizures
____ Kidney problems
____ Muscle/bone disease
____ Genetic disease or major birth defects
____ Childhood hearing impairment
____ Tuberculosis
____ Other immunosuppression
____ Dental decay
____ Alcohol/drug abuse
____ Tobacco use
____ Learning disorder
____ Mental retardation
____ Psychiatric disorder
____ Physical/sexual/emotional abuse
____ Domestic violence
____ Other

Explanation of positive history:

Client Information

Name: _____
DOB: _____ /_____/ _____ Age: _____Sex: _____
SSN/Record No.: _____
Race/Ethnicity: _____
Informant/Relationship: _____
Medical Home: _____

Birth/Delivery

Place of birth _____
Birth attendant _____
Hours of labor_____

____Term
____Premature (Weeks)_____
____More than 2 weeks overdue

Type of delivery:
____Vaginal
____C-Section
____Forceps

Complications:
____Breech
____Multiple birth
____Other

Explanation/Other:

Nursery Course

Birth Weight _____ Birth Length _____ FOC _____

____Difficulty with initial breathing
____Heart murmur
____Infection
____Transfusion
____Jaundice req. treatment
____Seizures

Age at discharge: _____ICN _____ days

Newborn blood screening (date/location):
1. _____
2. _____

Newborn hearing test (in hospital): ____ Normal _____Abnormal
Type of test: ____ABR ____OAE ____Unknown
Referral made: ____Y ____N
Comments:

Child's Medical History

Immunizations current: ___Y ___N __ Record unavailable
Dental care/sealants current: ___Y ___N

____Trauma/injuries
____Hospitalizations
____Surgery
____Medications
____Anemia
____Early childhood caries
____Hepatitis
____Strep throat
____Ear infections
____Bladder/kidney infections
____Pneumonia
____Developmental delays
____Vision problems
____Hearing problems
____Seizures
____Environmental toxin exposure (lead, etc.)
____Allergies
____Asthma
____Eczema
____Substance use (alcohol, drug, tobacco)
____Other

Explanation:

Date: _____ Signature/Title: _____ Signature/Title _____

Child Health History

If used for documentation:_____
Patient's Name: _____
Date: _____

Progress Notes

C.4 Child Health Record (Birth–1 Month) (2 Pages)

Birth–1 Month

Department of State Health Services
Child Health Record
Preventive Health Visit

Family Profile and Health

_____ No change in household since last visit
Child lives with:
_____ Mother ____ Father ____ Stepparent _____ Grandparent
_____ Other
Total adults living in home: _____
Total children living in home: _____
Primary caretaker for this child: _____
Relationship: _____
Family's concerns/problems:

Development

Parent's concerns:

Developmental Screening: _____P ____ F
Type of Developmental Screen:
Standardized Parent Questionnaire: _____
Standardized Observational Screen: _____
Other: _____
Further assessment needed: _____Y ____ N
Mental Health (see "Key Elements" on reverse side):

Child's Health

Allergies:
Does the system review note any problems or parent concerns: _____Y _____N
Explain:
Major illness, injury, hospitalization, surgery (state when and describe):

Medications taken regularly — Type/Reason:

Physical Examination

Temp _____ Pulse _____ Resp _____
FOC _____ Height _____ Weight _____
(%) _____ (%) _____ (%) _____

N	A	NE		N	A	NE	
___	___	___	Appearance	___	___	___	Heart/pulses
___	___	___	Head/fontanels	___	___	___	Lungs
___	___	___	Skin/nodes	___	___	___	Abdomen
___	___	___	Eyes (RR)	___	___	___	Genitalia/anus
___	___	___	Ears	___	___	___	Spine/hips
___	___	___	Nose	___	___	___	Extremities
___	___	___	Mouth/throat	**Neurologic:**			
___	___	___	Teeth	___	___	___	Muscle tone
___	___	___	Neck	___	___	___	DTRs
___	___	___	Chest/breasts	___	___	___	Primitive reflexes

Additional documentation:

Client Information

Name: _____
DOB: _____ / _____ / _____ Age: _____ Sex: _____
SSN/Record No.: _____
Race/Ethnicity: _____
Informant/Relationship: _____
Medical Home: _____

Nutrition

Problems: developmental, special diet, inappropriate weight gain/loss, chronic GI problems* _____Y _____N
**If answered yes, further assessment needed.*
Breast-fed: Number of feedings in last 24 hours: _____
Length of feedings: _____ **WIC:** _____Y _____N
Formula-fed: Type: _____
Iron fortified: _____Y _____N
Ounces consumed in 24 hours: _____ Fluoride: _____Y _____N
Solid foods introduced at age:

Sensory

Vision Screen: _____Normal _____Abnormal
Hearing Screen: _____Normal _____Abnormal
Screen used: _____Hearing Checklist for Parents

Health Education

Injury Prevention
___Car safety restraints
___Crib safety
___Burns
___Falls
___Drowning/bath safety
___911
___Sleep position (SIDS)
___Passive smoking

Behavior
___Crying/colic
___Sleeping
___Infant temperature

Health Promotion
___Care of skin, umbilical cord, circumcision
___Family planning
___Well-child care
___When to call doctor

Nutrition
___Breastfeeding
___No solids until 4 months
___Formula preparation
___Infant held for bottle
___No bottle in bed

Assessment

Plan

WIC: __ Referred __ Refused __ N/A
Immunizations: __ Up to date __ To be given today __ Deferred
Explain:
Lab:
Newborn Screening: _____Up to date ____ To be done today
Next appointment:

Date: _____ Signature/Title: _____ Signature/Title _____

Birth–1 Month

If used for documentation:_____
Patient's Name: _____
Date: _____

Key Elements

Systems Review

Skin: Rashes, infections, jaundice, cyanosis
Ears: Hearing or ear problems
Eyes: Eye discharge, excessive tearing
Nose/Mouth/Throat: Nasal congestion

Cardio/respiratory: History of murmur, trouble with breathing, wheezing
Gastrointestinal: Bowel movement frequency, problems/concerns, vomiting
Genitourinary: (Male) Normal stream, circumcision, number of wet diapers
Neuromuscular: Seizures, sucking reflex, swallowing
Musculoskeletal: Range of motion

Mental Health

The mental health assessment of this age also includes the developmental assessment and information from the family profile.

Feelings: Anxious, cries excessively or too little, irritable
Behavior: Overactivity, listlessness
Social Interaction: Failure to respond socially
Thinking: Unattentive
Physical Problems: Low weight for age, weight loss, vomits, problem eating, lacks energy, sleeping problems
Other: Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse

Progress Notes

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C

C.5 Child Health Record (2–6 Months) (2 Pages)

2–6 Months

Department of State Health Services
Child Health Record
Preventive Health Visit

Family Profile and Health

_____ No change in household since last visit
Child lives with:
_____ Mother ____ Father ____ Stepparent _____ Grandparent
_____ Other
Total adults living in home: _____
Total children living in home: _____
Primary caretaker for this child: _____
Relationship: _____
Family's concerns/problems:

Development

Parent's concerns:

Developmental Screening: _____P ____ F
Type of Developmental Screen:
Standardized Parent Questionnaire: _____
Standardized Observational Screen: _____
Other: _____
Further assessment needed: _____Y ____ N
Mental Health (see "Key Elements" on reverse side):

Child's Health

Allergies:
Does the system review note any problems or parent concerns: _____Y _____N
Explain:
Major illness, injury, hospitalization, surgery (since last visit):

Medications taken regularly — Type/Reason:

Physical Examination

Hct/Hgb _____ Lead _____
Temp _____ Pulse _____ Resp _____
FOC _____ Height _____ Weight _____
(%) _____ (%) _____ (%) _____

N	A	NE		N	A	NE	
____	__	___	Appearance	____	__	___	Heart/pulses
____	__	___	Head/fontanels	____	__	___	Lungs
____	__	___	Skin/nodes	____	__	___	Abdomen
____	__	___	Eyes (RR)	____	__	___	Genitalia/anus
____	__	___	Ears	____	__	___	Spine/hips
____	__	___	Nose	____	__	___	Extremities
____	__	___	Mouth/throat	**Neurologic:**			
____	__	___	Teeth	____	__	___	Muscle tone
____	__	___	Neck	____	__	___	DTRs
____	__	___	Chest/breasts	____	__	___	Primitive reflexes

Additional documentation:

Client Information

Name: _____
DOB: _____ /_____/ _____ Age: _____ Sex: _____
SSN/Record No.: _____
Race/Ethnicity: _____
Informant/Relationship: _____
Medical Home: _____

Nutrition

Problems: developmental, special diet, inappropriate weight gain/loss, chronic GI problems* _____Y _____N
**If answered yes, further assessment needed.*
Breast-fed: Number of feedings in last 24 hours: _____
Length of feedings: _____ **WIC:** _____Y _____N
Formula-fed: Type: _____
Iron fortified: _____Y _____N
Ounces consumed in 24 hours: _____ Fluoride: _____Y _____N
Solid foods introduced at age:

Sensory

Vision Screen: _____Normal _____Abnormal
Hearing Screen: _____Normal _____Abnormal
Screen used: _____Hearing Checklist for Parents

Health Education

Injury Prevention
____Car safety restraints
____Falls, Infant walker
____Burns
____Choking management
____Sleep position (SIDS)
____Passive smoking
____Pool/bath safety

Behavior
____Parent/infant interaction
____Sleeping
____Inappropriate expectations
____Daycare/babysitters

Health Promotion
____Immunizations
____Thermometer use, Tylenol
____Teething, wipe teeth
____When to call doctor
____Well-child care
____Family planning

Nutrition
____Breastfeeding
____No solids until 4 months
____Formula preparation
____Infant held (no bottle in bed)

Assessment

Plan

WIC: ____Referred ___Refused _ ___N/A
Immunizations: Up to date To be given today ___Deferred
Explain:
Lab:
Newborn Screening: Up to date ____ To be done today
Next appointment:

Date: _____ Signature/Title: _____ Signature/Title _____

2–6 Months

If used for documentation:_____
Patient's Name: _____
Date: _____

Key Elements

Systems Review

Skin: Rashes, infections
Ears: Hearing or ear problems
Eyes: Eye discharge, deviation, excessive tearing
Nose/Mouth/Throat: Nasal congestion

Cardio/respiratory: History of murmur, trouble with breathing, wheezing
Gastrointestinal: Bowel movement frequency, problems/concerns, vomiting
Genitourinary: (Male) Normal stream, number of wet diapers
Neuromuscular: Seizures, coordinated movements
Musculoskeletal: Fractures, range of motion

Mental Health

The mental health assessment of this age also includes the developmental assessment and information from the family profile.

Feelings: Anxious, cries excessively or too little, irritable
Behavior: Overactivity, listlessness
Social Interaction: Failure to respond socially
Thinking: Unattentive
Physical Problems: Low weight for age, weight loss, vomits, problem eating, lacks energy, sleeping problems
Other: Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse

Progress Notes

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C

C.6 Child Health Record (7–12 Months) (2 Pages)

7–12 Months

Department of State Health Services
Child Health Record
Preventive Health Visit

Family Profile and Health

_____No change in household since last visit
Child lives with:
_____Mother ____ Father ____ Stepparent _____Grandparent
_____Other
Total adults living in home: _____
Total children living in home: _____
Primary caretaker for this child: _____
Relationship: _____
Family's concerns/problems:

Development

Parent's concerns:

Developmental Screening: _____P ____ F
Type of Developmental Screen:
Standardized Parent Questionnaire: _____
Standardized Observational Screen: _____
Other: _____
Further assessment needed: _____Y ____ N
Mental Health (see "Key Elements" on reverse side):

Child's Health

Allergies:
Does the system review note any problems or parent concerns: _____Y _____N
Explain:
Major illness, injury, hospitalization, surgery (since last visit):

Medications taken regularly — Type/Reason:

Physical Examination

Temp _____ Pulse _____Resp _____
FOC_____ Height _____Weight_____
(%)_____ (%) _____(%)_____

N	A	NE		N	A	NE	
___	___	___	Appearance	___	___	___	Heart/pulses
___	___	___	Head/fontanels	___	___	___	Lungs
___	___	___	Skin/nodes	___	___	___	Abdomen
___	___	___	Eyes	___	___	___	Genitalia/anus
___	___	___	Ears	___	___	___	Spine/hips
___	___	___	Nose	___	___	___	Extremities
___	___	___	Mouth/throat	**Neurologic:**			
___	___	___	Teeth	___	___	___	Muscle tone
___	___	___	Neck	___	___	___	DTRs
___	___	___	Chest/breasts				

Additional documentation:

Client Information

Name: _____
DOB: _____ /_____/ _____Age: _____Sex: _____
SSN/Record No.: _____
Race/Ethnicity: _____
Informant/Relationship: _____
Medical Home: _____

Nutrition

Problems: developmental, special diet, inappropriate weight gain/loss, chronic GI problems* _____Y _____N
**If answered yes, further assessment needed.*
Breast-fed: Number of feedings in last 24 hours: _____
Length of feedings: _____ **WIC:** _____Y _____N
Formula-fed: Type: _____
Iron fortified: _____Y _____N
Ounces consumed in 24 hours: _____ Fluoride: _____Y _____N
Solid foods introduced at age:

Sensory

Vision Screen: _____Normal _____Abnormal
Hearing Screen: _____Normal _____Abnormal
Screen used: _____Hearing Checklist for Parents

Health Education

Injury Prevention
___Car safety restraints
___Falls (stairs, gates)
___Choking management
___Water safety/temp
___Poisoning
___Child proofing
___Passive smoking

Behavior
___Parent/infant interaction, expectations
___Speech development
___Sleep
___Separation protest
___Daycare

Health Promotion
___Immunizations
___Teething
___Cleaning teeth
___When to call doctor
___Well-child care
___Dental appointment
___Family planning

Nutrition
___Breastfeeding support
___Introduction of solids
___No bottle in bed
___Off bottle by 1 year

Assessment

Plan

TB: __ Y ___N **Dental referral made:** __ Y_ N
WIC: __ Referred ___Refused __ N/A
Immunizations: __ Up to date ___To be given today __ Deferred
Explain:
Lab:
Newborn Screening: ___ Up to date ___To be done today
Hct/Hgb ___Lead _____
Hep C (if 12 months old or older and born to HCV infected woman) _____
Next appointment:

Date: _____ Signature/Title: _____ Signature/Title _____

7–12 Months

If used for documentation:_____
Patient's Name: _____
Date: _____

Key Elements

Systems Review

Skin: Rashes, infections
Ears: Hearing or ear problems
Eyes: Eye discharge, deviation, wandering eye movement
Nose/Mouth/Throat/Teeth: Nasal congestion
Cardio/respiratory: History of murmur, trouble with breathing, wheezing
Gastrointestinal: Bowel movement frequency, problems/concerns, vomiting
Genitourinary: (Male) Normal stream
Neuromuscular: Coordination
Musculoskeletal: Fractures

Mental Health

The mental health assessment of this age also includes the developmental assessment and information from the family profile.

Feelings: Anxious, cries excessively or too little, irritable
Behavior: Overactivity, listlessness
Social Interaction: Failure to respond socially
Thinking: Unattentive
Physical Problems: Low weight for age, weight loss, vomits, problem eating, lacks energy, sleeping problems
Other: Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse

Progress Notes

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C

TEXAS Department of State Health Services

TDH-ECH-4

Rev. 9/07

C.7 Child Health Record (13 Months–2 Years) (2 Pages)

13 Months–2 Years

Department of State Health Services
Child Health Record
Preventive Health Visit

Client Information

Name: _____
DOB: _____ /_____/ _____ Age: _____ Sex: _____
SSN/Record No.: _____
Race/Ethnicity: _____
Informant/Relationship: _____
Medical Home: _____

Family Profile and Health

_____ No change in household since last visit
Child lives with:
_____ Mother ____ Father ____ Stepparent _____ Grandparent
_____ Other
Total adults living in home: _____
Total children living in home: _____
Primary caretaker for this child: _____
Relationship: _____
Family's concerns/problems:

Development

Parent's concerns:

Developmental Screening: _____P ____ F
Type of Developmental Screen:
Standardized Parent Questionnaire: _____
Standardized Observational Screen: _____
Other: _____
Further assessment needed: _____Y ____ N
Mental Health (see "Key Elements" on reverse side):

Child's Health

Allergies:
Does the system review note any problems or parent concerns: _____Y _____N
Explain:
Major illness, injury, hospitalization, surgery (since last visit):

Medications taken regularly — Type/Reason:

Dental Care:

Physical Examination

Temp _____ Pulse _____ Resp _____
FOC _____ Height _____ Weight _____
(%) _____ (%) _____ (%) _____

N	A	NE		N	A	NE	
____	__	___	Appearance	____	__	___	Heart/pulses
____	__	___	Head/fontanels	____	__	___	Lungs
____	__	___	Skin/nodes	____	__	___	Abdomen
____	__	___	Eyes	____	__	___	Genitalia/anus
____	__	___	Ears	____	__	___	Spine/hips
____	__	___	Nose	____	__	___	Extremities
____	__	___	Mouth/throat	**Neurologic:**			
____	__	___	Teeth	____	__	___	Muscle tone
____	__	___	Neck	____	__	___	DTRs
____	__	___	Chest/breasts				

Additional documentation:

Nutrition

Problems: special diet, inappropriate weight gain, anemic, chronic GI problems, major food allergies, refusal of any food group, developmental* _____Y _____N
**If answered yes, further assessment needed.*
Usual Servings Per Day:
____Dairy __ Formula ___Breast ___Vegetables WIC: ___Y __N
____Breads, cereal, rice, and pasta
____Meat, poultry, fish, eggs, and dry beans
____Fruits

Sensory

Vision Screen: _____Normal _____Abnormal
Hearing Screen: _____Normal _____Abnormal
Screen used: _____Hearing Checklist for Parents

Health Education

Injury Prevention
____Car safety restraints
____Choking, unsafe toys
____Poisoning
____Burns
____Water safety/temp
____Supervised play
____Electrical injury
____Passive smoking

Behavior
____Parent/infant interaction
____Social interaction
____Limit TV
____Set limits
____Sibling rivalry
____Toilet training

Health Promotion
____Immunizations
____Smoking in home
____Well-child care
____Dental care, appointment
____Family planning
____Daycare

Nutrition
____Healthy diet/snacks
____Iron-rich foods
____Physical activity
____Weaning
____Off bottle by age 1

Assessment

Plan

Dental referral made: ___Y ___N
WIC: ____Referred ___Refused ___N/A
Immunizations: ____Up to date ___To be given today ___Deferred
Explain:
Lab:
Hct/Hgb _____ Lead _____
Hep C (if 12 months old or older and born to HCV infected woman) _____
Next appointment:

Date: _____ Signature/Title: _____ Signature/Title _____

13 Months–2 Years

If used for documentation:_____
Patient's Name: _____
Date: _____

Key Elements

Systems Review

Skin: Rashes, infections
Ears: Hearing or ear problems
Eyes: Eye discharge, deviation, wandering eye movement
Nose/Mouth/Throat/Teeth: Nasal congestion

Cardio/respiratory: History of murmur, trouble with breathing, wheezing
Gastrointestinal: Bowel movement frequency
Genitourinary: Urinary frequency, (male) normal stream, dysuria, discharge
Neuromuscular: Seizures, coordination, gait
Musculoskeletal: Fractures

Mental Health

The mental health assessment of this age also includes the developmental assessment and information from the family profile.

Feelings: Angry, sad, fearful, sullen, anxious, cries excessively or too little
Behavior: Overactivity, listlessness, harms others, sexually acts out, refuses to talk
Social Interaction: Withdrawn, clings excessively
Thinking: Mistrustful, distracted, problems concentrating
Physical Problems: Low weight for age, weight loss, vomits, problem eating, lacks energy, sleeping problems
Other: Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse

Progress Notes

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C.8 Child Health Record (3–5 Years) (2 Pages)

3–5 Years

Department of State Health Services
Child Health Record
Preventive Health Visit

Client Information

Name: _____
DOB: _____ /_____/ _____ Age: _____ Sex: _____
SSN/Record No.: _____
Race/Ethnicity: _____
Informant/Relationship: _____
Medical Home: _____

Family Profile and Health

_____ No change in household since last visit
Child lives with:
_____ Mother ____ Father ____ Stepparent _____ Grandparent
_____ Other
Total adults living in home: _____
Total children living in home: _____
Primary caretaker for this child: _____
Relationship: _____
Family's concerns/problems:

Development

Parent's concerns:

Developmental Screening: _____P ____ F
Type of Developmental Screen:
Standardized Parent Questionnaire: _____
Standardized Observational Screen: _____
Other: _____
Further assessment needed: _____Y ____ N
Mental Health (see "Key Elements" on reverse side):

Child's Health

Allergies:
Does the system review note any problems
or parent concerns: _____Y _____N
Explain:
Major illness, injury, hospitalization, surgery (since last visit):

Medications taken regularly — Type/Reason:

Dental Care:

Physical Examination

Temp _____ Pulse _____ Resp _____
BP _____ Height _____ Weight _____
(%) _____ (%) _____ (%) _____

N	A	NE		N	A	NE	
____	__	___	Appearance	____	__	___	Heart/pulses
____	__	___	Head/fontanels	____	__	___	Lungs
____	__	___	Skin/nodes	____	__	___	Abdomen
____	__	___	Eyes	____	__	___	Genitalia/anus
____	__	___	Ears	____	__	___	Spine
____	__	___	Nose	____	__	___	Extremities
____	__	___	Mouth/throat	**Neurologic:**			
____	__	___	Teeth	____	__	___	Muscle tone
____	__	___	Neck	____	__	___	DTRs
____	__	___	Chest/breasts				

Additional documentation:

Nutrition

Problems: special diet, inappropriate weight gain, anemic, lead poisoning, chronic GI problems, major food allergies, refusal of any food group, developmental* _____Y _____N
**If answered yes, further assessment needed.*
Usual Servings Per Day:
____Dairy __ Vegetables__ WIC: ___Y __N
____Breads, cereal, rice, and pasta Flouride Supplements: ___Y __N
____Meat, poultry, fish, eggs, and dry beans
____Fruits Vitamins: ___Y __N

Sensory

Vision Screen: _____Normal ____Abnormal
Hearing Screen: _____Normal ____Abnormal
Hearing Screen Used: _____Hearing Checklist for Parents

Health Education

Injury Prevention
____Car safety restraints
____Poisoning
____Fire safety
____Firearms
____Street, water, bicycle safety
____Scissors/sharp objects
____Stranger safety
____Teach telephone no. & address
____Self-safety
____Passive smoking

Behavior
____Talk/read with child
____Exploration
____Limit television
____Discipline, consistency
____Toilet training
____Social interaction
____School readiness
____Sex education

Health Promotion
____Immunizations
____Well-child care
____Dental care, appointment
____Family planning
____Daycare

Nutrition
____Healthy diet/snacks
____Junk food
____Iron-rich foods
____Physical activity

Assessment

Plan

Dental referral made: ___Y ___N
WIC: ____Referred ___Refused ___N/A
Immunizations: ___Up to date ___To be given today ___Deferred
Explain:
Lab:
Hct/Hgb _____ Lead _____
Next appointment:

Date: _____ Signature/Title: _____ Signature/Title _____

3–5 Years

If used for documentation:_____
Patient's Name: _____
Date: _____

Key Elements

Systems Review

Skin: Rashes, infections
Ears: Hearing or ear problems
Eyes: Eye discharge, blinking, tearing
Nose/Mouth/Throat/Teeth: Nasal congestion

Cardio/respiratory: History of murmur, trouble with breathing, wheezing
Gastrointestinal: Bowel movement frequency, soiling
Genitourinary: Dysuria, discharge
Neuromuscular: Seizures, coordination, gait
Musculoskeletal: Fractures

Mental Health

The mental health assessment of this age also includes the developmental assessment and information from the family profile.

Feelings: Out of control, angry, sad, fearful, sullen, anxious
Behavior: Overactive, listlessness, harms others or property, sexually acts out, impulsive, frequently provokes other children, self-abuses
Social Interaction: Withdrawn, clings excessively, acts too young, communicates non-verbally rather than verbally
Thinking: Mistrustful, distracted, easily frustrated
Physical Problems: Low weight for age, weight loss, vomits, problem eating, lacks energy, sleeping problems
Other: Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse

Progress Notes

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C

TEXAS Department of State Health Services

TDH-ECH-6

Rev. 1/07

C.9 Child Health Record (6-10 Years) (2 Pages)

6–10 Years

Department of State Health Services
Child Health Record
Preventive Health Visit

Client Information

Name: _____
DOB: _____ /_____/ _____ Age: _____ Sex: _____
SSN/Record No.: _____
Race/Ethnicity: _____
Informant/Relationship: _____
Medical Home: _____

Family Profile and Health

_____ No change in household since last visit
Child lives with:
_____ Mother ____ Father ____ Stepparent _____ Grandparent
_____ Other
Total adults living in home: _____
Total children living in home: _____
Primary caretaker for this child: _____
Relationship: _____
Family's concerns/problems:

Mental Health

(+ indicates need for futher assessment)

____ Sleep Problems
____ Behavior/problems
____ Relationship problems with parents, siblings, peers
____ Problems in school
Grade Level _____
____ Special education classes
____ No/excessive extracurricular activities
____ Substance abuse/use
____ Self-concept problems

Comments:

Child's Health

Allergies:
Does the system review note any problems or parent concerns: _____ Y _____ N
Explain:
Major illness, injury, hospitalization, surgery (since last visit):

Medications taken regularly — Type/Reason:

Dental Care/sealants:

Physical Examination

Temp _____ Pulse _____ Resp _____
BP _____ Height _____ Weight _____
(%) _____ (%) _____ (%) _____

N	A	NE		N	A	NE	
____	__	___	Appearance	____	__	___	Heart/pulses
____	__	___	Head/fontanels	____	__	___	Lungs
____	__	___	Skin/nodes	____	__	___	Abdomen
____	__	___	Eyes	____	__	___	Genitalia/anus (Tanner stage)
____	__	___	Ears				
____	__	___	Nose	____	__	___	Spine
____	__	___	Mouth/throat	____	__	___	Extremities
____	__	___	Teeth	**Neurologic:**			
____	__	___	Neck	____	__	___	Muscle tone
____	__	___	Chest/breasts (Tanner stage)	____	__	___	DTRs

Additional documentation:

Nutrition

Problems: special diet, inappropriate weight gain, anemic, lead poisoning, chronic GI problems, major food allergies, refusal of any food group* _____ Y _____ N
**If answered yes, further assessment needed.*
Usual Servings Per Day:
____ Dairy ____ Vegetables __ Fruits
____ Breads, cereal, rice, and pasta
____ Meat, poultry, fish, eggs, and dry beans

Sensory

Vision Screen: _____ Normal ____ Abnormal
Hearing Screen: _____ Normal ____ Abnormal
Screen used: _____ Hearing Checklist for Parents

Health Education

Injury Prevention
____ Seat belt/auto safety
____ Bicycles/ATV
____ Athletics
____ Water safety
____ Smoke detectors
____ Firearm safety

Behavior
____ Substance abuse
____ Tobacco use
____ Security
____ Discipline patterns
____ Responsibility
____ Communication/conflict resolution

Health Promotion
____ Limit TV viewing
____ Passive smoking
____ Regular exercise
____ Pubertal changes/sexuality
____ Dental care/sealants

Nutrition
____ Healthy diet/snacks
____ Junk food
____ Iron-rich foods

Assessment

Plan

Dental referral made: ___ Y ___ N
Immunizations: ___ Up to date ___ To be given today ___ Deferred
Explain:
Lab:
Hct/Hgb _____ Lead _____
Next appointment:

Date: _____ Signature/Title: _____ Signature/Title _____

6–10 Years

If used for documentation:_____
Patient's Name: _____
Date: _____

Key Elements

Systems Review

Skin: Rashes, infections
Eyes: Eye discharge, blinking, tearing
Ears: Hearing or ear problems
Nose/Mouth/Throat/Teeth: Nasal congestion

Cardio/respiratory: History of murmur, trouble with breathing, wheezing
Gastrointestinal: Bowel movement frequency, problems/concerns, encopresis
Genitourinary: Dysuria, pubescent changes, penile/vaginal discharge or spotting, enuresis
Neuromuscular: Seizures
Musculoskeletal: Fractures, sprains, sport injuries

Progress Notes

C.10 Hearing Checklist for Parents

Hearing Checklist for Parents

Client Information

Name: _____

DOB: _____/_____/ _____Age: _____Sex: _____

SSN/Record No.:_____

Race/Ethnicity:_____

Informant/Relationship: _____

Medical Home: _____

Age 0 to 3 Yrs	Yes	No	
0 to 3 months	❑	❑	Does your baby get quiet for a moment when you talk to him/her?
	❑	❑	Does your baby act startled or stop moving for a moment when there are sudden loud noises?
4 to 6 months	❑	❑	Does your baby turn his/her eyes or head to the sound of your voice if he/she cannot see you?
	❑	❑	Does your baby smile or stop crying when you or someone else he/she knows speaks?
7 to 9 months	❑	❑	Does your baby stop and pay attention when you say "no" or call his/her name?
	❑	❑	Does your baby move his/her head around to try and find out where a new sound is coming from?
	❑	❑	Does your baby make strings of sounds ("ba ba ba, da da da")?
10 to 15 months	❑	❑	Does your baby give you toys or other objects (bottle) when you ask, without your having to use a gesture (holding out your hand or pointing)?
	❑	❑	Does your baby point to familiar objects if you ask ("dog," "light")?
16 to 24 months	❑	❑	Does your child use his/her voice most of the time to get what he/she wants or to communicate with you?
	❑	❑	Can your child go get familiar objects that are kept in a regular place if you ask him/her ("Get your shoes.")?
25 to 36 months	❑	❑	Does your child answer different kinds of questions ("When...," "Who...," "What...,")?
	❑	❑	Does your child notice different sounds (telephone ringing, shouting, doorbell)?

If you answered "no" to any of the above questions, ask your doctor about a hearing test for your baby. Babies can be tested as soon as the day of birth.

Date of visit	Age	Result	Signature of Provider
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TEXAS Department of State Health Services

Department of State Health Services
Publication No. EFO5-12234
8/05

C.11 Hearing Checklist for Parents (Spanish)

Lista de comprobación de audición para los padres

Información del cliente

Nombre: _____

Fecha de Nac.:_____/ _____/_____Edad:_____Sexo: _____

No. de SS/Expediente: _____

Raza o etnicidad: _____

Informante/Parentesco:_____

Médico personal: _____

De 0 a 3 años	Sí	No	
De 0 a 3 meses	❑	❑	¿Su bebé se tranquiliza por un momento cuando le habla?
	❑	❑	¿Su bebé actúa sorprendido o deja de moverse por un momento cuando hay ruidos fuertes repentinos?
De 4 a 6 meses	❑	❑	¿Su bebé dirige la mirada o gira la cabeza hacia el sonido de su voz si no la está viendo?
	❑	❑	¿Su bebé sonríe o deja de llorar cuando le habla usted u otra persona que él conoce?
De 7 a 9 meses	❑	❑	¿Su bebé deja de hacer lo que está haciendo y pone atención cuando le dice "no" o lo llama por su nombre?
	❑	❑	¿Su bebé gira la cabeza hacia todos lados y trata de encontrar de dónde viene algún sonido nuevo?
	❑	❑	¿Su bebé hace sonidos repetidos ("gu-gú, da-dá")?
De 10 a 15 meses	❑	❑	¿Su bebé le da a usted juguetes u otros objetos (la botella) cuando se los pide, sin tener que usar gestos (extender la mano o señalar)?
	❑	❑	¿Su bebé señala con el dedo objetos familiares si se lo pide ("el perro", "la luz")?
De 16 a 24 meses	❑	❑	¿Su hijo usa principalmente la voz para conseguir lo que quiere o cuando quiere comunicarse con usted?
	❑	❑	¿Su hijo puede ir a buscar objetos familiares guardados en lugares regulares si usted se lo pide ("Vé por tus zapatos")?
De 25 a 36 meses	❑	❑	¿Su hijo responde a diferentes tipos de preguntas ("Cuándo", "Quién", "Qué")?
	❑	❑	¿Su hijo distingue sonidos diferentes (el timbre del teléfono, gritos, el timbre de la puerta)?

Si contestó "No" a cualquiera de las preguntas anteriores pida a su médico un examen auditivo para su bebé. Se puede examinar a los bebés tan pronto como el día de su nacimiento.

Fecha de la visita	Edad	Resultado	Firma del proveedor
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/ /			

TEXAS Department of State Health Services

Departamento de servicios médicos estatales
Publicación No. EFO5-12234
8/05

C

C.12 Mental Health Interview Tool/Referral Form (Ages 0–2 Years)

Mental Health Interview Tool/Referral Form

Child's Name: _____

Birth Date: _____

Ages 0 to 2

Date: _____

*For this age group you will obtain information from the parent/caregiver and from your own observations of the child. Circle items of concern. * The presence of any of these symptoms or behaviors may signal that the child is in crisis, and efforts should be made to secure prompt evaluation.*

Feelings: Does your child display feelings that concern you or seem out of the ordinary?

Infants
- ❑ Anxious
- ❑ Cries excessively
- ❑ Cries too little

1 to 2 Years
- ❑ Irritable
- ❑ Angry
- ❑ Sad
- ❑ Fearful
- ❑ Sullen
- ❑ Anxious
- ❑ Cries excessively
- ❑ Cries too little

Behavior: Does your child display behavior that concerns you or seems out of the ordinary for his/her age?

Infants
- ❑ Overactive
- ❑ Listlessness

1 to 2 Years
- ❑ Overactive
- ❑ Listlessness
- ❑ Harms others
- ❑ Frequent temper tantrums

Social Interaction: Do you have concerns about how your child gets along with you? Other family members or adults? Siblings?

Infants
- ❑ No eye contact or smile
- ❑ Stiffens and arches
- ❑ Not responsive

1 to 2 Years
- ❑ * No eye contact or smile
- ❑ Clings excessively
- ❑ Not responsive
- ❑ Language delay

Thinking: Do you think your child's development is normal for age?

Infants (> 8 months)
- ❑ No communication skills (pointing to request an object) or efforts to make words

1 to 2 Year
- ❑ Mistrustful
- ❑ Problems concentrating or paying attention

Physical Problems: Do you have any concerns about your child's physical health? If physical problems exist, have they been medically evaluated?

Infants to 2 Years
- ❑ Low weight or weight loss
- ❑ Frequent vomiting
- ❑ Eating problem (poor appetite, eats nonfoods)
- ❑ Sleeping problem (frequent night waking)
- ❑ Lethargic

Other: Are there any situations which are causing your family particular stress at this time?
Has this child or his/her parents been subject to neglect, physical, sexual, or emotional abuse?
If yes, what form, when, treatment initiated, etc.?
Did the mother of this child use drugs or drink alcohol during the pregnancy?

Comments:

Signature/Title: _____

C.13 Mental Health Interview Tool/Referral Form (Ages 0–2 Years) (Spanish)

Instrumento para la Evaluación de la Salud Mental y Formulario para Tratamiento con un Especialista

Nombre del Niño:_____
Fecha de Nacimiento: _____
Fecha: _____

De Recién Nacido a 2 Años de Edad

*Para los niños que pertenecen a este grupo usted obtendrá información de los padres/personas encargadas y de sus propias observaciones del bebé. Marque las características que le preocupen. *La presencia de alguno de estos síntomas o comportamientos puede indicar que el niño está en una crisis, y se debe haces un esfuerzo para asegurar que se le evalúe pronto.*

Sentimientos: ¿Muestra su niño sentimientos que le preocupan o que parezcan extraños?

Recién Nacidos
- ❑ Ansioso
- ❑ Llora demasiado
- ❑ Llora muy poco

De 1 a 2 Años
- ❑ Se irrita
- ❑ Se enoja
- ❑ Está triste
- ❑ Tiene miedo
- ❑ Malhumorado
- ❑ Ansioso
- ❑ Llora demasiado
- ❑ Llora muy poco

Comportamientos: ¿Muestra su niño un compartamiento que le preocupa o que parezca extraño para su edad?

Recién Nacidos
- ❑ Es demasiado activo
- ❑ Es indiferente

De 1 a 2 Años
- ❑ Es demasiado activo
- ❑ Es indiferente
- ❑ Lastima a los demás
- ❑ Hace berrinches temperamentales frecuentemente

Interacciones Sociales: ¿Se preocupa sobre cómo se lleva su niño con usted? ¿Con otros miembros de la familia o adultos? ¿Con sus hermanos?

Recién Nacidos
- ❑ No ve a los ojos ni sonríe
- ❑ Se pone tieso y se dobla arqueando la espalada
- ❑ No muestra mucho interés

De 1 a 2 Años
- ❑ *No ve a los ojos ni sonríe
- ❑ Se pega a usted excesivamente
- ❑ No muestra mucho interés
- ❑ Está atrasado en el lenguaje

Pensamientos: ¿Cree usted que el desarrollo de su niño es normal para su edad?

Recién Nacidos (>8 meses)
- ❑ No tiene habilidad para comunicarse (apunta para pedir un objeto) ni se esfuerza para decir palabras

De 1 a 2 Años
- ❑ No tiene confianza
- ❑ Tiene problemas para concentrarse o para poner atención

Problemas Físicos: ¿Se preocupa sobre la salud física de su niño? Si existen problemas físicos, ¿han sido evaluados médicamente?

Recién Nacidos a 2 Años
- ❑ Peso bajo o pérdida de peso
- ❑ Se vomita frecuentemente
- ❑ Tiene problemas para comer (poco apetito, come alimentos que no son saludables)
- ❑ Tiene problemas para dormir (se despierta frecuentemente por las noches)
- ❑ Es letárgico

Otra: ¿Hay alguna situación que le esté causando a su familia cierta tensión ahora?
¿Ha sido este niño o sus padres sujetos a la negligencia, o al abuso físico, sexual o emocional?
Si contesta sí, ¿de qué manera?, ¿cuándo?, ¿se ha comenzado algún tratamiento?, etc.
¿Usó la mamá de este niño drogas o tomó bebidas alcohólicas durante su embarazo?

Comentarios:

Firma/Titulo de su puesto:_____

C.14 Mental Health Interview Tool/Referral Form (Ages 3-9 Years)

Mental Health Interview Tool/Referral Form

Ages 3 to 9

Child's Name: _____
Birth Date: _____
Date: _____

*For this age group you will obtain information from the parent/caregiver and from your own observations of the child's behavior. If possible, interview the parent alone when asking questions about sexual or physical abuse. Circle items of concern. * The presence of any of these symptoms or behaviors may signal that the child is in crisis, and efforts should be made to secure prompt evaluation.*

Feelings:

Does your child display feelings that concern you or seem out of the ordinary for age?

- ❑ Restless
- ❑ Sad or cries easily
- ❑ Excessively guilty
- ❑ Lack of remorse
- ❑ Irritable, angers or temper tantrums easily
- ❑ Sullen
- ❑ Fearful or anxious

Behavior:

Does your child frequently display behavior that seems out of the ordinary for age?

- ❑ Problems in school
- ❑ * Harms other children or animals
- ❑ Lacks interest in things s/he used to enjoy
- ❑ Engages in sexual play with others, toys, animals
- ❑ * Destroys possessions or other property
- ❑ Steals
- ❑ Refuses to talk
- ❑ * Sets fires
- ❑ Overactive
- ❑ * Self-destructive
- ❑ * Has been in trouble with the police (older child)

Social Interaction:

Do you have concerns about how child gets along with you, other family members, playmates, other adults?

- ❑ Withdraws including no eye contact
- ❑ Clings excessively
- ❑ Difficulty making and keeping friends
- ❑ Defiant, a discipline problem
- ❑ Severe or frequent tantrums
- ❑ Aggressive
- ❑ Argues excessively
- ❑ Refuses to go to school
- ❑ Prefers to be alone

Thinking:

Have you noticed any of the following to be a problem for your child?

- ❑ * Frequently confused
- ❑ Daydreams excessively
- ❑ Distracted, doesn't pay attention
- ❑ * Bizarre thoughts
- ❑ Mistrustful
- ❑ * Sees or hears things that are not there (excluding imaginary friends in younger children)
- ❑ Blames others for his/her misdeeds or thoughts
- ❑ * Talks about death
- ❑ * Frequent memory loss
- ❑ Schoolwork is slipping (grades going down)

Physical Problems:

Do you have any concerns about the following physical signs? Has this been evaluated?

- ❑ Daytime wetting
- ❑ Soils pants
- ❑ Refusal to eat
- ❑ Headaches
- ❑ Excessive weight loss or gain
- ❑ Sleep problems, nightmares, sleep-walking, early waking
- ❑ Vomits frequently
- ❑ Frequent stomachaches
- ❑ Lacks energy

Other:

Is this child accident-prone?
Are there any situations that are causing your family particular stress?
Has this child or his/her parents been subject to neglect, physical, sexual or emotional abuse? If yes, what type, when, treatment, etc.
* Is this child at risk for out-of-home placement because of behavior problems?

Comments:

Signature/Title: _____

C.15 Mental Health Interview Tool/Referral Form (Ages 3–9 Years) (Spanish)

Instrumento para la Entrevista de la Salud Mental y
Formulario para Tratamiento con un Especialista
De 3 a 9 Años de Edad

Nombre del Niño:_____
Fecha de Nacimiento: _____
Fecha: _____

*Para los niños que pertenecen a este grupo usted obtendrá informatción de los padres/tudor y de sus propias observaciones del comportamiento del niño. Si es posible, entreviste a los padres solos cuando haga preguntas sobre el abuso sexual o físico. Marque las características que le preocupen. *La presencia de alguno de estos síntomas o comportamientos pueden indicar que el niño está pasando por una crisis, y se debe hacer un esfuerzo para asegurar que se le evalúe pronto.*

Sentimientos:

¿Muestra su niño sentimientos que le preocupan o que parezcan extraños para su edad?

- ❑ Es inquieto
- ❑ Está triste o llora fácilmente
- ❑ Muestra mucha culpabilidad
- ❑ No tiene remordimiento
- ❑ Se irrita, enoja, o hace berrinches temperamentales fácilmente
- ❑ Es malhumorado
- ❑ Tiene miedo o está ansioso

Comportamiento:

¿Muestra su niño frecuentemente un comportamiento que le parezca extraño para su edad?

- ❑ Problemas en la escuela
- ❑ *Lastima a otros niños o a animales
- ❑ No tien interés en cosas que antes disfrutaba
- ❑ Participa en juegos sexuales con juguetes, animales, o con los demás
- ❑ *Destruye cosas personales o ajenas
- ❑ Roba
- ❑ Se niega a hablar
- ❑ Enciende fuegos
- ❑ Es demasiado activo
- ❑ *Tiene un comportamiento de autodestrucción
- ❑ *Ha tenido problemas con la policía (con otro niño)

Interacción Sociales:

¿Se preocupa sobre cómo se lleva su niño con usted? ¿Con otros miembros de la familia? ¿Con otros adultos? o ¿Con sus amigos de juego?

- ❑ Se retira sin dirgir la mirada a los ojos
- ❑ Se pega a usted excesivamente
- ❑ Se le dificulta hacer y mantener amistades
- ❑ Es desafiante, un problema de disciplina
- ❑ Hace berrinches temperamentales fuertes o frecuentemente
- ❑ Es agresivo
- ❑ Discute demasiado
- ❑ Se niega a ir a la escuela
- ❑ Prefiere estar solo

Pensamientos:

¿Ha notado si alguno de los siguientes es un problem para su niño?

- ❑ *Se confunde frecuentemente
- ❑ Sueña despierto demasiado
- ❑ Se distrae, no pone atención
- ❑ *Tiene pensamientos raros
- ❑ Es desconfiado
- ❑ *Mira u oye cosas que no están allí (excepto los amigos) imaginarios en niños más pequeños
- ❑ Culpa a otros por algo que hizo mal o por sus pensamientos
- ❑ *Habla sobre la muerte
- ❑ *Pierde la memoria frecuentemente
- ❑ Se está atrasando en el trabajo de la escuela (sus grados están bajando)

Problemas Físicos:

¿Le preocupa alguna de las siguientes señales físicas? ¿Han sido estas evaluadas?

- ❑ Se orina durante el día
- ❑ Se ensucia
- ❑ Se niega a comer
- ❑ Tiene dolores de cabeza
- ❑ Pérdida o aumento de peso excesivo
- ❑ Tiene problemas para dormir, pesadillas, sonambulismo, se despierta temprano
- ❑ Se vomita frecuentemente
- ❑ Tiene dolores de estómago frecuentemente
- ❑ No tiene energía

Otros:

¿Tiende este niño a tener accidentes? ¿Hay alguna situación que le esté causando a su familia tensión en particular? ¿Ha sido este niño o sus padres sujetos a la negligencia, o al abuso físico, sexual o emocional? Si, sí. ¿En que forma? ¿Cuando? ¿Tipo de tratamiento?, etc. *¿Corre el riesgo su niño de ser llevado a otro lugar fuera de casa por problemas de comportamiento?

Comentarios:

Firma/Titulo de su puesto:_____

C.16 Mental Health Interview Tool/Referral Form (Ages 10–12 Years)

Mental Health Parent Questionnaire

Ages 10 to 12 Years

Child's Name: _____

Birth Date: _____

Today's Date: _____

To the Parent: *If you will assist us by filling out this form, we can help you find your child's strengths and any problem areas, too. Your answers will help us to know if we need to talk with you and find out more about your child. Please check all items below that are true for your child. Some of the behaviors noted may be normal but if you are concerned please let us know.*

Feelings	Does your child (do you) show feelings that concern you or seem strange for their (your) age? ❑ Yes ❑ No	
	❑ Is restless ❑ Is sad or cries easily ❑ Is guilty ❑ Is irritable or angers easily	❑ Is sullen ❑ Is fearful ❑ Is bored

Behavior	Does your child (do you) often do things that seem strange for their (your) age? ❑ Yes ❑ No	
	❑ Has problems in school ❑ Threatens or harms other children or animals ❑ Lacks interest in things s/he used to enjoy ❑ Is involved in sexual activity ❑ Destroys possessions or other property ❑ Steals	❑ Refuses to talk ❑ Sets fires ❑ Is overactive ❑ Hurts himself or herself ❑ Has been in trouble with the police

Social Interaction	Do you have any concerns about how your child (you) get(s) along with family members? ❑ Yes ❑ No With other adults? ❑ Yes ❑ No With other children? ❑ Yes ❑ No	
	❑ Prefers to be alone ❑ Has a hard time making and keeping friends ❑ Is defiant, a disciplinary problem	❑ Picks on others a lot or often gets into fights (hitting, etc.) ❑ Argues too much ❑ Will not go to school

Thinking	Are any of these a problem for your child (you)? ❑ Yes ❑ No	
	❑ Is frequently confused (does not understand what is going on) ❑ Daydreams a lot ❑ Is distracted, doesn't pay attention ❑ Has very strange thoughts ❑ Schoolwork is slipping (grades going down)	❑ Does not trust others ❑ Sees or hears things that are not there ❑ Blames others for his/her misdeeds or thoughts ❑ Talks about death or suicide a lot ❑ Often cannot remember things

C.17 Mental Health Interview Tool/Referral Form (Ages 10–12 Years) (Spanish)

Instrumento para la Entrevista de la Salud Mental y
Formulario para Tratamiento con un Especialista
De 10 a 12 Años de Edad

Nombre del Niño:_____
Fecha de Nacimiento: _____
Fecha: _____

*Ambos, el niño y los padres podrán proveer información, y es importante incorporar al niño en la entrevista. En cada sección, se le hace una pregunta ejemplar a los padres. Obtenga, lo mejor que pueda, la percepción del niño sobre la respuesta de sus padres con una pregunta como "¿Estás de acuerdo con lo que dice tu mamá?" Sería conveniente dedicar tiempo para hablar solamente con el tutor del niño. Se debe entrevistar al niño solo cuando se hagan preguntas sobre el abuso sexual o físico y sobre el abuso de sustancias como las drogas y las bebidas alcohólicas. Marque las características que le preocupan. *La presencia de alguno de estos síntomas o comportamientos pueden indicar que el niño está pasando por una crisis, y se debe hacer un esfuerzo para asegurar que se le evalúe pronto.*

Sentimientos:

¿Tiene su niño (tienes) sentimientos que le (te) preocupupan o que parezcan extraños para su (tu) edad?

- ❑ Es inquieto
- ❑ Está triste o llora fácilmente
- ❑ Se siente culpable
- ❑ Se irrita o enoja fácilmente
- ❑ Es malhumorado
- ❑ Tien miedo o está ansioso
- ❑ Se aburre

Comportamiento:

¿Se (Te) comporta(s) de una manera que parecen extrañas para su (tu) edad?

- ❑ Problemas en la escuela
- ❑ Amenaza o lastima a otros niños o a animales
- ❑ No tiene interés en cosas que antes disfrutaba
- ❑ Participa en juegos sexuales con juguetes, animales, o con los demás
- ❑ *Destruye cosas personales o ajenas
- ❑ Roba
- ❑ Se niega a hablar
- ❑ *Enciende fuegos
- ❑ Es demasiado activo
- ❑ *Ha tenido problemas con la policía
- ❑ *Tiene un comportamiento de autodestrucción

Interacción Sociales:

¿Se preocupa(s) sobre cómo se (te) lleva(s) su niño con los miembros de la familia? ¿Con otros adultos? ¿O niños?

- ❑ Prefiere estar solo
- ❑ Se le dificulta hacer o tener amistades
- ❑ Es desafiante, un problema de disciplina
- ❑ Es agresivo
- ❑ Discute demasiado
- ❑ Se niega a ir a la escuela

Pensamientos:

¿Ha(s) notado si alguno de los siguientes es un problem para su niño (ti)?

- ❑ *Se confunde frecuentemente
- ❑ Sueña despierto demasiado
- ❑ Se distrae, no pone atención
- ❑ Es desconfiado
- ❑ *Mira u oye cosas que no están allí
- ❑ Culpa a otros por algo que hizo mal o por sus pensamientos
- ❑ *Habla sobre la muerte o el suicidio
- ❑ *Pierde la memoria frecuentemente
- ❑ *Tiene pensamientos raros
- ❑ Se está atrasando en el trabajo de la escuela (sus grados están bajando)

Problemas Físicos:

¿Le (te) preocupa alguna de las siguientes señales físicas? ¿Han sido estas evaluadas?

- ❑ No tiene energía
- ❑ Usa laxantes
- ❑ Se vomita frecuentemente
- ❑ Se niega a comer, come a escondidas
- ❑ Tiene dolores de estómago frecuentemente
- ❑ Tiene dolores de cabeza
- ❑ Tiene problemas para dormir, pesadillas, sonambulismo, se despierta temprano, se despierta seguido por la noche

Otros:

¿Es este niño (Eres) propenso a tener accidentes? ¿Hay alguna situación que le esté causando a su (tu) familia tensión en particular? ¿Ha sido este niño (Has sido tu) o sus padres sujetos a la negligencia, o al abuso físico, sexual o emocional? Si, sí, ¿Que tipo?, ¿Cuándo?, ¿Tipo de tratamiento?

- ❑ *¿Corre el riesgo su niño de ser llevado a otro lugar fuera de casa por problemas de comportamiento?
- ❑ ¿Ha sido este niño tratado por problemas de salud mental o por el abuso de sustancias como drogas y bebidas alcohólicas?

Preguntas Sobre el Abuso de Sustancias: _____ _____

(Tal vez quiera usar pruebas de detección como TACE, CAGE, MAST para obtener información sobre el abuso de sustancias como drogas y bebidas alcóholicas.)

- ❑ Ha sido identificado como un problema

Comentarios:

C.18 Mental Health Interview Tool/Referral Form (Ages 13–20 Years)

Mental Health Interview Tool/Referral Form

Child's Name: _____

Birth Date: _____

Ages 13 to 20

Date: _____

*You may begin with a joint interview or begin with separate interviews with the parent/caregiver and adolescent. It is preferable to interview the adolescent first. Circle items of concern. * The presence of any of these symptoms or behaviors may signal that the child is in crisis, and efforts should be made to secure prompt evaluation.*

Feelings:

Do you (does your teen) have feelings that concern you or seem out of the ordinary for (their) age?

- ❑ Restless
- ❑ Sad or cries easily
- ❑ Guilty
- ❑ Irritable or angers easily
- ❑ Sullen
- ❑ Fearful or anxious
- ❑ Bored

Behavior:

Do you (does your child) behave in ways that seems out of the ordinary for your (their) age?

- ❑ Problems at school or work
- ❑ * Threatens or harms other children or animals
- ❑ Lacks interest in things s/he used to enjoy
- ❑ Engages in sexual play with others, toys, animals
- ❑ * Destroys possessions or other property
- ❑ Steals
- ❑ Refuses to talk
- ❑ * Sets fires
- ❑ Overactive
- ❑ * Has been in trouble with the police
- ❑ * Self-destructive

Social Interaction:

Do you have concerns about how (you) your child gets along with family members, other adults, or peers?

- ❑ Prefers to be alone
- ❑ Difficulty making and keeping friends
- ❑ Defiant, a discipline problem
- ❑ Aggressive
- ❑ Argues excessively
- ❑ Refuses to go to school

Thinking:

Have you noticed any of the following to be a problem for you (your child)?

- ❑ * Frequently confused
- ❑ Daydreams excessively
- ❑ Distracted, doesn't pay attention
- ❑ Mistrustful
- ❑ * Sees or hears things that are not there
- ❑ Blames others for his/her misdeeds or thoughts
- ❑ * Talks about death or suicide
- ❑ * Frequent memory loss
- ❑ * Bizarre thoughts
- ❑ Schoolwork is slipping (grades going down)

Physical Problems:

Do you have any concerns about the following physical signs? Has this been evaluated?

- ❑ Lacks energy
- ❑ Uses laxatives
- ❑ Vomits frequently
- ❑ Food refusal, secretive eating
- ❑ Frequent stomachaches
- ❑ Headaches
- ❑ Excessive weight loss or gain
- ❑ Sleep problems, nightmares, sleep-walking, early waking, frequent night waking

Other:

Are you (is this child) accident-prone?
Are there any situations that are causing your family particular stress?
Have you (has this child) or your (his/her) parents been subject to neglect, physical, sexual or emotional abuse? If yes, what type, when, treatment, etc.

- ❑ * Are you (is this child) at risk for out-of-home placement because of behavior problems?
- ❑ Have you (has this child) been treated for mental health problems or substance abuse?

Substance Abuse Questions:

(May want to use screens such as the TACE, CAGE, MAST to obtain information concerning substance abuse.)

- ❑ Has been identified as a problem

Comments:

Signature/Title: _____

C.19 Mental Health Interview Tool/Referral Form (Ages 13–20 Years) (Spanish)

Instrumento para la Entrevista sobre la Salud Mental/
Formulario para Tratamiento con un Especialista
De 13 a 20 Años

Nombre del Adolescente:_____
Fecha de Nacimiento: _____
Fecha: _____

Para los Padres: *Usted puede empezar con una entrevista con ambos el tutor y el adolescente. Es preferible que entreviste al adolescente primero. Marque las características que le preocupen. * La presencia de alguno de estos síntomas o comportamientos puede indicar que el adolescente está pasando por una crisis, y se debe hacer un esfuerzo para asegurar que se le evalúe pronto.*

Sentimientos:

¿Tiene su adolescente sentimientos que le preocupan o que le parezcan extraños para su edad?

- ❑ Es inquieto
- ❑ Es triste o llora fácilmente
- ❑ Se siente culpable
- ❑ Se irrita o enoja fácilmente
- ❑ Es malhumorado
- ❑ Siente miedo o ansiedad
- ❑ Se aburre

Comportamiento:

¿Se comporta su adolescente de una manera que parece extraña para su edad?

- ❑ Tiene problemas en la escuela o en el trabajo
- ❑ *Amenaza o lastima a otros niños o a animales
- ❑ No le interesan las cosas que antes disfrutaba
- ❑ Participa en juegos sexuales con jugetes, animales, o con los demás
- ❑ *Destruye cosas personales o ajenas
- ❑ Roba
- ❑ Se niega a hablar
- ❑ *Provoca incendios
- ❑ Es demasiado activo
- ❑ *Ha tenido problemas con la policía
- ❑ *Tiene un comportamiento de autodestrucción

Interacciones Sociales:

¿Le preocupan cómo se lleva su adolescente con los miembros de la familia? ¿con otros adultos? ¿con su grupo social?

- ❑ Prefiere estar solo
- ❑ Se le dificulta hacer y mantener amistades
- ❑ Es desafiante, un problema de disciplina
- ❑ Es agresivo
- ❑ Discute demasiado
- ❑ Se niega a ir a la escuela

Pensamientos:

¿Ha notado si alguno de los siguientes es un problema para su adolescente?

- ❑ *Se confunde frecuentemente
- ❑ Sueña despierto demasiado
- ❑ Se distrae, no pone atención
- ❑ Es desconfiado
- ❑ *Mira u oye cosas que no están allí
- ❑ Culpa a otros por algo malo que hizo o por sus pensamientos
- ❑ *Habla sobre la muerte el suicidio
- ❑ *Frecuentemente pierde la memoria
- ❑ *Tiene pensamientos raros
- ❑ Se está atrasando en el trabajo de la escuela (sus grados están bajando)

Problemas Físicos:

¿Le preocupan algunas de las siguientes señales físicas? ¿Han sido evaluadas?

- ❑ No tiene energía
- ❑ Usa laxantes
- ❑ Se vomita frecuentemente
- ❑ Se niega a comer, come en secreto
- ❑ Tiene dolores de estómago frecuentemente
- ❑ Tiene dolores de cabeza
- ❑ Ha perdido o aumentado peso excesivamente
- ❑ Tiene problemas para dormir, pesadillas, sonambulismo, se despierta temprano, frecuentemente camina en la noche

Otros:

¿Tiende a tener accidentes? ¿Hay alguna situación que le esté causando a su familia cierta tensión? ¿Ha sido es adolescente o sus padres sujetos a la negligencia o al abuso físico, sexual o emocional? Si sí, ¿en qué forma? ¿cuándo? ¿tipo de tratamiento?, etc.

* ¿Corre el riesgo de ser llevado a otro lugar fuera de casa por problemas de comportamiento?

¿Ha sido tratado por problemas de la salud mental o por el abuso de sustancias como bebidas alcohólicas o drogas?

Preguntas sobre el abuso de sustancias: *(Tal vez quiera usar pruebas de detección como TACE, CAGE, MAST para obtener información sobre el uso de sustancias.)*

- ❑ El abuso de sustancias como bebidas alcohólicas y drogas ha sido identificado como un problema.

Comentarios:

Firma/Titulo de su puesto:_____

C.20 Mental Health Parent Questionnaire (Ages Birth–2 Years) (2 Pages)

Mental Health Parent Questionnaire

Ages Birth to 2 Years

Child's Name: _____
Birth Date: _____
Today's Date: _____

To the Parent: *If you will assist us by filling out this form, we can help you find your child's strengths and any problem areas, too. Your answers will help us to know if we need to talk with you and find out more about your child. Please check all items below that are true for your child. Some of the behaviors noted may be normal but if you are concerned please let us know.*

Feelings

Does your child show feelings that concern you or seem strange for their age? ❑ Yes ❑ No

Infants	1 to 2 Years	
❑ Fearful	❑ Is irritable	❑ Fearful
❑ Cries too much	❑ Is angry	❑ Cries too little
❑ Cries too little	❑ Is sad	❑ Cries too much
	❑ Is sullen	

Behavior

Does your child do things that concern you or seem strange for their age? ❑ Yes ❑ No

Infants	1 to 2 Years	
❑ Is overactive	❑ Is overactive	❑ Harms others
❑ Is listless (has little energy)	❑ Is listless (has little energy)	❑ Has temper tantrums often

Social Interaction

Do you have any concerns about how your child gets along with you? ❑ Yes ❑ No
With other family members or adults? ❑ Yes ❑ No
With brothers and sisters? ❑ Yes ❑ No

Infants	1 to 2 Years	
❑ Does not make eye contact or smile	❑ Does not make eye contact or smile	❑ Does not respond to you
❑ Stiffens and arches back		❑ Does not say any words yet
❑ Does not respond to you	❑ Clings to you too much	

Thinking

Do you think your child is as bright and thinks as clearly as others their age? ❑ Yes ❑ No

Infants	1 to 2 Years
❑ (>8 months) Does not point to or ask for things or try to make words	❑ Does not trust others
	❑ Has problems concentrating or paying attention

Physical Problems	Do you have any concerns about these things? ❑ Yes ❑ No If you think your child may have a health problem, has he/she seen a doctor or nurse about the problem? ❑ Yes ❑ No
	Infants to 2 Years ❑ Is low weight or has a lot of weight ❑ Vomits (throws up) often ❑ Has eating problems (poor appetite, eats non-foods) ❑ Has sleeping problems (wakes a lot at night) ❑ Has little energy

Other	Is anything causing your family stress right now? ❑ Yes ❑ No Has this child or his/her parents been subject to neglect, physical, sexual, or emotional abuse? If yes, what from? _____ When? _____ ❑ Yes ❑ No Treatment initiated? ❑ Yes ❑ No Did the mother of this child use drugs or alcohol during the pregnancy? ❑ Yes ❑ No

Comments: *(Please write anything else you want us to know about in this space.)*

Date: _____ Signature: _____

Relation to patient: _____

C.21 Mental Health Questionnaire (Ages Birth–2 Years) (2 Pages) (Spanish)

Cuestionario de la Salud Mental para los Padres

Nombre del Niño:_____
Fecha de Nacimiento: _____
Fecha: _____

De Recién Nacido a 2 Años de Edad

Para los Padres: *Si nos ayuda llenando este formulario, le podremos ayudar a encontrar las áreas fuertes y también cualquier área problémática que tenga su bebé. Sus respuestas nos ayudarán a saber si necesitamos hablar con usted y saber más sobre su bebé. Favor de marcar todas las características abajo que son ciertas para su bebé. Algunos de los comportamientos en las listas tal vez sean normales, pero si usted está preocupado, favor de informarnos*.

SENTIMIENTOS

¿Tiene su bebé sentimientos que le preocupan o tal vez parezcan extraños para su edad? ❑ Sí ❑ No

Bebés

- ❑ Siente miedo
- ❑ Llora mucho
- ❑ Llora muy poco

De 1 a 2 Años

- ❑ Es de mal carácter
- ❑ Es enojón
- ❑ Es triste
- ❑ Es malhumorado
- ❑ Siente miedo
- ❑ Llora muy poco
- ❑ Llora mucho

COMPORTAMIENTO

¿Hace su bebé cosas que le preocupan o que parezcan extrañas para su edad? ❑ Sí ❑ No

Bebés

- ❑ Es demasiado activo
- ❑ Es indiferente (tiene poca energía)

De 1 a 2 Años

- ❑ Es demasiado activo
- ❑ Es indiferente (tiene poca energía)
- ❑ Lastima a otros
- ❑ Hace berrinches frecuentemente

INTERACCIONES SOCIALES

¿Se preocupa sobre cómo se lleva su bebé con usted? ❑ Sí ❑ No
¿Con otros miembros de la familia o adultos? ❑ Sí ❑ No
¿Con sus hermanos o hermanas? ❑ Sí ❑ No

Bebés

- ❑ No ve a los ojos ni sonríe
- ❑ Se pone tieso y se dobla arqueando la espalda
- ❑ No le responde

De 1 a 2 Años

- ❑ No ve a los ojos ni sonríe
- ❑ La mayoría del tiempo no se le despega
- ❑ No le responde
- ❑ Todavía no dice ninguna palabra

PENSAMIENTOS

¿Piensa usted que su nino es tan inteligente y que piensa tan claramente como otros niños de su edad? ❑ Sí ❑ No

Bebés

- ❑ (>8 meses) No pide ni senala a las cosas o trata de decir palabras

De 1 a 2 Años

- ❑ No le tiene confianza a otros
- ❑ Tiene problemas para concentrarse y poner atención

PROBLEMAS FISICOS

¿Se preocupa usted sobre los siguientes problemas físicos? ❑ Sí ❑ No

Si usted piensa que su niño tiene un problema de salud, ¿Lo ha llevado a consultar con un médico o una enfermera debido a ese problema? ❑ Sí ❑ No

De recién nacidos a 2 Años

- ❑ Es de peso bajo o ha perdido mucho peso
- ❑ Se vomita frecuentemente
- ❑ Tiene problemas para comer (muy poco apetito, come alimentos que no son saludables)
- ❑ Tiene problemas para dormir (se despierta mucho durante la noche)
- ❑ Tiene muy poca energía

OTROS

¿Hay algo que le esté causando tensión a su familia ahora? ❑ Sí ❑ No

¿Ha estado este niño o sus padres sujetos a la negligencia o al abuso físicos, sexual o emocional? Si sí, ¿en qué forma?_____ ¿Cuándo?_____ ❑ Sí ❑ No

¿Empezó el tratamiento? ❑ Sí ❑ No

¿Usó drogas o tomó bebidas alcohólicas durante su embarazo la mamá de este niño? ❑ Sí ❑ No

Comentarios: *(Favor de escribir en este espacio cualquier comentario que quiera compartir con nosotros.)*

Fecha:_____ Firma:_____

Parentesco con el paciente:_____

C

C.22 Mental Health Parent Questionnaire (Ages 3–9 Years) (2 Pages)

Mental Health Parent Questionnaire

Ages 3 to 9 Years

Child's Name: _____

Birth Date: _____

Today's Date: _____

To the Parent: *If you will assist us by filling out this form, we can help you find your child's strengths and any problem areas, too. Your answers will help us to know if we need to talk with you and find out more about your child. Please check all items below that are true for your child. Some of the behaviors noted may be normal but if you are concerned please let us know.*

Feelings	Does your child show feelings that concern you or seem strange for their age? ❑ Yes ❑ No	
	❑ Is restless ❑ Is sad or cries easily ❑ Is overly guilty ❑ Lacks remorse	❑ Is irritable, angers or temper tantrums easily ❑ Is sullen ❑ Fearful

Behavior	Does your child do things that seem strange for their age? ❑ Yes ❑ No	
	❑ Has problems in school ❑ Harms other children or animals ❑ Lacks interest in things s/he used to enjoy ❑ Plays sexual games with others, toys, animals ❑ Destroys possessions or other property ❑ Steals	❑ Refuses to talk ❑ Sets fires ❑ Is over-active ❑ Hurts himself or herself ❑ Has been in trouble with the police

Social Interaction	Do you have any concerns about how your child gets along with you? ❑ Yes ❑ No With other family members or adults? ❑ Yes ❑ No With playmates? ❑ Yes ❑ No	
	❑ Withdraws and does not look into peoples' eyes ❑ Clings to you too much ❑ Has a hard time making and keeping friends ❑ Is defiant, has a disciplinary problem ❑ Severe or frequent tantrums	❑ Picks on others a lot or often gets into fights (hitting, etc.) ❑ Argues too much ❑ Will not go to school ❑ Prefers to be alone

Thinking	Are any of these a problem for your child? ❑ Yes ❑ No	
	❑ Is frequently confused (does not understand what is going on) ❑ Daydreams a lot ❑ Is distracted, doesn't pay attention ❑ Has very strange thoughts ❑ Schoolwork is slipping (grades going down)	❑ Does not trust others ❑ Sees or hears things that are not there ❑ Blames others for his/her misdeeds or thoughts ❑ Talks about death a lot ❑ Often cannot remember things

Physical Problems

Do you have any concerns about these things? ❑ Yes ❑ No

If you think your child may have a health problem, has he/she seen a doctor or nurse about the problem? ❑ Yes ❑ No

❑ Has daytime wetting	❑ Has sleeping problems, nightmares, sleep-walking, early waking
❑ Soils pants	❑ Vomits (throws up) often
❑ Will not eat	❑ Has stomach aches often
❑ Has headaches	❑ Lacks energy
❑ Has lost or gained a lot of weight	

Other

Is this child accident-prone? ❑ Yes ❑ No

Is anything causing your family stress right now? ❑ Yes ❑ No

Has this child or his/her parents been subject to neglect, physical, sexual, or emotional abuse? If yes, what from? _____ When? _____ ❑ Yes ❑ No

Treatment initiated? ❑ Yes ❑ No

Is this child at risk for out-of-home placement because of behavior problems? ❑ Yes ❑ No

Comments: *(Please write anything else you want us to know about in this space.)*

Date: _____ Signature: _____

Relation to patient: _____

C.23 Mental Health Parent Questionnaire (Ages 3–9 Years) (2 Pages) (Spanish)

Cuestionario de la Salud Mental para los Padres De 3 a 9 Años de Edad

Nombre del Niño:_____
Fecha de Nacimiento: _____
Fecha: _____

Para los Padres: *Si nos ayuda llenando este formulario, le podremos ayudar a encontrar las áreas fuertes y también cualquier área problématica que tenga su niño. Sus respuestas nos ayudarán a saber si necesitamos hablar con usted y saber más sobre su niño. Favor de marcar todas las características abajo que sean ciertas para su niño. Algunos de los comportamientos en las listas tal vez sean normales, pero si usted está preocupado, favor de informarnos*.

SENTIMIENTOS

¿Tiene su niño sentimientos que le preocupan o tal vez parezcan extraños para su edad? ❑ Sí ❑ No

- ❑ Es inquieto
- ❑ Es triste o llora fácilmente
- ❑ Se siente muy culpable
- ❑ No tiene remordimiento
- ❑ Es de mal carácter, enojón o hace berrinches temperamentales fácilmente
- ❑ Es malhumorado
- ❑ Siente miedo

COMPORTAMIENTO

¿Hace su niño cosas que le parezcan extrañas para su edad? ❑ Sí ❑ No

- ❑ Tiene problemas en la escuela
- ❑ Lastima a otros niños o a los animales
- ❑ No le interesan las cosas que antes le gustaban
- ❑ Juega juegos sexuales con otros niños, juguetes, o animales
- ❑ Destruye cosas personales u ajenas
- ❑ Roba
- ❑ Se niega a hablar
- ❑ Provoca incendios
- ❑ Es demasiado activo
- ❑ Se lastima
- ❑ Ha tenido problemas con la policía

INTERACCIONES SOCIALES

¿Se preocupa sobre cómo se lleva su niño con usted? ❑ Sí ❑ No
¿Con otros miembros de la familia o adultos? ❑ Sí ❑ No
¿Con sus compañeros de juego? ❑ Sí ❑ No

- ❑ Se aleja y no ve a nadie a los ojos
- ❑ La mayoría del tiempo no se le despega
- ❑ Se le dificulta hacer y mantener amistades
- ❑ Es desafiante, tiene un problema de disciplina
- ❑ Hace berrinches tempermentales fuertes o frecuentemente
- ❑ Siempre molesta a otros o frecuentemente se pelea (pegando, etc.)
- ❑ Discute mucho
- ❑ No quiere asistir a la escuela
- ❑ Prefiere estar solo

PENSAMIENTOS

¿Son algunas de estas características un problema para su niño? ❑ Sí ❑ No

- ❑ Se confunde frecuentemente (no entiende lo que está pasando)
- ❑ Sueña mucho despierto
- ❑ Se distrae, no pone atención
- ❑ Tiene pensamientos muy extraños
- ❑ Se está atrasando en el trabajo de la escuela (sus grados están bajando)
- ❑ No le tiene confianza a los demás
- ❑ Mira u oye cosas que no están allí
- ❑ Culpa a otros por algo que hizo mal o por sus pensamientos
- ❑ Habla mucho sobre la muerte
- ❑ Frecuentemente no se acuerda de cosas

PROBLEMAS FISICOS

¿Se preocupa usted sobre los siguientes problemas físicos? ❑ Sí ❑ No
Si usted piensa que su niño tiene un problema de salud, ¿Lo ha llevado a consultar con un médico o una enfermera debido a ese problema? ❑ Sí ❑ No

- ❑ Se orina durante el día
- ❑ Ensucia sus pantalones
- ❑ No quiere comer
- ❑ Tiene dolores de cabeza
- ❑ Ha perdido o aumentado mucho de peso
- ❑ Tiene problemas para dormir, pesadillas, se despierta temprano y sonámbulo
- ❑ Se vomita frecuentemente
- ❑ Tiene dolores de estómago frecuentemente
- ❑ No tiene energía

OTROS

¿Es propenso este niño a tener accidentes? ❑ Sí ❑ No
¿Hay algo que le está causando tensión a su familia ahora? ❑ Sí ❑ No
¿Ha estado este niño o sus padres sujetos a la negligencia o al abuso físico, sexual o emocional?
Si sí, ¿en qué forma?_____ ❑ Sí ❑ No

¿Cuándo? _____ ¿Empezó el tratamiento? ❑ Sí ❑ No

¿Corre el riesgo este niño de ser llevado a otro lugar fuera de su familia por problemas de comportamiento? ❑ Sí ❑ No

Comentario: *(Favor de escribir en este espacio cualquier comentario que quiera compartir con nosotros.)*

Fecha:_____ Firma:_____

Parentesco con el paciente:_____

C

C.24 Mental Health Parent Questionnaire (Ages 10–12 Years) (2 Pages)

Mental Health Parent Questionnaire

Ages 10 to 12 Years

Child's Name: _____

Birth Date: _____

Today's Date: _____

To the Parent: *If you will assist us by filling out this form, we can help you find your child's strengths and any problem areas, too. Your answers will help us to know if we need to talk with you and find out more about your child. Please check all items below that are true for your child. Some of the behaviors noted may be normal but if you are concerned please let us know.*

Feelings	Does your child (do you) show feelings that concern you or seem strange for their (your) age? ❑ Yes ❑ No	
	❑ Is restless ❑ Is sad or cries easily ❑ Is guilty ❑ Is irritable or angers easily	❑ Is sullen ❑ Is fearful ❑ Is bored

Behavior	Does your child (do you) often do things that seem strange for their (your) age? ❑ Yes ❑ No	
	❑ Has problems in school ❑ Threatens or harms other children or animals ❑ Lacks interest in things s/he used to enjoy ❑ Is involved in sexual activity ❑ Destroys possessions or other property ❑ Steals	❑ Refuses to talk ❑ Sets fires ❑ Is overactive ❑ Hurts himself or herself ❑ Has been in trouble with the police

Social Interaction	Do you have any concerns about how your child (you) get(s) along with family members? ❑ Yes ❑ No With other adults? ❑ Yes ❑ No With other children? ❑ Yes ❑ No	
	❑ Prefers to be alone ❑ Has a hard time making and keeping friends ❑ Is defiant, a disciplinary problem	❑ Picks on others a lot or often gets into fights (hitting, etc.) ❑ Argues too much ❑ Will not go to school

Thinking	Are any of these a problem for your child (you)? ❑ Yes ❑ No	
	❑ Is frequently confused (does not understand what is going on) ❑ Daydreams a lot ❑ Is distracted, doesn't pay attention ❑ Has very strange thoughts ❑ Schoolwork is slipping (grades going down)	❑ Does not trust others ❑ Sees or hears things that are not there ❑ Blames others for his/her misdeeds or thoughts ❑ Talks about death or suicide a lot ❑ Often cannot remember things

Physical Problems

Do you have any concerns about these things? ❑ Yes ❑ No

If you think your child (you) may have a health problem, has he/she (have you) seen a doctor or nurse about the problem? ❑ Yes ❑ No

❑ Lacks energy	❑ Has headaches
❑ Uses laxatives	❑ Has lost or gained a lot of weight
❑ Vomits (throws up) often	❑ Has sleeping problems, nightmares, sleep-walking, early waking, frequent night waking
❑ Won't eat in front of people, sneaks food later	
❑ Has stomach aches often	

Other

Is your child (you) accident-prone? ❑ Yes ❑ No

Is anything causing your family stress right now? ❑ Yes ❑ No

Has this child or his/her parents been subject to neglect, physical, sexual, or emotional abuse? If yes, what from? _____ When? _____ ❑ Yes ❑ No

Treatment initiated? ❑ Yes ❑ No

Is this child (are you) at risk for out-of-home placement because of behavior problems? ❑ Yes ❑ No

Does your child (do you) drink of use drugs (including street or over-the-counter)? ❑ Yes ❑ No

Has this child (have you) been treated for mental health problems or substance abuse? ❑ Yes ❑ No

Comments: *(Please write anything else you want us to know about in this space.)*

Date: _____ Signature: _____

Relation to patient: _____

C.25 Mental Health Parent Questionnaire (Ages 10–12 Years) (2 Pages) (Spanish)

Cuestionario de la Salud Mental para los Padres De 10 a 12 Años de Edad

Nombre del Niño:_____

Fecha de Nacimiento: _____

Fecha: _____

Para los Padres: *Si nos ayuda llenando este formulario, le podremos ayudar a encontrar las áreas fuertes y también cualquier área problématica que tenga su hijo. Sus respuestas nos ayudarán a saber si necesitamos hablar con usted y saber más sobre su niño. Favor de marcar todas las características abajo que son ciertas para su niño. Algunos de los comportamientos en las listas tal vez sean normales, pero si usted está preocupado, favor de informarnos*.

SENTIMIENTOS

¿Tiene su niño sentimientos que le preocupan o tal vez parezcan extraños para su edad? ❑ Sí ❑ No

- ❑ Es inquieto
- ❑ Es triste o llora fácilmente
- ❑ Se siente culpable
- ❑ Es de mal carácter o se enoja fácilmente
- ❑ Es malhumorado
- ❑ Siente miedo
- ❑ Se aburre

COMPORTAMIENTO

¿Hace su niño cosas que le parezcan extrañas para su edad? ❑ Sí ❑ No

- ❑ Tiene problemas en la escuela
- ❑ Amenaza o lastima a otros niños o a los animales
- ❑ No le interesan las cosas que antes le gustaban
- ❑ Participa en actividades sexuales
- ❑ Destruye cosas personales o ajenas
- ❑ Roba
- ❑ Se niega a hablar
- ❑ Provoca incendios
- ❑ Es demasiado activo
- ❑ Se lastima
- ❑ Ha tenido problemas con la policía

INTERACCIONES SOCIALES

¿Se preocupa sobre cómo se lleva su niño con usted? ❑ Sí ❑ No
¿Con otros adultos? ❑ Sí ❑ No
¿Con otros niños? ❑ Sí ❑ No

- ❑ Prefiere estar solo
- ❑ Se le dificulta hacer y mantener amistades
- ❑ Es desafiante, tiene un problema de disciplina
- ❑ Siempre molesta a otros o frecuentemente se pelea (pegando, etc.)
- ❑ Discute mucho
- ❑ No quiere asistir a la escuela

PENSAMIENTOS

¿Son algunas de estas características un problema para su niño? ❑ Sí ❑ No

- ❑ Se confunde frecuentemente (no entiende lo que está pasando)
- ❑ Sueña mucho despierto
- ❑ Se distrae, no pone atención
- ❑ Tiene pensamientos muy extraños
- ❑ Se está atrasando en el trabajo de la escuela (sus grados están bajando)
- ❑ No le tiene confianza a los demás
- ❑ Mira u oye cosas que no están allí
- ❑ Culpa a otros por algo que hizo mal o por sus pensamientos
- ❑ Habla mucho sobre la muerte o del suicidio
- ❑ Frecuentemente no se acuerda de cosas

PROBLEMAS FISICOS

¿Se preocupa usted sobre los siguientes problemas físicos? ❑ Sí ❑ No

Si piensa que su niño tiene un problema de salud, ¿ha ido a consultar con un médico o una enfermera debido a ese problema? ❑ Sí ❑ No

- ❑ La falta energía
- ❑ Usa laxantes
- ❑ Se vomita frecuentemente
- ❑ No come delante de la gente, come después a escondidas
- ❑ Tiene dolores de estómago frecuentemente
- ❑ Tiene dolores de cabeza
- ❑ Ha perdido o aumentado mucho peso
- ❑ Tiene problemas para dormir, pesadillas, sonambulismo, despierta temprano, despierta seguido por la noche

OTROS

¿Es propenso a tener accidentes su niño? ❑ Sí ❑ No

¿Hay algo que le está causando tensión a su familia ahora? ❑ Sí ❑ No

¿Ha sido este niño o sus padres sujetos a la negligencia o al abuso físico, sexual o emocional?

Si sí, ¿en qué forma?_____ ¿Cuándo? _____ ❑ Sí ❑ No

¿Empezó el tratamiento? ❑ Sí ❑ No

¿Corre este niño el riesgo de ser llevado a otro lugar fuera de su familia por problemas de comportamiento? ❑ Sí ❑ No

¿Toma bebidas alcohólicas o usa drogas su niño (incluyendo las de la calle y las que se venden sin receta)? ❑ Sí ❑ No

¿Ha recibido su niño tratamiento por problemas de la salud mental o por el abuso de sustancia como las drogas y bebidas alcohólicas? ❑ Sí ❑ No

Comentario: *(Favor de escribir en este espacio cualquier comentario que quiera compartir con nosotros.)*

C

Fecha:_____ Firma:_____

Parentesco con el paciente:_____

C.26 Mental Health Parent Questionnaire (Ages 13–20 Years) (2 Pages)

Mental Health Parent Questionnaire

Ages 13 to 20 Years

Teen's Name: _____

Birth Date: _____

Today's Date: _____

To the Teen or Parent: *If you will assist us by filling out this form, we can help you find your (your teen's) strengths and any problem areas, too. Your answers will help us to know if we need to talk with you (your teen) and find out more about you (your teen). Please check all items below that are true for you (your teen). Some of the behaviors noted may be normal but if you are concerned please let us know.*

Feelings	Do you (does your teen) show feelings that concern you or seem strange for your (their) age? ❑ Yes ❑ No	
	❑Restless ❑Sad or cry easily ❑Guilty ❑ Irritable or angered easily	❑ Sullen ❑ Fearful ❑ Bored

Behavior	Do you (does your teen) often do things that seem strange for your (their) age? ❑ Yes ❑ No	
	❑ Have problems in school or work ❑ Threaten or harm other children or animals ❑ Lack interest in things you used to enjoy ❑ Is involved in sexual activity ❑ Destroy possessions or other property ❑ Steal	❑ Refuse to talk ❑ Set fires ❑ Over-active ❑ Hurt yourself ❑ Have been in trouble with the police

Social Interaction	Do you have any concerns about how you (your teen) get(s) along with family members? ❑ Yes ❑ No With other adults? ❑ Yes ❑ No With peers? ❑ Yes ❑ No	
	❑ Prefer to be alone ❑ Have a hard time making and keeping friends ❑ Defiant, a disciplinary problem	❑ Pick on others a lot or often get into fights (hitting, etc.) ❑ Argue too much ❑ Will not go to school

Thinking	Are any of these a problem for you (your teen)? ❑ Yes ❑ No	
	❑ Frequently confused (does not understand what is going on) ❑ Daydream a lot ❑ Distracted, do not pay attention ❑ Have very strange thoughts ❑ Schoolwork is slipping (grades going down)	❑ Do not trust others ❑ See or hear things that are not there ❑ Blame others for your misdeeds or thoughts ❑ Talk about death or suicide a lot ❑ Often cannot remember things

Physical Problems

Do you have any concerns about these things? ❑ Yes ❑ No

If you think you (your teen) may have a health problem, have you (has he/she) seen a doctor or nurse about the problem? ❑ Yes ❑ No

❑ Lack energy	❑ Have headaches
❑ Use laxatives	❑ Have lost or gained a lot of weight
❑ Vomit (throw up) often	❑ Have sleeping problems, nightmares, sleep-walking, early waking, frequent night waking
❑ Won't eat in front of people, sneak food later	
❑ Have stomachaches often	

Other

Are you (is your teen) accident-prone? ❑ Yes ❑ No

Is anything causing your family stress right now? ❑ Yes ❑ No

Have you (has your teen) or your parents been subject to neglect, physical, sexual, or emotional abuse? If yes, what from? _____ When? _____ ❑ Yes ❑ No

Treatment initiated? ❑ Yes ❑ No

Are you (is this teen) at risk for out-of-home placement because of behavior problems? ❑ Yes ❑ No

Do you (does your child) drink of use drugs (including street or over-the-counter)? ❑ Yes ❑ No

Have you (has this teen) been treated for mental health problems or substance abuse? ❑ Yes ❑ No

Comments: *(Please write anything else you want us to know about in this space.)*

Date: _____ Signature: _____

Relation to patient: _____

C

C.27 Mental Health Parent Questionnaire (Ages 13–20 Years) (2 Pages) (Spanish)

Cuestionario de la Salud Mental para los Padres De 13 a 20 Años de Edad

Nombre del Adolescente:_____
Fecha de Nacimiento: _____
Fecha: _____

Para los Padres: *Si nos ayuda llenando este formulario, podremos ayudarle a encontrar las áreas fuertes que tenga su hijo y también cualquier área problemática. Sus respuestas nos ayudarán a saber si necesitamos hablar con su hijo y saber más sobre él. Favor de marcar todas las características abajo que son ciertas para su hijo. Algunos de los comportamientos en las listas tal vez sean normales, pero si usted está preocupado, favor de informarnos*.

SENTIMIENTOS

¿Tiene su hijo sentimientos que le preocupan o tal vez parezcan extraños para su edad? ❑ Sí ❑ No

- ❑ Es inquieto
- ❑ Es triste o llora fácilmente
- ❑ Se siente culpable
- ❑ Es irrita o enoja fácilmente
- ❑ Es malhumorado
- ❑ Siente miedo
- ❑ Se aburre

COMPORTAMIENTO

¿Hace su hijo cosas frecuentemente que le parezcan extrañas para su edad? ❑ Sí ❑ No

- ❑ Tiene problemas en la escuela o en el trabajo
- ❑ Amenaza o lastima a otros niños o a los animales
- ❑ No le interesan las cosas que antes le gustaban
- ❑ Está envuelto en actividades sexuales
- ❑ Destruye cosas personales u otras cosas ajenas
- ❑ Roba
- ❑ Se niega a hablar
- ❑ Provoca incendios
- ❑ Es demasiado activo
- ❑ Se lastima
- ❑ Ha tenido problemas con la policía

INTERACCIONES SOCIALES

¿Le preocupa cómo se lleva su hijo con los miembros de la familia? ❑ Sí ❑ No
¿Con otros adultos? ❑ Sí ❑ No
¿Con su grupo social? ❑ Sí ❑ No

- ❑ Prefiere estar solo
- ❑ Se le dificulta hacer y mantener amistades
- ❑ Es desafiante, tiene un problema de disciplina
- ❑ Molesta mucho a otros o frecuentemente se pelea (pegando, etc.)
- ❑ Discute mucho
- ❑ No quiere asistir a la escuela

PENSAMIENTOS

¿Son algunas de estas características un problema para su hijo? ❑ Sí ❑ No

- ❑ Se confunde frecuentemente (no entiende lo que está pasando)
- ❑ Sueña mucho despierto
- ❑ Se distrae, no pone atención
- ❑ Tiene pensamientos muy extraños
- ❑ Se está atrasando en el trabajo de la escuela (sus grados están bajando)
- ❑ No le tiene confianza a los demás
- ❑ Mira u oye cosas que no están allí
- ❑ Culpa a otros por algo que hizo mal o por sus pensamientos
- ❑ Habla mucho sobre la muerte o el suicidio
- ❑ Frecuentemente no se acuerda de cosas

PROBLEMAS FISICOS	¿Se preocupa por estas cosas? ❑ Sí ❑ No Si piensa que su hijo tiene un problema de salud, ¿ha ido a consultar con un médico o una enfermera por este problema? ❑ Sí ❑ No	
	❑ No tiene energía	❑ Tiene dolores de cabeza
	❑ Usa laxantes	❑ Ha perdido o aumentado mucho peso
	❑ Se vomita frecuentemente	❑ Tiene problemas para dormir, pesadillas, se despierta temprano, sonámbulo y frecuentemente despierta durante la noche
	❑ No come delante de la gente, come después a esconidas	
	❑ Tiene dolores de estómago frecuentemente	
OTROS	¿Es su hijo propenso a tener accidentes? ❑ Sí ❑ No	
	¿Hay algo que le está causando tensión a su familia ahora? ❑ Sí ❑ No	
	¿Ha sido su hijo o sus padres sujetos a la negligencia o al abuso físico, sexual o emocional? ❑ Sí ❑ No Si sí, ¿en qué forma?_____ ¿Cuándo? _____	
	¿Empezó el tratamiento? ❑ Sí ❑ No	
	¿Corre el riesgo su hijo de ser llevado a otro lugar fuera de su familia por problemas de comportamiento? ❑ Sí ❑ No	
	¿Toma su hijo bebidas alcohólicas o drogas (incluyendo las de la calle y las que se venden sin receta)? ❑ Sí ❑ No	
	¿Ha recibido su hijo tratamiento por problemas de la salud mental o por el abuso de sustancias como drogas o bebidas alcohólicas? ❑ Sí ❑ No	

Comentario: *(Favor de escribir en este espacio cualquier comentario que quiera compartir con nosotros.)*

Fecha:_____ Firma:_____

Parentesco con el paciente:_____

C.28 Form Pb-110, Risk Assessment for Lead Exposure

TEXAS Department of State Health Services

Texas Childhood Lead Poisoning Prevention Program

Form Pb-110 Risk Assessment for Lead Exposure

NOTES to Healthcare Provider:

- **This risk assessment questionnaire replaces, and should be used in place of, the Abbreviated and the Detailed Parent Questionnaires. Questions appear on reverse.**
- **The risk assessment questionnaire is designed to be administered to the parent by the provider. Questions are provided in English along with Spanish versions to assist with Spanish speaking parents.**

Instructions:

- Medicaid requires a blood lead test at **12 months** and **24 months** for all Texas Health Steps patients. This questionnaire may be used with any child, whether or not enrolled in Texas Health Steps.
- At any visit, you may choose to perform a blood lead test rather than use the risk assessment questionnaire.
- At any visit after 12 months of age, you must administer a blood lead test if there is no evidence of a previous blood lead test for the patient.
- Refer to the table below for scheduling use of the risk assessment questionnaire.
- A "yes" or "don't know" answer to any question on the risk assessment questionnaire indicates that a blood lead test should be administered.

Schedule for Blood Lead Testing and Use of Risk Assessment Questionnaire

Child's Age	Parent Questionnaire	Blood Lead Test
6 months	YES	
12 months		YES
15 months	YES	
18 months	YES	
24 months		YES
3, 4, 5, and 6 years	YES	

TX CLPPP
Be a Healthy Texas Kid!

For more information, contact the Texas Childhood Lead Poisoning Prevention Program at:
1-800-588-1248
http://www.dshs.state.tx.us/lead

Fax completed form to 512-458-7699, or mail to the address below.

Texas Childhood Lead Poisoning Prevention Program
Epidemiology & Surveillance Unit • Texas Department of State Health Services
1100 West 49th St. • Austin, TX 78756-3199

Form Pb-110 Page 1 Rev. 07-06

Patient's Name:	DOB:	Medicaid #:
Provider's Name:	Administered by:	Date:

Parent Questionnaire

	Yes	Don't know	No
1 Does your child live in or often visit a home, daycare facility or other building			
–that was probably built before 1978?			
–with ongoing repairs or remodeling?			
2 Does your child eat or chew on non-food things like paint chips or dirt?			
3 Does your child have a family member or playmate who has or has had lead poisoning?			
4 Is your child frequently exposed to any of the following (if YES, check all that apply):			

Perform a Blood Lead Test

Contamination from a parent, relative, or friend with jobs or hobbies like these?

- ❑ Radiator repair
- ❑ Pottery making
- ❑ Lead smelting
- ❑ Welding
- ❑ Making fishing weights
- ❑ House construction or repair
- ❑ Battery manufacture or repair
- ❑ Burning lead-painted wood
- ❑ Automotive repair shop or junkyard
- ❑ Going to a firing range or reloading bullets
- ❑ Chemical preparation
- ❑ Valve and pipe fittings
- ❑ Brass/copper foundry
- ❑ Refinishing furniture
- ❑ Other:

Sources of lead in food and remedies?

- ❑ Imported or glazed pottery such as a Mexican bean pot
- ❑ Imported candy, (like Chaca Chaca) especially from Mexico
- ❑ Nutritional pills other than vitamins
- ❑ Other:
- ❑ Foods canned or packaged outside the U.S.
- ❑ Remedies such as greta, azarcón, alarcón, alkohl, bali goli, coral, ghasard, liga, pay-loo-ah, rueda

Cuestionario de Padre

	Sí	No lo se	No
1 ¿Vive su hijo(a) en o visita frecuentemente una casa, centro de guardería u otro edificio			
–que probablemente haya sido construida antes de 1978?			
–que está siendo pintada, remodelada, o en la que están pelando o lijando la pintura?			
2 ¿Su hijo(a) come o mastica cosas que no son comida, como pedazos de pintura o tierra?			
3 Han tenido parientes o compañeritos de juego de su hijo(a) altos niveles de plomo en la sangre?			
4 Ha sido expuesto frecuentemente su hijo(a) a cualquier de los siguientes (si SÍ, marque todos que apliquen):			

Le haga al niño una prueba de plomo en el sangre

Contaminación de un padre, pariente, o amigo con trabajos o pasatiempos como estas?

- ❑ Reparación de radiadores
- ❑ Fabricación de cerámica
- ❑ Industria del plomo
- ❑ Soldadura
- ❑ Fabricación de pesas para pescar
- ❑ Construción o reparación de casas
- ❑ Fabricación o reparación de baterías
- ❑ Quema de madera pintada con plomo
- ❑ Taller mecánico para autos o lote de chatarra
- ❑ Ir a un campo de tiro o recargar balas
- ❑ Preparación de químicos
- ❑ Partes sueltas para tubos de cañerías y válvulas
- ❑ Fundición de latón/cobre
- ❑ Terminado de muebles
- ❑ Otros:

Fuentes de plomo en comidas y remedios?

- ❑ Productos de cerámica importada o con recubrimiento de barniz, como una olla para frijoles de México
- ❑ Productos enlatados o empacados fuera de los Estados Unidos
- ❑ Dulces importados, (como Chaca Chaca) especialmente de México
- ❑ Remedios tradicionales como greta, azarcón, alarcón, alkohl, bali goli, coral, ghasard, liga, pay-loo-ah, rueda
- ❑ Píldoras alimenticias con excepción de las vitaminas
- ❑ Otros:

Fax completed form to 512-458-7699, or mail to the address below.

Texas Childhood Lead Poisoning Prevention Program
Epidemiology & Surveillance Unit • Texas Department of State Health Services
1100 West 49th St. • Austin, TX 78756-3199

C

C.29 San Antonio State Chest Hospital Cervical Cancer Cytology Laboratory

Women's Health Laboratories
2303 S.E. Military Dr., Bldg 533, Suite #1
San Antonio, TX 78223-3597
Phone (210) 531-4596 Toll-Free (888) 440-5002
FAX (210) 531-4506
CLIA: 45D0911298 / CAP: 2140102

TEXAS Department of State Health Services

Please Print Legibly

Patient Name Last	First	M.I.	Date of Birth

Street Address	City	State	Zip

Patient Phone	Patient ID	SSN

Sex: Female Male Race: W H B AI Asian Other:

Clinic Code	Clinic: FP MTY AH DYS THS STD CD TB	Ordering Clinician

Date Collected (time if applicable)	ICD9 #1	ICD9 #2	ICD9 #3	Attending Physician (if applicable)

Clinical Consultant Available

Patient Funding:
Title V Title X Title XX
THS BCCCP TB Elim
SDI STD/HIV Indigent
Medicaid Medicare IPP
Recipient Number:_____
Service Contract Bill Patient
Private Insurance. Please include copy of patient's insurance card, front and back.

CLINICAL HISTORY / NARRATIVE: _____

LMP:_____ High Risk Prev Abn Hormone Pregnant Post Partum PMP
Cryo Hysterectomy Prior Bx LEEP Laser Chemo IUD
Tuberculosis Diabetes Anemia Hypertension Hx of STD Tubal Ligation Colposcopy

Surgical Pathology: Biopsy 88305 Leep 88307 **(please include colposcopy or exam form)** Leep at _____ Leep at _____
Cx Bx at _____ Cx Bx at _____ ECC EMB Other _____ Other _____

Cytology		**Chemistry**		**Chemistry (continued)**		**Reference**	
❑ Pap Smear *	88150	❑ Glucose,2 spec.	82950	❑ Calcium	82310	❑ CEA	82378
❑ Liquid Based Pap *	88142	❑ Glucose,3 spec.	82951	❑ Cholest, HDL	83718	❑ Hgb A1C	83036
❑ NonGyn Cytology *	88160	❑ Glucose,4 spec.	82951/82952	❑ Cholest, Tot.	82465	❑ PSA	84153
*** For all above please state Site(s):**		❑ Glucose,5 spec.	82951/82952 x2	❑ Creatinine	82565	❑ T3, Total	84480
❑ Cervix ❑ Endocervix		**Microbiology**		❑ Ferritin	82728	❑ T4, Free	84439
❑ Vagina		❑ Occult Blood, Stool	82270	❑ FSH	83001	❑ HSV I & II Ab serum	86695/86696
❑ Other:		❑ Urine Culture clean catch	87086	❑ Glu, Fasting	82947		
HPV Testing		❑ Bacteria Culture *	87070	❑ Glu, Random	82947	**Immunology**	
❑ HPV	87621	❑ Gram Stain *	87205	❑ Glu, 1hr	82947	❑ ANA	86255
❑ HPV reflex	87621	❑ Grp B Strep DNA probe *	87149	❑ Glu, 2hr pp	82947	❑ Hep A Ab, IgM	86709
STD Screen		❑ Acid Fast Smear *	87206	❑ HCG, Quant	84702	❑ Hep A Ab, Total	86708
❑ DNA probe CT/GC	87490/87590	❑ Acid Fast Culture *	87015/87116	❑ HCG, Qual	84703	❑ Hep Bs Ab	86706
❑ Amp DNA CT/GC	87491/87591	❑ KOH Exam *	87210/87220	❑ Iron, Total	83540	❑ Hep Bs Ag	87340
❑ HSV I&II Rpd Mtd*	87252/87274	❑ Fungal Culture *	87101/87102	❑ Iron, TIBC.	83550	❑ Hep Bc Ab	86704
*** For above please state Site:**		*** For all above please state Site:**		❑ LH	83002	❑ Hep C Ab	86803
				❑ Potassium	84132	❑ HIV, Oral	86701
Panels ***See back for Panels***		**Note:** If indicated, ID & Sensitivity will be performed with additional charges.		❑ Prolactin	84146	❑ HIV, Serum	86701
❑ Basic Metabolic Panel	80048	**Hematology**		❑ Sodium	84295	❑ WesternBlot (reflex)	86689
❑ Comprehensive Panel	80053	❑ CBC w/Auto Diff	85025	❑ T3, Uptake	84479	❑ RPR w/reflex IgG	86592
❑ Electrolyte Panel	80051	❑ CBC Manual Diff	85023	❑ Thyroxin (T4)	84436	❑ Rubella Ab	86762
❑ Acute Hepatitis Panel	80074	❑ Hemoglobin	85018	❑ Triglycerides	84478	❑ Rheumatoid Factor	86430
❑ Hepatic Function	80076	❑ Hematocrit	85014	❑ TSH	84443	❑ Mono Screen	86308
❑ Lipid Panel	80061	❑ Reticulocyte count	85044	❑ Uric Acid	84550	**Urinalysis**	
❑ High Risk Panel	custom	❑ Sickle cell screen	85660	**Transfusion Medicine**		❑ Urinalysis w/o Scope	81003
❑ OB Panel	80055	**Chemistry**		❑ ABO, Rh	86900/86901	❑ UA w/Scope & Culture If indicated	81000/87086
❑ OB Panel w/out CBC	custom	❑ Albumin	82040	❑ Antibody Screen	86850	❑ Urine Culture	87086
❑ Iron Panel	custom	❑ Alkaline Phos	84075	❑ Direct Coombs	86880		
❑ Triple Screen (attach MSAFP form)		❑ Amylase	82150	❑ Cord Blood		**FOR LAB USE ONLY:**	
❑ AFP Serum	82105	❑ ALT	84460	**TB Elimination Testing**		Red ___ Urine Cup ___	
❑ ßhCG Quantitative	84702	❑ AST	84450	❑ LFT – 4 Test	custom	GrayTop___ Gray UR ___	
❑ Free Estriol	82677	❑ Bilirubin, Direct	82248	❑ LFT – 6 Test	custom	Yellow ___ Yellow UR ___	
Drug Screen: ❑ 3test ❑ 7test		❑ Bilirubin, Total	82247	**Other Testing**		Purple ___ Cltr Swab ___	
❑ Glucose. Gest.2spec.	82947/82950	❑ BUN	84520	❑		Serum ___ Digene ___	
				❑		SST ___ SurePath ___	
				❑		Other ___ Amp ___	
				❑			

Clinic Name & Address:

WHL-Public500(M47) Revised: 06/04

Laboratory Protocols

CBC w/Auto Diff Reflex:

- Abnormal CBC: Manual Diff reported
- A CBC is abnormal when it meets the approved criteria. (Criteria available upon request.)

Urinalysis Reflex:

- Abnormal UA: microscopic and /or confirmatory testing performed when abnormal results are observed for protein, nitrite, leukocyte esterase and/or blood.

Urine Culture Reflex:

Abnormal UA with positive nitrite, leukocyte esterase, >5 WBC's or >2+ bacteria: Culture performed.

TSH Reflex:

- Abnormal TSH (<0.1 or >10.0 mIU/ml): Free T4 performed.

RPR:

- Positive Syphilis IgG AB, AB Index and RPR quantitative (titer).

Rheumatoid Factor Reflex:

- Positive RA Factor: titer performed.

HIV Reflex:

- Positive HIV: Western Blot performed.

Hepatitis B Surface Ag (HBsAg) Reflex:

- HbsAg borderline or positive samples will be confirmed by neutralization.

Hepatitis B Surface Ab (HbsAB):

- Positive: Semi-quantitative value reported for immune status.

Antibody Screen Reflex:

- Positive AB Screen: antibody identification will be performed.

Direct Coombs (DAT) Reflex:

- Positive DAT: IgG, C3 testing.

Cryptococci Reflex:

- Positive: Titer performed.

ANA Screen Reflex:

- Positive: anti-DNA testing performed (reference lab).

Panels

80048 Basic Metabolic Panel (BMP)
Calcium
CO2
Chloride
Creatinine
Glucose
Potassium
Sodium
Urea Nitrogen (BUN)

80053 Comprehensive Metabolic Panel (CMP)

Albumin	Calcium
Alk. Phosphatase	ALT (SGPT)
Bilirubin (total)	AST (SGOT)
CO2	Sodium
Chloride	Potassium
Creatinine	Total Protein
Glucose	Urea Nitrogen (BUN)

80051 Electrolyte Panel
Sodium
Potassium
Chloride
CO2
Anion Gap (Calculated)

80074 Acute Hepatitis Panel
Hepatitis A antibody, IgM
Hepatitis B core antibody, IgM
Hepatitis B Surface antigen
Hepatitis C antibody

80076 Hepatic Function Panel
Albumin
Bilirubin (total)
Bilirubin (direct)
Alk. Phosphatase
Total Protein
ALT (SGPT)
AST (SGOT)

80061 Lipid Panel
Cholesterol
HDL
Triglycerides

Custom High Risk Panel

Glucose	**82947**
Cholesterol	**82465**
Triglycerides	**84478**

80055 OB Panel
CBC w/diff
Hepatitis B surface antigen
Rubella antibody
RPR
Antibody Screen, RBC
ABO/Rh

Custom OB Panel without CBC
Hepatitis B surface antigen
Rubella antibody
RPR
Antibody Screen, RBC
ABO/Rh

Custom Iron Panel

Iron, Total	**83550**
TIBC	**83550**
Transferrin Sat.	
Ferritin	**82728**

80100 Urine Drug Screen Panel 3
Cocaine
THC
Opiates

80100 Urine Drug Screen Panel 7

Amphetamines	Methadone
Barbiturates	Opiates
Benzodiazepines	THC
Cocaine	

82947/82950 Glucose, Gest. 2 specimens
Glucose, Fasting BS
Glucose, 1hr

82950 Glucose, 2 specimens
Glucose, Fasting BS
Glucose, 2hr

82951 Glucose, 3 specimens
Glucose, Fasting BS
Glucose, 1hr
Glucose, 2hr

82951/82952 Glucose, 4 specimens
Glucose, Fasting BS
Glucose, 1hr
Glucose, 2hr
Glucose, 3hr

82951/82952 x2 Glucose, 5 specimens

Glucose, Fasting BS	
Glucose, 1hr	Glucose, 3hr
Glucose, 2hr	Glucose, 4hr

Triple Screen

AFP Serum	**82105**
hCG Quantitative	**84702**
Free Estriol	**82677**

Custom LFT 4 (TB Elimination)

ALT (SGPT)	**84460**
AST (SGOT)	**84450**
Bilirubin, Total	**82247**
Alk. Phosphatase	**84075**

Custom LFT 6 (TB Elimination)

ALT (SGPT)	**84460**
AST (SGOT)	**84450**
Bilirubin, Total	**82247**
Alk. Phosphatase	**84075**
BUN	**84520**
Creatinine	**82565**

Note: *Medicare does not pay for routine screening tests (except PAP smears and some occult blood tests, please see current Medicare guidelines for approved screening intervals). Medicare will only pay for tests that are medically necessary for the diagnosis or treatment of the patient. The ordering physician must obtain a signed Advance Beneficiary Notice, (ABN), prior to submitting specimen to the laboratory if it is believed that Medicare is likely to deny payment. Components of panels may be ordered individually and billed separately to ensure physicians have adequate choice when making decisions regarding which tests are medically necessary for an individual patient. Physicians shall provide ICD-9 codes for all tests or panels in the space provided. The Office of the Inspector General takes the position that a physician who orders medically unnecessary tests may be subject to civil penalties.*

Microbiology CPT codes for additional procedures (such as susceptibility testing, sero-typing, etc) will be billed in addition to primary culture codes when appropriate.

The M47 test requisition form is only a partial list of tests available. If a test you require is not listed on the requisition form please call 1-888-440-5002 for information.

C.30 Specimen Submission Form G-1B, Biochemistry, Instructions (2 Pages)

March 2006 Page 1 of 2

Biochemistry and Genetics

G-1B Specimen Submission Form's Instructions

For mailing and specimen packaging information, visit DSHS Laboratory Services Section's web page at http://www.dshs.state.tx.us/lab/.

The specimen submission form ***must*** accompany each specimen.
The patient's name listed on the specimen ***must*** match the patient's name listed on the form.
If the Date of Collection field is not completed, the specimen will be rejected.

Place Bar Code Label Here: Place the specimen bar code label that will be used to identify and track the specimen in the DSHS laboratory information management system. If you are performing remote entry, place specimen bar code label here.

Section 1. SUBMITTER INFORMATION

All submitter information is required.

Submitter/TPI number, Submitter name and Address: The submitter number is a unique number that the Texas Department of State Health Services (DSHS) Laboratory Services Section assigns to each of our submitters. For Texas Health Steps (THSteps) specimens, use the pre-assigned Texas Provider Identifier (TPI) number. To obtain a TPI number and THSteps enrollment, contact Texas Medicaid and Healthcare Partnership (TMHP) at 1-800-925-9126.

To request a DSHS Laboratory Services Section submitter number, a master form, or to change submitter information, please call (888) 963-7111 x7578 or (512) 458-7578, or fax (512) 458-7533.

NPI Number: Beginning May 23, 2007, all health care providers must use the National Provider Identifier (NPI) number and the TPI number or other submitter number will no longer be used. The NPI number is the new national standard identifier for health care providers adopted by the Centers for Medicare & Medicaid Services (CMS) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. To obtain an NPI number, contact the National Plan and Provider Enumeration System (NPPES) toll free at 1-(800) 465-3203 or via their web site at https://nppes.cms.hhs.gov/NPPES/Welcome.do.

Indicate the submitter's name, address, city, state, and zip code. Please print clearly, use a pre-printed label, or use a photocopy of a master form provided by the Laboratory Services Section.

Contact Information: Indicate the telephone number, name, and fax number of the person to contact at the submitting facility in case the laboratory needs additional information about the specimen.

Clinic Code: Please provide, if applicable. This is a code that the submitter furnishes to help them identify which satellite office submits a specimen and to help the submitter identify where the lab report belongs, if the submitter has a primary mailing address with satellite offices.

Section 2. PATIENT INFORMATION

Complete all patient information including last name, first name, middle initial, address, city, state, zip code, telephone number, country of origin, race, ethnicity, date of birth (DOB), age, sex, social security number (SSN), pregnant, date of collection, time of collection, collected by, medical record number, ICD diagnosis code, and previous DSHS lab specimen number.

NOTE: The patient's name listed on the specimen ***must*** match the patient's name listed on the form.

Information that is required to bill Medicare, Medicaid, or private insurance has been marked with double asterisks (**). These fields must be completed.

Date of birth (DOB) and Age: Please list both the date of birth and age of the patient. If date of birth is not available, give the age of the patient and tell us whether the age is in days, months, or years.

Pregnant: If patient is a female, please indicate if she is pregnant by marking either Yes, No, or Unknown. Pregnancy can affect some test results.

Date of collection/Time of collection: Indicate the date and time the specimen was collected from the patient and who collected the specimen. Do not give the date the specimen was sent to DSHS. If the Date of Collection field is not completed, the specimen will be rejected.

Medical record number: Provide the identification number for matching purposes.

ICD diagnosis code: Indicate the diagnosis code that would help in processing, identifying, and billing of this specimen.

Previous DSHS specimen lab number: If this patient has had a previous specimen submitted to the DSHS Laboratory, please provide the DSHS lab specimen number.

Section 3. SPECIMEN TYPE

Specimen type: Please indicate the type of specimen that you are submitting.

Section 4. CLINICAL CHEMISTRY

Test Requested: Check or specify the specific test(s) to be performed by the Laboratory Services Section.

Hyperlipidemia and Glucose: *The time and date the specimen is removed from FREEZER **must** be provided to determine specimen acceptability. Please circle FREEZER.*

RhoGAM (HDN) Screening: *The time and date the specimen is removed from the REFRIGERATOR **must** be provided if the specimen will not be received within 24 hours. Please circle REFRIGERATOR. **Do not freeze specimens for HDN testing**.*

Section 5. PHYSICIAN INFORMATION

Physician's name, UPIN, and NPI Number: Give the name of the physician and their unique physician ID number (UPIN) and NPI number, if applicable. Beginning May 23, 2007, the NPI number will replace the UPIN. This information is required to bill Medicare and insurance.

Section 6. PAYOR SOURCE

THE SUBMITTER WILL BE BILLED, if the required billing information is not provided**.**

Indicate the party that will receive the bill.

Medicaid or Medicare:
- Mark the appropriate box, write in the Medicaid or Medicare number, and
- Supply a copy of the Medicaid or Medicare card.

Private Insurance:
- Mark the appropriate box,
- Supply a copy of the front and back of the insurance card, and
- Complete all fields on the form that have an asterisk (*).

DSHS Program:
- If you are contracting and/or enrolled with a DSHS program to provide services that require laboratory testing, please indicate which program. For program descriptions, see the Laboratory Services Section's Manual of Reference Services located on the web site at http://www.dshs.state.tx.us/lab/.
- Do NOT check a DSHS program as a Payor Source if the patient has Medicaid or Medicare, except for THSteps.
- If there is no other Payor Source for the patient and the patient meets the program's eligibility criteria, check the appropriate DSHS program.
- For THSteps, check *both THSteps **and** Medicaid* as the Payor Source. Supply a copy of the Medicaid card.
- For Title V, check either Family Planning or MCH.
- For BID, EIP, and ELC programs, check the "Other" box and list the program's name in the space provided.

HMO / Managed care / Insurance company: Print the name, address, city, state, and zip code of the insurance company to be billed.

Responsible party: Print the name of the responsible party, the insurance ID number, insurance company's phone number, group name, and group number.

Signature and Date: Have the responsible party sign and date to authorize the release of their information, if DSHS is to bill their insurance or HMO.

Section 7. NEWBORN REFERENCE TESTING

Test Requested: Check or specify the specific test to be performed by the Laboratory Services Section.

Section 8. DNA STUDIES

Select the requested test. The genes analyzed are phenylalanine hydroxylase for phenylketonuria testing and β-Globin for hemoglobin testing.

For phenylketonuria tests, select either Full Mutation Analysis or Carrier Mutation Analysis.

- Select Full Mutation Analysis to identify any possible mutations.
- Select Carrier Mutation Analysis to test specifically for the mutations already identified in a family member. If submitting a specimen for carrier mutation analysis, please provide the following information on the back of the form: *full name of family member(s) who have been tested, their test results, their date of birth, and relationship to the patient*. In addition, *draw a pedigree* showing the relationship and clinical diagnosis of each family member participating in the study.

For all hemoglobin DNA studies, select the Hemoglobin DNA Study box and write the name of the requested test(s) on the line. Available tests include:

- Beta Globin 6 mutation panel (Hb S, Hb C, Hb E, Hb D, beta-thalassemias -29 & -88)
- Beta Globin 5 mutation panel (Hb S, Hb C, Hb E, beta-thalassemias -29 & -88)
- Hemoglobin S&C mutation test
- Hemoglobin E mutation test
- Hemoglobin D mutation test
- Beta thalassemia -29 and -88 mutation test
- Beta Globin sequencing (from -105 of cap site to IVS-1-60)
- Beta Globin sequencing (from -105 of cap site to IVS-1-60) added to other test

For specific test instructions and information about tube types, see the Laboratory Services Section Manual of Reference Services on our web site at http://www.dshs.state.tx.us/lab/.

C.31 Specimen Submission Form G-1B, Biochemistry

TEXAS Department of State Health Services

Specimen Acquisition: (512) 458-7598

G-1B Specimen Submission Form (MAR 2006) Rev 6
CLIA #45D0660644
Laboratory Services Section
1100 W. 49th Street, MC-1947
Austin, Texas 78756-3194
(888) 963-7111 x7318 or (512) 458-7318
http://www.dshs.state.tx.us/lab

Place Bar Code Label Here

Section 1. SUBMITTER INFORMATION – (REQUIRED)**

Submitter/TPI Number ** | Submitter Name **
NPI Number ** | Address **
City ** | State ** | Zip Code **
Phone ** | Contact
Fax | Clinic Code

Section 2. PATIENT INFORMATION -- (REQUIRED)**

NOTE: **Patient name** on specimen is **REQUIRED & MUST** match name on this form & Medicare/Medicaid card.

Last Name ** | First Name ** | MI
Address ** | Telephone Number
City ** | State ** | Zip Code ** | Country of Origin
Race: ☐ White ☐ Black or African American ☐ American Indian / Native Alaskan ☐ Asian ☐ Native Hawaiian / Pacific Islander ☐ Other
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown
DOB (mm/dd/yyyy) ** | Age | Sex | SSN ** | Pregnant? ☐ Yes ☐ No ☐ Unknown
Date of Collection ** **(REQUIRED)** | Time of Collection | Collected By
Medical Record Number | ICD Diagnosis Code ** | Previous DSHS Specimen Lab Number

Section 3. SPECIMEN TYPE

☐ Blood: Capillary ☐ Blood: Venous ☐ Serum
☐ Blood: Filter Paper ☐ Plasma ☐ Other:

Section 4. CLINICAL CHEMISTRY

NOTES: ▲= For cholesterol, lipid profile, & glucose testing document **time & date** specimens were **removed from FREEZER / REFRIGERATOR** in the lower right-hand box.

♠ = Tests covered by THSteps or Title V Well-Child Health Programs.

Please see the form's instructions for details on how to complete this form. Details of test and specimen requirements can be found in the Laboratory Services Section's Manual of Reference Services. Visit our web site at http://www.dshs.state.tx.us/lab/.

Hyperlipidemia ▲ ♠
☐ **Fasting** (1)
☐ **Non-fasting** (2) (Total cholesterol, HDL)

☐ **Total Hemoglobin ♠**
☐ **Hemoglobin electrophoresis ♠**
☐ **Lead testing ♠**

☐ **HDN Screening (Rhogam) ▲**
(Includes ABO, Rh, & Antibody screen testing)
Do NOT Freeze.

Has patient received $Rh_o(D)$ Immunoglobulin within the past 6 mo.?
☐ Yes ☐ No

If yes, date: _____
Weeks gestation: _____

Reflex testing (AB type & titer) will be performed on positive antibody screens.

Diabetes ▲ ♠
☐ **Random** (1)
☐ **Fasting** (2)
☐ **2 Hr. Post prandial** (3)

Glucose tolerance ▲ ♠
☐ **Fasting** (4) ☐ **2 Hr.** (7)
☐ **1 Hr.** (6) ☐ **3 Hr.** (8)

__ __.__ **hrs.** Time since last meal

☐ **Syphilis (RPR) ♠**
☐ **Total cholesterol ▲ ♠**
☐ **Lipid profile ▲ ♠**

Section 5. PHYSICIAN INFORMATION -- (REQUIRED)**

Physician's Name **
Physician's UPIN ** | **Physician's NPI Number **

Section 6. PAYOR SOURCE -- (REQUIRED)

Indicate whether we should bill the submitter, Medicaid, Medicare, private insurance, or DSHS Program. If Medicaid or Medicare is indicated, the Medicaid/Medicare number is required and the copy of the card must be attached. If private insurance or DSHS Program is indicated, the required billing information below is designated with an asterisk (*). If required information is not provided, **THE SUBMITTER WILL BE BILLED.**

☐ Submitter ☐ Private Insurance
☐ Medicaid ☐ Medicare

Medicaid/Medicare #: _____
(attach copy of card)

DSHS Programs:
☐ THSteps ☐ Title V – Family Planning
☐ NBS Case Mgmt. ☐ Title V – MCH
☐ Refugee ☐ Title X – Family Planning
☐ TX CLPPP ☐ Title XX – Family Planning
☐ ☐ Other: _____

HMO / Managed Care / Insurance Company Name *
Address *
City * | State * | Zip Code *
Responsible Party *
Insurance Phone Number * | Responsible Party's Insurance ID Number *
Group Name * | Group Number *

"I hereby authorize the release of information related to the services described here and hereby assign any benefits to which I am entitled to the Texas Department of State Health Services, Laboratory Services Section." Signature of patient or responsible party.

Signature * Date *

Section 7. NEWBORN REFERENCE TESTING

☐ **Phenylalanine**

Section 8. DNA ANALYSIS +++ Preauthorization required +++

Phenylketonuria:
☐ **Full Mutation Analysis**
☐ **Carrier Mutation Analysis**

Hemoglobin DNA Test: _____

Clinical diagnosis: _____

▲ REQUIRED for cold shipments
REMOVAL from FREEZER / REFRIGERATOR

DATE	**TIME**

FOR LABORATORY USE ONLY

Specimen Received: ☐ Room Temp. ☐ Cold ☐ Frozen

C.32 Specimen Submission Form G-1B, Biochemistry, Spanish Instructions (3 Pages)

Bioquímica y genética

Instrucciones del formulario de remisión de muestras G-1B

Para obtener información sobre envíos por correo y el embalaje de las muestras, visite la página web de la Sección de Servicios de Laboratorio del DSHS en http://www.dshs.state.tx.us/lab/.

Debe acompañar cada muestra con un formulario de remisión de muestras.
El nombre del paciente de la muestra ***debe*** ser el mismo que el nombre del paciente del formulario.
Si no rellena el campo Fecha de obtención, se rechazará la muestra.

Coloque la etiqueta de código de barra aquí: coloque la etiqueta de código de barra de la muestra a ser usada para identificar y ubicar la muestra en el sistema de administración de datos del laboratorio del DSHS. Si está ingresando remotamente, coloque la etiqueta de código de barra de la muestra aquí.

Sección 1. DATOS DEL REMITENTE

Se requieren todos los datos del remitente.

Número de remitente y de TP y nombre y dirección del remitente: el número de remitente es un número único que la Sección de Servicios de Laboratorio del Departamento Estatal de Servicios de Salud de Texas (Texas Department of State Health Services [DSHS]) asigna a cada uno de nuestros remitentes. Para muestras de Pasos Sanos de Texas (Texas Health Steps [THSteps]), utilice el número Identificador de proveedor de Texas (Texas Provider Identifier [TPI]) preasignado. Para obtener un número de TPI e inscribirse en Pasos Sanos de Texas, llame a la Asociación de Medicaid y Salud de Texas (Texas and Healthcare Partnership [TMHP]) al 1-800-925-9126.

Para solicitar un número de remitente a la Sección de Servicios de Laboratorio del DSHS, el formulario original o para cambiar los datos del remitente, sírvase llamar al (888) 963-7111, extensión 7578, o al (512) 458-7578 o mandar un fax al (512) 458-7533.

Núm. de NPI: a partir del 23 de mayo de 2007, todos los proveedores de salud deberán usar el número Identificador de proveedor nacional (National Provider Identifier [NPI]) y ya no se usará el número de TPI u otro número de remitente. El número NPI es el nuevo identificador nacional oficial para proveedores de salud adoptado por los Centros de Servicios de Medicaid y Medicare (Centers for Medicare & Medicaid Services [CMS]) de conformidad con la Ley de Transferibilidad y Responsabilidad de Seguros Médicos (Health Insurance Portability and Accountability Act [HIPAA]) de 1996. Para obtener un número de NPI, llame al Sistema Nacional de Enumeración de Planes y Proveedores (National Plan and Provider Enumeration System [NPPES]) gratis al (800) 465-3203 o visite su sitio web en https://nppes.cms.hhs.gov/NPPES/Welcome.do.

Indique el nombre, dirección, ciudad, estado y código postal del remitente. Escriba claramente en letra de molde, utilice una etiqueta preimpresa o utilice una fotocopia del formulario original provisto por la Sección de Servicios de Laboratorio.

Datos de contacto: indique el número telefónico, nombre y número de fax de la persona a contactar en el centro remitente en caso de que el laboratorio necesite información adicional sobre la muestra.

Código de la clínica: sírvase proporcionarlo, de ser aplicable. Se trata de un código que el remitente provee para ayudar a identificar cuál oficina satélite remite una muestra y para ayudar al remitente a identificar adónde pertenece el informe de laboratorio, si el remitente tuviese una dirección de correo postal primaria con oficinas satélite.

Sección 2. DATOS DEL PACIENTE

Rellene todos los datos del paciente incluido el apellido, el nombre, la inicial del segundo nombre, la dirección, ciudad, estado, código postal, número telefónico, país de origen, raza, etnia, fecha de nacimiento, edad, sexo, número de Seguro Social, si es mujer si está embarazada, fecha de obtención, hora de obtención, quién la obtuvo, número de expediente médico, código diagnóstico de ICD y número previo del laboratorio de muestras del DSHS.

NOTA: el nombre del paciente de la muestra ***debe*** ser el mismo que el nombre del paciente del formulario.

La información requerida para facturar a Medicare, Medicaid o un seguro privado ha sido señalada con doble asterisco (**). Se deben rellenar esos campos.

Fecha de nacimiento y edad: indique tanto la fecha de nacimiento como la edad del paciente. Si la fecha de nacimiento no está disponible, proporcione la edad del paciente y díganos si la edad es en días, meses o años.

Si es mujer y está embarazada: si el paciente es mujer, sírvase indicar si está embarazada marcando ya sea "Sí", "No" o "Se desconoce". El embarazo puede afectar algunos resultados de pruebas.

Fecha de obtención/hora de obtención: indique la fecha y hora en que se obtuvo la muestra del paciente y quién obtuvo la muestra. No proporcione la fecha en que se envió la muestra al DSHS. Si no se rellena el campo Fecha de obtención, se rechazará la muestra.

Núm. de expediente médico: proporcione el número de identificación para propósitos de cotejo.

Código diagnóstico de ICD: indique el código diagnóstico que ayudaría a procesar, identificar y facturar la muestra.

Número previo del laboratorio de muestras del DSHS: si se ha remitido una muestra del paciente anteriormente al laboratorio del DSHS, sírvase proporcionar el número de muestra del laboratorio del DSHS.

Sección 3. TIPO DE MUESTRA

Tipo de muestra: sírvase indicar el tipo de muestra que remite.

Sección 4. QUÍMICA CLÍNICA

Prueba solicitada: marque o especifique la o las pruebas específicas a realizar la Sección de Servicios de Laboratorio.

Se realizarán pruebas secundarias (identificación (ID) de anticuerpos (Ab), tipo de antígenos (Ag) y titulación) a las pruebas de anticuerpos positivas.

Hiperlipemia y glucosa: *se **debe** proporcionar la fecha y hora de remoción de la muestra del CONGELADOR para determinar la aceptabilidad de la muestra. Sírvase encerrar en un círculo la palabra CONGELADOR.*

Prueba de enfermedad hemolítica perinatal (EHP) (RhoGAM): *se **debe** proporcionar la fecha y hora de remoción de la muestra del REFRIGERADOR si no se recibirá la muestra en 24 horas. Sírvase encerrar en un círculo la palabra REFRIGERADOR.* ***No congele las muestras para la prueba de HDN.***

Sección 5. DATOS DEL MÉDICO

Nombre y número de UPIN y NPI del médico: dé el nombre del médico y el número de identificación único del médico (Unique Physician ID Number [UPIN]) y el número NPI, de ser aplicable. A partir del 23 de mayo de 2007, el número NPI reemplazará al UPIN. Se requiere esta información para facturar a Medicare y al seguro.

Sección 6. PAGADOR

SE FACTURARÁ AL REMITENTE, si no se proporciona la información de facturación requerida**.**

Indique la parte que recibirá la factura.

Medicaid o Medicare:
- Marque la casilla correspondiente, escriba el número de Medicaid o Medicare y
- Provea una copia de la tarjeta de Medicaid o Medicare.

Seguro privado:
- Marque la casilla correspondiente,
- Provea una copia del frente y reverso de la tarjeta de seguro y
- Rellene todos los campos del formulario que tengan asterisco (*).

Programa del DSHS:
- Si está contratado o inscrito en un programa del DSHS para proporcionar servicios que requieran pruebas de laboratorio, sírvase indicar qué programa es. Encontrará las descripciones de los programas en el Manual de servicios de referencia de la Sección de Servicios de Laboratorio en el sitio web http://www.dshs.state.tx.us/lab/.
- NO marque un programa del DSHS como Pagador si el paciente cuenta con Medicaid o Medicare, a menos que sea Pasos Sanos de Texas.
- Si no existe otro Pagador del paciente y el paciente reúne los criterios de participación en el programa, marque el programa del DSHS correspondiente.
- Si es Pasos Sanos de Texas, marque tanto *Pasos Sanos de Texas **como** Medicaid* como pagadores. Proporcione una copia de la tarjeta de Medicaid.
- Si es el título V, marque ya sea Planificación familiar o MCH.
- Si son programas de BID, EIP y ELC, marque la casilla "Otro" e indique el nombre del programa en el espacio provisto.

HMO/Atención dirigida/aseguradora: ponga en letra de molde el nombre, dirección, ciudad, estado y código postal de la aseguradora a la que se facturará.

Parte responsable: ponga en letra de molde el nombre de la parte responsable, el número de identificación del seguro, el número telefónico de la aseguradora, el nombre del grupo y el número del grupo.

Firma y fecha: haga que la parte responsable firme y feche para autorizar la divulgación de los datos de la misma, si DSHS ha de facturar al seguro o HMO de ésta.

Sección 7. PRUEBAS DE REFERENCIA DE RECIÉN NACIDOS

Prueba solicitada: marque o especifique la prueba específica que ha de realizar la Sección de Servicios de Laboratorio.

Sección 8. ESTUDIOS DE ADN

Seleccione la prueba solicitada. Se analizan los genes de fenilalanina hidroxilasa en la prueba de fenilcetonuria y β-globina en pruebas de hemoglobina.

Para las pruebas de fenilcetonuria, seleccione ya sea el Análisis de mutación completa o Análisis de mutación de portador.

- Seleccione Análisis de mutación completa para identificar toda mutación posible.
- Seleccione Análisis de mutación de portador para la prueba específica de mutaciones ya identificadas en un familiar. Si remite una muestra para análisis de mutación de portador, sírvase proporcionar la siguiente información al reverso del formulario: *el nombre completo del o los familiares a quienes se ha hecho la prueba, los resultados*

de sus pruebas, su fecha de nacimiento y parentesco con el paciente. Además, *dibuje un árbol genealógico* que denote el parentesco y diagnóstico clínico de cada familiar que participe en el estudio.

Para todos los estudios de ADN de hemoglobina, seleccione la casilla Estudio de ADN de hemoglobina y escriba en la línea el nombre de la o las pruebas solicitadas. Los análisis disponibles incluyen:

- Panel de mutación de betaglobina 6 (Hb S, Hb C, Hb E, Hb D, betatalasemia 29 y 88)
- Panel de mutación de betaglobina 5 (Hb S, Hb C, Hb E, betatalasemia 29 y 88)
- Prueba de mutación de hemoglobina S y C
- Prueba de mutación de hemoglobina E
- Prueba de mutación de hemoglobina D
- Prueba de mutación de betatalasemia 29 y 88
- Secuenciación de betaglobina (del punto inicial 105 a IVS-1 posición 60)
- Secuenciación de betaglobina (del punto inicial 105 a IVS-1 posición 60) agregada a otra prueba

---

Puede encontrar instrucciones de pruebas e información específica sobre los tipos de probetas de ensayo en el Manual de servicios de referencia de la Sección de Servicios de Laboratorio en nuestro sitio web en http://www.dshs.state.tx.us/lab/.

C.33 Specimen Submission Form G-1B, Biochemistry (2 Pages) (Spanish)

TEXAS Department of State Health Services

Adquisición de muestras: (512) 458-7598

G-1B Formulario de remisión de muestras (MZO. 2006) Rev. 6

CLIA núm. 45D0660644

Laboratory Services Section
1100 W. 49th Street, MC-1947
Austin, Texas 78756-3194
(888) 963-7111, ext. 7318, o (512) 458-7318
http://www.dshs.state.tx.us/lab

Coloque la etiqueta de código de barra aquí

Sección 1. DATOS DEL REMITENTE – (REQUERIDO)**

Núm. de remitente/TPI **
Nombre del remitente **
Núm. de NPI **
Dirección **
Ciudad **
Estado **
Código Postal **
Núm. de teléfono **
Contacto
Fax
Código de la clínica

Sección 2. DATOS DEL PACIENTE -- (REQUERIDO)**

NOTA: se **REQUIERE** el **nombre del paciente** en la muestra **y** éste **DEBE** ser el mismo que el nombre del formulario y la tarjeta de Medicare/Medicaid.

Apellido **
Primer nombre **
Inicial del 2.º nombre
Dirección **
Núm. de teléfono
Ciudad **
Estado **
Código Postal **
País de origen

Raza: ☐ Blanca ☐ Negra o afroamericana ☐ Amerindia/nativa de Alaska ☐ Asiática ☐ Nativa de Hawai/isleña del Pacífico ☐ Otra

Etnia: ☐ Hispana ☐ No hispana ☐ Se desconoce

Fecha de nacimiento (mm/dd/aaaa) **
Edad
Sexo
Núm. de Seguro Social **
Si es mujer, ¿está embarazada? ☐ Sí ☐ No ☐ Se desconoce
Fecha de obtención ** **(REQUERIDA)**
Hora de obtención
Obtenida por
Núm. de expediente médico
Código diagnóstico de ICD **
Núm. previo de laboratorio de muestras del DSHS

Sección 3. TIPO DE MUESTRA

☐ Sangre: capilar ☐ Sangre: venosa ☐ Suero
☐ Sangre: papel filtrante ☐ Plasma ☐ Otro:

Sección 4. QUÍMICA CLÍNICA

NOTAS: ▲ = para pruebas de colesterol, perfil lípido y glucosa documente la **fecha y hora** en que las muestras se **retiraron del CONGELADOR/REFRIGERADOR** en la casilla inferior derecha.

♠ = pruebas cubiertas por Pasos Sanos de Texas o Programas de Niños Sanos del título V.

Consulte las instrucciones del formulario para conocer los detalles de cómo rellenarlo. Puede encontrar los detalles de los requisitos de pruebas y muestras en el Manual de servicios de referencia de la Sección de Servicios de Laboratorio. Visite nuestro sitio web en http://www.dshs.state.tx.us/lab/.

Hiperlipemia ▲ ♠
☐ **En ayunas** (1)
☐ **Sin ayunar** (2) (Colesterol total, HDL)

☐ **Hemoglobina total ♠**
☐ **Electroforesis de hemoglobina ♠**
☐ **Prueba de plomo ♠**

Diabetes ▲ ♠
☐ **Aleatoria** (1)
☐ **En ayunas** (2)
☐ **Posprandial de 2 horas** (3)

Tolerancia a la glucosa ▲ ♠
☐ **En ayunas** (4) ☐ **2 horas** (7)
☐ **1 hora** (6) ☐ **3 horas** (8)

Sección 5. DATOS DEL MÉDICO -- (REQUERIDO)**

Nombre del médico **
UPIN del médico **
Núm. NPI del médico **

Sección 6. PAGADOR -- (REQUERIDO)

Indique si debemos facturar al remitente, a Medicaid, a Medicare, al seguro privado o al programa del DSHS. Si indica Medicaid o Medicare, se requiere el número de Medicaid/Medicare y debe anexar la copia de la tarjeta. Si indica seguro privado o programa del DSHS, la siguiente información de facturación requerida se señala con un asterisco (*). Si no proporciona la información requerida, **SE FACTURARÁ AL REMITENTE.**

☐ Remitente ☐ Seguro privado
☐ Medicaid ☐ Medicare

Núm. de Medicaid/Medicare: (anexe la copia de la tarjeta)

Programas del DSHS:

☐ Pasos Sanos de Texas
☐ Gestión de casos de NBS
☐ Programa de Refugiados
☐ TX CLPPP
☐ Título V – Planificación familiar
☐ Título V – MCH
☐ Título X – Planificación familiar
☐ Título XX – Planificación familiar
☐ Otro: _____

Nombre de la HMO/Atención dirigida/aseguradora *
Dirección *
Ciudad *
Estado *
Código Postal *
Parte responsable *
Núm. tel. de aseguradora *
Núm. de id. de seguro de parte responsable *
Nombre del grupo *
Núm. del grupo *

"Por este conducto autorizo la divulgación de información relativa a los servicios aquí descritos y asimismo asigno toda prestación a la que tenga derecho a la Sección de Servicios de Laboratorio del Departamento Estatal de Servicios de Salud de Texas".
Firma del paciente o la parte responsable.

Firma *
Fecha *

Sección 7. PRUEBAS DE REFERENCIA DE RECIÉN NACIDOS

☐ **Fenilalanina**

Sección 8. ANÁLISIS DE ADN +++ Preautorización requerida +++

Fenilcetonuria:
☐ **Análisis de mutación completa**
☐ **Análisis de mutación de portador**

☐ **Prueba de enfermedad hemolítica perinatal (EHP) (Rhogam) ▲**
(Incluye prueba de ABO, Rh y anticuerpos)
NO se congele.

¿Recibió el paciente inmunoglobulina Rh_o(D) en los últimos 6 meses?

☐ Sí ☐ No

Si "sí", la fecha: _____

Semanas de gestación: _____

Se realizarán pruebas secundarias (tipo Ab y de titulación) a las pruebas de anticuerpos positivas.

__ __:__ **horas.** Tiempo desde el último alimento.

☐ **Sífilis (RPR) ♠**

☐ **Colesterol total ▲ ♠**

☐ **Perfil de lípidos ▲ ♠**

Prueba de ADN de hemoglobina: _____

Diagnóstico clínico: _____

▲ REQUERIDO para envíos fríos
REMOCIÓN del CONGELADOR/REFRIGERADOR

FECHA	HORA

FOR LABORATORY USE ONL

Specimen Received: ☐ Room Temp. ☐ Cold ☐ Frozen

C

C.34 Specimen Submission Form G-2A, Serology and Virology, Instructions (2 Pages)

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G-2A Specimen Submission Form's Instructions

For mailing and specimen packaging information, visit DSHS Laboratory Services Section's web page at http://www.dshs.state.tx.us/lab/.

The specimen submission form ***must*** accompany each specimen.
The patient's name listed on the specimen ***must*** match the patient's name listed on the form.
If the Date of Collection field is not completed, the specimen will be rejected.

Place Bar Code Label Here: Place the specimen bar code label that will be used to identify and track the specimen in the DSHS laboratory information management system. If you are performing remote entry, place specimen bar code label here.

Section 1. SUBMITTER INFORMATION

All submitter information is required.

Submitter/TPI number, Submitter name and Address: The submitter number is a unique number that the Texas Department of State Health Services (DSHS) Laboratory Services Section assigns to each of our submitters. For Texas Health Steps (THSteps) specimens, use the pre-assigned Texas Provider Identifier (TPI) number. To obtain a TPI number and THSteps enrollment, contact Texas Medicaid and Healthcare Partnership (TMHP) at 1-800-925-9126.

To request a DSHS Laboratory Services Section submitter number, a master form, or to change submitter information, please call (888) 963-7111 x7578 or (512) 458-7578, or fax (512) 458-7533.

NPI Number: Beginning May 23, 2007, all health care providers must use the National Provider Identifier (NPI) number and the TPI number or other submitter number will no longer be used. The NPI number is the new national standard identifier for health care providers adopted by the Centers for Medicare & Medicaid Services (CMS) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. To obtain an NPI number, contact the National Plan and Provider Enumeration System (NPPES) toll free at (800) 465-3203 or via their web site at https://nppes.cms.hhs.gov/NPPES/Welcome.do.

Indicate the submitter's name, address, city, state, and zip code. Please print clearly, use a pre-printed label, or use a photocopy of a master form provided by the Laboratory Services Section.

Contact Information: Indicate the telephone number, name, and fax number of the person to contact at the submitting facility in case the laboratory needs additional information about the specimen/isolate.

Clinic Code: Please provide, if applicable. This is a code that the submitter furnishes to help them identify which satellite office submits a specimen and to help the submitter identify where the lab report belongs, if the submitter has a primary mailing address with satellite offices.

Section 2. PATIENT INFORMATION

Complete all patient information including date of collection, time of collection, previous DSHS specimen lab number, last name, first name, middle initial, address, city, state, zip code, telephone number, date of birth (DOB), age, sex, social security number (SSN), pregnant, race, ethnicity, medical record number, ICD diagnosis code, country of origin, date of onset, diagnosis/symptoms, risk, and mark either inpatient/outpatient, outbreak association, and/or surveillance.

NOTE: The patient's name listed on the specimen ***must*** match the patient's name listed on the form.

Information that is required to bill Medicare, Medicaid, or private insurance has been marked with double asterisks (**). You may use a pre-printed patient label. *For anonymous HIV testing, indicate only the state, zip code, date of birth, and patient ID number.*

Patient Name: If patient is covered by Medicaid, Medicare, or Private Insurance, the name on the specimen form must match the name on the insurance card.

Date of birth (DOB) and Age: Please list both the date of birth and age of the patient. If date of birth is not available, give the age of the patient and tell us whether the age is in days, months, or years.

Pregnant: If patient is a female, please indicate is she is pregnant by marking either Yes, No, or Unknown. Pregnancy can affect some test results.

Date of Collection/Time of Collection: Indicate the date and time the specimen was collected from the patient or other source and who collected the specimen. Do not give the date the specimen was sent to DSHS. If the Date of Collection field is not completed, the specimen will be rejected.

Medical Record # / Alien # / CUI: Provide the identification number for matching purposes. For HIV screening, this number may be the eight-digit CDC number assigned to the patient. The CDC form sticker may be placed anywhere on the lower part of the form, as long as it does not obscure any tests ordered. CUI is the Clinic Unique Identifier number.

Previous DSHS Specimen Lab Number: If this patient has had a previous specimen submitted to the DSHS Laboratory, provide the DSHS specimen lab number.

ICD Diagnosis Code, Country of Origin, Date of Onset, Diagnosis/Symptoms, and Risk (if applicable): Indicate the diagnosis code or findings that would help in processing, identifying, and billing of this specimen/isolate. If the patient's country of origin is not the U.S., then please provide the patient's country of origin.

Inpatient or Outpatient (if applicable): Indicate if the patient is currently admitted to a hospital (required for TB patients).

Outbreak/Surveillance (if applicable): Tell us whether the specimen/isolate is part of an outbreak or cluster, or if the specimen is for routine surveillance. If the specimen is being submitted because of an outbreak, write in the associated name of the outbreak next to the outbreak box. If this form is being submitted for flu surveillance, the following patient information is required: Date of Onset, Date of Collection, Diagnosis/Symptoms, and Risk. Dates must be entered into the **Date of Onset** and **Date of Collection** boxes. In the **Diagnosis/Symptoms** box, list all the symptoms from the following list that apply: 1) malaise, 2) sore throat, 3) nasal congestion, 4) fever, 5) chills, 6) cough, 7) headache, 8) myalgia. In the **Risk** box, indicate whether the patient received the flu vaccine this season and the date given.

Section 3. SPECIMEN SOURCE OR TYPE

Specimen Source or Type: Indicate the kind of material you are submitting or the source of the specimen or isolate. Tests requiring Acute/Convalescent sera and dates are indicated with a '§' in the testing area of the form.

Section 4. PHYSICIAN INFORMATION

Physician's Name, UPIN, and NPI Number: Give the name of the physician and their unique physician ID number (UPIN) and NPI number, if applicable. Beginning May 23, 2007, the NPI number will replace the UPIN. This information is required to bill Medicare and insurance.

Section 5. PAYOR SOURCE

Indicate the party that will receive the bill.

THE SUBMITTER WILL BE BILLED, if the required billing information is not provided or multiple payor boxes are checked**.**

Checking Medicaid or Medicare:

- Mark the appropriate box.
- Write in the Medicaid or Medicare number.
- If the patient name on the form does not match the name on the card, the submitter will be billed.

Checking Private Insurance:

- Mark the appropriate box.
- Complete all fields on the form that have an asterisk (*).
- If the private insurance information is not provided on the specimen form, the submitter will be billed.

Checking a DSHS Program:

- If you are contracting and/or enrolled with a DSHS program to provide services that require laboratory testing, please indicate which program. For program descriptions, see the Laboratory Services Section's Manual of Reference Services located on the web site at http://www.dshs.state.tx.us/lab/.
- Do NOT check a DSHS program as a Payor Source if the patient has Medicaid or Medicare, except for THSteps.
- For THSteps, check THSteps as the Payor Source. Write the patient's Medicaid number in the appropriate field.
- For Title V, must check either Family Planning or MCH (Maternal & Child Health).
- If there is no other Payor Source for the patient and the patient meets the program's eligibility criteria, check the appropriate DSHS program.
- For anonymous HIV/STD testing, check the HIV/STD Program as Payor Source. The sections for HMO/Managed care/Insurance company name, Responsible Party, Signature, and Date information are not required.
- For BIDS (Border & Infectious Disease Surveillance), EIP (Emerging Infections Program), and ELC (Epidemiology & Laboratory Capacity) programs, check the "Other" box and list the program's name in the space provided.

HMO / Managed Care / Insurance Company: Print the name, address, city, state, and zip code of the insurance company to be billed. If all insurance information is not provided on the specimen form, the submitter will be billed.

Responsible Party: Print the name of the responsible party, the insurance ID number, insurance company's phone number, group name, and group number.

Signature and Date: Have the responsible party sign and date to authorize the release of their information, if DSHS is to bill their insurance or HMO.

TEST

Test Requested: Check or specify the specific test(s) to be performed by the DSHS Laboratory Services Section. Each test block requires a separate form AND a separate specimen. Examples of separate blocks are "Reference Serology/Immunology" or "Virology" or "HIV/HCV Screening". For specific test instructions, see the Laboratory Services Section Manual of Reference Services.

6. REFERENCE SEROLOGY/IMMUNOLOGY

If acute viral hepatitis is suspected based on the clinical symptoms and elevated serum amino transferase (ALT/AST), order Hepatitis Acute Panel which consists of 4 tests including Hepatitis B surface Ag (HBsAg), Hepatitis B core IgM (anti-HBc IgM), Hepatitis A IgM (anti-HAV), and Hepatitis C IgG (anti-HCV).

Fungal panel includes:

Histoplasma capsulatum (Mycelial phase)
Histoplasma capsulatum (Yeast phase)
Coccidioides immitis
Blastomyces dermatitidis

Aspergillosis testing includes:

Aspergillus flavus
Aspergillus fumigatus
Aspergillus niger
Aspergillus terreus

7. HIV/HCV SCREENING

Justification: Justification is required under 'Western blot only' for performing the requested test. Otherwise it will reflex to additional testing which will add to the final bill.

8. SYPHLIS SEROLOGY

Justification: Justification is required under 'RPR syphilis confirmation' for performing the requested test. Otherwise it will reflex to additional testing which will add to the final bill.

11. MOLECULAR STUDIES

PCR for: / PFGE for: Write the name of the organism requested for testing.

Other: Write any other special test request.

For special test requests, contact Molecular Biology at (888) 963-7111 x7735 or (512) 458-7735 prior to submitting specimens.

C

C.35 Specimen Submission Form G-2A, Serology and Virology

TEXAS Department of State Health Services

Specimen Acquisition: (512) 458-7598

G-2A Specimen Submission Form (MAR 2006) Rev 1
CLIA #45D0660644
Laboratory Services Section
1100 W. 49th Street, MC-1947
Austin, Texas 78756-3194
(888) 963-7111 x7318 or (512) 458-7318
http://www.dshs.state.tx.us/lab

Place Bar Code Label Here

Section 1. SUBMITTER INFORMATION – (** REQUIRED)

Submitter/TPI Number ** | Submitter Name **
NPI Number ** | Address **
City ** | State ** | Zip Code **
Phone ** | Contact
Fax | Clinic Code

Section 2. PATIENT INFORMATION -- (** REQUIRED)

NOTE: **Patient name** on specimen is **REQUIRED & MUST** match name on this form, Medicare/Medicaid card, & specimen container.

Last Name ** | First Name ** | MI
Address ** | Telephone Number
City ** | State ** | Zip Code ** | Country of Origin / Bi-National ID #

Race: ☐ White ☐ Black or African American ☐ American Indian / Native Alaskan ☐ Asian ☐ Native Hawaiian / Pacific Islander ☐ Other
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

DOB (mm/dd/yyyy) ** | Age | Sex | SSN ** | Pregnant? ☐ Yes ☐ No ☐ Unknown
Date of Collection ** **(REQUIRED)** | Time of Collection | Collected By
Medical Record # / Alien # / CUI | ICD Diagnosis Code ** | Previous DSHS Specimen Lab Number
Date of Onset | Diagnosis / Symptoms | Risk

☐ Inpatient ☐ Outpatient ☐ Outbreak association: ☐ Surveillance

Section 3. SPECIMEN SOURCE OR TYPE

- ☐ Abscess (site) _____
- ☐ Blood
- ☐ Blood: Filter paper
- ☐ Bone marrow
- ☐ Bronchial washings
- ☐ Cervical
- ☐ CSF
- ☐ Eye
- ☐ Feces/stool
- ☐ Gastric
- ☐ Lesion (site)_____
- ☐ Lymph node (site)_____
- ☐ Nasopharyngeal
- ☐ Oral fluid
- ☐ Plasma
- ☐ Rectal swab
- ☐ Serum:
  Acute date: ____/____/____
  Convl. date: ____/____/____
- ☐ Sputum: Induced
- ☐ Sputum: Natural
- ☐ Throat swab
- ☐ Tissue (site) _____
- ☐ Urethral
- ☐ Urine
- ☐ Vaginal
- ☐ Wound (site) _____
- ☐ Other:

Section 4. PHYSICIAN INFORMATION – (** REQUIRED)

Physician's Name **
Physician's UPIN ** | **Physician's NPI Number ****

Section 5. PAYOR SOURCE – (REQUIRED)

Indicate whether we should bill the submitter, Medicaid, Medicare, private insurance, or DSHS Program. If Medicaid or Medicare is indicated, the Medicaid/Medicare number is required. If private insurance or DSHS Program is indicated, the required billing information below is designated with an asterisk (*).
If required information is not provided,
THE SUBMITTER WILL BE BILLED.

☐ Submitter ☐ Private Insurance
☐ Medicaid ☐ Medicare

Medicaid/Medicare #: _____

DSHS Programs:

- ☐ THSteps
- ☐ BT Grant
- ☐ HIV / STD
- ☐ Immunizations
- ☐ IDEAS
- ☐ Refugee
- ☐ Title V – Family Planning
- ☐ Title V - MCH
- ☐ Title X – Family Planning
- ☐ Title XX – Family Planning
- ☐ Tuberculosis
- ☐ Zoonosis
- ☐ Other: _____

HMO / Managed Care / Insurance Company Name *
Address *
City * | State * | Zip Code *
Responsible Party *
Insurance Phone Number * | Responsible Party's Insurance ID Number *
Group Name * | Group Number *

"I hereby authorize the release of information related to the services described here and hereby assign any benefits to which I am entitled to the Texas Department of State Health Services, Laboratory Services Section."
Signature of patient or responsible party.

Signature * Date *

Section 6. REFERENCE SEROLOGY / IMMUNOLOGY

NOTES: **§** = Requires acute and convalescent specimens.
@ = Provide patient history on reverse side of form to avoid delay of specimen processing.
♣ = Reflex test(s) will be performed on positive results. Each test block (ex. Reference Serology / Immunology) requires a separate form and specimen.
♠ = Tests covered by THSteps or Title V Well-Child Health Programs **(Title V - MCH)**.
Please see the form's instructions for details on how to complete this form. Details of test and specimen requirements can be found in the Laboratory Services Section's Manual of Reference Services. Visit our web site at http://www.dshs.state.tx.us/lab/.

- ☐ Arbovirus (SLE / West Nile) @ ♣
- ☐ Aspergillosis Immunodiffusion
- ☐ Brucellosis § @
- ☐ Cat-scratch disease IgG § @
- ☐ Cytomegalovirus ☐ IgG § ☐ IgM
- ☐ Ehrlichia IgG §
- ☐ Fungal CF panel ♣
- ☐ Hantavirus IgG / IgM § @
- ☐ Acute Hepatitis Panel
- ☐ Hepatitis A (total Ab)
- ☐ Hepatitis A IgM
- ☐ Hepatitis B surface Ab
- ☐ Hepatitis B surface Ag
- ☐ Hepatitis B core (total Ab)
- ☐ Hepatitis B core IgM
- ☐ Hepatitis B eAg
- ☐ Hepatitis B eAb
- ☐ Hepatitis C IgG ♣
- ☐ Legionellosis IgG §
- ☐ Lyme disease IgG / IgM § @
- ☐ Mumps ☐ IgG § ☐ IgM @
- ☐ Plague § @
- ☐ Q fever IgG §
- ☐ Rickettsial panel (RMSF, typhus) §
- ☐ Rubella, Syphilis, Hep B sAg ♣ ♠
- ☐ Rubella, Syphilis, Hep B sAg, HIV ♣ ♠
- ☐ Rubella Screen (Title V – Family Planning) ♠
- ☐ Rubella ☐ IgG § ☐ IgM @
- ☐ Rubeola ☐ IgG § ☐ IgM @
- ☐ Toxoplasma ☐ IgG § ☐ IgM
- ☐ Tularemia § @
- ☐ Varicella Zoster IgG §
- ☐ Other: @

Section 7. HIV / HCV SCREENING

- ☐ HCV only
- ☐ HIV / HCV ♣
- ☐ HIV only ♣ ♠
- ☐ Western blot only
  Justification: _____

Section 8. SYPHILIS SEROLOGY

- ☐ RPR only – Test of cure
- ☐ RPR - Syphilis screen ♣
- ☐ VDRL (CSF only)
- ☐ RPR Syphilis confirmation
  Justification: _____

Section 9. CDC REFERENCE TESTS

- ☐ Chagas disease @
- ☐ Cystercercosis @
- ☐ Echinococcus @
- ☐ HIV-2 @
- ☐ HTLV-I @
- ☐ Leptospirosis @
- ☐ Toxocariasis @
- ☐ Other: @

Section 10. VIROLOGY

- ☐ Electron microscopy
- ☐ Influenza surveillance
  Vaccine received: ☐ Yes ☐ No
- ☐ Reference culture (Virus ID on isolate)
  Suspected: _____
  Submitted on: _____
- ☐ Virus isolation (comprehensive)
- ☐ Other:

Section 11. MOLECULAR STUDIES

- ☐ PCR for:
- ☐ PFGE for:
- ☐ Other:

FOR LABORATORY USE ONLY | Specimen Received: ☐ Room Temp. ☐ Cold ☐ Frozen

C.36 Specimen Submission Form G-2A, Serology and Virology (3 Pages) (Spanish Instructions)

Marzo de 2006 Página 1 de 3

Instrucciones del formulario de remisión de muestras G-2A

Para obtener información sobre envíos por correo y el embalaje de las muestras, visite la página web de la Sección de Servicios de Laboratorio del DSHS en http://www.dshs.state.tx.us/lab/.

Debe acompañar cada muestra con un formulario de remisión de muestras.
El nombre del paciente de la muestra ***debe*** ser el mismo que el nombre del paciente del formulario.
Si no rellena el campo Fecha de obtención, se rechazará la muestra.

Coloque la etiqueta de código de barra aquí: coloque la etiqueta de código de barra de la muestra a ser usada para identificar y ubicar la muestra en el sistema de administración de datos del laboratorio del DSHS. Si está ingresando remotamente, coloque la etiqueta de código de barra de la muestra aquí.

Sección 1. DATOS DEL REMITENTE

Se requieren todos los datos del remitente.

Número de remitente y de TPI, nombre y dirección del remitente: el número de remitente es un número único que la Sección de Servicios de Laboratorio del Departamento Estatal de Servicios de Salud de Texas (Texas Department of State Health Services [DSHS]) asigna a cada uno de nuestros remitentes. Para muestras de Pasos Sanos de Texas (Texas Health Steps [THSteps]), utilice el número Identificador de proveedor de Texas (Texas Provider Identifier [TPI]) preasignado. Para obtener un número de TPI e inscribirse en Pasos Sanos de Texas, llame a la Asociación de Medicaid y Salud de Texas (Texas and Healthcare Partnership [TMHP]) al 1-800-925-9126.

Para solicitar un número de remitente a la Sección de Servicios de Laboratorio del DSHS, el formulario original o para cambiar los datos del remitente, sírvase llamar al (888) 963-7111, extensión 7578, o al (512) 458-7578 o mandar un fax al (512) 458-7533.

Núm. de NPI: A partir del 23 de mayo de 2007, todos los proveedores de salud deben usar el número Identificador de proveedor nacional (National Provider Identifier [NPI]) y ya no se usará el número de TPI u otro número de remitente. El número NPI es el nuevo identificador nacional oficial para proveedores de salud adoptado por los Centros de Servicios de Medicaid y Medicare (Centers for Medicare & Medicaid Services [CMS]) de conformidad con la Ley de Transferibilidad y Responsabilidad de Seguros Médicos (Health Insurance Portability and Accountability Act [HIPAA]) de 1996. Para obtener un número de NPI, llame al Sistema Nacional de Enumeración de Planes y Proveedores (National Plan and Provider Enumeration System [NPPES]) gratis al (800) 465-3203 o visite su sitio web en https://nppes.cms.hhs.gov/NPPES/Welcome.do.

Indique el nombre, dirección, ciudad, estado y código postal del remitente. Escriba claramente en letra de molde, utilice una etiqueta preimpresa o utilice una fotocopia del formulario original proporcionado por la Sección de Servicios de Laboratorio.

Datos de contacto: indique el número de teléfono, nombre y número de fax de la persona a contactar en el centro remitente en caso de que el laboratorio necesite información adicional sobre la muestra o el aislamiento.

Código de la clínica: sírvase proporcionarlo, de ser aplicable. Se trata de un código que el remitente provee para ayudar a identificar cuál oficina satélite remite una muestra y para ayudar al remitente a identificar adónde pertenece el informe de laboratorio, si el remitente tuviese una dirección de correo postal primaria con oficinas satélite.

Sección 2. DATOS DEL PACIENTE

Rellene todos los datos del paciente incluida la fecha de obtención, la hora de obtención, el número previo del laboratorio de muestras del DSHS, el apellido, el nombre, la inicial del segundo nombre, la dirección, ciudad, estado, código postal, número telefónico, fecha de nacimiento, edad, sexo, número de Seguro Social, si es mujer si está embarazada, la raza, etnia, número de expediente médico, código diagnóstico de ICD, país de origen, fecha de aparición, diagnóstico/síntomas y riesgo y marque ya sea paciente interno/externo, asociación de brote o vigilancia.

NOTA: el nombre del paciente de la muestra *debe* ser el mismo que el nombre del paciente del formulario.

La información requerida para facturar a Medicare, Medicaid o un seguro privado ha sido señalada con doble asterisco (**). Puede utilizar una etiqueta de paciente preimpresa. *Para pruebas de VIH anónimas, indique solamente el estado, código postal, fecha de nacimiento y el número de identificación del paciente.*

Nombre del paciente: si al paciente lo cubre Medicaid, Medicare o un seguro privado, el nombre del formulario de muestras debe ser el mismo que el nombre en la tarjeta de seguro.

Fecha de nacimiento y edad: indique tanto la fecha de nacimiento como la edad del paciente. Si la fecha de nacimiento no está disponible, proporcione la edad del paciente y díganos si la edad es en días, meses o años.

Si es mujer y está embarazada: si el paciente es mujer, indique si está embarazada marcando ya sea Sí, No o Se desconoce. El embarazo puede afectar algunos resultados de pruebas.

Fecha de obtención/hora de obtención: indique la fecha y hora en que se obtuvo la muestra del paciente y quién obtuvo la muestra. No proporcione la fecha en que se remitió la muestra al DSHS. Si no se rellena el campo Fecha de obtención, se rechazará la muestra.

Núm. de expediente médico/núm. de extranjero/CUI: proporcione el número de identificación para propósitos de cotejo. Para pruebas de VIH, ese número puede ser el número de CDC de 8 dígitos asignado al paciente. Se puede colocar la etiqueta del formulario de CDC en cualquier lugar de la parte inferior del formulario, en tanto no oculte ninguna prueba solicitada. CUI (Clinic Unique Identifier) es el número único identificador de clínicas.

Número previo del laboratorio de muestras del DSHS: si se ha remitido una muestra del paciente anteriormente al laboratorio del DSHS, sírvase proporcionar el número del laboratorio de muestras del DSHS.

Código diagnóstico de ICD, país de origen, fecha de aparición, diagnóstico/síntomas y riesgo (de ser aplicable): indique el código diagnóstico o resultados que ayudarían a procesar, identificar y facturar la muestra o el aislamiento. Si el país de origen del paciente

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no es los Estados Unidos, sírvase proporcionar el país de origen del paciente.

Paciente interno o externo (de ser aplicable): indique si el paciente está hospitalizado actualmente (requerido para pacientes tuberculosos).

Brote/vigilancia (de ser aplicable): díganos si la muestra o aislamiento es parte de un brote o grupo y si la muestra es de vigilancia rutinaria. Si se remite la muestra debido a un brote, escriba el nombre asociado del brote al lado de la casilla de brote. Si se está remitiendo el formulario para vigilancia de gripe, se requiere la siguiente información del paciente: fecha de aparición, fecha de obtención, diagnóstico/síntomas y riesgo. Se deben ingresar fechas en las casillas **Fecha de aparición** y **Fecha de obtención**. En la casilla **Diagnóstico/síntomas**, liste todos los síntomas correspondientes de la siguiente lista: 1) malestar general, 2) dolor de garganta, 3) congestión nasal, 4) fiebre, 5) escalofríos, 6) tos, 7) dolor de cabeza, 8) mialgia. En la casilla **Riesgo**, indique si el paciente recibió la vacuna contra la gripe esta temporada y la fecha en que la recibió.

Sección 3. FUENTE O TIPO DE MUESTRA

Fuente o tipo de muestra: indique el tipo de material que remite o la fuente de la muestra o el aislamiento. Las pruebas que requieran suero agudo/convaleciente y fechas están señaladas con '§' en el área de pruebas del formulario.

Sección 4. DATOS DEL MÉDICO

Nombre y número de UPIN y NPI del médico: dé el nombre del médico y el número identificador único del médico (unique physician ID number [UPIN]) y el número NPI, de ser aplicable. A partir del 23 de mayo de 2007, el número NPI reemplazará al UPIN. Se requiere esa información para facturar a Medicare y al seguro.

Sección 5. PAGADOR

Indique la parte que recibirá la factura.

SE FACTURARÁ AL REMITENTE, si no se proporciona la información de facturación requerida o si se marcan múltiples casillas de pagador**.**

Marcación de Medicaid o Medicare:
- Marque la casilla correspondiente.
- Escriba el número de Medicaid o Medicare.
- Si el nombre del paciente del formulario no es el mismo que el nombre de la tarjeta, se facturará al remitente.

Marcación de seguro privado:
- Marque la casilla correspondiente.
- Rellene todos los campos del formulario que tengan asterisco (*).
- Si no proporciona los datos del seguro privado en el formulario de la muestra, se facturará al remitente.

Marcación de programa del DSHS:
- Si está contratado o inscrito en un programa del DSHS para proporcionar servicios que requieran pruebas de laboratorio, sírvase indicar qué programa es. Encontrará las descripciones de los programas en el Manual de servicios de referencia de la Sección de Servicios de Laboratorio en el sitio web http://www.dshs.state.tx.us/lab/.
- NO marque un programa del DSHS como Pagador si el paciente cuenta con Medicaid o Medicare, a menos que sea Pasos Sanos de Texas.
- Si es Pasos Sanos de Texas, marque Pasos Sanos de Texas como pagador. Escriba el número de Medicaid en el campo correspondiente.
- Para Título V, debe marcar ya sea Planificación familiar o MCH (Salud Materna e Infantil, Maternal & Child Health).
- Si no existe otro Pagador del paciente y el paciente reúne los criterios de participación del programa, marque el programa del DSHS correspondiente.
- Para pruebas anónimas de VIH/enfermedades venéreas, marque Programa de VIH/enfermedades venéreas como el pagador. No se requieren las secciones Nombre de la HMO/Atención dirigida/aseguradora, Parte responsable, Firma y Fecha.
- Para los programas BIDS (Vigilancia de Enfermedades Infecciosas y Fronterizas, Border & Infectious Disease Surveillance), EIP (Programa de Infecciones Emergentes, Emerging Infections Program) y ELC (Capacidad Epidemiológica y de Laboratorio, Epidemiology & Laboratory Capacity), marque la casilla "Otro" y liste el nombre del programa en el espacio provisto.

HMO/Atención dirigida/aseguradora: ponga en letra de molde el nombre, dirección, ciudad, estado y código postal de la aseguradora a la que se facturará. Si no proporciona todos los datos del seguro en el formulario de la muestra, se facturará al remitente.

Parte responsable: ponga en letra de molde el nombre de la parte responsable, el número de identificación del seguro, el número telefónico de la aseguradora, el nombre del grupo y el número del grupo.

Firma y fecha: haga que la parte responsable firme y feche para autorizar la divulgación de los datos de la misma, si DSHS ha de facturar al seguro o HMO de ésta.

PRUEBA

Prueba solicitada: marque o especifique la o las pruebas específicas que ha de realizar la Sección de Servicios de Laboratorio del DSHS. Cada sección de pruebas requiere un formulario Y una muestra por separado. "Serología/inmunología referencial" o "Virología" o "Prueba de VIH/VHC" serían ejemplos de secciones separadas. Puede consultar instrucciones de pruebas específicas en el Manual de servicios de referencia de la Sección de Servicios de Laboratorio.

6. SEROLOGÍA/INMUNOLOGÍA REFERENCIAL

Si se sospecha que se padece hepatitis viral aguda por los síntomas clínicos y la aminotransferencia de suero elevada (ALT/AST), solicite el Panel de hepatitis aguda que consiste de 4 pruebas incluida la Ag superficial de hepatitis B (HBsAg), IgM básico de hepatitis B (antiHBc IgM), Hepatitis A IgM (antiHAV) y Hepatitis C IgG (antiHCV).

El panel micótico incluye:
Histoplasma capsulatum (fase micelial)
Histoplasma capsulatum (fase levaduriforme)
Coccidioides immitis
Blastomyces dermatitidis

Las pruebas para aspergilosis incluyen:
Aspergillus flavus
Aspergillus fumigatus
Aspergillus niger
Aspergillus terreus

7. PRUEBA DE VIH/VHC

Justificación: se requiere justificación bajo 'Inmunotransferencia solamente' para realizar la prueba solicitada. De otra forma se harán pruebas adicionales, lo que aumentará la factura final.

8. SEROLOGÍA SIFILÍTICA

Justificación: se requiere justificación bajo 'Confirmación de sífilis RPR' para realizar la prueba solicitada. De otra forma se harán pruebas adicionales, lo que aumentará la factura final.

11. ESTUDIOS MOLECULARES

PCR para:/PFGE para: escriba el nombre del organismo solicitado para prueba.

Otro: escriba cualquier otra solicitud de prueba especial.

Para solicitudes de pruebas especiales, llame a Biología Molecular al (888) 963-7111, extensión 7735, o (512) 458-7735 antes de remitir las muestras.

C.37 Specimen Submission Form G-2A, Serology and Virology (2 Pages) (Spanish)

TEXAS Department of State Health Services

Adquisición de muestras: (512) 458-7598

G-2A Formulario de remisión de muestras (MZO. 2006) Rev. 1

CLIA núm.
45D0660644
Laboratory Services Section
1100 W. 49th Street, MC-1947
Austin, Texas 78756-3194
(888) 963-7111, ext. 7318, o (512) 458-7318
http://www.dshs.state.tx.us/lab

Coloque la etiqueta de código de barra aquí

Sección 1. DATOS DEL REMITENTE – (** REQUERIDO)

Núm. de remitente y de TPI **
Nombre del remitente **
Núm. de NPI **
Dirección **
Ciudad **
Estado **
Código Postal **
Núm. de teléfono **
Contacto
Fax
Código de la clínica

Sección 2. DATOS DEL PACIENTE -- (** REQUERIDO)

NOTA: se **REQUIERE** el n**ombre del paciente** en la muestra **y** éste **DEBE** ser el mismo que el nombre del formulario, la tarjeta de Medicare/Medicaid y el contenedor de la muestra.

Apellido **
Primer nombre **
Inicial del 2.° nombre
Dirección **
Núm. de teléfono
Ciudad **
Estado **
Código Postal **
País de origen/núm. de identificación binacional

Raza: ☐ Blanca ☐ Negra o afroamericana ☐ Amerindia/nativa de Alaska ☐ Asiática ☐ Nativa de Hawai/isleña del Pacífico ☐ Otra

Etnia: ☐ Hispana ☐ No hispana ☐ Se desconoce

Fecha de nacimiento (mm/dd/aaaa) **
Edad
Sexo
Núm. de Seguro Social **
Si es mujer, ¿está embarazada? ☐ Sí ☐ No ☐ Se desconoce

Fecha de obtención ** **(REQUERIDA)**
Hora de obtención
Obtenida por
Núm. de expediente médico/núm. de extranjero/CUI
Código diagnóstico de ICD **
Núm. previo de laboratorio de muestras del DSHS
Fecha de aparición
Diagnóstico/síntomas
Riesgo

☐ Paciente interno ☐ Paciente externo ☐ Asociación de brote: ☐ Vigilancia

Sección 3. FUENTE O TIPO DE MUESTRA

☐ Absceso (sitio) _____
☐ Sangre
☐ Sangre: Papel filtrante
☐ Médula ósea
☐ Lavados bronquiales
☐ Cervical
☐ Fluido cerebroespinal
☐ Ocular
☐ Heces/deposición
☐ Gástrica
☐ Lesión (sitio) _____
☐ Ganglio linfático (sitio) _____
☐ Nasofaríngeo
☐ Fluido oral
☐ Plasma
☐ Frotis rectal
☐ Suero:
Agudo (fecha): ____/_____/____
Convaleciente (fecha): ____/_____/____
☐ Esputo: inducido
☐ Esputo: natural
☐ Frotis de garganta
☐ Tejido (sitio) _____
☐ Uretral
☐ Orina
☐ Vaginal
☐ Herida (sitio) _____
☐ Otro:

Sección 4. DATOS DEL MÉDICO – (** REQUERIDO)

Nombre del médico **
UPIN del médico **
Núm. de NPI del médico **

Sección 5. PAGADOR – (REQUERIDO)

Indique si debemos facturar al remitente, a Medicaid, a Medicare, al seguro privado o al programa del DSHS. Si indica Medicaid o Medicare, se requiere el número de Medicaid/Medicare. Si indica seguro privado o programa del DSHS, la siguiente información de facturación requerida se señala con un asterisco (*).
Si no provee la información requerida,
SE FACTURARÁ AL REMITENTE.

☐ Remitente ☐ Seguro privado
☐ Medicaid ☐ Medicare

Núm. de Medicaid/Medicare: _____

Programas del DSHS:

☐ Pasos Sanos de Texas
☐ Subvención de BT
☐ VIH/enfermedades venéreas
☐ Inmunizaciones
☐ IDEAS
☐ Programa de Refugiados
☐ Título V – Planificación familiar
☐ Título V - MCH
☐ Título X – Planificación familiar
☐ Título XX – Planificación familiar
☐ Tuberculosis
☐ Zoonosis
☐ Otro: _____

Nombre de la HMO/Atención dirigida/aseguradora *
Dirección *
Ciudad *
Estado *
Código Postal *
Parte responsable *
Núm. telefónico de aseguradora *
Núm. de id. de seguro de parte responsable *
Nombre del grupo *
Núm. del grupo *

"Por este conducto autorizo la divulgación de información relativa a los servicios aquí descritos y asimismo asigno toda prestación a la que tenga derecho a la Sección de Servicios de Laboratorio del Departamento Estatal de Servicios de Salud de Texas".
Firma del paciente o la parte responsable.

Firma *
Fecha *

Sección 6. SEROLOGÍA/INMUNOLOGÍA REFERENCIAL

NOTAS: **§** = requiere muestras agudas y convalecientes.
@ = proporcione el historial del paciente al reverso del formulario para evitar que se retrase el procesamiento de la muestra.
♣ = se realizarán pruebas secundarias en las pruebas positivas. Cada sección de pruebas (p. ej. Serología/inmunología referencial) requiere un formulario y muestra por separado.
♠ = pruebas cubiertas por Pasos Sanos de Texas o Programas de Niños Sanos del título V **(Título V - MCH)**.
Consulte las instrucciones del formulario para conocer los detalles de cómo rellenarlo. Puede encontrar los detalles de los requisitos de pruebas y muestras en el Manual de servicios de referencia de la Sección de Servicios de Laboratorio. Visite nuestro sitio web en http://www.dshs.state.tx.us/lab/.

Sección 7. PRUEBA DE VIH/VHC

☐ VHC solamente
☐ VIH/VHC ♣
☐ VIH solamente ♣ ♠
☐ Inmunotransferencia solamente
Justificación: _____

Sección 8. SEROLOGÍA SIFILÍTICA

☐ RPR solamente – prueba de curación
☐ RPR - prueba de sífilis ♣
☐ VDRL (fluido cerebroespinal solamente)
☐ Confirmación de sífilis RPR
Justificación: _____

☐ Arbovirus (SLE/Nilo Occidental) @ ♣ ☐ Inmunodifusión Asper gillus ☐ Brucelosis § @ ☐ Linforeticulosis benigna IgG § @ ☐ Citomegalovirus ☐ IgG § ☐ IgM ☐ Erliquia IgG § ☐ Panel micótico CF ♣ ☐ Hantavirus IgG/IgM § @ ☐ Panel de hepatitis aguda ☐ Hepatitis A (Ab total) ☐ Hepatitis A IgM ☐ Ab superficial de hepatitis B ☐ Ag superficial de hepatitis B ☐ Hepatitis B básica (Ab total) ☐ IgM básico de hepatitis B ☐ Hepatitis B eAg ☐ Hepatitis B eAb	☐ Hepatitis C IgG ♣ ☐ Legionelosis IgG § ☐ Borreliosis IgG/IgM § @ ☐ Paperas ☐ IgG § ☐ IgM @ ☐ Peste § @ ☐ Fiebre Q IgG § ☐ Panel riquetsial (RMSF, tifus) § ☐ Rubeola, sífilis, hepatitis B sAg ♣ ♠ ☐ Rubeola, sífilis, hepatitis B sAg, VIH ♣ ♠ ☐ Prueba de rubeola (Título V – Planificación familiar) ♠ ☐ Rubeola ☐ IgG § ☐ IgM @ ☐ Rubeola ☐ IgG § ☐ IgM @ ☐ Toxoplasma ☐ IgG § ☐ IgM ☐ Tularemia § @ ☐ Varicela zoster IgG § ☐ Otro: @	**Sección 9. PRUEBAS REFERENCIALES DE CDC** ☐ Mal de Chagas @ ☐ Cisticercosis @ ☐ Equinococus @ ☐ VIH-2 @ ☐ HTLV-I @ ☐ Leptospirosis @ ☐ Toxocariasis @ ☐ Otro: @	**Sección 10. VIROLOGÍA** ☐ Microscopía electrónica ☐ Vigilancia de gripe Vacuna recibida: ☐ Sí ☐ No ☐ Cultivo referencial (Identificación de virus aislado) Sospecha: _____ Remitido el: _____ ☐ Aislamiento viral (exhaustivo) ☐ Otro:
		Sección 11. ESTUDIOS MOLECULARES ☐ PCR para: ☐ PFGE pa. ☐ Otro:	
FOR LABORATORY USE ONLY	Specimen Received: ☐ Room Temp. ☐ Cold ☐ Frozen		

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C.38 Specimen Submission Form G-2B, Bacteriology and Parasitology, Instructions (2 Pages)

March 2006 Page 1 of 2

G-2B Specimen Submission Form's Instructions

For mailing and specimen packaging information, visit DSHS Laboratory Services Section's web page at http://www.dshs.state.tx.us/lab/.

The specimen submission form ***must*** accompany each specimen.
The patient's name listed on the specimen ***must*** match the patient's name listed on the form.
If the Date of Collection field is not completed, the specimen will be rejected.

Place Bar Code Label Here: Place the specimen bar code label that will be used to identify and track the specimen in the DSHS laboratory information management system. If you are performing remote entry, place specimen bar code label here.

Section 1. SUBMITTER INFORMATION

All submitter information is required.

Submitter/TPI number, Submitter name and Address: The submitter number is a unique number that the Texas Department of State Health Services (DSHS) Laboratory Services Section assigns to each of our submitters. For Texas Health Steps (THSteps) specimens, use the pre-assigned Texas Provider Identifier (TPI) number. To obtain a TPI number and THSteps enrollment, contact Texas Medicaid and Healthcare Partnership (TMHP) at 1-800-925-9126.

To request a DSHS Laboratory Services Section submitter number, a master form, or to change submitter information, please call (888) 963-7111 x7578 or (512) 458-7578, or fax (512) 458-7533.

NPI Number: Beginning May 23, 2007, all health care providers must use the National Provider Identifier (NPI) number and the TPI number or other submitter number will no longer be used. The NPI number is the new national standard identifier for health care providers adopted by the Centers for Medicare & Medicaid Services (CMS) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. To obtain an NPI number, contact the National Plan and Provider Enumeration System (NPPES) toll free at (800) 465-3203 or via their web site at https://nppes.cms.hhs.gov/NPPES/Welcome.do.

Indicate the submitter's name, address, city, state, and zip code. Please print clearly, use a pre-printed label, or use a photocopy of a master form provided by the Laboratory Services Section.

Contact Information: Indicate the telephone number, name, and fax number of the person to contact at the submitting facility in case the laboratory needs additional information about the specimen/isolate.

Clinic Code: Please provide, if applicable. This is a code that the submitter furnishes to help them identify which satellite office submits a specimen and to help the submitter identify where the lab report belongs, if the submitter has a primary mailing address with satellite offices.

Section 2. PATIENT INFORMATION

Complete all patient information including date of collection, time of collection, previous DSHS specimen lab number, last name, first name, middle initial, address, city, state, zip code, telephone number, date of birth (DOB), age, sex, social security number (SSN), pregnant, race, ethnicity, medical record number, ICD diagnosis code, country of origin, date of onset, diagnosis/symptoms, risk, and mark either inpatient/outpatient, outbreak association, and/or surveillance.

NOTE: The patient's name listed on the specimen ***must*** match the patient's name listed on the form.

Information that is required to bill Medicare, Medicaid, or private insurance has been marked with double asterisks (**). You may use a pre-printed patient label.

Patient Name: If patient is covered by Medicaid, Medicare, or Private Insurance, the name on the specimen form must match the name on the insurance card.

Date of birth (DOB) and Age: Please list both the date of birth and age of the patient. If date of birth is not available, give the age of the patient and tell us whether the age is in days, months, or years.

Pregnant: If patient is a female, please indicate is she is pregnant by marking either Yes, No, or Unknown. Pregnancy can affect some test results.

Date of collection/Time of collection: Indicate the date and time the specimen was collected from the patient or other source and who collected the specimen. Do not give the date the specimen was sent to DSHS. If the Date of Collection field is not completed, the specimen will be rejected.

Medical Record # / Alien # / CUI: Provide the identification number for matching purposes. CUI is the Clinic Unique Identifier number.

Previous DSHS Specimen Lab Number: If this patient has had a previous specimen submitted to the DSHS Laboratory, provide the DSHS specimen lab number.

ICD Diagnosis Code, Country of Origin, Date of Onset, Diagnosis/Symptoms, and Risk (if applicable): Indicate the diagnosis code or findings that would help in processing, identifying, and billing of this specimen/isolate. If the patient's country of origin is not the U.S., then please provide the patient's country of origin.

Inpatient or Outpatient (if applicable): Indicate if the patient is currently admitted to a hospital (required for TB patients).

Outbreak/Surveillance (if applicable): Tell us whether the specimen/isolate is part of an outbreak or cluster, or if the specimen is for routine surveillance. If the specimen is being submitted because of an outbreak, write in the associated name of the outbreak next to the outbreak box.

Section 3. SPECIMEN SOURCE OR TYPE

Specimen Source or Type: Indicate the kind of material you are submitting or the source of the specimen or isolate. For mycobacteriology specimens, complete this section or the specimen will be rejected.

For tuberculosis treatment, a specimen source or type MUST be provided for specimens used for the diagnosis or monitoring of TB.

DO NOT leave this section blank. For specimens other than those listed, check the "Other" box and write in the site and source selected from the TB Elimination Division's list of Anatomic Sites and Corresponding Specimen Sources, which can be obtained from your local or regional health department.

Section 4. PHYSICIAN INFORMATION

Physician's name, UPIN, and NPI Number: Give the name of the physician and their unique physician ID number (UPIN) and NPI number, if applicable. Beginning May 23, 2007, the NPI number will replace the UPIN. This information is required to bill Medicare and insurance.

Section 5. PAYOR SOURCE

Indicate the party that will receive the bill.

THE SUBMITTER WILL BE BILLED, if the required billing information is not provided or multiple payor boxes are checked**.**

Checking Medicaid or Medicare:

- Mark the appropriate box.
- Write in the Medicaid or Medicare number.
- If the patient name on the form does not match the name on the card, the submitter will be billed.

Checking Private Insurance:

- Mark the appropriate box.
- Complete all fields on the form that have an asterisk (*).
- If the private insurance information is not provided on the specimen form, the submitter will be billed.

Checking a DSHS Program:

- If you are contracting and/or enrolled with a DSHS program to provide services that require laboratory testing, please indicate which program. For program descriptions, see the Laboratory Services Section's Manual of Reference Services located on the web site at http://www.dshs.state.tx.us/lab/.
- Do NOT check a DSHS program as a Payor Source if the patient has Medicaid or Medicare, except for THSteps.
- For THSteps, check THSteps as the Payor Source. Write the patient's Medicaid number in the appropriate field.
- For Title V, must check either Family Planning or MCH (Maternal & Child Health).
- If there is no other Payor Source for the patient and the patient meets the program's eligibility criteria, check the appropriate DSHS program.
- For BIDS (Border & Infectious Disease Surveillance), EIP (Emerging Infections Program), and ELC (Epidemiology & Laboratory Capacity) programs, check the "Other" box and list the program's name in the space provided.

HMO / Managed care / Insurance company: Print the name, address, city, state, and zip code of the insurance company to be billed. If all insurance information is not provided on the specimen form, the submitter will be billed.

Responsible party: Print the name of the responsible party, the insurance ID number, insurance company's phone number, group name, and group number.

Signature and Date: Have the responsible party sign and date to authorize the release of their information, if DSHS is to bill their insurance or HMO.

TEST

Test Requested: Check or specify the specific test(s) to be performed by the DSHS Laboratory Services Section. Each test block requires a separate form AND a separate specimen. Examples of separate blocks are "Bacteriology" or "Mycobacteriology/Mycology" or "Parasitology". For specific test instructions, see the Laboratory Services Section Manual of Reference Services.

6. BACTERIOLOGY

DNA Gen Probe for Gonorrhea (GC)/Chlamydia: Please follow the instructions listed below when submitting *Neisseria gonorrhoeae* and *Chlamydia trachomatis* specimens.

Under the "Bacteriology" section of the form:

1. Under "Clinical specimens:"
   a. Check the box marked "Gonorrhea/Chlamydia (genetic probe)", if submitting a sample in a GEN-PROBE specimen collection kit.
   b. Check the box marked "Gonorrhea culture", if the specimen is a clinical sample submitted on a transport media such as Remel Transgrow, Remel GC transport media, GemBec Plates, etc.
2. Under "Pure cultures:"
   a. If *Neisseria gonorrhoeae* is isolated and a pure culture is being submitted, please check the box "Aerobe ID only" under "Pure Cultures". Please either hand write in GC or *Neisseria gonorrhoeae* next to the "Aerobe ID: Organism suspected" or attach a copy of any lab work performed at your facility.

Toxin/Other: If requesting Clostridium toxin, please be aware that this test is performed on *Clostridium species, not C. perfringens*.

7. MOLECULAR STUDIES

PCR for: / PFGE for: Write the name of the organism requested for testing.

Other: Write any other special test request.

For special test requests, contact Molecular Biology at (888) 963-7111 x7735 or (512) 458-7735 prior to submitting specimens.

11. PARASITOLOGY

Other: If requesting ID on suspected *Naegleria fowleri*, *Acanthamoeba species*, *Pneumocystis carinii, Leishmania species, Toxoplasma gondii, Trypanosoma species,* or cultures for amebiasis, mark "Other" and write the name the organism suspected. Before submitting the specimen, please notify the Laboratory by calling: (888) 963-7111 x7560 or (512) 458-7560.

C.39 Specimen Submission Form G-2B, Bacteriology and Parasitology

TEXAS Department of State Health Services

Specimen Acquisition: (512) 458-7598

G-2B Specimen Submission Form (MAR 2006) Rev. 1
CLIA #45D0660644
Laboratory Services Section
1100 W. 49th Street, MC-1947
Austin, Texas 78756-3194
(888) 963-7111 x7318 or (512) 458-7318
http://www.dshs.state.tx.us/lab

Place Bar Code Label Here

Section 1. SUBMITTER INFORMATION – (** REQUIRED)

Submitter/TPI Number ** | Submitter Name **
NPI Number ** | Address
City ** | State ** | Zip Code **
Phone ** | Contact
Fax | Clinic Code

Section 2. PATIENT INFORMATION -- (** REQUIRED)

NOTE: **Patient name** on specimen is **REQUIRED & MUST** match name on this form, Medicare/Medicaid card, & specimen container.

Last Name ** | First Name ** | MI
Address ** | Telephone Number
City ** | State ** | Zip Code ** | Country of Origin / Bi-National ID #

Race: ☐ White ☐ Black or African American ☐ American Indian / Native Alaskan ☐ Asian ☐ Native Hawaiian / Pacific Islander ☐ Other
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

DOB (mm/dd/yyyy) ** | Age | Sex ** | SSN ** | Pregnant? ☐ Yes ☐ No ☐ Unknown
Date of Collection ** **(REQUIRED)** | Time of Collection | Collected By
Medical Record # / Alien # / CUI | ICD Diagnosis Code ** | Previous DSHS Specimen Lab Number
Date of Onset | Diagnosis / Symptoms | Risk

☐ Inpatient ☐ Outpatient ☐ Outbreak association: ☐ Surveillance

Section 3. SPECIMEN SOURCE OR TYPE -- (REQUIRED for Mycobacteriology specimens)

☐ Abscess (site) _____
☐ Blood
☐ Bone marrow
☐ Bronchial washings
☐ Cervical
☐ CSF
☐ Eye
☐ Feces/stool
☐ Gastric
☐ Lesion (site)_____
☐ Lymph node (site)_____
☐ Nasopharyngeal
☐ Plasma
☐ Rectal swab
☐ Serum
☐ Sputum: Induced
☐ Sputum: Natural
☐ Throat swab
☐ Tissue (site) _____
☐ Urethral
☐ Urine
☐ Vaginal
☐ Wound (site) _____
☐ Other:

Section 6. BACTERIOLOGY

NOTES: @ = Provide patient history on reverse side of form to avoid delay of specimen processing.
♠ = Tests covered by THSteps or Title V Well-Child Health Programs.
For pure culture ID and typing, please provide biochemical reactions on reverse side of form or attach copy of biochemistry printout. Each test block (ex. Bacteriology) requires a separate form and specimen. Please see the form's instructions for details on how to complete this form. Details of test and specimen requirements can be found in the Laboratory Services Section's Manual of Reference Services. Visit our web site at http://www.dshs.state.tx.us/lab/.

Clinical specimens:
☐ Aerobe isolation
☐ Amplified probe (for Gonorrhea/Chlamydia only)
☐ Anaerobe isolation
☐ Botulism @
☐ Diphtheria screen
☐ Enteric pathogens
☐ Gonorrhea/Chlamydia (genetic probe) ♠
☐ Gonorrhea culture
☐ Pertussis culture
☐ Strep screen (Group B only)
☐ Toxin / EHEC
☐ Toxin / Other: _____

Pure cultures:
☐ Aerobe ID only
Organism suspected: _____
☐ Anaerobe ID only
Organism suspected: _____
☐ Campylobacter ID only

Special studies:
☐ Toxin studies
☐ Other: _____

ID and typing:
☐ E. coli (EHEC confirmation)
☐ Haemophilus influenzae
☐ Neisseria meningitidis
☐ Salmonella
☐ Shigella
☐ Other:

Section 7. MOLECULAR STUDIES

☐ PCR for:
☐ PFGE for:
☐ Other:

Section 8. ENTOMOLOGY

☐ Insect ID
☐ Other:

Section 4. PHYSICIAN INFORMATION -- (** REQUIRED)

Physician's Name **
Physician's UPIN ** | **Physician's NPI Number ****

Section 5. PAYOR SOURCE – (REQUIRED)

Indicate whether we should bill the submitter, Medicaid, Medicare, private insurance, or DSHS Program. If Medicaid or Medicare is indicated, the Medicaid/Medicare number is required. If private insurance or DSHS Program is indicated, the required billing information below is designated with an asterisk (*).
If required information is not provided,
THE SUBMITTER WILL BE BILLED.

☐ Submitter ☐ Private Insurance
☐ Medicaid ☐ Medicare

Medicaid/Medicare #: _____

DSHS Programs:
☐ BT Grant ☐ Title V – Family Planning
☐ HIV / STD ☐ Title V – MCH
☐ Immunizations ☐ Title X – Family Planning
☐ IDEAS ☐ Title XX – Family Planning
☐ Refugee ☐ Tuberculosis
☐ THSteps ☐ Zoonosis
☐ Other: _____

HMO / Managed Care / Insurance Company Name *
Address *
City * | State * | Zip Code *
Insurance Phone Number * | Responsible Party's Insurance ID Number *
Group Name * | Group Number *

"I hereby authorize the release of information related to the services described here and hereby assign any benefits to which I am entitled to the Texas Department of State Health Services, Laboratory Services Section."
Signature of patient or responsible party.

Signature * Date *

Section 9. CHEMICAL TERRORISM (CT)

☐ CT Panel (blood and urine)
Justification: _____

Section 10. MYCOBACTERIOLOGY / MYCOLOGY

Clinical specimens:
☐ AFB smear & culture
☐ Direct HPLC only
Multi-drug Treatment Start Date: _____

Pure cultures:
☐ AFB ID
☐ Fungus ID
☐ MTB 1st drug panel
☐ MTB 2nd drug panel
☐ MTB PZA
☐ Other aerobic actinomycetes ID
☐ Other:

Section 11. PARASITOLOGY

☐ Blood/Tissue parasites @
☐ Intestinal parasites @
☐ Worm ID @
☐ Pin Worm Prep
☐ Fixative: _____
☐ Stain: _____
☐ Other:

FOR LABORATORY USE ONLY
☐ Room Temp. ☐ Cold ☐ Frozen

C.40 Specimen Submission Form G-2B, Bacteriology and Parasitology (3 Pages) (Spanish)

Marzo de 2006 Página 1 de 3

Instrucciones del formulario de remisión de muestras G-2B

Para obtener información sobre envíos por correo y el embalaje de las muestras, visite la página web de la Sección de Servicios de Laboratorio del DSHS en http://www.dshs.state.tx.us/lab/.

Debe acompañar cada muestra con un formulario de remisión de muestras.
El nombre del paciente de la muestra ***debe*** ser el mismo que el nombre del paciente del formulario.
Si no rellena el campo Fecha de obtención, se rechazará la muestra.

Coloque la etiqueta de código de barra aquí: coloque la etiqueta de código de barra de la muestra a ser usada para identificar y ubicar la muestra en el sistema de administración de datos del laboratorio del DSHS. Si está ingresando remotamente, coloque la etiqueta de código de barra de la muestra aquí.

Sección 1. DATOS DEL REMITENTE

Se requieren todos los datos del remitente.

Número de remitente y de TPI, nombre y dirección del remitente: el número de remitente es un número único que la Sección de Servicios de Laboratorio del Departamento Estatal de Servicios de Salud de Texas (Texas Department of State Health Services [DSHS]) asigna a cada uno de nuestros remitentes. Para muestras de Pasos Sanos de Texas (Texas Health Steps [THSteps]), utilice el número Identificador de proveedor de Texas (Texas Provider Identifier [TPI]) preasignado. Para obtener un número de TPI e inscribirse en Pasos Sanos de Texas, llame a la Asociación de Medicaid y Salud de Texas (Texas and Healthcare Partnership [TMHP]) al 1-800-925-9126.

Para solicitar un número de remitente a la Sección de Servicios de Laboratorio del DSHS, el formulario original o para cambiar los datos del remitente, sírvase llamar al (888) 963-7111, extensión 7578, o al (512) 458-7578 o mandar un fax al (512) 458-7533.

Núm. de NPI: a partir del 23 de mayo de 2007, todos los proveedores de salud deben usar el número Identificador de proveedor nacional (National Provider Identifier [NPI]) y ya no se usará el número de TPI u otro número de remitente. El número NPI es el nuevo identificador nacional oficial para proveedores de salud adoptado por los Centros de Servicios de Medicaid y Medicare (Centers for Medicare & Medicaid Services [CMS]) de conformidad con la Ley de Transferibilidad y Responsabilidad de Seguros Médicos (Health Insurance Portability and Accountability Act [HIPAA]) de 1996. Para obtener un número de NPI, llame al Sistema Nacional de Enumeración de Planes y Proveedores (National Plan and Provider Enumeration System [NPPES]) gratis al (800) 465-3203 o visite su sitio web en https://nppes.cms.hhs.gov/NPPES/Welcome.do.

Indique el nombre, dirección, ciudad, estado y código postal del remitente. Escriba claramente en letra de molde, utilice una etiqueta preimpresa o utilice una fotocopia del formulario original proporcionado por la Sección de Servicios de Laboratorio.

Datos de contacto: indique el número de teléfono, nombre y número de fax de la persona a contactar en el centro remitente en caso de que el laboratorio necesite información adicional sobre la muestra o el aislamiento.

Código de la clínica: sírvase proporcionarlo, de ser aplicable. Se trata de un código que el remitente provee para ayudar a identificar cuál oficina satélite remite una muestra y para ayudar al remitente a identificar adónde pertenece el informe de laboratorio, si el remitente tuviese una dirección de correo postal primaria con oficinas satélite.

Sección 2. DATOS DEL PACIENTE

Rellene todos los datos del paciente incluida la fecha de obtención, la hora de obtención, el número previo del laboratorio de muestras del DSHS, el apellido, el nombre, la inicial del segundo nombre, la dirección, ciudad, estado, código postal, número telefónico, fecha de nacimiento, edad, sexo, número de Seguro Social, si es mujer si está embarazada, la raza, etnia, número de expediente médico, código diagnóstico de ICD, país de origen, fecha de aparición, diagnóstico/síntomas y riesgo y marque ya sea paciente interno/externo, asociación de brote o vigilancia.

NOTA: el nombre del paciente de la muestra ***debe*** ser el mismo que el nombre del paciente del formulario.

La información requerida para facturar a Medicare, Medicaid o un seguro privado ha sido señalada con doble asterisco (**). Puede utilizar una etiqueta de paciente preimpresa.

Nombre del paciente: si al paciente lo cubre Medicaid, Medicare o un seguro privado, el nombre del formulario de muestras debe ser el mismo que el nombre de la tarjeta de seguro.

Fecha de nacimiento y edad: indique tanto la fecha de nacimiento como la edad del paciente. Si la fecha de nacimiento no está disponible, proporcione la edad del paciente y díganos si la edad es en días, meses o años.

Si es mujer y está embarazada: si el paciente es mujer, indique si está embarazada marcando ya sea Sí, No o Se desconoce. El embarazo puede afectar algunos resultados de pruebas.

Fecha de obtención/hora de obtención: indique la fecha y hora en que se obtuvo la muestra del paciente y quién obtuvo la muestra. No proporcione la fecha en que se remitió la muestra al DSHS. Si no se rellena el campo Fecha de obtención, se rechazará la muestra.

Núm. de expediente médico/núm. de extranjero/CUI: proporcione el número de identificación para propósitos de cotejo. CUI (Clinic Unique Identifier) es el número único identificador de clínicas.

Número previo del laboratorio de muestras del DSHS: si se ha remitido una muestra del paciente anteriormente al laboratorio del DSHS, sírvase proporcionar el número del laboratorio de muestras del DSHS.

Código diagnóstico de ICD, país de origen, fecha de aparición, diagnóstico/síntomas y riesgo (de ser aplicable): indique el código diagnóstico o resultados que ayudarían a procesar, identificar y facturar la muestra o el aislamiento. Si el país de origen del paciente no es los Estados Unidos, sírvase proporcionar el país de origen del paciente.

Paciente interno o externo (de ser aplicable): indique si el paciente está hospitalizado actualmente (requerido para pacientes tuberculosos).

Brote/vigilancia (de ser aplicable): díganos si la muestra o aislamiento es parte de un brote o grupo y si la muestra es de vigilancia rutinaria. Si se remite la muestra debido a un brote, escriba el nombre asociado del brote al lado de la casilla de brote.

Sección 3. FUENTE O TIPO DE MUESTRA

Fuente o tipo de muestra: indique el tipo de material que remite o la fuente de la muestra o el aislamiento. Para muestras de micobacteriología, rellene esta sección o se rechazará la muestra.

Para tratamiento tuberculoso, se DEBE proporcionar la fuente o tipo de muestra de las muestras usadas en el diagnóstico o control de tuberculosis. NO deje en blanco esta sección. Para muestras distintas a las de la lista, marque la casilla "Otra" y escriba el sitio y fuente seleccionados de la lista de Sitios anatómicos y fuentes de muestras correspondientes de la División de Eliminación de Tuberculosis, que puede obtenerse del departamento de salud local o regional.

Sección 4. DATOS DEL MÉDICO

Nombre y número de UPIN y NPI del médico: dé el nombre del médico y el número identificador único del médico (unique physician ID number [UPIN]) y el número NPI, de ser aplicable. A partir del 23 de mayo de 2007, el número NPI reemplazará al UPIN. Se requiere esa información para facturar a Medicare y al seguro.

Sección 5. PAGADOR

Indique la parte que recibirá la factura.

SE FACTURARÁ AL REMITENTE, si no se proporciona la información de facturación requerida o si se marcan múltiples casillas de pagador**.**

Marcación de Medicaid o Medicare:
- Marque la casilla correspondiente.
- Escriba el número de Medicaid o Medicare.
- Si el nombre del paciente del formulario no es el mismo que el nombre de la tarjeta, se facturará al remitente.

Marcación de seguro privado:
- Marque la casilla correspondiente.
- Rellene todos los campos del formulario que tengan asterisco (*).
- Si no proporciona los datos del seguro privado en el formulario de la muestra, se facturará al remitente.

Marcación de programa del DSHS:
- Si está contratado o inscrito en un programa del DSHS para proporcionar servicios que requieran pruebas de laboratorio, sírvase indicar qué programa es. Encontrará las descripciones de los programas en el Manual de servicios de referencia de la Sección de Servicios de Laboratorio en el sitio web http://www.dshs.state.tx.us/lab/.
- NO marque un programa del DSHS como Pagador si el paciente cuenta con Medicaid o Medicare, a menos que sea Pasos Sanos de Texas.
- Si es Pasos Sanos de Texas, marque Pasos Sanos de Texas como pagador. Escriba el número de Medicaid en el campo correspondiente.
- Para Título V, debe marcar ya sea Planificación familiar o MCH (Salud Materna e Infantil, Maternal & Child Health).
- Si no existe otro Pagador del paciente y el paciente reúne los criterios de participación del programa , marque el programa del DSHS correspondiente.
- Para los programas BIDS (Vigilancia de Enfermedades Infecciosas y Fronterizas, Border & Infectious Disease Surveillance), EIP (Programa de Infecciones Emergentes, Emerging Infections Program) y ELC (Capacidad Epidemiológica y de Laboratorio, Epidemiology & Laboratory Capacity), marque la casilla "Otro" y liste el nombre del programa en el espacio provisto.

HMO/Atención dirigida/aseguradora: ponga en letra de molde el nombre, dirección, ciudad, estado y código postal de la aseguradora a la que se facturará. Si no proporciona todos los datos del seguro en el formulario de la muestra, se facturará al remitente.

Parte responsable: ponga en letra de molde el nombre de la parte responsable, el número de identificación del seguro, el número telefónico de la aseguradora, el nombre del grupo y el número del grupo.

Firma y fecha: haga que la parte responsable firme y feche para autorizar la divulgación de los datos de la misma, si DSHS ha de facturar al seguro o HMO de ésta.

PRUEBA

Prueba solicitada: marque o especifique la o las pruebas específicas que ha de realizar la Sección de Servicios de Laboratorio del DSHS. Cada sección de pruebas requiere un formulario Y una muestra por separado. "Bacteriología" o "Micobacteriología/micología" o "Parasitología" serían ejemplos de secciones separadas. Puede consultar instrucciones de pruebas específicas en el Manual de servicios de referencia de la Sección de Servicios de Laboratorio.

6. BACTERIOLOGÍA

Sonda general de ADN de gonorrea (GC)/clamidia: sírvase seguir las siguientes instrucciones al remitir muestras de *Neisseria gonorrhoeae* y *Chlamydia trachomatis*.

Bajo la sección "Bacteriología" del formulario:

1. Bajo "Muestras clínicas":
   a. Marque la casilla "Gonorrea/clamidia (sonda genética)", si remite una muestra en un equipo de obtención de muestras GEN-PROBE.
   b. Marque la casilla "Cultivo de gonorrea", si la muestra es una muestra clínica remitida en un medio de transporte como Remel Transgrow, medio de transporte Remel GC, bandejas GemBec, etc.
2. Bajo "Cultivos puros":
   a. Si se aísla *Neisseria gonorrhoeae* y se remite un cultivo puro, sírvase marcar la casilla "Identificación aeróbica solamente" bajo "Cultivos puros". Sírvase ya sea escribir GC o *Neisseria gonorrhoeae* junto a "Identificación aeróbica: sospecha de organismo" o adjunte una copia del trabajo de laboratorio realizado en su centro.

Toxina/otra: si pide la prueba de toxina de Clostridium, sírvase tomar en cuenta que la prueba se realiza en *las especies de Clostridium y no en C. perfringens*.

7. ESTUDIOS MOLECULARES

PCR para:/PFGE para: escriba el nombre del organismo solicitado para prueba.

Otro: ponga cualquier otra solicitud de prueba especial.

Para solicitudes de pruebas especiales, llame a Biología Molecular al (888) 963-7111, extensión 7735, o (512) 458-7735 antes de remitir las muestras.

11. PARASITOLOGÍA

Otro: si solicita identificación de sospecha de *Naegleria fowleri*, *especies de Acanthamoeba*, *Pneumocystis carinii, especies de Leishmania, Toxoplasma gondii, especies de Trypanosoma* o cultivos de amebiasis, marque "Otro" y escriba el nombre del organismo bajo sospecha. Antes de remitir la muestra, sírvase informar al laboratorio llamando al: (888) 963-7111, extensión 7560, o (512) 458-7560.

C.41 Specimen Submission Form G-2B, Bacteriology and Parasitology (2 Pages) (Spanish)

TEXAS Department of State Health Services

Adquisición de muestras: (512) 458-7598

G-2B Formulario de remisión de muestras (MZO. 2006) Rev. 1

CLIA núm. 45D0660644

Laboratory Services Section
1100 W. 49th Street, MC-1947
Austin, Texas 78756-3194
(888) 963-7111, ext. 7318, o (512) 458-7318
http://www.dshs.state.tx.us/lab

Coloque la etiqueta de código de barra aquí

Sección 1. DATOS DEL REMITENTE – (** REQUERIDO)

Núm. de remitente y de TPI **	Nombre del remitente **	
**Núm. de NPI ** **	Dirección	
Ciudad **	Estado **	Código Postal **
Núm. de teléfono **	Contacto	
Fax	Código de la clínica	

Sección 2. DATOS DEL PACIENTE -- (** REQUERIDO)

NOTA: se **REQUIERE** el **nombre del paciente** en la muestra **y** éste **DEBE** ser el mismo que el nombre del formulario, la tarjeta de Medicare/Medicaid y el contenedor de la muestra.

Apellido **	Primer nombre **	Inicial del 2.º nombre
Dirección **	Núm. de teléfono	
Ciudad **	Estado **	Código Postal ** / País de origen/núm. de identificación binacional

Raza: ☐ Blanca ☐ Negra o afroamericana ☐ Amerindia/nativa de Alaska ☐ Asiática ☐ Nativa de Hawai/isleña del Pacífico ☐ Otra

Etnia: ☐ Hispana ☐ No hispana ☐ Se desconoce

Fecha de nacimiento (mm/dd/aaaa) **	Edad	Sexo **	Núm. de Seguro Social **	Si es mujer, ¿está embarazada? ☐ Sí ☐ No ☐ Se desconoce

Fecha de obtención ** **(REQUERIDA)**	Hora de obtención	Obtenida por
Núm. de expediente médico/núm. de extranjero/CUI	Código diagnóstico de ICD **	Núm. previo de laboratorio de muestras del DSHS
Fecha de aparición	Diagnóstico/síntomas	Riesgo

☐ Paciente interno ☐ Paciente externo ☐ Asociación de brote: ☐ Vigilancia

Sección 3. FUENTE O TIPO DE MUESTRA -- (REQUERIDO para muestras de micobacteriología)

☐ Absceso (sitio) _____
☐ Sangre
☐ Médula ósea
☐ Lavados bronquiales
☐ Cervical
☐ Fluido cerebroespinal
☐ Ocular
☐ Heces/deposición
☐ Gástrico
☐ Lesión (sitio) _____
☐ Ganglio linfático (sitio) _____
☐ Nasofaríngeo
☐ Plasma
☐ Frotis rectal
☐ Suero
☐ Esputo: inducido
☐ Esputo: natural
☐ Frotis de garganta
☐ Tejido (sitio) _____
☐ Uretral
☐ Orina
☐ Vaginal
☐ Herida (sitio) _____
☐ Otro:

Sección 6. BACTERIOLOGÍA

NOTAS: @ = proporcione el historial del paciente al reverso del formulario para evitar que se retrase el procesamiento de la muestra.

♠ = pruebas cubiertas por Pasos Sanos de Texas o Programas de Niños Sanos del título V.

Para identificación y clasificación del cultivo puro, sírvase proporcionar las reacciones bioquímicas al reverso del formulario o adjunte una copia de la impresión bioquímica. Cada sección de prueba (Bacteriología, por ejemplo) requiere un formulario y una muestra por separado. Consulte las instrucciones del formulario para conocer los detalles de cómo rellenarlo. Puede encontrar los detalles de los requisitos de pruebas y muestras en el Manual de servicios de referencia de la Sección de Servicios de Laboratorio. Visite nuestro sitio web en http://www.dshs.state.tx.us/lab/.

Muestras clínicas:
☐ Aislamiento aeróbico
☐ Sonda amplificada (de gonorrea/clamidia solamente)

Cultivos puros:
☐ Identificación aeróbica solamente
Sospecha de organismo: _____

Sección 4. DATOS DEL MÉDICO -- (** REQUERIDO)

Nombre del médico **	
UPIN del médico **	**Núm. de NPI del médico ** **

Sección 5. PAGADOR – (REQUERIDO)

Indique si debemos facturar al remitente, a Medicaid, a Medicare, al seguro privado o al programa del DSHS. Si indica Medicaid o Medicare, se requiere el número de Medicaid/Medicare. Si indica seguro privado o programa del DSHS, la siguiente información de facturación requerida se señala con un asterisco (*).

Si no provee la información requerida,
SE FACTURARÁ AL REMITENTE.

☐ Remitente ☐ Seguro privado
☐ Medicaid ☐ Medicare

Núm. de Medicaid/Medicare: _____

Programas del DSHS:

☐ Subvención de BT
☐ VIH/enfermedades venéreas
☐ Inmunizaciones
☐ IDEAS
☐ Programa de Refugiados
☐ Pasos Sanos de Texas
☐ Otro: _____
☐ Título V – Planificación familiar
☐ Título V – MCH
☐ Título X – Planificación familiar
☐ Título XX – Planificación familiar
☐ Tuberculosis
☐ Zoonosis

Nombre de la HMO/Atención dirigida/aseguradora *		
Dirección *		
Ciudad *	Estado *	Código Postal *
Núm. telefónico de aseguradora *	Núm. de id. de seguro de parte responsable *	
Nombre del grupo *	Núm. del grupo *	

"Por este conducto autorizo la divulgación de información relativa a los servicios aquí descritos y asimismo asigno toda prestación a la que tenga derecho a la Sección de Servicios de Laboratorio del Departamento Estatal de Servicios de Salud de Texas".
Firma del paciente o la parte responsable.

Firma * Fecha *

Sección 9. TERRORISMO QUÍMICO (CT)

☐ Perfil de CT (sangre y orina)
Justificación: _____

Sección 10. MICOBACTERIOLOGÍA/MICOLOGÍA

Muestras clínicas:
☐ Citología y cultivo AFB (bacilo acidoresistente)

☐ Cromatografía líquida (HPLC) directa solamente

Fecha de inicio de tratamiento con fármacos múltiples: _____

Cultivos puros:
☐ Identificación de bacilo acidoresistente (AFB ID)

☐ Aislamiento anaeróbico

☐ Botulismo @

☐ Prueba de difteria
☐ Patógenos entéricos
☐ Gonorrea/clamidia (sonda genética) ♠
☐ Cultivo de gonorrea
☐ Cultivo de tos ferina
☐ Prueba de estreptococo (sólo grupo B)
☐ Toxina/EHEC
☐ Toxina/otra: _____

Sección 7. ESTUDIOS MOLECULARES

☐ PCR para:

☐ PFGE para:

☐ Otro:

☐ Identificación anaeróbica solamente
Sospecha de organismo:
_____

☐ Identificación de Campylobacter solamente

Estudios especiales:
☐ Estudios tóxicos
☐ Otro: _____

Identificación y clasificación:
☐ E. coli (confirmación de EHEC)
☐ Haemophilus influenzae
☐ Neisseria meningitidis
☐ Salmonela
☐ Shigella
☐ Otro:

Sección 8. ENTOMOLOGÍA

☐ Identificación de insectos
☐ Otro:

☐ Identificación micótica
☐ MTB: primer panel de fármacos
☐ MTB: segundo panel de fármacos
☐ MTB PZA
☐ Identificación de otros actinomicetos aeróbicos
☐ Otro:

Sección 11. PARASITOLOGÍA

☐ Parásitos en sangre/tejidos @
☐ Parásitos intestinales @
☐ Identificación de lombrices @
☐ Preparación de lombriz intestinal
☐ Fijador: _____
☐ Coloración: _____
☐ Otro:

FOR LABORATORY USE ONLY

☐ Room Temp. ☐ Cold ☐ Frozen

C

C.42 Guidelines: Tuberculosis Skin Testing (2 Pages)

DEPARTMENT OF STATE HEALTH SERVICES
GUIDELINES: TUBERCULOSIS SKIN TESTING
(PPD/MANTOUX)

Purpose:

The tuberculosis intradermal skin test is used to detect tuberculosis infection.

- To detect infection, either past or present, with *Mycobacterium tuberculosis*.
- To serve as a diagnostic procedure in selected patients.

Equipment:

- PPD (purified protein derivative) tuberculin antigen
- Tuberculin syringe
- 1/4" to 1/2", 27-gauge needle
- Alcohol sponge or swab

Procedures:

Nursing Action:	Rationale/Amplification:
1. Determine if patient has ever had BCG vaccine, a previously positive skin test, recent viral disease or immunization with a live virus vaccine within the last 30 days, immunosuppression by disease, drugs, or steroids.	1. A history of BCG vaccine should be documented but does not cancel the need for tuberculin skin testing.
2. Draw up 0.1 ml of PPD-tuberculin into tuberculin syringe. Each 0.1 ml should contain 5 TU (tuberculin units of PPD-tuberculin).	2. Use immediately to avoid adsorption onto the plastic/glass syringe.
3. Cleanse the skin of the volar (palm side) surface of the **left** arm with alcohol. Allow to dry.	3. An intradermal test may be applied at any site but the use of the left arm is practiced universally to facilitate identifying the location of the injection site by the health care worker who reads the test. If the test is applied at another site, document the exact site of injection.
4. Stretch the skin taut.	4. Facilitates the introduction of the needle.
5. Hold the tuberculin syringe close to the skin, bevel up, so that the hub of the needle touches it as the needle is introduced.	5. Holding the syringe in this way will reduce the needle angle at the skin surface, promoting the correct entry for a proper intradermal injection.
6. Inject the tuberculin into the superficial layer of the skin to form a wheal 6mm to 10 mm in diameter.	6. If no wheal appears (because the injection was made too deep), or the wheal is smaller than 6 mm (because the needle was not under the skin and part of the antigen leaked on the outer surface of the skin), reapply test at another site at least five centimeters (two inches) from the original site.

To Read the Test:	Further Clarification to Reading the Test:
1. Read the test within 48–72 hours.	1. Tuberculin skin tests are tests of delayed hypersensitivity.
2. Have a good light available. Flex the forearm slightly at the elbow.	
3. Inspect for the presence of induration. Inspect from a side view against the light. Inspect by direct light.	3. Induration refers to hardening or thickening of the tissues.
4. Palpate: lightly rub the finger across the injection site from the area of normal skin to the area of induration. Outline the diameter of induration.	
5. Measure the maximum transverse diameter of induration (not erythema) in millimeters with a flexible ruler.	5. Erythema (redness) without induration is generally considered to be of no significance.

DEPARTMENT OF STATE HEALTH SERVICES
GUIDELINES: TUBERCULOSIS SKIN TESTING
(PPD/MANTOUX)

Procedures

Interpretation

1. Negative reaction: An induration of 0–< 5 mm

2. Positive Reaction:
   a. An induration of 5 mm or more is considered to be positive for:
      1) HIV-positive persons
      2) Recent contacts of TB case
      3) Individuals with fibrotic changes on chest radiograph consistent with old TB
      4) Patients with organ transplants and other immunosuppressed patients (receiving the equivalent of > 15 mg/d Prednisone for > 1 month)
   b. An induration of 10 mm or more is considered to be positive for:
      1) Recent arrivals (< 5 yr) from high-prevalence countries
      2) Injection drug users
      3) Residents and employees* of high-risk congregate settings: prisons and jails, nursing homes and other healthcare facilities, residential facilites for AIDS patients, and homeless shelters
      4) Mycobacteriology laboratory personnel
      5) Persons with clinical conditions that make them high-risk: silicosis, diabetes mellitus, chronic renal failure, some hematologic disorders (e.g., leukemias and lymphomas), other specific malignancies (e.g., carcinoma of the head or neck and lung), weight loss of > 10 % of ideal body weight, gastrectomy, jejunoileal bypass
      6) Children < 4 yrs of age or infants, children, and adolescents exposed to adults in high-risk categories
   c. An induration of 15 mm or more is considered to be positive in individuals with no risk factors for tuberculosis

1. This shows either a lack of tuberculin sensitivity or a low grade sensitivity that most likely is not caused by M. tuberculosis. A negative test does not rule out the presence of tuberculosis. Because of the possibility of a false-negative result, the tuberculin skin test should never be used to exclude the possibility of active disease among persons for whom the diagnosis is being considered.

2a. A positive reaction indicates that a patient has had contact with the bacillus that causes tuberculosis. It does not necessarily mean that active disease is present in the lung; however, further evaluation is required.

Individuals who are in close contact with persons with active tuberculosis and who have reactions $\geq$ 5 mm should be considered positive and be evalutated for treatment of either latent tuberculosis infection or active tuberculosis disease.

2b. Individuals with skin test results of $\geq$ 10 mm should be evaluated for treatment of either latent tuberculosis infection or active tuberculosis disease.

Note: For persons with negative tuberculin skin test reactions who undergo repeat skin testing (e.g., healthcare workers), an increase in reaction size of 10 mm or more within a period of 2 yrs should be considered a skin test conversion indicative of recent infection with *M. tuberculosis*. In some individuals who have been infected with nontuberculous mycobacteria or have undergone BCG vaccination, the skin test may show some degree of induration. For these individuals, a conversion to "positive" is defined as an increase in induration by 10 mm on subsequent tests.

2b3. * For persons who are otherwise at low risk and are tested at entry into employment, a reaction of > 15 mm induration is considered positive.

Documentation

1. Record name of antigen, manufacturer, lot number, date of testing, and date of reading.
2. Record site of application of test if applied at site other than the left volar surface.
3. Record the size of induration.

References

1. Diagnostic Standards and Classification of Tuberculosis in Adults and Children, *Am J Respir Crit Care Med*; 161, pp 1376–1395, 2000
2. Interactive Core Curriculum on Tuberculosis: What the Clinician Should Know, CDC, 2004, www.cdc.gov/nchstp/tb/webcourses/CoreCurr/index.htm
3. Mantoux Tuberculin Skin Test Facilitator Guide, CDC, 2003, www.cdc.gov/nchstp/tb/pubs/Mantoux/tableofcontents.htm

C.43 Tuberculosis (TB) Screening and Education Tool

This screening tool for tuberculosis (TB) exposure risk is to be used annually to determine the need for tuberculin skin testing. In areas of high TB prevalence, the screening tool need not be done at visits for which tuberculin skin testing is required: 1 year of age, once between 4 through 6 years of age, and once between 11 through 17 years of age.

The questions in this screening tool are intended as a minimum screen. Follow-up questions may be necessary to clarify hesitant or ambiguous responses. Questions specific to TB exposure risks in the child's community may need to be added.

- If all the answers are unqualified negatives, the child is considered at low risk for exposure to TB and will not need tuberculin skin testing.
- If the answer to any question is "Yes" or "I don't know," the child should be tuberculin skin tested.
- In the case of the child for whom an answer in the past of "Yes" or "I don't know" prompted a skin test, which was negative, the skin test *may* not have to be repeated annually.
- The decision to administer a skin test must be made by the medical provider based upon an assessment of the possibility of exposure. A negative tuberculin skin test never excludes tuberculosis infection or active disease.
- Bacillus of Calmette and Guérin (BCG) vaccinated children should also have the screening tool administered annually. Previous BCG vaccination is not a contraindication to tuberculin skin testing. Positive tuberculin skin tests in BCG vaccinated children are interpreted using the same guidelines used for non-BCG vaccinated children.
- Children who have had a positive TB skin test in the past (whether treated or not), should be re-evaluated at least annually by a physician for signs and symptoms of TB.

Care of children who are newly discovered to be tuberculin skin test positive includes:

- An evaluation for signs and symptoms of TB.
- A chest X-ray to rule out active disease.
- Oral medications to prevent progression to active disease or multi-drug therapy if active disease is present.
- Referral for consultation by a pediatric TB specialist is recommended if active disease is present.
- A report to the local health authority for investigation to find the source of the infection.

Feel free to photocopy the screening and education tool from this publication.

C.44 TB Questionnaire

Name of Child_____Date of Birth _____

Organization administering questionnaire_____ Date_____

Tuberculosis (TB) is a disease caused by TB germs and is usually transmitted by an adult person with active TB lung disease. It is spread to another person by coughing or sneezing TB germs into the air. These germs may be breathed in by the child.

Adults who have active TB disease usually have many of the following symptoms: cough for more that two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills and night sweats.

A person can have TB germs in his or her body but not have active TB disease (this is called latent TB infection or LTBI).

Tuberculosis is preventable and treatable. TB skin testing (often called the PPD or Mantoux test) is used to see if your child has been infected with TB germs. No vaccine is recommended for use in the United States to prevent tuberculosis. The skin test is not a vaccination against TB.

We need your help to find out if your child has been exposed to tuberculosis.

Place a mark in the appropriate box:	Yes	No	Don't Know
TB can cause fever of long duration, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood. As far as you know: has your child been around anyone with any of these symptoms or problems? or has your child had any of these symptoms or problems? or has your child been around anyone sick with TB?			
Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia?			
Has your child traveled in the past year to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia for longer than 3 weeks? If so, specify which country/countries?_____			
To your knowledge, has your child spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison or recently came to the United States from another country?			

Has your child been tested for TB? Yes___ (if yes, specify date ____/____) No___
Has your child ever had a positive TB skin test? Yes___ (if yes, specify date ____/____) No___

For school/healthcare provider use only
****

PPD administered Yes___ No___
If yes,
Date administered _____/_____/_____ Date read _____/_____/_____ Result of PPD test _____ mm response

Type of service provider (i.e. school, Health Steps, other clinics) _____

PPD provider _____ _____
signature printed name

Provider phone number _____

City _____ County _____

If positive, referral to healthcare provider Yes___ No___

If yes, name of provider _____

EF12-11494 TB Questionnaire for Children (Rev. 08/04)

TEXAS Department of State Health Services

C.45 Cuestionario Para la Detección de Tuberculosis

Nombre del niño o niña _____

Organización _____ Fecha _____

La Tuberculosis (TB) es una enfermedad causada por gérmenes de TB y en la mayoriá de los casos es trasmitida por una persona adulta con tuberculosis pulmonar activa. Se transmite a otra persona por la tos y por el estornudo al expelir gérmenes de TB al aire que pueden ser respirados por los niños.

Los adultos que tienen la enfermedad activa casi siempre tienen varios de los siguientes síntomas: tos con duración de más de dos semanas, pérdida de apetito, pérdida de peso de diez libras o más en un período corto de tiempo, fiebre, escalofríos y sudores nocturnos.

Una persona puede tener gérmenes de TB en su cuerpo pero no tener la enfermedad activa. Esto se llama infección latente de TB (o LTBI por su sigla en inglés).

La TB es prevenible y curable. La prueba tuberculínica, también llamada PPD o prueba de Mantoux, se utiliza para saber si su niño o niña ha sido infectado/a con el germen de TB. No se recomienda ninguna vacuna para prevenir la tuberculosis. La prueba tuberculínica no es una vacuna contra la tuberculosis.

Necesitamos de su ayuda para saber si su niño/niña ha sido expuesto/a a la tuberculosis.

	Sí	No	No se sabe
La tuberculosis puede causar fiebre de larga duración, pérdida de peso inexplicable, tos severa (con más de dos semanas de duración), o tos con sangre. ¿Es de su conocimiento si: su niño o niña ha estado cerca de algún adulto con esos síntomas o problemas? su niño o niña ha tenido algunos de estos síntomas o problemas? su niño o niña ha estado cerca de alguna persona enferma de tuberculosis?			
¿Su niño o niña nació en México en o cualquier otro país de América Latina, el Caribe, Africa, Europa Oriental o Asia?			
¿Su niño o niña viajó a México o a cualquier otro país de América Latina, el Caribe, Africa, Europa Oriental o Asia durante el último año por más de 3 semanas? Si su respuesta es positiva, favor de especificar a qué país o países.			
¿Es de su conocimiento, si su niño o niña pasó un tiempo (más de 3 semanas) con alguna persona que es o ha sido usuario de droga intravenosa (IV), infectado por VIH, en la prisión, o haya llegado recientemente a los Estados Unidos?			

¿A su niño o niña se le ha realizado la prueba tuberculínica recientemente? Sí___ (si sí, especifique la fecha ____/____) No___
¿Su niño o niña alguna vez tuvo reacción positiva a la tuberculina? Sí___ (si sí, especifique la fecha ____/____) No___

Solamente para uso de la escuela o del proveedor de servicios médicos
****

¿Se administró PPD? Sí___ No___
Si sí,
Fecha en que fue administrada_____/_____/_____ Fecha de lectura _____/_____/_____ Resultado de la prueba_____ mm

Tipo de proveedor de servicio (ej.: escuela, Health Steps, otras clínicas) _____

Administrador de PPD _____ _____
firma nombre en letra de molde (imprenta)

Número de teléfono del administrador de PPD _____

Ciudad_____ Condado_____

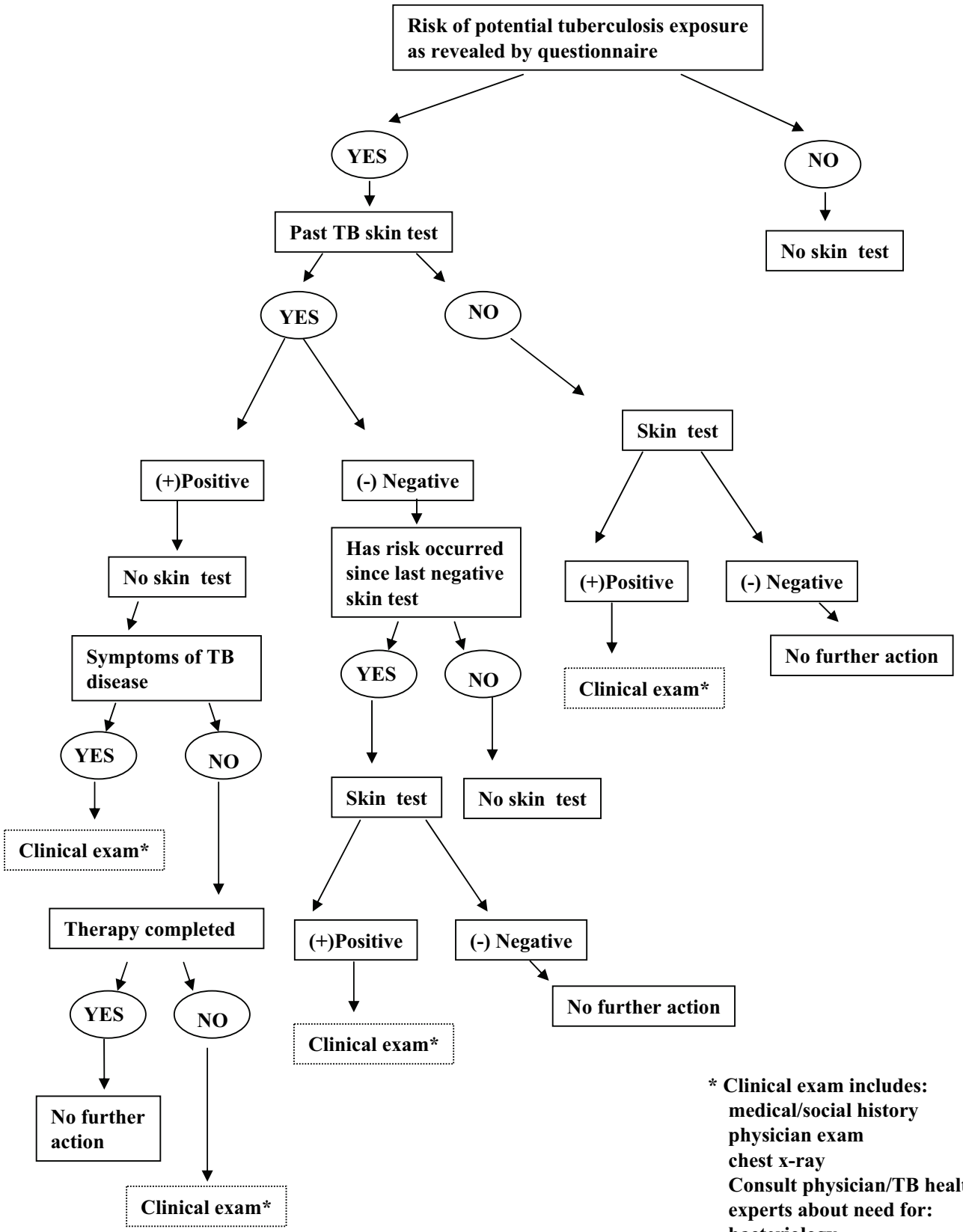
Si resultó positivo, ¿se refirió al proveedor de servicios de salud? Sí___ No___

Si sí, nombre del proveedor (médico o clínica, etc.) _____

TEXAS Department of State Health Services

EF12-11494A (Rev. 08/04)

C.46 How to Determine TB Risk



C

C.47 PPD Agreement for Texas Health Steps Providers

Infectious Disease Control Unit
PPD Agreement for Texas Health Steps Providers

Please Print
Facility Name: _____

Address: _____(City, State)_____(Zip)_____

Provider Name: _____ Provider Title: _____

Contact Name: _____ Contact Title: _____

Contact Phone: _____ Contact Fax: _____

In order to receive State-supplied PPD at no cost to me, I, on behalf of myself and any and all practitioners associated with this medical office, group practice, health department, community/migrant/rural health clinic, or other organization of which I am the physician in charge or equivalent, agree to the following:

1. I agree to provide/arrange training for all personnel in administering, reading, and recording the TB skin test results. I agree to instruct all patients that the TB skin test is a two (2)-part test and they must return in 48 to 72 hours for their test to be read by trained personnel so the test result can be documented. I agree to have all results documented in millimeters and a negative test will be recorded as 0 mm not negative. I agree to supply written documentation of the training to administer TB skin testing, reading and recording upon request of the health department issuing the PPD.
2. I agree to do the screening for TB risk factors on each patient and **ONLY** place the TB skin test on those patients that have a **TB risk factor or have some other medical necessity that is documented in their chart or are entering foster care**.
3. I agree to submit TB-400 forms or refer clients to the health department for medical evaluation or additional follow-up when they have latent TB infection (positive skin test result and a negative chest x-ray).
4. In accordance with the Texas Administrative Code, Title 25, Part 1, Chapter 97, Subchapter A, I shall report to the local health authority any known or suspected case of TB within one working day and any new diagnosis of latent TB infection within one week.
5. I agree to submit the Monthly Tuberculin Skin Testing Form (EF12-12168). This form will be sent at the first of each month showing our TB testing numbers for the previous month. I agree to monitor my stock levels so that emergency orders will be kept to a minimum.
6. As a private clinic or health care facility, I agree to use this PPD only for TB screening of children as part of a Texas Health Steps medical check-up and to identify and document TB risk factors before placing the PPD.
7. Either the State or I may terminate this agreement at any time. My failure or the failure of any others outlined above to comply with these requirements will be grounds for the State to terminate this agreement.

_____ _____
Provider Signature Date
Sign and Return to:

A copy of this agreement will be returned to you.

_____ _____
Health Department Representative Signature Date

EF12-12105 PPD Agreement (Rev. 6/05)

C.48 TVFC Patient Eligibility Screening Record

TEXAS VACCINES FOR CHILDREN PROGRAM (TVFC)
PATIENT ELIGIBILITY SCREENING RECORD

CLINIC USE ONLY:
TVFC Eligible:
☐ Yes ☐ No

Purpose: To determine eligibility and the source of funds for the Texas Department of State Health Services to be reimbursed for vaccines. A record must be kept in the office of the health care provider that reflects the status of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children Program. The record may be completed by the parent, guardian, or individual of record. This same record may be used for all subsequent visits as long as the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines.

Date of Screening: _____

Child's Name:

_____
Last Name First Name MI

Child's Date of Birth: ____/____/____
mm/dd/yy

Parent/Guardian/Individual of Record:

_____
Last Name First Name MI

Provider's/Clinic's Name:

_____

The above named child qualifies for vaccines through the Texas Vaccines for Children Program because he/she (check the first category that applies, check only one):

- ☐ (a) is enrolled in Medicaid, or
- ☐ (b) does not have health insurance, or
- ☐ (c) is an American Indian, or
- ☐ (d) is an Alaskan Native, or
- ☐ (e) is underinsured (has health insurance that **Does Not** pay for vaccines, has a co-pay or deductible the family cannot meet, or has insurance that provides limited wellness or prevention coverage), or
- ☐ (f) is a patient who is served by any type of public health clinic and does not meet any of the above criteria, or
- ☐ (g) is a patient who receives benefits from the Children's Health Insurance Plan (CHIP)
- ☐ **None of the above, not eligible for TVFC vaccine**

Signature: _____ Date: _____

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

Texas Department of State Health Services
Immunization Branch

TEXAS Department of State Health Services

Stock No. C-10
Revised 04/06

C

C.49 TVFC Patient Eligibility Screening Record (Spanish)

TEXAS VACCINES FOR CHILDREN PROGRAM (TVFC)
[EL PROGRAMA DE VACUNAS PARA LOS NIÑOS DE TEXAS, *TVFC*, por sus siglas en inglés]
ARCHIVO QUE DETERMINA LA ELEGIBILIDAD DEL PACIENTE

uso de la clínica solamente: (CLINIC USE ONLY:)
TVFC Eligible:
☐ Yes ☐ No

Propósito: El determinar la elegibilidad y la fuente de los fondos para el reembolso al *Texas Department of State Health Services* [Departamento Estatal de Servicios de Salud de Texas] para las vacunas. Un archivo debe guardarse en la oficina del proveedor de atención médica, el cual refleja el estatus de todos los niños de 18 años de edad o menores quienes reciben inmunizaciones a través del Programa de Vacunas Para los Niños de Texas. El formulario podría ser llenado por el padre, la madre, el tutor legal o el individuo del registro. Este mismo formulario puede utilizarse para todas las visitas subsiguientes con tal de que el estatus de elegibilidad del niño no haya cambiado. Aunque la verificación de las respuestas no es requerida, es necesario retener éste, o un archivo similar, para cada niño que reciba vacunas.

Fecha de determinación: _____

Nombre del niño:

_____
Apellido | Primer nombre | Inicial del segundo nombre

Fecha de nacimiento del niño: ____/____/____
(mes/día/año)

Padre / Madre / Tutor legal / Individuo del registro:

_____
Apellido | Primer nombre | Inicial del segundo nombre

Nombre del proveedor / nombre de la clínica:

_____

El niño nombrado arriba cumple con los requisitos para recibir vacunas a través del Programa de Vacunas para los Niños de Texas porque él (marque la primera categoría que se aplica; marque solamente una):

- ☐ (a) está inscrito en Medicaid o
- ☐ (b) no tiene seguro médico o
- ☐ (c) es indio-americano o
- ☐ (d) es nativo de Alaska o
- ☐ (e) no tiene seguro médico suficiente (tiene seguro médico que **NO** paga por las vacunas; tiene un co-pago o un deducible que la familia no puede pagar; o tiene un seguro que proporciona una cobertura limitada para el bienestar o la prevención) o
- ☐ (f) es un paciente que recibe servicios de cualquier clínica pública y no reúne ninguno de los criterios indicados anteriormente o
- ☐ (g) es un paciente que recibe beneficios del *Children's Health Insurance Plan* [Plan de seguro médico para niños, *CHIP*, por sus siglas en inglés]
- ☐ **Ninguna de las respuestas anteriores; no es elegible para las vacunas del *TVFC***

Firma: _____ Fecha: _____

Con pocas excepciones, usted tiene el derecho a pedir y ser informado(a) sobre la información que el Estado de Texas reúne sobre usted. Usted tiene el derecho a recibir y examinar la información al pedirla. Usted también tiene el derecho a pedirle a la agencia estatal que corrija cualquier información que se determina ser incorrecta. Vaya a http://www.dshs.state.tx.us para más información acerca de la Notificación sobre la Privacidad. (Referencia: *Government Code, Section* 552.021, 552.023, 559.003 y 559.004)

Texas Department of State Health Services
Immunization Branch

TEXAS Department of State Health Services

Stock No. C-10
Revised 04/06

C.50 TVFC Provider Enrollment (3 Pages)

TEXAS VACCINES FOR CHILDREN PROGRAM (TVFC): PROVIDER ENROLLMENT

☐ Initial enrollment* ☐ Re-enrollment ☐ Provider PIN Number __ __ __ __ __ __

*Contact the Health Services Region (HSR) in your area to obtain PIN

Name of Facility, Practice, or Clinic: _____

Provider Name (M.D., D.O., N.P., P.A., or C.N.M.*): _____
(Last Name) (First Name) (MI) (Title)

Contact: _____
(Last Name) (First Name) (MI) (Title)

Mailing Address: _____
(P.O. Box or Street Address) (City) (Zip)

Address for Vaccine Delivery: _____
(Street Address and Suite Number) (City) (County) (Zip)

Telephone Number: (_____) _____–_____ Fax Number: (_____) _____–_____

E-mail Address: _____

In order to participate in the Texas Vaccines for Children Program and/or to receive federally- and state-supplied vaccines provided to me at no cost, I, on behalf of myself and any and all practitioners associated with this medical office, group practice, health department, community/migrant/rural health clinic, or other organization, agree to the following:

1) Before administering vaccines obtained through the Texas Vaccines for Children Program (TVFC), this office/facility will determine VFC eligibility. The Patient Eligibility Screening Form will be provided to the parent or guardian to declare each child's eligibility.
2) This office/facility will maintain records of the parent/guardian/authorized representative's responses on the Patient Eligibility Screening Form for at least three years. If requested, this office/facility will make such records available to the Texas Department of State Health Services (DSHS), the local health department/authority, or the U.S. Department of Health and Human Services.
3) This office/facility will comply with the appropriate vaccination schedule, dosage, and contraindications, as established by the Advisory Committee on Immunization Practices, unless (a) in making a medical judgment in accordance with accepted medical practice, this office/facility deems such compliance to be medically inappropriate, or (b) the particular requirement is not in compliance with Texas Law, including laws relating to religious and medical exemptions.
4) This office/facility will provide the most current Vaccine Information Statements (VIS) to the responsible adult, parent, or guardian and maintain records in accordance with the National Childhood Vaccine Injury Act. Signatures are required for informed consent. (The Texas Addendum portion of the VIS may be used to document informed consent.)
5) This office/facility will not charge for vaccines supplied by DSHS and administered to a child who is eligible for the TVFC.
6) This office/facility may charge a vaccine administration fee. This office/facility will not impose a charge for the administration of the vaccine in any amount higher than the maximum fee established by DSHS. Medicaid patients cannot be charged for the vaccine, administration of vaccine, or an office visit associated with Medicaid services.
7) This office/facility will not deny administration of a TVFC vaccine to a child because of the inability of the child's parent or guardian/individual of record to pay an administrative fee.
8) This office/facility will comply with the State's requirements for ordering vaccine and other requirements as described by DSHS.
9) This office/facility or the State may terminate this agreement at any time for failure to comply with these requirements.
10) This office/facility will allow DSHS (or its contractors) to conduct on-site visits as required by VFC regulations.

_____ _____
(Signature*) (Date)

_____
(Print Name and Title)

* A licensed Medical Doctor, Doctor of Osteopathy, Nurse Practitioner, Physician Assistant, or a Certified Nurse Midwife must sign the TVFC Enrollment form.

Texas Department of State Health Services
Immunization Branch

TEXAS Department of State Health Services

Stock Number EC6-102
Revised 06/2007

C

TEXAS VACCINES FOR CHILDREN PROGRAM

PROVIDER PROFILE FOR PIN ___ ___ ___ ___ ___ ___

Is your facility a Federally Qualified Health Center, Migrant Health Clinic, or Rural Health Clinic?
(Circle one) YES NO

Type of Clinic: (√ check one)

- ☐ Public Health Department/District
- ☐ Public Hospital
- ☐ Other Private Clinic
- ☐ Private Hospital
- ☐ Private Practice (Individual or Group)
- ☐ Other Public Clinic

PATIENT PROFILE:

Please enter the number of children for each of the following categories and by age group who will be vaccinated at your clinic in the next 12-month period.

NUMBER OF CHILDREN IN EACH CATEGORY	< 1 year old	1 - 6 years	7 - 18 years	Total
Enrolled in Medicaid.				
Uninsured. *(Note: Children enrolled in Health Maintenance Organizations are considered insured)*				
American Indians.				
Alaskan Natives.				
Underinsured. (Has health insurance that **Does Not** pay for vaccines, has a co-pay or deductible the family cannot meet, or has insurance that provides limited wellness or prevention coverage)				
(For Public Health Clinic Use ONLY) Children who do not meet any of the above criteria, but still receive vaccinations at **public health clinics.**				
Children who receive benefits from the Children's Health Insurance Plan (CHIP).				
Children who are vaccinated in your practice, but are **NOT** TVFC-eligible.				
TOTAL PATIENTS: (Add columns)				

TEXAS VACCINES FOR CHILDREN PROGRAM PROVIDER LIST

Please list all individuals within the practice who will be administering TVFC supplied vaccine.

Last Name(List provider who signed Provider Enrollment Form first)	First Name	Middle Initial	Title (M.D., D.O., N.P., P.A., R.N., L.V.N., M.A.)	National Provider Identification	Medical License Number	Specialty (Family Medicine, Pediatrics, etc.)

Texas Department of State Health Services
Immunization Branch

TEXAS Department of State Health Services

Stock Number 6-102
Revised 06/2007

TEXAS VACCINES FOR CHILDREN PROGRAM

PROVIDER LIST-ADDENDUM FOR PIN ___ ___ ___ ___ ___ ___

Please list all individuals within the practice who will be administering TVFC supplied vaccine.

Last Name (List provider who signed Provider Enrollment Form first)	First Name	Middle Initial	Title (M.D., D.O., N.P., P.A., R.N., L.V.N., M.A.)	National Provider Identification	Medical License Number	Specialty (Family Medicine, Pediatrics, etc.)

Texas Department of State Health Services
Immunization Branch

Stock Number EC6-102
Revised 06/2007

C.51 TVFC Questions and Answers (3 Pages)

Texas Vaccines For Children Program

Questions and Answers

Texas Vaccines For Children Program (TVFC)

Question 1: What is the TVFC?

Answer: *This is our version of the Federal Vaccines For Children (VFC) Program. The TVFC was initiated by the passage of the Omnibus Budget Reconciliation Act of 1993. This legislation guaranteed vaccines would be available at no cost to providers, in order to immunize children (birth - 18 years of age) who meet the eligibility requirements.*

Why Enroll?

Question 2: Why should a health care provider enroll in the TVFC?

Answer:

- *You can get free vaccine for your eligible patients.*
- *You will not need to refer patients to public clinics for vaccines.*
- *You can provide vaccinations to your patients as part of a comprehensive care package; this will enhance the opportunity for patients to find a medical home.*

Patients Served

Question 3: Once enrolled, are providers required to immunize children who are not their patients?

Answer: *No, you control whom you see in your practice.*

Children Who Qualify

Question 4: Which children qualify for free vaccines?

Answer: *All children (birth - 18 years of age) are eligible for free vaccine, except:*

- *Children with insurance that pays for immunization services, and*
- *Children whose parents or guardians are able to pay the co-pay or deductibles for immunization services.*

TEXAS Department of State Health Services

Texas Department of State Health Services
Immunization Branch

Stock No. 11-11221
Revised 06/2007

Texas Vaccines For Children Program

Questions and Answers

Children's Health Insurance Program (CHIP) Enrollment

Question 5: Are children who are enrolled in CHIP eligible?

Answer: *Yes, through special arrangement CHIP children are also eligible.*

Medicaid Enrollment

Question 6: To participate in TVFC, must providers enroll as a Texas Medicaid Provider?

Answer: *No, however, if you are enrolled in the Texas Medicaid Program, you must enroll in TVFC in order to receive free vaccine.*

Question 7: Will the Texas Medicaid Program reimburse private providers for vaccines administered to Medicaid patients?

Answer: *The Texas Medicaid Program will not reimburse providers for the cost of the vaccine. However, the Texas Medicaid Program will reimburse providers for the administration of the vaccine.*

Vaccine Related Fees

Question 8: Why are there fee caps on what providers can charge for administering vaccine?

Answer: *Federal Legislation requires fee caps for administration on a statewide basis that balance the provider's financial need and the patient's ability to pay.*

Question 9: Will TVFC reimburse an administration fee for non-Medicaid, TVFC eligible children?

Answer: *No, for non-Medicaid TVFC eligible children, providers may charge a maximum of $14.85 per vaccine directly to the patient; administration fees **may not** exceed this amount. (Combination vaccines such as DTaP are considered **one vaccine**.)*

TEXAS Department of State Health Services

Texas Vaccines For Children Program

Questions and Answers

Question 10: ***Will providers be required to increase the amount of vaccine information materials they provide to parents because of the TVFC?***

Answer: *No, materials required of all providers through the National Childhood Vaccine Injury Act are sufficient.*

Eligibility Status

Question 11: ***Must providers screen patients for eligibility status each time they come for a vaccination visit?***

Answer: *No, once a patient is declared eligible, you only rescreen when there is reason to believe a child's eligibility status has changed.*

Question 12: ***How are providers expected to verify responses for TVFC eligibility?***

Answer: *Providers are not expected to do anything more than ask the patient what the child's eligibility status is and then record the response. TVFC provides a Patient Eligibility Screening Form that can be used for this.*

Question 13: ***Why must providers complete a Provider Profile describing patients by eligibility category?***

Answer: *This information allows the Texas Department of State Health Services to determine how the cost of vaccine will be divided among state and federal funds. Each year, you may find your profile information has changed. The Provider Profile must be updated annually, in accordance with Federal requirements.*

TEXAS Department of State Health Services

Claim Form Examples

Note: *This section contains claim form examples* only. *These examples are not accurate depictions of claim form data required for claims adjudication. Refer to Section 4 "Claims Filing" for information about completing claim forms for submission to TMHP.*

Claims prepared by computer billing services or office-based computers may have "Signature on File" printed in the signature block. Printing of the provider's name instead of "Signature on File" is not acceptable.

Refer to: "Provider Signature on Claims" on page 5-21 for more details.

D.1 Ambulance 1

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) X MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Pye, Sherrie	3. PATIENT'S BIRTH DATE MM DD YY: 02 02 1970 SEX: M F X
5. PATIENT'S ADDRESS (No., Street): 341 Tosser Way	6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other
CITY: Houston STATE: TX	8. PATIENT STATUS: Single Married Other
ZIP CODE: 77485 TELEPHONE (Include Area Code): (123) 555-1234	Employed Full-Time Student Part-Time Student
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous): YES X NO
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M F	b. AUTO ACCIDENT? YES X NO PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES X NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI 9876012345
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 879.3 2. 459 3. 958.0 4. 780.09	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 01 2008 01 01 2008	3		A0429	SH	1	40.00	1		NPI	1234567-89 / 9087654321
2	01 01 2008 01 01 2008	3		A0422		1	20.00	1		NPI	1234567-89 / 9087654321
3	01 01 2008 01 01 2008	3		A0382		2	2.00	2		NPI	1234567-89 / 9087654321
4	01 01 2008 01 01 2008	3		A0382		1	15.00	5		NPI	1234567-89 / 9087654321
5	01 01 2008 01 01 2008	3		A0425	ET		48.00	8		NPI	1234567-89 / 9087654321
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.: 12345	27. ACCEPT ASSIGNMENT? (For govt. claims, see back): X YES NO	28. TOTAL CHARGE: $ 123.00
29. AMOUNT PAID: $	30. BALANCE DUE: $		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.): **Signature on File** 01 10 2008 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION: Junction Hospital, 332 Junction Street, Houston, TX 77883; a. 4302198765 b.		33. BILLING PROVIDER INFO & PH #: ( ) Spindle Ambulance, 4000 Main Street, Houston, TX 77883; a. 9876543021 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

D.2 Ambulance 2

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) X MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, Catherine	3. PATIENT'S BIRTH DATE MM DD YY: 05 28 1964 SEX: M F X
5. PATIENT'S ADDRESS (No., Street): 338 West Boone	6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other
CITY: Belvedere STATE: TX	8. PATIENT STATUS: Single Married Other
ZIP CODE: 77435 TELEPHONE (Include Area Code): (123) 555-1234	Employed Full-Time Student Part-Time Student
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous): YES X NO
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M F	b. AUTO ACCIDENT? YES X NO PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES X NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 585.9 2. 344.00 3. V13.5 4.	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER: 1234567890

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 01 2008 01 01 2008	5		A0382		1	15.00	1		NPI	1234567-89 / 9087654321
2	01 01 2008 01 01 2008	5		A0428	RG	1	150.00	1		NPI	1234567-89 / 9087654321
3	01 01 2008 01 01 2008	5		A0425		1	125.00	50		NPI	1234567-89 / 9087654321
4	01 01 2008 01 01 2008	5		A0422		1	30.00	1		NPI	1234567-89 / 9087654321
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.: 12345	27. ACCEPT ASSIGNMENT? (For govt. claims, see back): X YES NO	28. TOTAL CHARGE: $ 320.00
29. AMOUNT PAID: $	30. BALANCE DUE: $		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.): *Duke Wellington* 01 08 2008 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION: Get Well Hospital, 9929 Seventh Street, Anytown, TX 77883; a. 4302198765 b.		33. BILLING PROVIDER INFO & PH #: ( ) Wellington Ambulance, 2222 Tulia, Randall, TX 77777; a. 9876543021 b.

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APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

D.3 Ambulance 3

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Tracy, Bill	3. PATIENT'S BIRTH DATE: 05 02 1960 SEX: M [X] F [ ]
5. PATIENT'S ADDRESS (No., Street): 2242 Spencer	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]
CITY: San Antonio STATE: TX	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]
ZIP CODE: 78228 TELEPHONE (Include Area Code): (123) 555-1234	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

	11. INSURED'S POLICY GROUP OR FECA NUMBER
	a. INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]
	b. EMPLOYER'S NAME OR SCHOOL NAME
	c. INSURANCE PLAN NAME OR PROGRAM NAME
	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. [ ] 17b. NPI [ ]
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES [ ]
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. L 994.7 2. [ ] 3. [ ] 4. [ ]	22. MEDICAID RESUBMISSION CODE [ ] ORIGINAL REF. NO. [ ] 23. PRIOR AUTHORIZATION NUMBER [ ]

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 01 2008 01 01 2008	3		A0429	RH	1	200.00	1		NPI	1234567-89
										NPI	9087654321
2	01 01 2008 01 01 2008	3		A0425	ET	1	30.00	6		NPI	1234567-89
										NPI	9087654321
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]	26. PATIENT'S ACCOUNT NO.: 12345	27. ACCEPT ASSIGNMENT? (For govt. claims, see back): YES [X] NO [ ]	28. TOTAL CHARGE: $ 230.00
29. AMOUNT PAID: $	30. BALANCE DUE: $		

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.): *Mike Harrahan* 01 10 2008 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION: Texas Hospital 209 West 45th Street Anywhere, TX 78500 a. 4302198765 b.
33. BILLING PROVIDER INFO & PH #: Harrahan Ambulance 345 Morning Star San Antonio, TX 77777 ( ) a. 9876543021 b.	

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.4 Ambulatory Surgical Center

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Reddig, Sarah J.	3. PATIENT'S BIRTH DATE: 08 12 1927 SEX: M [ ] F [X]
5. PATIENT'S ADDRESS (No., Street): 901 East Street	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
CITY: Del Rio STATE: TX	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]
ZIP CODE: 78840 TELEPHONE (Include Area Code): (123) 555-1234	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

	11. INSURED'S POLICY GROUP OR FECA NUMBER
	a. INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]
	b. EMPLOYER'S NAME OR SCHOOL NAME
	c. INSURANCE PLAN NAME OR PROGRAM NAME
	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED **Signature on File** DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Charles Sotos, M.D.	17a. [ ] 17b. NPI 9876012345
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES [ ]
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 3669 2. [ ] 3. [ ] 4. [ ]	22. MEDICAID RESUBMISSION CODE [ ] ORIGINAL REF. NO. [ ] 23. PRIOR AUTHORIZATION NUMBER [ ]

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 01 2008 01 01 2008	5		66984	LT	1	750.00	1		NPI	1234567-89
										NPI	9087654321
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]	26. PATIENT'S ACCOUNT NO.: 123456	27. ACCEPT ASSIGNMENT? (For govt. claims, see back): YES [X] NO [ ]	28. TOTAL CHARGE: $ 750.00
29. AMOUNT PAID: $	30. BALANCE DUE: $		

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.): *Raquel Del Sol* 01 10 2008 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION: a. NPI b.
33. BILLING PROVIDER INFO & PH #: Del Rio Surgery Center 345 Morning Star San Antonio, TX 77777 210-555-1234 ( ) a. 9876543021 b.	

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.5 Anesthesia

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) [X] | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Stirney, Brenda K.

3. PATIENT'S BIRTH DATE: 01 04 1960 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1200 N. Main Street

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse Child Other

7. INSURED'S ADDRESS (No., Street):

CITY: Bay City STATE: TX

8. PATIENT STATUS: Single [ ] Married Other

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (123) 555-1234

Employed [ ] Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED Signature on File

14. DATE OF CURRENT: MM DD YY 04 03 2008 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 641 01 3. 2. 646 21 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 01 2008	01 01 2008	3	7	01961	AA 1	500.00		53 min.		NPI	1234567-89 9087654321
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ] 123456

26. PATIENT'S ACCOUNT NO. X

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO

28. TOTAL CHARGE $ 500.00

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Susan Johnson, M.D. 01 08 2008

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

Doctor's Hospital
3321 Medical Drive
Bay City, TX 77414

a. 4302198765 b.

33. BILLING PROVIDER INFO & PH # ( )

Susan Johnson, M.D.
438 Norlins Way
Bay City, TX 77414

a. 9876543021 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.6 Birthing Center

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) [X] | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jones, Nora K.

3. PATIENT'S BIRTH DATE: 12 01 1974 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 901 East Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other

7. INSURED'S ADDRESS (No., Street):

CITY: San Antonio STATE: TX

8. PATIENT STATUS: Single Married [X] Other

CITY STATE

ZIP CODE: 78218 TELEPHONE (Include Area Code): (210) 555-1234

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY 04 03 2008 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Mary Smith, CNM

17a.

17b. NPI 1234056789

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 650 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 01 2008	01 01 2008	7		59409		1	503.84	1		NPI	1234567-89 9087654321
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO. 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO

28. TOTAL CHARGE $ 503.84

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Sally Jones 01 09 2008

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

South Texas Birthing Center
1118 Rio Grande
San Antonio, TX 78201

a. 9876543021 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.7 Blind Children's Vocational Discovery and Development Program (BCVDDP)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)	MEDICAID (Medicaid #) X
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Martin, Joel M.
3. PATIENT'S BIRTH DATE SEX	12 20 1993 M X F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)	563 Magicians Ct.
6. PATIENT RELATIONSHIP TO INSURED	Self X Spouse Child Other
7. INSURED'S ADDRESS (No., Street)	
CITY / STATE	Pharr / TX
8. PATIENT STATUS	Single Married Other; Employed Full-Time Student Part-Time Student
CITY / STATE	
ZIP CODE / TELEPHONE (Include Area Code)	78535 / ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
10. IS PATIENT'S CONDITION RELATED TO:	a. EMPLOYMENT? (Current or Previous) NO; b. AUTO ACCIDENT? NO PLACE (State); c. OTHER ACCIDENT? NO
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	
a. INSURED'S DATE OF BIRTH SEX	M F
b. OTHER INSURED'S DATE OF BIRTH SEX	M F
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	
10d. RESERVED FOR LOCAL USE	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	FROM TO
19. RESERVED FOR LOCAL USE	
20. OUTSIDE LAB?	YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)	1. 369.00 2. 3. 4.
22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER	

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 01 2008 01 01 2008	2		G9012		1	100.00	1		NPI	1234567-89 / 9087654321
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID / 30. BALANCE DUE
	123456	X YES NO	$ 100.00	$ / $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	Richard Glass 01 10 2008 SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION	a. NPI b.
33. BILLING PROVIDER INFO & PH #	Texas Commission for the Blind 1200 Front St. Pharr, TX 78201 ( ) a. 9876543021 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.8 Case Management for Early Childhood Intervention (ECI)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)	MEDICAID (Medicaid #) X
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Monroe, Angela T.
3. PATIENT'S BIRTH DATE SEX	07 16 2006 M F X
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)	12 Rodeo Drive
6. PATIENT RELATIONSHIP TO INSURED	Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)	
CITY / STATE	Blanco / TX
8. PATIENT STATUS	Single Married Other; Employed Full-Time Student Part-Time Student
CITY / STATE	
ZIP CODE / TELEPHONE (Include Area Code)	78606 / ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
10. IS PATIENT'S CONDITION RELATED TO:	a. EMPLOYMENT? (Current or Previous) NO; b. AUTO ACCIDENT? NO PLACE (State); c. OTHER ACCIDENT? NO
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	
a. INSURED'S DATE OF BIRTH SEX	M F
b. OTHER INSURED'S DATE OF BIRTH SEX	M F
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	
10d. RESERVED FOR LOCAL USE	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	FROM TO
19. RESERVED FOR LOCAL USE	
20. OUTSIDE LAB?	YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)	1. 315.9 2. 3. 4.
22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER	

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 01 2008 01 01 2008	2		G9012		1	141.83	1		NPI	1234567-89 / 9087654321
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID / 30. BALANCE DUE
		X YES NO	$ 141.83	$ / $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	Tom White 01 10 2008 SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION	a. NPI b.
33. BILLING PROVIDER INFO & PH #	ECI Program 1223 Baltic Ave. Blanco, TX 78606 ( ) a. 9876543021 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.9 Case Management for Children and Pregnant Women (CPW)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) [ ] MEDICAID (Medicaid #) [ ] TRICARE CHAMPUS (Sponsor's SSN) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID) [ ]	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Barton, Josie M.	3. PATIENT'S BIRTH DATE MM DD YY: 10 15 2001; SEX M [ ] F [X]
5. PATIENT'S ADDRESS (No., Street): 300 Atlantic Ave.	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]
CITY: Paris; STATE: TX	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]
ZIP CODE: 75460; TELEPHONE (Include Area Code): (903) 555-1234	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO
b. OTHER INSURED'S DATE OF BIRTH MM DD YY; SEX M [ ] F [ ]	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? [ ] YES [X] NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

CITY	STATE
ZIP CODE	TELEPHONE (Include Area Code): ( )
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH MM DD YY	SEX M [ ] F [ ]
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes*, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____

14. DATE OF CURRENT: MM DD YY; ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 3438 3. 2. 4.	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER: 9892126567

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 01 2008 01 01 2008	1		G9012	U2 U5	1	60 00	1		NPI	1234567-89 9087654321
2 01 25 2008 01 25 2008	1		G9012	TS U5	1	60 00	1		NPI	1234567-89 9087654321
3 02 10 2008 02 10 2008	9		G9012	TS	1	20 00	1		NPI	1234567-89 9087654321
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.: 12345	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO	28. TOTAL CHARGE: $ 140 00
29. AMOUNT PAID: $	30. BALANCE DUE: $		

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION
Robert Jackson 02 10 2008 SIGNED DATE	a. NPI b.
33. BILLING PROVIDER INFO & PH # ( ): 123 Case Management Inc. 1200 Medical Circle Paris, TX 75460	a. 9876543021 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.10 Certified Nurse-Midwife (CNM)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) [ ] MEDICAID (Medicaid #) [X] TRICARE CHAMPUS (Sponsor's SSN) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID) [ ]	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Green, Kelly J.	3. PATIENT'S BIRTH DATE MM DD YY: 06 10 1971; SEX M [ ] F [X]
5. PATIENT'S ADDRESS (No., Street): 901 East Street	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
CITY: San Antonio; STATE: TX	8. PATIENT STATUS: Single [ ] Married [X] Other [ ]
ZIP CODE: 78218; TELEPHONE (Include Area Code): (210) 555-1234	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO
b. OTHER INSURED'S DATE OF BIRTH MM DD YY; SEX M [ ] F [ ]	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? [ ] YES [X] NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

CITY	STATE
ZIP CODE	TELEPHONE (Include Area Code): ( )
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH MM DD YY	SEX M [ ] F [ ]
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes*, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED Signature on File DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____

14. DATE OF CURRENT: MM DD YY 04 02 2007; ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. V22 0 3. 2. 650 4.	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER: 1234567890

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 01 2008 01 01 2008	1		99211	TH	1	22 80			NPI	1234567-89 9087654321
2 01 08 2008 01 08 2008	2		59410		2	700 00			NPI	1234567-89 9087654321
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.: 12345	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO	28. TOTAL CHARGE: $ 722 80
29. AMOUNT PAID: $	30. BALANCE DUE: $		

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION: Sisters of Mercy Hospital 1242 Bogen Blvd. Texas City, TX 77592
Alicia Thomas, CNM 01 17 2008 SIGNED DATE	a. 4302198765 b.
33. BILLING PROVIDER INFO & PH # ( ): Alicia Thomas, CNM 184 Marron Way Texas City, TX 77592	a. 9876543021 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.11 Certified Registered Nurse Anesthetist (CRNA)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, Janet M.

3. PATIENT'S BIRTH DATE MM DD YY: 06 05 1957 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 800 Avenue C

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Austin STATE: TX

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]

CITY: STATE:

ZIP CODE: 78710 TELEPHONE (Include Area Code): (512) 555-1234

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on File DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED:

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP):

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE:

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. V25.2 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 01 2008	01 01 2008	3		00950	QX 2S	1	131.75	55 min.		NPI	1234567-89 9087654321
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $ 131.75

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Sarah Jones RN, CRNA

01 10 2008 SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

Texas Hospital
1234 Medical Way
Austin, TX 78712

a. 4302198765 b.

33. BILLING PROVIDER INFO & PH # ( )

Sarah Jones RN, CRNA
1234 Main Street
Austin, TX 78712

a. 9876543021 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.12 Certified Respiratory Care Practitioner (CRCP)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE [X] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Hanson, Patricia A.

3. PATIENT'S BIRTH DATE MM DD YY: 05 27 1964 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 422 Pine Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Laredo STATE: TX

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 12345 TELEPHONE (Include Area Code): (210) 555-1234

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on File DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED:

14. DATE OF CURRENT: 12 29 99 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP):

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: B.J. Higgins, M.D.

17a.

17b. NPI 1234567089

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 518.5 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 123456789

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 01 2008	01 07 2008	2		99503		1	466.76	7		NPI	1234567-89 9087654321
2 01 12 2008	01 12 2008	2		99503		1	1111.26	1		NPI	1234567-89 9087654321
3 01 16 2008	01 16 2008	2		99503		1	66.68	1		NPI	1234567-89 9087654321
4 01 20 2008	01 20 2008	2		99503		1	66.68	1		NPI	1234567-89 9087654321
5 01 21 2008	01 21 2008	2		99503		1	854.15	1		NPI	1234567-89 9087654321
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $ 2565.53

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Julie Harris, RCP 01 24 2008 SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Julie Harris, RCP
1204 East Ave.
Laredo, TX 78041

a. 9876543021 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.13 Chemical Dependency Treatment Facility

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, John	3. PATIENT'S BIRTH DATE: 03 17 1980 SEX: M X F
5. PATIENT'S ADDRESS (No., Street): 920 Chaning Way	6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other
CITY: Dallas STATE: TX	8. PATIENT STATUS: Single Married Other
ZIP CODE: 75235 TELEPHONE (Include Area Code): (123) 555-1234	Employed Full-Time Student Part-Time Student
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous): YES X NO
b. OTHER INSURED'S DATE OF BIRTH: SEX M F	b. AUTO ACCIDENT? PLACE (State): YES X NO
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES X NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE

11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH: SEX M F	
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.	

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Samuel Jones, M.D.	17a. 17b. NPI 1234567889
19. RESERVED FOR LOCAL USE	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 304.90	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM TO	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM TO	
20. OUTSIDE LAB? $ CHARGES: YES X NO	
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER	

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1											1234567-89
01 01 2008	01 01 2008	5		H0005	HF	1	16 00	1		NPI	9087654321
2											1234567-89
01 01 2008	01 01 2008	5		H0004	HF	1	47 00			NPI	9087654321
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.: 12345	27. ACCEPT ASSIGNMENT? (For govt. claims, see back): X YES NO	28. TOTAL CHARGE: $ 63 00
29. AMOUNT PAID: $	30. BALANCE DUE: $		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.): Joe Harris 01 10 2008 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION: a. NPI b.		33. BILLING PROVIDER INFO & PH #: ( ) Chemical Dependency of Texas 111 Medical Way Dallas, TX 75213 a. 9876543021 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.14 Chiropractic Services

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jones, Clara	3. PATIENT'S BIRTH DATE: 09 23 1987 SEX: M X F
5. PATIENT'S ADDRESS (No., Street): 1424 Ridgeway	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other
CITY: West STATE: TX	8. PATIENT STATUS: Single X Married Other
ZIP CODE: 78212 TELEPHONE (Include Area Code): (817) 555-1234	Employed Full-Time Student Part-Time Student
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous): YES X NO
b. OTHER INSURED'S DATE OF BIRTH: SEX M F	b. AUTO ACCIDENT? PLACE (State): YES X NO
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES X NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE

11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH: SEX M F	
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.	

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
19. RESERVED FOR LOCAL USE	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 839.03 Acute subluxation of spine-C3 x-rays 12/01/2004	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM TO	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM TO	
20. OUTSIDE LAB? $ CHARGES: YES X NO	
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER	

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1											1234567-89
01 01 2008	01 01 2008	1		98941	AT	1	25 00			NPI	9087654321
2											1234567-89
01 03 2008	01 03 2008	1		98940	AT	1	25 00			NPI	9087654321
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.: 12345	27. ACCEPT ASSIGNMENT? (For govt. claims, see back): X YES NO	28. TOTAL CHARGE: $ 50 00
29. AMOUNT PAID: $	30. BALANCE DUE: $		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.): Carl Smith, DC 01 15 2008 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION: a. NPI b.		33. BILLING PROVIDER INFO & PH #: ( ) Carl Smith, D.C. 3207 Main Street West, TX 78213 a. 9876543021 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.15 Comprehensive Outpatient Rehabilitation Facility (CORF) (THSteps-CCP Only)

1 Rehabilitation Health Center 2600 West Drive Texarkana, TX 75503 903-555-1234	2	3a PAT. CNTL # 12345 b. MED. REC. # 123456 5 FED. TAX NO.	4 TYPE OF BILL 0131 6 STATEMENT COVERS PERIOD FROM 01232008 THROUGH 01292008 7
8 PATIENT NAME a Freeman, Angela	9 PATIENT ADDRESS a 9504 Dale St., Houston, TX 77057		
10 BIRTHDATE 03241996	11 SEX F	12 ADMISSION DATE 01232008	13 HR 14 TYPE 10 15 SRC
16 DHR	17 STAT	18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES	29 ACDT STATE 30

31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE SPAN CODE FROM THROUGH	36 OCCURRENCE SPAN CODE FROM THROUGH	37
a						a
b						b

38

39 VALUE CODES CODE AMOUNT	40 VALUE CODES CODE AMOUNT	41 VALUE CODES CODE AMOUNT
a		
b		
c		
d		

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
424	Comp. Outpatient Therapy Eval.	1-97001	01232008	1	40 00		
440	Speech Therapy	1-92506	01252008	1	50 00		
420	Physical Therapy	1-97110	01292008	1	45 00		
		Total Charges			135 00		
	PAGE ____ OF ____	CREATION DATE		TOTALS			

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO.	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57 OTHER PRV ID
A Medicaid						1234506789	9876543-21
B							
C							

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A Hearn, Jennifer K.		123456789		
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A 123456789		
B		
C		

66 DX 34210 A B C D E F G H I J K L M N O P Q 68

69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI	73
	a b c		a b c	

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75	76 ATTENDING NPI QUAL LAST FIRST
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE		77 OPERATING NPI QUAL LAST FIRST
				78 OTHER NPI QUAL LAST FIRST
				79 OTHER NPI QUAL LAST FIRST

80 REMARKS	81 CC
Hemplegia, Spastic	a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

D.16 Dental (Doctor of Dentistry)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA — CARRIER

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
	X						123456789

PATIENT AND INSURED INFORMATION

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Sanches, Donna K.	02 14 1944 M F X	
5. PATIENT'S ADDRESS (No., Street) 8001 Austin Place	6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY: East — STATE: TX	8. PATIENT STATUS Single Married X Other Employed Full-Time Student Part-Time Student	CITY — STATE
ZIP CODE: 72342 — TELEPHONE (Include Area Code): (817) 555-1234		ZIP CODE — TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M F	b. AUTO ACCIDENT? YES X NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED Signature on File DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Jeff Jones, M.D.	17a. 17b. NPI 1234567089	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES X NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. L 208 . 00 — 3. L ____ . ____ 2. L 522 . 5 — 4. L ____ . ____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 099011997

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 01 01 2008 01 01 2008	1		41850	2	52 94	1		NPI	1234567-89 9087654321
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
	123456	X YES NO	$ 52 94	$ ( )	$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
Signature on File 01 01 2008 SIGNED DATE	a. NPI b.	John Brown, D.D.S. 1414 Green St. East, TX 72341 a. 9087654321 b.

NUCC Instruction Manual available at: www.nucc.org APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.17 Diagnosis and Treatment (Referral from THSteps Check Up)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) — X MEDICAID (Medicaid #)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Braunfeld, Gerald

3. PATIENT'S BIRTH DATE: 04 09 1994 — SEX: X M / F

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 2608 Best Street

6. PATIENT RELATIONSHIP TO INSURED: Self / Spouse / Child / Other

7. INSURED'S ADDRESS (No., Street):

CITY: Dallas — STATE: TX

8. PATIENT STATUS: Single / Married / Other; Employed / Full-Time Student / Part-Time Student

CITY: — STATE:

ZIP CODE: 75227 — TELEPHONE (Include Area Code): (123)555-1234

ZIP CODE: — TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous): YES / X NO

a. INSURED'S DATE OF BIRTH: SEX M / F

b. OTHER INSURED'S DATE OF BIRTH: SEX M / F

b. AUTO ACCIDENT? X NO — PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO — *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED:

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP):

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Sidney Medical Clinic

17a.

17b. NPI: 1234560987

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES / NO — $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 493.90 3. 2. 4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 01 01 2008	01 01 2008	1		99213		1	40.00	1		NPI	1234567-89 9087654321
2 01 01 2008	01 01 2008	1		71010		1	45.00	1		NPI	1234567-89 9087654321
3 01 01 2008	01 01 2008	1		J0170		1	18.00	1		NPI	1234567-89 9087654321
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: SSN / EIN

26. PATIENT'S ACCOUNT NO.: 1234567890

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES / NO

28. TOTAL CHARGE: $ 103.00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File 01 09 2008

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Norman Joseph, M.D.
105 Medical Parkway
Anytown, TX 77711

a. 9876543021 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

D.18 Dialysis Training

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) — X MEDICAID (Medicaid #)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Gilbert, Melinda

3. PATIENT'S BIRTH DATE: 06 14 1964 — SEX: M / X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 9901 Channing Cross

6. PATIENT RELATIONSHIP TO INSURED: Self / Spouse / Child / Other

7. INSURED'S ADDRESS (No., Street):

CITY: Bryan — STATE: TX

8. PATIENT STATUS: Single / Married / Other; Employed / Full-Time Student / Part-Time Student

CITY: — STATE:

ZIP CODE: 77081 — TELEPHONE (Include Area Code): (409) 555-1234

ZIP CODE: — TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous): YES / X NO

a. INSURED'S DATE OF BIRTH: SEX M / F

b. OTHER INSURED'S DATE OF BIRTH: SEX M / F

b. AUTO ACCIDENT? X NO — PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO — *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED:

14. DATE OF CURRENT: 12 01 2007 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP):

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE:

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM TO

19. RESERVED FOR LOCAL USE: ONSET 120198

20. OUTSIDE LAB? YES / X NO — $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 727.06 3. 2. 4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 01 01 2008	01 01 2008	1		90989	AT	1	500.00			NPI	1234567-89 9087654321
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: SSN / EIN

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES / NO

28. TOTAL CHARGE: $ 500.00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Justin Blake 01 08 2008

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

The Blake Clinic
911 Medical Drive
Bryan, TX 77082

a. 9876543021 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

D.19 Durable Medical Equipment (THSteps-CCP Only)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

1. MEDICARE | MEDICAID | TRICARE CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER
(Medicare #) [X] (Medicaid #) [ ] (Sponsor's SSN) [ ] (Member ID#) [ ] (SSN or ID) [ ] (SSN) [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Williams, Sarah M.

3. PATIENT'S BIRTH DATE (MM DD YY) 09 14 1988 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 1201 Carning Place

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Plano | STATE: TX

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY | STATE

ZIP CODE: 75432 | TELEPHONE (Include Area Code): ( )

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH (MM DD YY) SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: Signature on File | DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

14. DATE OF CURRENT: (MM DD YY) ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE (MM DD YY)

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM DD YY) FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Paul Burnes, M.D.

17a.

17b. NPI 1234567089

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 854.00 3. 2. 4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 999266123

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 01 2008	01 01 2008	2		B9998		1	120.00	1		NPI	1234567-89 9087654321
2	01 01 2008	01 01 2008	2		T4529		1	15.00	50		NPI	1234567-89 9087654321
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 1234567

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 135.00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
David Patten 01 10 2008
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )
General Supply Company
1902 Bunker Hill
Hillsboro, TX 74932
a. 9876543021 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.20 Early Childhood Intervention (THSteps-CCP Only)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

1. MEDICARE | MEDICAID | TRICARE CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER
(Medicare #) [X] (Medicaid #) [ ] (Sponsor's SSN) [ ] (Member ID#) [ ] (SSN or ID) [ ] (SSN) [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Clark, Amy B.

3. PATIENT'S BIRTH DATE (MM DD YY) 03 24 2006 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 632 Baker Lane

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Austin | STATE: TX

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY | STATE

ZIP CODE: 78757 | TELEPHONE (Include Area Code): ( )

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH (MM DD YY) SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: Signature on File | DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: Signature on File

14. DATE OF CURRENT: (MM DD YY) ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE (MM DD YY)

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM DD YY) FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Jim Blanks, M.D.

17a.

17b. NPI 1234567089

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 783.40 3. 2. 315.31 4. 611660000

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 05 2008	01 05 2008	1		97003	TL	1	30.00	1		NPI	1234567-89 9087654321
2	01 05 2008	01 05 2008	1		97532	TL	1	25.00	2		NPI	1234567-89 9087654321
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 55.00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Julie Brown 02 01 2008
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.

33. BILLING PROVIDER INFO & PH # (512) 555-1234
Early Child hood Clinic
123 Springdale Drive
Austin, TX 78759
a. 9876543021 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.21 Family Planning Claim Form

Family Planning 2017 Claim Form

1. Family Planning Program: V ☐ XIX ☐ XX ☐
1a. Title X Only ☐ Full Pay ☐ Partial Pay ☐ No Pay ☐
2a. Billing Provider TPI: 1234567-89
2b. Billing Provider NPI: 9870654321
3. Provider Name: Joe Smith
4. Eligibility Date (V or XX) (MM/DD/CCYY): 01/02/2008
5. Family Planning No. (Medicaid PCN if XIX):
6. Patient's Name (Last Name, First Name, Middle Initial): Pye, Sherrie
7. Address (Street, City, State): 341 Tosser Way, Houston, TX
7a. ZIP code: 77485
8. County of Residence: Harris
9. Date of Birth (MM/DD/CCYY): 02/02/1971
10. Sex: F [X] M ☐
11. Patient Status: New Patient [X] Established Patient ☐
12. Patient's Social Security Number: 123 - 45 - 6789
13. Race (Code #): 1 — White (1) Black (2) AmIndian/AlaskaNat (4) Asian (5) Unk/NotRep (6) NatHawaii/PacIsland (7) More than one race (8)
13a. Ethnicity: 0 — Hispanic (5) Non-Hispanic (0)
14. Marital Status: 3 — (1) Married (2) Never Married (3) Formerly Married
15. Family Income (All): $ 1
15a. Family Size: 2
16. Number Times Pregnant: 1
17. Number Live Births: 1
18. Number Living Children: 1
19. Primary Birth Control Method Before Initial Visit: G
20. Primary Birth Control Method at End of This Visit: A
a=Oral Contraceptive; b=1-Month hormonal injection; c=3-Month hormonal injection; d=Cervical cap/diaphragm; e=Abstinence; f= Hormonal Implant; g=Male condom; h=Female condom; i=Hormonal/Contraceptive patch; j=Spermicide (used alone); k=Intrauterine device (IUD); l=Vaginal ring; m=Fertility awareness method (FAM); n=Sterilization; o=Contraceptive sponge; p=Other method; q=Method unknown; r=No method (if used for #20, must complete #21)
21. If No Method Used at End of This Visit, Give Reason (Required only if #20 = r): a=Refused; b=Pregnant; c=Inconclusive Preg Test; d=Seeking Preg; e=Infertile; f=Rely on Partner; g=Medical
22. Is There Other Insurance Available? Y ☐ N ☐ If Y, Complete Items 23 – 25a
23. Other Insurance Name and Address:
24a. Insured's Policy/Group No.:
24b. Benefit Code:
25. Other Insurance Pd. Amt. $:
25a. Date of Notification:
26. Name of Referring Provider:
27a. Referring Other ID:
27b. Referring NPI:
28. Level of Practitioner: Physician ☐ Nurse ☐ Mid Level ☐ Other ☐
29. Diagnosis Code (Relate Items 1,2,3,or 4 to Item 32D by Line # in 32E): 1. V25.09 2. 3. 4.
30. Authorization Number:
31. Date of Occurrence (MM / DD / CCYY):

32. A Dates of Service From MM	DD	CCYY	To MM	DD	CCYY	B Place of Service	C Reserved for Local Use	D Procedures, Services, or Supplies CPT/HCPCS	Modifier	E Dx. Ref. (29)	F Units or Days (Quantity) No. of Participants (Teen Counseling)	G $ Charges	H Performing Provider #
01	02	2008	01	02	2008	1	1	99203	FP	1	1	$48 27	32H(a) TPI / 32H(b) NPI
													32H(a) TPI / 32H(b) NPI
													32H(a) TPI / 32H(b) NPI
													32H(a) TPI / 32H(b) NPI
													32H(a) TPI / 32H(b) NPI

33. Federal Tax ID Number/EIN:
34. Patient's Account No. (optional):
35. Patient Co-Pay Assessed (V, X or XX) $:
36. **Total Charges** $48.27
37. Signature of Physician or Supplier Date: 01/02/2008 Signed: Joe Smith
38. Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office):
38a. NPI:
38b. Other ID:
39. Physician's, Supplier's Billing Name, Address, Zip Code & Phone No.: Joe Smith, 1234 Oak Drive, Houston, Texas 77485, (281)123-4567

Form Revised: January 2007

D.22 Family Planning Services for Hospitals, FQHCs

Refer to: The Family Planning section to determine which claim form to complete.

1 Federally Qualified Health, 1242 Medical Drive, The Colony, Texas 75321
3a PAT. CNTL #: 12345678
b. MED. REC. #: 987651234
4 TYPE OF BILL: 0731
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD: FROM THROUGH
8 PATIENT NAME: Kent, Sara L.
9 PATIENT ADDRESS: 1234 Bartland Way, Plano, Texas 75011
10 BIRTHDATE: 02141977
11 SEX: F
12 ADMISSION DATE: 01012007
13 HR 14 TYPE 15 SRC: 11
16 DHR 17 STAT
CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28
29 ACDT STATE 30
31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37
38
39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
520	Annual Family Planning Exam	1-99203 FP	01012007	1	47 57	
307	Urinalysis	5-81015 FP	01012007	1	4 31	
		Total Charges			51 88	

PAGE ____ OF ____ CREATION DATE TOTALS

50 PAYER NAME: Medicaid
51 HEALTH PLAN ID
52 REL INFO
53 ASG BEN
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI: 1324650879
57 OTHER PRV ID: 9876543-21
58 INSURED'S NAME: Kent, Sara L.
59 P REL
60 INSURED'S UNIQUE ID: 123456789
61 GROUP NAME
62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES: 1234567890
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME
66 DX: V2509
69 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI
74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
75
76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST
80 REMARKS: Annual Family Planning Exam
81CC

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

D.23 FQHC Encounter (T1015)

1 Rio Grande Community
1200 Medical Circle
Rio Grande, Texas 78582

2

3a PAT. CNTL # 12345678
b. MED. REC. # A12345

4 TYPE OF BILL 0731

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM THROUGH

7

8 PATIENT NAME a Bates, Jason M.

9 PATIENT ADDRESS a 1403 Reese Lane, Rio Grande, Texas 78582

10 BIRTHDATE 11031990

11 SEX M

12 ADMISSION DATE 01012008

13 HR 14 TYPE 10 15 SRC 16 DHR 17 STAT

18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES

29 ACDT STATE 30

31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37

38

39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
520	Encounter	1-T1015	01012008	1	35 00		
	Total Charges				35 00		
	PAGE ____ OF ____	CREATION DATE		TOTALS			

50 PAYER NAME: Medicaid
51 HEALTH PLAN ID
52 REL INFO
53 ASG BEN
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI 1324570986
57 OTHER PRV ID 9876543-21

58 INSURED'S NAME: Bates, Jason M.
59 P REL
60 INSURED'S UNIQUE ID: 123456789
61 GROUP NAME
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES: 1234567890
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX: 07799

67 A B C D E F G H I J K L M N O P Q

68

69 ADMIT DX
70 PATIENT REASON DX a b c
71 PPS CODE
72 ECI a b c
73

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS: Conjunctivitis

81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

D.24 FQHC Follow-Up

1 Valley Health Center
105 Medical Avenue
Valley, Texas 78321

2

3a PAT. CNTL # 12345678
b. MED. REC. # 123456

4 TYPE OF BILL 0731

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM THROUGH

7

8 PATIENT NAME a Turner, Margie C.

9 PATIENT ADDRESS a 1902 Park Place, Valley, Texas 78321

10 BIRTHDATE 01041976

11 SEX F

12 ADMISSION DATE 01012008

13 HR 14 TYPE 13 15 SRC 16 DHR 17 STAT

18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES

29 ACDT STATE 30

31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37

38

39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
520	Antepartum Encounter	1-T1015	01012008	1	25 00		
520	Delivery	1-T1015	01012008	1	550 00		
	Total Charges				fc575 00		
	PAGE ____ OF ____	CREATION DATE		TOTALS			

50 PAYER NAME: Medicaid
51 HEALTH PLAN ID
52 REL INFO
53 ASG BEN
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI 1324657908
57 OTHER PRV ID 9876543-21

58 INSURED'S NAME: Turner, Margie C.
59 P REL
60 INSURED'S UNIQUE ID: 123456789
61 GROUP NAME
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES: 1234567890
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX: V221 V302

67 A B C D E F G H I J K L M N O P Q

68 V302

69 ADMIT DX
70 PATIENT REASON DX a b c
71 PPS CODE
72 ECI a b c
73

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS: Pregnancy, Delivery

81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

D.25 Genetics

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Kelly, Ethel W.	3. PATIENT'S BIRTH DATE MM DD YY: 08 16 1959 SEX M [ ] F [X]
5. PATIENT'S ADDRESS (No., Street): 1604 Major Circle	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
CITY: Webster STATE: TX	8. PATIENT STATUS: Single [ ] Married [X] Other [ ]
ZIP CODE: 77591 TELEPHONE (Include Area Code): (210)555-1234	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

CITY STATE	11. INSURED'S POLICY GROUP OR FECA NUMBER
ZIP CODE TELEPHONE (Include Area Code)	a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
	b. EMPLOYER'S NAME OR SCHOOL NAME
	c. INSURANCE PLAN NAME OR PROGRAM NAME
	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED Signature on File DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Christopher Casey, MD	17a. 17b. NPI 1234567089
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 659.53 2. 3. 4.	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM TO MM DD YY
	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM TO MM DD YY

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 01 2008 01 01 2008	1		99244	TG		100.00	1		NPI	1234567-89 9087654321
2	01 01 2008 01 01 2008	1		99404	TG		50.00	1		NPI	1234567-89 9087654321
3	01 01 2008 01 01 2008	1		84999			200.00	1		NPI	1234567-89 9087654321
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.: 123415	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE: $ 350.00
29. AMOUNT PAID: $	30. BALANCE DUE: $		

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Jane Smith, M'D 01 10 2008 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.
	33. BILLING PROVIDER INFO & PH # ( ) Genetics Clinic 1221 Robin Blvd. Webster, TX 77598 a. 9876543021 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

D.26 Hearing Aid Assessments

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jackson, Robert K.	3. PATIENT'S BIRTH DATE MM DD YY: 10 26 2000 SEX M [X] F [ ]
5. PATIENT'S ADDRESS (No., Street): 460 Jennings Lane	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]
CITY: Palestine STATE: TX	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]
ZIP CODE: 75801 TELEPHONE (Include Area Code): (409) 555-1234	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

CITY STATE	11. INSURED'S POLICY GROUP OR FECA NUMBER
ZIP CODE TELEPHONE (Include Area Code)	a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
	b. EMPLOYER'S NAME OR SCHOOL NAME
	c. INSURANCE PLAN NAME OR PROGRAM NAME
	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED Signature on File DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES [X] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 389.9 2. 3. 4.	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM TO MM DD YY
	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM TO MM DD YY

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 01 2008 01 01 2008	1		92551		1	62.12	1		NPI	1234567-89 9087654321
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.: 123456	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE: $ 62.12
29. AMOUNT PAID: $	30. BALANCE DUE: $		

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Tom White 01 10 2008 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.
	33. BILLING PROVIDER INFO & PH # ( ) The Hearing Aid Store/Service Ctr. 432 New Pines Palestine, TX 75801 a. 9876543021 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

D.27 Home Health Services DME/Medical Supplies

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) [X] MEDICAID (Medicaid #) [ ] TRICARE CHAMPUS (Sponsor's SSN) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID) [ ]

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, Mary Lou

3. PATIENT'S BIRTH DATE MM DD YY: 11 22 1934 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Smith, Mary Lou

5. PATIENT'S ADDRESS (No., Street): 123 North Main Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 123 North Main Street

CITY: Dallas STATE: TX

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: Dallas STATE: TX

ZIP CODE: 75236 TELEPHONE (Include Area Code): (214) 555-1234

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 75236 TELEPHONE (Include Area Code): (214) 555-1234

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): N/A

10. IS PATIENT'S CONDITION RELATED TO: IDDM, Asthma

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 11 22 1934 SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Medicaid

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Home Health Services Associates

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 493.90
2. 250.00
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 7123220000

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 07 01 2008	08 31 2008	02		A9150			5.00	00		NPI	1234567-89 9087654321
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 451 23 4567

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 5.00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Jane Doe SIGNED 07 01 2008 DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (214) 234-7900

Home Health Services Associates & DME
555 Broadway
Dallas, TX 75234

a. 9876543021 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.28 Home Health Services Skilled Nursing Visit

1 Home Nursing Services
2214 Health Care
Dallas, Texas 75235

3a PAT. CNTL # 12345678
b. MED. REC. # 123456
4 TYPE OF BILL 0331
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7

8 PATIENT NAME a Lake, William W
9 PATIENT ADDRESS a 2200 Trape Lane Harlingen, TX 78550

10 BIRTHDATE 02141949
11 SEX M
12 ADMISSION DATE 01012008
13 HR 14 TYPE 15 SRC
16 DHR
17 STAT
18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES
29 ACDT STATE
30

31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37

38

39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
550	Skilled Nursing Visit	C-G0154	01012008	1	50.00	
550	Skilled Nursing Visit (PRN)	C-G0154	01012008	1	50.00	
570	Home Health Aide	C-G0156	01012008	1	40.00	
				Total Charges	140.00	

PAGE ____ OF ____ CREATION DATE TOTALS

50 PAYER NAME: All Health Insurance / Medicaid
51 HEALTH PLAN ID
52 REL INFO
53 ASG BEN
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI 1324658709
57 OTHER 9876543-21 PRV ID

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A Lake, Susan K.	S	123456789	All Mart Corp.	G1234
B Lake, William W.		123456789		

63 TREATMENT AUTHORIZATION CODES: 1234567890
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME: All Mart Corp. 1200 Hwy. 6, Dallas, TX 75474

66 DX: 5696
67 A B C D E F G H I J K L M N O P Q
68

69 ADMIT DX: V443
70 PATIENT REASON DX a b c
71 PPS CODE
72 ECI a b c
73

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE

80 REMARKS: Colostomy - After Surgery
81CC a b c d

76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

D.29 Home Health Services Skilled Nursing Visit and Physical Therapy

1 Home Care Association
1200 Terrace Ct.
Webster, TX 77598

3a PAT. CNTL #: 123A45
b. MED. REC. #: 123456
4 TYPE OF BILL: 0331
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD: FROM / THROUGH
7

8 PATIENT NAME: a Hernandez, Jorge C.
9 PATIENT ADDRESS: a 6789 Ave. A Webster, TX 77598

10 BIRTHDATE: 05021949
11 SEX: M
12 ADMISSION DATE: 01012008
13 HR / 14 TYPE / 15 SRC / 16 DHR
17 STAT
18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES
29 ACDT STATE
30

31 OCCURRENCE CODE / DATE: a 27 01012008
32 OCCURRENCE CODE / DATE
33 OCCURRENCE CODE / DATE
34 OCCURRENCE CODE / DATE
35 OCCURRENCE SPAN CODE / FROM / THROUGH
36 OCCURRENCE SPAN CODE / FROM / THROUGH
37

38

39 VALUE CODES CODE / AMOUNT
40 VALUE CODES CODE / AMOUNT
41 VALUE CODES CODE / AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
550	SNV 68/69	C-G0154	01012008	1	50.00	
420	P.T. Treatment and Exercise 30 min. 67	C-97110 AT	01012008	1	88.20	
430	O.T. Application of a modality, to one or more areas, traction, mechanical	C-97012 AT	01012008	1	11.82	
		Total Charges			150.02	

PAGE ____ OF ____ CREATION DATE TOTALS

50 PAYER NAME: Medicaid
51 HEALTH PLAN ID: 9876543021
52 REL. INFO / 53 ASG. BEN. / 54 PRIOR PAYMENTS / 55 EST. AMOUNT DUE
56 NPI: 1324657908
57 OTHER PRV ID: 9876543-21

58 INSURED'S NAME: Hernandez, Jorge C.
59 P REL
60 INSURED'S UNIQUE ID: 123456789
61 GROUP NAME
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES: 1234567890
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX: 73314
67 A B C D E F G H I J K L M N O P Q
68: 73314

69 ADMIT DX: 73314
70 PATIENT REASON DX: a b c
71 PPS CODE
72 ECI
73

74 PRINCIPAL PROCEDURE CODE / DATE
a. OTHER PROCEDURE CODE / DATE
b. OTHER PROCEDURE CODE / DATE
75
c. OTHER PROCEDURE CODE / DATE
d. OTHER PROCEDURE CODE / DATE
e. OTHER PROCEDURE CODE / DATE

76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS: Injury to neck of femur
81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

D.30 Hospital-Based ASC

1 Greatland Hospital Center
4004 Elm Loop
Westville, TX
512-555-1234

3a PAT. CNTL #: 123456B
b. MED. REC. #: E123456
4 TYPE OF BILL: 0131
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD: FROM / THROUGH
7

8 PATIENT NAME: a Lei, Wei Chu
9 PATIENT ADDRESS: a 6789 Courtland Circle Westville TX 79065

10 BIRTHDATE: 12161964
11 SEX: M
12 ADMISSION DATE: 01012008
13 HR: 11 / 14 TYPE / 15 SRC / 16 DHR
17 STAT
18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES
29 ACDT STATE
30

31 OCCURRENCE CODE / DATE
32 OCCURRENCE CODE / DATE
33 OCCURRENCE CODE / DATE
34 OCCURRENCE CODE / DATE
35 OCCURRENCE SPAN CODE / FROM / THROUGH
36 OCCURRENCE SPAN CODE / FROM / THROUGH
37

38

39 VALUE CODES CODE / AMOUNT
40 VALUE CODES CODE / AMOUNT
41 VALUE CODES CODE / AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
360	Typano W/ masto and chain reconstruct	F-69641	01012008	1	871.87	
		Total Charges			871.87	

PAGE ____ OF ____ CREATION DATE TOTALS

50 PAYER NAME: Medicaid
51 HEALTH PLAN ID
52 REL. INFO / 53 ASG. BEN. / 54 PRIOR PAYMENTS / 55 EST. AMOUNT DUE
56 NPI: 1324658709
57 OTHER PRV ID: 9876543-21

58 INSURED'S NAME: Lei, Wei Chu
59 P REL
60 INSURED'S UNIQUE ID: 123456789
61 GROUP NAME
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES: 1234567890
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX: 38903
67 A B C D E F G H I J K L M N O P Q
68: 38900

69 ADMIT DX: 38421
70 PATIENT REASON DX: a b c
71 PPS CODE
72 ECI
73

74 PRINCIPAL PROCEDURE CODE / DATE
a. OTHER PROCEDURE CODE / DATE
b. OTHER PROCEDURE CODE / DATE
75
c. OTHER PROCEDURE CODE / DATE
d. OTHER PROCEDURE CODE / DATE
e. OTHER PROCEDURE CODE / DATE

76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS: Hearing Loss, Left Ear
81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

D.31 Hospital Inpatient

1 Texas Hospital
209 W. 45th
El Paso, Texas 77905
915-555-1234

3a PAT. CNTL #: 12345
b. MED. REC. #: 123456
4 TYPE OF BILL: 0111
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM: 01012008 THROUGH: 01042008

8 PATIENT NAME: b Skye, Amber L.
9 PATIENT ADDRESS: b 1200 Whispering Pines El Paso TX 77903

10 BIRTHDATE: 03271975
11 SEX: F
ADMISSION 12 DATE: 01012008 13 HR: 14 14 TYPE: 2 15 SRC: 1
16 DHR: 10
17 STAT: 01

31 OCCURRENCE CODE / DATE: 10 04012005
32 OCCURRENCE CODE / DATE: 24 02012005

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
112	Room and Board - O.B.	Room 106.67 Rate	01012008		320 01	
250	Pharmacy		01012008		165 00	
258	Pharmacy - IV Solution		01012008		89 00	
270	Medical Surgical Supplies		01012008		712 43	
300	Laboratory		01012008		234 00	
720	Labor Room/Delivery		01012008		1100 00	
		Total Charges			2620 44	

PAGE ____ OF ____ CREATION DATE TOTALS

50 PAYER NAME: A Alm Insurance; B Medicaid
56 NPI: 1324658709
OTHER PRV ID: 9876543-21

58 INSURED'S NAME	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A Skye, John	500-94-1998	Alm Insurance	1998 AB
C Skye, Amber	500-94-1998		

65 EMPLOYER NAME: ABC Roofing, IH-25 S 7100, El Paso, TX

66 DX: 650
69 ADMIT DX: V270
74 PRINCIPAL PROCEDURE CODE: 73.59 DATE: 010199

80 REMARKS: Pregnancy/Delivery.
Alm Insurance, 11 Maple Dr.,
Boston, MA 11211 denied 02 01 2004
for pre-existing condition.

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

D.32 Hospital Outpatient

1 Texas Hospital
209 W. 45th
El Paso, Texas 77905
915-555-1234

3a PAT. CNTL #: 12345
b. MED. REC. #: 123456
4 TYPE OF BILL: 0131
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM: THROUGH:

8 PATIENT NAME: a Baker, Ann C.
9 PATIENT ADDRESS: a 6789 Ave. A Austin, TX 78711

10 BIRTHDATE: 03271965
11 SEX: F
ADMISSION 12 DATE: 01012008 13 HR: 12

31 OCCURRENCE CODE / DATE: 05 01012008

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
450	Emergency Room		01012008	1	68 00	
272	Suture Kit		01012008	1	15 32	
258	Pharmacy - IV Solution		01012008	1		7 80
		Total Charges			91 12	

PAGE ____ OF ____ CREATION DATE TOTALS

50 PAYER NAME: A Medicaid
56 NPI: 1342658079
OTHER PRV ID: 9876543-21

58 INSURED'S NAME	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A Baker, Ann C.	500-01-1998		

66 DX: 8930

80 REMARKS: Lacerated toe, Rt.

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

D.33 In-Home Total Parenteral Nutrition (TPN)/Hyperalimentation Supplier

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE / MEDICAID / TRICARE CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) X (Medicaid #) ☐ (Sponsor's SSN) ☐ (Member ID#) ☐ (SSN or ID) ☐ (SSN) ☐ (ID) ☐	123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Jefferson, Martha	3. PATIENT'S BIRTH DATE MM DD YY: 09 27 1957 SEX: M ☐ F X
5. PATIENT'S ADDRESS (No., Street) 5668 Marlin Avenue	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse ☐ Child ☐ Other ☐
CITY: San Antonio — STATE: TX	8. PATIENT STATUS: Single X Married ☐ Other ☐
ZIP CODE: 77718 — TELEPHONE (Include Area Code): ( )	Employed ☐ Full-Time Student ☐ Part-Time Student ☐
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous): YES ☐ NO X
b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX: M ☐ F ☐	b. AUTO ACCIDENT? YES ☐ NO X PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES ☐ NO X
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: Signature on File — DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED:

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dan Smith, M.D.	17a. ☐ 17b. NPI 1234567089
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES ☐ NO X $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 579.2 3. ☐ 2. ☐ 4. ☐	22. MEDICAID RESUBMISSION CODE ☐ ORIGINAL REF. NO. ☐ 23. PRIOR AUTHORIZATION NUMBER ☐

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES (1234567890)	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 01 01 2008	01 01 2008	2		S9364		1	580.00	4		NPI	1234567-89 / 9087654321
2 01 05 2008	01 05 2008	2		S9368		1	145.00	1		NPI	1234567-89 / 9087654321
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
☐ ☐	12345678	X YES ☐ NO	$ 725.00	$	$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
Carl Smith 02 10 2008 SIGNED DATE	a. NPI b.	Hyperalimentation Supply 2801 West Street San Antonio, TX 77711 (214) 555-1234 a. 9876543021 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

D.34 Independent Laboratory

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE / MEDICAID / TRICARE CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) X (Medicaid #) ☐ (Sponsor's SSN) ☐ (Member ID#) ☐ (SSN or ID) ☐ (SSN) ☐ (ID) ☐	123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Platt, Sylvia J.	3. PATIENT'S BIRTH DATE MM DD YY: 08 03 1953 SEX: M ☐ F X
5. PATIENT'S ADDRESS (No., Street) 942 Hartford Drive	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse ☐ Child ☐ Other ☐
CITY: Comfort — STATE: TX	8. PATIENT STATUS: Single X Married ☐ Other ☐
ZIP CODE: 78013 — TELEPHONE (Include Area Code): (512) 555-1234	Employed ☐ Full-Time Student ☐ Part-Time Student ☐
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous): YES ☐ NO X
b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX: M ☐ F ☐	b. AUTO ACCIDENT? YES ☐ NO X PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES ☐ NO X
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: Signature on File — DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED:

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Stan Levelson, M.D.	17a. ☐ 17b. NPI 1234567089
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES X NO ☐ $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. V72.6 3. ☐ 2. 583.89 4. ☐	22. MEDICAID RESUBMISSION CODE ☐ ORIGINAL REF. NO. ☐ 23. PRIOR AUTHORIZATION NUMBER ☐

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 01 01 2008	01 01 2008	6		80053		1	18.17			NPI	1234567-89 / 9087654321
2 01 01 2008	01 01 2008	6		88305		2	45.42			NPI	1234567-89 / 9087654321
3 01 01 2008	01 01 2008	6		88346		2	18.27			NPI	1234567-89 / 9087654321
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
☐ ☐	12345	X YES ☐ NO	$ 81.86	$	$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
Signature on File 01 09 2008 SIGNED DATE	a. NPI b.	ABC Laboratory Services 1242 Medical Place Comfort, TX 78013 ( ) a. 9876543021 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

D.35 Licensed Clinical Social Worker (LCSW)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) — [X] MEDICAID (Medicaid #)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Escovedo, Doris M.

3. PATIENT'S BIRTH DATE (MM DD YY): 01 01 1995 — SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 4630 Liebe Cove

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Dale — STATE: TX

8. PATIENT STATUS: Single [X] Married [ ] Other [ ] — Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: — STATE:

ZIP CODE: 78218 — TELEPHONE (Include Area Code): (210) 555-1234

ZIP CODE: — TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH (MM DD YY): — SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH (MM DD YY): — SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on File — DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED:

14. DATE OF CURRENT: (MM DD YY) ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP):

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE (MM DD YY):

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM DD YY) FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE:

17a.

17b. NPI:

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) FROM TO

19. RESERVED FOR LOCAL USE:

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 296.20 3. 2. 4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A. DATE(S) OF SERVICE From (MM DD YY)	To (MM DD YY)	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 01 2008	01 01 2008	1		90806		1	60 00	1		NPI	1234567-89 9087654321
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 60 00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Sophie Buschbaum, LCSW

SIGNED — 01 10 2008 DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Sophie Buschbaum, LCSW
1204 Mozart Street
Dale, TX 78216

a. 9876543021 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.36 Licensed Dietitians (THSteps-CCP Only)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) — [X] MEDICAID (Medicaid #)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Marberry, Kayla M.

3. PATIENT'S BIRTH DATE (MM DD YY): 10 26 1983 — SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1544 Britanny Trail

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Austin — STATE: TX

8. PATIENT STATUS: Single [X] Married [ ] Other [ ] — Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: — STATE:

ZIP CODE: 78727 — TELEPHONE (Include Area Code): ( )

ZIP CODE: — TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH (MM DD YY): — SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH (MM DD YY): — SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on File — DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: Signature on File

14. DATE OF CURRENT: (MM DD YY) ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP):

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE (MM DD YY):

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM DD YY) FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Jim Smith, M.D.

17a.

17b. NPI: 1234567089

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) FROM TO

19. RESERVED FOR LOCAL USE:

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 250.00 3. 2. 4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER: 1234567890

24. A. DATE(S) OF SERVICE From (MM DD YY)	To (MM DD YY)	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 01 2008	01 01 2008	1		S9470		1	30 00	1		NPI	1234567-89 9087654321
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 30 00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Jill Brown

SIGNED — 01 10 2008 DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (512) 555-1234

Jill Brown
2010 Main Street
Austin, TX 78728

a. 9876543021 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.37 Licensed Marriage and Family Therapist (LMFT)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Thomas, Robin

3. PATIENT'S BIRTH DATE MM DD YY: 02 24 1993 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1544 Lansing Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Austin STATE: TX

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 78727 TELEPHONE (Include Area Code): (512) 555-1234

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on File DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: Signature on File

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 309.28 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 01 2008	01 01 2008	1		90806		1	60.00	1		NPI	1234567-89 9087654321
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $ 60.00

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Susan Daines, LMFT

SIGNED 01 10 2008 DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Susan Daines, LMFT
4063 Lilling Road
Austin, TX 78728

a. 9876543021 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.38 Licensed Professional Counselor (LPC)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Manning, Megan B.

3. PATIENT'S BIRTH DATE MM DD YY: 02 24 1993 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1544 Lansing Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Austin STATE: TX

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 75067 TELEPHONE (Include Area Code): (512) 555-1234

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on File DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: Signature on File

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 309.28 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 01 2008	01 01 2008	1		90806		1	60.00	1		NPI	1234567-89 9087654321
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $ 60.00

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Susan Daines, LPC

SIGNED 01 10 2008 DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Susan Daines, LPC
4063 Lilling Road
Austin, TX 75067

a. 9876543021 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.39 Maternity Service Clinic

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA — CARRIER

1. MEDICARE [ ] (Medicare #) | MEDICAID [ ] (Medicaid #) | TRICARE CHAMPUS [ ] (Sponsor's SSN) | CHAMPVA [ ] (Member ID#) | GROUP HEALTH PLAN [ ] (SSN or ID) | FECA BLK LUNG [ ] (SSN) | OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Cook, Irene M.

3. PATIENT'S BIRTH DATE: 12 20 1971 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 563 Malvern Ct.

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Pharr — STATE: TX

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: — STATE:

ZIP CODE: 78576 — TELEPHONE (Include Area Code): (956)555-1234

ZIP CODE: — TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH: SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on File — DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED:

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): 01 01 2008

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE:

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM TO

19. RESERVED FOR LOCAL USE:

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. V22.0 3. 2. 4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 01 2008	01 01 2008	1		99211	TH	1	22.80	1		NPI	1234567-89
										NPI	9087654321
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 22.80

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File — SIGNED — 01 09 2008 DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Alvin Maternity Clinic
402 Chippendale Dr.
Pharr, TX 78577

a. 9876543021 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.40 Mental Health Case Management

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA — CARRIER

1. MEDICARE [ ] (Medicare #) | MEDICAID [X] (Medicaid #) | TRICARE CHAMPUS [ ] (Sponsor's SSN) | CHAMPVA [ ] (Member ID#) | GROUP HEALTH PLAN [ ] (SSN or ID) | FECA BLK LUNG [ ] (SSN) | OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Crew, Sarah J.

3. PATIENT'S BIRTH DATE: 06 11 1946 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1200 Route 4

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [X]

7. INSURED'S ADDRESS (No., Street):

CITY: Bastrop — STATE: TX

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: — STATE:

ZIP CODE: 78602 — TELEPHONE (Include Area Code): (512)555-1234

ZIP CODE: — TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH: SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on File — DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED:

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP):

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE:

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM TO

19. RESERVED FOR LOCAL USE:

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 295.03 3. 2. 4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 01 2008	01 01 2008	1		G9012		1	63.89	1		NPI	1234567-89
										NPI	9087654321
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 63.89

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Sally Smith — SIGNED — 01 10 2008 DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

TDMR Facility
411 Main Street
Bastrop, TX 78601

a. 9876543021 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.41 Military Hospital (Emergency Inpatient)

Field	Entry
1	Clayham AFB 123 Military Drive Pampa, TX 79065 512-555-1234
2	
3a PAT. CNTL #	12345M2
b. MED. REC. #	AC1234C1
4 TYPE OF BILL	111
5 FED. TAX NO.	
6 STATEMENT COVERS PERIOD FROM / THROUGH	01012008 / 01032008
7	
8 PATIENT NAME a	Miller, Jason B.
9 PATIENT ADDRESS a	6789 Courtland Circle Pampa, TX 79065
10 BIRTHDATE	07101972
11 SEX	M
ADMISSION 12 DATE	01012008
13 HR	04
14 TYPE	1
15 SRC	7
16 DHR	08
17 STAT	05
18–28 CONDITION CODES	
29 ACDT STATE	
30	
31 OCCURRENCE CODE / DATE	05 / 01012008
32–34 OCCURRENCE CODE / DATE	
35–36 OCCURRENCE SPAN CODE / FROM / THROUGH	
37	
38	
39 VALUE CODES AMOUNT a	04.00
40–41 VALUE CODES	

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
120	Room	$5000 per day	01012008	2	10000 00		
001	Total Charges				10000 00		

PAGE ____ OF ____ CREATION DATE TOTALS

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
A Medicaid						1342658079
						57 OTHER PRV ID: 9876543-21

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A Miller, Jason B.		123456789		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A 1234567890		

66 DX: 9940
67–68:

69 ADMIT DX: 99400 | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE / DATE | a.–e. OTHER PROCEDURE CODE / DATE | 75

76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS: Struck by lightning, pt. badly burned and in shock
81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

D.42 Nurse Practitioner/Clinical Nurse Specialist (Family Planning)

Family Planning 2017 Claim Form

1. Family Planning Program: V ☐ XIX ☐ XX ☐

1a. Title X Only: Full Pay ☐ Partial Pay ☐ No Pay ☐

2a. Billing Provider TPI: 1234567-89

2b. Billing Provider NPI: 9768450132

3. Provider Name: Smith, Jenny

4. Eligibility Date (V or XX) (MM/DD/CCYY): 01/02/2008

5. Family Planning No. (Medicaid PCN if XIX):

6. Patient's Name (Last Name, First Name, Middle Initial): Pye, Sherrie

7. Address (Street, City, State): 341 Tosser Way, Houston, TX

7a. ZIP code: 77485

8. County of Residence: Harris

9. Date of Birth (MM/DD/CCYY): 02/02/1971

10. Sex: F ☒ M ☐

11. Patient Status: New Patient ☐ Established Patient ☒

12. Patient's Social Security Number: 123 - 456 - 7089

13. Race (Code #): 1 — White (1) Black (2) AmIndian/AlaskaNat (4) Asian (5) Unk/NotRep (6) NatHawaii/PacIsland (7) More than one race (8)

13a. Ethnicity: 0 — Hispanic (5) Non-Hispanic (0)

14. Marital Status: 3 — (1) Married (2) Never Married (3) Formerly Married

15. Family Income (All): $ 1

15a. Family Size: 2

16. Number Times Pregnant: 1

17. Number Live Births: 1

18. Number Living Children: 1

19. Primary Birth Control Method Before Initial Visit: G

20. Primary Birth Control Method at End of This Visit: K

a=Oral Contraceptive; b=1-Month hormonal injection; c=3-Month hormonal injection; d=Cervical cap/diaphragm; e=Abstinence; f= Hormonal Implant; g=Male condom; h=Female condom; i=Hormonal/Contraceptive patch; j=Spermicide (used alone); k=Intrauterine device (IUD); l=Vaginal ring; m=Fertility awareness method (FAM); n=Sterilization; o=Contraceptive sponge; p=Other method; q=Method unknown; r=No method (if used for #20, must complete #21)

21. If No Method Used at End of This Visit, Give Reason (Required only if #20 = r): ☐ — a=Refused; b=Pregnant; c=Inconclusive Preg Test; d=Seeking Preg; e=Infertile; f=Rely on Partner; g=Medical

22. Is There Other Insurance Available? Y ☐ N ☐ If Y, Complete Items 23 – 25a

23. Other Insurance Name and Address

24a. Insured's Policy/Group No.

24b. Benefit Code

25. Other Insurance Pd. Amt. $

25a. Date of Notification

26. Name of Referring Provider

27a. Referring Other ID

27b. Referring NPI

28. Level of Practitioner: Physician ☐ Nurse ☐ Mid Level ☐ Other ☐

29. Diagnosis Code (Relate Items 1,2,3,or 4 to Item 32D by Line # in 32E)
1. V25.1
2. V25.42
3.
4.

30. Authorization Number

31. Date of Occurrence (MM / DD / CCYY)

32. A Dates of Service From MM	DD	CCYY	To MM	DD	CCYY	B Place of Service	C Reserved for Local Use	D Procedures, Services, or Supplies CPT/HCPCS Modifier	E Dx. Ref. (29)	F Units or Days (Quantity) No. of Participants (Teen Counseling)	G $ Charges	H Performing Provider #
												32H(a) TPI
01	02	2008	01	02	2008	1	4	74000	1	1	$22 91	32H(b) NPI
												32H(a) TPI
												32H(b) NPI
												32H(a) TPI
												32H(b) NPI
												32H(a) TPI
												32H(b) NPI
												32H(a) TPI
												32H(b) NPI

33. Federal Tax ID Number/EIN

34. Patient's Account No. (optional)

35. Patient Co-Pay Assessed (V, X or XX) $

36. **Total Charges**: $22.91

37. Signature of Physician or Supplier
Date: 01/02/2008
Signed: Joe Smith

38. Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)

38a. NPI

38b. Other ID

39. Physician's, Supplier's Billing Name, Address, Zip Code & Phone No.
Joe Smith
1234 Oak Drive
Houston, Texas 77485

Form Revised: January 2007

D.43 Occupational Therapists (THSteps-CCP Only)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) [x] / MEDICAID (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Rodriguez, Maria L.	3. PATIENT'S BIRTH DATE: 03 27 1985 SEX: M [ ] F [x]
5. PATIENT'S ADDRESS (No., Street): 1234 Glen Drive	6. PATIENT RELATIONSHIP TO INSURED: Self [x] Spouse [ ] Child [ ] Other [ ]
CITY: Webster STATE: TX	8. PATIENT STATUS: Single [x] Married [ ] Other [ ]
ZIP CODE: 78218 TELEPHONE (Include Area Code): ( )	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous): YES [ ] NO [x]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [x] PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [x]
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]	
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED Signature on File DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED Signature on File

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Phyllis Merrick, M.D.	17a. / 17b. NPI 1234567089
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 714.31 2. 3. 4.	22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER: 1234567890

	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 01 2008 01 01 2008	1		97003		1	20.00	1		NPI	1234567-89 / 9087654321
2 01 01 2008 01 01 2008	1		97532		1	20.00	2		NPI	1234567-89 / 9087654321
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO. 12345	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [x] NO [ ]	28. TOTAL CHARGE $ 40.00	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Colin K. Smith, OT 01 10 2008 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.		33. BILLING PROVIDER INFO & PH # (210) 555-1234 Colin K. Smith, OT 406 Kings Hwy. Webster, TX 78801 a. 9876543021 b.		

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.44 Office Visit with Lab and Radiology

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE / MEDICAID (Medicaid #) [x] / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Murphy, Molly	3. PATIENT'S BIRTH DATE: 11 20 1963 SEX: M [ ] F [x]
5. PATIENT'S ADDRESS (No., Street): 6702 Field St. #129	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]
CITY: Houston STATE: TX	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]
ZIP CODE: 77093 TELEPHONE (Include Area Code): (713) 555-1234	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Filed with Merchants on	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER: 09/01/95 have not heard	a. EMPLOYMENT? (Current or Previous): YES [ ] NO [x]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [x] PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME: Back from OI.	c. OTHER ACCIDENT? YES [ ] NO [x]
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER: Merchants Inc. Co.	
a. INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]	
b. EMPLOYER'S NAME OR SCHOOL NAME: 1313 Main St. Card, TX 75633	
c. INSURANCE PLAN NAME OR PROGRAM NAME: Policy #73721, Subscriber #3198	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED Signature on File DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 785.1 2. 427.9 3. 786.50 4.	22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 05 2008 01 05 2008	1		99212		1	25.00			NPI	1234567-89 / 9087654321
2 01 05 2008 01 05 2008	1		93005	TC	3	50.00			NPI	1234567-89 / 9087654321
3 01 05 2008 01 05 2008	1		93224		2	350.00			NPI	1234567-89 / 9087654321
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [x] NO [ ]	28. TOTAL CHARGE $ 425.00	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Duane P. Olseen, DO 01 09 2008 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.		33. BILLING PROVIDER INFO & PH # (715) 555-1234 Duane P. Olseen, D.O. 1111 Pax Dr. Houston, TX 77029 713-555-1234 a. 9876543021 b.		

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.45 Orthotic and Prosthetic Suppliers (THSteps-CCP Only)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

1. MEDICARE (Medicare #) [X] MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jimenez, Jorge	3. PATIENT'S BIRTH DATE: 11 23 1994 SEX: M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 563 Lake Ct.	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street)
CITY: Pharr STATE: TX	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]	CITY STATE
ZIP CODE: 75235 TELEPHONE (Include Area Code): ( )	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]	ZIP CODE TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: Signature on File DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED:

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Joanne Wallace, M.D.	17a. 17b. NPI 1234567089	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 343.9 3. 2. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 1234567890

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 01 2008 01 01 2008	1		L1960		1	887.35	2		NPI	1234567-89 9087654321
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
	123456	[X] YES [ ] NO	$ 887.35	$	$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (214) 555-1234
Signature on File SIGNED 01 10 2008 DATE	a. NPI b.	Nederland Orthotics 67 Medical Blvd. Nederland, TX 77627 a. 9876543021 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

D.46 Pharmacy (THSteps-CCP Only)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

1. MEDICARE (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): May, Sharon P.	3. PATIENT'S BIRTH DATE: 03 15 1994 SEX: M [ ] F [X]	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 1500 Sansin Court	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street)
CITY: Austin STATE: TX	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]	CITY STATE
ZIP CODE: 75067 TELEPHONE (Include Area Code): (512) 555-1234	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]	ZIP CODE TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: Signature on File DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: Signature on File

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Jim Smith, M.D.	17a. 17b. NPI 1234567089	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. No Diagnosis Codes Required 3. 2. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 1234567890

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 01 2008 01 01 2008	2		B4150		1	22.20	12		NPI	1234567-89 9087654321
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
	123456	[X] YES [ ] NO	$ 22.20	$	$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (512) 555-1234
Signature on File SIGNED 01 10 2008 DATE	a. NPI b.	Super X Drugstore 104 South Main Austin, TX 75067 512-555-1234 a. 9876543021 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

D.47 Physical Therapist

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) [X] MEDICAID (Medicaid #) [ ] TRICARE CHAMPUS (Sponsor's SSN) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID) [ ]

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Gildon, Melinda

3. PATIENT'S BIRTH DATE MM DD YY: 06 14 1964 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 9901 Channing Cross

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Bryan STATE: TX

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 77081 TELEPHONE (Include Area Code): (409)555-1234

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED:

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP):

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: John Martinez, M.D.

17a.

17b. NPI 1234567089

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 767.6

2.

3.

4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 01 2008	01 01 2008	1		97761	AT	1	30 00			NPI	1234567-89 9087654321
2 01 01 2008	01 01 2008	1		97761	AT 76	1	13 45			NPI	1234567-89 9087654321
3 neck area 01 01 2008	01 01 2008	1		97520	AT 76	1	13 45			NPI	1234567-89 9087654321
4 left arm										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 56 90

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Patricia Brown, LPT 01 09 2008

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Patricia Brown, LPT
911 Medical Drive
Bryan, TX 77801

a. 9876543021 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.48 Physical Therapists (THSteps-CCP Only)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) [X] MEDICAID (Medicaid #) [ ] TRICARE CHAMPUS (Sponsor's SSN) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID) [ ]

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Brown, Julie C.

3. PATIENT'S BIRTH DATE MM DD YY: 12 06 1995 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1200 Baltic

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Conroe STATE: TX

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 77305 TELEPHONE (Include Area Code): (409) 555-1234

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on File DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED:

14. DATE OF CURRENT: MM DD YY 01 01 2008 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP):

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: David Jones, M.D.

17a.

17b. NPI 1234567089

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 454.2

2.

3.

4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 02 2008	01 02 2008	1		97001		1	40 00	1		NPI	1234567-89 9087654321
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 40 00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Larry Jones 01 10 2008

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Larry Jones
1242 Rosewood
Conroe, TX 77307

a. 9876543021 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.49 Private Duty Nurses (THSteps-CCP Only)

- 1: ABC Homebound Care, 123 Main Street, Austin, TX 78725
- 3a PAT. CNTL #: 12345678
- b. MED. REC. #: 123456
- 4 TYPE OF BILL: 0331
- 6 STATEMENT COVERS PERIOD FROM: 01212008 THROUGH: 01232008
- 8 PATIENT NAME: a Butler, Adele
- 9 PATIENT ADDRESS: a 3201 Crow Road Austin TX 78729
- 10 BIRTHDATE: 11062001
- 11 SEX: F

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
550	Home Heath Services LVN/RN, private duty nursing per hour	C-T1002	01212008	5	200 00	
		Total Charges			200 00	

- PAGE ____ OF ____ CREATION DATE TOTALS
- 50 PAYER NAME: Medicaid
- 56 NPI: 1342659087
- 57 OTHER PRV ID: 9876543-21
- 58 INSURED'S NAME: Butler, Adele
- 60 INSURED'S UNIQUE ID: 123456789
- 63 TREATMENT AUTHORIZATION CODES: 9956619801
- 66 DX: 7580
- 69 ADMIT DX: 38903
- 80 REMARKS: Down's Syndrome

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

D.50 Psychiatric Hospital/Facility (THSteps-CCP Only)

- 1: The First Hospital, 123 Oak Street, Austin, TX 78701, 512-555-1234
- 3a PAT. CNTL #: 123456
- b. MED. REC. #: 123456
- 4 TYPE OF BILL: 0111
- 6 STATEMENT COVERS PERIOD FROM: 01012008 THROUGH: 01062008
- 8 PATIENT NAME: a Mador, Cory L.
- 9 PATIENT ADDRESS: a 876 Avenue A Austin TX 78701
- 10 BIRTHDATE: 01012001
- 11 SEX: F
- 12 ADMISSION DATE: 01012008; 13 HR: 14; 14 TYPE: 3; 15 SRC: 1; 16 DHR: 15; 17 STAT: 01

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
124	Room and Board	555.00		5	2775 00	
250	Pharmacy			1	102 00	
300	Laboratory			1	438 00	
915	Psychotherapy - Group			1	325 00	
		Total Charges			3640 00	

- PAGE ____ OF ____ CREATION DATE TOTALS
- 50 PAYER NAME: Medicaid
- 56 NPI: 1534276098
- 57 OTHER PRV ID: 9876543-21
- 58 INSURED'S NAME: Mador, Cory L.
- 60 INSURED'S UNIQUE ID: 123456789
- 63 TREATMENT AUTHORIZATION CODES: 1234567890
- 66 DX: 29500
- 69 ADMIT DX: 29500
- 80 REMARKS: Depressive Disorder

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

D.51 Psychologist

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) [ ] MEDICAID (Medicaid #) [ ] TRICARE CHAMPUS (Sponsor's SSN) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID) [ ]	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Mata, Joel L.	3. PATIENT'S BIRTH DATE: 05 19 2001 SEX: M [X] F [ ]
5. PATIENT'S ADDRESS (No., Street): 506 Medical Lane	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]
CITY: Terrell STATE: TX	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]
ZIP CODE: 78218 TELEPHONE (Include Area Code): (210) 555-1234	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Jane Smith, M.D.	17a. 17b. NPI 1234567089
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 296.20 2. 3. 4.	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 01 2008 01 01 2008	1		90801		1	78.47	1		NPI	1234567-89 / 9087654321
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]	26. PATIENT'S ACCOUNT NO.: 12345	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE: $ 78.47
29. AMOUNT PAID: $	30. BALANCE DUE: $		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.): *Carla Herrera, PhD* SIGNED 01 10 2008 DATE	32. SERVICE FACILITY LOCATION INFORMATION: a. NPI b.		33. BILLING PROVIDER INFO & PH #: ( ) Carla Herrera, Ph.D. 463 Swan St. Crane, TX 79731 a. 9876543021 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.52 Radiation Therapy

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) [ ] MEDICAID (Medicaid #) [X] TRICARE CHAMPUS (Sponsor's SSN) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID) [ ]	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Garcia, Helmut E.	3. PATIENT'S BIRTH DATE: 08 08 1957 SEX: M [X] F [ ]
5. PATIENT'S ADDRESS (No., Street): 901 West Street	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
CITY: San Antonio STATE: TX	8. PATIENT STATUS: Single [X] Married [ ] Other [ ]
ZIP CODE: 78218 TELEPHONE (Include Area Code): (210) 555-1234	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED **Signature on File** DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____

14. DATE OF CURRENT: MM DD YY 01 13 2008 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. V10.72 2. 3. 4.	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 01 2008 01 01 2008	1		77427		1	105.00	1		NPI	1234567-89 / 9087654321
2 01 01 2008 01 01 2008	1		77427		1	105.00	1		NPI	1234567-89 / 9087654321
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]	26. PATIENT'S ACCOUNT NO.: 12345	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE: $ 210.00
29. AMOUNT PAID: $	30. BALANCE DUE: $		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.): *Jared Blanco, MD* SIGNED 01 13 2008 DATE	32. SERVICE FACILITY LOCATION INFORMATION: a. NPI b.		33. BILLING PROVIDER INFO & PH #: ( ) Jared Blanco, MD 1242 Garrick Way Bryan, TX 77802 a. 9876543021 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.53 Radiological/Physiological Laboratory and Portable X-Ray Supplier

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
	X						123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Osgood, Paul T.	01 04 1961 M X F	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
8001 Apt., Way #2	Self Spouse Child Other	
CITY / STATE	8. PATIENT STATUS	CITY / STATE
Del Rio TX	Single Married Other	
ZIP CODE / TELEPHONE (Include Area Code)	Employed Full-Time Student Part-Time Student	ZIP CODE / TELEPHONE (Include Area Code)
78841 ( )		( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M F	b. AUTO ACCIDENT? YES X NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED **Signature on File** DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED **Signature on File**

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
Blake Jones, M.D.	17b. NPI 1234567089	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
1. L V72.5 3. 2. 4.		23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 01 01 2008	01 01 2008	1		70030		1	19.35	1		NPI	1234567-89 9087654321
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
	12345	X YES NO	$ 19.35	$	$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (210) 555-1234
Signature on File 01 10 2008 SIGNED DATE	a. NPI b.	Portable X-Ray Services 1242 South Main Del Rio, TX 78840 210-555-1234 a. 9876543021 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

D.54 Rehabilitation Hospital (THSteps-CCP Only)

1 Rehabilitation Hospital
999 West Blvd.
Tyler, TX 75702
903-555-1234

2

3a PAT CNTL # 12345678
b. MED REC. # 12346K

4 TYPE OF BILL 0111

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM 01012008 THROUGH 01152008

7

8 PATIENT NAME a Hearn, Jennifer K.

9 PATIENT ADDRESS a 4312 Branbury Cross Tyler, TX 75702

10 BIRTHDATE 04032001 | 11 SEX F | 12 ADMISSION DATE 01012008 | 13 HR 10 | 14 TYPE 2 | 15 SRC 1 | 16 DHR 13 | 17 STAT 06 | CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 | 29 ACDT STATE | 30

31 OCCURRENCE CODE DATE | 32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE SPAN CODE FROM THROUGH | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37

38

39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
124	Semi Private Room	Room 400.00 Rate		14	5600.00		
250	Pharmacy				298.63		
270	Medical/Surgical Supplies				542.16		
300	Laboratory				210.28		
420	Physical Therapy				4878.00		
430	Occupational Therapy				6878.00		
910	Psychiatric Services - General				1794.00		
		Total Charges			20201.07		
	PAGE ____ OF ____	CREATION DATE		TOTALS			

50 PAYER NAME: Medicaid | 51 HEALTH PLAN ID | 52 REL. INFO | 53 ASG. BEN. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 NPI 3142650978 | 57 OTHER 9876543-21 PRV ID

58 INSURED'S NAME: Hearn, Jennifer K. | 59 P REL | 60 INSURED'S UNIQUE ID 123456789 | 61 GROUP NAME | 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES: 6116660000 | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX: 34210 | 67 A B C D E F G H I J K L M N O P Q | 68

69 ADMIT DX: 34210 | 70 PATIENT REASON DX a b c | 71 PPS CODE | 72 ECI a b c | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI QUAL LAST FIRST

77 OPERATING NPI QUAL LAST FIRST

78 OTHER NPI QUAL LAST FIRST

79 OTHER NPI QUAL LAST FIRST

80 REMARKS: Hemplegia, Spastic | 81CC a b c d

UB-04 CMS-1450 | APPROVED OMB NO. 0938-0997 | NUBC National Uniform Billing Committee | THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

D.55 Renal Dialysis Facility CAPD Training

1 Renal Hospital
1113 Hospital Dr.
Victoria, TX 77123
1-495-555-1234

2

3a PAT. CNTL # 12345678
b. MED. REC. # 123456S
4 TYPE OF BILL 0721
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 06042008 THROUGH 06302008
7

8 PATIENT NAME a Smith, Sue S.
9 PATIENT ADDRESS a 111 Broadway Victoria TX 77123

10 BIRTHDATE 05191963
11 SEX F
12 ADMISSION DATE 06042008
13 HR 10
14 TYPE
15 SRC
16 DHR
17 STAT
18 19 20 21 CONDITION CODES
22 23 24 25 26 27 28
29 ACDT STATE
30

31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37

38
39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
821	HEMODIALYSIS-IN CENTER		06042008	1	129 00		
821	HEMODIALYSIS-IN CENTER		06072008	1	129 00		
821	HEMODIALYSIS-IN CENTER		06092008	1	129 00		
821	HEMODIALYSIS-IN CENTER		06112008	1	129 00		
821	HEMODIALYSIS-IN CENTER		06142008	1	129 00		
821	HEMODIALYSIS-IN CENTER		06162008	1	129 00		
821	HEMODIALYSIS-IN CENTER		06212008	1	129 00		
821	HEMODIALYSIS-IN CENTER		06232008	1	129 00		
821	HEMODIALYSIS-IN CENTER		06252008	1	129 00		
821	HEMODIALYSIS-IN CENTER		06302008	1	129 00		
		TOTAL:		10	1,290 00		
	PAGE ____ OF ____ CREATION DATE			TOTALS	1,290 00		

50 PAYER NAME: MEDICAID OF TX
51 HEALTH PLAN ID
52 REL INFO
53 ASG BEN
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI 3142659087
57 OTHER PRV ID 9876543-21

58 INSURED'S NAME
59 P REL
60 INSURED'S UNIQUE ID 123456789
61 GROUP NAME
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX 58500
67 A B C D E F G H I J K L M N O P Q
68

69 ADMIT DX 2848
70 PATIENT REASON DX
71 PPS CODE
72 ECI
73

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS: Onset Date of Dialysis 01012000
81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

D.56 Renal Dialysis Facility CAPD/CCPD

1 Rural Community Clinic
1242 Medical Loop
Point West, Texas 77364

2

3a PAT. CNTL # A64322
b. MED. REC. # A12345
4 TYPE OF BILL 0721
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7

8 PATIENT NAME a Johnson, Jack C.
9 PATIENT ADDRESS a 6789 Courtland Circle, New Caney, TX 79065

10 BIRTHDATE 12161991
11 SEX M
12 ADMISSION DATE 01012008
13 HR 10
14 TYPE
15 SRC
16 DHR
17 STAT
18 19 20 21 CONDITION CODES 22 23 24 25 26 27 28
29 ACDT STATE
30

31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37

38
39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
845	Clinic Visit		01012008	1	75 00		
		Total Charges			75 00		
	PAGE ____ OF ____ CREATION DATE			TOTALS			

50 PAYER NAME: Medicaid
51 HEALTH PLAN ID
52 REL INFO
53 ASG BEN
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI 3142650978
57 OTHER PRV ID 1234567-89

58 INSURED'S NAME: Johnson, Jack C.
59 P REL
60 INSURED'S UNIQUE ID 501361999
61 GROUP NAME
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES: 1234567890
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX 92310
67 A B C D E F G H I J K L M N O P Q
68

69 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI
73

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS: Pain in Arm
81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

D.57 Renal Dialysis CMS-1500 Example

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

MEDICAID OF TX

PO BOX 20055
AUSTIN, TX 78720-0555

CARRIER

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #) X	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Pye, Sherrie

3. PATIENT'S BIRTH DATE (MM DD YY): 02 02 1971 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 341 Tosser Way

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Houston STATE: TX

8. PATIENT STATUS: Single [ ] Married [ ] Other [X]

CITY: STATE:

ZIP CODE: 12345 TELEPHONE (Include Area Code): (123) 555-1234

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH (MM DD YY): SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH (MM DD YY): SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE: ONSET 05/13/06

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 585.00 3. 280.9

2. 274.11 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 06 20 2008	06 20 2008	5		J2501	KX	1,2	22.00	5		NPI	1234567-89 9087654321
2 06 21 2008	06 21 2008	5		J2501	KX	1,2	22.00	5		NPI	1234567-89 9087654321
3 06 22 2008	06 22 2008	5		J2916	KX	1,2	22.50	5		NPI	1234567-89 9087654321
4 06 23 2008	06 23 2008	5		J2916	KX	1,3	73.10	10		NPI	1234567-89 9087654321
5 06 24 2008	06 24 2008	5		J3370	KX	1,3	10.95	10		NPI	1234567-89 9087654321
6 06 25 2008	06 25 2008	5		J3370	KX	1,3	10.95	10		NPI	1234567-89 9087654321

25. FEDERAL TAX I.D. NUMBER SSN EIN: 55-5555555 X

26. PATIENT'S ACCOUNT NO.: 12345678

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 161.50

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File 07/10/2008
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
Renal Healthcare
3305 Bayshore Blvd.
Houston, TX 77777

a. 3142650978 b.

33. BILLING PROVIDER INFO & PH # ( )
Renal Healthcare
3305 Bayshore Blvd.
Houston, TX 77777

a. 3142650978 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.58 Rural Health Clinic Freestanding

1 Rural Community Clinic
1242 Medical Loop
Point West, Texas 77364

3a PAT CNTL # A64322
b. MED REC. # A12345
4 TYPE OF BILL 0711
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7

8 PATIENT NAME a Johnson, Jack C.
9 PATIENT ADDRESS a 6789 Courtland Circle, New Caney, TX 79065

10 BIRTHDATE 12161991
11 SEX M
12 ADMISSION DATE 01012008
13 HR
14 TYPE 10
15 SRC
16 DHR
17 STAT
CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28
29 ACDT STATE
30

31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37

38

39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
521	Clinic Visit	T1015 AM	01012008	1	75.00		
		Total Charges			75.00		

PAGE ____ OF ____ CREATION DATE TOTALS

50 PAYER NAME: Medicaid
51 HEALTH PLAN ID
52 REL. INFO
53 ASG. BEN.
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI 3142650987
57 OTHER PRV ID 1234567-89

58 INSURED'S NAME: Johnson, Jack C.
59 P REL
60 INSURED'S UNIQUE ID: 501361999
61 GROUP NAME
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES: 1234567890
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX: 92310
A B C D E F G H I J K L M N O P Q
68

69 ADMIT DX
70 PATIENT REASON DX a b c
71 PPS CODE
72 ECI a b c
73

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE

80 REMARKS: Pain in Arm

81CC a b c d

76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

D.59 Rural Health Clinic Freestanding (Immunization)

1 Rural Community Clinic 1242 Medical Loop Point West, Texas 77357	2	3a PAT. CNTL # A64322 b. MED. REC. # A12345 5 FED. TAX NO.	4 TYPE OF BILL 0711 6 STATEMENT COVERS PERIOD FROM THROUGH 7
8 PATIENT NAME a Johnson, Jack C.	9 PATIENT ADDRESS a 6789 Courtland Circle, New Caney, TX 79065		
10 BIRTHDATE 12161991	11 SEX M	12 ADMISSION DATE 01012008	13 HR 14 TYPE 10 15 SRC 16 DHR 17 STAT 29 ACDT STATE 30
31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE 35 OCCURRENCE SPAN CODE FROM THROUGH 36 OCCURRENCE SPAN CODE FROM THROUGH 37
38	39 VALUE CODES CODE AMOUNT	40 VALUE CODES CODE AMOUNT	41 VALUE CODES CODE AMOUNT

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	521	Clinic Visit	T1015 AM	01012008	1	75.00		
2	771	DTP #3	90471	01012008	1	5.00		
3			90701	01012008				
13			Total Charges			80.00		
23		PAGE ____ OF ____	CREATION DATE		TOTALS			

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
A Medicaid					

56 NPI	9786543021
57 OTHER	1234567-89
PRV ID	

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME / 62 INSURANCE GROUP NO.
A Johnson, Jack C.		501361998	

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX 37200 — 67 A B C D E F G H I J K L M N O P Q — 68

69 ADMIT DX | 70 PATIENT REASON DX a b c | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE	

76 ATTENDING	NPI	QUAL	LAST	FIRST
77 OPERATING	NPI	QUAL	LAST	FIRST
78 OTHER	NPI	QUAL	LAST	FIRST
79 OTHER	NPI	QUAL	LAST	FIRST

80 REMARKS: Conjunctivitis — 81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

D.60 Rural Health Clinic Hospital-Based

1 Community Clinic 8008 Medical Drive New Cany, Texas 77357	2	3a PAT. CNTL # A12345 b. MED. REC. # 5 FED. TAX NO.	4 TYPE OF BILL 0711 6 STATEMENT COVERS PERIOD FROM THROUGH 7
8 PATIENT NAME a Johnson, Miguel F.	9 PATIENT ADDRESS a 6789 Courtland Circle New Caney, TX 79065		
10 BIRTHDATE 10081964	11 SEX M	12 ADMISSION DATE 01012008	13 HR 14 TYPE 15 SRC 16 DHR 17 STAT 29 ACDT STATE 30
31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE 35 OCCURRENCE SPAN CODE FROM THROUGH 36 OCCURRENCE SPAN CODE FROM THROUGH 37
38	39 VALUE CODES CODE AMOUNT	40 VALUE CODES CODE AMOUNT	41 VALUE CODES CODE AMOUNT

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	521	Clinic Visit	1-T1015	01012008	1	36.00		
13			Total Charges			36.00		
23		PAGE ____ OF ____	CREATION DATE		TOTALS			

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
A Medicaid					

56 NPI	1342657098
57 OTHER	9876543-21
PRV ID	

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME / 62 INSURANCE GROUP NO.
A Johnson, Miguel F.		123456789	

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX 4578 — 67 A B C D E F G H I J K L M N O P Q — 68

69 ADMIT DX | 70 PATIENT REASON DX a b c | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE	

76 ATTENDING	NPI	QUAL	LAST	FIRST
77 OPERATING	NPI	QUAL	LAST	FIRST
78 OTHER	NPI	QUAL	LAST	FIRST
79 OTHER	NPI	QUAL	LAST	FIRST

80 REMARKS — 81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

D.61 School Health and Related Services (SHARS)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [X] / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Blake, Pamela A.	3. PATIENT'S BIRTH DATE: 07 02 1999 SEX: M [ ] F [X]
5. PATIENT'S ADDRESS (No., Street): 4420 Avenue C	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]
CITY: El Paso STATE: TX	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]
ZIP CODE: 79985 TELEPHONE (Include Area Code): ( )	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

CITY: STATE:	11. INSURED'S POLICY GROUP OR FECA NUMBER
ZIP CODE: TELEPHONE (Include Area Code): ( )	a. INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]
	b. EMPLOYER'S NAME OR SCHOOL NAME
	c. INSURANCE PLAN NAME OR PROGRAM NAME
	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: Signature on File DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED:

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Adam Gaite, M.D.	17a. 17b. NPI 1234567089
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 359.1 2. 3. 4.	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 01 2008	01 01 2008	1		97001		1	12.00	4		NPI	1234567-89 / 9087654321
2	01 03 2008	01 03 2008	1		97110		1	6.00	2		NPI	1234567-89 / 9087654321
3	01 05 2008	01 05 2008	1		97110		1	3.00	1		NPI	1234567-89 / 9087654321
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.: 12345	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE: $ 21.00	29. AMOUNT PAID: $	30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.): Sally Smith 01 15 2008 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION: a. NPI b.
33. BILLING PROVIDER INFO & PH #: (915) 555-1234 El Paso I.S.D. 1223 Peacock Lane El Paso, TX 79985 a. 9876543021 b.	

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.62 Speech-Language Pathologists (THSteps-CCP Only)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [X] / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Hughes, Amanda J.	3. PATIENT'S BIRTH DATE: 06 15 2000 SEX: M [ ] F [X]
5. PATIENT'S ADDRESS (No., Street): 506 Unterhalt Street	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
CITY: Terrell STATE: TX	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]
ZIP CODE: 78218 TELEPHONE (Include Area Code): ( )	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

CITY: STATE:	11. INSURED'S POLICY GROUP OR FECA NUMBER
ZIP CODE: TELEPHONE (Include Area Code): ( )	a. INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]
	b. EMPLOYER'S NAME OR SCHOOL NAME
	c. INSURANCE PLAN NAME OR PROGRAM NAME
	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: Signature on File DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED:

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Karen Belman, M.D.	17a. 17b. NPI 1234567089
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 750.0 2. 3. 4.	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER: 1234567890

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 01 2008	01 01 2008	1		97535			40.00	1		NPI	1234567-89 / 9087654321
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.: 12345	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE: $ 40.00	29. AMOUNT PAID: $	30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.): Jay Masters 01 10 2008 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION: a. NPI b.
33. BILLING PROVIDER INFO & PH #: (210) 555-1234 Jay Masters 1402 Silver Blvd. Terrell, TX 75160 a. 9876543021 b.	

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.63 Surgery

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) [X] MEDICAID (Medicaid #) [ ] TRICARE CHAMPUS (Sponsor's SSN) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID) [ ]	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Baker, Ruth L.	3. PATIENT'S BIRTH DATE MM DD YY: 08 03 1981; SEX M [ ] F [X]
5. PATIENT'S ADDRESS (No., Street): 1523 Robinson Street	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
CITY: Goliad; STATE: TX	8. PATIENT STATUS: Single [X] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
ZIP CODE: 77963; TELEPHONE (Include Area Code): (713)555-1234	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO
b. OTHER INSURED'S DATE OF BIRTH MM DD YY; SEX M [ ] F [ ]	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? [ ] YES [X] NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH MM DD YY; SEX M [ ] F [ ]	
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes*, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: Signature on File DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED:

14. DATE OF CURRENT: MM DD YY; ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. ; 17b. NPI
19. RESERVED FOR LOCAL USE: Hysterectomy acknowledgement attached	20. OUTSIDE LAB? [ ] YES [X] NO; $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 218.9 ; 2. 626.8 ; 3. ; 4.	22. MEDICAID RESUBMISSION CODE; ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 07 2008 01 07 2008	3		58260		1	970.00			NPI	5432109876 / 1234567-89
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.: 12345	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO	28. TOTAL CHARGE: $ 970.00
29. AMOUNT PAID: $	30. BALANCE DUE: $		

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
Jane Smith, MD 01 10 2008 SIGNED DATE	Unity Hospital 923 Medical Drive Goliad, TX 77963 a. 3142650987 b.	Woman's Health Center 921 Raite Place Goliad, TX 77963 a. 9876543021 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.64 THSteps Example of a New Patient, Immunization, Physical Examination by a Nurse Practitioner, and FQHC Billing

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

MEDICAID OF TX

PO BOX 200555
AUSTIN, TX 78720-0555

PICA

1. MEDICARE (Medicare #) [ ] MEDICAID (Medicaid #) [X] TRICARE CHAMPUS (Sponsor's SSN) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID) [ ]	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 727272727
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Child, Sally J.	3. PATIENT'S BIRTH DATE MM DD YY: 03 15 2005; SEX M [ ] F [X]
5. PATIENT'S ADDRESS (No., Street): 5432 West Main St.	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
CITY: Star; STATE: TX	8. PATIENT STATUS: Single [X] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
ZIP CODE: 77787; TELEPHONE (Include Area Code): ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO
b. OTHER INSURED'S DATE OF BIRTH MM DD YY; SEX M [ ] F [ ]	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? [ ] YES [X] NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH MM DD YY; SEX M [ ] F [ ]	
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes*, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED:

14. DATE OF CURRENT: MM DD YY; ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. ; 17b. NPI
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? [ ] YES [X] NO; $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. V202 ; 2. ; 3. ; 4.	22. MEDICAID RESUBMISSION CODE; ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 05 2008 01 05 2008	1	NU	99382	SA EP	1	88.00	1		NPI	1234567-89 / 9087654321
2 01 05 2008 01 05 2008	1	NU	90471	SA EP	1	5.00	1		NPI	1234567-89 / 9087654321
3 01 05 2008 01 05 2008	1	NU	90700	SA EP	1	0.01	1		NPI	1234567-89 / 9087654321
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO	28. TOTAL CHARGE: $ 93.01
29. AMOUNT PAID: $	30. BALANCE DUE: $		

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
Signature on File 01/20/2008 SIGNED DATE	a. NPI b.	Star Community Health Center 100 Main St. Star, TX 77777 a. 5454545001 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.65 THSteps Example of an Established Patient and Referral, TB Skin Test, and Physical Examination by a Physician

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

MEDICAID OF TX

PO BOX 200555
AUSTIN, TX 78720-0555

CARRIER

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #) X	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smiles, D.W

3. PATIENT'S BIRTH DATE: 02 01 1999 SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 500 24th Place

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street):

CITY: Lubbock STATE: TX

8. PATIENT STATUS: Single X Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: 79488 TELEPHONE (Include Area Code): ( )

ZIP CODE TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous): YES X NO

a. INSURED'S DATE OF BIRTH SEX: M F

b. OTHER INSURED'S DATE OF BIRTH SEX: M F

b. AUTO ACCIDENT? YES X NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES X NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. V202 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 02 2008	01 02 2008	1	ST	99393	AM 32	1	120 00			NPI	1234567-89 9087654321
2 01 02 2008	01 02 2008	1	ST	86580	AM 32	1	0 01			NPI	1234567-89 9087654321
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE $ 120 01

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File 01/20/2008
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Carl Kidd, M.D., and Associates
3301 Hill Lane
Lubbock, TX 79488

a. 9876543021 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.66 Tuberculosis (TB)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #) X	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jane C.

3. PATIENT'S BIRTH DATE: 12 06 1965 SEX: M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1200 Baltic Avenue

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street):

CITY: Conroe STATE: TX

8. PATIENT STATUS: Single Married X Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: 77302 TELEPHONE (Include Area Code): (123) 555-1234

ZIP CODE TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous): YES X NO

a. INSURED'S DATE OF BIRTH SEX: M F

b. OTHER INSURED'S DATE OF BIRTH SEX: M F

b. AUTO ACCIDENT? YES X NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES X NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. V01 1 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 01 2008	01 01 2008	1		99204	TF AM	1	75 70	1		NPI	1234567-89 9087654321
2 01 01 2008	01 01 2008	1		71010		1	25 00	1		NPI	1234567-89 9087654321
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE $ 100 70

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Sally Green, ANP 01 10 2008
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Sally Green, ANP
1242 Rosewood
Conroe, TX 77307

a. 9876543021 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

D.67 Vision

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [X] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 512345678

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jones, Mary

3. PATIENT'S BIRTH DATE: 01 01 2001 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1234 N. Main Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown STATE: TX

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 77123 TELEPHONE (Include Area Code): (123) 555-1234

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Jones, Jim

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 412345678A

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 123456789

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH SEX

b. OTHER INSURED'S DATE OF BIRTH SEX: 05 01 1966 M [X] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME: ABCD, Inc. Prudential

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on File DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: Signature on File

14. DATE OF CURRENT: 05 01 2008 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Dr. Dan Smith

17a.

17b. NPI 8819004002

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3671.
2. 367.9
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05 01 2008	05 01 2008	1	E	V2020		1, 2	175.00			NPI	1234567-89
										NPI	9087654321
2				V2214						NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 123456

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 175.00

29. AMOUNT PAID: $ 20.00

30. BALANCE DUE: $ 155.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Dr. Dan Smith, MD 05 01 2008
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

Eyecare Clinic
124 S. First Street
Anytown, TX 77123

a. NPI b.

33. BILLING PROVIDER INFO & PH # (111)222-3333

Dr. Dan Smith, M.D.
1234 S. First Street
Anytown, TX 77123

a. 1234567089 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Vendor Drug Program

E.1 Vendor Drug Program (VDP)

The Texas Medicaid Vendor Drug Program (VDP) makes payment for prescriptions of covered outpatient drugs only to those pharmacy providers contracted with the VDP. In-state pharmacies licensed as Class A or C by the Texas State Board of Pharmacy are eligible for enrollment in the VDP. Out-of-state pharmacies and pharmacies holding any other class of pharmacy license are considered for inclusion in the program on a case-by-case basis, relative to the benefits made available to a client eligible for Medicaid. Contracts are not granted to applicants unless additional benefits to the recipient are established.

The only drugs eligible for VDP reimbursement are listed in the current *Texas Listing of National Drug Codes*. Additionally, the Texas Drug Code Index (TDCI) can be found on the HHSC website at www.hhsc.state.tx.us. The VDP does not reimburse claims for nutritional products (enteral or parenteral), medical supplies, or equipment.

For more information on the VDP, contact:

Vendor Drug Area	Telephone Number
Covered outpatient drugs and billing: The 800 number is for pharmacy use only and can be used to reach anyone in the VDP.	1-800-435-4165
Pharmacy contracts	1-512-491-1163
Policy	1-512-491-1340
Administration	1-512-491-1124
Drug formulary (Texas listing of national drug codes)	1-512-491-1157

The Texas Medicaid Preferred Drug List is now available on the Epocrates drug information system. The service is free and provides instant access to information on the drugs covered by the Texas formulary on a Palm or Pocket PC handheld device. To register for the service, go to the Epocrates website at www.epocrates.com/products/ and sign up for Epocrates Rx.

Clients who are not locked-in to a specific pharmacy may obtain their drugs or supplies from any contracted Medicaid provider of pharmaceutical services.

Refer to: "Client Limited Program" on page 4-5 for more information about lock-in limitations.

Family planning services are excluded from lock-in limitation. Though TMHP reimburses family planning agencies and physicians for family planning drugs and supplies, the following family planning drugs and supplies are also available through the VDP:

- Diaphragms.
- Oral contraceptives.
- Jellies, creams, foams, suppositories, vaginal contraceptive film, and contraceptive sponge.
- Condoms.
- Medication for treatment of vaginal/cervical/genital infections (subject to the three prescription limit).

The VDP is limited to three prescriptions per month, per client, except for:

- Clients enrolled in waiver programs such as managed care, Class, Community-Based Alternatives (CBA).
- Texas Health Steps (THSteps)-eligible (clients younger than 21 years of age), unlimited but must be medically necessary and appropriate.
- Residents in skilled nursing facilities, unlimited.
- Clients enrolled in the State of Texas Access Reform (STAR) Program, and residing in a STAR Program service area, unlimited.

  Refer to: "Service Area and STAR HMO Choices" on page 7-16
- Prescriptions for family planning drugs and supplies are not subject to the three prescription limit.

E.1.1 Free Delivery of Medicaid Prescriptions

Many Medicaid pharmacies across the state offer free delivery of prescriptions to Medicaid clients. To find out which pharmacies offer home delivery, refer clients to the HHSC website at www.hhsc.state.tx.us/HCF/vdp/vdpstart.html or the TMHP client helpline at 1-888-302-6688.

Contracted Medicaid pharmacy providers are reimbursed a delivery fee that is included in the medication dispensing fee formula. The delivery fee is paid to HHSC-approved pharmacy providers, who have certified that delivery services meet minimum conditions for payment of the delivery fee.

The conditions include:

- Deliveries are made to individuals rather than to institutions, such as nursing homes.
- Offering no-charge prescription delivery to all Medicaid recipients requesting delivery in the same manner as to the general public.
- Displaying publicly the availability of prescription delivery services at no charge in a prominent place in the pharmacy store (window/door).
- Providing the delivery service without requiring retention of the Medicaid client's form (H3087).

This delivery fee is not applicable for mail order prescriptions.

For more information, call the Vendor Drug Help Desk at 1-800-435-4165 and ask for Pharmacy Contracts.

E.1.2 Lotions Available Through the Vendor Drug Program

The VDP offers Coats Aloe Vera products to Medicaid and THSteps-Comprehensive Care Program (CCP) clients with a physician's prescription. Coats Aloe Vera products are available in cream, lotion, gel, liniment, and liquid form

and they contain no alcohol or fragrances. The product information states that cetyl alcohol is a component. Cetyl alcohol, however, does not have alcohol as a base, does not act like alcohol, but is used as a thickener. The liniment form contains methylsalicylate (wintergreen). The following Coats Aloe Vera creme, lotion, gel, liniment, and liquid products are available from the VDP with a physician's prescription:

TX Drug Code	Name and Strength	
58826070108	Coats Aloe Vera	Liquid, 100% (soaking)
58826070128	Coats Aloe Vera	Liquid, 100% (soaking)
58826070202	Coats Aloe Vera	85% Lotion
58826070208	Coats Aloe Vera	85% Lotion
58826070233	Coats Aloe Vera	85% Lotion
58826070304	Coats Aloe Vera	75% Creme
58826070316	Coats Aloe Vera	75% Creme
58826070408	Coats Aloe Vera	Liniment 85%, 11% methylsalicylate
58826070508	Coats Aloe Vera	90% Jelly
58826070533	Coats Aloe Vera	90% Jelly

If a physician does not wish to use these products, the physician is allowed to make a request to THSteps-CCP for another product, with specific documentation of the medical necessity for another product. THSteps-CCP does not provide nonlegend, cosmetic-type skin lotions and cremes.

E.2 Services Available for Children and Adolescents

Medically necessary drugs and supplies that are not covered by the VDP Program may be available to children and adolescents (birth through 20 years of age) through the THSteps-CCP.

Contact the THSteps-CCP Customer Service at 1-800-846-7470.

The Prior Authorization Fax number is 1-512-514-4212.

For more information about pharmacy enrollment in THSteps-CCP, see "Pharmacies (THSteps-CCP Only)" on page 43-70.

E.3 Palivizumab *(Synagis)* Available Through the Vendor Drug Program

Palivizumab is available to physicians for administering to Medicaid clients through the VDP. This option enables physicians to have palivizumab shipped directly to their office from a network pharmacy. Physicians will not need to purchase the drug. Physicians that obtain palivizumab through the VDP may not bill Medicaid for the drug.

E.3.1 Participating Palizivumab Distribution Pharmacies

Curascript

Telephone: 1-866-297-0933

Fax: 1-866-297-0934

Accredo/Nova Factor

Telephone: 1-877-482-5927

Fax: 1-877-369-3447

Refer to: "Obtaining Palivizumab" on page 43-39.

Acronym Dictionary

Term	Definition
A/EEG	Ambulatory Electroencephalogram
A/R	Accounts Receivable
AAC	Augmentative and Alternative Communication
AAFP	American Academy of Family Physicians
AAP	American Academy of Pediatrics
AAPD	American Academy of Pediatric Dentistry
ABMG	American Board of Medical Geneticists
ABR	Auditory Brainstem Response
ACD	Augmentative Communication Device
ACH	Automated Clearinghouse
ACIP	Advisory Committee on Immunization Practices
ACOG	American College of Obstetricians and Gynecologists
ACT	Assertive Community Treatment
ADA	American Dental Association
ADL	Activities of Daily Living
AFP	Abdominal Flat Plates
AHA	American Heart Association
AHI	Apnea/Hypopnea Index
AI	Auditory Impairment
AIDS	Acquired Immunodeficiency Syndrome
AIS	Automated Inquiry System
ALS	Advanced Life Support
AMA	American Medical Association
ANSI	American National Standards Institute
AP	Anterior-posterior
API	Atypical Provider Identifier
APN	Advanced Practice Nurse
ARD	Admission, Review, and Dismissal
ASA	American Society of Anesthesiologists
ASC	Ambulatory Surgical Center
ASHA	American Speech-Language-Hearing Association
ASL	American Sign Language
ASP	Average Sales Price
ATM	Automated Teller Machine
AWP	Average Wholesale Price
BCG	Bacillus Calmette-Guérin
BCVDDP	Blind Children's Vocational Discovery and Development Program
BHO	Behavioral Health Organization

Term	Definition
BICROS	Bilateral Contralateral Routing of Offside Signal
BIDS	Border Infectious Disease Surveillance
BiPAP	Bi-level Positive Airway Pressure
BLL	Blood Lead Level
BLS	Basic Life Support
BMI	Body Mass Index
BMT	Bone Marrow Transplantation
BNE	Board of Nurse Examiners
BON	(Texas) Board of Nursing
BPH	Benign Prostatic Hyperplasia
BRC	Bureau of Radiation Control
BUN	Blood Urea Nitrogen
BVIC	Blind and Visually Impaired Children
BVS	Bureau of Vital Statistics
C21	Compass21
CAH	Critical Access Hospital
CAPD	Continuous Ambulatory Peritoneal Dialysis
CARE	Client Assessment, Review, and Evaluation
CAT	Caries-risk Assessment Tool
CBA	Community-Based Alternatives (Program)
CCIP	Comprehensive Care Inpatient Psychiatric (Unit)
CCP	Comprehensive Care Program
CCPD	Continuous Cycling Peritoneal Dialysis
CDC	Centers for Disease Control and Prevention
CDT	Current Dental Terminology
CDTF	Chemical Dependency Treatment Facility
CFR	*Code of Federal Regulations*
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHC	Comprehensive Health Centers
CHIP	Children's Health Insurance Program
CHS	Community Health Services
CIHCP	County Indigent Health Care Program
CLASS	Community Living Assistance and Support Services
CLD	Chronic Lung Disease
CLIA	*Clinical Laboratory Improvement Amendments*
CLPPP	Childhood Lead Poisoning Prevention Program
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
CMV	Cytomegalovirus
CNM	Certified Nurse-Midwife
CNS	Clinical Nurse Specialist
COP	Condition of Parole
COPD	Chronic Obstructive Pulmonary Disease
CORF	Comprehensive Outpatient Rehabilitation Facility

Term	Definition
CPAP	Continuous Positive Airway Pressure
CPE	Certification of Public Expenditures
CPM	Continuous Passive Motion
CPR	Cardiopulmonary Resuscitation
CPT	Current Procedural Terminology
CPW	Children and Pregnant Women (Program)
CRCP	Certified Respiratory Care Practitioner
CRD	Chronic Renal Disease
CRNA	Certified Registered Nurse Anesthetist
CROS	Contralateral Routing of Offside Signal
CSHCN	Children with Special Health Care Needs (Services Program)
CSI	Claim Status Inquiry
CT	Computed Tomography
CUI	Clinic Unique Identifier
DADS	Department of Aging and Disability Services
DARS	Department of Assistive and Rehabilitative Services
dB	Decibel
DBS	Division for Blind Services
DC	Doctor of Chiropractic Medicine
DDS	Doctor of Dental Surgery
DEA	Drug Enforcement Agency
DEFRA	*Deficit Reduction Act* of 1984
DFPS	Department of Family and Protective Services
DHHS	(United States) Department of Health and Human Services (cf. HHS)
DMARD	Disease-Modifying Anti-Rheumatic Drugs
DMD	Doctor of Medical Dentistry
DME	Durable Medical Equipment
DMEH	Durable Medical Equipment–Home Health Services
DMERC	Durable Medical Equipment Regional Carrier
DNA	Deoxyribonucleic acid
DO	Doctor of Osteopathy
DOB	Date of Birth
DOC	Dynamic Orthotic Cranioplasty
DOPT	Directly Observed Preventive Therapy
DOS	Date of Service
DOT	Directly Observed Therapy
DPC	Diagnostic Procedure Code
DPM	Doctor of Podiatric Medicine
DRG	Diagnosis-Related Group
DSHS	(Texas) Department of State Health Services
DSM-IV	*Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition
DU	Demographic Update (form)
E/M	Evaluation and Management (Services)
ECC	Early Childhood Caries

Term	Definition
ECF	Extended Care Facility
ECG	Electrocardiogram
ECI	Early Childhood Intervention
ECMO	Extracorporeal Membrane Oxygenation
EDC	Estimated Date of Confinement
EDD	Expected Date of Delivery
EDI	Electronic Data Interchange
EEG	Electroencephalogram
EFT	Electronic Funds Transfer
EGD	Esophagogastroduodenoscopy
EIN	Employer Identification Number
EIP	Emerging Infections Program
EKG	Electrocardiogram
ELC	Epidemiology and Laboratory Capacity
EMG	Electromyography
EMR	Electronic Medical Record
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
ENT	Ear, Nose, and Throat
EOB	Explanation of Benefits
EOG	Electro-Oculogram
EOMB	Explanation of Medicare Benefits
EOPS	Explanation of Pending Status
EPO	Erythropoietin Alfa
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ER	Emergency Room
ER&S	Electronic Remittance and Status Report
ERCP	Endoscopic Retrograde Cholangiopancreatography
eSP™	eScreener Plus
ESRD	End Stage Renal Disease
FDA	(United States) Food and Drug Administration
FEV	Forced Expiratory Volume
FFP	Federal Financial Participation
FFY	Federal Fiscal Year
FIUT	Fetal Intrauterine Transfusion
FMAP	Federal Medical Assistance Percentage
FNP	Family Nurse Practitioner
FOC	Frontal Occipital Circumference
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FQS	Federally Qualified Satellite
FSR	Financial Status Report
FTA	Fluorescent Treponemal Antibody Absorbed
FTS	Full Time Student

Term	Definition
FY	Fiscal Year
FYE	Fiscal Year End
GAF	Global Assessment of Functioning
GAO	General Accounting Office
G-CSF	Granulocyte-colony Stimulating Factors
GED	Gastrointestinal Endoscopy
GM-CSF	Granulocyte-Macrophage Colony Stimulating Factor
GME	Graduate Medical Education
GYN	Gynecology/Gynecological
HASC	Hospital-based Ambulatory Surgical Center
H.B.	House Bill
HBOT	Hyperbaric Oxygen Therapy
HBV	Hepatitis B Virus
HCFA	Health Care Financing Administration
HCPCS	Healthcare Common Procedure Coding System
HCS	Home and Community-Based Services
HDL	High Density Lipoproteins
HEENT	Head, Eyes, Ears, Nose, and Throat
HepA	Hepatitis A
HepB	Hepatitis B
HFCWCS	High-Frequency Chest Wall Compression System
HHA	Home Health Aide
HHS	(United States Department of) Health and Human Services
HHSC	(Texas) Health and Human Services Commission
HIC	Health Insurance Claim (Number)
HIPAA	*Health Insurance Portability and Accountability Act*
HIPPS	Health Insurance Premium Payment System
HIV	Human Immunodeficiency Virus
HLD	Handicapping Labio-Lingual Deviations
HMO	Health Maintenance Organization
HOTV	A type of eye test chart that uses the letters H, O, T, and V
HPRT	Hypoxanthine-guanine phosphoribosyltransferase
HPV	Human Papillomavirus
HRC	*Texas Human Resource Code*
HSC	*Texas Health and Safety Code*
HTLV	Human T-cell lymphotrophic virus
ICD-9-CM	*International Classification of Diseases*, Ninth Revision, Clinical Modification
ICF	Intermediate Care Facility (see also SNF and ECF)
ICF-MR	Intermediate Care Facility for the Mentally Retarded
ICHP	Institute for Child Health Policy
ICM	Integrated Care Management
ICN	Internal Control Number (in 24-digit Medicaid ICN)
ID	Identification
IDCU/TB	Infectious Disease Control Unit Tuberculosis Program

Term	Definition
IDEA	*Individuals with Disabilities Education Act*
IEP	Individualized Education Plan
IFSP	Individualized Family Service Plan
IM	Intramuscular
IMD	Institution for Mental Diseases
ImmTrac	Immunization Tracking system
IOL	Intraocular Lens
IPD	Intermittent Peritoneal Dialysis
IPPB	Intermittent Positive-Pressure Breathing
IPV	Intrapulmonary Percussive Ventilation
IRF	Inpatient Rehabilitation Facility
IRS	Internal Revenue Service
ISD	Independent School District
ITP	Idiopathic Thrombocytopenia
IUD	Intrauterine Device
IV	Intravenous
JCIH	Joint Committee on Infant Hearing
KUB	Kidneys, Ureters, Bladder
LASIK	Laser-Assisted in Situ Keratomileusis
LCDC	Licensed Chemical Dependency Counselor
LCSW	Licensed Clinical Social Worker
LDL	Low Density Lipoprotein
LEA	Local Education Agency
LEP	Limited English Proficiency
LLC	Limited Liability Company
LMFT	Licensed Marriage and Family Therapist
LMP	Last Menstrual Period
LOCM	Low Osmolar Contrast Material
LOS	Length of Stay
LPC	Licensed Professional Counselor
LPTA	Licensed Physical Therapist Assistant
LTBI	Latent Tuberculosis Infection
LTC	Long Term Care
LTCH	Long Term Care Hospital
LVN/LPN	Licensed Vocational Nurse/Licensed Practical Nurse
MAO	Medical Assistance Only
MCH	Maternal and Child Health
MCLS	Mucocutaneous Lymph Node Syndrome
MCO	Managed Care Organization
MCP	Monthly Capitation Payment
MD	Doctor of Medicine
MDCP	Medically Dependent Children Program
MFADS	Medicaid Fraud and Abuse Detection System
MFCU	Medicaid Fraud Control Unit

Term	Definition
MH	Mental Health
MMPI	Minnesota Multiphasic Personality Inventory
MMWR	Morbidity and Mortality Weekly Report
MNC	Medically Needy Clearinghouse
MNP	Medically Needy Program
MPI	Medicaid Program Integrity
MQMB	Medicaid Qualified Medicare Beneficiary
MR	Mental Retardation
MR	Mentally Retarded
MRA	Magnetic Resonance Angiography
MRAN	Medicare Remittance Advice Notice
MRDA	Mental Retardation Diagnosis Assessment
MREP	Medicare Remit Easy Print
MRI	Magnetic Resonance Imaging
MRLA	Mental Retardation Local Authority
MRSA	Methicillin Resistant Staphylococcus Aureus
MRT	Magnetic Resonance Technology
MSC	Maternity Service Clinic
MSRP	Manufacturer's Suggested Retail Price
MTP	Medical Transportation Program
MUA	Medically Underserved Area
MUP	Medically Underserved Population
NBS	Newborn Screen (Neonatal Screen)
NCQA	National Committee for Quality Assurance
NCVIA	*National Childhood Vaccine Injury Act*
NEC	Not Elsewhere Classified
NF	Nursing Facility
NG	Nasogastric
NICU	Neonatal Intensive Care Unit
NMDP	National Marrow Donor Program
NOS	Not Otherwise Specified
NP	Nurse Practitioner
NPI	National Provider Identifier
NPR	Notice of Program Reimbursement
NSAID	Nonsteriodal Anti-inflammatory Drugs
NUCC	National Uniform Claim Committee
OAE	Otoacoustic Emissions
OAG	Office of the Attorney General
OB	Obstetrics
OB-GYN	Obstetric and Gynecology
OBRA	*Omnibus Budget Reconciliation Act*
OCR	Office of Civil Rights
OD	Doctor of Optometry
OI	Other Insurance

Term	Definition
OIG	Office of the Inspector General
OMT	Osteopathic Manipulation Treatment
OPO	Organ Procurement Organization
OPT/SP	Outpatient Physical Therapy/Speech Pathology
OPTN	Organ Procurement and Transportation Network
ORF	Outpatient Rehabilitation Facility
OSHA	Occupational Safety and Health Administration
OT	Occupational Therapy
OTC	Over the Counter
PA	Physician Assistant
PACT	Program for Amplification for Children of Texas (Hearing Aids/Services)
PAN	Prior Authorization Number
PASARR	Preadmission (MH/MR) Screening and Annual Resident Review
PC	Personal Computer
PCCM	Primary Care Case Management (Program)
PCN	Patient Control Number
PDA	Personal Digital Assistant
PDF	Portable Document Format
PDN	Private Duty Nursing
PE	Presumptive Eligibility
PENS	Percutaneous Electrical Nerve Stimulator
PEP	Positive Expiratory Pressure
PHC	Primary Home Care
PIC	Provider Information Change
PIF	Provider Information Form
PIP	Personal Injury Protection
PKU	Phenylketonuria
P.L.	Public Law
PNP	Pediatric Nurse Practitioner
POC	Plan of Care
POS	Place of Service
PPD	Purified Protein Derivative
PPMP	Physician Performed Microscopy Procedure (CLIA-Certified)
PPO	Preferred Provider Organization
PPS	Prospective Payment System
PRK	Photorefractive Keratectomy
PRN	Pro Re Nata (As Needed)
PT	Physical Therapy
PTA	Percutaneous Transluminal Angioplasty
QA	Quality Assurance
QC	Quality Control
QCC	Qualified Credentialed Counselor
QMB	Qualified Medicare Beneficiary
R&S	Remittance and Status report

Term	Definition
RBRVS	Resource-Based Relative Value Scale
RDC	Renal Dialysis Center
RDI	Respiratory Disturbance Index
RDS	Respiratory Distress Syndrome
REM	Rapid Eye Movement
RFP	Request For Proposal
RGO	Reciprocating Gait Orthoses
RHC	Rural Health Clinic
RIMS	Referral Identification Monitoring System
RN	Registered Nurse
RPR	Rapid Plasma Reagin
RR	Reference Range
RSDI	Retirement Survivors Disability Insurance
RSV	Respiratory Syncytial Virus
RVU	Relative Value Unit
SA	Service Area
SADMERC	Statistical Analysis DME Regional Carrier
SAR	State Action Request
SARS	Severe Acute Respiratory Syndrome
S.B.	Senate Bill
SCID	Severe Combined Immunodeficiency
SDA	Standard Dollar Amount
SED	Serious Emotional Disturbance
SFY	State Fiscal Year (September 1 – August 31)
SHARS	School Health and Related Services
SID	Surface Identification
SIDS	Sudden Infant Death Syndrome
SIMV	Synchronized intermittent mandatory ventilation
SLIAG	State Legalization Impact Assistance Grant
SLP	Speech-Language Pathology
SNF	Skilled Nursing Facility (see also ICF and ECF)
SOC	Start of Care (concerning Home Health Services claims)
SPMI	Severe and Persistent Mental Illness
SQ/SC	Subcutaneous
SSA	Social Security Administration
SSI	Supplemental Security Income (Program)
SSL	Secure Socket Layer
SSN	Social Security Number
ST	Speech Therapy
STAR	State of Texas Access Reform (Program)
STD	Sexually Transmitted Disease
SUR	Surveillance/Utilization Review
TAA	Texas Access Alliance
TAC	*Texas Administrative Code*

Term	Definition
TANF	Temporary Assistance for Needy Families
TB	Tuberculosis
TCADA	Texas Commission on Alcohol and Drug Abuse
TCU	Temperature Control Unit
TDCI	Texas Drug Code Index
TDD	Telecommunications Device for the Deaf
TEA	Texas Education Agency
TEFRA	*Tax Equity and Fiscal Responsibility Act* (of 1982)
TEHDI	Texas Early Hearing Detection and Intervention
TENS	Transcutaneous Electrical Nerve Stimulator
TESS	Texas Eligibility Screening System
THKAO	Thoracic-Hip-Knee-Ankle Orthoses
THSteps	Texas Health Steps
THSteps-CCP	Texas Health Steps-Comprehensive Care Program
TID	Tooth Identification Number
TIFB	Telecommunications Infrastructure Fund Board
TIN	Tax Identification Number
TMHP	Texas Medicaid & Healthcare Partnership
TMPPM	Texas Medicaid Provider Procedures Manual
TMRM	Texas Medicaid Reimbursement Methodology
TMRP	Texas Medical Review Program
TNA	Texas Nurses Association
TNF	Tumor Necrosis Factor
TOB	Type of Bill
TORCH	Toxoplasmosis, Other agents, Rubella, Cytomegalo virus, Herpes simplex (congenital perinatal infection)
TOS	Type of Service
TP	Type Program
TPI	Texas Provider Identifier
TPN	Total Parenteral Nutrition
TP-PA	Treponema pallidum Particle Agglutination
TPR	Third Party Resources
TRAM	Transverse Rectus Abdominis Myocutaneous
TSBDE	Texas State Board of Dental Examiners
TURP	Transurethral Resection of the Prostate
TVFC	Texas Vaccines for Children (Program)
TxDOT	Texas Department of Transportation
UB-04	Uniform Billing-04 (CMS-1450)
UCB	University of California at Berkeley
UM	Utilization Management
UNOS	United Network for Organ Sharing
UPIN	Universal Provider Identification Number or Unique Physician Identification Number
UR	Utilization Review
USC	*United States Code*

Term	Definition
USDA	United States Department of Agriculture
VA	Veteran's Administration
VAERS	Vaccine Adverse Events Reporting System
VDP	Vendor Drug Program
VDRL	Venereal Disease Research Laboratory
VIS	Vaccine Information System or Vaccine Information Statement
VPN	Virtual Private Network
VRE	Vancomycin-resistant Enterococci
WAIS-R	Wechsler Adult Intelligence Scale–Revised
WHP	Women's Health Program
WIC	Women, Infants, and Children
YAG	Yttrium Aluminum Garnet

HIV/AIDS

G.1 Model Workplace Guidelines for Businesses, State Agencies, and State Contractors

G.1.1 Purpose

The purpose of this policy is to protect the employment rights and privileges of individuals infected with the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) through compliance with federal, state, and local laws. This policy will provide Texas employers, especially state agencies, with a uniform approach to developing policies and education programs that address HIV/AIDS in the workplace. The Department of State Health Services (DSHS) encourages all employers to establish workplace policies concerning persons with HIV/AIDS. Employers can adapt this model to fit the particular needs of their organization, work force, and clients. However, the content and intent must remain consistent with this document and the *Health and Safety Code* (HSC).

G.1.2 Authority

Governance for this policy is found in *Vernon's Texas Codes Annotated*, *Health & Safety Code* (HSC) §85.010, "Educational Course for Employees and Clients of Health Care Facilities"; §85.111, "Education of State Employees"; §85.112, "Workplace Guidelines"; and §85.113, "Workplace Guidelines for State Contractors."

The model workplace guidelines developed by the DSHS HIV/ Sexually Transmitted Disease (STD) Comprehensive Services Branch, as required by HSC §85.012, "Model Workplace Guidelines," and adopted as HIV/STD Policy No. 090.021, are considered the minimum standards for the development of guidelines for state agencies. This policy also serves as the minimum standard for contractors of certain designated state agencies and organizations funded by those state agencies (HSC §85.113). "State Agencies Listed Under HSC §85.113" on page G-4 These guidelines are also the standard for health-care facilities licensed by DSHS and the Department of Aging and Disability Services (DADS) as stated in HSC §85.010, "Educational Course for Employees and Clients of Health Care Facilities."

G.1.3 Who Must Use Workplace Guidelines

G.1.3.1 State Agencies

State law requires that each state agency adopt and carry out workplace guidelines. The agency's workplace guidelines should incorporate, at a minimum, the DSHS model workplace guidelines in this policy.

G.1.3.2 State Contractors

A program involving direct client contact, which contracts with or is funded by any of the state agencies listed on page G-4, will adopt and carry out workplace guidelines as stated in HSC §85.113.

G.1.4 Why Have Guidelines

Employers should develop and carry out policies and education programs concerning potentially limiting medical conditions before a crisis arises. Such policies and education programs help reduce employees' fears and misconceptions about HIV/AIDS and help to:

- Provide current and accurate scientific evidence that people with HIV infection do not pose a risk of transmitting the virus to coworkers through ordinary workplace contact.
- Provide workers with current information about HIV risk reduction for employees and their families.
- Avoid conflict between the infected employee and the employer regarding discrimination or other employment issues.
- Prevent work disruption and rejection of the infected employee by coworkers.
- Inform employees that they have rights regarding work continuation, confidentiality of medical and insurance records, and general health and safety.
- Provide specific and ongoing education and equipment to employees in health-care settings who are at risk of exposure to HIV, and to assure that appropriate infection-control procedures are used.
- Reduce the financial impact, legal implications, and other possible effects of HIV/AIDS in the workplace.

G.1.5 Development of Workplace Policy Content

Individuals infected with HIV have the same rights and opportunities as other individuals. While some employers prefer a policy specific to HIV/AIDS and its unique issues, others prefer a general policy concerning illnesses and disabilities. A general policy should address HIV/AIDS in the same way as other major illnesses. We encourage use of the following statements in agency policy:

- Use of a person's HIV status to decide employment status, service delivery, or to deny services to HIV infected individuals is not acceptable. Employees who believe that they have been discriminated against because of HIV or AIDS should contact the personnel office to discuss the matter, or initiate action through the agency's grievance procedure. Other legal options may also be available.
- This policy is consistent with current information from public health authorities, such as the Centers for Disease Control and Prevention (CDC) of the U.S. Public Health Service, and with state and federal laws and regulations.

While the approach and resolution of each employee's situation may vary, similar issues may arise. A workplace policy should address the following issues about HIV/AIDS and other life-threatening illnesses or disabilities:

- *Discrimination.* The *Americans with Disabilities Act* of 1990 prohibits discrimination against people with disabilities, which include HIV and AIDS, in employment, public accommodations, public transportation, and other situations.

  A specific policy statement that no one will be denied employment or employment opportunities because of a disability, satisfies the employer and employee's need to address discrimination. Such a statement might be, "This agency complies with the *Americans with Disabilities Act* protections of all people with disabilities against discrimination in job application procedures, hiring, promotions, discharge, compensation, job training, and other terms or conditions of employment." Managers may want to define ways in which they will deal with discriminatory actions.

- *Desire and Ability to Work.* A workplace policy should address the infected employee's desire and need to work and the infected employee's value to the workplace. Such a statement reassures employees that the employer supports them.

  The health status of someone with HIV may vary from healthy to critically ill. In the work setting, the ultimate concern is whether or not the employee can satisfy job expectations. A policy statement may say, for example, "Procedures may be adapted to provide reasonable accommodation so that people with disabilities may remain employed and productive for as long as possible. All employees, however, are expected to perform the essential functions of their job with or without reasonable accommodation."

- *Performance Standards.* The *Americans with Disabilities Act* provides protections for disabled persons "qualified" to perform their jobs. And although an employer may be expected to provide reasonable accommodation to a disabled employee or applicant; employers may terminate employees and refuse to hire individuals who cannot perform the essential functions of the job, with or without the reasonable accommodation.

  One suggested statement is, "While the *Americans with Disabilities Act* does protect disabled employees from employment discrimination, all employees, those with and without disabilities, have the same performance and conduct standards regarding hiring, promotion, transfer, and dismissal."

- *Reasonable Accommodation.* The *Americans with Disabilities Act* requires employers to provide reasonable accommodations for employees with disabilities. Employers do not have an obligation to provide any accommodation that imposes an undue hardship on the employer. Specific questions about the issue of reasonable accommodation and undue hardship should be directed to staff responsible for coordinating the requirements of the *Americans with Disabilities Act*.

  Such a policy statement might read, "The following options may be considered for people with HIV/AIDS: possible assignment or reassignment of job duties, working at home, leaves of absence, and flexible work schedules."

- *Confidentiality and Privacy.* Organizations that receive funds from a state agency for residential or direct client services or programs shall develop and use confidentiality guidelines to protect their clients' HIV/AIDS related medical information (HSC §85.115, "Confidentiality Guidelines"). Organizations that fail to adopt and use confidentiality guidelines are ineligible to receive state funds.

  Employees are not required to reveal their HIV status to employers. All medical information that an HIV-infected employee provides to medical or management personnel is confidential and private. Employers may not reveal this information without the employee's knowledge and written consent, except as provided by law (HSC §81.103, "Confidentiality; Criminal Penalty").

  A suggested policy statement might be, "This agency will protect the confidentiality of employee medical records and information. Written consent of the employee must be obtained to share any confidential information with other staff. Those with access to confidential information must maintain strict confidentiality and privacy, separating this information from employees' personnel records. Individuals who fail to protect these employee rights commit a serious offense, which may be cause for litigation resulting in both civil and criminal penalties, and may result in dismissal."

- *Coworker Concerns.* Employers need to be aware of the concerns that coworkers may have about an HIV-infected coworker. A policy statement that acknowledges employee concerns and offers HIV/AIDS education helps to increase awareness and decrease fear. Equally important is a policy statement that clarifies the limits of an employer's response to coworker concerns, e.g., "Employees do not have the right to refuse to work with someone who has any disability."

- *Employee Education.* Any health-care facility licensed by the DSHS or the DADS must require its employees to complete an educational course about HIV infection (HSC §85.010). A suggested policy statement may be: "All employees will receive education about methods of transmission and prevention of HIV infection and related conditions." In response to HSC, §85.004, "Educational Programs," DSHS developed model education program guidelines. These are available from DSHS, HIV/STD Comprehensive Services Branch, 1100 W. 49th St., Austin, TX. 78756-3199, (512) 533-3000. Employers may also find the CDC's educa-

tional kit, *Business Responds to AIDS*, useful in developing educational courses. HIV/AIDS education should address employee concerns about HIV communicability to themselves, their families, and coworkers. Experience shows that educated coworkers usually respond to persons with HIV/AIDS with support, rather than with fear and ostracism due to misconceptions.

Education programs must stress that agency employees who provide direct client services may face occupational exposure to a client's blood, semen, vaginal secretions, or other body fluids that are considered to be high-risk for transmission of blood born pathogens, including HIV/AIDS. All individuals receiving direct services are clients and include individuals who are physically or mentally impaired and individuals confined to correctional or residential facilities. All state agencies should have, as part of their employee education program, comprehensive policies and protocols based on universal precautions, body substance isolation, and barrier methods. These precautions prevent the spread of infection in clinical settings. The employer's careful planning will reflect a commitment to the health and well-being of the work force and the community being served.

- *Assistance.* Some employers have designated benefits programs available to employees and family members with HIV infection. Such programs may:
  - Make referrals for testing, counseling, medical, and psychosocial services.
  - Provide HIV/AIDS workplace training for managerial staff.
  - Serve as a liaison between management and the employer's clinical and occupational health programs.
  - Provide counseling for employees who irrationally fear coworkers or clients.

Employers who have no employee assistance program may consider working with other organizations that provide assistance. Some of these groups include local health departments, AIDS services organizations, American Red Cross chapters, community support groups, clinical treatment and counseling services, and the religious community.

A suggested policy statement might be: "An employee who wants assistance concerning a disability or a life-threatening illness should contact the Personnel Office. This agency offers the following resources to help employees and managers deal with these issues: education and information concerning HIV/AIDS; confidential referral to supportive services for employees and dependents affected by life-threatening illnesses; and benefits consultation to help employees effectively manage health, leave, and other benefits."

G.1.6 Where to Go for Help

Employees may call 2-1-1 for HIV/STD testing locations in Texas. For questions related to issues such as transmission, signs and symptoms, or other concerns about HIV or other sexually transmitted infections, employees may call 1-800-CDC-INFO (English/Espanol) or 1-888-232-6348 (TTY).

G.1.7 State Agencies Listed Under HSC §85.113

HSC §85.113, "Workplace Guidelines for State Contractors" states "An entity that contracts with or is funded by…to operate a program involving direct client contact shall adopt and implement workplace guidelines similar to the guidelines adopted by the agency that funds or contracts with the entity." H.B. 2292, 78th Leg., abolished 10 of the 12 existing health and human services agencies and transferred their powers and duties to three new state agencies and to HHSC; therefore rendering the state agency list found in HSC §85.113 obsolete. The list below reflects the state agency consolidation brought about by H.B. 2292 and identifies the state agencies to who HSC §85.113 applies.

- DADS
- Department of Assistive and Rehabilitative Services (DARS)
- DSHS
- HHSC
- Texas Department of Criminal Justice
- Texas Juvenile Probation Commission
- Texas Youth Commission

G.2 CDC Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings

Sexually active adolescents should be tested for gonorrhea, chlamydia, syphilis, and HIV. HIV should be offered as an opt-out test in accordance with CDC testing guidelines, which may be viewed at www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm.

Immunizations

H.1 Immunizations Overview

Children must be immunized according to the Recommended Childhood Immunization Schedule for the United States. The check up provider is responsible for the administration of immunizations and may not refer children to local health departments. The Department of State Health Services (DSHS) requires that immunizations be administered during the Texas Health Steps (THSteps) medical check up, unless they are medically contraindicated or excluded from immunization for reasons of conscience, including a religious belief.

Providers, in both public and private sectors, are required by federal mandate to provide a Vaccine Information Statement (VIS) to the responsible adult accompanying a child for an immunization. These statements are specific to each vaccine and inform the responsible adult about the risks and benefits. It is important that providers use the most current VIS.

Providers interested in obtaining copies of current VISs and other immunization forms or literature may call the DSHS Immunization Branch at 1-512-458-7284. VISs may also be downloaded from the DSHS Immunization Branch's website at www.immunizetexas.com.

H.1.1 Vaccine Adverse Event Reporting System (VAERS)

The *National Childhood Vaccine Injury Act* of 1986 (NCVIA) requires health-care providers to report:

- Any reaction listed by the vaccine manufacturer as a contraindication to subsequent doses of the vaccine.
- Any reaction listed in the Reportable Events Table that occurs within the specified time period after vaccination.
- A copy of the Reportable Events Table can be obtained by calling VAERS at 1-800-822-7967 or by downloading it from vaers.hhs.gov/pubs.htm.

Clinically significant adverse events should be reported even if it is unclear whether a vaccine caused the event.

Note: *Documentation of the injection site is recommended, but not required. For additional information regarding documentation, providers can refer to www.hrsa.gov/vaccinecompensation/filing_claim.htm and www.cdc.gov/od/science/iso/professional_info/providers_role.htm.*

H.1.2 TVFC vs. Non-TVFC Vaccines/Toxoids

When single antigen vaccine(s)/toxoid(s) or comparable antigen vaccine(s)/toxoid(s) are available for distribution through TVFC, but the provider chooses to use a different Advisory Committee on Immunization Practices (ACIP)-recommended product, the vaccine/toxoid will not be covered; however, the administration fee will be considered.

Note: *All administered vaccines/toxoids must be reported to DSHS. DSHS submits all vaccines/toxoids reported with parental consent to a centralized repository of immunization histories for children younger than 18 years of age. This repository is known in Texas as ImmTrac.*

Refer to: "How to Report Immunization Records to ImmTrac, the Texas Immunization Registry" on page H-7

H.1.3 Exemption from Immunization for School and Child-care Facilities

Parents may choose not to vaccinate their children. Immunization requirements for school and childcare entry offer an exemption from these requirements for reasons of conscience or religious beliefs. An exemption is also available for children who are medically contraindicated from receiving a vaccine. For more information on exemptions call 1-512-458-7284, or visit www.immunizetexas.com.

Refer to: "Texas Health Steps (THSteps)" on page 43-1

H.2 Recommended Childhood Immunization Schedule

The Recommended Childhood Immunization Schedule indicates the recommended age for routine administration of currently licensed childhood vaccines. This schedule is approved by the ACIP, the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

Some combination vaccines are available and may be used whenever any component of the combination is indicated and its other components are not contraindicated. Providers should consult the manufacturers package insert for detailed recommendations.

Vaccines should be administered at recommended ages. Any dose not given at the recommended age should be given as a catch-up immunization on any subsequent visit when indicated and feasible.

A current copy of the Recommended Childhood Immunization Schedule can be accessed at www.cdc.gov/vaccines/recs/schedules/default.htm.

H.2.1 Recommended Childhood and Adolescent Immunization Schedule, 2007

DEPARTMENT OF HEALTH AND HUMAN SERVICES • CENTERS FOR DISEASE CONTROL AND PREVENTION

Recommended Immunization Schedule for Persons Aged 0–6 Years—UNITED STATES • 2007

Vaccine ▼ Age ▶	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
Hepatitis B[1]	HepB	HepB		see footnote 1	HepB				HepB Series		
Rotavirus[2]			Rota	Rota	Rota						
Diphtheria, Tetanus, Pertussis[3]			DTaP	DTaP	DTaP		DTaP				DTaP
Haemophilus influenzae type b[4]			Hib	Hib	*Hib*[4]	Hib		Hib			
Pneumococcal[5]			PCV	PCV	PCV	PCV				PCV	PPV
Inactivated Poliovirus			IPV	IPV	IPV						IPV
Influenza[6]					Influenza (Yearly)						
Measles, Mumps, Rubella[7]						MMR					MMR
Varicella[8]						Varicella					Varicella
Hepatitis A[9]						HepA (2 doses)				HepA Series	
Meningococcal[10]										MPSV4	

Range of recommended ages

Catch-up immunization

Certain high-risk groups

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2006, for children aged 0–6 years. Additional information is available at http://www.cdc.gov/nip/recs/child-schedule.htm. Any dose not administered at the recommended age should be administered at any subsequent visit, when indicated and feasible. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective Advisory Committee on Immunization Practices statement for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at **http://www.vaers**, **hhs.gov** or by telephone, **800-822-7967**.

1. Hepatitis B vaccine (HepB). *(Minimum age: birth)*

At birth:

- Administer monovalent HepB to all newborns before hospital discharge.
- If mother is hepatitis surface antigen (HBsAg)-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
- If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine the HBsAg status as soon as possible and if HBsAg-positive, administer HBIG (no later than age 1 week).
- If mother is HBsAg-negative, the birth dose can only be delayed with physician's order and mother's negative HBsAg laboratory report documented in the infant's medical record.

After the birth dose:

- The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at age 1–2 months. The final dose should be administered at age ≥24 weeks. Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg after completion of ≥3 doses of a licensed HepB series, at age 9–18 months (generally at the next well-child visit).

4-month dose:

- It is permissible to administer 4 doses of HepB when combination vaccines are administered after the birth dose. If monovalent HepB is used for doses after the birth dose, a dose at age 4 months is not needed.

2. Rotavirus vaccine (Rota). *(Minimum age: 6 weeks)*

- Administer the first dose at age 6–12 weeks. Do not start the series later than age 12 weeks.
- Administer the final dose in the series by age 32 weeks. Do not administer a dose later than age 32 weeks.
- Data on safety and efficacy outside of these age ranges are insufficient.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). *(Minimum age: 6 weeks)*

- The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose.
- Administer the final dose in the series at age 4–6 years.

4. *Haemophilus influenzae* type b conjugate vaccine (Hib). *(Minimum age: 6 weeks)*

- If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required.
- TriHiBit® (DTaP/Hib) combination products should not be used for primary immunization but can be used as boosters following any Hib vaccine in children aged ≥12 months.

5. Pneumococcal vaccine. *(Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPV])*

- Administer PCV at ages 24–59 months in certain high-risk groups. Administer PPV to children aged ≥2 years in certain high-risk groups. See *MMWR* 2000;49(No. RR-9):1–35.

6. Influenza vaccine. *(Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 5 years for live, attenuated influenza vaccine [LAIV])*

- All children aged 6–59 months and close contacts of all children aged 0–59 months are recommended to receive influenza vaccine.
- Influenza vaccine is recommended annually for children aged ≥59 months with certain risk factors, health-care workers, and other persons (including household members) in close contact with persons in groups at high risk. See *MMWR* 2006;55(No. RR-10):1–41.
- For healthy persons aged 5–49 years, LAIV may be used as an alternative to TIV.
- Children receiving TIV should receive 0.25 mL if aged 6–35 months or 0.5 mL if aged ≥3 years.
- Children aged <9 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by ≥4 weeks for TIV and ≥6 weeks for LAIV).

7. Measles, mumps, and rubella vaccine (MMR). *(Minimum age: 12 months)*

- Administer the second dose of MMR at age 4–6 years. MMR may be administered before age 4–6 years, provided ≥4 weeks have elapsed since the first dose and both doses are administered at age ≥12 months.

8. Varicella vaccine. *(Minimum age: 12 months)*

- Administer the second dose of varicella vaccine at age 4–6 years. Varicella vaccine may be administered before age 4–6 years, provided that ≥3 months have elapsed since the first dose and both doses are administered at age ≥12 months. If second dose was administered ≥28 days following the first dose, the second dose does not need to be repeated.

9. Hepatitis A vaccine (HepA). *(Minimum age: 12 months)*

- HepA is recommended for all children aged 1 year (i.e., aged 12–23 months). The 2 doses in the series should be administered at least 6 months apart.
- Children not fully vaccinated by age 2 years can be vaccinated at subsequent visits.
- HepA is recommended for certain other groups of children, including in areas where vaccination programs target older children. See *MMWR* 2006;55(No. RR-7):1–23.

10. Meningococcal polysaccharide vaccine (MPSV4). *(Minimum age: 2 years)*

- Administer MPSV4 to children aged 2–10 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high-risk groups. See *MMWR* 2005;54(No. RR-7):1–21.

The Recommended Immunization Schedules for Persons Aged 0–18 Years are approved by the Advisory Committee on Immunization Practices (http://www.cdc.gov/nip/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).

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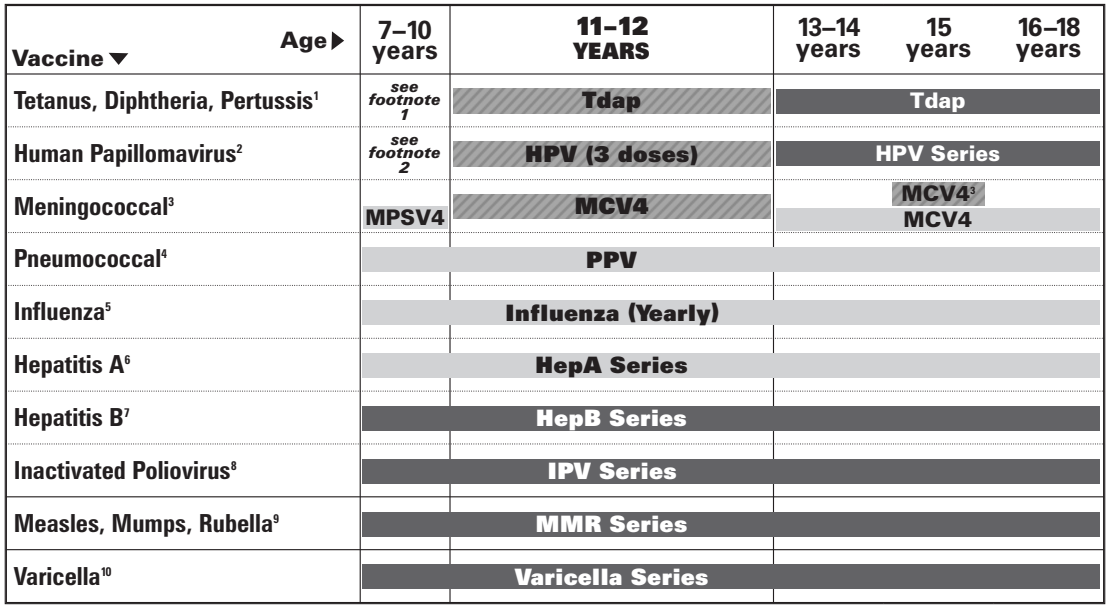
DEPARTMENT OF HEALTH AND HUMAN SERVICES • CENTERS FOR DISEASE CONTROL AND PREVENTION

Recommended Immunization Schedule for Persons Aged 7–18 Years—UNITED STATES • 2007



This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2006, for children aged 7–18 years. Additional information is available at **http://www.cdc.gov/nip/recs/child-schedule.htm**. Any dose not administered at the recommended age should be administered at any subsequent visit, when indicated and feasible. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective Advisory Committee on Immunization Practices statement for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at **http://www.vaers.hhs.gov** or by telephone, **800-822-7967**.

1. Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).
(Minimum age: 10 years for BOOSTRIX® and 11 years for ADACEL™)
- Administer at age 11–12 years for those who have completed the recommended childhood DTP/DTaP vaccination series and have not received a tetanus and diphtheria toxoids vaccine (Td) booster dose.
- Adolescents aged 13–18 years who missed the 11–12 year Td/Tdap booster dose should also receive a single dose of Tdap if they have completed the recommended childhood DTP/DTaP vaccination series.

2. Human papillomavirus vaccine (HPV). *(Minimum age: 9 years)*
- Administer the first dose of the HPV vaccine series to females at age 11–12 years.
- Administer the second dose 2 months after the first dose and the third dose 6 months after the first dose.
- Administer the HPV vaccine series to females at age 13–18 years if not previously vaccinated.

3. Meningococcal vaccine. *(Minimum age: 11 years for meningococcal conjugate vaccine [MCV4]; 2 years for meningococcal polysaccharide vaccine [MPSV4])*
- Administer MCV4 at age 11–12 years and to previously unvaccinated adolescents at high school entry (at approximately age 15 years).
- Administer MCV4 to previously unvaccinated college freshmen living in dormitories; MPSV4 is an acceptable alternative.
- Vaccination against invasive meningococcal disease is recommended for children and adolescents aged ≥2 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high-risk groups. See *MMWR* 2005;54(No. RR-7):1–21. Use MPSV4 for children aged 2–10 years and MCV4 or MPSV4 for older children.

4. Pneumococcal polysaccharide vaccine (PPV). *(Minimum age: 2 years)*
- Administer for certain high-risk groups. See *MMWR* 1997;46(No. RR-8):1–24, and *MMWR* 2000;49(No. RR-9):1–35.

5. Influenza vaccine. *(Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 5 years for live, attenuated influenza vaccine [LAIV])*
- Influenza vaccine is recommended annually for persons with certain risk factors, health-care workers, and other persons (including household members) in close contact with persons in groups at high risk. See *MMWR* 2006;55 (No. RR-10):1–41.
- For healthy persons aged 5–49 years, LAIV may be used as an alternative to TIV.
- Children aged <9 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by ≥4 weeks for TIV and ≥6 weeks for LAIV).

6. Hepatitis A vaccine (HepA). *(Minimum age: 12 months)*
- The 2 doses in the series should be administered at least 6 months apart.
- HepA is recommended for certain other groups of children, including in areas where vaccination programs target older children. See *MMWR* 2006;55 (No. RR-7):1–23.

7. Hepatitis B vaccine (HepB). *(Minimum age: birth)*
- Administer the 3-dose series to those who were not previously vaccinated.
- A 2-dose series of Recombivax HB® is licensed for children aged 11–15 years.

8. Inactivated poliovirus vaccine (IPV). *(Minimum age: 6 weeks)*
- For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if the third dose was administered at age ≥4 years.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.

9. Measles, mumps, and rubella vaccine (MMR). *(Minimum age: 12 months)*
- If not previously vaccinated, administer 2 doses of MMR during any visit, with ≥4 weeks between the doses.

10. Varicella vaccine. *(Minimum age: 12 months)*
- Administer 2 doses of varicella vaccine to persons without evidence of immunity.
- Administer 2 doses of varicella vaccine to persons aged <13 years at least 3 months apart. Do not repeat the second dose, if administered ≥28 days after the first dose.
- Administer 2 doses of varicella vaccine to persons aged ≥13 years at least 4 weeks apart.

The Recommended Immunization Schedules for Persons Aged 0–18 Years are approved by the Advisory Committee on Immunization Practices (http://www.cdc.gov/nip/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).

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Catch-up Immunization Schedule for Persons Aged 4 Months–18 Years Who Start Late or Who Are More Than 1 Month Behind

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The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age.

CATCH-UP SCHEDULE FOR PERSONS AGED 4 MONTHS–6 YEARS					
Vaccine	**Minimum Age for Dose 1**	**Minimum Interval Between Doses**			
		Dose 1 to Dose 2	**Dose 2 to Dose 3**	**Dose 3 to Dose 4**	**Dose 4 to Dose 5**
Hepatitis B[1]	**Birth**	**4 weeks**	**8 weeks** (and 16 weeks after first dose)		
Rotavirus[2]	**6 wks**	**4 weeks**	**4 weeks**		
Diphtheria, Tetanus, Pertussis[3]	**6 wks**	**4 weeks**	**4 weeks**	**6 months**	**6 months**[3]
***Haemophilus influenzae* type b**[4]	**6 wks**	**4 weeks** if first dose administered at age <12 months **8 weeks (as final dose)** if first dose administered at age 12-14 months **No further doses needed** if first dose administered at age ≥15 months	**4 weeks**[4] if current age <12 months **8 weeks (as final dose)**[4] if current age ≥12 months and second dose administered at age <15 months **No further doses needed** if previous dose administered at age ≥15 months	**8 weeks (as final dose)** This dose only necessary for children aged 12 months–5 years who received 3 doses before age 12 months	
Pneumococcal[5]	**6 wks**	**4 weeks** if first dose administered at age <12 months and current age <24 months **8 weeks (as final dose)** if first dose administered at age ≥12 months or current age 24–59 months **No further doses needed** for healthy children if first dose administered at age ≥24 months	**4 weeks** if current age <12 months **8 weeks (as final dose)** if current age ≥12 months **No further doses needed** for healthy children if previous dose administered at age ≥24 months	**8 weeks (as final dose)** This dose only necessary for children aged 12 months–5 years who received 3 doses before age 12 months	
Inactivated Poliovirus[6]	**6 wks**	**4 weeks**	**4 weeks**	**4 weeks**[6]	
Measles, Mumps, Rubella[7]	**12 mos**	**4 weeks**			
Varicella[8]	**12 mos**	**3 months**			
Hepatitis A[9]	**12 mos**	**6 months**			
CATCH-UP SCHEDULE FOR PERSONS AGED 7–18 YEARS					
Tetanus, Diphtheria/ Tetanus, Diphtheria, Pertussis[10]	**7 yrs**[10]	**4 weeks**	**8 weeks** if first dose administered at age <12 months **6 months** if first dose administered at age ≥12 months	**6 months** if first dose administered at age <12 months	
Human Papillomavirus[11]	**9 yrs**	**4 weeks**	**12 weeks**		
Hepatitis A[9]	**12 mos**	**6 months**			
Hepatitis B[1]	**Birth**	**4 weeks**	**8 weeks** (and 16 weeks after first dose)		
Inactivated Poliovirus[6]	**6 wks**	**4 weeks**	**4 weeks**	**4 weeks**[6]	
Measles, Mumps, Rubella[7]	**12 mos**	**4 weeks**			
Varicella[8]	**12 mos**	**4 weeks** if first dose administered at age ≥13 years **3 months** if first dose administered at age <13 years			

1. Hepatitis B vaccine (HepB). *(Minimum age: birth)*
- Administer the 3-dose series to those who were not previously vaccinated.
- A 2-dose series of Recombivax HB® is licensed for children aged 11–15 years.

2. Rotavirus vaccine (Rota). *(Minimum age: 6 weeks)*
- Do not start the series later than age 12 weeks.
- Administer the final dose in the series by age 32 weeks. Do not administer a dose later than age 32 weeks.
- Data on safety and efficacy outside of these age ranges are insufficient.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). *(Minimum age: 6 weeks)*
- The fifth dose is not necessary if the fourth dose was administered at age ≥4 years.
- DTaP is not indicated for persons aged ≥7 years.

4. *Haemophilus influenzae* type b conjugate vaccine (Hib). *(Minimum age: 6 weeks)*
- Vaccine is not generally recommended for children aged ≥5 years.
- If current age <12 months and the first 2 doses were PRP-OMP (PedvaxHIB® or ComVax® [Merck]), the third (and final) dose should be administered at age 12– 15 months and at least 8 weeks after the second dose.
- If first dose was administered at age 7–11 months, administer 2 doses separated by 4 weeks plus a booster at age 12–15 months.

5. Pneumococcal conjugate vaccine (PCV). *(Minimum age: 6 weeks)*
- Vaccine is not generally recommended for children aged ≥5 years.

6. Inactivated poliovirus vaccine (IPV). *(Minimum age: 6 weeks)*
- For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if third dose was administered at age ≥4 years.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.

7. Measles, mumps, and rubella vaccine (MMR). *(Minimum age: 12 months)*
- The second dose of MMR is recommended routinely at age 4–6 years but may be administered earlier if desired.
- If not previously vaccinated, administer 2 doses of MMR during any visit with ≥4 weeks between the doses.

8. Varicella vaccine. *(Minimum age: 12 months)*
- The second dose of varicella vaccine is recommended routinely at age 4–6 years but may be administered earlier if desired.
- Do not repeat the second dose in persons aged <13 years if administered ≥28 days after the first dose.

9. Hepatitis A vaccine (HepA). *(Minimum age: 12 months)*
- HepA is recommended for certain groups of children, including in areas where vaccination programs target older children. See *MMWR* 2006;55(No. RR-7):1–23.

10. Tetanus and diphtheria toxoids vaccine (Td) and tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap). *(Minimum ages: 7 years for Td, 10 years for BOOSTRIX®, and 11 years for ADACEL™)*
- Tdap should be substituted for a single dose of Td in the primary catch-up series or as a booster if age appropriate; use Td for other doses.
- A 5-year interval from the last Td dose is encouraged when Tdap is used as a booster dose. A booster (fourth) dose is needed if any of the previous doses were administered at age <12 months. Refer to ACIP recommendations for further information. See *MMWR* 2006;55(No. RR-3).

11. Human papillomavirus vaccine (HPV). *(Minimum age: 9 years)*
- Administer the HPV vaccine series to females at age 13–18 years if not previously vaccinated.

Information about reporting reactions after immunization is available online at **http://www.vaers.hhs.gov** or by telephone via the 24-hour national toll-free information line 800-822-7967. Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for immunization, is available from the National Center for Immunization and Respiratory Diseases at **http://www.cdc.gov/nip/default.htm** or telephone, **800-CDC-INFO (800-232-4636)**.

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CS103164

H.3 General Recommendations

For information about vaccine administration, dosing, and contraindications, immunization providers should consult vaccine package inserts and the December 1, 2006, issue of the *Morbidity and Mortality Weekly Report* (MMWR), *General Recommendations on Immunization, Recommendations of the Advisory Committee on Immunization Practices*. For copies of the *General Recommendations on Immunization* or the MMWR, contact the Immunization Branch at 1-512-458-7284.

H.3.1 How to Obtain Free Vaccines

Texas Vaccines for Children (TVFC) Program provides routinely recommended ACIP vaccines for immunization of THSteps and other Medicaid-eligible patients free of charge to providers who are enrolled in TVFC. The local health department/district or DSHS regional office provides information on how to order, account for, and inventory vaccines. Monthly reports are required in order to receive state-purchased vaccine. Physicians who request and accept state-supplied vaccines must complete and sign the provider enrollment and profile forms annually.

Additional information can be found at www.immunizetexas.com.

H.3.2 Provider Administration Reimbursement Fee

Vaccine/toxoid administration fees for clients birth through 20 years of age will be reimbursed based on the number of state defined components administered per injection.

- The provider must bill an administration fee without a modifier when a vaccine/toxoid with one state defined component is administered. The administration fee billed without a modifier is reimbursed at $8.00 each.
- The provider must bill an administration fee with state defined modifier U2 when a vaccine/ toxoid with two state defined components is administered. The administration fee billed with modifier U2 is reimbursed at $12.00 each.
- The provider must bill an administration fee with state defined modifier U3 when a vaccine/ toxoid with three state defined components is administered, The administration fee billed with modifier U3 is reimbursed at $16.00 each.

Modifier	Description
U2	State Defined Modifier: Administration of vaccine/toxoid with two state defined components
U3	State Defined Modifier: Administration of vaccine/toxoid with three state defined components

H.3.2.1 Vaccine Procedure Codes and State Defined Components

Procedure Codes	Number of Components
1/S-90632*	1
1/S-90633*	1
1/S-90636	2
1/S-90645	1
1/S-90646	1
1/S-90647	1
1/S-90648*	1
1/S-90649*	1
1/S-90655*	1
1/S-90656*	1
1/S-90657*	1
1/S-90658*	1
1/S-90660*	1
1/S-90669*	1
1/S-90680*	1
1/S-90700*	1
1/S-90702*	1
1-90703	1
1/S-90707*	1
1/S-90710*	2
1/S-90713*	1
1/S-90714*	1
1/S-90715*	2
1/S-90716*	1
1/S-90718	1
1/S-90723*	3
1-90732*	1
1/S-90733	1
1/S-90734*	1
1-90740	1
1/S-90743	1
1/S-90744*	1
1/S-90746*	1
1-90747	1
1/S-90748*	2
1/S-90749	1
***TVFC distributed vaccine/toxoid**	

H.3.3 Requirements for TVFC Providers

By enrolling, public and private providers agree to:

- Determine TVFC eligibility before administering vaccines obtained through TVFC. The Patient Eligibility Screening Form will be provided to the parent or guardian to declare each child's eligibility.
- Maintain records of the parent, guardian, or authorized representative's responses on the Patient Eligibility Screening Form for at least three years. If requested, the provider will make such records available to DSHS, the local health department authority, or the U.S. Department of Health and Human Services (HHS).
- Comply with the appropriate vaccination schedule, dosage, and contraindications, as established by ACIP, unless (a) in making a medical judgment in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate, or (b) the particular requirement is not in compliance with Texas law, including laws relating to religious and medical exemptions.
- Provide VISs to the responsible adult, parent, or guardian and maintain records in accordance with the NCVIA. (Signatures are not required for the VISs but are recommended.)
- Not charge for vaccines supplied by DSHS and administered to a child who is eligible for TVFC.
- Charge a vaccine administration fee to the Texas Medicaid Program, but not impose a charge for the administration of the vaccine in any amount higher than the maximum administration fee established by DSHS (providers may charge a vaccine administration fee to Medicaid, but not a fee for the vaccine). Medicaid patients cannot be charged any out-of-pocket expense for the vaccine, administration of the vaccine, or an office visit associated with Medicaid services.
- Not deny administration of a TVFC vaccine to a child because of the inability of the child's parent or guardian/individual of record to pay an administrative fee.
- Comply with the state's requirements for ordering vaccines and other requirements as described by DSHS.
- Allow DSHS (or its contractors) to conduct onsite visits as required by TVFC regulations.

The provider or the state may terminate the agreement at any time for failure to comply with the requirements listed above.

H.3.4 How to Report Immunization Records to ImmTrac, the Texas Immunization Registry

Texas law requires all medical providers and payors to report *all immunizations* administered to children under 18 of years of age to ImmTrac, the Texas immunization registry operated by DSHS (*Texas Health and Safety Code* §§161.007-161.009). Providers must report all immunization information within 30 days of administration of the vaccine, and payors must report within 30 days of receipt of data elements from a provider. Prior to reporting immunizations to ImmTrac, providers must first register for registry participation and access.

ImmTrac is a centralized repository of immunization histories for children younger than 18 years of age and is a free service and benefit available to all Texans. Registry information is confidential, and by law, may be released only to:

- The child’s parent, legal guardian, or managing conservator.
- The child’s physician, school, or licensed child-care facility in which the child is enrolled o Public health districts or local health departments.
- The insurance company, health maintenance organization, or other organization that pays for the provision of the child's health-care benefits.
- A health-care provider authorized to administer a vaccine.
- A state agency that has legal custody of the child.

ImmTrac offers three methods to report immunizations to DSHS: Direct Internet Entry, Electronic Data Transfer (Import), and Paper Reporting Form.

H.3.4.1 Direct Internet Entry

This method allows providers to access and review clients' immunization histories prior to administering vaccines. Providers then update their client’s immunization record directly into the ImmTrac web application after administering vaccines to the patient.

H.3.4.2 Electronic Data Transfer (Import)

This method allows providers to report immunizations from an electronic medical record (EMR) software application via extract file for import into ImmTrac. Providers may still have access to the ImmTrac web application to access and review their clients' immunization histories.

H.3.4.3 Paper Reporting Form

This method of reporting is available to providers without Internet or computer access. Providers report immunizations to the registry via the ImmTrac Paper Reporting Form. In this case, providers are not able to access and view their clients’ immunization histories in ImmTrac.

Before including a child’s immunization information in ImmTrac, DSHS must verify that written consent for registry participation has been granted by the child's parent, legal guardian, or managing conservator. Most parents grant consent for ImmTrac participation during the birth certificate application process. Written parental consent for ImmTrac participation applies to all past, present, and future immunizations. Texas law also permits a parent, managing conservator, or guardian to withdraw consent for ImmTrac participation at any time.

Medical providers may report directly to ImmTrac by entering immunizations online for patients currently participating in the registry. The online (Direct Internet Entry) and Electronic Data Transfer (Import) reporting options allow providers to access, review, and update a patient's immunization history at any time. Before reporting immunizations to ImmTrac via any of these options, providers must complete an ImmTrac Registration Packet (for providers and schools) and receive login credentials from ImmTrac Customer Support. A copy of this packet may be obtained from www.ImmTrac.com or requested from ImmTrac Customer Support by calling 1-800-348-9158.

H.4 Texas Vaccines for Children Program Packet

Refer to: "TVFC Patient Eligibility Screening Record" on page C-79

"TVFC Provider Enrollment (3 Pages)" on page C-81

"TVFC Questions and Answers (3 Pages)" on page C-84

Medical Transportation

I.1 Medical Transportation

The Medical Transportation Program (MTP) is funded with federal and state funds to provide nonemergency transportation to medical or dental appointments for eligible clients and their attendants. When eligible clients and their attendants have no other means of transportation, the Texas Department of Transportation (TxDOT) arranges the most cost-effective mode of transportation to and from a medically necessary health-care facility that can meet the client's medical needs, including dental services for clients younger than 21 years of age.

I.1.1 MTP Eligibility

People who are currently eligible for Medicaid, Medicaid Managed Care, and Children with Special Health Care Needs (CSHCN) Services Program benefits and their attendants are eligible to receive services. The client's attending physician must certify the need for an attendant unless the client is a CSHCN Services Program client or a minor, or a language or other barrier to communication or mobility exists that requires the assistance of an attendant. For Medicaid and CSHCN Services Program clients younger than 21 years of age, MTP provides advance funds for travel. Additionally, when health-care services require an eligible client to remain overnight, MTP provides for meals and lodging for the eligible child and attendant. CSHCN Services Program clients older than 21 years of age diagnosed with cystic fibrosis may also qualify for these services.

I.1.2 MTP Requirements

To receive MTP services, eligible clients and their attendants must have no other means of transportation. In some cases, the client's attending provider is asked to complete Form 3113, Health Care Provider Statement of Need. Form 3113 is required to determine if a particular health-care service is a Medicaid-covered benefit for which federal financial participation (FFP) is available, the service is medically necessary, and the health-care provider is *reasonably close*.

The client's attending provider may also be asked to provide a Form 3113 to assist with determining the appropriate mode of transportation when a client cannot utilize public transit services.

I.1.3 Contacting MTP

Clients or their advocates should call the statewide MTP toll-free number (1-877-633-8747) to request transportation services. For transportation services within the county where the client lives, clients or their advocates must call the MTP office at least two business days before the scheduled appointment. For clients who need to travel beyond the county where they live, clients or their advocates must call the MTP office at least five business days before the scheduled appointment. The following client information must be provided to the intake operator at the time of the call:

- Medicaid number, CSHCN Services Program number, or Social Security number (SSN).
- Name, address, and telephone number, if available.
- Name, address, and telephone number of the health-care provider.
- Purpose of the trip.
- Affirmation that no other means of transportation are available.
- Special needs, wheelchair lift, or attendant need.

I.1.4 MTP Program Limitations

Clients and their attendants are *not* eligible to receive medical transportation services under the following circumstances (this list is not all-inclusive):

- Emergency transportation or nonemergency ambulance services.
- Transportation for children who are younger than 18 years of age and not accompanied by a parent or legal guardian, unless one of the following conditions exists:
  - The client is 15 through 17 years of age and provides a written consent for the transportation services, signed by the parents or legal guardian. The signed consent must be on file with MTP prior to the date of travel.
  - The treatment to which the minor is being transported is such that the law extends confidentiality to the minor for this treatment.
- Transportation to or from a day activity health services facility, personal care home, state institution, nursing facility (unless the client requires dialysis treatment), or facility participating in another Title XIX Program for which the reimbursement rate structure includes transportation funds.
- Transportation when the client or another person or entity providing care for the client receives direct payment of worker's compensation benefits, U.S. Department of Veterans Affairs benefits, or other third-party resources for transportation to health-care services on the client's behalf.
- Transportation when the client is an inpatient in a health-care facility.
- Transportation of deceased clients.
- Transportation passenger assistance beyond that which is necessary to ensure that clients enter and exit vehicles safely.

Refer to: Title 1, Part 15, Chapter 380 of the *Texas Administrative Code* (TAC) for more information.

Lead Screening

J.1 Blood Lead Screening Procedures and Follow-up Testing

Every Texas child should have a blood lead test at *12 and 24 months* of age. This testing is required for all children enrolled in the Texas Health Steps (THSteps) Program. The Risk Assessment for Lead Exposure questionnaire (PB110) should be administered to the parent by the provider at all other visits up to and including 6 years of age. At any visit after 12 months of age, a blood lead test should be conducted if there is no evidence of a previous blood lead test for the patient. A "yes" or "don't know" answer to any question on the risk assessment questionnaire indicates that a blood lead test should be administered.

J.2 Symptoms of Lead Poisoning

Children with elevated blood lead levels (EBLLs) in the range of 10–45µg/dL are generally asymptomatic, although neurodevelopment impairment may become evident as they age. Symptoms usually do not appear until blood lead levels (BLLs) are in the higher ranges. Very high lead levels may cause colic, constipation, anorexia and vomiting. Venous blood lead levels over 70µg/dL are a serious medical emergency. Most children seen by healthcare providers in Texas present with BLLs less than 30µg/dL and have no symptoms; however it is important not to equate absence of symptoms with absence of toxicity.

J.3 Measuring Blood Lead Levels

Recent or ongoing exposures to lead can be detected by a blood test. Blood lead levels are stated as micrograms of lead per deciliter of whole blood. The Centers for Disease Control and Prevention (CDC) defines a blood lead level of 10 µg/dL a "level of concern," which is also the measurement standard in Texas for an "elevated blood lead level" and requires follow-up. The blood lead "level of concern" should not be interpreted as a definitive toxicological threshold. Mounting evidence suggests adverse health effects in children with blood lead levels below 10µg/dL and no definitive threshold for adverse effects has been demonstrated.

Blood lead tests, in order of occurrence:

- Screening test—A blood lead test to determine whether the client has an elevated blood lead level.
- Diagnostic test (confirmatory)—A venous blood lead test performed within recommended guidelines on a client who has previously had an elevated blood lead level on a screening test. Unless the diagnostic test occurs within six months of the screening date, it is not a diagnostic test but rather a new screening test.
- Follow-up test—A blood lead test to monitor the status of a client with a previously elevated diagnostic test for lead.

Note: *This is not related to the THSteps follow-up visit. A visit to monitor a child with elevated blood lead tests would be submitted as an acute care evaluation and management (E/M) visit.*

A screening test may be drawn from a venous site or capillary. Venous drawn is strongly recommended and preferred. Providers are responsible for conducting a diagnostic test when a screening test finds lead at 10 µg/dL or greater.

Note: *The capillary lead screen analysis is subject to a false-elevated result from skin lead contamination during collection. A soap and water wash of the patient's hands or feet and the collector's hands (or the wearing of gloves) must be performed to minimize the chance of contamination. Alcohol cleansing alone is not sufficient.*

If the initial blood lead test is 10 µg/dL or above, recalling a client for an office visit to take a venous blood sample may be billed as a THSteps follow-up visit. The specimen may be submitted, using the appropriate Department of State Health Services (DSHS) laboratory form, to the DSHS Clinical Chemistry Laboratory the same way as for all other THSteps laboratory blood specimens. An initial blood lead test collected as part of a THSteps medical check up must be submitted to the DSHS laboratory; subsequent screens for the same client may be sent to a private laboratory.

Refer to: Form Pb-109 "Form Pb-109: Physician Reference on Follow-up Testing and Case Management" on page J-3 for interpretation of laboratory test results and guidelines for follow-up for clients with elevated blood lead levels.

Providers may obtain more information about the medical and environmental management of lead-poisoned children from the DSHS Childhood Lead Poisoning Prevention Program (CLPPP) by visiting the website at www.dshs.state.tx.us/lead/ or by calling 1-800-588-1248.

J.4 Form Pb-109: Physician Reference on Follow-up Testing and Case Management

TX CLPPP
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Texas Childhood Lead Poisoning Prevention Program

Form Pb-109 - Physician Reference on Follow-up Testing and Case Management

Table 1:

Recommended Schedule for Obtaining a Diagnostic Venous Sample

Screening test results (µg/dL):	Perform a venous diagnostic test within:
10-19	5 weeks
20-39	1 week-4 weeks*
40-59	48 hours
60-69	24 hours
70 and up	Immediately as an emergency lab test

*The higher the Blood Lead Level (BLL) on the screening test, the more urgent the need for diagnostic testing.

Local Health Department Childhood Lead Poisoning Prevention Programs

Austin/Travis County	512-972-6650	Fax: 512-972-6665
City of Dallas	214-670-7663	Fax: 214-670-8991
San Antonio/Bexar County	210-434-0077	Fax: 210-434-1540
City of Houston	713-794-9349	Fax: 713-794-2988
Harris County	713-439-6126	Fax: 713-439-6376

Table 2:

Schedule for Follow-Up Blood Lead Testing

Venous blood lead level (µg/dL)	Early follow-up (first 2-4 tests after identification)	Late follow-up (after BLL begins to decline)
10-14	3 months	6-9 months
15-19	1-3 months	3-6 months
20-24	1-3 months	1-3 months
25-44	2 weeks-1 month	1 month
45 and up	As soon as possible	Chelation w/subsequent follow-up *

Keep This Form for Your Records

Table 3:

Time Frame for Environmental Investigation and Other Case Management Activities

Venous Blood Lead Level (µg/dL)	Activities	Timeframe for Beginning Activity
10-14	Provide caregiver lead education. Provide follow-up testing. Refer the child for social services if necessary.	Within 30 days
15-19	Above actions, plus: If BLLs persist (i.e., 2 venous BLLs in this range at least 3 months apart) or increase, proceed according to actions for BLLs 20-44.	Within 2 weeks
20-39	Above actions, plus: Provide coordination of care (case management). Provide clinical evaluation and care. Provide environmental investigation and control current lead hazards.	Within 1 week
40-69	Above actions, plus hospitalize child for chelation therapy. *	Within 48 hours
70 or higher	Above actions, plus hospitalize child for chelation therapy immediately. *	Within 24 hours

* Primary care providers should consult with an expert in the management of these lead levels before administering chelation. Contact your local Poison Control Center or contact Texas CLPPP at 1-800-588-1248 for a referral.

Chelation therapy should never be administered before a venous confirmation is obtained.

TEXAS Department of State Health Services

Tables adapted from *Managing Elevated Blood Lead Levels Among Young Children:* CDC; March 2002.

Texas Department of State Health Services • Childhood Lead Poisoning Prevention Program

1100 West 49th St. • Austin, TX 78756-3199
1-800-588-1248 • http://www.dshs.state.tx.us/lead

Form Pb-109 Page 1 of 1 Revised 11-07

J.5 Lead Poisoning Prevention Educational Materials and Forms

Providers may order lead poisoning prevention educational materials and forms by writing or faxing the DSHS warehouse or by contacting the warehouse online at webds.dshs.state.tx.us/mamd/litcat/default.asp. Other materials are available for download from the Texas CLPPP website at www.dshs.state.tx.us/lead/default.shtm.

Written requests for warehoused materials can be faxed to 1-512-458-7707 or sent to the DSHS warehouse at:

DSHS Literature and Forms
Attn: Warehouse Manager
1100 West 49th Street
Austin, TX 78756-3199

Include the catalog number, title of item, quantity needed, and your mailing address.

The following table lists materials available to providers at no cost.

Free Lead Poisoning Prevention Materials Available Online and from the DSHS Warehouse	
1-26**	Protect Your Children From Lead Poisoning
1-26a**	Protect Your Children From Lead Poisoning (Spanish)
1-307**	Lead Around the Home (English/Spanish, front and back)
1-308**	Lead in Your Food and Remedies (English/Spanish, front and back)
1-309**	Lead in the Workplace and at Home (English/Spanish, front and back)
1-310**	My Child Has a High Lead Level (English/Spanish, front and back)
1-311**	How Lead Affects Your Child's Health (English/Spanish, front and back)
1-312**	Educator's Brochure
1-313**	Getting a Good Specimen (Poster)
Pb-100***	Lead Assessment Interview Tool
Pb-101***	Request for Environmental Investigation
Pb-102***	Provider Follow-up Questionnaire
Pb-104***	Physician Checklist for Parent Education Topics
Pb-109***	Physician Reference on Follow-up Testing and Case Management
Pb-110***	Risk Assessment for Lead Exposure Questionnaire
13-32*	Get the Lead Out With Good Nutrition

*** Available only from the warehouse**

**** Available from the warehouse or online (PDF format) from the Texas CLPPP website at www.dshs.state.tx.us/lead/default.shtm**

***** Available only online (PDF format)**

K

Texas Health Steps Statutory State Requirements

K.1 Legislative Requirements

Several specific legislative requirements affect Texas Health Steps (THSteps) and the provider's participation in the Texas Medicaid program. The legislation includes, but is not limited to, those included in this appendix.

K.2 Texas Health Steps (THSteps) Program

The Texas Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is mandated by Title XIX of the *Social Security Act*. EPSDT is a program of prevention, diagnosis, and treatment for Medicaid recipients birth through 20 years of age.

In Texas, EPSDT is known as the THSteps program. The Texas Department of State Health Services (DSHS), by authorization of HHSC, operationalizes and administers outreach and informing, medical and dental check-ups, and the dental treatment utilization components of this program. State authority is found in Title 25 *Texas Administrative Code* (TAC), Chapter 33, Part 1.

K.3 Communicable Disease Reporting

Diagnosis of sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV), are reportable conditions under 25 TAC, Chapter 97, Subchapter F. Providers must report confirmed diagnosis of STDs as required by 25 TAC §§97.132-134.

K.4 Early Childhood Intervention (ECI) Referrals

ECI is a coordinated system of services available in every Texas county for children from birth to 3 years of age with disabilities or delays. ECI is federally and state funded through the Title 20 *Individuals with Disabilities Education Act* (IDEA), Chapter 33, and *Texas Human Resources Code* (HRC), Chapter 73. ECI provides support to families to help their children reach their potential through developmental services.

Texas families who have children younger than 3 years of age with a disability or suspected delays in development must be referred to ECI. A medical diagnosis or a confirmed developmental delay is not needed for referral. A referral can be based on professional judgment or a family's concern.

All primary referral sources must refer a child younger than 3 years of age who may be in need of and/or qualify for comprehensive early intervention services. Referrals must occur within two work days of identification and must be made to a contracted provider for evaluation and assessment of the child.

For more information and referral to services, visit the Department of Assistive and Rehabilitative Services (DARS) website at www.dars.state.tx.us/ecis, or call the DARS Inquiries Line at 1-800-628-5155, the DARS TDD/TTY at 1-866-581-9328, or the ECI state office at 1-512-424-6745.

Refer to: 34 *Code of Federal Regulations* (CFR), §303.321.

40 TAC §108.61.

K.5 Parental Accompaniment

HRC §§32.024(s)-(s-1) requires DSHS to require, as a condition for provider reimbursement, that a child younger than 15 years of age be accompanied by the child's parent, guardian, or other authorized adult during medical and dental check ups or screenings and dental treatment. DSHS has implemented this requirement through rules found in 25 TAC §33.134 (THSteps medical) and 25 TAC §33.318 (THSteps dental) and the definitions found in 25 TAC §33.15 for medical and 25 TAC §33.301 for dental.

The DSHS rules require that the parent, guardian, or authorized adult come with the child to the check up or screening, and that the parent, guardian, or authorized adult must continue to wait for the child while the check up, treatment, or service takes place.

Providers will not be required to submit documentation to TMHP to verify compliance with this policy in order for TMHP to process claims. By submitting the claim for reimbursement, the provider acknowledges compliance with all Medicaid requirements. Additional assurances are not necessary.

Exception: *School health clinics, Head Start programs, and childcare facilities are exempt from this policy if the clinic, program, or facility encourages parental involvement in the health care of the child and obtains written consent for the services. The consent from the child's parent or guardian must have been received within the one-year period before the date on which the services are provided and must not have been revoked.*

Refer to: HRC §§32.024(s)-(s-1)25 TAC §33.15, §33.134, §33.301, and §33.318.

K.6 Newborn Blood Screening

The *Health and Safety Code* (HSC), Chapter 33, Subchapter B, implemented by the rules found at 25 TAC, Chapter 37, Subchapter D, requires testing of all newborns for phenylketonuria (PKU), other heritable diseases, or hypothyroidism. A current list of 27 disorders is found at www.dshs.state.tx.us/newborn /quickreference.shtm.

This testing is the responsibility of the physician who is attending a newborn client (defined as up to the age of 30 days by rule in 25 TAC §37.52) or the person who is attending the delivery of a newborn child who is not attended by a physician to screen for the disorders within 24 to 48 hours of birth.

All infants must be tested a second time at one to two weeks of age. If there is any doubt that a client younger than 12 months of age was properly tested, the provider should submit the blood sample on the appropriate DSHS Form NBS-3 to the DSHS Newborn Screening Laboratory.

K.7 Abuse and Neglect

K.7.1 Requirements for Reporting Abuse or Neglect

Providers are required to report abuse or neglect as outlined in "Provider Responsibilities" on page 1-5.

Additionally, the *General Appropriations Act*, Article II, Rider 33 under DSHS, and Rider 13 under HHSC, of Senate Bill (S.B.) 1, 79th Legislative Regular Session, 2005, require that DSHS and HHSC distribute or provide appropriated funds only to recipients who show good faith efforts to comply with all child abuse and reporting requirements set forth in the *Texas Family Code* (TFC), Chapter 261, relating to investigations of reports of child abuse and neglect.

K.7.1.1 Procedures for Reporting Abuse or Neglect

Professionals, as defined in TFC §261.101 (b), are required to report abuse or neglect no later than the 48th hour after the hour in which the professional first has cause to believe the child has been or may be abused or is the victim of the offense of indecency with a child.

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

A report must be made regardless of whether the provider staff suspects that a report may have previously been made. Reports of abuse or indecency with a child should be made to one of the following:

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

The law requires that the report include the following:

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

Reports can be made anonymously.

Providers can also report nonemergency abuse online at www.txabusehotline.org.

A provider may not reveal whether the child has been tested or diagnosed with HIV or acquired immunodeficiency syndrome (AIDS). If the minor's identity is unknown (e.g., the minor is at the provider's office to receive testing for HIV or an STD anonymously), no report is required.

K.7.1.2 Staff Training on Reporting Abuse and Neglect

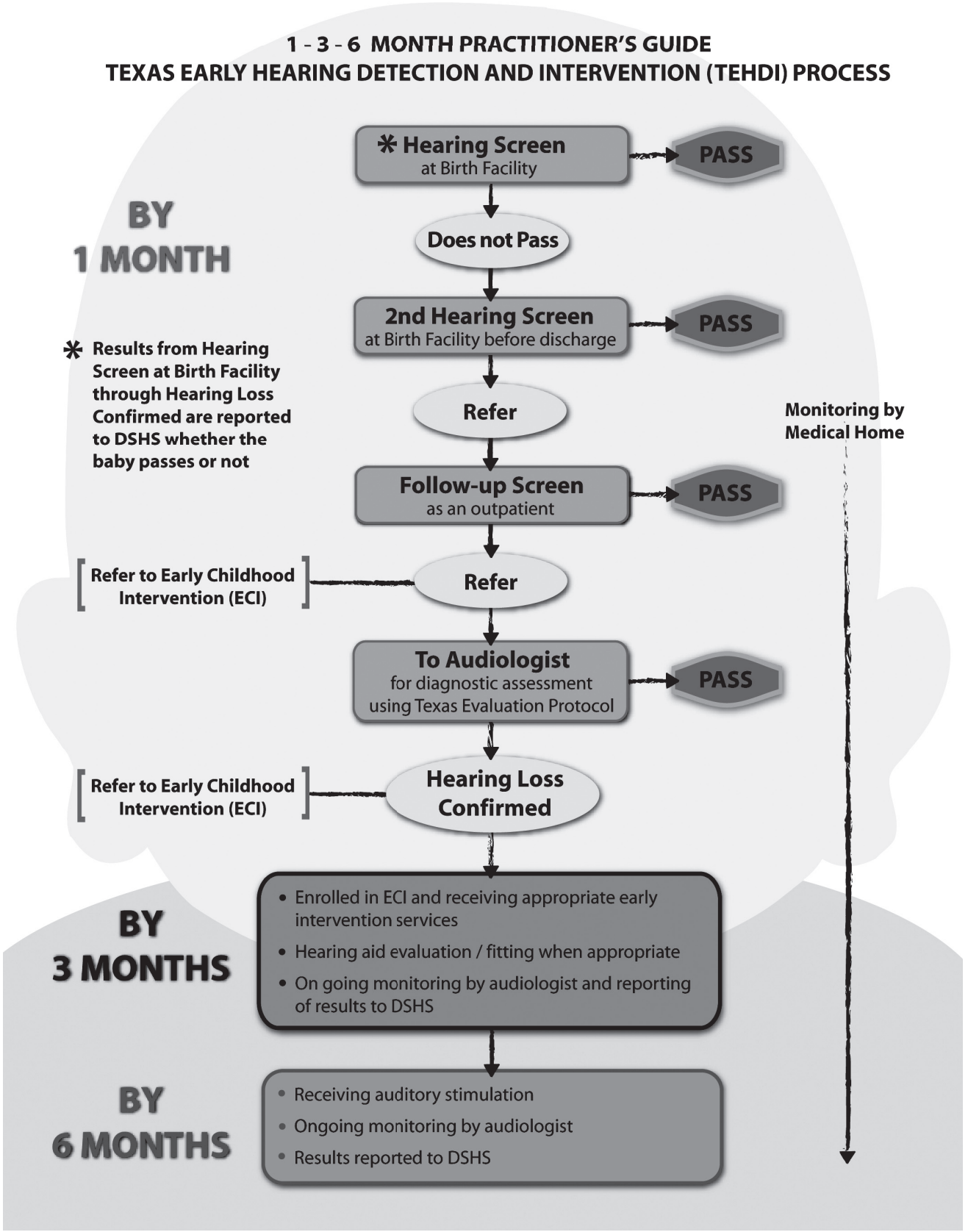
All providers shall develop training for all staff on the policies and procedures in regard to reporting child abuse, including sexual abuse and neglect. New staff shall receive this training as part of their initial training or orientation.

Training shall be documented. As part of the training, staff shall be informed that the staff person who conducts the screening and has cause to suspect abuse has occurred is legally responsible for reporting. A joint report may be made with the supervisor.

Several specific legislative requirements affect THSteps and the provider's participation in the Texas Medicaid program. The legislation includes, but is not limited to, those included in this appendix.

Hearing Screening Information

L.1 Newborn Hearing



Texas Early Hearing Detection and Intervention (TEHDI)

1. **Birth Screen**
   - Parental permission is required
   - Test is either Auditory Brainstem Response (ABR) or Transient or Distortion Product Otoacoustic Emissions (OAE)
   - A second screen is done before discharge if the first is not passed
   - Written results are given to the parents and primary care physician (PCP)
   - Results are reported to DSHS, but are de-identified for infants who pass. Parental permission is given for identified results to be reported
   - Referral to a local audiology resource is made for outpatient re-screen when an infant does not pass the second screen

2. **Outpatient Re-screen**
   - ABR or OAE tests are used
   - If the infant does not pass, referrals are made to an audiologist for diagnostic hearing testing and to Early Childhood Intervention (ECI) at 1-800-628-5115
   - Financial assistance is available for Medicaid qualified families through the Program for Amplification for Children of Texas (PACT). See www.dshs.state.tx.us/audio/pactpro.shtm or call 1-800-252-8023
   - Results are reported to DSHS

3. **Audiologic Evaluation**
   - Diagnostic ABR and, to verify cochlear involvement, OAE if not previously done
   - The Texas Pediatric Protocol for Evaluation is used. See www.dshs.state.tx.us/audio/assumpt.shtm
   - Results are reported to the referral source and to DSHS
   - Referral is made to ECI upon the diagnosis of hearing loss
   - Referral to an otologist for a medical examination of the ear (required by PACT)
   - Fitting of hearing aids by an audiologist when appropriate
   - Ongoing audiological assessment and monitoring as needed

4. **Referral to ECI**
   - Must be within two working days of the diagnosis of hearing loss
   - Service coordination is provided by ECI
   - Parents may refuse ECI services
   - An Individual Family Services Plan (ISFP) will be developed by ECI within 45 days of referral
   - ECI and the Local Education Agency (LEA) have shared service responsibility for children with hearing loss
   - ECI services are available until the child's third birthday, and then transition to the LEA is coordinated

5. **Deaf Education and other special education services** are available from ages 3 – 21 when determined by the Individual Education Plan (IEP)

6. **For children who pass the newborn hearing screen,** the Medical Home/ PCP continues to monitor for developing hearing loss. See www.aap.org/policy/jcihyr2000.pdf for suggested monitoring protocols

Additional Resources: www.callier.utdallas.edu/txc.html for Texas Connect - Educational Information; Educational Resource Center on Deafness at 1-800-332-3873

TEXAS Department of Assistive and Rehabilitative Services

TEXAS Department of State Health Services

Rev. March 2007 Publication No. 05-12258

L.2 Texas Early Hearing Detection and Intervention (TEHDI) Process

The following is a list of processes for early hearing detection and intervention:

- *Birth Screen*: will be either screening auditory brainstem response (ABR), or transient or distortion product otoacoustic emissions (OAE):
  - A newborn's hearing is screened at the birth facility. If a newborn does not pass the screen, hearing is re-screened before discharge.
  - The birth facility reports results to the Department of State Health Services (DSHS) using the web-based eScreener Plus (eSP™) system.
  - The newborn's family and physician/medical home receive a written report of the hearing screen outcome.
  - If a newborn passes the screen, the physician monitors hearing as part of well child visits.
  - If a newborn does not pass the second screen, a referral is made to a local resource for outpatient rescreen. See the following steps.
- *Outpatient Rescreen*: will be either screening by ABR or OAE:
  - The physician/medical home receives the written report of results from the birth facility.
  - The screener/physician reports results to the DSHS contractor, OZ Systems, using the web-based eSP system, by calling 1-866-427-5768, or faxing 1-214-631-4231.
  - If the newborn passes the outpatient re-screen, the physician monitors hearing as part of well child visits.
  - If a newborn does not pass (refers) the outpatient re-screen, a referral is made to an audiologist for evaluation using the Texas Pediatric Protocol for Evaluation. Visit www.dshs.state.tx.us/audio/assumpt.shtm for more information.
  - For children whose families need financial assistance for testing, make an application to the DSHS Program for Amplification for Children of Texas (PACT). Consult the provider list at www.dshs.state.tx.us/audio/pactpro.shtm. Click on the area of the state and then on the city, or call 1-800-252-8023.
- *Evaluation using Texas Pediatric Protocol for Audiology:* will be diagnostic ABR and, if not previously done, OAE to verify cochlear involvement:
  - Audiologists use equipment norms for newborns, preferably ones that they have collected on their equipment.
  - Protocols include air and bone conduction results using tone burst ABR, as well as click ABR, so the amplification may be appropriately fit.
  - The physician/medical home receives results and makes the referral to Early Childhood Intervention (ECI) using the web-based eSP system or by calling 1-800-250-2246.
  - The physician/medical home monitors the child. See the *American Academy of Pediatrics Position Statement* at www.aap.org/policy/re9846.html.
  - The audiologist reports results to the DSHS contractor as noted above and makes the referral to ECI.
  - Includes the fitting of hearing aids by an audiologist when appropriate.
  - Continue audiological assessment and/or monitoring as needed (usually monitor each three months for the first year of hearing aid use).
- *Referral to an ECI program:* will be performed by an audiologist or physician within two working days of identification of hearing loss as required by law:
  - Service coordination provided by ECI.
  - ECI will refer to the Local Education Agency (LEA) for auditory impairment (AI) services as outlined in the *Memorandum of Understanding between TEA and DARS ECI.*
  - An evaluation and Individual Family Service Plan (IFSP) will occur within 45 days of referral to ECI.
  - ECI and LEA services are available up to age three when determined by an IFSP.
  - ECI and LEA will coordinate transition services upon the child's third birthday.
- *The physician/medical home continues to monitor periodically:* see the Joint Committee on Infant Hearing (JCIH) 2000 for suggested monitoring protocols at www.aap.org/policy/jcihyr2000.pdf.
- Deaf education and/or other special education services available from 3 to 21 years of age when determined by an individualized education program.
- Regional specialists from Deaf and Hard of Hearing Services at the Department of Assistive and Rehabilitative Services (DARS) will provide technical assistance to birth facilities, audiologists, and ear, nose, and throat (ENT) physicians to ensure reporting of screening and evaluation results. Provders can call 1-512-407-3250 for assistance.

L.3 JCIH 2007 Position Statement

The JCIH 2007 position statement is available on the JCIH website at www.jcih.org/posstatemts.htm. The 2007 position statement lists the indicators that are associated with permanent congenital, delayed-onset or progressive hearing loss in childhood.

Appendix

M

THSteps Quick Reference Guide

M.1 Texas Health Steps Quick Reference Guide

TMHP
TEXAS MEDICAID HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Texas Health Steps Quick Reference Guide

*** Use THSteps Provider Identifier** **• Diagnosis Code V202** **• Type of service S**

THSteps Medical Check Up Billing Codes

THSteps Medical Check Ups

99381	99382	99383	99384	99385
99391	99392	99393	99394	99395

THSteps Follow-up Visit

Use procedure code 99211 for a THSteps follow-up visit.

Immunizations Administered

Each immunization must have a corresponding vaccine code.

- If only one immunization is administered during a check up, providers should bill procedure code 90471/90473 or 90465/90467 with a quantity of 1.
- If two or more immunizations are administered, providers should bill procedure code 90471/90473 or 90465/90467 with a quantity of 1, procedure code 90472/90474 or 90466/90468 with a quantity of 1 or more (depending on the number of vaccines administered), and the appropriate national procedure codes that describe each immunization administered.

Procedure Codes	Vaccine
90632* or 90633* with (90471/90472 or 90465/90466)	Hep A
90645, 90646, 90647, or 90648* with (90471/90472 or 90465/90466)	Hib
90655*, 90656*, 90657*, or 90658* with (90471/90472 or 90465/90466) or 90660* with (90473/90474 or 90467/90468)	Influenza
90649* with 90471/90472	HPV
90669* with (90471/90472 or 90465/90466)	PCV7
90680* with (90473/90474 or 90467/90468)	Rotavirus
90700* with (90471/90472 or 90465/90466)	DTaP
90702* with (90471/90472 or 90465/90466)	DT
90707* with (90471/90472 or 90465/90466)	MMR
90710* with (90471/90472 or 90465/90466)	MMRV
90713* with (90471/90472 or 90465/90466)	IPV
90714* or 90718 with (90471/90472 or 90465/90466)	Td
90715* with (90471/90472 or 90465/90466)	Tdap
90716* with (90471/90472 or 90465/90466)	Varicella
90723* with (90471/90472 or 90465/90466)	DTap-Hep B-IPV
90732 * with (90471/90472 or 90465/90466)	Pneumococcal
90733 or 90734* with (90471/90472 or 90465/90466)	Meningococcal
90740, 90743, 90744*, 90746*, or 90747 with (90471/90472 or 90465/90466)	Hep B
90748* with (90471/90472 or 90465/90466)	Hib-Hep B

* Indicates a vaccine distributed by TVFC

Modifiers

Performing Provider
Use to indicate the practitioner who is performing the unclothed physical examination component of the medical check up.

AM	SA	TD	U7

Exception to Periodicity
Use with THSteps medical check ups procedure codes to indicate the reason for an exception to periodicity.

23	32	SC

FQHC
Federally qualified health center (FQHC) providers must use modifier EP for THSteps medical check up.

Vaccine/Toxoids
Use to indicate a vaccine/toxoid *not available* through TVFC and the number of state defined components administered per vaccine.

U1**	Vaccine/toxoid privately purchased by provider when TVFC vaccine/toxoid is not available
U2	Administration of vaccine/toxoid with two state defined components
U3	Administration of vaccine/toxoid with three state defined components

Condition Indicator Codes

Use one of the indicators below if a referral was made.

Condition Indicator	Condition Indicator Codes	Description
N	NU	Not used (no referral)
Y	ST	New services requested
Y	S2	Under treatment

TB Skin Test

Be sure to include a charge of at least $.01 for procedure code 86580, even though this code is not reimbursed separately.

*** U1 modifier only applies to the following vaccines: influenza, HPV and rotavirus, MMRV, and Tdap.*

Contact Information

THSteps Medical Check Up Claims Inquiries

Call the following number to obtain answers to questions or determine the status of claims:

1-800-757-5691

THSteps Outreach & Informing Service, Missed Appointment & Referral Services

1-877-THSteps (847-8377)

THSteps Website

www.dshs.state.tx.us/thsteps/default.shtm

THSteps-Comprehensive Care Program (THSteps-CCP)

Telephone: 1-800-846-7470
Fax: 1-512-514-4212

Texas Immunization Registry (ImmTrac)

1-800-348-9158
www.dshs.state.tx.us/immunize/immtrac/default.shtm

Texas Vaccines for Children Program (TVFC)

1-800-252-9152
www.dshs.state.tx.us/immunize/tvfc/default.shtm

Texas Medicaid & Healthcare Partnership (TMHP)

www.tmhp.com

Case Management for Children and Pregnant Women (CPW)

1-512-458-7111 x 2168
www.dshs.state.tx.us/caseman/default.shtm

Early Childhood Intervention (ECI)

www.dars.state.tx.us/ecis/index.shtml

Hearing Evaluation/Hearing Aid

For recipients needing these services, refer to the Program for Amplification for Children of Texas (PACT). For THSteps Medicaid clients under 21 years of age, Form H3087 will have a "P" in the column under "Hearing Aid," which indicates that prior approval must be obtained from PACT for hearing aid services.

Physicians, health department employees, school nurses, teachers, education service center employees, public officials, and other state agency employees may refer recipients to PACT. In addition, parents of recipients may apply for these services at the following addresses. **For regular mail, please contact:**

Program for Amplification for Children of Texas
Department of State Health Services
PO Box 149347
Austin, TX 78714-9347

For mailing hearing aids, please mail to:

Program for Amplification for Children of Texas- MC 1918
Department of State Health Services
1100 West 49th Street
Austin, TX 78756
1-800-252-8023
www.dshs.state.tx.us/audio

Laboratory

Requests for THSteps supplies from the Department of State Health Services (DSHS) should be made on Form G399 and submitted to:

Container Preparation & Supplies
Laboratory Services Section, MC 1947
Department of State Health Services
PO Box 149347
Austin, TX 78714-9347

Supplies: 1-512-458-7661
Fax: 1-512-458-7672
Technical Questions: 1-512-458-7680
Test Results: 1-512-458-7578

A written request for Newborn Screening (NBS) specimen collection form (NBS-3) and NBS supplies is required. To obtain an order form for written requests, call: **1-512-458-7661**

The Newborn Screen is the only test performed by the DSHS Laboratory for Children's Health Insurance Program (CHIP) recipients.

To obtain Newborn Screening test results, call the Newborn Screening Automated Voice Response System (personal identification number required): **1-512-458-7300**

PAP Smear supplies may be ordered from:

Texas Center for Infectious Disease
2303 Southeast Military Drive
San Antonio, TX 78223
Attn: Customer Service
1-210-531-4596

Obtain guidelines for collecting and handling specific types of specimens at: **www.dshs.state.tx.us/lab/default.shtm**

Medical Transportation Program (MTP) - Texas Department of Transportation

1-877-633-8747
www.dot.state.tx.us/PTN/mtp/mtphome.htm

Medicaid Fraud:

To report potential Medicaid fraud, contact one of the following hotlines, or visit the website:

HHSC Client or Provider Fraud Investigations:
1-800-436-6184

www.hhs.state.tx.us/OIG/Fraud_Report_Home.shtml

Childhood Lead Poisoning Prevention Program

1 800- 588-1248

www.dshs.state.tx.us/lead/default.shtm

Child Health Record Forms

May be downloaded from the THSteps website or camera-ready copies may be ordered from:

THSteps Program
PO Box is 149347
Austin, TX 78714
1-512-458-7745
www.thstepsproducts.com

Appendix

N

THSteps Dental Guidelines

N.1 American Academy of Pediatric Dentistry Periodicity Guidelines

Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Children

Originating Committee
Clinical Affairs Committee

Review Council
Council on Clinical Affairs

Adopted
1991

Revised
1992, 1996, 2000, 2003

Purpose

The American Academy of Pediatric Dentistry (AAPD) intends this guideline to help practitioners make clinical decisions concerning preventive oral health care for infants, children, and adolescents. Because each child is unique, these recommendations are designed for the care of children who have no contributory medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from the normal.

Methods

This guideline is a compilation of pediatric oral health literature and national reports and recommendations, in addition to related policies and guidelines published in the AAPD Reference Manual.[1-24] The related policies and guidelines provide references for individual recommendations. Some recommendations are evidence-based, while others represent best clinical practice and expert opinion.

Background

The AAPD emphasizes the importance of professional oral health intervention very early in childhood. Caries-risk assessment[11] is an essential element of contemporary clinical care for infants, children, and adolescents. Continuity of care is based on the assessed needs of the individual patient. Although evidenced-based research supporting the benefits of an infant dental intervention is limited, there is sufficient evidence that certain groups of children are at greater risk for development of early childhood caries (ECC) and would benefit from infant oral health care. ECC can be a costly, devastating disease with a lasting detrimental impact on the dentition and systemic health issues.[7] The characteristics of ECC and the availability of preventive methods support anticipatory guidance as an important strategy in addressing this significant pediatric health problem. Major benefits of early intervention, in addition to assessment of risk status, include analysis of fluoride exposure and feeding practices, as well as oral hygiene counseling. The early dental visit should be seen as the foundation upon which a lifetime of preventive education and oral health care can be built. Clinicians must consider each infant's, child's, and adolescent's individual needs and risk indicators to determine the appropriate interval and frequency of dental visits.

Recommendations

Birth to 12 months

1. Complete the clinical oral examination with appropriate diagnostic tests to assess oral growth and development, pathology, and/or injuries; provide diagnosis.
2. Provide oral hygiene counseling for parents, guardians, and caregivers, including the implications of the oral health of the caregiver.
3. Remove supragingival and subgingival stains or deposits as indicated.
4. Assess the child's systemic and topical fluoride status (including type of infant formula used, if any, and exposure to fluoridated toothpaste) and provide counseling regarding fluoride. Prescribe systemic fluoride supplements, if indicated, following assessment of total fluoride intake from drinking water, diet, and oral hygiene products.
5. Assess appropriateness of feeding practices, including bottle and breast-feeding, and provide counseling as indicated.
6. Provide dietary counseling related to oral health.
7. Provide age-appropriate injury prevention counseling for orofacial trauma.
8. Provide counseling for nonnutritive oral habits (eg, digit, pacifiers).
9. Provide required treatment and/or appropriate referral for any oral diseases or injuries.
10. Provide anticipatory guidance for parent/guardian/caregiver.
11. Consult with the child's physician as needed.
12. Based on evaluation and history, assess the patient's risk for oral disease.
13. Determine the interval for periodic re-evaluation.

12 to 24 months

1. Repeat birth to 12-month procedures every 6 months or as indicated by individual patient's risk status/susceptibility to disease.
2. Assess appropriateness of feeding practices, including bottle, breast-feeding, and no-spill training cups, and provide counseling as indicated.
3. Review patient's fluoride status–including any childcare arrangements, which may impact systemic fluoride intake–and provide parental counseling.
4. Provide topical fluoride treatments every 6 months or as indicated by the individual patient's needs.

2 to 6 years

1. Repeat 12- to 24-month procedures every 6 months or as indicated by individual patient's risk status/susceptibility to disease. Provide age-appropriate oral hygiene instructions.
2. Complete a radiographic assessment of pathology and/or abnormal growth and development, as indicated by individual patient's needs.
3. Scale and clean the teeth every 6 months or as indicated by individual patient's needs.
4. Provide pit and fissure sealants for primary and permanent teeth as indicated by individual patient's needs.
5. Provide counseling and services (athletic mouthguards) as needed for orofacial trauma prevention.
6. Provide assessment/treatment or referral of developing malocclusion as indicated by individual patient's needs.
7. Provide required treatment and/or appropriate referral for any oral diseases, habits, or injuries as indicated.
8. Assess speech and language development and provide appropriate referral as indicated.

6 to 12 years

1. Repeat 2- to 6-year procedures every 6 months or as indicated by individual patient's risk status /susceptibility to disease.
2. Provide substance abuse counseling (eg, smoking, smokeless tobacco).
3. Provide counseling on intraoral and perioral piercing.

12 years and older

1. Repeat 6- to 12-year procedures every 6 months or as indicated by individual patient's risk status/susceptibility to disease.
2. At an age determined by patient, parent/guardian, and pediatric dentist, refer the patient to a general dentist for continuing oral care.

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10. American Academy of Pediatric Dentistry. Clinical guideline on the role of prophylaxis in pediatric dentistry. Pediatr Dent 2003;25(suppl):64-66.
11. American Academy of Pediatric Dentistry. Policy on the use of a caries-risk assessment tool (CAT) for infants, children, and adolescents. Pediatr Dent 2003;25(suppl):18-20.
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17. American Academy of Pediatric Dentistry. Policy on prevention of sports-related orofacial injuries. Pediatr Dent 2003;25(suppl):37.
18. American Academy of Pediatric Dentistry. Clinical guideline on management of acute dental trauma. Pediatr Dent 2003;25(suppl):92-97.
19. American Academy of Pediatric Dentistry. Clinical guideline on management of the developing dentition in pediatric dentistry. Pediatr Dent 2003;25(suppl):98-101.
20. American Academy of Pediatric Dentistry. Clinical guideline on acquired temporomandibular disorders in infants, children, and adolescents. Pediatr Dent 2003; 25(suppl):102-103.
21. American Academy of Pediatric Dentistry. Policy on tobacco use. Pediatr Dent 2003;25(suppl):33-34.
22. American Academy of Pediatric Dentistry. Clinical guideline on adolescent oral health care. Pediatr Dent 2003;25(suppl):55-60.
23. American Academy of Pediatric Dentistry. Policy on intraoral and perioral piercing. Pediatr Dent 2003; 25(suppl):35.
24. American Academy of Pediatric Dentistry. Policy on oral and maxillofacial surgery for infants, children, and adolescents. Pediatr Dent 2003;25(suppl):116.

N

Recommendations for Pediatric Oral Health Care

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal.

The American Academy of Pediatric Dentistry (AAPD) emphasizes the importance of *very* early professional intervention and the continuity of care based on the individualized needs of the child.

Age	6–12 months	12–24 months	2–6 years	6–12 years	12 years and older
Clinical oral examination[1]	•	•	•	•	•
Assess oral growth and development[2]	•	•	•	•	•
Caries-risk assessment[3]	•	•	•	•	•
Prophylaxis and topical fluoride treatment[4]		•	•	•	•
Fluoride supplementation[5,6]	•	•	•	•	•
Anticipatory guidance[7]	•	•	•	•	•
Oral hygiene counseling[8]	Parents/guardians/ caregivers	Parents/guardians/ caregivers	Patient/parents/ guardians/caregivers	Patient/parents/ guardians/caregivers	Patient
Dietary counseling[9]	•	•	•	•	•
Injury prevention counseling[10]	•	•	•	•	•
Counseling for nonnutritive habits[11]	•	•	•	•	•
Substance abuse counseling				•	•
Counseling for intraoral/ perioral piercing				•	•
Radiographic assessment[12]			•	•	•
Treatment of dental disease/injury	•	•	•	•	•
Assessment and treatment of developing malocclusion			•	•	•
Pit and fissure sealants[13]			•	•	•
Assessment and/or removal of third molars					•
Referral for regular and periodic dental care					•

1. First examination at the eruption of the first tooth and no later than 12 months.
2. By clinical examination.
3. As per AAPD "Policy on the use of a caries-risk assessment tool (CAT) for infants, children, and adolescents."
4. Especially for children at high risk for caries and periodontal disease.
5. As per American Academy of Pediatrics/American Dental Association guidelines and the water source.
6. Up to at least 16 years.
7. Appropriate discussion and counseling should be an integral part of each visit for care.
8. Initially, responsibility of parent; as child develops, jointly with parents; then, when indicated, only child.
9. At every appointment discuss the role of refined carbohydrates, frequency of snacking.
10. Initially play objects, pacifiers, car seats; then when learning to walk, sports and routine playing.
11. At first discuss the need for additional sucking: digits vs pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.
12. As per AAPD "Clinical guideline on prescribing dental radiographs."
13. For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and/or fissures; placed as soon as possible after eruption.

N.2 American Dental Association Guidelines for Prescribing Dental Radiographs

GUIDELINES FOR PRESCRIBING DENTAL RADIOGRAPHS

The recommendations in this chart are subject to clinical judgment and may not apply to every patient. They are to be used by dentists only after reviewing the patient's health history and completing a clinical examination. Because every precaution should be taken to minimize radiation exposure, protective thyroid collars and aprons should be used whenever possible. This practice is strongly recommended for children, women of childbearing age and pregnant women.

TYPE OF ENCOUNTER	PATIENT AGE AND DENTAL DEVELOPMENTAL STAGE				
	Child with Primary Dentition (prior to eruption of first permanent tooth)	**Child with Transitional Dentition** (after eruption of first permanent tooth)	**Adolescent with Permanent Dentition** (prior to eruption of third molars)	**Adult, Dentate or Partially Edentulous**	**Adult, Edentulous**
New patient* being evaluated for dental diseases and dental development	Individualized radiographic exam consisting of selected periapical/occlusal views and/or posterior bitewings if proximal surfaces cannot be visualized or probed. Patients without evidence of disease and with open proximal contacts may not require a radiographic exam at this time.	Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images.	Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images. A full mouth intraoral radiographic exam is preferred when the patient has clinical evidence of generalized dental disease or a history of extensive dental treatment.		Individualized radiographic exam, based on clinical signs and symptoms.
Recall patient* with clinical caries or at increased risk for caries**	Posterior bitewing exam at 6-12 month intervals if proximal surfaces cannot be examined visually or with a probe			Posterior bitewing exam at 6-18 month intervals	Not applicable
Recall patient* with no clinical caries and not at increased risk for caries**	Posterior bitewing exam at 12-24 month intervals if proximal surfaces cannot be examined visually or with a probe		Posterior bitewing exam at 18-36 month intervals	Posterior bitewing exam at 24-36 month intervals	Not applicable

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GUIDELINES FOR PRESCRIBING DENTAL RADIOGRAPHS, cont'd.

TYPE OF ENCOUNTER	PATIENT AGE AND DENTAL DEVELOPMENTAL STAGE				
	Child with Primary Dentition (prior to eruption of first permanent tooth)	**Child with Transitional Dentition** (after eruption of first permanent tooth)	**Adolescent with Permanent Dentition** (prior to eruption of third molars)	**Adult Dentate and Partially Edentulous**	**Adult Edentulous**
Recall patient* with periodontal disease	Clinical judgment as to the need for and type of radiographic images for the evaluation of periodontal disease. Imaging may consist of, but is not limited to, selected bitewing and/or periapical images of areas where periodontal disease (other than nonspecific gingivitis) can be identified clinically.				Not applicable
Patient for monitoring of growth and development	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development		Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development. Panoramic or periapical exam to assess developing third molars	Usually not indicated	
Patient with other circumstances including, but not limited to, proposed or existing implants, pathology, restorative/endodontic needs, treated periodontal disease and caries remineralization	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring in these circumstances.				

***Clinical situations for which radiographs may be indicated include but are not limited to:**

A. Positive Historical Findings

1. Previous periodontal or endodontic treatment
2. History of pain or trauma
3. Familial history of dental anomalies
4. Postoperative evaluation of healing

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5. Remineralization monitoring
6. Presence of implants or evaluation for implant placement

B. Positive Clinical Signs/Symptoms

1. Clinical evidence of periodontal disease
2. Large or deep restorations
3. Deep carious lesions
4. Malposed or clinically impacted teeth
5. Swelling
6. Evidence of dental/facial trauma
7. Mobility of teeth
8. Sinus tract ("fistula")
9. Clinically suspected sinus pathology
10. Growth abnormalities
11. Oral involvement in known or suspected systemic disease
12. Positive neurologic findings in the head and neck
13. Evidence of foreign objects
14. Pain and/or dysfunction of the temporomandibular joint
15. Facial asymmetry
16. Abutment teeth for fixed or removable partial prosthesis
17. Unexplained bleeding
18. Unexplained sensitivity of teeth
19. Unusual eruption, spacing or migration of teeth
20. Unusual tooth morphology, calcification or color
21. Unexplained absence of teeth
22. Clinical erosion

****Factors increasing risk for caries may include but are not limited to:**

1. High level of caries experience or demineralization
2. History of recurrent caries
3. High titers of cariogenic bacteria
4. Existing restoration(s) of poor quality
5. Poor oral hygiene
6. Inadequate fluoride exposure
7. Prolonged nursing (bottle or breast)
8. Frequent high sucrose content in diet
9. Poor family dental health
10. Developmental or acquired enamel defects

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11. Developmental or acquired disability
12. Xerostomia
13. Genetic abnormality of teeth
14. Many multisurface restorations
15. Chemo/radiation therapy
16. Eating disorders
17. Drug/alcohol abuse
18. Irregular dental care

Document created: November 2004

Women's Health Program

O.1 Guidelines for Women's Health Program Family Planning Providers

HHSC implemented a new family planning program, the Women's Health Program (WHP), in January 2007. The program was authorized by the 79th Texas Legislature in 2005. The Centers for Medicare & Medicaid Services (CMS) granted HHSC a demonstration waiver to operate WHP from January 1, 2007 through December 31, 2011. The goal of the program is to expand access to family planning services to reduce unintended pregnancies in the eligible population. WHP participants receive a limited, family planning benefit that supports the goal of the program. WHP participants do not have access to full Medicaid coverage

WHP provides an annual family planning exam, family planning services, and contraception to women 18 to 44 years of age who are United States citizens or eligible immigrants and Texas residents with a net family income at or below 185 percent of the Federal Poverty Level.

Family planning services are provided by a physician or under physician direction, not necessarily personal supervision. A physician provides direction for family planning services through written standing delegation orders and medical protocols. The physician is not required to be on the premises for the provision of family planning services by a registered nurse (RN), physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS). WHP participants may receive services from any provider that participates in the WHP.

Family planning clients must be allowed freedom of choice in the selection of contraceptive methods as medically appropriate. They must also be allowed the freedom to accept or reject services without coercion. All Food and Drug Administration (FDA) approved methods of contraception must be made available to the client, either directly or by referral to another provider of contraceptive services. Services must be provided without regard to age, marital status, sex, race/ethnicity, parenthood, handicap, religion, national origin, or contraceptive preference. Only family planning clients, not their parents, spouses, or any other individuals may consent to the provision of family planning services funded by Title XIX.

O.2 Provider Enrollment

Providers who may bill family planning services under the WHP include: physician, NP, CNS, PA, certified nurse-midwives (CNMs), federally qualified health center (FQHC), or family planning agency.

To be considered for reimbursement, providers who render noninstitutional professional services billed on a CMS-1500 or Family Planning (FP) 2017 claim to WHP clients must be enrolled in the Texas Medicaid Program as professional service providers. HHSC limits referrals of WHP clients for primary care only to providers who do not perform or promote elective abortions, or do not contract or affiliate with entities that perform or promote elective abortions.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

"Title XIX Enrollment" on page 20-3.

O.3 Reimbursement

WHP noninstitutional professional services are covered by the Texas Medicaid Program (Title XIX) and considered for payment on an existing reimbursement schedule based on provider type. Services are also on a fee-for-service basis, even in areas with managed care.

FQHCs are paid according to the existing prospective payment system (PPS). Up to three encounter rates per calendar year per client may be reimbursed to FQHCs for WHP visits when only family planning services occurred during the visit. To obtain the encounter rate, FQHCs must bill family planning services provided during a WHP visit using one of the following procedure codes: 1-99204 with modifier FP, 1-99214 with modifier FP, or 1-J7300. These procedure codes must be submitted in conjunction with the most appropriate informational procedure codes for services that were rendered.

For any family planning service other than an intrauterine device or an annual exam with a new patient, FQHCs should bill code 1-99214 with modifier FP with the claim so FQHCs can receive an encounter rate reimbursement. This includes family planning services that are not annual exams and visits where only a contraceptive injection is provided. FQHCs are only reimbursed for procedure codes 1-99204, 1-99214, and 1-J7300. All other procedure codes are marked as "informational." Procedure codes 1-99204 and 1-99214 must be billed with modifier FP.

Hospital-based ambulatory surgical centers and free-standing ambulatory surgical centers may be reimbursed for procedure codes F-58600, F-58615, F-58670, and F-58671.

0.4 Benefits and Limitations

0.4.1 Diagnosis Codes

Providers should use one of the following diagnosis codes in conjunction with all procedures and services. The choice of diagnosis code should be based on the type of family planning service performed.

Diagnosis Codes				
V2501	V2502	V2509	V251	V252
V2540	V2541	V2542	V2543	V2549
V255	V258	V259	V615	V2651
V4551	V4559			

0.4.2 Procedure Codes

The procedure codes listed are authorized for family planning billing. Use only the codes listed. Failure to do so may result in claim denials.

Refer to: "Procedure Codes and Reimbursement Amounts" on page 20-7

0.4.2.1 Family Planning Annual Exams

Procedure code 1-99204 or 1-99214 with modifier FP and WHP diagnosis consists of a comprehensive health history and physical examination, including medical laboratory evaluations as indicated, an assessment of the client's problems and needs, and the implementation of an appropriate contraceptive management plan. The annual exam is allowed once per year, per client, per provider. Subsequent visits within the same year must be billed as an office visit or other outpatient visit.

Procedure Code	Fee for Physicians	Fee for Family Planning Clinics
1-99204 with FP modifier	Clients 20 years of age and younger: $90.07 Clients 21 years of age and older: $81.24	$70.64
1-99214 with FP modifier	Clients 20 years of age and younger: $52.86 Clients 21 years of age and older: $47.68	$41.46

0.4.2.2 Office or Other Outpatient Visit

Providers may use the following procedure codes with modifier FP and a WHP diagnosis for other family planning office or outpatient visits:

Procedure Codes				
1-99201	1-99202	1-99203	1-99205	1-99211
1-99212	1-99213	1-99215		

The above procedure codes are allowed for routine contraceptive surveillance, family planning counseling and education, contraceptive problems, suspicion of pregnancy, genitourinary infections, and evaluation of other reproductive system symptoms. Depending on the extent of the services provided during the office visit, providers may bill for the maximum allowable fees.

Procedure Code	Fee for Pysicians, Clients 20 yrs. and Younger	Fee for Pysicians, Clients 21 yrs. and Older
1-99201	$28.87	$26.04
1-99202	$45.56	$41.09
1-99203	$61.56	$55.52
1-99205	$111.98	$101.00
1-99211 FP	$14.96	$13.49
1-99212 FP	$25.04	$22.59
1-99213 FP	$37.64	$33.95
1-99215 FP	$81.38	$73.40

During any visit for a medical problem or follow-up visit the following must occur:

- An update of the client's relevant history.
- Physical exam, if indicated.
- Laboratory tests, if indicated.
- Treatment or referral, if indicated.
- Education/counseling or referral, if indicated.
- Scheduling of office or clinic visit if indicated.

0.4.2.3 Laboratory Services

Medicaid family planning service providers must document all laboratory services ordered in the client's medical record as medically necessary and reference an appropriate diagnosis. Any test specimen sent to a laboratory for interpretation should not be billed on the family planning provider's claim. The laboratory bills the Texas Medicaid Program directly for the tests the laboratory performs.

All providers of laboratory services must comply with the rules and regulations of the *Clinical Laboratory Improvement Amendments* (CLIA). Providers not complying with CLIA will not be reimbursed for laboratory services. Only the office or lab actually performing the laboratory test procedure and holding the appropriate CLIA certificate may bill for the procedure.

A provider that does not perform the laboratory procedure may be reimbursed one lab-handling fee per day, per client, unless multiple specimens are obtained and sent to different laboratories. Procedure code 1-99000 with modifier FP is paid for handling and/or conveyance of the specimen for transfer from the physician's office to a laboratory.

Handling fees are not paid for Pap smears or cultures. When billing for Pap smear interpretations, the claim must indicate that the screening and interpretation were actually performed in the office (place of service [POS] 1) by using the modifier SU, Procedure performed in physician's office (e.g., 5-88150-SU).

Providers must forward the client's name, address, Medicaid number, and a family planning diagnosis with any specimen, including Pap smears, to the reference laboratory so the laboratory may bill the WHP for its family planning lab services.

When family planning test specimens, such as Pap smears, are collected, providers must direct the laboratory to indicate that the claim for the test is to be billed as a family planning service (i.e., procedure must be billed with a WHP diagnosis).

The following is a list of laboratory procedures and reimbursement amounts authorized for billing by Title XIX family planning service providers with appropriate documentation in the client record. This list is not all-inclusive:

Procedure Code	Fee for Physicians
5-80061	$18.51
5-81000	$4.37
5-81001	$4.37
5-81002	$3.54
5-81003	$3.10
5-81015	$4.20
5-81025	$8.74
5-82947	$5.42
5-82948	$4.37
5-84702	$12.07
5-84703	$10.38
5-85013	$3.27
5-85014	$3.27
5-85018	$3.27
5-85025	$10.74
5-85027	$8.95
5-86318	$17.89
5-86580	$7.36
5-86592	$5.90
5-86689	$26.75
5-86701	$12.28
5-86703	$18.96
5-86762	$19.89
5-86803	$19.73
5-86900	$4.12
5-86901	$9.27
I-86901	$9.27
5-87070	$11.90
5-87086	$11.16
5-87088	$11.18
5-87102	$11.61
5-87110	$27.08
5-87205	$5.90
5-87210	$5.90
5-87220	$5.90
5-87340	$14.27
5-87480	$27.71
5-87490	$27.71
5-87491	$48.50
5-87510	$27.71
5-87590	$27.71
5-87591	$48.50
5-87621	$48.50
5-87660	$27.71
5-87797	$27.71
5-87800	$27.71
5-87810	$16.58
5-87850	$16.58
I-88141	Clients 20 years of age and younger: $22.34 Clients 21 years of age and older: $21.28
5-88142	$25.00
5-88150	$14.60
5-88164	$7.50
5-88175	$37.01
5-Q0111	$5.90

Procedure code 5-87797 will be denied if submitted for the same date of service as procedure code 5-87800. Providers are reminded to code to the highest level of specificity with a diagnosis to support medical necessity when submitting procedure code 5-87797. Claims may be subject to retrospective review if they are submitted with diagnosis codes that do not support medical necessity.

If more than one of procedure codes 5-87480, 5-87510, 5-87660, or 5-87800 is submitted by the same provider for the same client with the same date of service, all of the procedure codes will be denied.

Procedure codes 5-87480, 5-87510, 5-87660, 5-87797, and 5-87800 are not payable in the inpatient hospital setting.

0.4.2.4 Contraceptive Devices and Related Procedures

Procedure Code	Fee for Physicians
2-57170	Clients 20 years of age and younger:$38.00 Clients 21 years of age and older: $45.25
2-58300	Clients 20 years of age and younger: $72.45 Clients 21 years of age and older: $69.00
2-58301	$70.45
9-A4261	$24.22
9-A4266	$10.01
1-J7300	$403.75
1-J7302	$420.48
1-J7303	$40.65
1-J7304	$15.36

Procedure codes 1-J7300 or 1-J7302 must be billed with 2-58300 on the same date of service for both the insertion and the device to be reimbursed.

Procedure code 2-58300 may be considered for reimbursement when submitted with the same date of service as an office visit. Procedure code 2-58301 will not be considered for reimbursement if it is submitted with the same date of service as an office visit.

0.4.2.5 Radiology

Procedure Code	Fee for Physicians
4-74000	$22.91
I-74000	$7.64
T-74000	$15.27
4-74010	$27.00
I-74010	$10.09
T-74010	$16.91
4-76830	$74.74
I-76830	$30.28
T-76830	$44.46

Procedure code 4/I/T-76830 should be used for the purpose of localization of an intrauterine device.

0.4.2.6 Drugs and Supplies

The only prescription drugs covered under the WHP are contraceptives. Family planning providers can either dispense family planning drugs and supplies directly to the client and bill TMHP, or give clients prescriptions to take to a pharmacy. Family planning drugs and supplies that are dispensed directly to the client are billed to TMHP. Pharmacies under the Vendor Drug Program are allowed to fill the prescription for up to six months at a time, rather than a one-month supply.

The following procedure codes are payable for WHP:

Procedure Code	Fee
1-A4267	$0.22
1-A4268	$2.00
1-A4269	$4.00
1-J1055	$53.48
1-S4993*	$2.80

*** Code not payable to physicians.**

0.4.2.7 Instruction in Natural Family Planning Methods (Per Session)

Procedure code 1-H1010 is intended to instruct a couple or an individual in methods of natural family planning and may consist of two sessions. Each session may be billed separately or the two sessions may be billed together with a total charge for both sessions

0.4.3 Sterilization and Sterilization-Related Procedures

Sterilization services are a benefit when billed by an agency, an FQHC, or physician. Physicians must use the most appropriate Current Procedural Terminology (CPT) procedure code for payment.

Sterilizations are considered to be permanent, once-per-lifetime procedures. When a client's claim history shows a previous sterilization, providers will be asked to appeal and must provide supporting documentation for the need for repeat sterilization. *Per 42* Code of Federal Regulations *(CFR) 50, Subpart B, all sterilization procedures require an approved Sterilization Consent Form.*

Sterilization Consent Form Instructions

Clients must be *at least 21 years of age* when the consent form is signed. If the client was not 21 years of age when the consent form was signed, the consent will be denied. Changing signature dates is considered fraudulent and will be reported to the Office of the Inspector General (OIG).

Listed below are field descriptions for the Sterilization Consent Form published in this manual. Completion of *all* sections is required to validate the consent form, with only two exceptions:

- Race and ethnicity designation is requested but not required.
- The Interpreter's Statement is not required as long as the consent form is written in the client's language, or the person obtaining the consent speaks the client's language. However, if this section is only partially completed, the consent will not be accepted as a valid consent.

This Sterilization Consent Form may be copied for provider use. Providers are encouraged to frequently recopy the original form to ensure legible copies and to expedite consent validation. Fax fully completed Sterilization Consent Forms to TMHP at 1-512-514-4229.

Required Fields

All of the fields must be legible in order for the consent form to be valid. Any illegible field will result in a denial of the submitted consent form. Resubmission of legible information must be indicated on the consent form itself. Resubmission with information indicated on a cover page or letter will not be accepted.

Consent to Sterilization

- Name of Doctor or Clinic.
- Name of the Sterilization Operation.
- Client's Date of Birth (month, day, year).
- Client's Name [First and last names are required. This name should match the other client name fields on this form as well as on the associated claim(s)].
- Name of Doctor or Clinic.
- Name of the Sterilization Operation.
- Client's Signature.
- Date of Client Signature.
- Client must be at least 21 years of age on this date. This date cannot be altered or added at a later date.

Interpreter's Statement (If applicable)

- Name of Language Used by Interpreter.
- Interpreter's Signature.
- Date of Interpreter's Signature (month, day, year).

Statement of Person Obtaining Consent

- Client's Name (first and last names are required).
- Name of the Sterilization Operation.
- Signature of Person Obtaining Consent – The statement of person obtaining consent must be completed by the person who explains the surgery and its implications and alternate methods of birth control. The signature of person obtaining consent must be completed at the time the consent is obtained. The signature must be an original signature, not a rubber stamp.
- Date of the Person Obtaining Consent's Signature (month, day, year) – Must be the same date as the client's signature date.
- Facility Name – Clinic/office where the client received the sterilization information.
- Facility Address – Clinic/office where the client received the sterilization information.

Physician's Statement

- Client's Name (first and last names are required).
- Date of Sterilization Procedure (month, day, year) – Must be at least 30 days and no more than 180 days from the date of the client's consent except in cases of premature delivery or emergency abdominal surgery.
- Name of the Sterilization Operation.
- Expected Date of Delivery (EDD) – Required when there are less than 30 days between the date of the client consent and date of surgery. Client's signature date must be at least 30 days prior to EDD.
- Circumstances of Emergency Surgery – Operative report(s) detailing the need for emergency abdominal surgery are required.
- Physician's Signature – Stamped or computer-generated signatures are not acceptable.
- Date of Physician's Signature (month, day, year) – This date must be on or after the date of surgery.

Paperwork Reduction Act Statement.

This is a required statement and must be included on every Sterilization Consent Form submitted.

Additional Required Fields

- Medicaid or Family Planning Number.
- Date Client Signed the Consent (month, day, year).
- Provider identifier – Including the nine-digit provider identification number will expedite the processing of the consent form.
- Provider/Clinic Phone Number.
- Provider/Clinic Fax Number (If available).
- Family Planning Title for Client – Indicate by circling XIX (Medicaid).

Tubal Ligation

Tubal ligation is a benefit of the WHP. The provider should use the most appropriate procedure code when billing for tubal ligation.

Procedure Code	Fee for Physicians
1-58600	Not a benefit
2-58600	$728.77
8-58600	$116.60
2-58611	$301.46
8-58611	$48.23
2-58615	$635.39
8-58615	$101.66
2-58670	$584.64
2-58671	$599.87

Anesthesia for Sterilization

Use procedure code 7-00851 modifier FP when reporting anesthesia services for a sterilization procedure. Procedure code 7-00851 is reimbursed at $139.32 for clients 20 years of age and younger, and $117.48 for clients 21 years of age and older.

0.4.4 Eligibility Verification

The WHP Medicaid Identification card (Form H3087) visibly indicates the program in the black box in the upper right area of the card. The card also contains a notice to providers that WHP-covered services are limited to an annual visit and exam and contraception, except emergency contraception. Client eligibility may be verified using the following sources:

- www.tmhp.com.
- Automated Inquiry System (AIS).

- TDHconnect.

Refer to: "Eligibility Verification" on page 4-4 for additional information.

WHP clients will have the following identifiers on the feedback received from the stated source:

- Medicaid Coverage: W – MA – WHP.
- Program Type: 68 – MEDICAL ASISTANCE – WOMEN'S HEALTH PR.
- Program: 100 – MEDICAID.
- Benefit Plan: 100 – Traditional Medicaid.

Providers must verify if a woman has been certified for the WHP prior to billing, or the claim may be denied. If a claim is denied prior to certification, providers can resubmit claims once a woman is certified.

0.5 WHP Claim Billing

0.5.1 WHP and Third Party Insurance

Federal and state regulations mandate that family planning client information be kept confidential. Because seeking information from third-party insurance resources may jeopardize the client's confidentiality, third-party billing for WHP is not allowed.

0.5.2 Claims Information

Providers must bill for WHP services on the appropriate claim form based on their provider type.

FQHCs may use either the UB-04 CMS-1450 or the Family Planning 2017 claim form to bill family planning Medicaid services. However, if an FQHC also contracts with DSHS to provide Titles V, X, or XX family planning services, the Family Planning 2017 claim form/format must be used to submit all family planning claims, including Title XIX family planning claims.

Family planning agencies that also contract with DSHS for Title V, X, or XX must bill in an approved electronic format or on the Family Planning Claim Form 2017 with the indication of Title XIX. Medicaid family planning providers who do not also contract with DSHS for Title V, X, or XX, may use either the Family Planning 2017 claim form or the CMS-1500 claim form.

All other providers are encouraged to use the Family Planning Claim Form 2017. Providers may copy the Family Planning 2017 claim form provided in this manual on page 5-47 or download it from the TMHP website at www.tmhp.com.

Providers may purchase UB-04 CMS-1450 or CMS-1500 claim forms from the provider of their choice. TMHP does not supply the forms.

When completing a UB-04 CMS-1450 or CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 (EDI)" for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"UB-04 CMS-1450 Claim Filing Instructions" on page 5-30 for instructions on completing UB-04 CMS-1450 paper claims.

"CMS-1500 Claim Filing Instructions" on page 5-22 for instructions on completing CMS-1500 paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Providers can call the TMHP Contact Center at 1-800-925-9126 for provider inquiries regarding family planning services, such as reimbursement rates, procedures, or claims filing questions.

0.5.2.1 Filing Deadlines

The filing deadline for Title XIX claims is 95 days from the date of service on the claim or from the "add date," which is the date the eligibility is received and added to the TMHP eligibility file. Appeals may be submitted 120 days from the date of the R&S report on which the claim reached a finalized status.

Note: *If the filing deadline falls on a weekend or holiday, the filing deadline is extended until the next business day*

0.5.2.2 Claims Appeals

An appeal is a request for reconsideration of a previously dispositioned claim.

Providers may use two methods to appeal WHP claims to TMHP: electronic or paper.

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

Refer to: "Appeals" on page 6-1 for more information.

0.5.3 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
TMHP Claims Submission	5-10
Family Planning 2017 Claim Form	5-49
Family Planning 2017 Claim For Filing Instructions	5-49
Communication Guide	A-1
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